AN INTERSUBJECTIVE PERSPECTIVE ON THE ROLE OF PERSONAL THERAPY IN BEING A PSYCHOTHERAPIST

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ABSTRACT

The purpose of this study was to explore how personal therapy influences experienced psychodynamic psychotherapists’ ways of being clinicians, and, by implication, their professional development. A hermeneutic research method, which also drew upon aspects of grounded theory methodology, was therefore devised to explore and examine how personal therapy and professional practice relate to each other and to the therapist’s development, and to deepen this descriptive account into a more differentiated and theoretically viable understanding. In-depth, semi-structured interviews were conducted with eight psychodynamic psychotherapists who were working as clinicians and who were concurrently in therapy. Keeping the research objective in mind, a list of questions was developed from the interview material through which the data was re-read and edited. In accordance with the aims of the study, and as suggested by the results of the initial phase of the textual analysis, intersubjective theory, mainly that of Jessica Benjamin, was used to generate a conceptual framework through which the interview material was further interpreted. This foregrounded the shifting power distributions and the varying processes of identification between the treating therapists and the participants. The Jungian notion of the wounded healer was intersubjectively reconfigured as indicating a therapist whose (often unacknowledged) needs and vulnerabilities engender a proclivity to relate to patients as objects rather than subjects. The participants could all be described as having started out their professional lives as wounded healers. The effects of personal therapy on their clinical work were conceptualised in terms of increased abilities for subject-to-subject relating. These were linked to augmented capacities for reflective and symbolic thinking and an enhanced openness to the implicit, unformulated and opaque aspects of experiences in the therapeutic space. Finally an intersubjective model of personal therapy and development as a therapist was generated. It was concluded that because of the focus on the therapeutic relationship as the vehicle for change in psychodynamic psychotherapy, as well as the current increasing emphasis on the use of the therapist’s subjectivity, the therapist’s capacity to engage in and sustain subject-to-subject relating and, by implication, the therapist’s personal therapy, are of pivotal importance for all therapists doing the work of psychodynamic psychotherapy.
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But where and how is the poor wretch to acquire the ideal qualifications which he will need in his profession? The answer is, in an analysis of himself, with which his preparation for his future activity begins.

(Freud, 1937, p. 248)

But to develop, it is necessary to liberate ourselves from our parents, our analysts, and our teachers.

(Klauber, 1981, p. xxi)
CHAPTER ONE

INTRODUCTION

1.1 PROLOGUE

This research marks both the beginning and the end of a personal journey. It began years ago when I first trained as a clinical psychologist. I trained at a university where at that time the student's own therapy was not seen as being a part of the training. It was, in fact, frowned upon as indicative of serious emotional problems, and the general consensus among students was that if one was in therapy, that would probably compromise one’s chances of being admitted to the course.

When starting out as a psychotherapist, I was aware that I was struggling to keep to my “brief” to “be genuine, to have unconditional positive regard for patients” and to communicate my “accurate” understanding of patients’ experiences to them in an empathic way (Rogers, 1957). Being “genuine” and having “unconditional positive regard” were often quite incompatible and “accurate” understanding was always dubious. There was also the rather unrealistic and unhelpful idea that the therapist’s feelings and values should not impinge on or impede the process of therapy. But there were feelings - patients’ and mine - getting entangled and messy, for which I had neither a conceptual framework nor the emotional resources. Although matters improved as I became more experienced as a therapist, I was always aware of some lack in my understanding and thinking, of not being able to go far or deep enough.

And so my wanderings into and disillusionment with different theoretical paradigms began. It ended when I came into contact with the South African Institute for Psychotherapy and commenced the Diploma in Psychoanalytic Psychotherapy. One of the course requirements was personal psychotherapy.

The course and the therapy opened up a rich world of possibilities. Of course the theoretical input was also important, and went hand-in-hand with the therapy and supervision. As far as the therapy went, I realised that there was a whole dimension of experience and understanding that I had never known before. I also came to recognise in a very real way how handicapped I had been as a clinician in not having started working with at least some therapy behind me, to make theory alive in the therapy room and also to be more receptive to and have a clearer way of thinking about what actually happens in therapy. Through having my own therapy, I came to know the therapist’s self-understanding as an essential aspect of the paradoxical therapeutic task of being both willing and
able to be thrown into sensing and experiencing that which occurs between therapist and patient, while remaining able to reflect upon and to conceptualise that which is experienced.

In working as a psychotherapist and being in my own therapy, I was struck by the intricate intermingling of those two sets of experiences. Sometimes the dyad of therapist and patient in my consulting room became a triad. Unexpectedly and without necessarily being thought of, my therapist would enter and become a vital third presence in the form of his words, his ways of thinking and his interpretations. He would support and guide me at precarious moments and be critical when I made mistakes. His failures became warnings and reminders of what not do in my work. As I got to know my own vulnerabilities and what being in therapy is like, my patients became others like me, rather than being those who are injured, weak and cannot cope with life’s vicissitudes.

I took these altered experiences of being-a-therapist back to my own therapy to explore. I wondered how this apparent conflation of therapists and therapeutic spaces worked and how it all fitted together, but I could never quite unravel the strange and baffling mixture of therapy and therapy, of being in personal therapy and doing the work of therapy. Reading about and around the topic of therapists’ own therapies and asking colleagues questions about their own therapies, and about being therapist-patients and therapists, only added to my curiosity. So this research journey got on its way inadvertently and almost unnoticed.

At present I no longer idealise the therapist’s personal therapy. It is only part of the process and work of being an accountable and (I hope) an effective therapist and it can only take one so far. Therapy may (as I know from both my own experiences and from colleagues’ accounts of their own therapies), even when the patient is a psychotherapist, at times be an indifferent or negative and even harmful experience. Taking all of this into account, I still believe the therapist’s own therapy to be an essential aspect of being-a-clinician. This is certainly true for the beginning therapist and while therapists may not need to be in “interminable” (Freud, 1937) therapy, they do need to be in therapy for a significant part of their professional lives.

So I do not come to this research taking a “neutral” or “objective” stance on this issue; that is, I am not debating the question whether or not personal therapy should be a part of training as a psychotherapist and if it is a necessary part of being a therapist. My interest rather lies in gaining
some understanding of what happens when a therapist is actually in therapy and how this influences and changes his being-a-therapist.

Personal therapy and the linked changes of working as a clinician produce a somewhat different picture at a later phase in the psychotherapist’s professional life than when the therapist is a trainee or a novice. Although I certainly consider therapy to be an indispensable part of the initial training, my questions about personal therapy rather concern how it affects being-a-therapist in a more ongoing way and when the therapist is past the first flush of initial training or being a novice therapist.

1.2 PERSONAL THERAPY AND THE PRACTICE OF PSYCHODYNAMIC PSYCHOTHERAPY IN SOUTH AFRICA

For the purposes of this study the term “psychodynamic psychotherapy” is understood as encompassing a variety of therapies where the focus of work and possibility for change are to be found in the therapeutic relationship, that is, in the transference-countertransference matrix. Psychodynamic psychotherapy includes some version of the notion of there being unconscious aspects of human existence, that is, Freud’s (1917, p. 143) decentring from the illusion that “the ego … is master in its own house”. While there is a fundamental premise that understanding the unconscious meaning of human mental activity offers a powerful potential for change (Stokoe, 2000), there is also an acknowledgement that what is unconscious is by definition “outside conscious awareness and control” (Flax, 1993, p. 96) and that such an understanding will consequently always be partial and provisional (Flax, 1994).

Rather than being marked by specific techniques, psychodynamic therapies are underpinned by a sensibility, an attitudinal stance that the therapist brings to his work. Ivey (1999, p. 4) writes about this “analytic attitude” as being “a deeply-rooted, coherent, professional mind-set that incorporates philosophical, ideological, psychological and ethical concerns”. “Rules” and “techniques” are subordinate to the analytic attitude and may be conceptualised as its concrete and lived expression.

1 When the flow of the sentence allows it, I have used “his or her” and “he or she”. When this has seemed too clumsy, I have used “he” or “his” in the generic sense; that is, it is not a reflection of an insensitivity to the possibility of bias, but is done to facilitate ease of reading.
2 Psychoanalysis “proper” and psychodynamic psychotherapy (which has its origins in psychoanalysis) are not separate paradigms, but overlap and exist on a continuum. Their fundamental assumptions and thought about the work of therapy are not significantly different. Differences rather lie in intensity and emphasis. Psychoanalysis takes place three to five times a week lying down on the couch and there is a greater prominence given to the role of insight and interpretation (especially of the transference) in bringing about change. Psychodynamic psychotherapy is possible with sessions once or twice a week, lying on the couch or face-to-face. There is also sometimes more of an emphasis on the supportive elements of therapy (Prochaska & Norcross, 1999).
3 I shall use the terms “therapy” and “analysis”, as well as “therapist” and “analyst” interchangeably.
in the therapy room. The analytic attitude extends into and is related to the analytic task, process and setting. The task of psychodynamic psychotherapy is “to facilitate a greater degree of psychological freedom though the insightful resolution of unconscious conflicts” and the process is the unfolding of this task over time (Ibid.). The analytic setting or “frame” (Langs, 1982) has to do with the therapist’s provision of the “literal and metaphorical” space in which the work of therapy is possible and may be safely contained (Ivey, 1999, p. 5).

The historical origins of the idea that the psychodynamic psychotherapist’s personal therapy is a necessary experience in becoming and in continuing to be a competent clinician can be traced to the beginning phases of the psychoanalytic and Jungian movements. Within the confines of these paradigms a personal analysis or training analysis is, together with supervision and academic requirements, presently still considered a pivotal and compulsory aspect of training (Sinason, 1999; Kirsch, 2000). In the wider psychotherapeutic culture, personal therapy for therapists is a much more controversial issue: the importance attached to it tends to “vary according to personal belief and theoretical orientation”, but within the domain of psychodynamic therapy it is seen as desirable and necessary (Macran & Shapiro, 1998, p. 13).

While surveys indicate that in the United States and the United Kingdom “between two-thirds and three-fourths of therapists” have had personal therapy (Macran, Smith & Stiles, 1999, p. 419), such information is not available on South African psychotherapists. Personal therapy is not stipulated as either an entry or a training requirement in the training of clinical psychologists (who form the greater part of the population of psychotherapists in this country) at South African universities, but those universities with psychodynamic orientations (estimated at five in number) encourage their students to have personal therapy and may even facilitate this process (Malcolm, 2001).

Nevertheless, even if initial training may make them aware of the fundamentals of psychodynamic psychotherapy and may sometimes contribute towards their initial development as therapists, all clinical psychologists are not psychodynamic therapists. Being a psychologist, even a clinical psychologist, also does not necessarily imply being a competent psychotherapist.

According to Ivey (1992, p. 31), humanistic and cognitive orientations lack an emphasis on the “transference-countertransference dimension of therapeutic relating”. In 1992 he (Ivey, Ibid.) contended that there was a predominance of humanistic and cognitive orientations within psychology departments at South African academic institutions and that this was largely responsible for fostering a specific and problematic aspect of “countertransference pathology”
commonly found among South African psychologists. He (Ivey, Ibid.) ascribed this negative therapist attribute to the psychologist/psychotherapist’s unworked-through proclivity towards enacting his own unconscious and unacknowledged needs and desires, which leads to his claiming the space of therapy for himself while ostensibly yielding it to the patient. Although this is a problem that most psychotherapists sometimes grapple with, it would certainly be exacerbated if its non-recognition were not just personal, but also institutionalised. Adherence to a theoretical model that does recognise the existence and meaning of transference and countertransference, and, by implication, the importance of supervision and, especially, that of therapy, may not eradicate such countertransference enactments, but they do provide a means of addressing such a potentially iatrogenic aspect of being-a-therapist and of transforming it into a useful part of the therapeutic process.

However, in considering the above, it has to be taken into account that Ivey wrote from a strictly psychoanalytic/object-relations viewpoint. He also did not actually research either the question of the specific theoretical paradigms adhered to by psychology departments at South African universities or that of how this may relate to countertransference problems and enactments among South African psychologists. Since what may one call Ivey’s unresearched and speculative opinion, nobody else has researched these pertinent issues. Further research would certainly be valuable to explore and clarify these matters, since Ivey expresses a viewpoint which was and still is probably held by the majority of South African psychologists who practise psychodynamic psychotherapy, and which may or may not be true.

In South Africa psychodynamic psychotherapy is also practised by members of other professional groups, for example, by social workers, psychiatrists, ministers of religion, and so forth. As Milton (2000, p. 75) points out: “Psychotherapy, by rights, is the domain of psychotherapists - who may or may not be psychologists … Psychology, in fact, came late in the day to the practice of psychotherapy.” Getting an idea of the actual practice of psychodynamic psychotherapy in South Africa and of how the individual psychotherapist may equip himself sufficiently to practise responsibly and competently under the auspices of the analytic attitude, accordingly requires going beyond the entry into and confines of any of these professions.

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4 “This thesis is based on the alarmingly high incidence of informal reports, from both psychotherapy patients and fellow clinical psychologists, of questionable behaviour by practising clinicians and counselling psychologists” (Ivey, 1992, p. 37).

5 I am only describing the situation and am deliberately avoiding becoming entangled in the quagmire of debates about whether a specific professional group is or is not competent and qualified, and should or should not be legally sanctioned to practise psychotherapy.
Specialised post-qualification training in in-depth psychodynamic psychotherapy is presently
developing in South Africa and is being offered by a range of centres, institutes and various
professional groups that could be broadly described as being engaged in furthering education and
training in psychodynamic in-depth therapy (SAFPP, 2001). These all support the necessity of
personal therapy for therapists. While there is currently no formal psychoanalytic training available
in South Africa, the Southern African Association of Jungian Analysts (SAAJA) provides a Cape
Town-based accredited training for Jungian analysts. In Cape Town there are also, for example, the
Cape Town Society for Psychoanalytic Psychotherapy (CTSPP), the South African Institute for
Psychotherapy (SAIP), and the Self-Psychology Group. These groups all provide workshops,
courses and meetings that support the development of theoretical and clinical knowledge. In
addition, the members are required to have had a certain amount of personal therapy. Among the
members there is also an underlying assumption that being a psychotherapist in a responsible way
means that even if the therapist does not have therapy or supervision on an ongoing basis (which is
seen as being optimal), these will be sought when necessary.

1.3 LITERATURE REVIEW: THE VALUE OF PERSONAL THERAPY FOR
PSYCHOTHERAPISTS

The necessity of personal analysis for those “who want to apply psychoanalytic technique” (Freud,
cf. Benedek, 1969, p. 437) had already been expressed by Freud in his 1910 discussion of
countertransference. While the idea that personal therapy should be a requisite aspect of becoming
a psychotherapist is traditionally attributed to Freud (1910, 1937), it was actually Jung who
instituted the practice of the training analysis while he was still a Freudian psychoanalyst (Freud,
1912; Freud & Ferenczi, 1994; Kirsch, 1995). Originally it was hoped that the training analysis
would enable the analyst to develop a spontaneous capacity for self-analysis (Beiser, 1984;
Chessick, 1990), but later Freud (1937) became more pessimistic about analysts’ abilities to engage
in self-analysis and “recommended periodic formal re-analysis for psychoanalysts every five years”
(Chessick, 1990, p. 312).

The training analysis purports to be a way to acquaint the would-be analyst with the nature of the
analytic process and to be “the most direct route to the analyst’s subjective apprehension of
psychoanalytic phenomena”, especially unconscious processes, resistance, transference and
countertransference (Meisels, 1990, p. 112). It is also seen as familiarising analysts with their own
unconscious and neurotic propensities, their unresolved anxieties and defences, and helps them to
deal with these (Chessick, 1990). These aims of personal analysis have also become part of the
rationale for personal therapy for psychodynamic psychotherapists.
Norcross, Strausser-Kirtland and Missar (1988, pp. 36-37) identify some of “the recurring commonalities in the literature” about the ways in which personal therapy is regarded as enhancing the therapist’s clinical work. Personal therapy “improves the emotional and mental functioning” of the psychotherapist and makes him more able to bear the “emotional stresses and burdens” inherent in doing the work of therapy. It deepens his understanding of “personal dynamics, interpersonal elicitations” and thus makes countertransference enactments less probable. Having his own experience of the “transformational power” of psychotherapy “establishes a sense of conviction about the validity of psychotherapy”. The experience of also being a patient facilitates empathy, as the therapist becomes sensitised “to the interpersonal reactions and needs” of their patients and more respectful of the difficulties and struggles of their patients. Personal therapy also provides an opportunity to observe the treating therapist at work and to use him as a model.

As far as actual research about personal therapy is concerned, surveys in the United States and the United Kingdom have indicated that the majority of psychotherapists in those countries have had therapy (mostly psychodynamic) (Macran & Shapiro, 1998). Macran and Shapiro (Ibid., p. 15) comment that although “a not insignificant minority” had negative therapy experiences (and some of those had still regarded therapy as necessary), therapy had mostly been a useful and helpful experience which had made the respondents more aware of the patient-therapist relationship, both on a personal level and as it pertained to the transference-countertransference dimension. Respondents had also reported that personal therapy had increased their tolerance, empathy and patience when working with patients (Ibid.).

As indicated by the most recent national survey in which 84% of the respondents reported having been in therapy, the United States appears to be the country where the highest number of therapists (in this case psychologists) have made use of personal therapy (Pope & Tabachnick, 1994). A recent international survey on therapists’ “current and career professional development” was conducted by Orlinsky and the Society for Psychotherapy Research (SPR) Collaborative Research Network (Orlinsky, Rinnestad, Ambühl, Willutzki, Botermans, Cierpka, Davis, & Davis, 1999, p. 203). About 3,900 therapists (who were not only psychologists) in about 17 countries (which did not include South Africa) participated in this. Although this varied from country to country, about 78% of the respondents indicated having had therapy (Wiseman & Shefler, 2001).

One of the interesting findings of this study was that that “the therapists’ sense of experienced growth did not decline as a function of years in practice, but remained at a generally high level, even among those who had been in practice for more than two decades” (Orlinsky et al., Ibid., p.
Orlinsky et al. (Ibid.) ask themselves whether this has been due to a “collective myth” of continuous “personal growth” among therapists, but decide against this explanation, because there was a significant degree of variation in currently experienced growth. They therefore make the hypothesis that “the therapists’ currently experienced growth reflects a renewal of the morale and motivation needed to practice therapy, a replenishment of the energy and refreshing of the acumen demanded by therapeutic work”. This “restoration” is needed “as a consequence of the continuous investment that therapists make in their work rather than as a result of their inexperience”. Orlinsky et al. (Ibid.) link this with what is denoted as “continuous professional reflection” (Skovholt & Rønnestad, 1995, p. 105). The importance of the therapist’s having a sustained “reflective stance” (Skovholt & Rønnestad, 1995, p. 107) foregrounds the importance of therapy in a more ongoing way, rather than just as pertaining to the trainee or inexperienced therapist.

Does having personal therapy result in therapists’ being more effective clinicians? The results of studies that attempt to determine the relationship between personal therapy and patient outcome are inconclusive. In reviewing the relevant literature, Clark (1986) and Greenberg and Staller (1981) found seven studies in which no indications of such a relationship could be found. Only two (Guild, 1969, cf. Greenberg & Staller, 1981; Kernberg, 1973) supported the notion that personal therapy increased therapist effectiveness. Unfortunately therapist experience was not factored out in the Kernberg study. A study by Garfield and Bergin (1971) with trainee therapists showed a negative relationship between personal therapy and patient outcome, but this may have been due to the therapists’ inexperience. The results of these studies therefore neither support nor are evidence against the notion that personal therapy has a significant positive effect on therapist efficacy. Beutler, Machado and Neufeld (1994) argue that therapists enter personal therapy for diverse reasons and the effects on therapist efficacy are thus also varied, so that no significant conclusions are possible.

There have also been some studies about the impact of personal therapy on aspects of the therapy process with patients. Some of the findings were that there were indications that personal therapy had some positive impact on empathy (Strupp, 1958); genuineness and empathy (Peebles, 1980); and countertransference awareness (MacDevitt, 1987). Wogan and Norcross (1985) found that therapists who had had personal therapy tended to place more emphasis on their relationships with patients, while those therapists who had had no therapy tended to highlight the use of techniques. On the other hand, Wheeler (1991, p. 193) found a negative relationship between the amount of personal therapy and the “measure of therapeutic alliance achieved”. The findings of these studies provide a measure of support for the notion that personal therapy is associated with the therapist’s
capacity to relate to the patient with genuineness, empathy and warmth (Rogers, 1957). However, as Macran and Shapiro (1998) point out, these studies suffer from methodological shortcomings such as small sample sizes and a lack of adequate controls, and their findings are therefore also inconclusive if evaluated in a logical positivist frame.

It is not surprising that these quantitative studies (especially the outcome and process ones) have such methodological problems and struggle to “measure” even aspects of the complex phenomenon constituted by the therapist’s therapy, his work, and the relationship between these two, and that their results are accordingly generally inconclusive. This seems to be an impossible task full of variables that cannot be “controlled” or “factored out”. It is also clear that if one really wants a meaningful and encompassing view of what it is that actually comes to pass in a therapist’s work when he is in personal therapy and how this happens, any quantitative study will fall woefully short in capturing the rich depth and intricate nuances of this complex phenomenon. There are certainly more useful questions than simply whether or not therapists’ personal therapies lead to greater therapist competence. Examples of those would be how the experience of concurrently being therapist and patient changes the therapist’s manner of working and influences his development as a professional. Such questions bring us into the domain of qualitative research, where very little has as yet been done.

In South Africa, Straker and Becker (1997) conducted a qualitative study with participants who were simultaneously therapists and patients. Their study concerned facets of what was experienced to be therapeutic in therapy by participants who were both therapists and patients, from the different perspectives of patient and therapist. They found being-a-patient and being-a-therapist to be different but related positions, but did not explore the complexities of the relationship between these.

There are only a few qualitative studies about how personal therapy affects therapists’ work as clinicians (Mackey & Mackey, 1993; Macran, Smith & Stiles, 1999; Wiseman & Shefler, 2001). The main findings of these studies are briefly stated and there will be more detailed references to their results in the later discussions of the interview material.

In Mackey and Mackey’s (1993, p. 101) study of the value of personal psychotherapy to clinical practice, the data yielded three themes:

1. “[T]he therapist as model” (that is, identification with the therapist).
2. “[U]nderstanding the therapeutic process”.

9
Integrating the professional and personal aspects of life.

In conceptualising the results of their multiple case study on the effects of personal therapy on therapists’ practice, Macran, Smith and Stiles (1999) found twelve themes emerging from their analysis of the interviews. They further organised these themes into three broader domains, which were not totally separate or independent (Macran, Smith, & Stiles, 1999, p. 429):

1. “Orienting to the therapist: humanity, power, boundaries” they see as concerning “the therapist as a person and as a social role”.
2. “Orienting to the client: trust, respect, patience” as pertaining to the “therapist’s attitude towards the client and the consequences of this attitude for the client’s attitude towards himself”.
3. “Listening with the third ear” as relating to “the understanding of communications and meanings that go beyond the denotation of spoken words”; that is, at a deeper and more unconscious level.

Wiseman and Shefler (2001) did a multiple case study about psychoanalytically oriented therapists’ narrative accounts of their personal therapies and the impacts of these on professional and personal development. They (Ibid., p. 140) identified the following domains (each containing a number of categories):

1. Importance of personal therapy for therapists: Past and current attitudes …
2. Impacts of personal therapy on the professional self: Identity …
3. Impacts of personal therapy on one’s being in the session: Process …
4. The therapist as patient: Past and current experiences …
5. The therapist as patient: Self in relation to the personal therapist …
6. Mutual and unique influences of didactic learning, supervision and personal therapy.”

These qualitative studies depict some of the many and diverse effects of personal therapy on clinical work, and their findings provide some useful insights of how these come about. However, while conceptual language is (to a certain extent) used to portray and explain the results of these studies, which are expressed in terms of various themes or domains, this takes place at a level that is primarily descriptive. There is a lack of a further interpretive level going beyond this to relate and knit together these themes or domains in such a manner that it would be possible to understand and think about this phenomenon both as a whole and in terms of an individual therapist. It therefore appeared that there was a need for a theoretical account that is more satisfactory in the sense of coherently and comprehensively encompassing and incorporating the many interwoven,
different and changing aspects (that is, intrapsychic, intersubjective and possibly systems elements) that are involved in this complex and multi-faceted phenomenon. This pointed the way towards the possibility of using an intersubjective theoretical framework, particularly one that would allow considering the research participants’ experiences of their therapies, work and the relationships between those on both intrapsychic and intersubjective levels, in developing an interpretive account of the interview material.

1.4 THE AIMS OF THIS STUDY
Against the background of the literature review and in the light of my research interests spawned by my own experience of being-a-therapist and being-in-therapy therapy, the aims of this study were:

(1) To explore how personal therapy influences experienced psychodynamic psychotherapists’ ways of working as and being clinicians, and, by implication, their professional development.

(2) To depict this phenomenon constituted by the therapist’s personal therapy and the related changes in working as and being a clinician.

(3) To deepen this descriptive account into an understanding that is also theoretically viable, comprehensive and coherent.
CHAPTER TWO

RESEARCH METHODOLOGY

2.1 CONTEXTUALISING THE RESEARCH METHOD

The aim of this study was to provide an understanding (and in some instances interpretations) of psychodynamic therapists’ subjective experiences of how their personal therapies influence their work and development as clinicians and to broaden and deepen this understanding through linking it with theory.

The contemporary postmodern approach to qualitative research is marked by “a refusal to privilege any method or theory” (Richardson, 1997, cf. Denzin & Lincoln, 2000, p. 4). There consequently are no “prepackaged designs” (Crabtree & Miller, 1999, p. xvi) for qualitative research. The researcher needs to be an “interpretive bricoleur” (Denzin & Lincoln, 2000, p. 4) who pieces together representations of the phenomenon being investigated in order to create a coherent picture of it. The emergent “bricolage” or “solution” (Denzin & Lincoln, 2000, p. 4) is no photograph of what is being investigated, but is rather like an impressionistic painting or a collage created by superimposing different images over one another.

However, an “anti-positivist orientation” and “methodological flexibility” do not imply degeneration into “methodological indifference” and a kind of conceptual anarchy (Bryant, 2002, p. 25). Keeping in mind that the research question and context determine the research methodology (and not vice versa), the onus is on the researcher to select, adapt and create his own research methodology from the multiple available options. For this he is answerable and of this process he should therefore leave a clear audit trail (Kelly, 1999a).

The purpose of the study was both to describe and interpret participants’ experiences of how their own therapies influence their work and also to explain (that is, to develop a theoretical perspective) of what it is that happens and how this happens. I would therefore locate the research methodology used within the paradigm that Kelly (1999c, p. 398) termed “interpretive research” or “hermeneutics in action” which may be contrasted with a more positivistic research paradigm.

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6 “A Jack of all trades or a kind of professional do-it-yourself” (Lévi-Strauss, 1966, p. 17).
2.2 AN INTERPRETIVE OR HERMENEUTIC APPROACH TO RESEARCH

A hermeneutic approach to the research process goes “beyond phenomenology” in that its goal is “to use the interpretation of lived experience to better understand the … context in which it occurs” (Miller & Crabtree, 1999a, p. 28). As the “theory of understanding” hermeneutics concerns both the question of what is involved in the process of understanding and of what understanding essentially is (Palmer, 1969, p. 130). An underlying assumption of the hermeneutic approach is that living interpretively is fundamental to human existence (Heidegger, 1962). “Hermeneutics as a methodology of interpretation for the humanities is a derivative form resting on and growing out of the primary ontological function of interpreting” (Palmer, 1969, p. 130).

Ricoeur (1981) draws an analogy between “reading and interpreting texts” and “interpreting meaningful human action” (Brown, Tappan, Gilligan, Miller & Argyris, 1989, p. 145). He (Ricoeur, 1981) uses this “model of the text” to address the tension between understanding (verstehen) and explanation (erklären) in acquiring knowledge about complex human phenomena by interpretive means. Dilthey (1900/1976) contends that, unlike in the natural sciences, in the human sciences verstehen is the only appropriate interpretive method. Ricoeur (1981) extends Dilthey’s notion by arguing that “understanding of a situation needs to be developed both from being in the context (empathy) and from the perspective of distanciation, using interpretation” (Kelly, 1999c, pp. 400-401). This means an ongoing dialectic between verstehen and erklären when the text is “read” (Ricoeur, 1981).

The research approach used in this study involved complex and multiple layers of interpretation. While the researcher should take care not to override the participants’ self-accounts, his understanding would remain rather limited if it remained at the level of the participants’ understanding of their realities (Kelly, 1999b). From an interpretive perspective, even the interviews themselves are not seen as direct representations of what is being investigated, but as representations that are being co-created by researcher and participants. Transforming the interviews into transcripts also implies further and successive levels of interpretation. The text that I used for further interpretation (that is, specifically for the textual analysis), consisted of both the actual recordings of the interviews and their transcriptions.

The nature of the interpretive process (and accordingly that of the various circular, iterative interpretive processes employed in this study) may be clarified by considering the concept of the

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7 “A text is any record of life held over after the moment of its production for later comprehension and interpretation” (Kelly, 1999b, p. 379), and is therefore “the basis for analytic work” (Miller & Crabtree, 1999b, p. 129).
The researcher engages with the process of meaning-making by entering this “paradoxical” circle, where the whole can only be understood in terms of the parts and the “parts only acquire their proper meaning in the context of the whole” (Brown et al., 1989, p. 144). Meaning, which is arrived at “through a questioning responsiveness to the matter being encountered”, comes to locate itself within this circularity (Palmer, 1969, p. 165). Such understanding is always situated and it is never an immutable and final truth, but is a continual creation and re-creation of the whole by extrapolating on the basis of partial understanding. The interpreter “… projects before himself a meaning for the text as a whole as soon as some initial meaning arises in the text” (Gadamer, 1975, p. 236).

The researcher aims to gain “legitimate access” to the circle by adopting an “appropriate perspective” (Packer, 1989, p. 103). Since interpretation is “never a presuppositionless grasping of something” (Heidegger, 1962, par. 150), this appropriate perspective should be a viewpoint that is informed in the sense of the researcher’s existing knowledge and attitudes being reflected on and (as far as possible) being articulated.

Once the researcher has entered the broader hermeneutic circle of developing an interpretive account, there is a continual and reciprocal dialogue between the researcher and the text comprised by the interview material. This dialogue is constituted by the many microprocesses of the “flip-flop” (Henwood & Pidgeon, 2003, p. 135), back-and-forth movements of the researcher between the “data” and his own interpretation of the “data”, which may, at different moments, be his understanding, thinking, reflections, theorising, questions, and so forth.

At this point I should like to briefly comment on the use of the term “data”, which is so commonly used when writing about qualitative research. As I did in the above instance, the term “data” is usually employed for “ease of explanation” (Terre Blanche & Kelly, 1999, p. 127). However, its use is somewhat problematic. “Data” gives the idea of “bits of discrete information” rather than that of “richly interrelated material” (Ibid.). There also is a sense of “data” being linked to a mechanical process of analysis rather than to a creative interpretive process of textual analysis.

To return to the evolving interpretive process: In the forward arc of the hermeneutic circle the researcher is thrust into and immerses himself in a certain way of seeing and understanding by which he is moved and transformed. In the backward arc the researcher gathers himself in reflection, uncovering and evaluating his understanding (Packer & Addison, 1989a). This may be

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8 A concept introduced by Schleiermacher and also used by Dilthey, Heidegger and Gadamer (Palmer, 1969).
thought of as providing a way to “analyse texts in a way that incorporates both experience-near and distanciated perspectives” (Kelly, 1999c, p. 408).

The hermeneutic circle should not be seen as a “vicious one” (Heidegger, 1962, par. 153), where what is expected and already known is re-affirmed in a solipsistic turning in on itself, but as one where both interpreter and text are continually and mutually re-invented and re-created and each understanding becomes a misunderstanding as it evolves into a renewed expansion of meaning which replaces the previous understanding.

2.3 STARTING THE RESEARCH PROCESS

I was aware that I had not come to the research process as a tabula rasa and that my “initial conscious, acknowledged, or foregrounded assumptions” (Addison, 1999, p. 147) would be the lens through which I would make discoveries. I also expected that I would, as the research process unfolded, learn more about my “unconscious, unacknowledged, or background assumptions” (Ibid.).

In being (and having had been) both therapist and patient, my perspective was very much that of an insider. I knew that my curiosity about and my reasons for choosing to research this particular topic probably had a lot to do with having this perspective and with my belief that one cannot practise psychodynamic psychotherapy in an effective and responsible way if one has not had one’s own personal therapy. After all, meaningful research questions do often arise out of our “values, passions, and preoccupations” (Mareck, Fine & Kidder, 1997, cf. Russell & Kelly, 2002, par. 19).

I came to this research not only informed by my own experiences and beliefs, but also by the popular lore among therapists about why they choose this profession and how their own therapies contribute to their development. For example, most psychodynamic therapists are very aware of the whole idea of therapists’ being “wounded healers”; of the role that this plays in coming to this profession and how pivotal one’s own therapy is in moving to a place in one’s work where (even if one is not necessarily “healed”), one may no longer be so prone to use patients to fulfil unmet needs. In the background there were also colleagues’ stories about their own therapies: some were about experiences of being transformed, growing and developing; others were about being hurt and damaged by negative therapy experiences; others were about therapy being rather indifferent and of little specific significance.
Seeing that I had not wanted to “re invent the wheel”, I had also read the available literature around the research topic. For example, I had read about the history of the training analysis and of how this tradition had become part of psychodynamic therapy. As far as research goes, it was clear that quantitative research could not really say anything conclusive about the effects of personal therapy on clinical work. The few available qualitative studies did give a more satisfactory picture of what changes about the therapist’s clinical work when he is in therapy, of how this happens and of some of the ways in which he may develop as a professional as result of this. However, although theoretical concepts were used to describe and make sense of the findings of these studies, these did not quite cohere in a way that made theoretical sense of the phenomenon as a whole.

There seemed to be both a space and a need for developing a theoretical framework for thinking about this aspect of being a psychotherapist. In order to do this (and as I have outlined earlier), I have used an interpretive or hermeneutic approach (Kelly, 1999c) to the research process and (within this context) also employed some useful aspects of grounded theory (Addison, 1989, 1992, 1999; Charmaz, 2000; Henwood & Pidgeon, 2003).

2.4 THE PARTICIPANTS

To test the Interview Guide and to familiarise myself with actually conducting the interviews, I conducted a pilot study with two female psychotherapists whom I know on a collegial level. I listened to both interviews and decided to include the second one (done with Therapist BP) in the main study.

My aim was to focus on learning about what was central and crucial to the phenomenon that I was investigating, that is, the ways in which being-a-patient impacts on and confers meaning to being-a-therapist. In order to allow aspects of this phenomenon to emerge clearly, it was necessary to select participants who had had some depth of experience with this phenomenon; that is “exemplars” (Mishler, 1990) and who were (in some respects) relatively similar (Rennie, Phillips & Quartaro, 1988; Hill, Thompson & Williams, 1997). It was also important that the participants should be articulate enough to give rich or “thick” descriptions (Geertz, 1973); that is, thorough descriptions of the “characteristics, processes, transactions and contexts that constitute the phenomenon being studied” (Terre Blanche & Kelly, 1999, p. 139) and that they would be “willing to give complete and sensitive accounts” (Wilson & Hutchinson, 1991, p. 269).

Participants who were concurrently in therapy or analysis and practising psychodynamic therapy were therefore purposefully sought and selected from (and were all members of one or more of) the
following local professional groups: the Cape Town Society for Psychoanalytic Psychotherapy (CTSPP), the South African Institute for Psychotherapy (SAIP), the Southern African Association of Jungian Analysts (SAAJA) and the Self-Psychology Group.

For the purposes of this study, I did not consider it necessary to draw a distinction between “therapy” and “analysis” or between “therapist” and “analyst”. This was both for pragmatic reasons (locally there only being Jungian training which has analysis as part of it) and also because I did not think that this kind of distinction was important to what was being investigated. I accordingly subsumed both the kinds of therapies that the participants were doing and were undergoing under the rubric of “psychodynamic psychotherapy”.

I knew that participants’ accounts of events would inevitably involve a certain amount of “narrative smoothing” (Spence, 1986, 1987). Kelly (1994, p. 56) describes “narrative smoothing” as “the process whereby the inchoate and fragmented moments of life … are transformed into sequential, coherent, unambiguous accounts of experience”. According to Spence (Ibid.), this is an inevitable feature of any attempt to represent the world. I thought that this would happen to a lesser degree and that the participants would be less inclined to give theoretical reconstructions of what had happened if their accounts were of more recent events rather than of the more abstracted and “smoothed” memories of their past experiences. I therefore decided to limit the study to participants who were presently concurrently working as clinicians and in therapy.

Gaining cooperation from therapists to participate in any research project can be problematic (Henry, Sims & Spray, 1971; Vachon, Susman, Wynne, Birringer, Olshefsky & Cox, 1995; Hill, Thompson & Williams, 1997). According to these authors, therapists are often reluctant to participate in such studies because of time constraints and because of feeling that the information sought is too personal and an invasion of professional privacy. However, Hill et al. (1997) did find that therapists seemed more willing to participate when studies were about topics that were personally relevant and where a limited amount of time and involvement was required.

The process of actually finding participants was indeed lengthy and difficult. The research is in an area that I also have experience of, that is, I have been and still am both a therapist and a patient. This probably made it easier for me to imagine what being asked certain questions might be like and alerted me to the fact that I was entering an area which is very private: in a sense I would be treading on “holy ground” which needed to be treated with the greatest respect. It was also my impression that psychotherapists generally do not easily or lightly talk about this aspect of their
lives. As in many instances in this study, I was also aware that these were my own assumptions and that participants’ feelings about participating in such a study might in fact be quite different from what I anticipated them to be.

To find participants, I wrote a letter (Appendix A) in which I explained the purpose of the research, what would be required of participants, and briefly addressed the issue of confidentiality. I am a member of the CTSPP and when I told the chairman about my planned research, he kindly offered to e-mail the letter to group members. As the various branches of this group meet on a regular basis, I also had the opportunity to inform group members personally about my research and ask for volunteers. The deadly and uncomfortable silence that followed my first “talk” at the main group meeting of the CTSPP confirmed my worst fears about not finding a sufficient number of volunteers. Two members did make some encouraging remarks, but only one therapist (B) volunteered. At later meetings of the other branches of the CTSPP there were a few therapists who were interested, but who were not in therapy at the time. One therapist (D) had already volunteered after receiving the e-mailed letter.

I then mailed letters to those members of the CTSPP who were not present at these meetings and who did not have e-mail, as well as to members of the other three groups previously mentioned. After a rather tense week of waiting there were some responses: some were again from therapists who were interested, but who were not in therapy at that time. One therapist volunteered, but later withdrew, because she felt that her circumstances would make her too recognisable. Two further therapists (A and E) volunteered and I started feeling more optimistic about finding enough participants. Another week passed and two more therapists (C and F) volunteered. I also had a discussion about my research with G, who is also a member of the CTSPP. As I knew her to be an articulate person, and she was interested in the research, I asked her to consider actually taking part and she agreed.

At this point there were eight volunteers and I had already started the process of setting up and doing the interviews.

Six of the eight participants were self-selected and two agreed to participate after I had approached them. Two were men, six were women; their ages ranged from twenty-nine to fifty-four years and all of them were white, middle-class and mostly working in private practice. Seven were English-speaking and one was Afrikaans-speaking. These details may convey something about who is actually doing in-depth psychodynamic psychotherapy in Cape Town, South Africa.
The participants were all doing in-depth psychodynamic work as well as being in in-depth psychodynamic psychotherapy. The length of time during which they had been psychotherapists doing in-depth psychodynamic psychotherapy varied between four and eighteen years (some of them had also had a number of years’ experience doing other kinds of therapy or “counselling”). There were two social workers and the rest were all clinical psychologists. I had a previous collegial acquaintance with four of the participants and the other four I met for the first time when doing the research.

Four of the participants described their therapists’ theoretical orientations as “Jungian”, while the rest of the treating therapists consisted of one who was “psycho-analytic” and three who had “object-relations”1 as their primary theoretical orientations. Two of the participants (who also had “Jungian” therapists) described themselves as being “Jungian”; one was “intersubjective”; one had an “integrative psychoanalytic” approach and the other four described themselves as having “object-relations” theoretical orientations. Only one participant described herself as “purely” Jungian: the others all had a “mix” of a primary theoretical orientation with some other theoretical perspectives added in.

The length of time that the participants had been in their present therapies varied between two and eleven years. Three of the participants were still with their original therapists: the others had also had different therapists and therapies. Three of the participants were still in the therapies they had entered as part of training; one had entered his present therapy with the kind of therapist he had wanted to become very much in mind, and the others had all entered therapy because of some personal issue or crisis. Even for these latter four participants the specific therapists they had gone to had been very important in terms of their knowing that those therapists would have a significant impact on themselves as clinicians. Whether they had entered therapy for more professional or personal reasons had, in fact, not made much difference to the focus of therapy, because those two domains were essentially interwoven.

The interviews were conducted in English. The Afrikaans-speaking participant did not find this a problem. Like most Afrikaans-speaking psychotherapists who work in Cape Town, she is completely bilingual.

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1 In Cape Town an “object-relations” theoretical orientation usually means a Kleinian one. Winnicott is also a strong influence in local object-relations thinking.
Most of the participants did have some concerns (such as time constraints, about not being “good enough” and about confidentiality) about entering the research process, but all of them also saw it as a valuable opportunity to reflect upon this aspect of their lives. Although several of them had also had some negative therapeutic experiences, they had all found their own therapies to be a pivotal aspect of becoming and being a therapist. All of them had strong feelings (in some cases almost “missionary zeal”) about the necessity for therapists to have personal therapy and it appeared (at least on a conscious level) that it was primarily those feelings that had led them to participate in the research process.

2.5 ETHICAL CONSIDERATIONS

The ethical concerns raised by qualitative research overlap with, but are also different from, those involved in the more “formal and socially distant methods” that constitute positivistic and quantitative research (Punch, 1998, p. 177). In qualitative research the aim is “to understand and articulate the meanings of people’s experiences rather than formulate general laws of behaviour” (Hadjistavropoulos & Smythe, 2001, p. 163). The interaction between researcher and participant is consequently highlighted in qualitative research methodology, as well as the notion that the person of the researcher, rather than any method used, is the research instrument (King, 1996). In fact, a research interview may sometimes come dangerously close to being like a therapeutic session and the researcher who is also a psychotherapist should keep in mind that the objectives of these are very different (King, 1996; Kvale, 1996). In-depth interviewing, especially, can evoke powerful emotions and make participants vulnerable (King, 1996). This foregrounds the tension that may at times exist between the researcher’s quest for knowledge and his ethical responsibility towards the participants (Kvale, 1996).

Since this study was conducted with colleagues, it did not start out from an inherent “hierarchical relationship” (Miller & Crabtree, 1999c, p. 92) between researcher and researched, but rather concerned what has been termed “studying sideways” (which may be contrasted with “studying up” and “studying down”) (Shrijvers, 1991, cf. Kelly, 1999b, p. 386). The participants were not “naïve subjects” and their consent to take part was both informed and voluntary (Durrheim & Wassenaar, 1999). They were interested in the topic of the research, had strong feelings about it, were attracted to the study because they wanted the opportunity to reflect on their own experiences of the influence of their therapies on their work and felt that they could make a contribution to knowledge about this aspect of being-a-therapist that both they and I considered to be so pivotal.
In the initial letter inviting psychotherapists to participate, I had set out what this would entail and additional information was divulged and questions answered when the interviews were set up. At the beginning of each interview and before the interview proper started, the participants had a further opportunity to discuss any concerns or ask any questions. At this point confidentiality was also negotiated. The research topic was clearly a sensitive one. The participants would be talking about themselves and while the research emphasised their work, the personal and professional are so interwoven in this profession that the interviews had the potential of being personally revealing and vulnerable-making. The participants would also be talking about third parties (Hadjistavropoulos & Smythe, 2001), that is, about both their patients and therapists. The latter group was especially problematic in terms of confidentiality. The community of psychodynamic psychotherapists who practise in Cape Town is quite small and “incestuous”. I therefore knew that the treating therapists could be recognisable, even if pseudonyms were used. Four of the participants had chosen to withhold their therapists’ names. However, through little, seemingly insignificant details that slipped through one of these participants’ accounts, I became aware of who his therapist was. I took cognisance that this meant being very careful with any of the interview material that could become publicly available.

Confidentiality meant anonymity for participants and those individuals that they talked about. Identifying details were changed when doing that did not alter the meaning or were omitted if it did. After each interview I enquired if there were any details or parts of the interview that the participant wanted left out of the transcription. As a further precaution I also scrutinised the excerpts from the interviews that were used in the discussions of interview material for details that could compromise anonymity. As had been agreed with the participants, I did the transcription of the interviews myself. I also undertook that the interviews in their entirety would not be published or made publicly available in any way. This meant that they could only be read by the supervisor and examiners and would be destroyed at the end of the study.

The participants had always had the choice of whether or not they wanted to talk about something, but there had been moments when they had revealed aspects of themselves and their histories that had been very personal. Although their feedback about the impact of the research process indicated that they had experienced it as interesting, valuable, focusing, clarifying, and so forth, three of the participants had also found it more exposing and vulnerable-making than they had anticipated, and one wondered whether the interview had been satisfactory from my perspective. Two participants also questioned what would be done with the material that they had provided.
I was very aware of the trust that the participants had placed in me and had the firm resolve not to betray that. This had been relatively straightforward in terms of confidentiality and being respectful of what they were divulging. However, there were also other aspects of the interviews and later data analysis where the ethical domain became much murkier and where there were sometimes no clear answers. There were moments when an interview did not remain at the level of the participant’s talking about his therapy, but where it took me and the participant straight into the heart of the closed container of his therapy. This did not necessarily always happen in a negative sense. Here I recall a specific instance where the participant’s insight into his therapy might even have provided useful grist to the therapeutic mill. My concern rather lies with how such a research interview may breach and have an impact on the closed space of therapy.

This also pertained to the analysis of interview material. I was aware that the participants were likely to read the dissertation once it was finished and to be curious about their own part in it. I was also conscious that while the actual interview relationship had been a mostly egalitarian one, where meanings had been negotiated, the participants had no say or power in my actual interpretations of what they had told me. I therefore speculated about the impact of these on the participants themselves and on their therapies that were still ongoing. This especially concerned those parts of the discussion of interview material that had to do with issues of power between participant and therapist or instances when the negation of the participant by the therapist had never been resolved satisfactorily. In this regard, I had the sense of moving on a really slippery slope. On the one hand the participants were also therapists and should be able to know that my interpretations were not “truths”, but only my interpretations, and could be useful comments on their therapies. On the other hand, these interpretations could also invade the space of therapy, do real damage there and also undermine the participant’s ability “to interpret his experience in his own way” (Hadjistavropoulos & Smythe, 2001, p. 164).

This matter could to some extent have been addressed if there had been a second round of interviews where aspects of the data analysis and the participants’ reactions to these could have been explored. I would not have seen this as a way of validating the “correctness” of my interpretations, but rather as a means of empowering the participants to share in the meaning-making process at a further level.
2.6 INTERVIEWS

2.6.1 Interview Guide and process

“With qualitative research we are always throwing a net to see what we can catch. If we throw a fine-meshed net we will probably catch lots of small things, some important and some less so. If we are lucky, once in a while we may find a pearl. If we throw a large-meshed net, we will miss many of the smaller findings, but we may get a better look at the larger issues. There are always choices, and it is [the researcher] who makes those choices” (Meek, 2003, par. 14).

To cast the “net” of the research, an Interview Guide (Appendix B) was developed. This was based on the relevant literature, my own experiences as therapist and patient, and discussions with a colleague who shared my curiosity about this particular aspect of being-a-therapist.

To ease the participants into the interview situation, the Interview Guide commenced with a few “warm-up”, mostly factual questions. After that followed the main or “grand tour” (Miller & Crabtree, 1999c, p. 98), broad and open-ended question:

“Could you describe as fully as possible how your own therapy or analysis influences your work as a therapist? Please try to describe this in terms of your own experience rather than just giving a theoretical explanation of what happens. Where possible, could you also try to describe specific instances of this?”

Further questions about the participants’ own therapies and how these and other aspects of their being-therapists related to their being-clinicians followed. Prompts were used if the participant was unclear about what a question meant or felt unsure and needed encouragement. Probes were used if I thought that an answer needed further exploration and elucidation.

Research interviews are not “neutral tools of data gathering” (Fontana & Frey, 2000, p. 646). It is doubtful that the researcher can put himself aside by “bracketing” (Denzin, 1989, cf. Miller & Crabtree, 1999c, p. 102) his pre-suppositions and own subjectivity in order to be pristinely “value-free and objective” (Russell & Kelly, 2002, par. 4). Just as in the analysis of the interview material, the researcher’s “fore-structures of understanding” (Bleicher, 1980, p. 108) play a role in the interview questions that are asked and the aspects of answers that are picked up on and further explored. This highlights the necessity of the process constituted by the “iterative cycle” (Miller & Crabtree, 1999b, p. 131) of “reflective reflexivity” (Addison, 1999, p. 152) previously described in Section 2.3.

Such a process continued throughout the duration of this research and also involved my keeping notes or memos about my observations, thoughts, feelings, “insights”, and so forth. It also entailed
my “keeping my critical voice active” by questioning, looking for ambiguities, contradictions, inconsistencies and omissions (Addison, 1999, p. 156). As far as the “self-reflexive loop” (Miller & Crabtree, 1999b, p. 131) specifically pertained to the interview process, I was conscious that just because I shared a profession, theoretical language and the notion of personal therapy as a necessary requirement for being-a-therapist with the participants, I could not assume that I knew what they were talking about. This meant listening attentively and carefully “for what’s said and not said, listening for the silences, the cracks between words, the hesitation, the contradictions, the glorious expositions” (Stamberg, 1993, cf. Dilley, 2000, p. 134). And when listening did not suffice, to pursue and clarify what the participants meant in greater detail.

From a hermeneutic perspective the research interview is viewed as a “special type of partnership and communicative … event” (Miller & Crabtree, 1999c, p. 91), where the interaction between researcher and participant leads to a “fusion of [the] horizons” (Gadamer, 1975, p. 358) of understanding between them. This results in a negotiated “coconstruction of [their] experience and understanding of the topic of interest” (Miller & Crabtree, 1999c, p. 93). The researcher is therefore an active participant and co-author of the research process and the text that results from the research interview is not a mere reflection of the participant’s “reality”. Of course this does not mean that there is not such an external reality, but rather that what “is captured in the text” of the interview is constructed “out of the flow of information and interpretation” between researcher and participant (Russell & Kelly, 2002, par. 13).

Taking the above into account, my aim was also that the nature of the interview context would be such that the participants would be sufficiently empowered to be “speaking subject[s]” (Benjamin, 1998b, p. 9), so that their “voices” would be heard as clearly as possible. The questions were open-ended to allow participants to use their own words to describe what they considered to be most meaningful or salient. Apart from the “warm-up” and main questions, the interview questions did not necessarily follow in any specific order and I tried to find answers to the questions by, where possible, picking up on and further exploring what the participants themselves were already speaking about. Tracking the participants rather than leading in the interviews meant that I had to memorise the Interview Guide before the start of the interview process.

The actual interviews were preceded by two pilot interviews, one of which was also used in the main study. This was followed by a few minor changes to the Interview Guide. Subsequently an in-depth, semi-structured interview of one-and-a half-to-two hours was done with each participant. Each interview was recorded and later transcribed. The participants had the choice of where the
interview could take place. Six were done in the participants’ consulting rooms, that is, their everyday work-places and two took place in my consulting room. To avoid cluttering up the interview space and time, I sent the participants a pre-interview questionnaire (Appendix C) in order to obtain some basic information about their therapies, work, professional lives and development before the actual interviews.

As indicated in Appendix A, I had originally intended to go back to the participants after a six-month interval with further questions based on the initial analysis of the interview material. However, this proved unfeasible. The sheer volume, nuanced richness and depth of the interview material obtained in the first round of interviews were quite adequate for the purposes of this study. Of course a second round of interviews with these participants (or with other suitable participants) with questions that were more theoretically focused, would have been interesting and significant. It would also have meant the research project’s moving on to the stage of theoretical sampling (Glaser & Strauss, 1967; Charmaz, 2000; Henwood & Pidgeon, 2003). However, that would really have entailed another study, since it would have taken me far beyond the limits of what was practicably possible to do within the confines of one research project.

3.6.2 Recording and transcription of interviews

To ensure good sound quality, the interviews were recorded digitally (Sony Portable MiniDisc Recorder MZ-R55) and then transferred to audiocassettes. One of my undertakings to the participants had been that I would do the transcribing of interviews myself. Together with a voice recognition program (Dragon NaturallySpeaking Professional V5), I used these audiocassettes in a transcribing machine with a foot pedal (Sanyo TRC-8800 Transcribing System) to transcribe the interviews. After completing the transcription of each interview, I used the digital recording to make corrections and to listen to parts that had not been clear on the audiocassette. To protect the confidentiality of the participants, identifying details were changed. When participants asked that specific details be changed or I thought it necessary to change such details which could not be done without changing the meaning, those details were omitted and were indicated as being omitted.

The translation of spoken discourse into written text is problematic (Kvale, 1996). Even if technically “correct”, transcriptions are only partial accounts of a much richer interaction experience (Poland, 1995). The process of transcribing therefore implies construction as well as analysis at some level (Lapadat, 1999).
According to Kvale (1996, p. 166), researchers should ask themselves: “What is a useful transcription for my research purposes?” and make decisions accordingly. My intention was to do the data analysis at the level of the participants’ actual words. However, these words are often spoken in the context of nonverbal behaviour (e.g., pointing), non-language utterances (e.g., sighs, laughs), and paralinguistic elements/verbal fillers (e.g., “you know”, “okay”, “mmm”), tone of voice and so forth. These may sometimes be important in making an interpretation. Although I did not transcribe these in minute detail, I did give some indications of these “contexts” of the words and endeavoured to do so in a consistent manner.

During the process of doing the transcriptions I made the decision (see Section 2.7.1) to use QSR NUD*IST N5 software for data analysis. In transcribing I also had to keep in mind in what way the interviews needed to be prepared to be imported into N5. Word processed documents have to be saved as “text only” to import them, which means that formatting is lost (Richards, 2000). Therefore the interviews had to be transcribed in such a way that they remained intelligible even when this happened.

The transcription of interviews was time-consuming (six to eight hours per interview), but it also afforded me a means to begin engaging with the data in a very immediate and direct way, thus immersing myself in the interview material and starting with a tentative process of data analysis from the beginning of data collection.

2.7 UNDERSTANDING AND INTERPRETING THE INTERVIEWS

2.7.1 The decision to use Computer-Aided Qualitative Data Analysis Software (CAQDAS)

As I commenced the interviews, I became aware of how complex and disorganised the material was and what a daunting task it would be to carry out the mechanics of analysis. This would consist of constructing an organising scheme, that is, a way to identify similarities, differences and relationships between different text passages, so that text segments could be retrieved from different parts of the text corpus (manually or by using a word-processing package). Therefore I started thinking about using a CAQDAS program and about some of the methodological considerations which this would entail. It soon became obvious that controversy and debate surround this issue, with little clarity for the researcher. Consequently I took a pragmatic approach to this metaphorical “can of worms”, which is discussed below.

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10 This was later upgraded to QSR N6, which, although it has more functions than N5, is basically the same as N5.
The question of whether and how to use computer programs as an aid to data analysis, foregrounds the researcher’s ontological and epistemological assumptions concerning meaning-making and textual interpretations, and also holds certain design and contextual considerations (Baptiste, 2001). A closer look at the philosophical and epistemological roots of interpretive research and the nature of hermeneutic verstehen evokes a certain caution against the use of computer software for text analysis (Kelle, 1997). This begs the question whether using computer technology “does not seem a huge distance away from Dilthey’s suggestion that empathy is the foundation of epistemological practice in the human sciences” (Terre Blanche & Kelly, 1999, p. 142).

Could the use of CAQDAS programs not lead to researchers adopting “a new orthodoxy of qualitative analysis” (Kelle, 1997, par. 1.1) that could enforce analysis strategies that go against the constructivist and postmodern methodological and theoretical approaches? Is the use of CAQDAS not contrary to the tendency towards pluralism and polyvocality that present-day qualitative researchers see as the hallmark of their work? Or may it rather be that the software does not represent a developing orthodoxy, but rather “the multitooling of qualitative researchers, making available to them … a wide range of different analytic strategies”? (Lee & Fielding, 1996, par. 2.2).

According to Kelle (1997, par. 1.4), the use of terms such as “computer-aided qualitative data analysis” or “software program for theory building” may give the impression that the use of computer programs as tools for the analysis of textual data could be directly compared to software packages that perform statistical analyses. On the one hand this could lead to over-optimistic forecasts that computers could make the research process more transparent and rigorous, and on the other hand this could also inspire fears of the “dark side of the technological advance” (Barry, 1998, par. 2.1), the computer becoming a kind of archetypal “Frankenstein monster” taking over the analysis.

Many qualitative researchers (even some of those involved in the development of these programs) have therefore expressed concerns that the use of computers could alienate researchers from their data (Kelle, 1997). As Kvale (1996, p. 174) warns: “The current emphasis on coding may lead to the analysis of isolated variables abstracted from their context in live interpersonal interactions.” Barry (1998) argues that there are always researchers who produce an analysis after just “a superficial brush with the data” (par. 2.3). In the case of the use of CAQDAS, this could mean that the researcher would only read the text in context during the initial coding. Then again, the same could happen when manual methods or word processor functions are utilised, thus also leading to analyses “lacking in rigour and depth” (Ibid.).
Lonkila (1995) suggests that aspects of grounded theory may have been overemphasised in the development of qualitative data analysis software, leading to a glib association between CAQDAS and a kind of simplified “grounded theory” analysis, linked by an emphasis on data coding procedures. Grounded theorising is more than coding, and standardised, often mechanistic procedures are no substitute for genuinely “grounded” engagement with the data (Coffey, Holbrook & Atkinson, 1996). “It may be that some kind of coding is needed in most qualitative research, but it is also possible that coding is overemphasized, given the fact that a large part of the researcher’s work consists of interpretation and a fine-grained hermeneutic analysis” (Lonkila, 1995, p. 49).

However, Kelle (1997, par. 1.5) argues that the basic operations of “coding and retrieval” (indexing and comparing text segments) should rather be seen as representing an “open technology” (i.e., “open” to whatever way the researcher may use or misuse it), which can be a creative and fruitful part of hermeneutic work. He further comments that even the newer, so-called “third generation software for qualitative analysis” (par. 2.6) does not provide a totally different logic of textual data management from the simple code-and-retrieve programs, but is only a more complicated extension of code and retrieve facilities.

Kelle does caution researchers that if the newly developed coding and retrieval techniques are applied without taking the necessary methodological underpinnings into consideration, software for the management of textual data may indeed exert a harmful influence on the qualitative research process. This danger pertains mainly to the recently proposed methodological strategies for qualitative “theory building” and “hypothesis examination”, which sometimes draw on the positivistic methodology and rhetoric of classical hypothesis testing without having observed the necessary prerequisites. The application of “strict rules” to “vague and fuzzy” codes could easily lead to the production of artefacts (par. 6.2).

Qualitative researchers also need to be circumspect about what a computer can and cannot do on a practical level: there are aspects of the use of software that may or may not be problematic, but that definitely should be kept in mind in terms of how the use of the program may enhance or constrain the analysis process. Some of these are:

- Although CAQDAS provides tools, which may “explicitly support … intellectual efforts, making it easier … to think coherently about the meaning of … data” (Weitzman & Miles, 1995, p. 330), it cannot actually “build theory”. These programs do not know how to search creatively for associations between different aspects of an account, nor can they formulate or reformulate research questions.
The ease and speed with which operations can be carried out could tempt qualitative researchers to do “‘quick and dirty’ research with its attendant danger of premature theoretical closure” (Fielding & Lee, 1991, p. 8).

The researcher should be aware of the conceptual assumptions underpinning a specific program or program functions he or she intends to use. An example of this may be that the program allows the researcher to directly represent hierarchical relationships among codes, but not non-hierarchical relationships (this is the case with NUD*IST), which may encourage the researcher to think in this way and not circularly or in a less structured way. The researcher may therefore choose to use another program (such as ATLAS/ti) or if he or she still wishes to use the program (as I did), he or she could, if necessary, work around the underlying assumptions in the program by, for example, also keeping a separate non-hierarchical code map.

This process of grappling with these issues and debates left me with the caveat of being cautious of whatever uses that I would or could make of any CAQDAS program (which is, after all, just a tool with its accompanying faults and benefits) and with the clear idea (Kelle, 1997, par. 6.3) that these programs should probably primarily be seen as software for “data administration and archiving” rather than as tools for “data analysis”, although they may (it was hoped) also be of help in the data analysis.

This brought me to the point of considering which program would be suitable for my research purposes and needs. On a practical level the novice researcher is confronted with an interesting but confusing array of computer software that could be an aid to the research process. It is clear that there is no one “best program” and that one has to find a program suitable to the structure of one’s data and one’s analysis plans, as well as a program that one feels comfortable with and is able to use and afford (the last being especially important in a country where the currency is continually losing value!).

Some of the functions that these programs can be used for (Weitzman, 2000, pp. 805-806), and in which I was specifically interested, are:

- **Storage**: Organising a database and keeping text within that.
- **Coding**: Attaching “key words or tags” to text segments “to permit later retrieval”. The speed and flexibility with which coding and other operations can be achieved should free time up for other analytic tasks.
- **Data “linking”:** Connecting “relevant data segments” to one another and forming categories, thus providing more complex ways to look at data.

- **Search and retrieval:** Locating relevant words or segments of text and “making them available for inspection”. It was important that the program would allow me to keep close contact with the original text of interviews, not just with text segments as part of categories, but also with each interview as a whole and that any decontextualised text segment could immediately be recontextualised, not just within a category, but also within the original interview.

- **Memoing:** Providing a formal structure for writing “reflective commentaries” on aspects of the data, theory or method “as a basis for deeper analysis” and for storing these memos.

- **Theory building:** Developing systematic explanations of findings as an aid to conceptual and theoretical thinking about the data. (I did have some reservations about this.)

My requirements meant that I would be looking at obtaining one of the so-called “Code-based Theory Builders”, the “third generation software for qualitative analysis” (such as AnSWR, Atlas/ti, NUDI*ST, and winMAX) (Weitzman, 2000). These programs have special features (such as representing relationships between codes, building higher-order classifications and categories, formulating and testing theoretical propositions, powerful memoing functions and sophisticated search-and-retrieval functions) that go beyond the functions of code-and-retrieve programs (Weitzman, 2000).

Although I briefly did look at software such as AnSWR (which can be downloaded free from the Internet, but which at first glance looked difficult to use) and winMax (its newer version Maxqda, into which rich text can be imported was not yet available at that time), the main focus of my investigation about the “right” software for my purposes and my personal needs was on Atlas/ti and NUD*IST (Non-numerical Unstructured Data Indexing Searching and Theorising), which seem to be the most serious contenders in meeting the needs of researchers (Weitzman & Miles, 1995; Barry, 1998). To help me make the decision, I downloaded demonstration versions of Atlas/ti, and NUD*IST’s N4 Classic, N5 11 (the newer version of N4) and NVivo from the Internet and experimented a bit with them.

There are many similarities between Atlas/ti and NUD*IST (or Nudist, as it is sometimes referred to). The main differences are that “Nudist represents a sophisticated coding and theory building

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11 During the course of the study N5 was upgraded to N6. Although N6 has some added features, the two programs are intrinsically the same.
package and Atlas/ti is more of a hypertext package …. Atlas/ti operates in a more visual and
spatial medium with data and software functions organised in pictorial form, while Nudist’s
operation is predominantly verbal” (Barry, 1998, par. 6.2). In these two packages software structure
is therefore “dichotomised between structured, sequential, verbal versus visual, spatial,
interconnected modes of operation” (Barry, 1998, Abstract).

I had to decide which one I felt more comfortable using and decided that NUD*IST was more
compatible with the way I think and work; I especially found its more structured ways of working
reassuring and less anxiety-provoking. However, I was not sure that I would be able to make full
use of its more sophisticated functions, because there are few training courses in these software
packages available in South Africa and I was also not sure what kind of support was available.

An e-mail discussion with Dr Lyn Richards, one of the developers of NUD*IST, helped me to
decide which version of the software would adequately perform the basic functions that I needed it
to do, keeping in mind that I would probably only have the available literature and Internet support
as recourses; and I finally decided to buy QSR NUD*IST N5. I was very aware that buying this
software package entailed a calculated risk: I could not really know at the moment of making the
decision whether it would be viable in terms of financial cost or in terms of the time and effort it
would take to learn to use it and to prepare the data.

### 2.7.2 From transcribed interviews to QSR NUD*IST N6

The interviews were transcribed into individual Microsoft Word files. After being saved as Text
Only files, they were put in the RAWFILES folder of the N6 project named PERSONAL
THERAPY. From the RAWFILES folder these interview files were imported to become documents
in the N6 project and in this way the interviews became available for coding and further data
analysis.

When importing the documents into the project, the interviews were divided into text units, using
sentences as the text unit type. I did, in a few instances, for grammatical reasons or for reasons of clarity, put more than one sentence in a text unit.

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12 QSR NUD*IST N5 (Student Edition) bought from QSR International (www.qsrinternational.com) in September 2001 at a cost of £141. Because I had originally bought N5 product maintenance at £40, I later received the N6 upgrade free of charge.

13 I did, in a few instances, for grammatical reasons or for reasons of clarity, put more than one sentence in a text unit.
2.7.3 Quoting from the interviews

In quoting from the interviews, my aim was to have the participants speak for themselves in their own words. However, for the sake of clarity and brevity, some slight “cleaning up” of the quoted extracts was done. Repetitions of words, irrelevant phrases, and some of the “contexts” in which the participants’ words were spoken in the transcriptions (such as nonverbal behaviours, non-language utterances, and paralinguistic elements/verbal fillers, tone of voice and so forth) were omitted in the extracts without an indication that they were omitted.

For Microsoft Word documents to be compatible with N6, they must be in Text Only format. This means that there are restrictions on the fonts that may be used. When a participant emphasised something, I used capital letters. When I later wanted to emphasise something in an extract, I used bold lettering. A pause was indicated by the ellipsis … .

When using extracts from the transcribed interviews, a letter denotes both the interview and the research participant. Numbers indicate the text unit. For example, A, 133, means interview A and research participant A, text unit 133. After every excerpt the specific participant concerned is indicated, for example, (A). *R indicates the researcher.

In the extracts the text unit number appears to the left of every text unit.

Identifying details were changed (when that did not change the meaning) or omitted. Omission was denoted as [omitted].

Because the extracts appear in the form of numbered text units, it is quite clear to see when a text unit has been omitted. In the case of a single text unit, it is usually one of the above “contexts” that has been left out. Because the researcher’s questions and comments were used as sub-headers (Richards, 2002) in N6, there is also an “empty” text unit after every text unit ensuing from the researcher.

When some text units (rather than just one) have been left out (because of conciseness and/or because I thought it to be irrelevant or not contributing to what had gone before or followed), that was not specifically indicated, because the numbering of text units makes it clear that those units were left out. Because I tried to be as flexible as possible in asking and following up questions, the participants talked about the same question in different parts of the interviews (that is, they did not

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14 By indicating the researcher as *R (rather than R).
necessarily complete a specific aspect of or answer to a question “in one go”). Therefore the same excerpt pertaining to one participant may contain text units from different parts of his interview. This is also clear from the numbering of text units.

2.7.4 Developing an interpretive account of the interview material

Within the framework of a hermeneutic approach, the researcher’s interpretive methods may be located on a continuum that ranges from “experience-near (contextually derived) to experience distant (theoretically led)” (Kelly, 1999c, p. 405). Since both “theory which is not grounded” and “description which is not theorised” will lead to a interpretive account that is unsatisfactory and limited, the research methodology should preferably include both these perspectives and hold the tension between them (Ibid., p. 406). Kelly (Ibid., p. 405) views the grounded theory approach (Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1994, 1998) as “spanning contextual and theoretical orientations”; that is, it is a “system for developing theoretical accounts whilst keeping close to the phenomenological ‘ground’”. On a practical level grounded theory does provide the researcher with clear and explicit guidelines of how go about doing the actual data analysis by clearly setting out how the “development, refinement and interrelation of concepts” take place (Charmaz, 2000, p. 510). This is rare in qualitative methodology and very reassuring to the novice researcher.

However, there are some inherent problematic aspects to some of the underlying assumptions and requirements of this method. While the more traditional Glaserian and Straussian views of grounded theory methodology have in some ways taken up conflicting positions in what grounded theory is and should be, both “remain imbued in positivism, with its objectivist underpinnings” (Charmaz, 2000, p. 510). Glaser and Strauss’s perspectives lean towards the notion of the researcher being a neutral observer gathering data about an external reality. This kind of positivistic stance is not compatible with the ideas underpinning an interpretive or hermeneutic view of the research process and has also become largely discredited in contemporary thinking about qualitative research (Bryant, 2003).

Henwood and Pidgeon (2003, p. 134) ascribe these positivistic inclinations to the concealed “epistemological tension” within grounded theory. This relates to what Hammersley (1989, cf. 15 Glaser (1992) parted ways with Strauss primarily because he saw Strauss as “forcing” data into preconceived categories, which (according to him) does not lead to the emergence of grounded theory, but rather to “a forced, preconceived, full conceptual description” (Ibid., p. 3). Since then Glaser has expended a great amount of time and energy on discrediting those “dissidents” bent on eroding (his version of) grounded theory. An example of this can be seen in his impassioned and rather vitriolic comments about Charmaz ‘s (2000) ideas about a constructivist version of grounded theory (Glaser, 2002).
Henwood & Pidgeon, 2003, p. 134) calls the *dilemma of qualitative method*, where the researcher is simultaneously committed to realism by directly reflecting the participants’ accounts and viewpoints *and* to “generating new understandings and theory”. The latter cannot just “emerge” from the data, but is created by the researcher by means of his interpretations of the data. Such interpretations are furthermore inevitably constructed within the context of the pre-understandings that the researcher brings to the research process (Henwood & Pidgeon, 2003). Rennie (2000, cf. Henwood & Pidgeon, 2003, p.134n1) elaborates on this idea by suggesting that grounded theory actually involves a “double hermeneutic”, since both theory generation and the data that has been collected are subject to “preinterpretation”.

Charmaz (2000), as well as Henwood and Pidgeon (2003), therefore suggest a constructivist reading or revision of grounded theory. This would encompass both the “systematic rigor in analysis with the essentially creative and dynamic character of interpretive research” (Henwood & Pidgeon, 2003, p. 135). Thus grounded theory could move beyond the “soft” positivism of assuming that research is a process that reveals phenomena that already exist (Madill, Jordan & Shirley, 2000). From the constructivist perspective, theory is not waiting *in* the data, but *constructed through* the dialogue between researcher and data and analytical work “is done in the interplay of the original text with the conceptual structure used for and created by its exploration” (Richards & Richards, 1992, p. 5). Theory is therefore *generated from* instead of being *discovered in* the data. The researcher’s development of increasingly focused and deeper conceptualisations also does not simply imply an inductive process, but a “flip-flop” movement between data and theory-making, where the one illuminates and informs the other (Henwood & Pidgeon, 2003, p.135).

While I did have some reservations about grounded theory, I decided to take up Charmaz’s (2000, p. 510) suggestion that we “can use grounded theory methods as flexible, heuristic strategies rather than as formulaic procedures”. In this section I shall therefore describe how I employed these useful methods within the more general context of an interpretive or hermeneutic approach to the research process. In devising this research methodology I drew on Addison’s (1989, 1992, 1999) *grounded hermeneutic approach*, Charmaz’s (2000) *constructivist grounded theory*, and Henwood and Pidgeon’s (2003) *constructivist revision of grounded theory*, because these (rather than the more traditional grounded theory methods) seemed more compatible with the methodology suited to this study.
As could be seen in the section about the interview process, the analysis of the interview material begins long before the commencement of the formal data analysis. Data collection and data analysis are not discrete processes. They exist on a continuum where there is a point where there is a “fading out” of data collection and a “fading in” of data analysis (Terre Blanche & Kelly, 1999, p. 139). The researcher accordingly has to decide how to approach and relate to the data; that is, on an organising style (Miller & Crabtree, 1999b) to guide the data analysis. I should therefore like to consider how such organising styles were deployed in this study.

Sometimes my engagement with the interview material would consist of repeated immersions in the interviews in their entirety by listening to and reading them with, for example, questions or theoretical sensitivities16 in mind. Out of these repeated “vertical passes” (Borkan, 1999, p. 186) at the interview material, I would be able to develop a listening or reading guide (Brown et al., 1989; Kelly, 1994, 1999c; Gilligan, Spencer, Weinberg & Bertsch, 2003), through which the interviews could again be listened to and read. According to Kelly (1994, p. 78), the Listening or Reading Guide Method is “a method of textual interpretation developed for extricating from a text those features of the text which clarify the data in terms of the particular questions one wants to ask of it”. As the researcher proceeds with the research process, he is continually formulating new questions, refining and condensing these into a list through which the material may be listened to or read. In this sense research may be thought of as leading “not so much to findings but to further questions” (Kelly, 1999c, p. 411).

Questions, ideas, theoretical sensitivities, and so forth, were also used as part of the “horizontal passes” made at the interview material by my reading, listening to and subsequently editing the interview material through them. Such a deployment of the editing organising style of analysis (Addison, 1999; Miller & Crabtree, 1999b) further meant that my questions and conceptualisations were used to “fracture” (Dey, 1993) the interviews by identifying and segmenting relevant interview material into categories “which captured uniformities in the data” (Dey, 1999, p. 4). Segments or excerpts of text were categorised or assigned codes. Such categories were a means of linking and clustering text segments, and were refined into sub-categories to which codes were also assigned. Categories were also linked and related to one another.

QSR NUD*IST (N6 or sixth version) software was used to perform these editing organising functions. As described before, the interviews had already been imported into N6 and were

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16 “Theoretical sensitivities are qualitative researchers’ way of approaching the analysis of data: Rather than being held as true until found to be false, such sensitivities are viewed as tools that can be vision-making or vision-blinkering ….” (Henwood & Pidgeon, 2003, p. 135).
available as numbered text units. Categories or nodes were created and the coding of interview text was done according to these. Nodes were created to label and organise so-called “base data” about participants (N6 Reference Guide, 2002; Richards, 2002). Further nodes ranged from those at a descriptive level to those that were more abstract and conceptual. Definitions were written for each node and memos were often added. Although sometimes inclining more towards the one or the other, coding was never solely “top down” (deducted from my questions or theoretical thinking), nor “bottom up” (inducted from the interview text), but was rather the result of the iterative movement between these two.

During the process of data analysis, coding could be deleted, added, reformulated and merged. Coding and nodes were not regarded as “fixed” but rather as “heuristic devices” in the evolving understanding and multi-layered interpretations of the text (Seidel & Kelle, 1995, p. 54). The nodes were further refined by also coding them and creating “child” nodes below a “parent” node (N6 Reference Guide, 2002; Richards, 2002). The initial unrelated or “free nodes” were arranged into hierarchical “parent” and “child” “tree nodes”, forming a system of index trees. In the end this resulted in the creation of 210 tree nodes. The nodes made it easy to retrieve relevant text excerpts according to categories or sub-categories; that is “decontextualizing data in order to recontextualize by topic” (Tesch, 1990, cf. Richards & Richards, 1992, p. 3). It was also possible to return directly to the original text from the nodes.

Exercising coding made it possible to implement grounded theory’s constant comparative method of analysis (Glaser & Strauss, 1967; Addison, 1999; Henwood & Pidgeon, 2003) to identify conceptual similarities, differences and relationships between different text passages within, between and across nodes. Practically this had entailed comparing data from various participants (for example, their accounts, actions, views and experiences); comparing data from the same participant that referred to experiences at different points in time or at different stages of therapy or professional development; comparing data with nodes; comparing nodes with other nodes; and so forth (Charmaz, 2000). This methodological strategy is a pivotal aspect of “dense conceptual development” (Henwood & Pidgeon, 2003, p. 140).

N6 certainly facilitated the ease of “archiving and administration” (Kelle, 1997, par. 6.3) and some exploration of the interview material. However, the usefulness of N6 to take the data analysis beyond the level of just doing coding and retrieval, thus making N6 more than a “filing cabinet” (even if a very sophisticated filing cabinet), was more questionable (Richards & Richards, 1999, p. 3). Applying a code is not the same as exploring a concept (Richards & Richards, 1992). The
hierarchical coding system meant that other ways had to be found to link text concerning theorising and concepts that were not related in this way, for example, text units pertaining to the nature of the participant’s identifications with his therapist and those relevant to the power differential between participant and therapist. In that instance (and in other similar ones), my solution was to have two “child” nodes that were identical in the sense of containing the same excerpts from the interviews, but appeared with different names under the related “parent” nodes. A “child” node called “Identification” was therefore created under “Power”, and one called “Power” under “Identification”.

Text searches (for words or strings of words) were sometimes helpful, for example, when I remembered that a participant had used a specific word or a particular expression, but could not remember who had used it or where or when it had been used. It was also useful to locate instances where participants talked about something specific like “supervision”. However, asking the interview text more tentative or intricate questions and doing coding via text searches were of limited use. Mostly this was because what I was asking or looking for was too complex or only became evident through my interpretations of the data. For example, I could do a text search for a concept like “countertransference” and find some instances of it. However, while the word “countertransference” itself may not have been used, I could have interpreted the participant’s description as signifying that. Practically this had meant that although N6 was used for coding throughout the research process, conceptual explorations of the interview material usually required returning to the original interviews. While being time-consuming, this had caused the analytic work never to take place only by using discrete fragments of text or on the level of dry abstractions, but to include a continual involvement with the living words of the participants and the textured nuances of the interviews in their entirety.

Even taking into account that my skills with the more complex N6 search functions would probably have been better had I been able to receive some formal training, all of this points to the fact that such a software program is only a tool and not ultimately the interpreter of data or the creator of theory. I furthermore had to keep in mind that using a program like N6 is never “methodologically innocent” (Richards & Richards, 1999, p. 6). This had meant not being deterred from doing what I could not do with it and not being seduced into doing too much of what was easier to do with it (Ibid.).
2.7.5 The final analysis

Data analysis “proper” is ushered in by the researcher’s gaining access to the meaning-making hermeneutic “circle of understanding and interpretation”, which constitutes the interpretive process, from “an appropriate perspective” (Packer, 1989, p. 103). Kelly (1994, p. 94) reminds us that “the data does not speak without being asked questions” and in this study my point of entry consisted of a list of questions, that is, of the following listening/reading guide:

1. What effects did the participants’ being patients have on their being therapists?
2. What kinds of experiences of the participants’ being patients made a difference to their being therapists?
3. What was the nature of the processes that linked the participants’ being patients and their being therapists?
4. How did the participants’ choice of profession come about?
5. What role did personal therapy play in the participants’ becoming and developing as therapists?
6. What was the relationship between the theoretical perspectives held by the participants and their personal therapies?
7. What was the relationship between their experiences of supervision and those of their personal therapies?
8. What kinds of issues were generated or highlighted in the therapeutic relationships because the participants were also therapists?
9. What were the ideas/opinions/beliefs about training and of developing as therapists that the participants held and how were those influenced by the experience of their own therapies?

These questions had crystallised out of my immersing (Borkan, 1999) myself in the interviews through repeatedly reading and listening to them, while keeping the purpose of the study in mind. They were formulated as initial ways of thinking about the phenomenon, comprised of the participants’ personal therapies, clinical work and the relationship between these. I used these questions in conjunction with the editing organising style of analysis (Addison, 1999; Miller & Crabtree, 1999b). The interviews were listened to and read through the questions and also “edited” with the questions serving as the point of departure for further coding of the text. As described before, N6 was used to perform these functions.

The “picture” that emerged from this “pass” at the interview material was rather loose and very much at a descriptive level. A more comprehensive and focused way of thinking was clearly required. The nature of the findings of this initial engagement with the data pointed me towards relational and intersubjective theorising, and specifically to the work of Jessica Benjamin and her notion of intersubjectivity as the development of subject-to-subject relating.

This landed me in the confusing and still ongoing debate about the use of pre-existing theory, which has its origins within the more classical versions of grounded theory. Even Glaser and Strauss do not expect the researcher to enter the research process as a tabula rasa (Henwood & Pidgeon, 2003). But they (Glaser & Strauss, 1967, p. 46) warn that the use of “preconceived theory” can be a serious impediment to the development of the theoretical sensitivity that would
enable the researcher to “conceptualize and formulate a theory as it emerges from the data”. Glaser and Strauss (Ibid.) concede that there may be “some existing” concepts that are “clearly useful”. However, the “use of theoretical literature to sharpen the initial focus” of research has been problematised in grounded theorising, because it is feared that this may result in the “open-ended, explanatory research activities” that maintain “sensitivity to relevance in the data” degenerating into “theory verification” (Henwood & Pidgeon, 2003, pp. 137-138). According to Henwood and Pigeon (Ibid., p. 139), this may be prevented and it is possible to generate theory “which is well-grounded” in the data “if the use of the researcher’s own imagination and theoretical sensitivities” happens in tandem with and is “disciplined by the requirement that codes and categories provided should fit (provide a well-recognizable description of the data)”.

At this point a colleague with an interest in and knowledge of intersubjective theory and Jessica Benjamin’s theoretical ideas also became involved in the research process. Categories or nodes and the fit of coding to the relevant excerpts which were used as part of deepening and focusing conceptual development were extensively discussed in a number of consultations with this colleague.

As a next step in the various circular, iterative, “flip-flop” interpretive processes, I proceeded to commence writing the chapter about the conceptual underpinnings of this study with the interviews and the results of the first round of data analysis very much in mind. In its turn, this was brought back to the interview text. In addition, some secondary literature pertinent to specific aspects or themes that had emerged during the course of the initial data analysis was also brought in and, where possible, dialogued with the existing theoretical framework and made part of it. For example, by drawing on Benjamin’s thinking, the Jungian concept of the wounded healer was reconfigured in terms of compromised subject-to-subject relating. These further conceptualisations were also dialogued with the interviews as theoretical sensitivities through which the interview text was once more “edited”.

A “voice” that had not been clearly audible in my initial encounters with the interviews, was that of the discourse of power between participant and therapist. The fundamental place that the role of power occupies in Benjamin’s thinking served to foreground the shifting and changing power differentials between therapists and participants and made power a central organising concept in this study. This, in its turn, sharpened the theoretical lens offered by concepts like recognition and

17 See Chapter Three.
negation and led to a more differentiated understanding of processes like the evolvement of subject-to-subject relating and the participants’ identifications with their therapists.

The data analysis further resulted in the identification and conceptual elaboration of the particular therapist skills that were enhanced and developed during the course of the participants’ therapies. By situating the findings of the interpretive process within the more encompassing and distanced context of a systems perspective, an intersubjective model of personal therapy and development as a therapist was also generated.

2.8 THE QUESTION OF RIGOUR IN THE RESEARCH PROCESS

Qualitative research produces “a distinct form of knowledge” that cannot be judged by “conventional measures” of validity (that is, whether the research findings accurately reflect some underlying reality) and reliability (that is, whether the same findings may be reproduced by repeating the research procedures) (Mays & Pope, 2000, p. 2). As Kelly (1999a, p. 423) points out, the emergence of interpretive research as a reaction to positivism has been accompanied by the “rejection of positivist notions of reliability and validity”. Standards of rigour for interpretive researchers are therefore currently still in flux, not agreed-upon and evolving. In this section I shall consider a few of the ways in which I have endeavoured to render the research process trustworthy (Stiles, 1993), that is, to maintain a measure of rigour in an ongoing way.

Apart from the supervisor (and occasional discussions with other colleagues with an interest in research), two colleagues were also involved in the research process. One was interested in the research topic and I discussed the development of the Interview Guide with her. The other one was part of the study for a longer period and the coding of the interview material and the emerging theoretical account were the main areas of our discussions. This was not done to have a kind of “inter-rater reliability” (Yardley, 2000, p. 218) to ensure my interpretations of the data to be “correct”, but rather to have another perspective, a dialogue that would make it less likely that the “circularity of understanding” (Packer & Addison, 1989b, p. 34) of the interpretive inquiry would be an insularly solipsistic one.

I made a concerted effort to sustain a questioning attitude towards and a critical perspective on the research process and methodology by (as has already been described) being reflectively reflexive (Addison, 1999). Devising a research methodology that I considered appropriate to the research question did consequently not imply an indiscriminate combination of methods and strategies that seemed useful. It meant being aware of the ontological and epistemological underpinnings of any
method, so that I could take underlying contradictions into account. I therefore endeavoured to be thoughtful of what I was and was not doing.

For example, although I drew on grounded theory methodology and consider the theoretical account that was developed in this study to be grounded in the data, I never used a grounded theory method in its entirety and never developed a grounded theory as an answer to the research question. However, I made extensive use of grounded theory’s constant comparative method. But apart from the later reading that I did to make sense of the interview material, I also did a conventional literature review before starting the study as a means of situating it in the relevant body of knowledge. This is certainly recommended in other qualitative research paradigms, and it also made intuitive sense to me (since I did not want to “reinvent the wheel”). For Glaser (1992) this would definitely put my research beyond the pale of what he would consider constituting grounded theory. Conversely, other and later grounded theory adherents do not seem to condemn such a foray into the literature so roundly. More serious in making my research method not a grounded theory one (according to the strict parameters of what constitutes grounded theory), is the matter of its never “progressing” to the stage of additional theoretical sampling (Glaser & Strauss, 1967; Charmaz, 2000; Henwood & Pidgeon, 2003). The reasons for this I have explained earlier.18 While a grounded theory study often starts off with data being collected on other grounds than theoretical sampling (Henwood & Pidgeon, 2003), Charmaz (2000, p. 519) emphasises that “a solid grounded theory [cannot be produced] through one-shot interviewing in a single data collection phase”.

I have attempted to leave a research trail which “signposts” the “conceptualization phases and practical contingencies” that culminated in the final product (Bong, 2002, par. 5). This audit trail does not provide a “smooth and seamless” account (Kelly 1999a, p. 426), but also reveals the research journey’s struggles, flaws, contradictions and limitations. While I grounded the theoretical account in examples from the interviews, such examples were subject to my interpretations of the “fit” between data and theory. Because of reasons of confidentiality I could not, unfortunately, include the interviews in their entirety (as an appendix). But in other ways I have endeavoured to document a transparent and detailed account of both what I omitted to do and what I did, and also of the perspectives from which I thought, made decisions and acted.

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18 See p. 25.
At the end of the literature review it was suggested that there was a need for a deeper and more encompassing theoretical framework than those employed in the existing qualitative studies. I had thought that this would be useful to clarify, understand and interpret the interview material and to take the textual analysis beyond a descriptive to a more conceptual level. During the course of this chapter it was shown how my attention was drawn to the thinking of Benjamin and related theorists. A conceptual framework was subsequently generated by drawing upon the work of these thinkers. Secondary literature pertaining to specific themes that had emerged during the data analysis was also incorporated into this. In the following chapter I shall therefore outline the main concepts that were used in the textual analysis.
CHAPTER THREE

CONCEPTUAL UNDERPINNINGS OF THE TEXTUAL ANALYSIS

3.1 INTRODUCTION: TOWARDS AN INTERSUBJECTIVE FOCUS

In this section the main theoretical focus of this study will be introduced. This will be further outlined and elaborated in Sections 3.2 and 3.3. These three sections constitute the general theoretical framework that was used throughout the analysis of the interview material.

3.1.1 The therapist and the participant-patient

In psychodynamic psychotherapy, the “patient’s world is to be examined in the open, while the [therapist’s] is essentially private, or masked, except at a few contact points with the patient”; that is, the subjective positions of patient and therapist are different (Kennedy, 1998, p. 204). Aron (1996) points out that though the therapeutic relationship is mutual (that is, there is a system of reciprocal influence and mutual regulation between therapist and patient), it is also asymmetrical (in terms of roles, functions, responsibilities and the distribution of power).

According to Mitchell (2000), it is therefore the analyst’s task to constantly keep the analytic relationship analytic. Exactly what this means may vary (according to the specific theoretical variant of analytic therapy underpinning the therapist’s work), but there is an overarching assumption that the patient is asked to surrender to “an analytic constructed irresponsibility”; that is, he is free to experience, to feel and think and discover himself and is not responsible for accomplishing all kinds of goals, especially those pertaining to the therapist’s needs and desires (Ibid., p. 131). This enables the patient to enter the room confident of having the therapeutic space for himself and the therapist to himself, and to be assured that the therapeutic dyad is a bounded and private container. And, of course, from an ethical point of view, this is correct.

However, although the therapeutic encounter is supposed to be primarily shaped by what the patient brings to it, the subjectivities of both therapist and patient come into play (albeit in an asymmetrical way) in creating the third unconscious subject of analysis (Ogden, 1994). Knowingly and unknowingly - consciously, preconsciously and unconsciously - the therapist introduces
personal and professional discourses into the therapeutic dyad. This is usually unknown to, but often sensed by the patient. However, this is frequently not the case when the patient is a fellow professional (Berman, 1995; Crastnopol, 1999a). Berman (1995, p. 532) describes how such a patient, who is in the same professional community as his therapist, may be “flooded with information and impressions about the [therapist’s] personality, life, and functioning in various professional contexts”. The therapist is often primarily chosen because of what the therapist-patient knows about him as a professional. This knowledge is usually not only based on reality, but also involves the therapist-patient’s fantasies about the therapist as a professional.

3.1.2 Contextualising the intersubjective focus of this study
The theoretical focus of this study is on intersubjective thinking, specifically the work of Jessica Benjamin and her notion of intersubjectivity as the development of subject-to-subject relating. While there are references to the work of other relational and intersubjective theorists, I primarily draw on Benjamin’s work in developing a theoretical framework for thinking about the nature of therapist-patients’ relationships with their therapists and the influence of therapists’ personal therapies on their work. As indicated in the previous chapter, the use of Benjamin’s version of intersubjectivity, which is underpinned by the notion that therapy holds the possibility of engendering subject-to-subject relating, and in which facets of the therapeutic relationship such as recognition and negation, power and identification are elucidated, was suggested by the results of the initial round of the data analysis and lent itself to the further interpretation and conceptualisation of the interview material. (A further and more comprehensive discussion of the value of Benjamin’s ideas for this study, which relates to its data-driven nature, will follow in Section 3.1.5.)

From an intersubjective perspective, some of the questions posed by this study were therefore about how the participant’s being-a-patient could be conceptualised as an evolving process in the intersubjective third of his personal therapy (the therapeutic third) and how this would relate to his being-a-clinician in the intersubjective third of his work as a therapist (the clinical third). This also included exploring the nature of the Thirds that participants’ personal therapies formed to their work as clinicians.

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19 Flax (1994, p. 2) defines a discourse as “a system of possibilities for knowledge, practices, and power” and adds that “[d]iscursive formations include sets of usually tacit rules”. Harris (1998, p. 48) sees discourse as “a layered set of codes, regulatory practices, rules both obligatory and optional, [which] all arise in both local, familial conditions and in wider, ideologically laced practices within the culture and come to be the forces through which experiences of individual life and body life are constituted as subjective experience”.

20 I shall use Third specifically for a third perspective that triangulates the dyad and third to denote all other instances of “thirdness” (that is, primarily the “intersubjective” third) that is constellation between the two members of the therapeutic dyad. See also p. 57.
As Ogden (1994, p. 105) notes, both “the term and the concept intersubjectivity is not a contribution of contemporary psychology; rather, it is an idea that for centuries has been used in philosophy”. Benjamin’s (1995) thinking is located within the domain of current intersubjectivity theory that forms part of the wider relational perspective, which is presently in the foreground of psychoanalytic thinking in the United States. Although “there is no one hegemonic discourse or technical practice that defines current relational theory or the intersubjective turn” (Gerhardt, Sweetnam, & Borton, 2000, p. 7), it is useful to contextualise intersubjectivity by briefly considering relational theory in terms of its origins and main lines of thought.

The origins of relational theory can be situated within the long-standing and increasing discontent with both the classical and the interpersonal paradigms. According to Aron (1996, p. x): “Relational theory is based on the shift from the classical idea that it is the patient’s mind that is being studied … to the relational notion that mind is inherently dyadic, social, interactional, and interpersonal … [where] the analytic process necessarily entails a study of the intersubjective field. The distinction between the classical and relational views … is often discussed under the problematic rubric of a shift from a one-person to a two-person psychology.” Aron (1996) later argues that while contemporary classical theory has also moved in a relational direction, it is still significantly different from relational theory.

Whereas relational theory emphasises both external interpersonal relations and “intrapsychic, internal, fantasized, and imaginary relations”, interpersonal theory (Sullivan, 1953) has been criticised for referring only to external relationships between “real” people (Aron, 1996, p. 13). Benjamin follows this line of thought (that is, that both “internal” and “external” relationships should be taken into account) even further. For her (1990, p. 186), intersubjectivity “refers to that zone of experience or theory in which the other is not merely the object of the ego’s need/drive or cognition/perception, but has a separate and equivalent center of self”; that is, “where objects were, subjects must be” (1998b, p. xii).

Relational theory has therefore developed out of multiple theoretical points of view such as object relations, self psychology and interpersonal trends, and it has also been influenced by postmodern psychoanalytic thinking, such as the ideas espoused by social-constructivism and American psychoanalytic feminism (Benjamin, 1995; Berman, 1997b; Mitchell & Aron, 1999a). The relational trend was first specifically formulated by Greenberg and Mitchell (1983). They identified

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21 The term object-relations theory refers “to a group of psychoanalytic theories holding in common a loosely knit set of metaphors that address the intrapsychic and interpersonal effects of relationships among unconscious ‘internal objects’ (i.e. among unconscious split-off parts of the personality)” (Ogden, 2002, p. 768n1).
two major traditions within psychoanalytic thinking: “drive/structure” and “relational/structure” (Berman, 1997b, p. 195). The latter relational trend was explicitly set out in Mitchell’s (1988) attempt at integrating Sullivan’s thinking (the interpersonal model), British object relations and self psychology.

Current relational thinking draws on and tries to integrate “ideas from object relations theory, self psychology, interpersonal psychoanalysis, neo-Kleinian theory and certain currents within contemporary Freudian (post-ego-psychological) thinking” (Aron, 1996, p. x). “Relational psychoanalysis” is therefore not a “school” of thought as such but “rather a broad integrative orientation focusing on Self and Other”, where interpersonal history is seen as the primary determinant of personality (Berman, 1997b, p. 185; Frankel, 1998a). Aron (1996, p. 18) calls it “a contemporary eclectic theory anchored in the idea that it is relationships (internal and external, real and imagined) that are central”. All of this makes “the relational turn” in psychoanalysis richly diverse, but the “relational stew” (Aron, 1996, p. 37) is sometimes also quite confusing, and, at times, theoretically obscure and inconsistent.

According to Benjamin (1995, p. 3), “the relational perspective has added to object relations theory an insistence that psychoanalysis be viewed as operating in a two-person rather than a one-person field, so that two subjectivities, each with its own set of internal relations, begin to create a new set between them”. This brings us to the domain of intersubjectivity. It lies between subjects and is the realm of common engagement, action and communication, where “subjectivity is articulated and defined” and “in which we encounter ourselves” (Malpas, 2000, p. 591). It is therefore clear that, within relational theory, intersubjectivity represents a new and different way of articulating and conceptualising transference/countertransference.

A distinguishing feature of Benjamin’s version of intersubjectivity, which was pivotal in developing an understanding of the results of this study, is that she (Benjamin 1998b) does not only use intersubjectivity to indicate that there are two individuals creating an interpersonal field. By using and elaborating the notion of mutual recognition (which she conceptualises as part of evolving thirdness within the therapist-patient dyad), Benjamin addresses the issue of how two

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23 See pp. 61-62 for a further discussion of this.
human beings sharing a psychic space (in this instance the space of therapy) may both relate to each other and achieve/retain an independent existence.

3.1.3 The relevance of the therapist’s subjectivity in relational and intersubjective thinking

The emphasis on the use of the therapist’s subjectivity (which particularly concerns this study) is an important facet of both relational thinking and intersubjectivity. It may therefore be useful to briefly consider some of the ways in which the term subjectivity is used. Flax (1996) points out that postmodern thinkers prefer to use the term subjectivity rather than self. For them, subjectivity is a more general term, referring to “a person’s way of being in the world” (Fairfield, 2001, p. 223), where the subject is continually being constituted in a unique way and where multiple positions (for example, being both “agent and object”) are possible (Flax, 1996, p. 578).

There are also other and more specific views of subjectivity. Frankel (1993, pp. 229-230) summarises Ogden’s (1986) notion of subjectivity: “Subjectivity is defined by the feeling that one is the creator of the forms by which one perceives the world. One feels oneself to be an interpreting subject, the subject of one’s own experience; one does not feel simply reactive, an object of other people, or helplessly driven by one’s impulses. Being fully subjective is more than simply being conscious. One is aware of oneself as the ‘I’ who is doing, being, experiencing.” Kennedy (1998) emphasises that analytic subjectivity is a specific form of subjectivity, marked by receptivity to the unconscious and the ability to tolerate uncertainty, ambiguity and paradox. Gerhardt and Stinson (1995) understand analytic subjectivity in terms of the capacity to adopt a self-reflective stance.

Historically the “tradition of interest in the analyst’s subjectivity” (Harris, 1998, p. 40) may be traced from Ferenczi (1932) through Winnicott (1947) and Green (1975) to a wide range of contemporary analysts such as Aron (1996); Benjamin (1997, 1998b, 2000a); Bollas (1992, 1999); Ogden (1986, 1994, 2001).

The idea of “using the therapist’s subjectivity” begs the question about what we actually mean by this rather impressive-sounding but also quite generic notion. Highlighting “using the therapist’s

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24 This grappling with the question of relating to “the other’s independent consciousness” (Benjamin, 1998b, p. xii) is not unique to Benjamin or to psychoanalytic thinking, but has also been an issue raised by philosophers (such as Hegel, whose ideas have been fundamental in Benjamin’s theorising), and has been evocatively described by poets and novelists. For example, George Eliot (1872, p. 243) writes about how much easier it is to devote ourselves submissively to the other and to imagine that we may become “wise and strong in his strength and wisdom, than to conceive with that distinctness, which is no longer reflection but feeling … that he [has] an equivalent centre of self, whence the lights and shadows must always fall with a certain difference”.

25 Both Bollas and Ogden depict the ways in which the therapist’s openness to his own subjectivity facilitates unconscious communication and the creation of an unconscious intersubjective third between therapist and patient.
subjectivity” is certainly not confined to relational thinking. The prominence given to the therapist’s subjectivity may more generally be linked to the expanding view of countertransference, which includes the notions that countertransference may usefully inform the therapeutic process instead of just being an impediment to it and that transference and countertransference are intricately interrelated.

Benjamin (1997, p. 794n2) points out that there are “crucial differences among those that believe in using one’s subjectivity … we can delineate a difference between the self psychological use of subjectivity to resonate and create empathic participation, the Kleinian use of subjectivity to receive projective identification and the relational-conflict use of subjectivity to analyze a co-created relationship of mutual influence”. Mitchell (1993, pp. 76-77) suggests how these different views could be complementary rather than just oppositional; that is, seen in this way, theories that describe and track “the patient’s subjective experience can provide a useful corrective … where there is a tendency to drift into a preoccupation with the analyst’s participation”, while “thinking about the analyst’s participation serves as a corrective experience for those … who believe that they … know what the patient needs”. Within intersubjective thinking there is also an increased understanding of the complex ways in which the subjectivities of patient and therapist come together to create the intersubjective therapeutic third.

While there may be various ways of viewing the therapist’s use of his subjectivity, the ability to do so in a thoughtful and responsible way can be linked to certain therapist attributes (such as being open to one’s dreams, reveries, fragments of thoughts and images, affects or bodily states and reactions without becoming overwhelmed or self-absorbed; being able to represent these and think about them and so forth) which may emerge and/or develop during the course of the therapist’s personal therapy.

3.1.4 Some implications of the emphasis on the therapist’s subjectivity

If the therapist is regarded as being subjective, what happens to his authority and power? One of the prominent precursors of the relational position in object relations and self psychology has been the opposition to and replacement of the notion of the analyst as the “one who knows” (espoused by “classical” North American theory) by the idea of the analyst as “the one who knows me”, thus “embracing the maternal ideal of holding or mirroring in contrast to the phallic image of the penetrating knower” (Benjamin, 1997, p. 793).
This still implies “knowing”, even if the “knowing” is hermeneutic and mediated through being “subjective” rather than “objective”. But how can one be “subjective” and still “know” and what can be known from this perspective? Does this mean giving up the intellectual, theoretical side of the work and becoming a caring “healer-redeemer” (Benjamin, 1997, p. 796)?

In current relational thinking, “the role of the authoritative analyst” is deconstructed even further – it is, in fact, eschewed and replaced with “a view of the analyst as a coparticipant involved in a mutual if asymmetrical endeavour” (Aron, 1996, p. 258). *Mutuality* speaks of the impact of the therapist on the patient (and not just *vice versa*), and the new *asymmetry* speaks of the burden that the therapist must assume by giving up the positivistic “God’s eye view” of his “aperspectival objectivity” and certainty, while retaining the responsibility and power subsumed in the position of being the therapist rather than the patient (Aron, 1996, p. 261; Benjamin, 1997).

There is an ongoing tension between asymmetry and mutuality (Aron, 1996; Benjamin, 1997, 1998b). The therapist now no longer has the authority of the old objectivist position to fall back on. What also has to be kept in mind in this interplay of mutuality and asymmetry, however, is the fact that even if the therapist *himself* has personally abnegated the classical position of authority, there remains a power differential between therapist and patient, just because of the therapist’s being in the position of therapist. In this regard, Hoffman (1998, p. 203) discusses the ongoing dialectic “between the patient’s perception of the analyst as a person like himself or herself and the patient’s perception of the analyst as a person with superior knowledge, wisdom, judgement and power”.

The postmodern relational opening up to the possibilities of multiple realities and multiple truths that foregrounds the role of the therapist’s subjectivity in shaping, expanding and limiting the analytic relationship, could bring new freedom of thought and action to the therapeutic endeavour. One now further has to ask whether the “decline and fall of the blank-screen analyst” (Gabbard, 1997, p. 15) and related ideas such as the therapist’s being “irreducibly subjective” (Renik, 1998, p. 487), “poetic-philosophically uncertain” (Böhm, 1999, p. 493), with “misunderstanding … being the natural state of affairs” (Stern, 1991, p. 56) have, as reversals of positivistic objectivity, not also become problematic in themselves.

It is certainly “a corrective to the old authority relationships to promote identification with the relational models of mutuality and uncertainty” and the therapist’s use of his own subjectivity

26 That is, a *like* subject (Benjamin, 1995).
(Benjamin, 1997, p. 797). However, this also begs the question if throwing away “the book” has not perhaps become “the book” (Hoffman, 1994, Slavin & Kriegman, 1998b). Idealising this new position (which includes “not-knowing”) could, for all its appearance of almost anarchistic freedom, become just as narrowly dogmatic and prescriptive as the old one. Slavin and Kriegman (1998b, p. 278) accordingly warn that the “idealization of therapeutic spontaneity” could in itself become “a new agenda” … “biased towards the needs and views of those who come to advocate it”. Within postmodern theorising there is an acknowledgement that “the problem of authority and of unjustified privileged claims to know” has not been resolved (Harris, 2002, p. 1004). In fact, “authority can easily be mystified in apparently democratic and healing practices” (Ibid.) Taking up the negative of positivism also does not “resolve the dilemmas that gave rise to the old authority position” (Benjamin, 1997, p. 797). These predicaments are the difficult and painful realities of the therapist’s experience of his own limitations in working as a clinician: the sense of always lacking in some respect and of never knowing enough; the fear of failing to heal the patient; the sense (even if it is not all that conscious) that what he thinks and what he does are always suffused by his own subjectivity.

How then may the tools and knowledge of the old “objective” position not necessarily be renounced, but rather be redeployed without the negatives of either the necessity of “removing” the therapist’s subjectivity or reverting to “the stultifying self-assurance of dogmatism and orthodoxy” (Hanley, 1995, p. 907)? And if there is “mutuality” and if the therapist’s subjectivity (which includes the power brought by the position as therapist and also the therapist’s inevitable lacks and limitations) is to be acknowledged as being part of and actively and deliberately used in the therapeutic enterprise, we have to ask how this may happen without compromising professional integrity, responsibility, expertise or discipline. This again brings the therapist’s own therapy (and all the questions already posed) to the foreground.

Some relational thinkers have grappled with these questions and have made attempts to answer them. Aron (1996, p. 261) urges that “dialectical objectivity” (which “is informed by subjectivity and includes within itself reflection on the subjective”), would be a better option than “radical relativity and undisciplined subjectivity”. This resonates with Mitchell’s (1997, p. 268) idea that “good analytic technique” pertains to continual “hard thinking” rather than aspiring to “correct actions”. He sees this “hard thinking” as being part of the therapist’s engagement in a process of “self-reflective responsiveness of a particular (psychoanalytic) sort” (Ibid., p. 193).
Another pertinent matter is the possibility that the relational and intersubjective emphasis on the therapist’s subjectivity, while correcting the “one-sidedness” of the notion of a neutral and objective therapist, could lead to highlighting the relational reality of the therapeutic dyad (Bernstein, 1999, p. 278). This holds the possibility of the intersubjective remaining at the level of the interpersonal and a focus on the conscious aspects of intersubjectivity, which has been debated within relational theorising and is also a criticism that has been levelled at relational thinking (Bernstein, 1999, 2001; Greenberg, 2001; Ringstrom, 2001a). If we accept that the therapist does influence the therapeutic process on a personal level, we also have to take Bernstein’s (1999, p. 280) warning that “countertransferentially guided interpretations [could] constitute an elegant disguise for an analyst’s narcissistic gratifications” seriously. After all, one of the fundamental tenets of psychodynamic psychotherapy, which is also ethically relevant, is that the space of therapy belongs to the patient and not to the therapist and should not be crowded by the therapist as an individual with needs and desires.

The impact of the therapist’s subjectivity should also be seen as going beyond the purely interpersonal level of mutual reciprocal influences into the symbolic aspects of unconscious intersubjectivity. Gerhardt, Sweetnam and Borton (2000, p. 8) consequently see a therapeutic relationship that stays at the level of “mutual reciprocal influence” as reflecting a collapse of the therapeutic space. Crastnopol (1999a, p. 460) further notes that instead of mutuality always just becoming a “truncated end in itself”, it could actually provide “a secure base for going beyond it”.

Benjamin (2000a, p. 45) clarifies the notion of going beyond the “merely interpersonal” (Gerhardt, Sweetnam & Borton, 2000, p. 8) by differentiating “subjecthood” (that is, “how we come to accept alterity, otherness”) from “personhood” or subjectivity (that is, “personal subjectivity”). Being self-expressive (which the therapist inevitably is) does not necessarily imply any deliberate self-disclosures. The nature of the presence of the therapist as a separate and different other, that is, his alterity, should further depend on where the therapy and the patient are at in a specific moment.

According to Bollas (1999) (and this is similar to Benjamin’s thinking), there is a difference between being subjective and being personal. Indeed, a focus on the therapist’s “personal response” may sometimes “unwittingly evacuate[s] the work of subjectivity in the name of being personal” (Ibid., p. 51). Ogden (2001, p. 42) clarifies this distinction between the therapist’s being personal and his using his subjectivity within the transference-countertransference relationship in his

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27 Bollas has been criticised for “undertheorising” his own impact on the analytic process (Renik, 1995; Aron, 1996). See also p. 108n77.
evocative description of how he (Ogden) attempts to speak to the patient from his reverie experience rather than about his experience of reverie. The intersubjective encounter should therefore be seen as also taking place at the level of unconscious internal processes, where the therapist “is being composed by and is in turn composing the patient’s material”, rather than just in mutuality or reciprocal effects (Bollas, 2001, p. 96).

3.1.5 The intersubjective focus of this study
There were specific reasons why intersubjective thinking, and particularly the brand of intersubjectivity espoused in the works of Jessica Benjamin, was used to deepen the more descriptive results that ensued from the initial data analysis into a conceptual account. It was clear that such a theoretical account would need to encompass both the intrapsychic and intersubjective aspects of the participants’ experiences of being in therapy, working as therapists and the links between those. This is precisely what Benjamin’s thinking made possible, as will become evident later in this chapter, and in the next one where the textual analysis is discussed.

Benjamin’s (2000a, p. 44) description of evolving thirdness “in developmental terms as a kind of intersubjective trajectory”, or what could be called a trajectory of thirdness within the therapeutic dyad, where there is a movement towards mutual recognition and subject-to-subject relating, contributed towards envisaging the participants’ professional development as changes that are both wrought within the therapeutic third (between participant and therapist) and constellated within the clinical third (between participant and patient). Features of therapy, such as the power differential between therapist and patient, idealisation and identification, which are (to a greater or lesser extent) present in all therapies, but that were foregrounded in this group of participant-therapists’ therapies, are fundamental tenets of Benjamin’s conceptualisation of intersubjectivity as the evolvement of subject-to-subject relating.

While inclusive of different theoretical viewpoints (which she often creatively reconfigures in terms of her own ideas), Benjamin (1995) locates her intersubjective perspective within the relational domain. Benjamin’s work has a strong philosophical grounding and she (Benjamin, 2000b, p. 293) succinctly states that her current notion of intersubjectivity, which is “based on a dialectic of recognition and destruction”, grew out of an “unlikely resonance between Hegel and Winnicott”. While thinking intersubjectively, Benjamin retains strong links with object relations theory and that of Freud (and with some references to Lacan).

28 See also pp. 209-211.
29 This will be discussed in Section 3.3.
The main theoretical grounding of this study has therefore been Benjamin’s relational conception of intersubjectivity. The rich (and sometimes confusing) intricacies of her theoretical voice are her own, but through and within those a diverse range of theorists, including philosophers, feminists and psychoanalytic thinkers appear (or may be glimpsed), are critically considered, sometimes assimilated and sometimes turned away from. I have also employed the thinking of some of those psychoanalytic theorists, such as Lewis Aron, Christopher Bollas and Thomas Ogden, where this “fills out” or elucidates and helps to unpack Benjamin’s theorising. I have limited the use of these “other thinkers” to those whose work was not only specifically useful for the purposes of this study, but whose ideas are also theoretically compatible with (and/or add to) those of Benjamin. That is, those who broadly fall within the spectrum of relational psychoanalytic theorists or those whose notions of intersubjectivity are congruent with that of Benjamin.

Aron (1996) is probably more of a relational than an intersubjective thinker, but has also written about the Third that a therapist’s relationship with his professional identity forms to his relationship with patients (Aron, 1999). He (Aron, 2000) has utilised Benjamin’s ideas in his own theorising and has collaborated with her in the development of an intersubjective rendition of the ability to think reflectively (Benjamin & Aron, 1999). Strictly speaking, Ogden (1994, 2001) and Bollas (1999, 2001) are intersubjective rather than relational thinkers. One could call Bollas (Ibid.) a neo-Freudian, as well as a Freudian intersubjectivist. While Ogden (Ibid.) makes extensive use of Freud’s ideas, he also uses the work of object-relations theorists, such as Bion, Klein and Winnicott, in developing his ideas concerning the “analytic third”. In some regards Ogden could be considered to have “intersubjectivised” Klein.

To “capture” the interview material at a phenomenological level, the point of departure of the conceptualisation of the data took place in terms of the intrapsychic and intersubjective. Particular emphasis was placed on Benjamin’s notion of intersubjectivity as the development of subject-to-subject relating, that is, as an expansion of the therapist-patient’s “capacity for appreciating the different subjectivity [or selfhood] of [his] therapist, [as well as that of his patients]” (Buirski & Haglund, 2001, p. 41). Ogden (1994) also addresses (albeit somewhat differently) some aspects of subject-to-subject relating in his conceptualisation of the “subjugating third”, a negative variant of his “analytic third”. In this study, subject-to-subject relating pertained both to what was happening between the participant and his therapist (the therapeutic third) and between the participant and his patient(s) (the clinical third).
Benjamin (1998b, 2001) and Ogden (1994, 2001), as well as, to some extent, Bollas (1992, 1999, 2001) and some relational and Lacanian theorists, elaborate their intersubjective thinking in terms of specific and detailed conceptualisations of thirdness (the intersubjective third) and Thirds (third points of reference outside the therapeutic dyad).\(^{30}\) This was used to clarify and explore the notion of thirdness and Thirds,\(^{31}\) which became a central part of making theoretical sense of the interview material and sharpening the conceptual focus.

In the final phase of the data analysis, a systems perspective, which depicted the interplay of the therapeutic and clinical thirds with each other, as well as with other Thirds, was employed to develop an intersubjective model of the development of the psychodynamic psychotherapist. In doing this, I moved from an intersubjective model (which encompassed both the intrapsychic and the intersubjective dimensions of experience) to a “systems lens” (Coburn, 2002, p. 657). As Coburn (Ibid.) points out, this may be indicative of a movement from a more phenomenological to an increasingly explanatory level of conceptualisation, rather than suggesting the introduction of an untenable merging of contradictory models.

For the reason that I wanted to avoid this kind of indiscriminate “model-mixing”, and because I deemed the intersubjective approaches already mentioned to be more suitable for the specific proposes of this study, I have mostly omitted a large and significant body of intersubjective theory, that is, “intersubjective systems theory” (Stolorow, 2001, p. xii) from the theoretical discussions. The focus of this approach is “on the field created by the coming together of subjectivities of both patient and therapist” (Buirski & Haglund, 2001, p. 22).

Stolorow and his colleagues (Atwood & Stolorow, 1984; Stolorow & Atwood, 1992; Stolorow, Atwood & Brandchaft, 1994) introduced the term “intersubjectivity” into psychoanalysis and, together with other like-minded theorists, developed this notion further into the contextualist or systems intersubjective approach (Orange, 1995; Orange, Atwood & Stolorow, 1997; Buirski & Haglund, 2001). Although Stolorow (1992) asserts that his notion of intersubjectivity did not grow out of self psychology, but rather developed parallel to it, the thinking of Stolorow et al. is clearly underpinned by self psychological concepts. Intersubjective systems theory further “draws heavily on the hermeneutic tradition, … [where in] … a continuously interpenetrating process, meaning influences subjectivity and subjectivity selectively organizes context” (Buirski & Haglund, 2001, p. 13).

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\(^{30}\) Bollas, and especially Ogden, add to Benjamin’s notion of thirdness by their emphases on the unconscious aspects of the intersubjective third.

\(^{31}\) See Section 3.2.
Although Benjamin (2000b) acknowledges some influence of Kohut (1977) on her early work, the epistemological roots of Benjamin’s notion of intersubjectivity and that of Stolorow et al. are quite different. There are some similarities in their underpinning assumptions, but a careful reading of their theories reveals an epistemological divergence.

In both approaches there is an emphasis on the subjectivities of both patient and therapist, as well as on the notion of a therapeutic relationship that is asymmetrical, but where mutual regulation takes place between therapist and patient (Aron, 1996; Buirski & Haglund, 2001). In relational theory, relational history is seen as the primary determinant of personality (Berman, 1997b; Frankel, 1998a). Relational theory is therefore “anchored in the idea that it is relationships (internal and external, real and imagined) that are central” in shaping experience (Aron, 1996, p. 18). Intersubjective systems theory is concerned with the way in which people structure their experience, that is, the structures of experience (Atwood & Stolorow, 1984) that emerge from “formative relationships” with caregivers and significant others (Buirski & Haglund, p. 31).

However, the conceptual approach of intersubjective systems theory is more specifically systemic or contextualist than that of relational theory, where thinking often happens in terms of the intrapsychic and the interpersonal. According to Stolorow (2001, p. xii-xii), from the “intersubjective perspective, clinical phenomena … [are understood] as taking form at the interface of the interacting experiential worlds of patient and therapist … Experiential worlds and intersubjective fields are seen to mutually constitute one another”. Relational theory is also more broadly eclectic (Aron, 1996), while intersubjective systems theory is imbued with self-psychology concepts and language.

Apart from the other reasons (which were previously mentioned) for particularly using Benjamin’s intersubjective version, I considered the more explicitly and detailed notions of thirdness and Thirds to be more useful and suitable for the purposes of this study than Stolorow and colleagues’ theorising, which takes place in terms of a general intersubjective field, that is, “a system of reciprocal mutual influence” (Stolorow, Atwood, & Brandchaft, 1994, p. 37). I did use the notion of fluid and interpenetrating systems, also espoused by intersubjective systems theory, in developing an intersubjective model of the psychodynamic therapist’s therapy, but this was done at the level of the interplay of Thirds, rather than at that of the subjectivities of therapist and patient.

For example, according to Buirski and Haglund (2001, p. 40), “patients are at the deepest level seeking a selfobject relationship in which their developmental strivings can be repaired”.

See Section 3.2.
Of course Benjamin, Aron, Bollas and Ogden differ in their areas of theoretical interest as well as in their emphases on specific concepts, but their work also often links up and overlaps. For all of these relational and/or intersubjective thinkers, “the analyst’s conscious and unconscious participation constitutes an ineradicable part of the analytic exchange” (Gerhardt, Sweetnam & Borton, 2000, p. 8). This means that the therapist’s presence and subjectivity are explicitly theorised (albeit in somewhat different ways) as a basis for knowledge in the task of patient and therapist’s co-constructing subjective and intersubjective meanings in the therapeutic intersubjectivity. However, in this regard it is not the issue of the therapist’s self-disclosure (that is, if he self-discloses or not) that is primarily important, but rather how he or she becomes a “voice” in the therapeutic space when speaking from a subjective position without necessarily speaking of that position (Ogden, 2001). Speaking from a subjective position does therefore not mean being inappropriately self-revealing and indiscriminately disclosing of personal material. According to Benjamin (1997, p. 796), what is of primary importance is “how we think about our use of our felt responses and how we make access to our thinking available to our patient”. Mitchell (2000, p. 76) concurs with this: “Among the most important judgements the analyst has to make are those concerning what he says about what he feels and does.”

Thinking points to the presence of a psychoanalytic consciousness, variously named by these theorists. This psychoanalytic consciousness (rather than a “technical stance”) becomes a way for the therapist to tolerate working “within a situation that, as Bion said, ought to inspire fear” (Benjamin, 1997, p. 796). The psychoanalytic consciousness exists in dialectical tension with the therapist’s immersion in his own experiences of the therapeutic intersubjectivity, that is, with the psychoanalytic unconscious (Spezzano, 1993, p. 212). It is therefore important for the therapist to be able to remain open to the “indeterminate shapes” of these “unformulated experiences” (Stern, 1997, p. 196) even when they appear fragmented and idiosyncratically subjective, and to be capable of turning the lens of his psychoanalytic consciousness on them for reflective (but non-pejorative) scrutiny (that is, to be aware, to think, and reflect). In this way the therapist’s presence could become a “third mediating voice” (Gerhardt, Sweetnam & Borton, 2000, p. 8) that triangulates the dyadic encounter and opens up possibilities for further analytic work.

34 Gerhardt, Sweetnam and Borton (2000, p. 9) use the term analytic consciousness, but since the theoretical “lens” I am using is psychoanalytic rather than Jungian, I think that psychoanalytic consciousness would be the more accurate term.

35 Stern (1997, p. 187) highlights that the therapist’s “primary problem is not to select a correct interpretation… [but] is how to sense that there is something there to interpret”.

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3.2 THIRDNESS AND THIRDS

In this section I shall, as precisely and concisely as possible, attempt to provide an outline of the current (and ongoing) debates surrounding thirdness and Thirds. Illustrations of some of these points will be used in the chapter where the analysis of the material is presented.

3.2.1 Contextualising thirdness and Thirds

Thirdness refers to the psychoanalytic third, which is also referred to as the analytic third, or just the third or the Third. This concept was introduced into psychoanalysis by Lacan (1988), whose work Benjamin (1998a) acknowledges as being influential in the evolvement of her thinking and who developed the notion of intersubjectivity outside of relational theory (he and his followers described how subjectivity emerged in the context of and through the mediation of language and other cultural structures). It is a useful, relatively new concept that is commonly used in intersubjective and relational thinking, and also by those theorists with strong Lacanian leanings (Benjamin, 2001; Ringstrom, 2001a). From a semiotic perspective, Hervey (1982, p. 24) asserts that a “given thing is a ‘third’ if its nature (in fact its overriding purpose … ) is to mediate a particular, otherwise non-existent, relationship between two further things”. He also calls this the “hierarchically highest level of existence”.

Unfortunately, as Ringstrom (2001a, p. 743n9) points out, within psychoanalytic thinking, this concept is “riddled with all the vagaries and multiplicities of meaning that beset other high-level abstractions such as the concepts of transference and projective identification”. While the idea of thirdness is readily appropriated and used, it is often not clear exactly what is meant by it.

The matter of denoting thirdness as third or Third is also frequently confusing and inconsistent. Thirdness is referred to as the Third within the context of the Lacanian notion of thirdness, where the Third is seen as an independent, pre-existing, “culturally bound structure” that grounds the patient-therapist dyad (Ringstrom, 2001b, p. 5). Outside Lacanian theory, it appears that third is usually used to refer to the emerging thirdness co-created between the members of the therapeutic dyad, while Third is used to indicate an outside perspective (like the therapist’s professional allegiances) that triangulates the therapeutic dyad (this can be positive or negative). To complicate matters even further, both the co-created intersubjective third and a third perspective may also sometimes become a structuring Third. When possible, I shall attempt to distinguish these forms according to their function, using third for the intersubjective third and Third for a third vertex that triangulates the dyad.
Different theorists understand and use the notion of thirdness in a variety of related ways. Bollas (2001, p. 93), who focuses “on what we may think of as the intersubjective within the Freudian frame of reference”, where the aim is the unconscious communication of the “Freudian pair” (Ibid., p. 95) of therapist and patient, is an example of how even the same theorist may do this. He (Bollas, 1992, p. 112) sees “the third intermediate object” as being created in a similar way that Ogden does. In his theory of unconscious intersubjectivity, the idea of the preconsciously rendered material from both patient and analyst being available for “free-associative recollections” or “links” in an “intermediate space” between patient and therapist may be interpreted as constituting a third (Bollas, 2001, p. 96). However, his notion of thirdness also hints at a more Lacanian tilt, when he conceptualises the analytical process as “a third object”, mutually recognised by therapist and patient, as holding the analytical couple, preceding and outliving them (Bollas, 1999, p. 6).

To explore and elucidate this concept, it is useful to attempt to categorise its meanings and uses, even if the resulting categories are not all that clear-cut and tend to overlap.

3.2.2 The meanings and uses of thirdness and Thirds

3.2.2.1 Co-created thirdness

For some theorists, the third is an “unconsciously, co-created state” of intersubjectivity (Ringstrom, 2001a, p. 743n9). Used in this way, thirdness refers to “the property of intersubjectivity [that concerns] the creation of something that no longer identifiably emanates from one person or the other but mediates between them” (Benjamin, 2002, p. 49). Thirdness further denotes “a state of optimal subject to subject relating, wherein the engagement of the two parties in the dyad is ineluctably mutually influential” (Ringstrom, 2001b, p. 6). It is newly created in every therapeutic couple; that is, it ensues from a specific therapeutic relationship and its nature depends on the way that the members of the specific therapeutic couple relate to each other. It is also continually changing within the context of a specific therapeutic dyad.

3.2.2.1.1 Ogden’s analytic third

This idea of the third is explicitly and comprehensively described in Ogden’s (1994, 1997, 2001) theorising around the analytic third. Ogden’s original notion of the psychoanalytic third (also referred to as the analytic third) is the culmination of his elaboration on the work of Freud, Klein, Bion and Winnicott into a “radically intersubjective” vision (Mitchell & Aron, 1999b, p. 460). Ogden perceives the analytic situation “as generating a profound form of unconscious connection” (Ibid.) between therapist and patient; that is, the analytic third, which is therefore “an emergent
construct arising intersubjectively” (Cooper, 1999, p. 34n1) with “a life of its own” (Ogden, 2001, p. 11).

Because the concepts of “dialectic” and “dialectical interplay” are so central to Ogden’s work and to intersubjective thinking (and will be referred to again), it is useful to digress at this point and to consider what he means by these notions. He (Ogden, 1994, p. 14) defines the term dialectic as follows:

*A dialectic is a process in which opposing elements each create, inform, preserve, and negate the other, each stands in a dynamic, ever-changing relationship with the other. Dialectical movement tends toward integrations that are never achieved. Each potential integration creates a new form of opposition characterized by its own distinct form of dialectical tension. That which is generated dialectically is perpetually in motion, perpetually in the process of being created and negated ... In addition, dialectical thinking involves a concept of the interdependence of subject and object ... One cannot begin to comprehend either subject or object in isolation from one another.*

In Ogden's version of the dialectic, the idea is to maintain a tension, not to resolve a contradiction in favour of a “synthesis” (Benjamin, 1999b, p. 397). This is similar to Winnicott's (1971) understanding of paradox: “that it is never finally resolved”; that is, it “persists as a tension” (Benjamin, 1999b, p. 397). Benjamin (Ibid.) notes that Hegel conceptualised the dialectic as a linear process where the synthesis of contradictory polarities would repeatedly be dissolved, creating a new contradiction that would once again lead to a new synthesis, “thus abandoning the old positions and moving forward in a linear way toward final telos”. Ogden's work therefore “represents a transformation of the dialectic as conceptualised by Hegel in a direction suggested by more contemporary thinkers” (Ibid.).

Therapist and patient create one another as subjects of analysis and as “partners” (vertices of experience); in the tension of this dialectical process they exist and can be conceptualised and understood only in terms of each other. Ogden conceptualises the ever-changing unconscious intersubjective analytic third as a third subject of analysis that is generated in the same moment that therapist and patient are created as subjects of analysis. Benjamin (2001, p. 18) calls Ogden’s analytic third “a kind of co-created subject-object”, a “pattern or a relational dynamic that appears to form outside our conscious will”.

The analytic third is “a product of a unique dialectic generated by/between the separate subjectivities” of therapist and patient (Ogden, 1994, p. 64) that is unconsciously, jointly but
asymmetrically, co-created by the individual subjectivities of patient and therapist and may be thought of as “the unconscious representations of the interaction of the analytic pair” (Cooper, 1999, p. 34n1). Ogden (2001, p. 19) sees therapist and patient as both contributing to this “experiential base”, which he calls “a pool of unconscious experience”. While therapist and patient both draw on the third in generating their experience of the therapeutic relationship, it also stands “in dialectical tension” with them as separate individuals (Ogden, 2001, p. 12).

The analytic third is given form by and in its turn also shapes the therapeutic relationship (in an enriching or constricting way) and transforms patient and therapist (and is transformed by them). Ogden’s thinking about the third means that whatever patient or therapist experiences must be understood within the context of the dialectic of individuality and intersubjectivity. It is with the intricate fluidity of the complexity of this dialectic that the therapist needs to grapple: what belongs to whom is never quite clear or self-evident.

Ogden (1994, p. 94) emphasises that the work of analysis does not constitute “a democratic process of mutual analysis”; that is, in the analytic discourse it is the conscious and unconscious experience of the patient that is privileged and the analyst’s experience of the third is a means of understanding this. He (Ogden, 2001) therefore highlights the importance of the therapist’s close attentiveness and attunement to the fine contours and textures of what happens in the therapeutic space. “Experiential shapes” (such as the therapist’s reveries, the patient’s dreams or mutual enactments), “the psychological purposes” served by them being generated and the manner in which they are linked together, open the way towards “an expanded sense of the fundamental nature of the third” (Ogden, 1999, pp. 488-489).

In his thinking about the subjugating third, Ogden focuses on the dialectic between “the subordinating relation and the recognizing third” (Benjamin, 1999b, p. 398). He (Ogden, 1994, p. 97) describes the subjugating third in terms of projective identification, which is “a form of intersubjective thirdness” that is underpinned by “the interplay of mutual subjugation and mutual recognition”. Ogden sees the “negating moment” as being essential and “breakdowns” as also having creative potential (Benjamin, 1999b, p. 398).

This means that the “relational third can be experienced either as a vehicle of recognition or something we have to submit to” (Benjamin, 2001, p. 18). Within the dialectic of mutual subjugation and mutual recognition, the potential space of thirdness may collapse and the individual subjectivities of therapist and patient may be subsumed by the subjugating third (that is,
both patient and therapist have submitted to it), but their subjectivities may also be reappropriated as transformed when thirldness is reinstated. For Ogden (1994, p. 106), the “act of mutual recognition” (and re-established thirldness) happens through the therapist’s “interpretation of the transference-countertransference” and the patient’s use of this interpretation.

3.2.2.1.2 Benjamin and thirldness as the evolvement of subject-to-subject relating

There are similarities between Ogden and Benjamin’s thinking about the intersubjective third. However, as Benjamin (1998b, p. xv) points out, Ogden (1994) posits the analytic dialogue itself as a “third”, but her meaning is “limited to an internal mental space created through a dialogue that recognizes the other”; that is, where subject-to-subject relating becomes possible. Benjamin and Ogden’s theorising specifically overlaps in Ogden’s (1994) conceptual elaboration of the *subjugating third* (which has already been discussed).

She (Benjamin 1995, p. 28) posits recognition as the process of being acknowledged by the other “as an equivalent center of experience”. Recognition “begins with the other’s confirming response, which tells us that we have created meaning, had an impact, revealed an intention” (Benjamin, 1995, p. 33)... and “makes meaningful the feelings, intentions, and actions of the self. It allows the self to realize its agency and authorship in a tangible way” (Benjamin, 1988, p. 12).

Benjamin (1998b, p. xv) conceptualises the third position as coming into being in the “communicative relationship, which creates a dialogue, that is an entity in itself, a potential space outside the web of identifications”. While Benjamin (Ibid.) sees the patient and therapist’s identifications with each other as possible bridges to thirldness and mutual recognition, the patient and therapist may also get entangled in the “web” of identifications (or in the transference-countertransference matrix).

Benjamin comments (1998b, p. xiv) that in current relational theory the therapeutic dyad, that was previously seen as being constituted by “knowing subject and object of knowledge”, is reconfigured to a dyad where both therapist and patient are subjects. Therefore both the subjectivity of the therapist is acknowledged (that is, the therapist’s subjectivity as a “fallible being” is restored), and the patient is elevated “to the position of a subject who collaborates and knows” (Benjamin, 1998b, p. xii, p. xv). However, Benjamin’s (1998b, p. xv) theorising about the creation of thirldness goes further than this reversal and “reintegration of subjectivity and mutuality” in envisaging thirldness as a space which holds the possibility for both subjects to “recognize the difference of the other”, that is, for the evolvement of mutual recognition (Benjamin 1998b, p. xii).
Benjamin (1988, p. 40) emphasises the relational nature of mutual recognition: “Mutual recognition cannot be achieved through obedience, through identification with the other’s power, or through repression. It requires, finally, contact with the other.”

The idea of mutual recognition holds a paradox: in order to exist as an autonomous being (who can have an impact on an other), one is dependent on the recognition of an other, who should also be recognised as an independent being (Benjamin, 1988, 1995). Ogden (1994, p. 104) notes: “It is only through the recognition by an other who is recognized as a separate (and yet interdependent) person that one becomes increasingly (self-reflectively) human.” Dependence and independence are no longer seen as oppositional dichotomies, but as being held in tension in an interactive system (Benjamin, 2002). “Thus, at the moment when we become agents, we lose a sense of our own absoluteness and omnipotence. We become vulnerable to the impact of an ‘other’” (Pollock & Slavin, 1998, p. 863). And further: “At the very moment we come to understand the meaning of I, myself, we are forced to see the limitations of that self” (Benjamin, 1995, p. 37). Intersubjectively viewed, mutual recognition is therefore constituted by “two active subjects … [who] … may exchange, may alternate in expressing and receiving, cocreating a mutuality that allows for and presumes separateness” within the dialogue that develops into thirdness (Benjamin, 1998b, p. 29).

Pollock and Slavin (1998, p. 866) highlight the similarity between what they call “reciprocal agency” and Benjamin’s concept of mutual recognition. “In the classical/structural model, agency was represented by the capacity to be, in some sense, the owner and master of one’s drives and motives … ”, but they reconfigure the idea of agency, which may accordingly be understood as “the internalized experience of being able to have an impact on one’s relational world” (Ibid., p. 861), in the context of relational theory (rather than just in terms of “internal impulses”) (Ibid., p. 858). Thus the apparent opposites of dependence and independence may become reconciled by the notion of “agency within an interactive system” (Benjamin, 2002, p. 45). A “mature sense of agency” (Pollock & Slavin, 1998, p. 861) further implies a “certain level of self-other differentiation” (Ibid. p. 863) and the ability to trust one’s own perceptions.

According to these authors (Pollock & Slavin, Ibid. p. 861), a mature sense of agency is a prerequisite for an individual to be able to construct “a cohesive and coherent sense of self”. Their emphasis is on the constructed nature of this coherent sense of self; that is, this does not mean that

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36 “In mature agency, the individual becomes capable of moving between the pole of self-awareness, characterized by the capacity to recognize the distinctions between one’s own and someone else’s agenda, and the pole of reciprocal connection, in which the individual can recognize, affect, and let oneself be truly influenced by another person” (Pollock & Slavin, 1998, p. 864). This resonates with Benjamin’s notion of there being a dialectic of recognition and negation.
“a single consistent identity” is developed, thus also supporting the postmodern relational notion of “multiple self-states” (Ibid.). This may be clarified by considering Flax’s (1990, pp. 218-219) criticism that in post-modern thinking the notions of a “core” self (that is, “a sense of continuity or ‘going-on-being’”) and a “unitary” self are often conflated. To this one may add Layton’s (cf. Pizer, 1998, p. 153) comments: “In the relational paradigm, ‘core’ does not mean innate, nor does it imply a true self … But ‘core’ does imply something internal that recognizably persists even while it may continuously and subtly alter…” Benjamin (1995) further points out that the usage of the term subject in psychoanalysis does not denote a unitary self and needs to retain some notion of the subject’s unique idiom (Bollas, 1992), which would include the idea of the self as “a historical being that preserves its history in the unconscious” (Benjamin, 1995, p. 13). Rivera (1989, cf. Aron, 1996, p. 74) gives an eloquent description of the idea that “our understanding of subjectivity should include both ‘identity’ and ‘multiplicity’”:

[It is] not the silencing of different voices with different points of view – but the growing ability to call all those voices “I”, to disidentify with any one of them as the whole story, and to recognize that the construction of personal identity is a complex continuing affair …

The idea of mutual recognition may be further elucidated by differentiating between “the subject’s relationship to others and objects” (Benjamin, 1998b, p. 80). This necessitates distinguishing between object and other, or between “an ‘inside’ versus an ‘outside’ perspective on otherness” (Gerhardt, Sweetnam, & Borton, 2000, p. 10). Benjamin (1995, p. 6) uses Winnicott’s (1969) distinction between object relating (that is, relating “to the other as an object of identification/projection”), where the object remains subjective, and object usage (that is, relating “to the other as an independent outside subject”) in developing her thinking about the differentiation between object and other. Object therefore refers to the role of the “intrapsychically cast” other “as constituted by the unconscious phantasy, need, wish and defense” and other to the way one relates to the “real” external other (Gerhardt, Sweetnam, & Borton, 2000, p. 11). Although some object relations theorists (for example, Fairbairn, 1944) do take account of the formative effect of early significant others in a child’s life, the main focus in object relations theory is on the role of the other as the “object of internalization, identification and projection”, that is, on the other rendered an internal object constituted by “the self’s omnipotent phantasizing” (Gerhardt, Sweetnam, & Borton, 2000, p. 11).
Benjamin (1995) specifically links intersubjectivity with not just relating to the other as an object, but also recognising the other as an *equivalent* but *different* centre of being; that is, a *subject*.

Identificatory processes are involved in acts of recognition, but when identification only takes place in the context of “relating to the internal object” (that is, becoming the other’s object or casting the other in the role of one’s object), this could impede recognition (Benjamin, 1999b, p. 396). Recognition concerns the destruction of the other as object and his survival as subject.

Benjamin’s notion of thirdness therefore concerns that quality of intersubjective relating wherein both persons in the dyad can be more fully acknowledged, more fully mutually recognised. Within the space of therapy, therapist and patient may therefore come to exist as *like subjects*, each with his own version of “power, freedom and desire” (Benjamin, 2000a, p. 46). Nonetheless, for Benjamin (2000a), intersubjectivity is not to be found in the “achievement” of mutual recognition, but rather lies in the process where mutual recognition is constantly being lost and found in the dialectic of recognition and negation. Recognition therefore cannot exist without negation, and as “a moment of self-assertion, directed towards the other”, negation is an essential counterpart to recognition (Benjamin, 1995, p. 210). Recognition and negation are indeed mutually and reciprocally constitutive of each other Benjamin (Ibid.) adds: “Any act of the subject that has an impact ‘negates’ the other … the other is no longer exactly what she or he was a moment before. Negation is also “irreducible to the subject’s own mental world … ” (Benjamin 1998b, p. 94). The change in the other furthermore constitutes “the recognition the subject seeks …” (Benjamin, 1995, p. 210). The “negative moment” then becomes reintegrated “to create a sustained tension rather than an opposition” (Benjamin 1995, p. 23).

For the patient to feel recognised, the therapist therefore “has to change” (Benjamin, 2001, p. 24). For that reason the ”fundamental quality of therapeutic recognition – whether conveyed in verbal, gestural, or tonal form, is that the therapist is making an internal adjustment to the patient; the therapist is registering the imprint of the patient’s state even while striving to preserve personal integrity and equilibrium” (Pizer, 1998, p. 130).

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37 Frankel (2003, p. 516) comments that Benjamin’s notion that we need to recognise (that is, value) the other in order to gain the recognition that “will give meaning to our own subjectivity”, highlights that “the analytic [and therapeutic] endeavour is a moral undertaking” (Ibid., p. 514).

38 According to Winnicott (1969), “the recognition of the other involves a paradoxical process in which the object is in *fantasy* always being destroyed”; that is, “the object must be destroyed *inside* in order that we know it to have survived *outside*; thus we can recognize it as not subject to our mental control” (Benjamin, 1988, p. 38). It is when this sequence fails, that internalisation happens (Benjamin, 1998b).
Benjamin (1998b) postulates a dialectic between recognition and negation that incrementally lends itself to the formation of a new intersubjective structure wherein the participants are able not only to relate as subject-to-object, but also in a more subject-to-subject manner. According to Ogden (1994, p. 104), “an intersubjective dialectic of recognizing and being recognized serves as the foundation of the creation of individual subjectivity”. Benjamin (2002, p. 49) further compares this evolving thirdness to “following a shared theme in musical improvisation … that two … partners simultaneously create and surrender to”.

Therefore “the third is that to which we surrender, and thirdness is the mental space that facilitates or results from surrender” (Benjamin 2001, p. 1). As Benjamin (2001) indicates, surrender is a term that has been extensively discussed by Ghent (1990, 2001). By surrender, Ghent means “transcendence and acceptance”, and a willingness to embrace the unknown rather than subjugation to dominance and control (Mitchell & Aron, 1999a, p. 212). Ghent (1990, p. 220) contrasts surrender with its “ever available lookalike” submission. He sees submission as “losing oneself in the power of the other, becoming enslaved in one or other way to the master”. The therapist should therefore not confuse his “collusive participation in the subjugating, negative third with surrender or empathic recognition” (Benjamin, 2001, p. 20). While resignation is what accompanies submission, acceptance is a part of surrender.

Benjamin (2001, p. 2) thinks of surrender as implying recognition, that is, being both connected to somebody and accepting his “separateness and difference” without trying to control or coerce him. For example, for the treating therapist one way of dominating the therapist-patient is to be the one who knows by “invoking the rank of theory” (Ringtrom, 2003, p. 199). Surrender does not mean “giving in” (that is, submitting) to somebody, but rather a “letting go into being” with him (Benjamin, 2001, p. 2). While the therapist should not submit to the patient, his surrender to the patient’s way of being (that could be variously described as attunement, empathy, acceptance, and so forth) and the recognition of the patient that this brings are fundamental components of the evolving trajectory of thirdness, as well as what “potentially reanimates intersubjectivity” in the difficult moments of impasse (Ringstrom, 2003, p. 199).

For the therapist this could mean recognising or accepting the patient as he is, rather than trying to help or change him (Ghent, 2001). It could also mean surrendering to the negating experience of immersing himself in being empathically identified with a patient who is filled with hostility and rage at a particular point in time. However, Benjamin (2001, p. 11) cautions that the therapist’s surrender to the patient should not be confused with an “ideal of ‘pure empathy’”, which could just
mean the therapist’s complying with and submitting to the patient’s view of what is happening. As Frankel (2003) points out, there is sometimes a very fine line between surrender and submission. Alterity (in various degrees) is always present and the therapist’s subjectivity cannot be denied as the therapist becomes “part of the problem and not just the solution” (Mitchell, cf. Benjamin, 2001, p. 17).

Like transitional experience (Winnicott, 1971), the co-created thirdness (that belongs to neither therapist nor patient and to which both therapist and patient surrender) is paradoxically both discovered and invented (Benjamin, 2002). It is in the tension between recognising the other and asserting the self that the thirdness that makes reflective thinking and the transitional space (Winnicott, 1971) of analytic “play” possible, is constellated (Benjamin, 1990, 1999a, 1999b).

Since all “negotiation of difference involves negation” (Benjamin, 1998b, p. 96), what one would expect in an ongoing therapy that is good-enough, is that thirdness would show itself in the shifting moments of the dialectic of recognition and negation that are also “repeatedly realized and failed moments of intimacy” between therapist and patient (Ringstrom, 2001b, p. 11). Mutual recognition is never finally established, but continually disrupted and reinstated. In terms of Benjamin’s musical metaphor this would be where the two dialogic partners are (even with there being some discordances), on the whole, attuned to the co-created pattern of the shared musical theme, improvising together and are managing to keep the improvisation going.

When negation is not survived, the dialectic collapses into “breakdown” or “full rupture” (Benjamin, 1998b, p. 96); “unassimilable difference” (Benjamin, 2000a, p. 44) may ensue and thirdness may (sometimes irrevocably) be compromised, leading to the ongoing constellation of a negative third (Benjamin, 2001, p. 19). The opposites of recognition versus negation are therefore not exactly the same as that of mutual recognition versus breakdown: the “first tension can exist within the second” (Benjamin, 1998b, p. 96). Benjamin’s negative third is similar to Ogden’s (1994, p. 97) subjugating third, which is “a negative of the third … [that] controls us, robs us of our subjectivity and eludes our efforts at mental formulating” (Benjamin, 2001, p. 18).

While thirdness makes reflective thinking possible, the therapist’s ability to think reflectively and symbolically may also generate and contribute towards reinstating thirdness in the therapeutic space. Of course, as Benjamin (1995, 1999a) points out, it is not just the therapist’s ability to think

39 See p. 60.
that re-establishes mutual recognition and intersubjective space. The subjectivities of both therapist and patient may, in various ways, also be involved in the processing of ruptures. In this study the focus will be both on the therapist’s (that is, the participant’s therapist and the participant-as-therapist’s) and on those of the participant-as-patient’s efforts to restore and preserve thirdness.

In a long-term, good-enough therapy (where, by implication, there is an evolving trajectory of thirdness), both therapist and (especially) patient would become more and more able to trust the therapeutic process and to surrender to it (and the overarching and developing “tune” of thirdness), rather than having the feeling of submitting to each other’s desires and demands. This would also underpin the increasing ability of the therapeutic pair to survive the unavoidable negating moments and even breakdowns of enactments and impasses.

### 3.2.2.2 Thirds

Rather than referring to thirdness co-created within the dyad, a Third is “an independent theory of mind” (Ringstrom, 2001a, p. 743) that “creates another point of reference outside the dyad” (Benjamin, 2001, p. 1). Examples of such pre-existing Thirds are “the language, culture, and values” that contextualise therapy, “the theory and procedures that define the task of therapy”, and the “therapist’s professional world and professional identifications” (Frankel, 2003, p. 516). Thirds therefore concern both “the realties out of which the treatment is constructed” and “the ideals that guide it” (Ibid.).

Such a Third may structure, anchor, frame and inform the work of therapy in a way that takes it beyond the merely interpersonal elements of the dyad and in so doing sustain the therapeutic relationship. It may also open up possibilities for meaning and thinking and that may move the therapeutic process to a higher and more complex (meta-level) of understanding.

On the other hand, the therapist may sometimes relate to such a third vertex (for example, theory, supervision, the therapeutic community, his own needs, desires, unresolved issues, and so forth) in such a way that the patient’s stake in the therapeutic space is reduced (that is, in Benjamin’s terms, the patient is negated). In this instance it may be useful to think of this as an antitherapeutic dyad being formed between the therapist and the third reference point so that this third point is no “true” Third, but actually truncates the intermediate therapeutic space in a way that forecloses the possibilities for symbolic and creative therapeutic play.

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40 This would not just involve the therapist’s capacity to think reflectively, but thinking reflectively interspersed with (that is, existing in a dialectical tension with), for example, what ensues from the therapist’s psychoanalytic unconscious.
3.2.2.2.1 The symbolic Third that structures and grounds the dyad

The Lacanian Third needs to be understood within the context of Lacan’s (1981, 1988) emphasis on the essential alterity of the Freudian unconscious. This highlights the “alienation of human consciousness from self-knowledge, and the corresponding margin of separateness that characterizes even the most profound connection between persons” (Hamburg, 1991, p. 347).

Those theorists (Bernstein, 1999; Muller, 1999), who are strongly influenced by Lacanian thinking, see intersubjectivity as being mediated by a Third, the symbolic realm of differentiation and separation, which Lacan equates with language and the law, that is, the symbolic father or phallus. Since Lacan argues that “the unconscious is the discourse of the Other” and that speech originates in the Other (which is “outside consciousness”), it follows that speech and language shape consciousness (Evans, 1996, p. 133). According to Ogden (1999, p. 488), the Lacanian Third, “the chain of signifiers constituting the language with which we speak … mediates and gives order to the relationship of the subject to his lived sensory experience and to his relations with others”.

The Other, the symbolic order, is therefore a third subject that pre-exists the analytic dyad and through which the two subjects relate to each other. The members of the analytic dyad are subjected to the unconscious “rules” of this Third that affect them in ways unknown to both of them and that also structurally ground the dyad (Ringstrom, 2001a, 2001b). The Third prevents the dyad from collapsing into either the seamless merger of the oneness of the imaginary order where difference cannot exist or into the power struggle that ensues when difference is split into opposing polarities (Hamburg, 1991; Benjamin, 2001).

According to Muller (1999, p. 474), “the analyst can be said to have one foot in the dyad and one foot in the Third … [which] is the point from which one can get a perspective on what is happening in the dyad”. The Third or Other, while it is unarticulated, is not “an abstraction, but an observable structure” (Muller, 1999 p. 477), “a semiotic field” of the preconscious and unconscious

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41 The symbolic order is signified by the “Name-of-the-Father” (Nom-du-Père) (Evans, 1996, p. 119) and it can be contrasted with the imaginary order “that structures our need for likeness and our need for identification with an other” (Bernstein, 1999, p. 291).

42 Freud uses the term “other” when speaking of both der Andere (the other person) and das Andere (otherness). Lacan, following Hegel, distinguishes between other and Other. Being inscribed in the imaginary order, the other is not really other, but a reflection and a projection of the ego; is simultaneously the counterpart and the specular image. The Other is indicative of “radical alterity … which transcends the illusory otherness of the imaginary, because it cannot be assimilated through identification”… The Other is “thus both another subject, in his radical alterity … and also the symbolic order which mediates the relationship with that other subject” (Evans, 1996, p. 133). In general (that is, not in the strictly “Lacanian” sense), other indicates another person, another consciousness (who may or may not be recognised as having a separate existence from oneself), while Other (which may be internal or external) denotes alterity and difference in a more abstract, symbolic sense.

43 Muller’s (1996, 1999) work is a synthesis of the thinking of Jacques Lacan and Charles Peirce (who wrote about semiotic codes).
“resonances of history and culture” (Muller, 1996, p. 189) that contains the work of therapy by clearly delineating the roles and structuring the unconscious formations of therapist and patient.

The meaning of the Other as another subject is secondary to that of the Other as symbolic order: this means that a subject may, by occupying this position, be the Other (Third) for another subject (and as such the therapist may be conceptualised as being the Other for the patient) (Evans, 1996). Although the therapist can therefore never be identical to the Third, he can “represent it as its delegate in [his] speech and [his] actions” (Muller, 1999, p. 477). The therapist’s speaking from the Third moves the dyad beyond solipsistic insularity, the “pull” towards “dyadic regression” and the accompanying “power struggles over the control of recognition” into the symbolic (Muller, 1999, p. 475).

In speaking from the position of the Third, the therapist may recognise the patient as a subject by means of a “performative speech act” (Muller, 1999, p. 473). In Lacanian terms this means recognising the patient’s desire (Muller, 1999), that is, his subjectivity (Crastnopol, 1999a). While empathy can lead to the experience of recognition, Muller (1999, p. 472) primarily sees it as “a form of coerced mirroring” that produces sameness. He contrasts empathy with recognition, which posits difference (that is, not “seeing the other as an extension or repetition of oneself”) (Muller, 1996, p. 24). For him recognition is most often found in accurate and well-timed interpretations. For Lacan the intersubjective third is therefore “constituted by recognition through speech, which allows difference of viewpoints and interest” (Benjamin, 2001, p. 4).

Ogden (1994, p. 64n2) explicitly differentiates his analytic third from the Lacanian “name-of-the-father”, which he sees as an “oedipal/symbolic third” and (Ogden, 1999, p. 488) “which, as the representative of law, culture and language, creates a space between mother and infant”. He (Ogden, 1999, p. 488) adds that there are many ways in which “the unconscious internal object father” plays a pivotal part in both the formation and function of his analytic third.

Benjamin (1998a) gives Lacan credit for his idea of the Third being influential in her own thinking about thirdness. However, she (Benjamin, 1998b, p. 28n5) further argues that, contrary to Lacanian thinking, the way out of the “dyadic trap” (which Lacan equates with the maternal and the imaginary) is not only the intercession of the “outside” Third (the symbolic father or phallus). She

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44 Although this appears to be what Muller actually means when he talks about the Third from a Lacanian perspective, he also (and quite confusingly) says that the “structuring Third” (Muller, 1999, p. 474) has been called by various names in psychoanalytic literature, citing Ogden’s analytic third (which is quite different from the Lacanian Third) as one of his examples. Crastnopol (1999a, p. 459) notes that “Muller and other Lacanians use the idea of the Third in somewhat diverse ways depending on the context of their discussion”.

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(Benjamin, 1998a, p. 593n1) asserts that “what is problematic in Lacan’s formulations is the persistence of the equation of the dyad with the maternal, the third term with the father’s oedipal intervention, and the Symbolic with language”.

For Benjamin (1998b, p. 28n5) the third intersubjective space could also be understood as being co-created in terms of the dialectic of recognition and negation between two subjects, that is, “the dialogue of the maternal dyad”. In only equating “the maternal dyad with imaginary twoness”, Lacan is therefore overlooking the early origins of thirdness within the maternal (or therapeutic) dyad (Benjamin, 2001, p. 6). Hamburg (1991, p. 358) also points out that Lacan “failed to consider the intricate manifestations of difference that precede the linguistic and oedipal symbolic order”. In fact, by exclusively linking maternal empathic attunement with the “pre-symbolic”, Lacan is placing it “beyond discourse” and understanding (Hamburg, 1991, p. 358). From the perspective of Benjamin’s developmental take on thirdness, Lacan’s “symbolic representation of the father, … the thirdness of speech” (Benjamin, 2001, p. 6) results and emerges from “preceding” positions of thirdness within the therapeutic dyad rather than endowing the dyad with thirdness.

3.2.2.2.2 The Third as a third element that intersects the dyad

This concerns the fact that while therapist and patient do meet alone in the therapy room, they are seldom two individuals meeting in isolation in a solely personal encounter (Aron, 1999). There is often another element that forms a third point of reference to the dyad that takes the dyad beyond the personal (Ibid.).

While this Third is somewhat similar to the notion of the symbolic Third in that it can also structure and ground the dyad, the emphasis is on the way that the patient and (especially) the therapist relate to it and whether this personal allegiance to the Third adds to or becomes a loyalty and focus that detract from the process of therapy (that is, whether it contributes towards or constricts the evolving trajectory of thirdness within the dyad). Although this Third is usually seen as something “outside” the dyad that the therapist relates to (for example, his professional allegiance), it could also (mostly) involve the patient or both therapist and patient. In fact, within the same dyad, there may be different patient-therapist-Third triangles and “several charged, shifting vectors of relations among them” (Aron, 1999, p. 8). Here one may think of how, when the patient is also a therapist, both therapist and patient have their own personal relationships to theory as a Third.

For certain relational theorists (Hoffman, 1994, 1998; Spezzano, 1998; Aron, 1999; Crastnopol, 1999a, 1999b), this Third seems to be specifically about the way that the therapist relates to his
professional association or professional identity; that is, it is about the professional and theoretical discourses that he unconsciously or preconsciously introduces into the therapeutic space. This Third pertains to how the therapist’s relationship to these discourses becomes alive in relation to the therapeutic dyad, where it may involve the therapist in “some form of symbolic oedipal partnership” which needs to be explored within the therapeutic dyad (Ringstrom, 2001a, p. 743n9).

According to Crastnopol (1999a), the issue of this kind of Third often comes to the fore when a patient comes up against the boundaries of the therapist’s personal involvement with him or her. These boundaries are usually largely determined by the therapist’s loyalty to certain professional discourses. These beliefs (often unconscious and preconscious) on the therapist’s part, which include discourses about theory, power and commitment, may often be inconsistent and contradictory in ways that the patient may find confusing and disturbing.45

One of the most significant debates in relational theorising has been around the issue of restraint and expressiveness on the part of the therapist, that is, the tension between asymmetry and mutuality. The therapist is no longer hiding behind the blank screen, and rather than seeing restraint on the part of the therapist in terms of neutrality, anonymity and abstinence, it can be thought of as implying “disciplined self-reflection” (Mitchell, 2000, p. 127). Hoffman (1994, 1998) conceptualises this issue in terms of the ongoing paradoxical dialectic between analytic “ritual” (the role-determined, formal and hierarchical aspects of the relationship) and “spontaneity” (the more informal, personal and egalitarian aspects of the relationship), with both poles working in tandem, “the one potentiating the impact of the other” (Ibid., 1998, p. 234). Ringstrom (2001a) uses the evocative metaphor of the classical and the improvisational theatre as a way of juxtaposing the “prescriptive” and “improvisational” aspects of psychoanalytic theory and practice. In commenting on Ringstrom’s paper, Knoblauch (2001, p. 793) notes that it is important to remember that “effective psychoanalytic improvisation is based on years of continuing analytic study and practice”.

45 Lindon (1991, p. 31) notes that there are two sets of theories: “those based on metapsychological abstractions” and “those based on experience-near clinical observation”. This resonates with Sandler’s (1992, p. 190) distinction between the explicit “public face” and the implicit “private” aspect of psychoanalytic practice. Analysts (even those doing “good” analytic work) often work from a framework of part-theories that are largely unconscious and that do not necessarily cohere. However, as long as they remain “unconscious”, Sandler does not see contradictions among these part-theories as problematic, and even considers them as probably more useful and appropriate than “official” theories. When these part-theories come together in a way that is acceptable to consciousness, they may give rise to new theory in the more public domain.

Hamilton’s (1996) empirical study of the theoretical and technical preferences of 65 experienced British and American analysts of diverse orientations also indicates that the professional realm (and therefore the “analytic preconscious” from which the therapist works) is varied and internally inconsistent, even among those clinicians with the same declared theoretical orientation or even among those who share an institute affiliation. She found the most cohesive groups to be the London Kleinians and the American self psychologists.
This specific idea of thirdness (that is, the Third formed by the therapist’s professional allegiances and stance) therefore represents a constructive effort to grapple with this ongoing issue of the deviation from the old authority position and to find “a new sensibility” representing “a higher level principle” rather than another set of rules (Slavin & Kriegman, 1998b, p. 278).

While the professional discourses that the therapist introduces into the therapeutic situation are the main focus of debate and theorising around this specific conceptualisation of the Third, they are not always limited to these aspects, but may also be seen as extending to the “wider … social and historical culture in which the dyad is embedded”, albeit in a different way to that in which it is conceptualised in Lacanian thinking (Aron, 1999, p. 6). According to Aron (Ibid.), thinking of the analytic situation in this manner therefore does not necessarily “entail imposing an oedipal triangular structure”. However, taking “account of the context within which the dyad operates” (which points to a wider context beyond the two individuals), may mean thinking of the “contextual Third” as well as the “oedipal third” (Ibid.).

For example, Ringstrom (2001b) describes the noxious Third (similar to Benjamin’s negative third and Ogden’s subjugating third) which may arise from the therapist and patient holding contradictory values owing to cultural differences. When this is not thought and talked about, a silent and unacknowledged power struggle about whose reality should prevail could ensue. (Considerable work needs to be done in contexts such as contemporary South Africa about the kinds of Thirds resulting from cultural and class differences between therapist and patient.)

3.2.3 The significance of thirdness and Thirds in this study

In this study I have used the multidimensional ways in which thirdness and Thirds may be conceptualised for understanding the participants’ descriptions of the effects of the therapeutic third on the clinical third. The different aspects of the participants’ experiences of their personal therapies could be understood in terms of the emerging and evolving trajectory of thirdness in the therapeutic third or linked with the intersubjectivity constituted by the dialectic of recognition and negation between the participants and their therapists. The participants’ being both patients and therapists was a theme that was always (to a greater and lesser extent) in some ways – consciously and unconsciously, implicitly and explicitly – part of the work with their own therapists. In the participants’ experiences of their own therapies, the difficult moments of impasses and enactments (that is, when there was negation and breakdown), also involved the possibility of the presence of an antitherapeutic dyad between the treating therapist and a third reference point.
The ways in which the therapeutic third could be linked to the clinical third (that is, the effects of personal therapy on clinical work) were also explored. In this regard the research participant’s own therapy could be conceptualised as forming a Third to his or her work as a clinician. Of course the same may be said for anything that the participant held in mind that triangulated the dyad(s) of participant and patient(s). It was kept in mind, however, that some kind of uneven developmental trajectory as a therapist, certain professional and personal discourses, as well as spill-overs from the research participant’s life events rather than just the research participant’s own therapy per se, could have been involved in determining the nature, function and role of the Third that his own therapy appeared to form in relation to his being-a-therapist.

Benjamin (2001, p. 1) posits that thirdness should not primarily be thought of in terms of the “things” (and, as already indicated, there may be a variety of them) that may serve as Thirds, but rather in terms of the “psychic capacity” to use them as such. In this sense, thirdness concerns “a quality of mental space” and “intersubjective relatedness” (Ibid.). Therefore one way of thinking about thirdness in regard to the participant’s own therapy, was that one should only think of the participant’s therapy as being a Third to the clinical third of his work if (at that particular moment in time) the therapist-participant is capable of using it as a Third in keeping the improvisational dance of the therapeutic pair (consisting of him and his patient) to the tune of their co-created third. At this point the clinical third could be understood as depicted in Figure 3.1 (overleaf).

It was also considered that when the participant’s own therapy was a third vantage point to the participant and his patient without there being thirdness within the dyad of the participant and his therapist, the participant’s therapy might form an antitherapeutic dyad with him in relation to his work as clinician. One of the questions that this brought forth is that of what about the participant’s own therapy (or what events or moments in his own therapy) made it a Third rather than just a third reference point that could also form an antitherapeutic dyad with the participant. These two ways of conceptualising the relationship of the therapist’s own therapy to his work as a clinician (that is, as a Third or as a kind of malignant dyad that invades and restricts the therapeutic space) might also be an oversimplification of a much more complex phenomenon. It may be more useful to think of the therapist's own therapy as not “being or not being” a Third to his work, but as always holding the possibility for just that. This third vantage point of the therapist’s own therapy could therefore be seen as involving more or less thirdness, and thirdness itself as something that is never finally achieved, but as ebbing and flowing.
In this way even the participant-therapist’s use of his own therapy or the imagined other of his own therapist in quite a concrete way (which may be what the participant-therapist needs and may be all that he is capable of at that particular moment)\textsuperscript{46} may be thought of as holding a kind of proto-thirdness and as being part of a movement towards thirdness rather than being designated as just indicating the absence of “true” thirdness. Another question that this would bring is how one could conceptualise “more or less” thirdness in the way the therapist’s own therapy relates to his work.

\textsuperscript{46} Of course this begs the question of what he would use at such a moment or what would happen if the space of his own therapy (and this “space” may be the result of more than one therapy) were not there.
The questions raised in this section clearly relate to what has been discussed and certainly need to be addressed. While this study will attempt to do some of this, it may also be that the complexity and depth of these issues may go beyond what is possible within the scope of this work.

3.3 THE TRAJECTORY OF THIRDNESS

This section also forms part of the conceptual background used in the discussions of interview material; it will specifically be used to develop an understanding of the participants’ descriptions of their experiences of their own therapies.

3.3.1 The trajectory of thirdness and clusters of thirdness

The main focus in Benjamin’s (2000a, p. 45) account of thirdness is on the “crisis of recognition” in which “the difference in desire, meaning, and perspective” between therapist and patient “has to be negotiated”. This process of negotiation is conceptualised in Benjamin’s (1995, 2000a, 2001) description of how both emerging thirdness and the linked mutual recognition evolve in the therapeutic space. She (Benjamin, 2000a, p. 44) sees this process in terms of phases constituted by certain markers which she calls “hallmark points” or “key moments of transformation” within a “developmental trajectory of intersubjectivity” (Benjamin, 1999b, p. 396), where the “core feature is recognizing the similarity of inner experience in tandem with difference” (Benjamin, 2000a, p. 44). I should like to use the term clusters of thirdness for denoting these “markers”.

The term clusters is a way of describing consecutive and different foci of thirdness that cohere loosely into phenomena within the therapeutic dyad and a means of clarifying thinking about what could be called the trajectory of thirdness and its evolvement. While these clusters are useful for describing and conceptualising a certain developmental progression or a trajectory of thirdness within the therapeutic dyad, they cannot, of course, be quite so exactly and neatly classified and also do not necessarily follow one another sequentially.

An example of this developmental progression would be the idea that “symbolic thirdness” is founded on there already being a “nascent pre-symbolic thirdness” (Benjamin, 2001, p. 16). This means that the dialogue between therapist and patient may have the appearance of symbolic thirdness (that is, there may be “interpretations” and “insights”), but this may be what Benjamin (Ibid.) calls “a mere simulacrum of thirdness”, unless there are (and have been) earlier clusters of thirdness that ground the dyad in an evolving trajectory of thirdness. This resonates with Straker and Becker’s (1997, p. 174) finding that “it would seem that understanding begins as an embodied
experience in the intersubjective field during a change moment, but it is only symbolically represented with the passage of time”.

While Benjamin’s trajectory of intersubjectivity within the therapeutic dyad thus has a definite developmental tilt (especially when she uses it in relation to the mother and child), it should be kept in mind that these clusters do not imply a linear progression of achieved positions with one cluster being superseded by the other. This means that a later cluster both preserves and refigures earlier ones, making possible a “flexible oscillation between levels of experience” (Benjamin, 1995, p. 71). These clusters of thirdness should be thought of as both (often sequentially) developing within the history of a specific therapeutic dyad and as being differently (that is, to a greater or lesser extent) foregrounded and overlapping at specific moments within the ever-changing and evolving trajectory of thirdness that is constellated between the therapist and patient in a good-enough therapy.

The idea of there being different and (in a certain sense) progressing clusters of thirdness also pertains to the idea that a viable therapeutic space (that is, in Benjamin’s terms, one where there is a sustained dialectic of recognition and negation) is not one-dimensional. The issue of whether it is “the reparative-developmental” or the “repetitive” dimensions of the transference-countertransference matrix that are crucial (and should be emphasised) in bringing about mutative therapeutic change has long been debated in psychoanalytic theorising (Stern, 1994, p. 343). Stern (Ibid.) attempts to resolve this issue by integrating Mitchell’s (1988) “relational-conflict” and “developmental-arrest” perspectives and proposing that in a good-enough therapy the “needed” and “repeated” relationships are, while also varyingly foregrounded in different therapies and at specific moments within the same therapy, both present and exist in tension with each other.

In this regard the therapist has been thought of as having different functions: both that of the maternal order (the therapist’s attunement, affective resonance, receptive reverie; that is, the patient’s being held and contained by the therapist) and that of the paternal order (which can be seen as a creative search for meanings; that is, the use of interpretation) (Bollas, 1996).

47 Although Benjamin often both refers to mother and child and speaks of the development of thirdness in terms of the evolving relationship between mother and child in developing her ideas about thirdness, I shall mostly use her ideas as they pertain to patient and therapist/analyst.

48 Although being somewhat different, there is a resonance between the idea of there being an interplay between the different clusters of thirdness constituting Benjamin’s trajectory of intersubjectivity and Ogden’s (1986, 1994, 1997) conceptualisation of the dialectical interplay of the different modes of generating experience, such as the depressive, paranoid-schizoid and autistic-contiguous positions. The negating and preserving interplay of these positions evolves along a diachronic (temporally sequential) axis as well as a synchronic one. Therefore these positions neither follow nor precede one another; each rather co-exists with the others in a dialectical relationship.
Slochower (1996b) also addresses this issue of the nature of the therapist’s functions, albeit somewhat differently. She (1996b, p. 20) relates these therapeutic functions to Winnicott’s (1966) ideas about “the male and female elements of ‘being’ and ‘doing’”. She (Slochower 1996b, p. 21) then divests “being” and “doing” of their specific genderedness and considers the therapist to be “both container and actor”. In describing their experiences of therapy from a “therapist perspective”, Straker and Becker’s (1997, p. 175) participants (who were both therapists and patients) noted that they had (on reflection) became aware of a “connecting split” or “healing link” between their “being” and “doing” therapist selves.

Benjamin (1998b, p. 44) problematises the idea (which originates from Freud) of separating the preoedipal and oedipal along gender lines, which is central to the idea that the therapist is required to assume both the “paternal (phallic) and maternal (holding) stances”. Embedded in this is the notion of the maternal function (also that of the therapist when working from a maternal stance) as being largely passive. The active-passive dimension may indeed be reconciled “in the work of the maternal subject” (Benjamin, 1998b, p. 29) and therefore in the maternal metaphor of the therapist by using the concept of recognition. Recognition is both the “processing of the other’s psychic material” and the “intersubjective expression” of this (Ibid.). This intersubjective expression would vary according to where the patient and the therapy are at in that particular moment, that is, in terms of the foregrounded cluster of the trajectory of thirdness.

While these clusters of thirdness may all be present within the therapeutic dyad, one cluster may be more prominent at a specific time. Thinking in terms of such a cluster (that is, the one that is foregrounded in the therapeutic dyad at a specific moment) provides a way of depicting and thinking about the dialectic of recognition and negation (and how it may break down and be restored) and the evolvement of thirdness within a specific therapeutic dyad.

In this study I have endeavoured to gain some understanding of the evolving trajectory of thirdness (See Figure 3.2) (in the dyads of research participants and their therapists) in terms of the participants-as-patients’ experiences of their own therapies and of the clusters of thirdness that are constellated. I have also tried to link these experiences of the participants-as-patients with those of the participants-as-clinicians.

49 Winnicott himself did not link “being” and “doing” with the different functions of the therapist.
50 Straker and Becker (1997, p. 175) write about the “subsequent integration” of these connecting splits. I would consider them rather as being held in tension than as being integrated.
3.3.2 Clusters of thirdness

3.3.2.1 The one in the third

3.3.2.1.1 The emergence of the dance of thirdness

Benjamin’s version of thirdness is ushered in by the cluster of thirdness that she describes as the “nascent” or “primordial” third (Benjamin 2001, p. 7). This comes about through the therapist’s ability to recognise the patient’s “specific needs, gestures, and acts” through being attuned and affectively resonant (Benjamin, 2002, p. 52). The therapist therefore surrenders to the patient’s way of being and this figures in the patient’s experience of specifically “being known or recognized”
(Sander, 2002, p. 39). Benjamin (2002, p. 50n1) calls the therapist’s “attunement and empathy" that make it possible to bridge difference with identification” and “to infuse observation with empathy”, the one in the third.

This accommodation by the therapist does not mean that the therapist submits to the patient’s demands, but rather pertains to the asymmetry inherent in the therapeutic relationship. This asymmetry implies that the therapist “recognises and respects the needs, limits, and capabilities” of the patient (Benjamin, 2002, p. 49). This is part of what Benjamin (2001, 2002) sees as the moral third that underpins any good-enough therapy. The moral third goes beyond ethical rules, that is, it concerns a “greater principle of necessity, rightness, goodness” (Benjamin, 2001, p. 10). It has to do with the therapist’s both respecting the patient as different and equal, as well as being mindful of and taking on the responsibility of the asymmetry of the therapeutic situation.

The moral third is related to what elsewhere has been described as the therapist’s agapaic capability, an “attitudinal substratum that underlies the transference/counter-transference” (Lambert, 1981, p. 24). This capacity has to do with the therapist’s “concern, patience and a capacity to remain-in-being for his patient” (Ibid.). “It is a combination of eros, humane feeling and respect, together with a freedom from god-almightiness” (Ibid.). The therapist's agapaic attitude is not a kind of lofty and idealistic position that arises out of “saintly or masochistic motivations” (Ibid., p. 41), but is “an attitude that is benign enough because the malignant elements have been made conscious and partly overcome” (Ibid., p. 40).

According to Coltart (1993b, p. 121), the therapist’s loving attitude towards the patient does not necessarily imply (always) liking the patient, but becomes the matrix, the “trustworthy container” in which the therapist may with some degree of safety also acknowledge feelings of hatred or rage against the patient. This agapaic or loving attitude shows itself in the therapist’s steady and reliable presence and his ability to remain empathic towards the patient, even the hateful or attacking patient. The therapist may feel himself unfairly provoked or negated by the patient and has to contain his own anxieties and anger and not become distant or retaliate. Racker (1968, p. 159)

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51 Bach (1994, p. 158n2) usefully distinguishes attunement from empathy: “Empathy implies a sharing and a receptivity to another person’s expressed thoughts and feelings; the identification of one ego with another. Attunement implies a receptivity to another’s not-yet verbalized wishes through resonance and harmony with his rhythms, gestures, sounds, and affect ... Although words may be used to express both empathy and attunement, empathy emphasizes their symbolic content whereas attunement emphasizes their form and function ...”

52 Agapaic derives from the Greek agape; that is, brotherly love (as distinct from erotic love). Drawing on Lambert’s (1981) thinking, the term agapaic capacity was formulated by Chris Milton, a well-known Cape Town psychotherapist.

53 I could not find such an evocative description of this pivotal aspect of being-a-therapist in a responsible, ethical and “moral” way in the psychoanalytic literature. Hence this venture into Jungian thinking, which is, strictly speaking, beyond the theoretical scope of this study.
reminds us that “behind the negative transference lies simply thwarted love … [Knowing this] helps the analyst to respond with love to this possibility of loving, to this nucleus of the patient however deeply it be buried beneath hate and fear”.

As the therapist accommodates to the patient’s way of being and the patient therefore also becomes able to accommodate to that of the therapist, the individual subjectivities of therapist and patient cohere into a oneness, a particular “fittedness” (Boston Change Process Study Group, 2002, p. 1052) which Sander (2002) calls a rhythmicity. This shared pattern consists of the “unique language, metaphors, rituals, little intimacies” and “particular forms of play” that develop between therapist and patient (Frankel, 2003, p. 517). According to Benjamin (2002, p. 49), thirdness is therefore constituted by an “attunement both to the other and to some deeper structure”, that is, the “dance” of the evolving third between therapist and patient.

### 3.3.2.1.2 Holding, mirroring, mutual recognition and the therapist’s subjectivity

If Benjamin sees the therapist as being attuned and affectively resonant, this could appear to mean that the therapist is assumed to adopt a *holding* position. The concept of holding has strong links to the maternal metaphor, where “(preoedipal) mothering”, especially as theorised in its “purest” form by Winnicott (1960b, 1960c 1963a), is used as a “tool” to understand the therapeutic process (Slochower, 1996b, p. 15). Through “identification and empathy” (that is, variants of Winnicott’s “primary maternal preoccupation”), the “soothing, all-giving analyst/mother” is able “to efface her own needs and concerns in order to attend to or minister to those of the patient/child” (Gerhardt, Sweetnam & Borton, 2000, p. 19).

For the patient, the holding metaphor means an experience where the therapist is finely and emphatically attuned to his (the patient’s) subjective world and his needs. (Although holding is commonly associated with patients’ dependency needs, it is also important for “patients struggling with issues of narcissism or rage” [Slochower, 1996a, p. 335].) It also means that the therapist does not challenge or question the patient’s experience (especially of the therapist and the therapy).

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54 These authors conceptualise this fittedness as arising in the “implicit domain” (Ibid., p. 1052) of therapeutic interaction, which they contrast with “the narrative/declarative level” (Ibid., p. 1051). They see this fittedness (which results from the intersubjective processes between therapist and patient) as changing the implicit procedural knowledge and expectations that patient and therapist have of each other and this “new context” as creating the potential for further elaboration of new forms of shared experience” (Ibid., p. 1059). What they describe therefore appears very similar to Benjamin’s nascent or primordial third.

55 Sander’s studies of early nursing patterns illustrate how, when the significant other is attuned, that is “permeable, responsive, recognizing”, a shared pattern of rhythmicity may evolve within the dyad (Benjamin, 2002, p. 48). Within the therapeutic dyad this rhythmicity means that rather than “directly striving to match each other”, both therapist and patient align with this “fundamental form of the third” (Benjamin, 2001, p. 7; 2002, p. 49). These rhythmic experiences are therefore both the early beginnings of thirdness and pivotal in the evolvement of thirdness.
According to Slochower (1996a, 1996b), the patient is allowed to remain unaware of his emotional impact on the therapist by the therapist’s containing those aspects of his experience of the patient that may feel dystonic to the patient. Although the idea that the therapist knows what would be dystonic to the patient could certainly be challenged from a relational-constructivist position, Slochower (1996a, p. 326) sees the therapist’s “position of certainty” as part of the co-created “illusion of attunement”. From this perspective, the therapist’s subjectivity is therefore largely conceived as being bracketed. In Winnicott’s (1969) terms this means that the therapist remains subjectively perceived by the patient and that difference is not introduced. For the patient, the therapist therefore remains an object rather than becoming a “like subject” (Benjamin, 1995).

While some theorists have included both mutuality and dependence in their thinking about the therapist-patient relationship, Winnicott (and others), who highlight the holding aspects of the therapeutic relationship (especially as it pertains to the patient’s dependency needs) have been criticised (from the relational-constructivist position) for “their positivist quasi-authoritarian perspective” (Slochower, 1996b, p. 140). At first glance it seems that the concepts of intersubjectivity and mutual recognition cannot readily be reconciled to the “holding trope” and its implied maternal tilt (Gerhardt, Sweetnam & Borton, 2000, p. 21). This consequently requires some deconstructive examination and questioning.

Does the idea of the therapist’s holding the patient not by its very nature foreclose the possibilities of any real mutual recognition, even when holding is more relationally viewed as an “illusion of absolute attunement” that is cocreated by therapist and patient (Slochower, 1996a, p. 326)? And does it not (as some of the relational-constructivist thinkers’ criticisms posit) imply that the therapist is emotionally “superior” and “all-knowing” (especially as it concerns what the patient needs), thereby infantilising the patient and rendering him less than the therapist (Slochower, 1996a, 1996b)?

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56 “This attunement … concerns the analyst’s capacity to understand and evenly and consistently to respond to the patient’s needs or feeling states. It is illusory because its maintenance requires that both parties temporarily bracket their awareness of the more complex aspects of the analytic interchange” (Slochower, 1996a, p. 326).


58 Slochower (1996a, 1996b) further comments that the relational perspective assumes that collaboration or mutuality between therapist and patient is possible, that is, in Winnicott’s (1969) sense, that the patient is capable of object usage. However, some patients may initially (or at times) be at Winnicott’s level of object relating (which the holding metaphor implies) rather than being capable of object usage. Slochower further emphasises that while holding is always an element in the analytic process, it shifts from being foreground to background and vice versa. The patient’s initial experience of being held may, in fact, bring him or her to the point where mutuality between therapist and patient is a possibility. Aron (1996, p. 149) clarifies this by making a definite distinction between “reciprocal influence and mutual regulation” and “mutual recognition”. According to him, “mutual regulation is a conceptual assumption of relational theory”, but “mutual recognition may be thought of as one of its primary goals”.

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There is a fine line between the therapist’s negating of the patient’s experience and subjectivity and the therapist’s not just conforming to the patient’s internal fantasy (that is, introducing some potential for difference or alterity). But how does a therapy move beyond the therapist’s holding the patient in what Grand (2003, p. 473) calls “the limitless maternal gaze”, which could, from a Lacanian perspective, mean the therapeutic pair’s being trapped in the seductive reflections of sameness found “in the blindly illuminating alleys of the imaginary order” (Bernstein, 1999, p. 279), without the patient’s subjectivity being imposed on and compromised?

While there is a resonance between the concepts of mirroring and holding, their meanings are somewhat different. I understand holding to be broader and encompassing a number of dimensions, of which mirroring is a central one. Within psychoanalytic theorising, the notion of mirroring has highlighted “the reflective qualities of human relationships” and has provided a way to think about the “interactions between self and other”, especially as this concerns developmental processes and the therapeutic relationship (Cartwright, 2000, p. 8).

The analogy of the therapist as mirror has been variously conceptualised since Freud (1912) first introduced it into psychoanalysis to depict the therapist’s ability to be objective and neutral, which is something that, as Freud acknowledged, can never be completely achieved (Cartwright, 2000). Freud’s (1919) later encounter with the mirror image or “double” prefigured the current conceptual tension between the mirror function of the therapist as affirming the wholeness, unity, and even the omnipotence and grandiosity of the patient’s self versus his (the therapist’s) reflection of the patient as also including alterity (Cartwright, 2000). Kohut, Lacan and Winnicott are probably the most significant contributors to current theorising in this area and, before returning to Benjamin’s use of this concept, their interpretations of mirroring will be briefly considered and compared.

Generally, and used as a basis for Benjamin’s thinking concerning this concept, mirroring is understood in Winnicott’s sense of the infant/patient’s image of himself being contingent to what is “given back” to him by the mother/therapist. “What does the baby see when he or she looks at the mother’s face? I am suggesting that, ordinarily, what the baby sees is himself or herself. In other words, the mother is looking at the baby and what she looks like is related to what she sees there” (Winnicott, 1967, p. 131). The child/patient’s sense of self is both discovered in the mirror image,

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59 “The doctor should be opaque to his patients, and like a mirror, should show them nothing but what is shown to him” (Freud, 1912, pp. 117-118).
which is and should be grounded in the individual, and authenticated by the experience of the mirror.

The Winnicotian mirror is therefore to be found in the mother/therapist’s face; it implies warmth and nurturance and will only appear if holding is sufficient (and has led to a sense of “I” or ego integration) (Winnicott, 1967; Cartwright, 2000). There is also a movement from the initial “narcissistic mirroring” to a more “mature form of mirroring”, where the mirror comes to represent both self, self-as-other and other, so that it becomes an area of transitional experience where sameness and difference, other and self, can exist simultaneously (Winnicott, 1971; Cartwright, 2000, p. 13). This is may be related to Winnicott’s (1969) notion that mature relating primarily relies on object usage rather than object relating, which is a distinction that Benjamin (1995) uses in differentiating relating to the other as subject and as object.

This Winnicotian idea of mirroring is quite different from that of Lacan (1949). Lacan’s (1949) mirror stage depicts the self-alienation, on which the maternal domain of the imaginary order is based, and that comes about through the ego’s misrecognition of itself as the unified and idealised specular image (Benjamin, 1995; Evans, 1996). This notion of mirroring has to be understood within the context of Lacan’s “relentless privileging of the symbolic function” and his dismissal of the sustaining empathy of the maternal as seductive and illusionary (Hamburg, 1991, p. 351). Lacan regards holding or nurturing (as represented by the maternal) as insignificant, and although he assigns a “critical developmental significance to the mirror function”, he emphasises its renunciation as an essential part of entering the paternal domain of symbolic transactions (Hamburg, 1991, p. 350). In the Lacanian mirror the subject sees something other (that is, himself as seen by the other) rather than himself, but mistakes this image as a model of himself, thus becoming alienated from his own subjectivity. Any emphasis on the use of the mirror to affirm and bolster the subject’s sense of self is thus based on an illusion of wholeness and cohesion and will lead to further self-alienation (Cartwright, 2000) Muller (1996, 1999), who writes from a Lacanian perspective, therefore sees empathy primarily as involving what he calls “coercive” mirroring (sameness) rather than recognition (difference).

A specific understanding of the notion of mirroring is a fundamental tenet of self-psychological thinking (Kohut, 1971, 1977, 1984). Kohut “reinterpreted psychic development in terms of the

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60 Otherwise a “false self” organisation could ensue (Winnicott, 1960b).
61 See pp. 63-64 also.
63 For Muller empathy therefore seems to be based on identifications that are concordant with self experience. See also p. 120.
self’s need to find cohesion and mirroring in the other” (Benjamin, 1988, p. 19), who then serves as the child’s/patient’s “selfobject” (Kohut, 1971, 1977, 1984). Kohut (Ibid.) describes and explores the different forms of selfobject transferences that are constellated in the therapeutic relationship, for example, twinship (somebody like me), idealising (somebody that I can look up to) and mirroring (somebody that understands me completely) (Hamburg, 1991).

This “mirroring selfobject” (Kohut, 1984, p. 23) responds to the child’s/patient’s being with a metaphorical “gleam in the eye” (Kohut, 1971, p. 117). By affirming the value of child’s/patient’s existence and his “sense of agency and self-esteem” (Benjamin, 1988, p. 283n43), the parent/therapist serves to sustain the “vitality and assertiveness” of the child’s/patient’s self (Kohut, 1984, p. 23). Kohut (1971, p. 117) further describes the central role of the empathic therapist’s “echoing, approving, and confirming” responsiveness in the “many instances of mirror transference” during the course of a therapy. This engenders a movement from the “stage of the fragmented self” to a more “cohesive self” (Ibid.).

Kohut (1971, 1977, 1984) thus sees the work of therapy as taking place within the containing matrix created by the therapist’s empathic mirroring of the patient. According to him (Ibid.), structural changes or “transmuting internalizations” come about when there is tolerable difference (“optimal frustration”). This is seen as happening owing to the therapist’s momentary empathic failures as the patient’s selfobject, which are bearable and thus do not re-traumatise the patient.

While Kohut (1971) gives some thought to the implications, the demands and difficulties that being the patient’s selfobject holds for the therapist, the therapist’s mirroring role essentially remains at the level of sameness, that is, in terms of the patient’s needs and desires. The therapist’s subjectivity is therefore not a fundamental part of Kohut’s thinking about difference. Rather than being subsumed in Benjamin’s dialectic of recognition and negation and possibly becoming a shared aspect of evolving subject-to-subject relating, the “burden of difference” (Hamburg, 1991, 64)

The function of selfobject relatedness is quite clear: “Selfobject relatedness is the person’s experience, at any age, of a significant human other or attachment figure as support for the establishment, development, and maintenance of continuous, cohesive and positive self-experience” (Orange, 1995, p. 177). However, the meaning of the term “selfobject” itself is much more slippery. As Hamburg (1991, p. 354) puts it, while selfobjects are defined as “internal representations of significant people or parts of people, … the location of this structure seems to wander between the intrapsychic and environmental”. What does it actually mean for the therapist to be the patient’s “selfobject”? How can this concept include the differences and gaps, additions and subtractions that are so typical of “the creative activity of intersubjectivity” (Hamburg, Ibid.).
Benjamin’s (1988, p. 251n16) comments that the idea of the patient’s using the therapist as a “selfobject”, that is, a “mirroring object”, misses the “key point” of the “intersubjective view”, since it “fails to distinguish between using others as ‘selfobjects’ and recognizing the other as an outside subject”. Orange (1995, p. 30), who writes from the contextualist or systems intersubjective perspective, contends that Kohut’s metaphor of the mirror, while “apt and evocative, needs enriching and complexifying” to make it a fully “intersubjective conception of mirroring”. The intersubjective implies there being self, other and an emerging “we”, who recognise in one another “a common emotional response to something” (Ibid.). The intersubjective conception of mirroring thus implies “both peculiarity and mutuality” (Ibid.). “I recognize you, and you see that it is you that I recognize. When recognition becomes fully mutual, we recognize each other” (Ibid.). This resonates with Benjamin’s conceptualisation of evolving thirdness and mutual recognition. Mirroring is therefore an intersubjectively constituted process, as opposed to a therapist-directed technique, and Benjamin (2000b, p. 293) emphasises that she does not subscribe to the “self-psychological notion of mirroring”.

While coming from different theoretical perspectives, Kohut and Winnicott both give prominence to the concept of mirroring as indicating an inherently warm and nurturing experience of relating and both explore what ensues from inadequate maternal care or therapist failures (Cartwright, 2000). While Kohut and Lacan both highlight “disintegration anxiety and put mirroring phenomena in the forefront of the processes of identification that shape subjective experience” (Muller, 1989, p. 363), the Kohutian mirror stands directly opposed to that of Lacan. For Lacan there is a difference “between the self and the mirror image”, but Kohut emphasises the experience of similarity and affirmation rather than that of the alienating image (Cartwright, 2000, p. 8).

Cartwright (2000, p. 13) makes the interesting suggestion that, rather than dismissing either of them, we should think of the Lacanian and Kohutian mirrors as conceptualisations of oppositional poles of what he calls the mirror dialectic. He bases this on Ogden’s (1994, pp. 52-53) idea that mirroring “is not a relationship of identity; it is a relationship of relative sameness and therefore of relative difference”. An intersubjective rendition of mirroring should therefore provide a means to take both sameness and alterity into account. The Winnicotian notion of the mirror is

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65 It has to be noted, however, that in contrast with “classical” self psychological thinking, and while also using the idea of the therapist’s serving as the patient’s selfobject, the contextualist or intersubjective systems approach specifically recognises and elucidates the role of the therapist’s subjectivity (Buirski & Haglund, 2001), albeit without Benjamin’s emphasis on difference and subject-to-subject relating.
unquestionably more comprehensive, and consequently lends itself more readily to an intersubjective way of thinking than either that of Kohut (who emphasises sameness) or that of Lacan (who emphasises difference), in the sense that it succeeds in portraying “the dialectical tension between these oppositions” (Cartwright, 2000, p. 15).

Benjamin (2000b) concedes that Winnicott, whose ideas have played a fundamental role in the development of her theorising, is inconsistent when it comes to taking the mother/therapist’s subjectivity into account. According to her (Benjamin, Ibid., p. 293), Winnicott’s thinking contains “competing contradictory strains, some in favor of maternal subjectivity and others idealizing primary maternal preoccupation”. In her thinking she (Ibid.) has emphasised “the side of Winnicott that theorized destruction and survival”; that is, the movement towards subject-to-subject relating. In this she (Ibid.) has found a strong argument in support of her specific intersubjective perspective and, by implication, for the necessity of taking maternal/therapist subjectivity into account. A truly intersubjective conceptualisation of mirroring hence has to be clear about not only taking into consideration the subjectivity of the child/patient, but also that of the parent/therapist.

Benjamin (1988, p. 24) accordingly problematises the idea of maternal mirroring that is divested of the mother’s/therapist’s subjectivity: “The mother [read therapist] cannot (and should not) be a mirror; she must not merely reflect back what the child [read patient] asserts; she must embody something of the not-me; she must be an independent other who responds in her different way.” In the same vein, Muller (1996, p. 65) writes about “a complex doubling that is not a reflection of sameness” and Pizer (1998, p. 31) remarks that one should rather think of the therapist as “squiggling” (Winnicott, 1964-1968) with a patient than as mirroring a patient.

Benjamin (2000a) disagrees with Gerhardt, Sweetnam and Borton’s (2000, p. 19) observation that her above-mentioned critical view of the notion of maternal mirroring also means that she rejects the “holding model” in psychotherapy. She (Benjamin, 2000a, p. 48) clarifies that it does not mean that she “impugn[s] holding” and, indeed, for Benjamin, “differentiation does not necessitate the repudiation of likeness” (Layton, 1999, p. 311). It rather has to do with the fact that in spite of the therapist’s being exquisitely attuned to the patient, mirroring will inevitably also mean that the therapist is always responding from his own subjectivity, thus changing what has been received from the patient, but modulating it sufficiently to be attuned (and unavoidably sometimes being misattuned) to the patient. The therapist’s mirroring/holding thus implies interpretation (although not necessarily in the sense of the therapist’s actually giving interpretations).
Benjamin (2000a) further argues that while the therapist’s *subjecthood* (that is, independent existence or alterity) may be held in abeyance, his *personhood* (that is, subjectivity) will still be conveyed to the patient by the way he expresses himself. She (Benjamin, 2000a, p. 49) therefore understands Slochower’s (1996a, 1996b) “holding … as fulfilling the function of initially establishing the analyst as someone different who can feel the same”. Before difference is confronted, the therapist’s recognition of the patient is therefore put across through the expression of his affective attunement and empathy with the patient, which is indicative of the felt, emotionally charged connection (the original space of thirdness) between therapist and patient. For Benjamin (2000a, p. 49), “holding or attunement should not be opposed to mutual recognition of alterity, for the latter is founded in the former”. Mutuality may also be understood in terms of the possibility of the therapist’s empathic identification with the patient moving the therapeutic pair beyond the power imbalance implicit in the idea of the therapist’s holding the patient.

This still leaves us with the “problem” of the therapist’s subjectivity. Slochower (1996a, 1996b) points out that what is not theorised explicitly enough in the maternal model of therapy, are the difficulties that the therapist may experience in assuming a holding position. Benjamin (2001, p. 8) comments that the therapist’s identifying with and responding sensitively to the patient does not merely signify “submission and self-abnegation” on his (the therapist’s) part. While she (Benjamin, 2000a, pp. 49-50) concurs with Slochower that the therapist should “change” sufficiently to give the patient the attunement and recognition that he needs, he (the therapist) should also be able to contain and internally preserve his subjectivity at the same time as tolerating the patient’s “assault” (without submitting or retaliating), thus “surviving internally for oneself and surviving for the other”. This therefore means the therapist’s holding the tension between his subjectivity/desires and the needs of the patient (Benjamin, 2001).

### 3.3.2.2 The third in the one

#### 3.3.2.2.1 Alterity and intersubjective negotiation

This brings us to the next cluster of thirdness, where twoness is transcended (Benjamin, 2001). This is underpinned by the *third in the one* (Benjamin, 2001, p. 11), that is, the therapist’s “ability to contain or suspend his immediate need without denying the difference” while doing the “maternal work” of “representing, reflecting and containing the [patient’s] mind” (Benjamin, 1998b, p. xv).

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66 While Winnicott had a rather “poetic perspective on the maternal function” (Slochower, 1996b, p. 17), he (Winnicott, 1947) also noted that there were good reasons for the mother to hate (as well as love) the baby and, by implication, for the holding therapist to hate (as well as love) the patient. This may be seen as a precursor to the later ideas about the impact of the therapist’s subjectivity on the patient.
Benjamin (2000a, p. 50) suggests that the therapist’s relating to the patient at this point could be considered as constituting “neither holding nor interpretation”. The therapist is, in fact, opening up the potential space of thirldness by providing the patient with “a very effective form of play” (Ibid.). There is an incremental trajectory of thirldness where what one may call the wheel of the dialectic of recognition and negation may start turning (forwards and backwards) by the therapist’s showing “a small edge of challenging alterity” which the patient may take on and respond to with “some tacit bit of recognition”, or from which he (the patient) may retreat (Ibid.). This concurs with Pizer’s (1998, p. 64) idea of the therapist as “transitional mirror”, where “mirroring must be both empathic (attuned) and inexact (different)”. Thus what Pizer (1998, pp. 3-5) calls the “process of intersubjective negotiation” (that is, the largely unconscious “give-and-take of subjectivity, desire, stricture, and demand between analyst and patient”) is set in motion.

Here one may think of how a therapist’s interpretations may both introduce alterity and cause the patient to feel held by the sense of being understood (Casement, 2002). However, it is when interpretations are indicative of the therapist’s negation of the patient’s subjectivity that the patient may experience them as attacking, controlling, impinging, and so forth. This happens particularly when, rather than being offered as possibilities for mutual consideration, interpretations are given as indisputable statements of “facts” that the therapist “knows” about the patient, (Ogden, 1986; Pizer, 1998; Casement, 2002). The patient could experience this as the therapist’s not negotiating meaning, but being negating by attempting to force him to substitute the therapist’s view for his own, and “unassimable difference” (Benjamin, 2000a, p. 44) may follow. What constitutes unassimable difference will, of course, be different in each therapeutic dyad and also at different points in time within every dyad.

3.3.2.2 Containment and complementary twoness

In her depiction of the third in the one Benjamin (2001) emphasises Bion’s (1962, 1967b) idea of the therapist’s functioning as a detoxifying container for the patient's intolerable affects and experiences. In further elaborations of the concept of containment, the patient is not only contained by the therapist, but also internalises the process of containing and becomes capable of containing himself (Hamilton, 1990; Ogden, 1994, Benjamin, 1998b). The question that then arises is how the therapist does not become a “negative container” (Grotstein, 1995, p. 489). Becoming a negative container means that the therapist becomes “destroyed” in Winnicott’s (1969) sense without “surviving” the destruction. The therapist submits to the patient’s demands or becomes emotionally absent and/or attacking.
The current emphasis on the therapist’s subjectivity means that the certainties of the objectivist-authoritarian position are no longer there to fall back on or to hide behind. This leaves therapists much more visible and vulnerable. The absence of a prescribed way of doing things may set the therapist free to work from his or her subjectivity, but it also brings a greater sense of personal responsibility, accompanied by anxiety and potential guilt around the awareness that harming the patient is always a real possibility in therapy. There are also specific patients (such as those with severe narcissistic disturbances, especially those who are hostile and full of rage) and specific situations which a particular therapist could find difficult and anxiety-provoking.

Both patient and therapist are usually involved in the creation of impasses and ruptures. These “occur most often when both patients’ and therapists’ primary vulnerabilities and defenses intersect in unmanageable ways” (Elkind, 1994, p. 3). From an object relations perspective, the concept of projective identification is often used to understand how the therapist becomes “enlisted in an interpersonal actualisation … of a segment of the patient’s internal object world” (Ogden, 1982, p. 69) to take up and play the role that the patient has unconsciously assigned to him (Sandler, 1976).

However, using the notion of projective identification in its original sense could give rise to the (rather outdated) idea that what the therapist experiences has been “put into him” via projective identification and can be understood and used as such (Sandler, 1993). Ringstrom (2003, p. 196) points out that “contemporary relational theories about projective identification” (that also take the subjectivity of the therapist into account) resonate with the ideas around “double-bind impasses”. He (Ibid.) also makes the interesting comment that the idea of the impasse actually goes “a step further” in that this may not just be about the patient’s unconsciously inducing the analyst to play some part in order to understand some “split-off, disavowed aspect of himself”, but could also be understood as the patient’s “flushing out something about the analyst’s authentic identity”.

In this study the emphasis was primarily on the therapist’s contributions to impasses. While impasses are inevitably (and sometimes usefully) a part of the process of therapy and are mutually created and maintained, the continued existence of an impasse could also point to and highlight some negative attribute or particular vulnerability of the therapist’s. One way of understanding this specific version of impasse on an intersubjective level may therefore be as the constellation of an antitherapeutic dyad between the therapist and a third point of reference and the presence of a negative third between therapist and patient (Benjamin, 2001). While only one of these two aspects may be evident in a specific impasse, it is more likely that both would be present, but in varying degrees. Such a situation is depicted in Figure 3.3.
In the “relational knots” (Pizer, 2003; Ringstrom, 2003) that are typical of “double bind impasses” (Ringstrom, 2003, p. 193), the therapeutic pair becomes locked in the symmetry of *complementary twoness* (Benjamin, 2001, p. 3) of the negative or subjugating third (Ogden, 1994). When the therapeutic dyad is in the throes of complementary twoness (that is, the dialectic of recognition and negation has collapsed), patient and therapist become “frozen” in the dichotomous polarities (“split complementarities”) (Benjamin, 1998b, p. 20) of “action-reaction” (Benjamin, 2001, p. 15) where neither is “able to think or speak clearly” (Ringstrom, 2003, p. 197). This “see-saw relationship” (Benjamin, 1998b, p. xiii) is marked by both therapist and patient feeling that they cannot acknowledge the other’s reality without abandoning their own: there is no “co-created reality” (Benjamin, 2001, p. 3) and the intimacy between therapist and patient becomes threatened and compromised (Ringstrom, 2001b). In object relations language one would therefore say that this is a situation where projective identification predominates.
The patient may experience his feelings as being denied and himself as being dismissed. The therapist may feel invaded by the patient’s “malignant emotional reality” and his sense of self may be threatened by the patient’s destructive view of him, so that he (the therapist) can no longer think without disidentifying (and withdrawing) from the patient (Benjamin, 2001, p. 22). The nonexistence of a space to negotiate meaning may become so palpably present that the therapist feels unable to move outside the narrow confines of what is dictated by the negative third: the meaning of what is happening cannot be discussed.

This is what Peltz (1998, p. 387) calls “the realm of enactment and coercion” and of “nonmeaning in the symbolic sense”. Here one has the power and the other one submits to it; one is aggressor and the other one victim; one is subject and the other is object; one is recognised and the other negated. The only choice is to submit to or resist the other’s demand (Benjamin, 2001). Patient and therapist find themselves locked in opposing and unequal positions, which are reversed through identification. One could therefore also understand complementary twoness as being constellated at a point in therapy where the fluid process of multiple reciprocal identifications and disidentifications between therapist and patient “goes wrong” in the sense that the therapeutic pair remains stuck in complementary positions of dominance and submission (Benjamin, 1998b; Ringstrom, 2001b).

3.3.2.2.3  Moving along through difficult moments

For therapist and patient to extricate themselves from complementary twoness requires the therapist’s becoming aware and recognising that he is both participating in the creation of the impasse and colluding in keeping awareness of the disconnection and collapse of thirdness at bay. The more conventional analytic methods, for example, elucidation, exploration, interpretation and even negotiation often prove to be insufficient and fail at such a moment of impasse (Pizer, 2003). While metacommunicating to the patient about their mutual process may go some way towards moving the therapeutic pair beyond the relational knot of the impasse, it may not be enough. Ringstrom’s (2001a) improvisational moments and Stern’s (1998) now moments are descriptions of the kinds of processes that are involved in the “mutative moments of change” that are particularly relevant at these difficult times in a therapy (Ringstrom, 2001a, p. 727). Improvisational and now moments also often concern acts of freedom (Symington, 1983) on the therapist’s part, where the therapist makes a complementary identification with an (often disowned) part of the patient and where the patient feels recognised by the therapist’s response that encompasses the impact of the patient on him (the therapist) and offers something new and different (Fonagy & Target, 1998).
Ringstrom (2001a, p. 727) sees an improvisational moment as resulting from the therapist’s surrendering his stake in the power play of the impasse and replacing it with “imaginative intersubjective engagement” with “disparate, often dissociatively disconnected parts of the patient”. This imaginative intersubjective engagement may be held in the therapist’s “own state of reverie”, and as such inform his interpretations (Ringstrom, 2003, p. 202). It may also lead to the therapist’s “changing” by momentarily stepping outside the prescribed “ritual” (Hoffman, 1998) of therapy and spontaneously engaging with the patient in a way “that conveys not only a moment of deep recognition but also the purest state of authentic engagement”; that is, it may bring about the arrival of an improvisational moment (Ringstrom, 2001a, p. 727).

Stern’s (1998, p. 302) unpremeditated now moments (which he sees as “nonlinear leaps” and “emergent properties of a complex, dynamic system”) may result in a “specific moment of meeting” (on both a conceptual and an affective level) between therapist and patient. Sander (2002, p. 13) posits that the arrival of such a moment of meeting may be ushered in by the patient’s experience of specifically being known or recognised by the therapist (for example, by the therapist’s making an appropriate and meaningful interpretation), which also contributes to a co-constructed “expanding specificity of recognition”. A moment of meeting creates the potential (“an open space”) for “a new and different intersubjective context” between therapist and patient, thus altering their relationship (that is, changing their presymbolic implicit or procedural knowledge of each other) (Stern, 1998, p. 302).

### 3.3.2.2.4 The therapist’s knowing recognition of the patient

These above-mentioned theorists seem to be talking about the therapist’s both being with the patient in a very specific emotionally alive way and about his having a measure of intuitively felt knowledge of the patient, constituted by some kind of hidden processes that are largely “unformulated” (Stern, 1998), as being pivotal at these moments. Coltart (1996, p. 30) describes the therapist’s experience of such vital moments: “It is as if one is lived from depths within oneself for a brief period, depths that one can trust, and which yield up the nearest thing to ‘inspiration’ that we ever experience.”

From a relational perspective, even if the real power asymmetry between therapist and patient is taken into account, the therapist is not “the one who knows”. However, the therapist also does “know” from a perspective that straddles the paradoxical positions of “knowing” from his own subjectivity and “knowing” as a responsible and competent professional.
According to Bollas (1995, p. 39), the therapist who works with a patient gradually gathers knowledge of and about the patient in the form of “an inner constellation of preconscious ideas, feelings, visual images, sonic metaphors, somatic dispositions, and body-ego acuities, a kind of psychosomatic organization that forms his matrix for unconscious communication with his patient”. The therapist’s immediate and intuitive “knowing” of the patient is therefore the result of complex and often unconscious (intrapsychic and intersubjective) processes that can be understood as “a network of the many different planes of reference that constitute [the therapist’s] subjectivity” (Bollas, 1995, p. 39). In terms of Benjamin’s thinking, the therapist’s “knowing” the patient (especially at those moments when he seems to step outside his “accustomed position”), constitutes a “deep recognition of the patient’s essential being” (Pizer, 1998, p. 4).

One could also understand this deep recognition as indicative of the vital emotional bond, potentially generative of new meanings, between therapist and patient. Straker and Becker (1997, p. 173) found that, from the “client perspective … change moments” were marked by their participants finding verbal content and insight (or rather “understanding”) to be backgrounded. What was more important at those change moments, was function rather than structure; “the music not the words”; that is, the “the emotional tone” of the relationship” (Ibid., pp.173-174).

One of the difficult aspects about being a therapist is to accept that one can never fully understand the patient; that is, that to some extent he always remains Other. According to Bollas (1995, p. 20), the therapist therefore plays both the roles “of the wise figure who sustains [the] illusion [of understanding] and [who] thereby encourages the patient to speak” and “the fool who does not know what is being said to him” in the transference. This also pertains to the therapist’s task encompassing the contradictory dimensions of both “knowing” the patient (in terms of Bollas’s matrix) and keeping in mind Bion’s (1967a) well-known injunction that every session should be approached without memory, desire or understanding. According to Bion, patients’ mental-emotional realities should be apprehended directly, rather than being distorted by the therapist’s prior memories and “facts” about the patient, expectations of the patient, desires for progress and notions of cure.

This therapeutic stance of “slouching towards” (Coltart, 1993a, borrowing from Yeats) rather than “arriving at” meaning implies neither a deconstructive watchfulness nor a kind of simplistic passivity, but a disciplined steadfastness. “I do not mean that ‘forgetting’ is enough: what is required is a positive act of refraining from memory and desire” (Bion, 1970, p. 31). This “generative uncertainty” (Ivey, 1999) speaks of therapists’ capacity to wait and to pay attention
without putting themselves into patients' experience too intrusively; to lay aside theoretical preconceptions (for example, Casement’s [1990] “psychoanalytic clichés”), which may be reached for because of the anxiety of not-knowing and to avoid grasping at premature pseudo-knowledge in order not to experience lack or absence. In the tension between what is known and what is unbidden (Stern, 1998), the therapeutic intersubjectivity may become alive in the “affectively resonant communication [which] in some sense precedes the discursive thirldness in which symbolic and universal/moral thirds predominate” (Benjamin, 2001, p. 26).

3.3.2.3 The symbolic third and mutual recognition

The earlier clusters of thirldness and the delicate balance between the patient’s experience of seamless and endless attunement and incrementally increasing alterity form the foundation for the third cluster of the trajectory of thirldness. Benjamin (2001, p. 16) calls this “the later, interpersonal symbolic third, the dimension of recognizing meaning and negotiating differences through speech”. Linked to the therapist’s ongoing process of recognition of the patient (even if interspersed by instants of negation) is a certain “progression” on the patient’s part: “agency, self-cohesion, and ultimately the ability to recognize the other” (Benjamin, 2002, p. 46).

This third cluster is therefore marked by increasing mutual recognition (that is interwoven with the necessary moments of negation) between therapist and patient. Here, rather than conceiving splitting “in opposition to some normative ideal of the whole self”, it may be viewed “as the initial form adopted by the self with respect to contradictions in feelings or apprehensions; it can either be transformed in relation to the outside other or reduce the other to the locus of the self’s disowned parts” (Benjamin, 1998b, p. 97). Accordingly “reversible complementarities” may be broken up; the underlying polarities be held in tension and thus the dialectic of recognition and negation may be sustained and, when necessary, reinstated (Benjamin 1998b, p. xiv). Therapist and patient become increasingly capable of playing both complementary roles (which involve the intrapsychic dimension, that is, “subject-object relatedness”) and those roles that involve mutuality (which involve the intersubjective dimension, that is, “subject-to-subject relatedness”) (Aron, 2000, p. 674).

The idea of subject-to-subject relatedness foregrounds the issue of the therapist’s establishing himself as being separate and different and also recognising the patient as such. For the patient, the

67 In terms of Ogden’s (1994) analytic third, the third subject of analysis, one could say that at this point experience within this (the third) is being generated and organised not just according to Klein’s (1988a, 1988b) thinking about the depressive position. There is a dialectical interplay of the depressive, the paranoid-schizoid and the autistic-contiguous modes of generating experience rather than a collapse of the dialectic in the direction of any one of these modes.
therapist as subject is both “real” and “not real” (and may thus serve as a transitional object) (Frankel, 1998b). The therapist is “real” in the sense of his subjective presence in the session, where what he does or does not do, and says and does not say, declare and make evident what he is, what he feels and thinks. He is “not real” in terms of the mask that the necessary asymmetry of the therapeutic relationship lays upon his presence. Being the therapist also means “making himself available to becoming everyone in the patient’s life (transferrationally) and no one (a person who is content not to be noticed, not to be attended to)” (Ogden, 2003, p. 598). While the therapist’s concern, caring and even love for the patient may be “real”, the fact of the patient’s paying for this and the end of each therapeutic hour signal the limits of the therapist’s involvement (Slavin & Kriegman, 1998b).

The therapist’s task is to find ways to communicate with the patient as subject-to-subject within this “inevitable asymmetry of responsibility” (Benjamin, 1998b, p. 98), that is in a “knowing” (Ibid., p. 23), authentic and personally involved way. In this context the therapist’s recognition of the patient as a subject could, for example, happen through “controlled communication of the patient’s emotional impact” (Ibid.) or through the therapist’s somehow “changing” through his experience of the patient (Slavin & Kriegman, 1998b).

In relational/intersubjective theory, it is accepted that the therapist is constantly, inadvertently and inevitably, non-verbally and verbally, revealing himself (that is, his subjectivity) to the patient (Renik, 1995; Aron, 1996; Benjamin, 2000). He is no longer an “omniscient sphinx” whose authority cannot be questioned and as such could contribute to the patient’s unwarranted and sustained idealisation of him (Renik, 1995, p. 478). However, the therapist’s “purposeful or deliberate self-revelations” are still controversial (Aron, 1996, p. 235). Benjamin (2000a, p. 48) comments that such self-disclosures on the part of the therapist should not be confused with the therapist’s establishing himself as being separate and different from the patient. To do so (self-disclose) under pressure from the patient would, in fact, be the converse of being “an independent subject” and in this case not disclosing may be the best way for the therapist to express his subjectivity (Ibid.).

In the symbolic third there is a growing sense of a vital, rich, finely nuanced and co-created intersubjective third. The two participants have come to know and trust the familiar reliability of this shared space and have also become open to the arrival of the spontaneous and unexpected. Boundaries between therapist and patient are less rigid, guarded, defended and more fluid. Things

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68 This is beyond the scope of this study. See Aron (1996) for a discussion of this issue.
no longer have to be only inflexibly the “this or that” of “alienated forms of complementarity, based on the idealization and repudiation created by splitting” (Benjamin (1998b, p. 97). Therefore many possible and even contradictory meanings may be simultaneously present in this space where difference holds creative potential rather than just being an ominous threat. This is the space where symbolic thinking and therapeutic play become possible.

As previously stated, the general theoretical framework set out in the first three sections of this chapter ensued from the process of asking the interview text the questions comprising the reading or listening guide. At the same time certain themes were identified which could be used as ways to think about the links between the participants’ therapies and their work. When possible, those were conceptually elaborated on by making use of further literature within the existing theoretical context. When literature pertaining to the specific topic but outside relational and intersubjective thinking was used, an attempt was made to dialogue this with the theoretical framework already employed. In the next four sections of this chapter, these themes and some of the thinking around them will be outlined. In the textual analysis these four sections became theoretical sensitivities through which the interview text was edited, organised and interpreted, and thus focal points for further thinking about and discussion of the data.

3.4 THE THERAPIST AS WOUNDED HEALER AND SUBJECT-TO-SUBJECT RELATING

The question of why someone would enter what Freud (1937, p. 248) called one of “those ‘impossible’ professions in which one can be sure beforehand of achieving unsatisfying results” is still a pertinent one. The nature of the work of doing therapy is often demanding and emotionally depleting and may even sometimes lead to the so-called burnout syndrome (Wheelis, 1956; Greenson, 1966; Freudenberg & Robbins, 1979; Fine, 1980; Cooper, 1986; Glickauf-Hughes & Mehlman, 1995; Sussman, 1995). Glickauf-Hughes & Mehlman (1995, p. 217) summarise some of the factors that have been found to contribute to “therapist burnout” (and that are often “related to unresolved narcissistic issues”) as “overextending oneself”, “conflicts between role demands and needs for personal gratification”, “high aspirations and ambiguous criteria for measuring accomplishments” and “nonreciprocated giving and attentiveness”.

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69 See p. 38.
Therapists come to this profession because of conscious and unconscious motivations, each bringing his own expectations and needs (Sussman, 1992; Glickhauf-Hughes & Mehlman, 1995). Doing the work of therapy is often accompanied by a strong feeling of vocation, that is, not in the religious sense of being “called”, but rather as “a profound emotional and intellectual conviction that one is pursuing a goal that is absolutely right for oneself” (Coltart, 1993b, p. 8). Coltart (1996, p. 34) describes the features of such a sense of vocation as “giftedness, belief in the power of the unconscious (indeed, in the unconscious itself), strength of purpose, reparativeness and curiosity”. There can be deep satisfaction in facilitating change and development in others; in using one's intellectual and emotional capacities to solve complex problems. However, patients’ transferential love and admiration, as well as the therapist's position of power and authority, can provide potent narcissistic gratifications (Stein, 1984; Finell, 1985; Welt & Herron, 1990; Billow, 1999).

The professional relationship between therapist and patient implicitly assumes that the therapist is the one who is strong, healthy and in command of the situation. Patients also often cast the therapist in the role of “prophet, saviour and redeemer” (Freud, 1923a, p. 50), who is “wise, insightful, caring and possessed of healing powers” (Ivey, 1995, p. 356). In such a situation the therapist may find it hard not to continue basking in the warmth of this very seductive and satisfactory image of himself.

Nevertheless, many therapists are also wounded healers\(^7\) the converse and often carefully hidden side of the “healer-redeemer” (Groesbeck, 1975; Miller & De Witt, 1987; Goldwert, 1992; Cushway, 1996; Benjamin, 1997, p. 796; Wolgien & Coady, 1997). Coltart (1993b, p. 7) comments that it is “almost an idée reçue in our strange world” that “a ‘normal’ person is unlikely to be a gifted therapist”, but adds (Coltart, 1996) that there is no final consensus that one has to be “wounded” in some way to do the work of therapy. However, the therapist’s own “wounds” do not only often play a significant role (usually not consciously) in his desire and decision to become a therapist and in making it possible for him to do the work of therapy, but may also sometimes come to the fore quite destructively in the crucible of the therapeutic situation (Guy, 1987; Sussman, 1992; Glickhauf-Hughes & Mehlman, 1995).

The therapist’s “woundedness” is usually understood as the narcissistic injury arising from being “extractively” (Bollas, 1987) rather than nurturingly treated in the family of origin and being

\(^7\) The term “wounded-healer” was originally used by some Jungian authors, who have noted Jung’s references to the Greek myth of Asklepios and who have written about it with specific reference to the constellation of the “wounded-healer” archetype and its countertransference dimensions in the therapeutic situation (Sedgwick, 1994). The use of this concept (if not always the term) is not confined to Jungian thinking.
designated the family “caretaker” (Miller, 1979, 1981; Racusin, Abromowitz, & Winter, 1981; Sussman, 1992; Glickauf-Hughes & Mehlman, 1995; Cushway, 1996). Miller (1981, p. 22) describes the therapist as often having been a “well-behaved, reliable, emphatic, understanding, and convenient child, who in fact was never a child at all” and who lived to “enliven” the other (Winnicott, cf. Phillips, 1988, p. 29) by means of his “sensibility, his empathy, his intense and differentiated emotional responsiveness, and his unusually powerful ‘antennae’” (Miller, Ibid.). The “wound” primes the therapist to do the work of therapy by leading to the development of an exquisite sensitivity to the unconscious needs of others and the ability to subjugate his own needs and desires in order to meet those of others. According to Gabbard (1995, p. 711), the latter may serve the dual purpose of “[providing] masochistic gratification and [enhancing] self-esteem”.

McClure and McClendon (1989, cf. Glickauf-Hughes & Mehlman, 1995, p. 215) observe that therapists often make “an early decision to be self-reliant, [and] to achieve without needing or acknowledging help”. This may become an impediment in the therapeutic situation when the therapist’s unmet needs are countertransferentially acted out; that is, when the patient becomes (in Benjamin’s terms) negated, rendered an object rather than being a like subject.

This process frequently happens in the guise of the therapist’s becoming “his patient’s patron or knight” (Ferenzci, 1919, cf. Berman, 1997a, p. 984) and therapist and patient enact the so-called “rescue fantasy” (Greenacre, 1966, p. 760). The “object of rescue” (that is, the patient) is “a projected version of the rescuer’s own disavowed vulnerability” (Berman, 1997a, p. 984) and if the therapist succeeds in “rescuing” the patient, he himself may be “enhanced, cured, saved” (Hardy, 1979, p. 70). The “rescuer fantasy” may be further elucidated by reconfiguring Miller’s (1981, p. 39) notion of the therapist’s woundedness as “grandiosity” and its converse “depression” in terms of Benjamin’s thinking as creating an interplay of opposing and reversible polarities within the therapeutic dyad.

Although the notion of the therapist as rescuer certainly implies the patient’s being disempowered and negated by becoming the “object” that is being rescued, this process is co-created in the sense of being underpinned by an unconscious “narcissistic collusion” between therapist and patient (Glickauf-Hughes & Mehlman, 1995, p. 217). The therapist becomes the powerful and inflated “healer-redeemer” (Benjamin, 1997, p. 796) and the patient the submissive and adoring acolyte. This could be part of the version of complementary twoness (quite commonly found in therapist-patients’ therapies) that is constellated by the collusive folie à deux between therapist and patient that marks a prolonged and enduring idealising transference. In this manner what Langs (1975, p.
calls “therapeutic misalliances” and Ivey (1995) denotes as “positive narcissistic symmetry” is created by the intersection of the therapist’s “countertransference fantasy of being a redeemer” and the patient’s transference fantasy of “him as the savior” (Benjamin, 1998b, p. 22). While the patient’s idealisation of the therapist is an accepted and potentially useful part of the therapeutic process, which the therapist should be able to tolerate and which should be understood rather than suppressed or avoided, such an idealising transference may become counterproductive when consciously or unconsciously solicited by the therapist (Renik, 1995).

The therapist’s own therapy could make him aware of the existence and nature of his “unresolved and disavowed” issues (Zeddies, 1999, p. 232), and of how his own “blind spot[s]” (Freud, 1912, p. 116) cast their shadows on the in-between space of therapy. It could also alert him to his own “bright spots” (Goldberger, 1993). This term refers to a variety of “blind spot” where the therapist identifies with an experience of the patient’s with which he himself is familiar or which is particularly meaningful for him (the therapist). He therefore makes the assumption that it has the same significance for him and the patient, thus potentially compromising and obscuring the particular meaning it has for the patient.

The therapist’s personal therapy could also bring an awareness of what it is like to grapple with one’s own issues in the (often disturbing) process of therapy and to be a patient (and of the vulnerability and disempowerment that this position brings). The therapist’s experience of being-a-patient could consequently facilitate his identifications with his own patients. Keeping in mind that even the most responsible and conscientious therapist will, at times, unintentionally “use” a particular patient for his own purposes, the therapist’s own therapy could contribute towards his being increasingly able to be close to his patients without being engulfed by or negating of them by (unconsciously and inadvertently) using or disempowering them.

As Benjamin (1998b, p. 103) puts it: “What cannot be mourned, cannot be let go, is held inside as abject, repudiated otherness.” She (Ibid., p. 108) continues: “Owning the other within diminishes the threat of the other without, so that the stranger outside is no longer identical with the strange within us …”.
3.5 POWER AND MUTUAL RECOGNITION

3.5.1 The discourse of power in the therapeutic relationship

The discourse of power in the therapeutic relationship is foregrounded in postmodern relational thinking and particularly in Benjamin’s work. As could be seen in the earlier discussions, domination and submission, empowerment and disempowerment, are constant themes in Benjamin’s thinking about the nature of therapeutic relationships. The distribution of power between therapist and patient needs to be continually negotiated to keep the therapeutic space a viable one. This is encapsulated in Benjamin’s notion of the evolvement of mutual recognition being a central task of therapy. As previously noted in the discussion of complementary twoness, thirdness between therapist and patient does sometimes collapse into binary opposites, and these “are inseparable from implicit or explicit hierarchies” (Flax, 1990, p. 101). Benjamin’s (1998b, p. 25) grappling with the question of how these complementaries that are constellated between therapist and patient may be dissolved, highlights the presence of the idealisations that are “intrinsic to [such] binary hierarchies”. Such idealisations are particularly relevant in the case of therapist-patients whose idealisations of their therapists often have the added feature of the therapist’s being the one who knows how to be a therapist. Such a chosen therapist may be perceived as having “discourse specific power-knowledge” (Flax, 1994, p. 6), which resonates with what Benjamin (1998b, p. 21) calls the “hidden dimension of power in knowledge”.

Even with the present emphasis on mutuality, the asymmetry of the therapeutic relationship still constitutes “an inherent power differential” between therapist and patient (Frankel, 2002, p. 126). “The patient is there because he feels he needs help and also love, and he pays for it. There is also some shame attached to these facts. The patient’s need and vulnerability put him in a one-down position. In contrast, the analyst has power not only by virtue of being the less needy party and because the patient’s prospect of getting help depends on him, but also for other reasons. Analysts are representative of the authority and prestige of a powerful social institution … The treatment is (and is conducted on) the analyst’s turf” (Frankel, 2002, p. 128).

The “ritualized asymmetry” of the therapeutic relationship is indeed what gives mutuality its power by making the participation of the therapist “in the spirit of mutuality” matter to the patient (Hoffman, 1998, p. 204). However, this asymmetry may combine with a therapist’s defensive need to preserve his position of power and as such become problematic in the sense of iatrogenically

71 Benjamin’s (1988, 1995, 1998b, p. xii) theorising about recognition and intersubjectivity originated in her thinking about the “problem of how we relate to the fact of the other’s independent consciousness” (in which power is a central concern). Her understanding of Hegel’s master-slave dialectic (as set out in his Phenomenology of Spirit) has been a fundamental tenet in the development of her work.
embedding the patient in the role of the lesser, the weaker, dependent one who does not know. Slavin (2001, p. 422) comments on the “dark side” of the therapeutic relationship where asymmetry may become connected to the therapist’s self-interest and exploitation of the patient. There is also the thought-provoking question of how “social or institutional power” figures in the constitution of “interpersonal power” in therapy (Harris & Gold, 2001, p. 367), but this is probably of more relevance in the case of actual psychoanalytic or Jungian training, which takes place within the context of the power politics that seem such an inherent part of psychoanalytic and Jungian institutes (Kirsch, 2000; Kirsner, 2000).

The mere fact of the therapist’s bringing and representing separateness and alterity (being and occupying the position of a different Other) may contribute to rendering him (the therapist) into the one that has the power. If the therapeutic space is to be vital, generative of new meaning and to go beyond what is already known, the therapist’s participation is often disruptive (Other) in the sense of its being his responsibly “to unseat self-limiting – perhaps self-deadening stability” (Hart, 1999, p. 190). Bollas (1995, p. 222) writes about the therapist’s “cracking up” the patient’s taken-for-granted ways of viewing himself, thus “undermining the arrogance of consciousness”. Lacan, who “ended his notoriously brief sessions … when the patient’s unconscious fooled him”, is probably the most well-known example of the therapist as “embodiment of the unconscious as disruptive other” (Bollas, 1995, p. 223).

It is, after all, the therapist’s task to engender the evolvement of an intersubjective space where the patient may find a more coherent voice for his mute and inchoate thoughts and feelings. This entails a “generative disruption” (Hart, 1999, p. 200) which is only possible within the context of an established and safe analytic space. “[S]uch safety is mainly derived from such features of analysis as the adherence to an analytic frame, the analyst’s nonretaliatory, reliable presence, and the conveyance of an enduring interest in the analysand’s elaboration of his or her experience …” (Hart, 1999, p. 200). Safety in the therapeutic space is therefore largely dependent on the therapist’s observance of the “analytic attitude” (Ivey, 1999), which should be accompanied by an ongoing sensitivity on the therapist’s part for what the patient is actually ready. In this regard the relational focus on “the nuances of impersonal impact” is important (Hart, 1999, p. 195). The therapist’s deconstruction of the patient’s established ways of being, thinking and feeling has both a creative and destructive potential, and is located on the slippery slope between “annihilatory destruction of the self and generative disruption of its self-protective wrappings” that therapy entails (Ibid., p.

This returns us to Benjamin’s dialectic of recognition and negation and the ever-present possibility of breakdown that the therapist’s alterity brings to the space of therapy.

Hart (1999, p. 200) highlights the importance of the therapist’s own therapy in his coming to trust and appreciate the multifaceted complexities (including the unsettling aspects) of the process of therapy. This comes about through actually having the “experience of [surviving] analytic disruption and [seeing] first hand its generative potential, despite its initial destructive threat” (Ibid.). It is through this experience of the therapist’s own therapy that his faith (Eigen, 1981) in the creatively mutative possibilities of an analytic attitude of openness to experience and a willingness to confront the emotional truth of one’s subjectivity may become a lived reality rather than just another desired therapist attribute to strive for.

By entering therapy, the patient (even one that is informed and knowledgeable about therapy) is taking a veritable leap of faith into the unknown. He is placing himself in the power of a process and a therapist in a space where he is without doubt at risk. He will almost certainly lose some of his accustomed (even if dysfunctional) ways of being and it is uncertain how much or what he will gain. In fact, the patient is (probably unknowingly), in a sense, placing himself in a position of disempowerment (although in a good-enough therapy this will not be an enduring state of affairs).

A reversal of the power differential (especially in the case of split complementarities) may also sometimes render the patient into the one occupying the position of power. Doing therapy undoubtedly also puts therapists at risk and therapists inevitably bring their own vulnerabilities to the therapeutic situation. Racker (1968), for example, highlights therapists’ “unconscious masochism”, which may lead to submissiveness rather than surrender, and Gabbard (1995, p. 711) thinks of this as the repetition of “a pathological childhood situation”. Therapists also need their patients to help them feel “secure, useful, competent, fulfilled, recognized” as therapists (Frankel, 2002, p. 133), and doing psychotherapy may sometimes become a way of regulating self-esteem (Gabbard, 1995). This may be exacerbated by the therapist’s own unmet needs and desires, which may, at times, tilt the therapeutic situation towards serving the therapist rather than the patient. For example, Searles (1981) writes about how patients may unconsciously strive to “cure” their therapists in order to enable them (the therapists) to do the work of therapy by secretly taking care of them.
3.5.2 The relevance of power when the patient is a therapist

The issue of power is somewhat different when the patient is also a therapist and little has been written or researched about this sensitive matter (Bridges, 1995; Gabbard, 1995; Norcross, Geller & Kurzawa, 2000). The treatment of a colleague or other mental health professional often involves the constellation of “vastly complicated relational dynamics, both internal and external” (Crastnopol, 1999a, p. 445). Although this is really outside the scope of this study, it is useful to briefly consider some of the factors that may come into play in this situation and as such may contextualise and influence the therapist-patient’s therapy and his work.

There is the fact (often implicitly understood but explicitly unacknowledged by both members of the therapeutic dyad) that therapist and patient are both relating as therapist and patient and in a more egalitarian way as colleagues (Berman, 1995; Norcross, Geller & Kurzawa, 2001). In part, this is due simply to the fact that the therapist-patient usually knows more about the professional (and sometimes the personal) life of the treating therapist than a “lay” patient (Gitelson, 1954, Elmhirst, 1982-1983) and that their professional lives may inadvertently cross (therapeutic communities are often small and notoriously incestuous) (Gitelson, 1954; Norcross, Strausser & Faltus, 1988; Berman, 1995; Kirsner, 2000; Norcross, Geller & Kurzawa, 2000). This means that in these therapies the roles of therapist and patient may more easily become confused and that boundaries are often more fluid and sometimes blurred than in therapies with “lay” patients (Norcross, Geller & Kurzawa, 2000).

The potential for relating as colleagues is probably greater when the therapist-patient is no longer a novice therapist. Although the overt and conscious intention of both parties may be to limit their interactions to the specified roles of therapist and patient, there will inevitably be shifts to just being colleagues. This may (at least partly) just be circumstantial and may actually sometimes be useful. Within therapeutic communities this is a sensitive topic with no clear-cut rules and is not comfortably or freely discussed. It is obvious that these apparently dichotomous polarities created by the therapeutic dyad consisting of both therapist and patient as a therapeutic pair and as colleagues need to be acknowledged and to be held in tension. This also begs the question of if and how the therapist-patient experiences being recognised by his therapist as being a like subject in terms of also being a therapist and if and how this can be linked to his work as clinician.

Working with colleagues (and being “chosen” for this task) is certainly flattering and alluring. Being a “therapist’s therapist” will without doubt add to one’s prestige in the therapeutic

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73 This could be a worthwhile and challenging topic for further research.
community to which one belongs (Greenberg & Kaslow, 1984; Fleisher & Wissler, 1985; Norcross, Geller & Kurzawa, 2001). While the work itself is often exciting and challenging, it also brings its own idiosyncratic difficulties and burdens, which may sometimes threaten the treating therapist’s professional self-esteem (Fleisher & Wissler, 1985; Bridges, 1995; Norcross, Geller & Kurzawa, 2000).

According to Bridges (1995, p. 175), psychotherapy with therapists “raises intense and complicated countertransferential feelings for the treating therapist and presents unique problems around recognition and management of identification issues”. She continues: “Strong, often unconscious feelings of envy, competitiveness, exposure, and vulnerability, together with a particularly close sense of self-identification and a powerful wish to be helpful, threaten to intrude into the treatment. Fears of criticism, issues of therapeutic narcissism, and protection of one’s professional self-esteem are likely to accompany any treatment with a therapist-patient.” These “usual countertransferential feelings produced by the treatment of therapist-patients” may become problematic when they “match or intersect with … [t]herapists’ personal vulnerabilities” (Ibid., p. 178).

If one is the treating therapist, the power conferred on one by such a “disciple” (that is, the therapist-patient), who has not only chosen one as the ideal of what he wants to be, but who is also emulating one’s way of being-a-clinician by various conscious and unconscious identifications, is certainly very seductive. This may productively create grist to the proverbial therapeutic mill, but it may also be concretely taken up (and it is certainly tempting to do so) by the treating therapist and infuse the intersubjective space with a particular and potentially destructive version of the power differential.

In the same vein the treating therapist-mentor may become narcissistically invested in the professional performance of his protégé (Gabbard, 1995) and even have an excessive sense of responsibility about the therapist-patient’s theoretical knowledge and/or behaviour as a clinician. One cannot, however, pretend that the treating therapist does not have a pivotal part (and an accompanying responsibility) in the manner of therapist that the therapist-patient becomes (Norcross, Geller & Kurzawa, 2001). Then again, it is when the therapist-patient’s way (or perceived way) of being a therapist (in this instance usually submissively being a therapist like the treating therapist) empowers the treating therapist in the sense of contributing to his sense of being a “good” therapist and knowing how to be a “good” therapist, that this process goes awry.
3.6 THERAPIST “MISTAKES” AND THE DIALECTIC OF RECOGNITION AND NEGATION

What happens in those instances when the patient perceives and/or feels that the therapist has made a mistake? What constitutes a mistake on the therapist’s part would depend on one’s specific theoretical viewpoint and is a debatable issue, but here I am referring specifically to those occasions where the patient, in Benjamin’s terms, feels negated by the therapist. This could concern a momentary occurrence or could take place in the more general context of felt recognition largely not featuring in the therapy. Most innocuously, this absence could simply pertain to a therapy being at the beginning stages and involving a greater degree of idealisation of the therapist. In the case of this study, the participants had generally chosen the treating therapists as models to emulate, so that those relationships had probably to some extent remained, even when there had been greater mutuality, somewhat tinged with idealisation. A patient’s experience of the absence of felt recognition may therefore mean that thirdness and an ongoing dialectic of recognition and negation have not yet been established, but are still only incipient. A significant lack of recognition could also be a more ongoing feature of a therapeutic relationship.

For the contemporary psychodynamic therapist (and more so for the one with relational leanings), those moments of miscommunication and disconnection, when the therapy could be at risk because of what he has (or has not) done, could be especially difficult and potentially threatening. What the patient feels can no longer “simply be attributed to transferences from figures outside the consulting room” (Slavin, Rahmani & Pollock, 1998, p. 199). The therapist cannot hide behind authoritative anonymity, but is both professionally and personally “deeply implicated in what transpires” (Ibid.).

Uncomfortable dimensions of being-a-therapist (even a good-enough therapist), like countertransferentially hating the patient (Winnicott, 1947), or the proclivity of therapists to “trip over the big feet of [their] self-interest” (McLaughlin, 1995, p. 435), are explicitly recognised and foregrounded. Such a therapist is probably much less clear about what belongs to the patient and what belongs to him or if what he is doing is actually fostering the patient’s interests rather than his own (Ogden, 1994; Slavin, Rahmani & Pollock, 1998). In spite of subscribing to the reassuring idea that it is acceptable (even desirable) not to be an omnipotent authority (that is, in the “old” objectivist-positivistic sense), all of this may contribute towards making the therapist’s relationship to his position of power an obscure and uneasy one.

\[74\] This is beyond the scope of this study.
At the moment when the patient feels negated, the therapist’s sense of himself as a therapist may feel threatened or become destroyed (in Winnicott’s sense); that is, be negated by the nature of the patient’s experience of him. In his (usually unconscious) efforts to defensively preserve his position of power, the therapist may not recognise the patient’s perceptions as valid by, for example, making a transference interpretation only in terms of the patient’s past relational history. The therapist may therefore not “change” (Benjamin, 2001, p. 24) in a way that could convey to the patient that he has actually had an impact on the therapist, thus providing him (the patient) with the recognition he seeks. The therapist may (even if only subtly) attack the patient or withdraw. In this instance, “mere negation” could become a “breakdown of recognition” (Benjamin, 1998b, p. 96).

Ferenczi (1949, p. 226) describes how the power disparity in a therapeutic situation may cause patients to identify with therapists in a way that effectively silences them (the patients):

> patients have an exceedingly refined sensitivity for the wishes, tendencies, whims, sympathies and antipathies of their analyst, even if the analyst is completely unaware of this sensitivity. Instead of contradicting the analyst or accusing him of errors and blindness, the patients identify themselves with him; ... normally they do not allow themselves to criticize [him], such a criticism does not even become conscious in them … .

What would make it possible for the patient to feel sufficiently empowered to be a “speaking subject” (Benjamin, 1998b, p. 9) and in so doing risk the therapist’s displeasure, anger or withdrawal? Ferenczi (1949, p. 227) comments:

> The setting free of [the patient’s] critical feelings, the willingness on our part to admit our mistakes and the honest endeavour to avoid them in future, all these go to create in the patient a confidence in the analyst.

It is clear that whether or not the patient will feel sufficiently trusting of the therapist and the process to be able to think about and speak of his “critical feelings”, is very much dependent on the specific nature of the intersubjective space (both in terms of its evolving history and what it is like at that particular moment).

Kelly (1996, p. 53) writes of therapy as a process involving both understandings and misunderstandings, where interpretation may be “dialogically engaged in” as “a distinctly exploratory activity” and hence become “playful” in Winnicott’s (1971) sense only if the safety of the therapeutic space is such that “being misunderstood is not attended by the threat of repudiation”. This is what makes it possible for the patient to become able to accept the inevitability of sometimes being failed by the therapist’s responses and interpretations (Kelly, Ibid.). A good-enough therapy is therefore understood as including these “optimal frustrations”
(Kohut, 1971, 1977, 1984) engendered by therapist failures where moments of miscommunication, disconnection, misrecognition and negation between therapist and patient do not actually lead to the breakdown of thirdness and the dialectic of recognition and negation.

In terms of Benjamin’s thinking (1998b, p. 22), this means that while the therapist cannot (and should not) “steer clear” of the “inevitable complementarity that ensues when an attacking object is on the screen”, he should also not become entrenched either as attacker or as victim. By the therapist’s being able to identify with and disidentify from both these positions, thus straddling “both sides of the divide”, the dyad becomes capable of moving from complementary twoness towards mutual recognition and bearable paradox (Ibid., p. 19).

The therapist needs to be open to the patient’s criticisms and respond to them in a manner that is both authentic and subjective “in a knowing way”, thus giving validity to the integrity of the patient’s perceptions (Benjamin, 1998b, p. 23). Therefore the way out of such difficult moments engendered by the therapist’s “mistakes” does not come about through the therapist’s sliding into submission to the patient’s demands by just being guilt-stricken and taking on the blame for what has gone wrong. Burdening the patient with “self-serving confession[s] or defensive apologies” is consequently excluded (Chused & Raphling, 1992, p. 111). Neither does the way out happen simply through the therapist’s “steadfast interpretation” (Benjamin, 2001, p. 19). Such a use of interpretation may mean that the therapist is “struggling to gain recognition from the patient to confirm his (the therapist’s) reality” or even that he is “insisting on his reality over that of the patient” (Ibid.).

In the findings of his study on the nature of the process of interpretation in psychodynamic psychotherapy, Kelly (1994) makes the point that interpretation is a mutual act. Taking into account that the patient’s viewpoint has equal value to that of the therapist in arriving at a shared understanding of what has happened, various theorists (for example, Bolas, 1989, 1992; Renik, 1995; Aron, 1996; Benjamin, 1998b; 2000a) discuss the patient’s possible collaboration in the meaning-making process. Aron, Bollas and Renik all describe how they invite patients to do this by sharing their own internal processes of thinking and associating (which includes their differing from themselves, their ambivalences and conflicts) with their patients and by asking their patients

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75 Renik (1995, p. 486) calls this “epistemological symmetry”. By this he means that therapist and patient are “equally subjective” and equally responsible for what they disclose of their thinking. He does, however, clearly differentiate this from Ferenczi’s mutual analysis and accordingly also retains the idea of asymmetry. The patient communicates his reality with the purpose of increasing his self-awareness, while the purpose of the therapist’s self-disclosures is also to increase the patient’s self-awareness.

76 With his (Bolas, 1989, 1995) dialectics of difference.
for their reactions to and deconstructions of this. Aron (1996) also engages patients in this process of generating co-created meanings by asking patients for their experiences and observations of him that may elucidate aspects of the therapeutic relationship. Of course all of this should not mean that the therapist’s thinking or subjectivity (instead of anonymity) is imposed on the patient nor that this should be a defensive collusion between therapist and patient to avoid exploring the patient’s inner experiences. It also requires that the patient perceives the therapist as being open to (and not threatened by) this kind of feedback.

There are also other ways to understand these kinds of therapeutic interactions. One could see such a therapist act as providing the patient with a model of how to engage with, question and reflect on one’s own internal processes (which is certainly one of the most important goals of any psychodynamic therapy). On a more symbolic level it could be thought of as a meta-communication from the therapist to the patient about his (the therapist’s) being an independent and separate subject.

According to Frankel (1993, p. 242) the “analyst’s temporary and limited loss of bearing is the gift that may allow the patient to give up the need for a perfect parent and to regain genuine contact with the other … the patient, learning that the analyst also has faults and frailties, may feel less different from other people and may gain greater hope that the analyst can understand him or her in a personal way”. The patient’s experience of a moment of negation may thus be received and held by the therapist and in that way “be revalued as a more equal term within the context of recognition itself as the superordinate value that allows negation to have impact” (Benjamin, 1998b, p. 96). In this manner the therapist’s mistake(s) could actually become part of the ongoing dialectic of recognition and negation and contribute towards therapist and patient also becoming like subjects in terms of the power differential.

### 3.7 THE BRIDGE OF IDENTIFICATION

Identification, that “detour through the other that defines the self” (Fuss, 1995, p. 2), originally revealed by “Freud’s insight that the ‘shadow of the object fell upon the ego’” (Benjamin, 1998b, p. xii), is a pivotal concept both in Benjamin’s work and in this study. As Pugh (2002, p. 1383) points out, this shadow is “no mere echo of the object … it has the capacity to criticise, to feel, to effect

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77 While what Bollas (1989, 1995) and Renik (1995) describe seems very similar, their theoretical perspectives are different. Bollas conceptualises the therapist’s subjectivity as a means of understanding the patient (that is, the therapist is a container for what is received from the patient and the therapist has to look for the patient within himself). Renik (1995), who sees the therapist as irreducibly subjective, criticises Bollas for under theorising his own impact on the analytic process.
and alter behaviour”. As well as identification denoting an ordinary and everyday process, its actual conceptualisation is far from simple. In this study it was employed to describe and think about complex phenomena.

In this section there are brief examinations of identification and the therapist-patient, and of identification in general psychoanalytic thinking, followed by comments about some of the implications of postmodernism for the use of this concept. The main focus of this discussion will be on Benjamin’s intersubjective reconfiguration of identification. This includes a consideration of how the changing nature of identification may be linked to the specific quality of the intersubjective space (that is, mutual recognition) between therapist and patient, especially as this pertains to the therapist-patient.

3.7.2 Identification and the therapist-patient

One of the givens in psychodynamic therapy is that patients do identify with their therapists in one way or another. Meissner (1981, p. 12) comments on how patients sometimes “adopt the mannerisms, personal habits of dress and behavior, and even the verbal expressions” of their therapists. “Patients begin to act like the analyst, or act as they believe the analyst would act or think in certain real life situations. They may even consciously ask themselves what the therapist might do or think or say in a given situation” (Ibid.).

Identification is particularly significant in the case of therapist-patients. It has indeed been found that “[m]any therapists report that identifications with their therapists constitute the single greatest influence on their professional development” (Norcross, Geller & Kurzawa, 2000, p. 204). As therapists we know (even if just intuitively) about the “lasting internal presence of and identifications with” one’s own therapist (Mitchell, 1997, p. 27). This does not just derive from what the therapist actually says or does (or, rather, from what the therapist-patient perceives him to be saying or doing), but from his “subjective way of being, a sense of what [he] is like, [his] feel for life” (Ibid.).

Therapist-patients’ identifications with treating therapists have an added dimension (which is generally not present in “lay” patients). While the therapist-patient’s therapist may, in a sense, lose

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78 In the qualitative studies about how personal therapy affects therapists’ work as clinicians, there is some discussion of the findings pertaining to participants’ identifications with their therapists and the different aspects of the manner in which this plays a role in the impact of personal therapy on clinical work (Mackey & Mackey, 1993; Macran, Smith & Stiles, 1999; Wiseman & Shefler, 2001). Only the study by Mackey and Mackey (1993) has this as a separate domain in their findings and as a specific focus in the discussion of their findings.

79 There are certainly more “added dimensions”, but this one is a specific focus in this study.
Identificatory processes often become interwoven with the particular discourse of power that is constellated in the therapist-patient’s therapy. What identifications purport are consequently very much dependent on the nature of the relationship between therapist and therapist-patient at that particular point in time and within the broader context of the therapeutic process. They may indicate that the therapist-patient is, in his own unique way, experientially learning to do therapy and how to be a therapist (that is, developing as a therapist) within the context of a mutually trusting and respectful relationship with somebody he has (often both consciously and unconsciously) chosen as a model with whom to identify. However, such identifications could also signal the therapist-patient’s submission to the powerful and idealised other by “importing” his (the treating therapist’s) superior version of being-a-therapist.

Meissner (1981, p. 12) posits that when identifications are “motivated by the need to please, placate, or attach oneself to an idealized or feared object, they must be recognized as defensive. They may also serve a narcissistic goal of becoming like the powerful object.” Gabbard (1995, p. 715) warns that the therapist-patient’s identifications may, especially when part of an ongoing and pervasive idealisation of the treating therapist, be part of the enactment of “the preconscious or unconscious fantasy” that “some of the lustre of this highly respected [therapist] will rub off” on the therapist-patient. If identification with the therapist, which Gabbard (Ibid.) sees as “a tempting shortcut” to avoid the arduous and painful work of therapy, becomes the goal of the therapist-patient’s therapy, this could entail the intersubjective therapeutic third of his therapy becoming compromised and no longer serving as a useful Third to the dyadic processes and entanglements in the clinical thirds of his work with patients.

One of the central questions posed by this study concerned the ways in which the participants’ therapists (as well as their manner of working) had become part of the way they (the participants) worked as therapists and of their sense of themselves as therapists. This may be conceptualised as the participants’ identifying with their therapists and their therapists’ ways of working and of these identifications becoming part of the participants’ identities as therapists. However, as Fuss (1995, p. 2) reminds us, while identification organises identity and “brings a sense of identity into being”, it also “calls that identity into question”. Identity therefore never approximates “the status of an
ontological given” (Ibid.). The therapist’s sense of identity as a therapist should therefore also not be seen as fixed or final, but as continually changing and evolving.

### 3.7.3 The general notion of identification and some related concepts

Identification may be understood as referring to “those processes whereby individuals increase their felt resemblance to other persons” (Geller & Farber, 1993, p. 167). In general psychoanalytic thinking, the notion of identification has contributed significantly to the understanding of the constitution of subjectivity and has been variously theorised (Freud, 1900, 1924, 1932; Schafer, 1968; Meissner, 1981; Sandler, 1988; Perlow, 1995). The main thrust of this is that identification is seen “both as a normal developmental mechanism [in ego and superego formation] and a mechanism of defense” (Sandler & Perlow, 1988, p. 9). Within general psychoanalytic theorising there are numerous debates surrounding the conceptualisation of identification, but these are beyond the scope of this study.

Identification is envisaged as an aspect of internalisation, an overarching process that also encompasses incorporation and introjection (Schafer, 1968; Meissner, 1981; Sandler & Perlow, 1988; Moore & Fine, 1990). “Internalization … is any process of transformation by which external relationships, object representations, and forms of regulation become part of the inner psychic structure and thus part of the ‘inner world’” (Meissner, 1981, p. 10). It can therefore also be described as a “process whereby intersubjective relations are transformed into intrasubjective ones” (Laplanche & Pontalis, 1980, p. 226). While the different processes of internalisation overlap, identification is usually seen as the most evolved (mature) form of internalisation (Moore & Fine, 1990).

Although it may derive from identification, imitation should not be confused with identification. Unlike identification, imitation is usually a conscious process and while it implies behaving like the other, it does not in itself necessarily involve a deep or significant attachment between self and other (Meissner, 1981). Meissner (Ibid., p. 11) further conceptualises imitation as “a form of learning”, where “one person can learn from another by a process of behavioral modelling”.

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80 Incorporation carries the connotation of being the most “primitive” and a relatively undifferentiated form of internalisation, where the object is taken in as a whole and where there is usually no separateness between subject and object (Meissner, 1981; Sandler, 1988).

81 Schafer (1968, pp. 72-73) sees an introject as an “inner presence with which one feels in a continuous or intermittent dynamic relationship”.

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Mimesis\textsuperscript{82} is related to imitation, but while it also pertains to behaving like the other, it is not imitation (Borsch-Jacobson, 1992; Harris, 1998). Harris (1998, p. 46) calls mimesis “the lived practice of identity … a form of identification that involves gesture, the style of being, and external patterns of acting … [which] can lead to mutually induced affective experiences”. The concept of mimetic identifications (Harris & Gold, 2001, p. 367) highlights that the co-created intersubjective space does not only concern a meeting of minds (Aron, 1996), but that it is also forged and vitalised at an embodied and affective level (Harris, 1998). The patient may, by adopting the therapist’s words or gestures, evoke a “mimetic resonance” (Benjamin, 1998b, p. 97) with the therapist’s presence and the shared “loving tie” (Benjamin, 1995, p. 7). As Harris and Gold (2001, p. 367) point out, the patient’s mimetic identifications “with the voice, and the persona” of the therapist are also “all aspects of the unspeakable, unremembered, constituting power of the other”.

3.7.4 Identification in a postmodern context

In postmodern thinking the notion of identity (and subjectivity) does not refer to a unitary endpoint of development, but is rather regarded as a “constantly rewoven web of processes” (Flax, 1996, p. 578). Corbett (2001, p. 325) points out that according to the postmodern viewpoint, “multiple identifications within the same subject can rival one another, overthrow one another, or even revive, following their apparent demise” (Ibid., p. 325). Therefore identity is both “founded on” and “confounded by” multiplicity (Ibid., p. 327), which Schafer (1968, p. 62) describes as an “implicit multiplication of minds within mind”.

Previous theories of identification do not encompass the full complexity of this and Fuss (1995, p. 39) comments that postmodern theorists tend to regard these theories “only as painful and poignant meditations on the possibility of identification’s own impossibility”. However, what is not taken into account sufficiently in this way of thinking, is that supporting the notion of multiple identifications does not justify peremptorily rejecting the intuitively felt and well-established ideas of there being a “force of identity persistence”, accompanied by an ongoing sense of “self-sameness” (Corbett, 2001, pp. 326). In this regard Benjamin (1998b, p. 93) reminds us that while the “intersubjective idea of negation” does lead to the notion of a “nonunified, constructed subject”, it does not “leave the subject merely decentered and dispersed”. Self (and identity is not self) can be “nonidentical”, but it is possible to postulate a “psychic subjectivity that takes up various positions through identification” (Benjamin, 1998b, p. 87).

\textsuperscript{82} This concept originates from the theory of drama, where, by assuming the characteristics and actions of the individuals that they are playing, actors become able to “live” the role (Harris, 1998).
Corbett (2001, p. 327) suggests that we circumvent the apparent “dead end” reached by the postmodern deconstruction of the subject and identity by thinking about this issue in a different way that takes into account both a “multiplicity of self experience” (Benjamin, 1998b, p. 105) and an ongoing subjective sense of self that is at least somewhat coherent. He (Corbett, 2001, p. 327) therefore proposes conceptualising identificatory processes and identity in terms of complex and open nonlinear systems “wherein identifications stimulate intricate feedback loops forming patterns of exchange and transfer”. Structure and regulation emerge “through the flow, feedback, and repetition of such patterns” (Ibid.).

This clearly requires a relational and, more specifically, an intersubjective refiguring of identification. In terms of this study it generated the questions of how the processes whereby the participant had identified with his therapist could be conceptualised within the (always shifting and evolving) particular therapeutic third of the participant-as-patient and his therapist and also how this could be linked to the clinical third(s) of the participant-as-therapist and his patient(s).

3.7.5 Identification and mutual recognition

3.7.5.1 A brief outline of Benjamin's view of identification and some other relevant relational and intersubjective theorising about this concept

Benjamin and other present-day relational and intersubjective theorists (Frankel, 1993, 1998b, 2002; Seligman, 1999; Stern, 2002) assume tacit knowledge of the notion of identification and make implicit use of its basic tenets in their thinking. Stern therefore (2002, p. 700) comments that identification has become “one of the most relied on but undertheorized concepts in current psychoanalytic discourse”.

Benjamin’s thinking about the ongoing processes of reciprocal identifications between therapists and patients, which are sometimes conscious but mostly unconscious, goes beyond the “intrapsychic projective-introjective register” in elucidating both the intrapsychic and intersubjective dimensions of identification (Gerhardt, Sweetnam & Borton, 2000, p. 26). For her (Benjamin, 1998b), embracing intersubjectivity does not mean that the intrapsychic is somehow transcended, but rather that it is changed and added to. Benjamin also does not just emphasise the importance of recognising the other as different, but also “elaborates the inverse trope – the need for identification and the experience of ‘being like’ the other, particularly when the other represents the ego ideal” (Gerhardt, Sweetnam & Borton, Ibid.), which is particularly relevant in the case of therapist-patients.
One of the central issues in Benjamin’s intersubjective version of identification concerns how recognition or negation from a significant other may influence the ways in which one identifies with him. The nature of these identifications is pivotal in facilitating or compromising one’s own ability to recognise this other, thus contributing to growing mutual recognition (and evolving thirdness) or impeding its development.

For her (Benjamin 1998b, p. xiii) it is consequently important to understand “the capacity for identification with others” as both furthering and impeding the recognition of others; as both bridging and obfuscating differences. Benjamin (Ibid.) therefore, as she is wont to do, attempts to work with the tension between these “two distinct tendencies” in psychoanalytic thinking about identification. On the one hand there are those theorists who “see the tendency to incorporate the other as a mental object primarily in its defensive … or imaginary aspects” (Ibid.). However, “proponents of Kleinian analysis, American ego psychology, or self-psychology stress … the structure-building or functional aspects of identification or introjection” (Ibid.). In this context Benjamin (Ibid.) then endeavours “to elaborate the distinction between kinds of identification: those that can help us break up an apparent objectivity based on distance, and those that simply draw us into a see-saw relationship … in which we can no longer perceive the other” (Ibid.).

In her thinking about the configuration of intersubjectively constellated identifications, Benjamin explores the role of the discourse of power underpinning the therapeutic relationship. She focuses particularly on what it means to identify with an idealised and more powerful other (that is, to identify with an other in a relationship where there is a significant disparity of power). In psychotherapy it is usually the patient who is cast into the role of the less empowered one, but the roles may also, at times, become reversed.

She (Benjamin) accordingly (and as far this is possible) comes to grips with some of the complex and multifaceted aspects of identificatory processes in therapy, such as the varying nature of the ways in which patient and therapist identify with each other; how such identifications may change against the backdrop of “increasing” thirdness and mutual recognition, and also how such identifications may be implicated in impasses in the therapeutic relationship.

Extending the notion of identification beyond the idea of becoming or behaving like the other, Seligman (1999, p. 141) posits that “identification … is with a dyadic relationship system rather than with a single role or … as an orientation of one’s subjectivity within a self-with-other.
relationship dyad characterized by oscillation between one position and another”. While identification therefore does not mean that one “necessarily takes on the attributes of another person”, it could indicate that “one’s experience is derived from, shaped, defined, and limited by, the parameters of a particular relational configuration” (Frankel, 2002, p. 106). As such, identification could thus be understood as an “appropriation of the total intersubjective experience” (Stern, 2002, p. 702).

One may juxtapose Seligman’s (1999, p. 141) ideas of identification being with the “relational process” (rather than with an “object representation” of the other), and that this identification entails movement between two unequal positions, and Benjamin’s related theorising around the split polarities of complementary twoness, where the positions of domination and submission are continually inverted through identification. In these kinds of relationships “the parameters of [the less powerful] one’s experiential world have not been negotiated” between the two relationship partners, but have been “imported from the mind” of the one who is in the position of power (Frankel, 2002, p. 106).

Some relational theorists (Frankel, 1993, 2002; Seligman, 1999; Stern, 2002) have also used relational/intersubjective reconfigurations of the concept of identification to explore the nature of identifications occurring in a relationship where there is a significant and enduring disparity of power (that is, an absence of mutual recognition). According to Frankel (1998b, p. 168), sadomasochistic “solutions are the alternative to intersubjective relationships” and both he (Frankel, 2002) and Stern (2002) therefore see such a power disparity in terms of a victim and an aggressor, that is, elaborate an intersubjective articulation of the idea of identification with the aggressor. Frankel (2002, p. 105) posits that the “victim” concordantly identifies with the aggressor’s experience of himself” (and thus “learns who he expects her to be”) and that her complementary identification subsequently guides her submissive compliance to him. This means that there are no subject-to-subject relations, but that the “victim” has taken up the role of the “attacker’s … inner object, his ‘other’” (Ibid.).

Such concordant and complementary identifications are involved in the constellation of unconscious collusions between therapist and patient, which unavoidably form part of therapeutic

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84 The original conceptualisation of this most well-known utilisation of identification as a defence is commonly attributed to Anna Freud (1936), but it was actually first discussed by (the much-maligned) Ferenczi (who has only during the last decade rightfully been reinstated as a psychoanalytic theorist of note) in a paper he presented at the Wiesbaden Congress of 1932. Although his paper was published in 1933, it was only published in English in 1949. This aspect of identification has been used and elaborated on extensively in work about trauma and abuse (Frankel, 2002).
relationships (Frankel, 1993). A collusion “involves an unconscious deal – a mutual denial, by patient and analyst, of some aspect of their relationship that frightens them both” (Ibid., p.228). Collusion may be contrasted with intimacy, which “implies the desire to know, and the capacity to accept, all that one may find in oneself and the other … therefore also … the acceptance of the other … [as] a separate person not in one’s grandiose orbit” (Ibid., p. 229); that is, relating to the other as a subject.

3.7.4.2 The therapist-patient’s identifications with the therapist: from “importing” the other to symbolic identification

The patient (who is also a therapist) usually specifically seeks out his therapist as “the magical mirror that reflects the self as it wants to be – the ideal in which [he] wants to recognize himself” (Benjamin, 1995, p. 100). Nevertheless, the outcome of the therapist-patient’s personal therapy should not just be the internalisation of and identification with his therapist as a supposedly superior model of being-a-therapist, but should also entail the discovery “of his … own unique desire”, that is, his subjectivity (Crastnopol, 1999a, p. 460). As Klauber (1981, p. 175) comments, it is very hard “to combine discipleship with originality”. How may the therapist-patient’s identification(s) with his therapist therefore both enrich and expand his being-a-therapist and not subvert and dominate his own manner of working as a clinician? How may the development of a “false analytic self” (Berman, 2000) be avoided?

The therapist-patient’s longed- and strived-for ideal therapist, who is represented by his therapist, cannot just be incorporated: identification also means “loving and having a relationship with the person who embodies the ideal” (Benjamin, 1998b, p. 61). One may therefore ask the further question of how this identificatory love that the therapist-patient has for his therapist may become a bridge towards “a sense of mutuality and subjectivity” (Gerhardt, Sweetnam & Borton, 2000, p. 27), rather than being perverted into “ideal love, the submission to a powerful other who seemingly embodies the agency and desire one lacks in oneself” (Benjamin, 1988, p. 100).

Identification is never a “one-way-street” (Benjamin, 1995, p. 153). To become a self-governing subject (that is, to be “freed from the axis of submission and defiance”) (Ibid., p. 155), the therapist-patient cannot just simply identify with his “self-mastering” therapist (Ibid., p. 153). He also needs the therapist’s “loving recognition” (Ibid., p. 155 ), in which is subsumed the therapist’s “reciprocal identification” with him (Gerhardt, Sweetnam & Borton, 2000, p. 26). This pertains to the idea that for “identification with the ideal to promote development of the self as subject, the
idealized other must find some way to acknowledge and reciprocate the self’s need for an identificatory other …” (Ibid.).

For Benjamin, identification and recognition have an intricate (and sometimes paradoxical) relationship. While both identification and recognition are dimensions of relatedness, identification implies self and other being like, and recognition implies self and other being separate, independent and different (Aron, 2000). For being able to represent oneself as a “subject who desires”, one needs both the “symbolic identification” with and the recognition from the powerful other with whom there is an affectively resonant emotional connection (Benjamin, 1995, p. 122). It is in this sense that the mutuality of therapist and patient both becoming and being each other’s love objects (that is, the “loving tie” between them constellating both of them as subjects who desire), could also hold the possibility of them becoming like subjects (Ibid., p. 7). At the point of therapist and therapist-patient being like subjects, one could also expect that the therapist would no longer be the ideal, but that the therapist-patient would see and experience him (the therapist) as being the representative of that ideal, that is, that that “the ideal and its representative” may be differentiated (Benjamin, 1998b, p. 71). This further means that the therapist-patient’s identifications with his therapist, rather than being literal and concrete, would happen at a symbolic level.

The nature of the connectedness between therapist and patient both contextualises and shapes the patient’s identifications with the therapist (and the therapist’s identifications with the patient) and is given form by them. The loving tie (between therapist and patient) may engender a shift from the therapist being the (intrapsychically cast) idealised object to a position of greater mutuality (that is, where therapist and patient are like subjects), where identification at a symbolic level is part of the co-created intersubjective space. On the other hand, when the therapeutic relationship becomes compromised, idealisation may become entrenched and degenerate into submission (and sometimes masochism), where the patient’s literal and concrete identifications with the therapist are both part of and signal his being “lesser” and may also be seen as invoking a mimetic resonance with the presence of and submission to the more powerful therapist.

3.7.4.3 The therapist’s sustained identification and empathy with the patient
The idea of identification as being a two-way street encompasses the patient’s identifying with the therapist and the therapist’s reciprocal identifications with the patient (Benjamin, 1995, 2001). The latter are part of the therapist’s empathically knowing (rather than just intellectually understanding)
Empathy is an inherent part of the therapist’s identifications with the patient. Since the act of identification is facilitated by empathic knowing, and that of empathic knowing by identificatory processes, one could understand empathy and identification as being mutually constitutive. As such, what could be called *empathic identification* and *identificatory empathy* could be useful terms to elucidate the way these concepts relate to each other.

Empathy has been considered a substrate of psychoanalytic discourse since its inception (Pigman, 1995). Nonetheless, traditional psychoanalysts have tended to discount the complexity of the role of empathy in therapy and assumed it to be “an easy precondition for interpretive work” (Hamburg, 1991, p. 351). Writing from a self psychological perspective, Kohut (1959) introduced “the empathic-introspective mode of inquiry” into psychoanalysis. Since then self psychological thinking has done a great deal to highlight and foreground the importance and usefulness of this concept (Pigman, 1995; Bolognini, 1997).

However, although Kohut (1971, 1977, 1984) carefully emphasised that, rather than being “an autonomous curative agent”, empathy is the *context* for therapeutic action and work, being the patient’s empathic selfobject has become “the holy Grail in the analytic quest” for some self psychological theorists and practitioners (Hamburg, 1991, p. 357). More generally, this has led to empathy sometimes being idealised as “a kind of all-purpose philosopher’s stone, potentially capable of resolving any clinical difficulty … ” (Bolognini, 1997, p. 279). For example, therapists may “overuse” empathy; that is, only respond in ways that are concordant with patients’ experiences as a way to deal with their own anxieties and fears of harming patients by introducing difference (Hart, 1999). While the vicissitudes of the various ways in which this concept is employed and the theoretical controversies surrounding it are mostly beyond the scope of this study, some of the aspects of its use within psychoanalytic thinking will be briefly considered before proceeding further.

Kohut (1984, p. 82) defines empathy as the “the capacity to think and feel oneself into the inner life of another person”. Within self psychology, and also more commonly, there has been a tendency to use the notion of empathy both for denoting the therapist’s responding to the patient with “care and

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85 Shared thirdness and mutual recognition could be understood as implying that both identification and empathy could be reciprocal.
concern” and as way to describe a method whereby the therapist gathers knowledge about the patient’s subjective experience (Buirski & Haglund, 2001, p. 22).

The conflation of these two uses of this concept, which also appears in Kohut’s later work, has led to conceptual confusion (Stolorow, 1984b). Stolorow (1984b, p. 44) therefore suggests that the term empathy be limited to indicate the therapist’s “investigatory stance” and that the therapist’s empathic responsiveness, which refers to the “emotional bond” between therapist and patient, be described by using the term “affective responsiveness”, also referred to as “affect attunement” (Buirski & Haglund, 2001, p. 22). For the purposes of this study, the notion of empathy will therefore be used to refer to the experiential knowing of an other’s inner state (Berger, 1987), rather than being linked to specific emotional attitudes, such as warmth, compassion or acceptance, underpinning the therapist’s responsiveness to the patient. That does not mean, however, that the necessity and significance of such desirable therapist attitudes are underestimated or dismissed.

Ghent (1994, p. 474), who writes from a relational perspective, defines empathy as “the higher-level integration of perceptual, affective and cognitive processes that are rooted in an effort to understand the quality and meaning of another’s emotional and motivational state”. Empathy requires the therapist’s being able to immerse himself in a temporary identification, that is, a trial identification (Fliess, 1942; Casement, 1985, 1990, 2002) with an aspect of the patient’s subjective experience without “‘drowning’ in the countertransference” (Racker, 1968, p. 132). This means holding on to his own subjectivity in such a way that, while he (the therapist) is able to feel his own feelings and think his own thoughts, he does not become so overwhelmed or self-absorbed that he loses sight of the patient. According to Ivey (1995, p. 355), such an ability to “imaginatively locate oneself in the psychological space of another requires a stable and separate sense of self that can be temporarily surrendered in the service of entering the other’s experiential world”.

While self psychological theorising has made valuable contributions to the understanding of empathy, its focus on “sustained empathic inquiry … [as being] … central in establishing, maintaining, and continually strengthening the selfobject dimension of the transference bond” with the therapist (Stolorow, 1994a, p. 148) is problematic. As has been discussed before, the notion of the therapist’s being the patient’s selfobject tends to privilege sameness and not to take difference into account. This could lead to a partial understanding of empathy and, as Sands (1997) points out, to the therapist’s emphasising “concordant identifications” and neglecting “complementary

86 See also p. 79n51.
87 See pp. 84-85.
identifications” (Racker, 1968, p. 135), that is, the therapist’s identifications with disowned or unthought aspects of the patient’s experience. In terms of Benjamin’s theoretical ideas, using empathy in this way would therefore exclude it from being part of an intersubjective perspective and understanding.

It should therefore be kept in mind that the therapist’s identifications with the patient should not collapse difference by just rendering him (the therapist) a participant in the patient’s inner world. The therapist’s task does not only concern engaging in trying to locate the patient’s perspective. Slavin and Kriegman (1998b, p. 276) point out that a consistent attempt from the therapist “to communicate to the patient exclusively from a vantage point within the patient’s subjective world”, may be (and/or be experienced as such by the patient) an effort by the therapist to remain defensively hidden from the patient. The therapist should therefore also introduce alterity in the form of his different viewpoint (Gabbard, 1997; Benjamin, 2000a). Of course a measure of otherness already inevitably exists in that the therapist’s empathy and identifications with the patient always happen from his (the therapist’s) own subjectivity.

In focusing more specifically on what the therapist identifies with in the effort to understand the patient, it is clear that in being empathic, the therapist does not just understand a patient in a way that is concordant with his (the patient’s) current self-experience, but also engages in complementary identifications”.88 The therapist’s being “on both sides of the divide” (Benjamin, 1998b, p. 19) and retaining contact with both halves of “split complementarities”(Ibid., p. 20), could move the therapy and the therapeutic pair beyond the absolute and literal concreteness of oscillating between these two divided positions into the more transitional and symbolic realm of shared thirdness, which is “beyond identity” (Ibid, p. 74). Rather than engaging in the kinds of identifications that appear in “split complementarities”, the therapist should therefore identify with the patient in ways “that retain[s] contact with the patient’s multiple and conflicting positions” (Ibid., p. 20).

The therapist’s receptive openness to different and even contradictory possibilities involves his running the risk of getting caught up in the criss-cross muddle of reciprocal identifications between himself and the patient. At times this could hold the strain of his being treated (in object-relations language) like the patient’s (internal) object rather than a subject. This could lead to his (the therapist’s) sense of himself as a therapist (as defined by that particular relationship or more

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88 Empathy does therefore not mean that the therapist has a “dogmatic, hyperconcordant” attitude towards the patient (Bolognini, 1997, p. 279).
generally) being threatened, compromised or even destroyed, that is, what Loewald (1979, p. 758) calls “emancipatory murder” taking place.

On the one hand the therapist’s empathic identifications with the patient may contribute towards bridging difference and redressing the power imbalance of one person’s being the therapist and the other the patient. Benjamin (2000a, p. 46) sees this power disparity as “the complementarity in which one person has the phallus and the other must be castrated, one subject and the other object”. The therapist’s power is also situated in his being able to bestow or withhold recognition of the patient’s “true self” (Benjamin, 1995, p. 147). For the purposes of this study, this could be extended to the therapist’s recognition of the participant-patient’s being-a-therapist.

Conversely, the therapist’s identification with the patient may touch some problematic aspect of himself, which may render compassion into what the author Milan Kundera (1984, p. 31) calls “… that sickness … the pain one feels with someone, for someone, a pain intensified by the imagination and prolonged by a hundred echoes”. This signifies that for the therapist, at such a moment of being subsumed by his own needs and desires, the patient’s subjectivity disappears from view (is thus negated) and the patient becomes no more than the therapist’s internal or fantasy object. In more conventional psychoanalytic language it could thus be said that the therapist is having a countertransference issue.

Benjamin (1995, p. 160n6) posits that it is precisely the acknowledgment of this “countertransference identification with the patient [that] distinguishes the intersubjective position from the opposing view that the analyst controls himself and holds fast to the mast of reality in order to carry the patient through the treacherous waters of the transference”. In this way the “inevitable return of the repressed” (in the form of the therapist’s identification[s] with the patient) is no longer just a “dangerous breakdown of analytic posture”, but also becomes “a necessary, potentially creative part of the endeavour” (Benjamin, 1998b, p. xvi). This is compatible with the present idea in more general psychoanalytic thinking that countertransference is ubiquitous and could be both an impediment to and usefully inform the therapeutic process (Jacobs, 1999).

Identification and moving towards mutual recognition

Benjamin (1998b, p. 20) highlights that the identifications (and, by implication, the disidentifications) that “become useful sources of knowledge” for therapist and patient are those that are “mediated by representation” rather than those involving “an unmediated assimilation of other and self”. This resonates with Frankel’s (2002, p. 106) idea that being in a disempowered
position in a relationship could result in an unnegotiated importation of “the parameters … of one’s experiential world … from the mind of the threatening other person”. Identifications developed around “unsymbolized or traumatic experience” (rather than all identifications involving unconscious thought) are therefore “nonsymbolic, immediate and also subject to the logic of primitive reversibility” (Benjamin, 1998b, p. 20n2). For Benjamin (Ibid., p. 20), “a point of freedom” is therefore not created by the “act of identification”, which, even for the therapist, is inevitable and “unthought”, but rather through “the act of representing the identification”, that is, being able to think symbolically about it.

This means that instead of remaining coercively embedded in an identification with the patient, the therapist, by becoming aware, by containing this awareness, by thinking and reflecting about it, is able to extricate himself from the power struggle of the symmetry of twoness into the paradoxical position of both identifying with and disidentifying from the patient. This process of stepping back should not be primarily based “on internalized thirds, superego contents, such as analytic dictums” but rather on the therapist’s subjective experience, that is, “the truth of his own feelings” (Benjamin, 2001, p. 26).

The therapist is consequently both able to surrender to and identify with the patient’s experience and feelings towards and about him (the therapist) and the therapy, and to disidentify from them, that is, to be both an internal object to the patient and to hold on to his or her (the therapist’s) own subjectivity. This concurs with Frankel’s (1998b, p. 165) warning that unless therapists’ identifications (and one could add, disidentifications) with their patients remain “playful” (in Winnicott’s [1971] sense), they could “constitute impingements” rather than recognition.

In this way the therapist both becomes the patient’s internal object by identifying with the patient and survives this negation (without abandoning the patient or retaliating) by disidentifying from the patient. The therapist thus recognises the patient, but does not forsake his own position and in so doing becomes and is “the one who entertains the double identification” (Benjamin, 1998b, p. 107). This also speaks of the therapist’s “ability to stand in the spaces between realities without losing any of them” (Bromberg, 1998, p. 186).

The therapist’s subjective experience of and thinking about such a process may be explicitly and directly shared with the patient as, for example, Bollas (1989, 1992) does when he practises what

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89 Pugh (2002) makes a similar point from the perspective of memory theory (which exists at the interface of psychoanalysis and cognitive neuroscience). He (Pugh, 2002, p. 1384) sees identification as a type of memory, that is, as part of “implicit or procedural memory”. He accordingly proposes that one way to understand insight in psychoanalysis is that the process of therapy leads to identifications becoming available for thought and reflection.
he terms *dialectics of difference*. This may also implicitly and unconsciously be communicated to the patient (that is, communicated at a meta-level) through the patient’s actual experience of what the therapist does. Benjamin (1998b, p. 107) understands the patient’s reciprocal identifications with the therapist (which take place in the context of being recognised by the therapist) as also being with this capacity of the therapist “to disidentify with any one version of the story and to suspend identity”.

### 3.7.4.5 Being love objects and like subjects in the space of mutual recognition

According to Pizer (1998, p. 169), Benjamin’s (1995) idea of mutual recognition, which involves the “paradoxical juxtaposition” of “like subjects” and “love objects”, concerns a “sustained identification with the other even when the subjective interests (needs, desires, affects) of the other stand in conflict with the subjective interests of the self”. He (Pizer, Ibid.) considers this “sustained identification” as involving a continual process of negotiation where one both identifies and disidentifies with the other. This concurs with Benjamin’s notion of what one could call “microprocesses” of multiple double positions constituted by the reciprocal identifications and disidentifications which take place between therapist and patient as part of mutual recognition. All of this adds up to Benjamin’s (1995, p. 75) idea of “replacing the discourse of identity with the notion of plural identifications”.

Such processes of negotiation could be expected to feature prominently in interactions between therapist and patient when the third cluster of the trajectory of thirdness is foregrounded. This is where the back-and forth flow of (often unconscious) identifications and disidentifications between therapist and patient serves to foster the connectedness between them at a subject-to-subject level. This is both characteristic of and contributes to a shared sense of being (Benjamin, 1998b; 2001). At this point identifications would tend to take place at a symbolic rather than at a concrete level.

### 3.7.5 Locating Benjamin’s intersubjective version of identification within this study

Benjamin’s elaboration of identificatory processes in therapy as being constituted by complex cycles of multiple mutual and reciprocal identifications and disidentifications between therapist and patient, which locates “the self in the fragile, unenclosed space of intersubjectivity” (Benjamin, 1998b, p. 105), makes identification a “structure that emerges in motion” (Corbett, 2001, p. 327). This viable intersubjective rendition of identification brings a postmodern sensibility (along the
lines suggested by Corbett\footnote{See p. 113.} to conceptualising identification by encompassing its multifaceted intricacies. In this study it provided a useful and comprehensive means of thinking about (and deepening that understanding) of how identificatory processes may be involved in linking the therapeutic and clinical thirds.
CHAPTER FOUR

RESULTS OF THE TEXTUAL ANALYSIS

4.1 THE THERAPIST AS WOUNDED HEALER AND SUBJECT-TO-SUBJECT RELATING

4.1.1 The psychodynamic therapist’s personal therapy

Although not extensively (and sometimes not even explicitly discussed), the participants and the researcher shared the belief and the understanding that personal therapy, even if not “interminable” (Freud, 1937), is a fundamental aspect of the psychodynamic therapist’s professional life.

The specific focus on the therapeutic relationship in psychoanalytic (and psychodynamic thinking), which currently includes the highlighting of the therapist’s subjectivity, renders the therapist’s own therapy particularly significant[92]. The same may not be true of a therapeutic paradigm that does not have this specific emphasis, for example, cognitive-behaviour therapy[93].

529: Well, my belief about therapy, about working as a therapist is that you do use yourself as a tool.
534 You're part of a process, you're part of a process happening in the patient.
535 Not only facilitating that process, you mix with it.
536 Something about who you are and what you are mixes in the third.
537 It is part of the catalyst for your patient's change.
538 And the therapy is just about keeping your tool clean and sharp and bright and shining (laughter).

262 It just is not possible to be a therapist without being in therapy.
270 Maybe, if you're working with cognitive-behaviour therapy and that's your model and that's your method and it's a method that doesn't require you to work with the intersubjective conjunctions and disjunctions and the intersubjective interaction, maybe then you don't need therapy.
271 Maybe you can do very, very excellent work without your own therapy.
273 I couldn't work like that, but maybe I need to modify that and say that if you are working in a psychoanalytic therapy, I think that therapy is absolutely completely part of the work. (F)

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[92] Although the views and arguments presented here are mostly in terms of relational and intersubjective theory, this (with variations or different emphases) would also hold true for other psychotherapies subsumed under the rubric of psychodynamic psychotherapy.
[93] It is a fallacy to think of such therapies as not containing the same relationship elements as psychodynamic therapies: those elements are just not explicitly foregrounded, theorised and taken into account and precisely that holds possible limitations, pitfalls and certainly potential danger. By that I am not implying that cognitive-behaviour therapy does not have a real place and worth. In some instances it is certainly a more appropriate form of treatment than psychodynamic therapy, especially in terms of symptom relief and in terms of what the patient is able to afford in terms of money and time. However, if one takes into account that therapists tend to seek therapy from somebody within the same theoretical paradigm, the fact that the majority of behaviour therapists opt for nonbehaviour personal therapy (Norcross & Aboyoun, 1994) and that most therapists who are (or have been) in therapy are (were) in some kind of variation of psychodynamic therapy (Darongkamas, Burton & Cushway, 1994; Macran & Shapiro, 1998; Macran, Smith & Stiles, 1999) speak about what therapists consider important for themselves when seeking therapy.
4.1.2 The nature and origins of the participants’ woundedness

When asked about their understanding of the reasons for choosing their profession, all eight participants described themselves in terms of the wounded healer concept. They depicted the nature and origins of their woundedness in a variety of ways. The wounded-healer phenomenon was seen as a combination of abilities and vulnerabilities, usually originating in early relationships with significant others, which had (often unconsciously) entangled them and which had shaped their ways of relating to others and of doing psychotherapy. To get beyond this had been a challenging and courageous struggle that had continued for many years, and that was still, to some extent, ongoing.

That's where I came from, trying to work out who the hell my mother was; what was going on; who I was.

It started out from a very, very deep desire to understand my mother and help her.

But the ravages and the actual effects of living with someone who is actually off her rocker in your childhood, is stuff I'm still working through, still distancing myself from. (A)

For me, I went into therapy saying: "I don't know why I'm in therapy, because I've come from the perfect family."

We laugh about it now, because, I mean, as much as I said it's perfect, it was so dysfunctional that I didn't see that.

Ja, of course, that's why I'm working with [omitted], because my father himself is [omitted] and what came out in therapy is that I was trying to rescue my dad.

In trying to rescue my dad, I'm trying to rescue everybody else. (C)

Ja, you see, [omitted], so I learnt through my own parents' neuroses that the way to deal with life was to take care of people, because I took care of my parents.

And that spilled over into my peer relationships, where I became a kind of caretaker amongst my peers and that I think was a natural preparation for the role of the therapist. (D)

I was very much the caretaker in my family and in my peer group, the listener, the caretaker.

I was primed to be a therapist from small, but it was a role that hurt me and I struggled.

I mean, I liked it, but it was a role that in myself was damaging, hurtful.

I couldn't be who I was, I couldn't be me.

I was there as an ear for other people, the rescuer, the helper, the looker-after. (F)

One of the aspects of being wounded was becoming prematurely independent and self-sufficient.

Ja, I think I started defending against dependency needs at a very early age.

Those that I depended upon did not feel safe, in a way, to depend upon, so I think my counter to that from a very young age was to do it myself and to grow up and to survive (sighs) ... (BP)
These early relational experiences had shaped the participants in becoming caretakers, rescuers and prematurely independent, that is, \textit{wounded healers}. If one reconfigures this concept relationally and in terms of Benjamin’s thinking, these participants identified with powerful others by whom they were not recognised, for whom they were but inner objects (and hence they became very aware of how to be “good” objects). Identification was with these relationships (rather than with the personal attributes of those identified with), and accordingly with the split complementarities consisting of two opposing and unequal positions.

A therapist who is a wounded healer enters his profession with a profound interest in understanding the inner world and behaviour of others and himself, that is, is \textit{psychologically-minded} (Appelbaum, 1973; Farber, 1985), and has an already-developed ability to be attuned others’ emotions. However, he also brings his (largely) unacknowledged vulnerabilities and neediness, which makes it hard to engage in subject-to-subject relating, especially when his defences and anxieties are provoked by what happens in therapy. At such moments the complex combination of the facets of the wounded healer could converge into the constellation of a therapeutic relationship in terms of the polarities of powerful healing therapist and submissively healing patient.

This makes it likely that therapy will go well as long as the therapist can be the rescuer or helper and the patient colludes in being a “good patient” (on the therapist’s terms) who does not threaten the therapist’s sense of himself as a “good therapist” unduly. Such a therapist may find it particularly difficult to differentiate himself from the patient (that is, not to relate to him as an object) when there are similarity and confusion between the “other within” and the “other without” (Benjamin, 1998b, p. 108); that is, when what is identified with in the patient is also a disowned aspect of himself (the therapist).

Being a wounded healer can therefore be a real liability when doing psychodynamic psychotherapy, where the emphasis is so much on the therapist’s use of self and the therapeutic relationship. However, the desire to understand oneself also leads to a profound interest in understanding the workings of the psyche and human relationships, and the development of the ability (for which there is already probably some aptitude) to think about oneself and others.

\begin{verbatim}
834   B: So I had the aptitude for this.
835   *R: What is that aptitude?
837   B: It's the capacity to see process over content; to realise that life isn't necessarily just about getting things right, but about finding one's own way and truth.
838   And that's why I think that people who have been injured, more so than people who haven't been injured, get that; they get that somehow something has gone astray, because if somehow you'd gone through life in a rather protected way, with a relatively well structured family, etc.,
\end{verbatim}
the capacity to try to understand life as a process is not developed, very strongly developed, because there's no motivation to develop that, because you're feeling all right, so you just then stay in the moment and live.  

But when things go wrong, and you can't quite work out why you feel terrible, then one starts to think: "Well, why do I feel terrible?"

You try to understand the relationships in your life, you try to understand what that means and try to change it.

You have some level of success at doing that.

Well, then you are a psychotherapist, aren't you?

A good therapist is someone who has battled to make meaning when they've been sore at some point in their life; succeeded to some extent; failed to some extent, but got that there's something in that process that's important.

If they've had to do that a lot, then they've built the skills of thinking and feeling things out a lot.  

Although the ability to think in this particular reflective way may rather inauspiciously begin as part of being “wounded”, it certainly is a necessary attribute for the psychodynamic psychotherapist. Of course that leads to the interesting question (which I do not presume to be able to answer) whether any one who has not to a significant extent experienced being “wounded” will really have the motivation and interest to pursue this “impossible profession” (Malcolm, 1980). This also emphasises that while the specific circumstances of one’s life may sometimes be unambivalently and clearly devastating and traumatic, being “wounded” does not always just pertain to those circumstances, but rather to those meanings that are assigned to them and how these meanings are lived.

4.1.3 Woundedness, becoming a psychotherapist and the participants’ personal therapies

Being “wounded” was both seen as being a fundamental part of being a psychotherapist and as holding the possibility of impeding the work of therapy.

Oh, I mean, people inevitably become psychotherapists as part of their way of trying to cope with their own suffering, you know.

If I focus on other people's pain, then I avoid my own.  

We also know well enough that none of us do this work if we've not been wounded.

So you sit with your own wounds and besides which, no human being is without blind spots.

So we're trying to do something that is quite impossible, anyway.

To try and be aware of your own blind spots is a bit of a paradox.  

Some of the participants had entered therapy because of some (usually relationship) problems in their own lives, but only B was clear that his woundedness had been the overt and conscious reason for his need for therapy. He also made an interesting comment about therapists’ only sometimes discovering this aspect of themselves after having entered therapy for more “professional” reasons.

My own personal hurts motivated me.

My own personal hurts and the need, the need to resolve them so that I can be happy, whatever that may mean.
It was not at that stage at all clear that I wanted to be a psychotherapist.
You know, you get two different kinds of psychotherapists.
You get the ones that went to therapy because they want to be a psychotherapist and discover that they've got a whole lot of personal hurts.
And I'm not one of those.
I'm someone who wanted to be a [omitted], who was doing [omitted], who was running into a lot of problems, had a very difficult history, went to therapy as a typical patient and then was motivated through my own transformation in therapy to study psychology further and eventually became a psychotherapist. (B)

Becoming a psychotherapist could be an inevitable and necessary part of surviving and moving beyond the entrapment of woundedness.
I think (sighs) in some ways I never had a choice: I had to be a psychotherapist.
There was nothing really else that I could have done and survived, initially.
So the strongest part has been motivated by my own attempt to try and understand the suffering of my own history and my current self. (B)
Oh, ja, I mean, it was a way of working through my own stuff, for sure. (E)

This choice of profession was often only retrospectively understood.
Okay, the obvious, overt reasons weren't why I became a therapist.
Now I understand it very much in terms of unconscious processes that were happening at that time, positive and negative things.
Partly it was about pathology that was happening in me and in my family that I was unconsciously aware of that I needed to heal, that I needed to bring out, but I've recently become aware of how really healthy a choice it was, how I really didn't understand it at that time.
I didn't know what I was doing at that time, but I was making a choice, a choice to change my ways of relating, my ways of speaking, my ways of processing what was happening or beginning to speak about things that I was aware of unconsciously and that were happening ...
I changed from wanting to spend my life not communicating with people [omitted] to a profession that was about relatedness, but relatedness in a different way.
I didn't have to look after ...
I think that's one of the traps in psychology, to want to rescue and look after and all of that.
*R: Was that something you had to work with?
F: Yes, it was something I had to work with, but I think it was an interesting choice at that age of [omitted] to choose relatedness above non-relatedness.
That's why I think it was a healthy choice ...
*R: Maybe it was about a kind of healing?
F: Although I didn't know what I was doing at that time. (F)

A psychotherapist who is a wounded healer may use his work and patients as a way of having a meaningful existence and maintaining his feelings of self-worth.
And the work gives you some meaning and some sense of worth.
You know, so I think this can be quite dangerous for therapists, because why they go into this work often for these reasons, is that they become dependent on their patients for their own self-worth and for reassurance that wounds can be healed, for hope, stuff like that ... (A)
The issues and difficulties that had ensued from being wounded had been such intrinsic parts of who the participants were, that change would not have been possible without therapy. This realisation had usually only come when looking back (that is, during the course of or after therapy).

464 And it's retrospectively that I can see the motivations with the consciousness that comes later, when you're no longer in that place of need, that you can see that you did have it.
465 At the time that you have it, you don't know it.
466 But it's that, that's basically what all these years of therapy and analysis have helped me with, is to put it in the right place. (A)

449 F: The unconscious enactment of not being true to myself, because everything I always was, was about accommodating to make someone else feel stronger or happier.
450 And it's in you.
451 It just is who you are.
452 It's not like something you can read about to learn about.
453 It's just who you are and that has to shift.
454 *R: You were also good at it?
455 F: I was good at it from this (indicates height of a small child)!
456 And I don't think that can shift in learning.
458 It's had to be a complete shift of who I am and how I relate.
459 Not complete, but I mean, it had to be significant enough, the shift in who I am and how I relate to ....
460 *R: How did that shift come about?
462 F: For me, that's come out of therapy, no two ways about it, no two ways about it ... (F)

The effects of therapy have been transformative in many ways.

631 I mean, my experience of analysis has been the most significant thing in my life.
632 It's impacted every aspect of my life.
644 It's been a deeply life-giving experience ...(E)

This has made the effort and expense (in terms of time and money) of therapy seem worthwhile.

508 I can say to you that my therapy is hard work.
509 I don't just go there.
510 No, it's very hard work; it's very, very hard.
511 But I wouldn't want it any other way.
512 I always say to people, to my friends and they also see the product, because I'm a stronger person, and they've never gone to therapy: "All that money; it's now been seven years and I could have taken all that money and actually bought myself a house; I could have had cash, but instead I bought a house inside me that is fuller and happier than having a house standing there that's empty."
513 So that is to me what therapy is, that it's hard, hard work, but I wouldn't have wanted it ANY OTHER way. (C)

Having one's own therapy may alter one's motivations for, the meaning, and way of being a therapist.

469 What I was saying just now was that over these many years it's kind of like I have moved from feeling pushed and shoved into this direction, not that I didn't feel properly that it was a free choice, it was and then it wasn't and then it was, you know, to actually really accepting this as this is what I'm doing and being fully committed to it as a craft also,
as an art and a craft and something that has become for me, of enormous interest.

But it's not a burden; it's a pleasure, it's interesting, because all of that becomes part of your virtuoso, your capacity to be with other people and other people's emotions without feeling frightened of it ... (A)

But another insight (laughs), I mean, really, when I think that I have been in therapy for [omitted] years, that has really only just come to me is that my task is not about alleviating suffering.

It is about facilitating the connection with the unconscious; it's about bearing the suffering; it's about knowing that suffering is part of life; not trying to avoid it. (E)

I think that there is no question about the fact that we as therapists do therapy because it's gratifying to ourselves in some way or another, but the INTENSITY of the need to help, that need to save, is vastly diminished if you've been in therapy.

And because it's diminished, I'm far more effective.

I am far freer to be emotionally attuned to my patients, but it's because it is good for them, as opposed to it being good for me. (G)

While it is possible to see in retrospect that one’s functioning as a therapist has become enhanced as a result of one’s own therapy, there is also the rather humbling realisation that one will never be totally free of one’s own issues: that a Third such as therapy or supervision is actually a necessary part of doing the work of therapy.

I even know the patients, I can see those patients before and after and I know who they are and I have like a regret about those patients from before and it's not deep regret, but some regret that I hadn't somehow gotten through the issue by the time they came to see me and I failed them in a way.

But, then one can also step into a lot of perspectives about what that means, because is one ever free from unconscious neurosis?

I don't know.

So there must be people I am seeing now who are stepping onto things that I'm unconscious of and that at some point in my therapy in the future I look back to: "Oh, my G**!" (laughs) ...

That's also why the therapist who is not in therapy really has to be careful, I think.

Really has to be careful, has to be in very good supervision, then. (B)

4.1.4 Moving towards subject-to-subject relating

4.1.4.1 Therapeutic experiences in the therapeutic third that engender subject-to-subject relating in the clinical third

Some of the crucial questions in this study were what about the participants’ own therapies helped them to work through their own issues and difficulties, as well as rendering them capable of and/or enhancing their abilities for subject-to subject relating with patients; what impeded this and how these kinds of processes affected their work. What, therefore, were the nature of the relationships and the links between the therapeutic thirds and the clinical thirds that the participants described?

Participant C contemplated this question:

What I am not sure of in terms of your question is, is it my own experience of therapy that is informing my work or are insights that I've
In listening to and reading the interviews, one becomes very aware of the loving respect and the ability to see the other in his own right (rather than being “perfect” technically) that mark the steady and unflagging presence of the kind of therapist that could engender the creation of a therapeutic space where such experiences were possible.

637 It's like you've been taken in by somebody else.
638 Not only understood, but that person has actually taken you in.
639 It's a very intimate experience, encounter.
640 I think that's what's transformative.
645 It's healing, it's containing.
646 It gives you that experience of being contained, which probably you had as an infant, but you don't usually have as an adult.
647 And it's not like being with a lover, you see, because with a lover there's not the understanding.
648 Lovers understand you, yes, but this is now a more verbalised understanding: "This person is actually thinking about me, has taken me into their mind and they're going to say something about me which is an exquisite understanding of elements of me."
649 For me, that's what's transformative.
625 Once you've had that experience, there's a shift in the way you think of things, the way you see things, the way you conceptualise things.
626 You never reverse it. (D)

In the following account by BP there are also indications of her therapist’s agapaic attitude (Lambert, 1981) or what Benjamin (2001, 2002) called the moral third underpinning the therapist’s work. Included in this is her experience of the different dimensions of therapy.

301 Maybe it's a real experience of being respected, all the things, I suppose, which is about the woundedness to start off with (becomes tearful).
302 I suppose there are aspects of the mother, a feeling of complete dedication to the process, care, being taken care of emotionally mixed with the guidance and the boundaries of the father.
307 And I think this experience of my therapist being able to contain that woundedness, I suppose it's the closest to feeling loved and how it frees one up to actually look at yourself within that environment, to actually face yourself and how impossible it is to face yourself in an environment where you don't feel loved by the therapist. (BP)

This had not been the case in a previous therapy, where she had to hide her own vulnerability in order to “protect” the therapist.

277 Not allowing myself to really get in touch with my own neediness, my own dependency needs, so I would present myself as quite together, as quite under control, not needing anything special, keep it on a quite superficial level, not being able to get in touch with dependency needs, basically. (BP)

In another therapy, this aspect of hers had made the therapist angry and he had given a harsh and punitive interpretation that was negating of her.

278 Which is what came out of that second therapy when I said: "I'm going
And he got angry, basically saying in quite an angry way: "Do you always look to other people to solve your problems?" (BP)

In the participants’ descriptions of their therapies one finds the different facets of recognition (interspersed by moments of negation) as set out in the different clusters of Benjamin’s *trajectory of thirdness*, ranging from the therapist’s attunement to and containment of the participant to the sharing of a co-created symbolic intersubjective space, where alterity is possible.

For Participant B it had been his first therapist’s recognition of him (64, 66, 67), which had to do with her attunement to him (72-74), accompanied by his recognition of her (75-76), and her specific awareness of him as somebody who had a certain potential (77), that had led him to considering becoming a therapist (78). Another way of viewing his wanting to become a therapist, is to consider it as a way of identifying with the powerful and idealised other as a way to become more empowered oneself.

Participant A described the distinctive quality that makes the therapeutic relationship a “healing” one (282, 284). She also recalled how her own experiences of being recognised in therapy (306) by her therapist’s attuned and non-intrusive, non-judgemental presence (309, 316-317) within the contained space of therapy (314) had enabled her to develop the capacity to also do this in her own work (322, 324).

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*94 This is further discussed in the section “Therapist ‘mistakes’ and the dialectic of recognition and negation”.*
A: It's mirroring, that's another word for it, but it is having the space to explore your own feelings without sanction; to say the unsayable and have it received without judgement.

So that container is the most important thing and it has to do with all the things, you know, the structure of the therapy and your time and keeping the frame intact and having respect for the frame.

And listen to that and be empathetic all the way, not with judgement.

So that capacity of the therapist to be able to see; to shut up and listen.

That is part of what I have developed over the years of my own therapy: the capacity, well to know that being listened to works and gradually experiencing more and more, getting more words to understand what that is, the vessel, the trust, the frame, whatever names we have for it, we all know it's that thing (laughs).

And to develop that capacity within myself by having been listened to; by listening to myself.

So that in itself is the growth that I experience in myself of having more of a sense of my own container, my own feet. (A)

These kinds of experiences had taken A beyond the extreme neediness (451) where she had been before to where she was able to have her own life in a fuller way (452-453). She was no longer at the point of intense vulnerability and dependence where she had been before (353). In this process, what she needed from therapy had also changed (352).

I'm not howling in the agony of not having had a mother.

I can see the fact of it; I can be more matter-of-fact about it, because I'm not a mess any more.

I can live my life and I can have my life.

I think, actually, the need now, is more really for mirroring than for being listened to, for having the space to talk about all the things I find growing inside of me.

Whereas before it was more like being lost in a fog and needing to hold somebody's hand while you're walking through that dark valley, where you don't know where to put your foot next, because you might fall. (A).

The evolvement of mutual recognition in a good-enough therapy encompassed surrendering to the "music" of a shared sense of being and the existence of difference. This enabled participants to work in a similar way.

So the words very quickly recede [omitted], but the sense of BEING, and the sense of being responded to, heard and seen, remains.

And that doesn't mean that the therapy is mushy or mirroring, because there's a lot of difference in the therapy. I greatly value the therapist's input, which is different and might shed a new light on what I'm dealing with.

So it's not just a mirroring response that I'm experiencing, but rather a challenging, engaged response and I find that I can be that too, very engaged in my therapy with patients and challenging where it is necessary. (G)

Alterity meant the therapist’s not colluding with the participant and not only submitting to the participant’s point of view. This could also become a way of working with which the participant could identify.

I think, what W would often do, is pick up on a manipulation and throw it right at my head and force me to actually look at that, when I would deny
that I was actually manipulating or trying to pull him into an alliance against [omitted].

313 Once he even said to me: "Oh, D, you are just incorrigible; there you go again, trying to pull me into an alliance against [omitted]."

314 And I would say: "But, W, that's not true; all I'm trying to do is to get some sort of support for these difficulties."

315 He replied: "Yes, but look at how you are doing it; you are wanting me to agree with you that [omitted] and you don't like it when I won't do that."

326 So I've been amazed at the way that people will fight that and often the fighting is very useful in the end. (D)

Of course there is also the possibility that one’s own therapy, while being transformative may also, especially in the intense and idealising beginning phases, assume greater importance than one’s “real” life, and that one may become increasingly self-preoccupied.

117 You know, I think, my own experience of analysis; there have been times when it has felt absolutely all-consuming, it's been the absolute central thing in my life.

243 But I can remember quite early in my therapy saying that it felt as though my therapy, my kind of inner world was happening in technicolour and the rest of my life was in monochrome.

244 And in some ways that has been the way that it's felt, that my analysis has been INCREDIBLY important to me.

245 It's completely changed my life. (E)

While participants’ descriptions were of (especially initial) experiences of therapy as being different from previous ways that significant others had related to them, this should not be interpreted as being indicative of their therapies being so-called corrective emotional experiences (Alexander & French, 1946), but rather as intricate amalgams of what Stern (1994) called the needed and repeated relationships.

326 So then what she brings alive for me, is that although she is not my mother in the room, something that is going on, is like my mother.

332 I will pick up that she is distant, whereas she might not be distant, but I will pick it up and it's important for me to say that to her, because then she knows we need to work with that, where I might not know how to work with that, because I'm the client.

333 And she will work with that with me.

334 And I don't know, it's almost as though I can see the mere fact that she then works it through with me already takes the process of my mother away, because my mother would never do that. (C)

Within the context of such therapeutic relationships, where different clusters of the trajectory of thirdness were appropriately foregrounded at different times, the participants were able to, at the same time as working through and becoming freer of their own difficulties, move towards being able to engage in subject-to-subject relating; that is, being less prone to (unconsciously) using patients for the gratification of their own needs and desires and increasingly becoming able to differentiate themselves from patients. As Benjamin (1998b, p. 103) puts it so succinctly: “Thus,

95 Participants’ identifications with their therapists were also involved in the ways that their manner of working as clinicians changed and developed, but this will be discussed in Section 4.4.
paradoxically, only inclusion, the reavowal of what was disavowed, in short owning, could allow that otherness a place outside the self in the realm of externality, could grant it recognition separate from self.”

These findings resonate somewhat with the results of other qualitative studies about the impact of therapists’ personal therapies on their work. Macran, Smith and Stiles (1999, p. 429) write about the “specific aspects of personal healing and growth” that contributed to therapist effectiveness. Wiseman and Shefler (2001, p. 138) describe how their participants had moved towards individuation during the course of their therapies. They (Ibid.) understand individuation in terms of Skovholt and Rønnestad’s (1995, p. 74) “individuation stage” of therapist development. For Wiseman and Shefler (2001, p. 138) the “central task” of this stage is “to move towards deeper authenticity while developing a highly individual and personalized way of functioning professionally”. Translated into Benjamin's thinking, this would mean therapists being able to engage in subject-to-subject relations with patients. Some of the other effects of therapy on working as a therapist that are described in these studies, such as becoming more attuned and empathic to patients; being aware of the space of therapy “belonging” to the patient; becoming more able to separate one’s feelings from that of patients (Mackey & Mackey, 1993; Macran, Smith & Stiles, 1999; Wiseman & Shefler, 2001), may also be understood as aspects of an increased capacity for subject-to-subject relating.

4.1.4.2 Woundedness, personal therapy and the changing nature of empathy with patients

Having their own therapies had made it possible for participants to identify with their patients’ experiences of therapy in ways that would otherwise not be possible, thus enhancing the possibility of patients becoming like subjects. When a therapist has had his own (often) iconoclastic and (even) narcissistically wounding experience of therapy, it becomes harder to write the patient off as being one of them, the patients, those who are weak and cannot cope with life and its inevitable difficulties, thus contributing to the therapist’s sense of mutuality with patients. Participant B discussed this issue (about which he had strong feelings) in relation to therapists without any significant own therapy experience.

186 B: In the [omitted] years or so that I've been working, I can see those therapists.
187 I am usually able to tell, when I meet them, that they've not really been in any serious therapy themselves.
188 *R: What do you see?
190 B: That there is no identification with the patient.
192 The patient is part of THEM, and the therapist is part of US.
193 You know, there is an US and THEM.
194 As soon as I see that, then I know that this is s*** therapy, you see, because the person doesn't know what it's like to sit in the other chair. (B)
On a very ordinary and pragmatic level, the actual experience of therapy brings empathy with patients in the process of therapy.

While suffering brings empathy with patients, it is also important to know from one’s own experience that therapy brings hope of getting beyond this.

Through therapy it becomes possible to acknowledge previously disowned vulnerability. This is an important facet of having “true” empathy with patients.

While being a wounded healer does mean that one is sensitive and attuned to the suffering of others, it also holds the real possibility of relating to the other as one’s internal object, that is, in terms of one’s own experiences. So the therapist’s own therapy becomes pivotal in taking empathy to a point where the therapist is able to identify with an other who is separate and different.

Participant A described how her therapy had helped her to be less “gripped” by her own issues, which had led to her empathy with patients not just leading to the kind of identifications that obscures difference and is suffused with “sameness” (127-129), so that she was able to retain her connectedness to patients (134-135); recognise them as being separate and different (143-144); be reflective of what was happening (146-147); and was consequently no longer so exhausted as in
earlier years (162-165) when she could not properly separate herself from her patients (443-444). This had left her with compassion for her patients (447). Her own therapy thus functioned as a Third that she was able to use for containing and working through problematic aspects of herself (448).

In time it started helping me with not being so much in that kind of identification with the patient's pain, which I operated a lot more from before. Which, I suppose to some extent is helpful, but one needs to be more objective and let people carry their own pain in order also to be more empathetic. Analysis definitely helped me with that, to be more in my own skin and stand separate as an empathetic observer that trusted that they could do the work themselves, but being there with an understanding of what it is taking and helping them walk the road.

It's not that I don't feel, but my feelings are more there as tools for information. It's not that I don't deeply feel for their suffering, but I don't get floored by it; I don't get overwhelmed by my compassion for them ...

If you cannot differentiate whether this feeling that you are having is coming from your own pain or from the patient's pain, you can actually really miss what's going on for them.

You can project your own stuff onto them and begin to steer them in a direction that actually has got nothing to do with them.

I think that what that also has also helped me with is to listen better, obviously, to sit back and listen and put on a hook more what I am feeling and seeing and so it's a process that goes on over there while I'm engaging here.

And waiting more before I would offer an intervention or a comment or a reflection.

With that I have found that the exhaustion that I used to feel in the beginning as a younger therapist ...

It's not that I don't get tired from the work, but it's not that kind of exhaustion that I used to have when I couldn't properly be separate.

I would carry much more ...

I suppose I would be much more burdened by their affects, their emotions, their suffering than what I am now.

And I would be far more over-mothering in my attempts to alleviate people's suffering around such pain.

I would get over-involved in the work, which as I'm sure you know, can have all sorts of catastrophic results and has had ...

I think what I'm left with is a real compassion for people who have had that suffering, but I don't feel linked to their suffering.

I've got mine, I've got my place where I'm working with it and I have had a whole lot more distance from it. (A)

Participant C also described how she had become more able to differentiate herself from patients.

I've also become stronger about what is their stuff and what is my stuff and I'm careful not to make their stuff my stuff, so let's say there's something uncomfortable and I feel bad about it, I then can sieve through it and I need to get it back to them and they need to work it through themselves.

So I'm able to separate that that's their stuff and that's my stuff. And if it is, then I'll say: "What is it in me?" (C)

Being able to differentiate oneself from patients had still meant maintaining a vital connectedness with them.
I think it’s a level of differentiation, and separateness as an intuitive therapist that you develop, without losing your affective attunement. (G)

A therapist’s empathy should not just be with the vulnerable aspects of the patient, but also with the patient’s negativity, anger and hatefulness. Participant BP described how her therapist’s capacity to retain contact with and keep in mind different and conflicting aspects of her, which included defensiveness and negativity (312, 319-320), had enabled her to be reflective (314-316) and to give the same kind of recognition to her own patients (313, 318). This excerpt may also be understood as BP’s being able to identify with her therapist’s way of working when she herself felt recognised, thus becoming able to be “on both sides of the divide” (Benjamin, 1998b, p. 19) by having the capacity to move between concordant and complementary identifications (Racker, 1968) with the patient.

Being able, in my own therapy, to experience my defences against my woundedness, the negativity and all the different defences against my woundedness and the therapist not acting out in countertransference, but being able to allow me to see what it is.

I think I've got a lot more patience with my own patients' negative transferences, negative behaviours, whatever else goes on there.

So maybe empathy then goes further than empathy for the vulnerable patient, but also empathy for the attacking, angry, destructive patient and not needing to retaliate and seeing the woundedness behind the nasty, attacking patient.

Just to keep in mind what is going on there and to be always bringing that back into an understanding.

To be able to see one's own negative behaviour in context, not as something to be retaliated against and to be punished, which is why you go to the therapist in the first place, because that has been your experience earlier in your life, but actually being able to see what goes on behind the attack, the wounded person behind that, to see the defensiveness of that and I suppose to bring those together, to bring the hateful patient together with the vulnerable patient and to integrate that.

It's the way that, although your, maybe, negative acting out in the therapy can be seen, can be mentioned, you can see what effect it has on the patient, he can digest it, you can work with that and then always bring together with that the knowledge of what goes on behind that defence.

I think it's in the bringing of those two together that it does not feel like an attack, it does not feel like a reprimand.

Whereas I think in previous therapies, like the therapy I described, I think that there was a counterattack, basically, which then just stops any understanding and reinforces your belief in the fact that your dependency needs cannot be met, should not be met, are bad...

I think up to very recently my patients had been incredibly courteous, nice and well behaved and I find that the more that I feel safe in my own therapy to also get in touch with anger, I find that my own patients to also be more free to get in touch with their anger and to attack me ... (BP)

Being able to differentiate oneself from a patient does not only pertain to “blind spots” (Freud, 1912), but also to the therapist’s “bright spots” (Goldberger, 1993). This further highlights the fundamental principle that the space of therapy belongs to the patient.
156 My main function really is intuition, so I often see pictures while the person is talking.
157 If they describe a dream, I see the dream or if they tell me events of their lives, I can see it ...
158 Earlier on in my work that used to excite me, sometimes so much that I would intrude, whereas now I'd sit and wait longer to see whether sometimes it actually comes from them then, spontaneously; what I was seeing over here does come from them. (A)

116 I feel far more aware of the fact that this is for the patient and not for me.
117 Whereas I think, before I was in therapy, there were certain issues that intrigued me in myself.
118 I'm almost sure that my own curiosity led the way. (G)

The therapist’s task has to do with “following” the patient, rather than his own needs and desires. In this regard, the therapist’s therapy may diminish the effects of his own blind spots on his work as clinician, something that is often picked up and responded to by patients.

76 I also find, very interestingly, that the things that I focus on in my own therapy, very soon, within a week or so of me exploring a certain area, it will come up.
77 Suddenly my patients seem to have issues and problems in those areas ...
82 I feel that the reason that I can deal with those things, is because they provoke less anxiety in me now and because I'm more consciously aware.
88 And I also believe that on an unconscious level, somehow, it gets communicated to the patient. (G)

On the other hand, the therapist’s working with his blind spots in therapy, may turn them into bright spots and that, even if subtly and temporarily, rather than the patients’ concerns, may become what shapes his work.

343 And sometimes I have to catch myself and hear myself after a really exciting own therapy session; hear myself working, almost as though I'm looking for the same thing.
348 And I think I just have to be aware of it, because it's going to happen anyway. (F)

While both Participant F’s and Participant G’s views, although contradictory, have validity, it is not just what is “correct” that is ultimately important, but rather being open to different possibilities and the ability to also think about the meaning of an aspect of working. This returns one to the importance of the therapist’s own therapy.

365 BUT maybe where the therapy helps, it does continually ask you to be self-reflective. (F)

4.1.4.3 The therapeutic third as ongoing Third to the clinical third

The therapeutic third may just be a place of sharing one’s experiences of being-a-clinician (and not being so alone with that).

519 It does still happen where something one of my patients is going through really touches something deep inside of me that is not necessarily negative, but I would like to share with somebody who would understand why it touched me so deeply. (A)
There are also the demands and ongoing stress of doing the work of therapy. In terms of these, the therapist’s own therapy may play a specific role (which may not have been the case for a non-therapist) as a Third, where there is containment and nurturing.

Well, I think that one of the reasons why I stick in therapy, is because I think it's such a place to clear out.

So I don't know that I'd be able to work the hours I do and to carry the kind of loads that I carry without having the individual therapy. (D)

You know, it's kind of like you can probably go by taking in from people and playing this role in this chair for a while, and then your system gets clogged up, and for me, having your own analysis is like cleaning your system up.

I can't see that you can't get blunted if you don't have your own place to take it to; to go and nurture yourself and to clean up your system; to breathe again.

Because as I said, at this stage in my life I feel a lot more balanced in myself.

I guess if I wasn't a therapist, I would say: "OK, I don't need to do this any more."

But this happens.

You sit with people with powerful affects.

If you open your heart to them to feel who they are and really be there in an empathetic way, you're going to have to be able to go and cry somewhere else about somebody else's pain or find some distance, some breathing space from that in order to come back to it ...

I listen to a lot of stories of trauma and it's hard.

You're using yourself.

You have to be aware of yourself, reflecting on yourself to use yourself as a tool, so that's also hard ...

Patients will evoke feelings in you, sometimes through the things they are going through that remind you of your own life or through things they challenge you with or just the way they are that challenges you in a very personal way.

And I don't know how one tolerates that without a therapy space to contain, to help you process that.

Something about who you are and what you are mixes in the third.

It is part of the catalyst for your patient's change.

And the therapy is just about keeping your tool clean and sharp and bright and shining (laughter).

You can use yourself better if you're in therapy (laughs)! (F)

The therapist’s own therapy (just as supervision) becomes part of the work of being a therapist, especially when clinical work runs aground because of some vulnerable aspect or difficulty that the therapist himself is struggling with.

Obviously I have my own unconscious defences of a particular kind, as everyone has, as we all do. I work with those.

But because they are unconscious, of course you don't just know them.

As I went through therapy, I started to become more aware of them.

And I remember sitting with a patient who used a very similar kind of mechanism and I could recognise it; I could see it; I could recognise it and I could say: "I see what you're doing."

Well, we could talk about it intellectually and I could recognise it and I could know that this was something that I knew about and I knew what she was doing.

I knew that the feeling was cut off.

I also knew that the therapy was just going around and around and around.
I knew that I use that mechanism and she uses that mechanism and together we are protecting each other from an affective experience, a real experience of what horror feels like. And then in my own therapy working on the kind of way that I use the mechanism; where I had used it and where it had originated from. And then it moved. The therapy moved on. So I think what I'm trying to say is that I think that therapy is a part of the whole process of therapeutic work. (F)

And then right in the beginning, the other part that I remember being very, very important, was just that containment and that I needed my therapy to help me get through [omitted], as well as the things that are happening inside you, because of the training you're going through and the change. It was important to have a place to go. That you can feel contained enough for your attention to be able to rove, able to flip between yourself and the patient and the interaction and just be able to work. So that was very important in the beginning. And still is, but to a much lesser degree, because, I suppose, what also happened, after ten years of therapy (laughs), hopefully it's done something! I'm a little bit more able to just simply do that for myself, more easily. (F)

So that in itself is the growth that I experience in myself of having more of a sense of my own container, my own feet. (A)

Over time the Third of the therapist’s personal therapy may also play a part in the development of his capacity for subject-to-subject relating, and to remain capable of reflective thinking in doing his work, that is, to the third in the therapist’s mind (Benjamin, 2001). Just like the Thirds of theoretical knowledge and supervision, the Third of the therapist’s own therapy may be therefore be thought of as contributing to the evolvement and ongoing existence of what Casement (1985, 1990, 2002) calls the therapist’s “internal supervisor”.^96^96Casement uses this term to denote the therapist’s capacity to both trial-identify with the patient’s experience of him (the therapist) and of therapy and to track and reflect on his own feelings and thoughts. According to him (Casement, 2002, p. 47), the “functions of internal supervision evolve from an student’s experience of his/her own analysis, from formal seminars, clinical seminars, and from following the clinical sequence of many sessions”.

4.2 POWER AND MUTUAL RECOGNITION

4.2.1 Vulnerability in the therapeutic and clinical thirds

Owing to the nature of the therapeutic process, being a patient is disempowering in the sense of the patient’s (to a greater or lesser extent) being made and becoming vulnerable.

I had the experience of my analyst going off for two months every year. That was his holiday time and that's a long time if you're feeling that dependent to be without and the kind of hell that that drops you into. (A)
I think it gave me an understanding of the experience of what it could be like to be in a therapy.

The anxiety at the beginning of going in, the anxiety of what somebody might be thinking of you.

Just the experience of being in therapy. (F)

The experiences of participants' own therapies had consequently brought an experiential awareness of how defenceless this process can render a patient and this extended to a felt cognisance of the kind of responsibility that this places on the therapist.97

I know when a person comes into therapy and they've never had therapy before; I know that I can expect if it works; if they latch on ...

I can expect an enormous need to be constellated, which would be extremely painful, humiliating and difficult to bear for them.

So my own attitude to that would be as respectful as I possibly can be of that and as supportive without injuring them, without making them feel less than what they are.

So certainly my own work in therapy has made me acutely aware of that, of the extreme fragility that is potentially there, in particular say in the first part of the analysis, when the dependency is that of a baby and the responsibility towards not injuring that is huge and the consequences of injuring that are huge; they can be catastrophic. (A)

You can try to deconstruct it, but the fact is, if you've ever been a patient, you'll know that largely you are very vulnerable; the therapist is in the position of strength; you're self-disclosing, they're not; they control the environment, you know. (B)

This gave prominence to the caveat that therapists not abuse their positions of power, especially as those positions pertain to being the one who knows.

L gave me some advice, which was actually detrimental, which I followed.

I am very careful about giving advice.

Advice is a dangerous thing ...

And if I am tempted to, at times, and I am at times tempted to give advice, I always tell them to take it for what it's worth. (A)

I respect what people call resistances.

I will not go there.

I will not break the resistance down.

I respect that there's something there that I don't understand and I'm prepared to wait.

If the person doesn't want to go into a certain place that I might think would be good for them, I won't push them there.

If they want to leave therapy, I won't stop them, because they may not be able to tell me all the reasons why.

And it's their right not to.

I don't have to know it all about them. (A)

According to Macran, Smith and Stiles (1999, p. 429), their participants had “translated” their experiences of their therapists’ positions of power into knowledge of “what not to do with their clients”.

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4.2.2 Power disparity and mutual recognition

It is important that therapists acknowledge and are sensitive to the inherently unequal positions of therapist and patient.

If the therapist is not conscious of that power and kind of theorises it away, which is what you can easily do, you can theoretically deconstruct the power differential and say: "Well, there's no real power differential, because it's two people." (B)

Benjamin’s concept of mutual recognition makes it possible to understand that, while there may be a power disparity between therapist and patient, there may, at the same time, also be the possibility for them to exist as like subjects. Rather than being mutually exclusive, these apparently contradictory positions may thus be conceptualised as existing in dialectical tension with each other.

So any attempts by them to reveal that they [therapists] are also persons just like you, trying to manage things, doesn't necessarily change the power differential, but what it does, is to create safety. (B)

Participant B explained what it would have signified if the therapist had acknowledged the validity of his experience of what was happening in the room in a situation where he had felt negated.

It would have meant that I felt again seen and heard and that I wasn't feeling that there is a power differential; that I was having a real experience of two people; that she wasn't just the therapist there; that she was also a person like me there, who gets what's going on. (B)

4.2.3 The disruptiveness of and faith in the therapeutic process

Participants had experienced their therapies as “cracking up” (Bollas, 1995) their accustomed views and ways of relating to themselves and others. This had been disruptive and disturbing, but was also an integral part of the shifts, personal and professional development that therapy had wrought in their lives.

It's made me conscious of the fact that, having thought that I lived a fairly functional, okay kind of life, that I have all sorts of demons lurking in the closet (laughs), which hasn't been a pleasant experience, but it's been a very necessary experience for me, as a clinician. (E)

In this regard, Participant A described an incident at the beginning of her analysis (116) that had, on an experiential level, dramatically (122) changed her way of relating to her analyst and her felt understanding of the process of analysis (124). What A described had closely resembled what Ringstrom (2001a) calls improvisational moments, as well as Stern’s (1998) now moments.

But then when I started with my analysis with P, I had a COMPLETELY different experience, which had a profound effect on me.

I remember experiencing P as very unemotional and thinking: "No, I don't think this is going to work for me."

And coming back after one session with him and I don't remember how I got back and the next thing I was sitting in a chair and an hour had passed.

And I didn't know what happened in that hour, I was so rattled with
something that he had said, which touched a deep truth in me, which had to do with [omitted].

I was telling P about an event from childhood when [omitted] and he made the comment of [omitted] and linked it somewhere [omitted].

And it was powerfully right for what I was experiencing [omitted].

And, ja, I mean from then on I was completely engaged in that process.

And I think that how that kind of work subsequently has influenced my work has been profound, because it is not just a theoretical understanding of the structure, of the depth psychology or the roots of your psyche.

Intially A had not felt an emotional connectedness with her analyst (120). However, he had made an interpretative comment, which had seemed to be based on his intuitively felt knowledge of her (217). This “act of freedom” (Symington, 1983) on his part had made her feel specifically known (Sander, 2002) and deeply recognised (Ringstrom, 2001a) (122, 221). This had also changed the intersubjective context of the therapy to a vital and authentic level of engagement (123).

Surviving and moving beyond this disruption is an important facet of why actually having one’s own therapy is so crucial in developing faith in the process of therapy: for getting to know in an experiential way (rather than just theoretically) that, in spite of how hard, painful and initially disempowering it is to surrender to the process, something that holds worthwhile transformative potential really happens between therapist and patient.

I know what it's like, I know what it takes, which is not always a cheerful story to tell people and may keep you busy for the rest of your life, but it's worthwhile doing it. (A)

I think in the initial stages of therapy, and I REALLY struggled with the whole notion of what a therapeutic relationship is (laughs) and WANTED an ordinary relationship with my analyst [omitted].

Then, encountering my analyst in an other than therapeutic situation and finding it absolutely unbearable, because there now isn't the safety of the frame and so, in that sense, KNOWING how protective the frame is and knowing at an ABSOLUTELY fundamental level the value of that, the containment of that, the protection of it, the liberation of it that suddenly, face-to-face with my analyst, in a different setting, it feels incredibly uncontained and unsafe and like I don't know what to say and neither does my analyst know what to say.

And knowing that it's only because of the absolute hermetically sealedness of the framework that the stuff can happen. (E)

4.2.4 The therapist-patient: meanings and dimensions added to the therapeutic third

Unlike the space of supervision, which they mostly regarded as being there for patients, the participants did see the therapeutic third as being there for themselves.

My therapy gives me the permission to be small, to be helpless, to be vulnerable, to expose parts of me that are not part of my professional persona. (G)
However, being both therapists and patients had added particular meanings and dimensions to the discourse of power in the therapeutic third.

4.2.4.1 Relating to the one who knows how to be a therapist

The very choice of therapist had been influenced (sometimes unconsciously and sometimes very consciously and explicitly) by the notion of and the longing to become a therapist like the “chosen one”, even when the reasons for entering therapy had not necessarily specifically or purely been “professional”. As such the idealising transference and its accompanying power disparity had often already been set up even before the start of therapy.

I saw in this man a combination of deep intellectual and theoretical rigour, like he knew what he was talking about way beyond where I was theoretically, combined with depth, with great depth and feeling and at the same time, a spiritual trajectory in life.

I identified those strong features in him, and so I sought him out. I said: "This is the person I want to go to therapy with."

So that transference of "these are the attributes that I want to be, these are the things that I want to have as a therapist myself" and me seeking him out as a therapist were there from the start. (B)

Idealisation of the therapist was especially evident in the early phases of therapy and was often accompanied by identifications at a concrete and direct level, that is, being a therapist just like the powerful other.

In the beginning I used to deny that he made mistakes. I would try to hunt down the accuracy of his interpretation. He would interpret that as well as my compliance and my need to find my identity with him rather than my identity with myself. (D)

Idealisation of the therapist was also part of the ongoing process of therapy; something to be noted and worked with.

BP: There are differences of opinion; we can't overcome them, but I trust enough that that will happen.

I think I tend to think the therapist knows better and he will eventually kind of be able to point out to me why there was that difference and how we can think about it in another way.

So I suppose, maybe I have to say, that the therapy still will have to go some time.

I still, at the end of the day, imagine the therapist to know best.

*R: What does that mean, "the therapist knows best"?

BP: There may still be quite a bit of idealisation going on...

So I suppose my feeling is that by the time that is resolved the therapy will also in a way, maybe, come to its end. (BP)

I sometimes have this thing and we discuss it that I put her on a pedestal and she doesn't like that and she says: "Don't put me on a pedestal, I'm not a genius person, you know, I'm like you and me." (C)

Idealising the therapist was frequently accompanied by the participants’ feeling “lesser”, particularly as clinicians. This could mostly be due to the participant’s own idiosyncratic reasons for feeling vulnerable and uncertain (such as being a less experienced therapist or having to deal
with a particularly difficult or threatening clinical situation or could be mainly ascribed to the absence of felt recognition or actual negation on the therapist’s part. It would appear that there was often some kind of amalgam of these two factors involved.

And in a sense it's, I think because I feel so vulnerable in the face of this guru, if you like, in the form of my analyst, that it feels incredibly risk-taking to take my work there, because finding the words is something I find difficult and my analyst has words and so to take my wordlessness around my work, there's been the wordlessness of the infant, if you like, but now this is the wordlessness of the clinician! (E)

Feeling “inferior” was often the case when participants had felt unsure of themselves as therapists, and was also associated with identification at a concrete rather than at a symbolic level.

It's quite, quite feelable, in the sense that I would at times of feeling inadequate think that they [patients] should rather go and see P; or J would know what to say under these circumstances ...

I would actually find myself repeating something that he had said to me the session before, because it seems to be absolutely the right thing for that other person as well ... (A)

There were fears about not being the kind of therapist (or as “good” a therapist as) these “superior” therapists had wanted the participants to be.

But initially I was afraid that he might not think that I'm a good therapist and that would like affect my reputation in the community. (B)

This had changed in tandem with the development of a known, trusted and reliable therapeutic third.

As time went by and we established rapport, I got that no matter how "bad" I was [omitted], he wouldn't have outing me in the community of therapists. (B)

As the therapeutic relationships had evolved (and participants had grown and changed), idealisation had lessened. An important facet of this was the participant’s also becoming aware of the therapist as a person/subject, rather than of him only being the omnipotent and omniscient one to emulate.

*R: What does it do, when he discloses his feelings?
BP: It immediately moves me from that place of feeling attacking to having empathy for the therapist, knowing what I'm doing, seeing the effect of what I'm doing on my therapist and feeling regretful, or at least seeing it for what it is. (BP)

In object-relations language this could be understood as BP talking about being in the depressive position (Klein, 1988a, 1988b). As BP (255) later emphasised, it was important that she could be aware of her therapist’s subjectivity without her feeling that he needed looking after.

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98 These are all reasons for feeling vulnerable as a professional. Of course there could also be more personal reasons, which are beyond the scope of this study. However, it is also true (even if we would like to believe it possible) that the professional and personal lives of therapists cannot really be so neatly separated.
Therapists and participants had accordingly moved towards being like subjects.

653 I think that as one grows up, you can always see blind spots and holes in your own therapist ...(A)

359: So the need is more a kind of sharing and hearing.
360 Somebody who I trust has also done this work; who knows what I'm talking about and has respect for that and therefore can help unfold some more of that; can appreciate what it is that I'm doing; who can, I suppose, continue to support my own belief in the importance of it.
361 So it's someone who has also been through their own analysis. (A)

359 As that began to move past, I had one of two reactions, depending on the import of the interpretation.
354 If we were working with something and he'd got something wrong I'd say: "No, W, that's wrong; I think it's like this."
355 And he would, if he felt I was right, he would correct himself and we'd just continue.
356 I used to feel that more as an alliance.
357 That it was good to have somebody to work with in that way. (D)

4.2.4.2 Negotiating power: moving from negation to mutual recognition
Despite all regarding their present therapies as good-enough, some participants described precarious moments of misrecognition, impasse and threatening rupture out of which the mired pair of participant and therapist had struggled to move. Such moments had often involved the therapist’s defensive need to preserve his position of power. What could ensue from this negative therapist attribute (which may be temporary or more enduring) may range from a collusive idealisation of the therapist to subtle and even crude boundary violations. Even the therapist’s defensively rigid allegiances to seemingly necessary prerequisites for and parts of psychodynamic therapy (for example, theory, adherence to the frame, lack of therapist self-disclosure, the use of interpretation, and so forth) may form antitherapeutic dyads that collapse the space of thirdness between therapist and patient.

Participant C described the power struggle that had ensued when she had not been the kind of therapist that her therapist had desired her to be.

359 I wanted to do the [omitted] course.
362 And I had started the first part and when I came back, I think JJ, I don't know if she was angry, but we worked at it and she said: "You know, it's funny, but when I go away, you kind of look for something else to mother you."
363 I disagreed with this and then she said to me: "Why are you going for this [omitted] course; it's some Mickey Mouse course."
364 And then, for the very first time, I got angry and I said: "How can you call that a Mickey Mouse course?"
365 Then she apologised and she said that she didn't mean that it was a Mickey Mouse course, but it wasn't psychoanalytical. (C)
However, this moment of negation had not led to an impasse, because what had followed (whether
in reality or fantasy) had made C feel that she had made an impact on her therapist; had been
recognised.

C: So there was a lot that was playing out between us and I also could
feel that she all of a sudden became more tuned in with me, because she
went and read up on all my notes.
She never told me that, but I just knew.
I just knew that, because she brought stuff into the room that
happened a long time ago and I thought (laughs): "JJ, you've read."
R: What it did mean to you that she read?
C: It meant that she spent time after hours; she thought about me. (C)

This was followed by the evolvement (along the trajectory of thirdness) of an intersubjective space
marked by *mutual recognition*, where difference could be negotiated. It is, of course, also possible
to argue that it is precisely these attributes of the therapeutic relationship (that is, mutual
recognition and the negotiation of difference) that had led to the development of this kind of
intersubjective third. The process of C’s anger being validated by her therapist and her therapist’s
both surviving C’s anger and having her own feelings and viewpoint, had also moved the therapy
beyond just being a repetition of earlier and dysfunctional relationships to being new and different.

C: That made me feel special, but I realised that there was something
deeper going on.
And then I was angry with her.
R: What made you angry?
C: It made me angry, because she told me what to do and I wanted to do
the course [omitted] and she's actually brought my thoughts into disarray
[omitted] and for a long time I was confused, but I'm going ahead now
with redoing the course.
And it also came in that she often felt that she had to be too much of a
mother to me.
And the mere fact that she allowed me to have my anger was just such an
eye-opener.
Because I was never allowed to be angry with my parents.
And I feel rooted in that, even if she disagrees and I'll then say to
her: "That's my path that I need to walk."
And I know that she will walk the path with me and not judge me.
She will work WITH me. (C)

These excerpts show how a therapy may veer towards becoming deadlocked and could potentially
run aground because of a power struggle. In the case of this participant, it had concerned the kind
of therapist she had wanted to become versus the sort of one her therapist had required her to
develop into. What had happened could be interpreted as ensuing from a “mistake” on the
therapist’s part. This “mistake” had been the therapist’s temporary lapse into attempting to use her
position of power to coerce the participant into submitting to her (the therapist’s) needs and desires
by becoming the version of therapist that she (the therapist) approved of (which was probably the
kind of therapist that she herself was). This could also be understood as the constellation of an
antitherapeutic dyad (which, by implication, had *negated* C) between the therapist and her
allegiance to *her* professional identity and the concomitant creation of a *negative third* between C and her therapist.

Nevertheless, rather than leading to an impasse, what had followed (that is, participant and therapist both surrendering to the process between them and negotiating their differences) had rendered this *a moment of negation* (in the overarching dialectic of recognition and negation) and had moved the therapeutic pair further along the trajectory of thirdness to a space of mutual recognition. Here alterity could exist and the power imbalance could (as far as this is actually possible in the therapeutic situation) be redressed.

### 4.3 THERAPIST “MISTAKES” AND THE DIALECTIC OF RECOGNITION AND NEGATION

#### 4.3.1 From non-recognition through negation to breakdown

Participant experiences of so-called therapist mistakes had ranged from non-recognition through temporary negation to irrevocable breakdown of the therapeutic third. Although some therapist acts undoubtedly constituted transgressions of the “analytic attitude” (Ivey, 1999), the participant’s felt experience of it (rather than just the act itself) occurred within the context of the specific nature of the therapeutic third (at that point and historically) and in terms of the degree to which it had positioned the participant as being disempowered and negated. Non-recognition and negation were often associated with the impression that the therapist had somehow become so involved in his own agenda and desires that he had withdrawn from the participant “into a state of solipsistic subjecthood” (Slochower, 2003, p. 466), that is, that he had lost sight of and contact with the participant as a subject and was relating to him as an object. That is typical of the problematic constellation of the therapist-patient dyad which was described in the *wounded healer* phenomenon.

434 I think it’s an insensitivity, where the therapist actually leaves the therapy room and goes entirely into his own process and reacts entirely from that process.

438 And then acts out something towards the client.

439 Unfortunately, in this kind of work there is always the danger of that, because the pulls and tugs are so extreme. (D)

Participant A made some thought-provoking comments, by both acknowledging the patient’s position as essentially being one of disempowerment and also questioning that notion.

672: You are in power as long as the patient is dependent on you, for as long as that lasts, but it is a power imbalance. (A)
To this she later added:

706 I think we all have within ourselves the capacity to say no to something that is really bad for you, even if you do love the person a lot; even if you do open yourself so completely, there is that.

726 In the final event we are adults seeing other adults.

727 None of us knows it all and certainly no one person can take responsibility for another person's fate. (A)

In terms of this study, a participant’s capacity to think critically about a therapist with whom there is a “loving tie” (Benjamin, 1995, p. 7) and to speak about this, needs to be understood against the template of him (the participant) as an individual within the context of the particular intersubjective therapeutic third. The participants’ also being therapists did empower them in a specific way: they were knowledgeable about therapy and they were accordingly (even if sometimes only retrospectively) quite aware of and able to describe their therapists’ mistakes. However, the ability to use this knowledge as such, varied according to the nature of the (moments or ongoing) experienced negation.

There were the unintentional (and probably unavoidable) acts of a therapist (like leaving for a prolonged period at a time when the patient was dependent on the actual physical presence of the therapist), when a participant would feel that he had been failed by the therapist and the therapy.

Then there were those instances of a participant’s being disappointed by a therapist, usually when the space of thirdness had been established and had evolved to some extent (and there was a sense of trust of the therapist and the process), where the participant had not felt significantly and “actively” negated, but had rather experienced non-recognition and some disconnection. Those momentary failures had usually been felt and understood as part of the therapist's idiosyncratic human failings, weaknesses or minor aberrations. Those occurrences could be accepted and forgiven. They had, in fact, often served the useful purpose of lessening the idealisation of the therapist and fostering the development of a more egalitarian relationship between therapist and participant. Because of the relative absence of disempowerment, such moments could also usefully inform clinical work.

358 And then, sometimes W gets on his “pluck” [sic].

359 He starts to deliver this long, rambling interpretation, which is going nowhere and I have a feeling it's going nowhere and then I just let him get to the end of it and then move on, because I have a sense that this is part of his sort of thinking out loud.

360 He's giving it to me, but it doesn't fit anywhere and I don't know what to do with it and it doesn't feel like the energy is there for a confrontation about it, you know.

361 So I just let it go past and then I'll move on to something else.

99 See A, 385-386, p. 142.
What I realise in my own therapy is, I have a very distinct feeling of when I'm going wrong. I think that that's born out of some of these mistakes that W makes, when he does make mistakes. It's sort of an empty feeling. And I'll say to the client: "I know it's not fitting." Then I either pull it back or see what the client does with it. I think what's been very useful has been the shift from the need for him to be right and to identify with him to something which feels a little bit more empathic.

Even within these good-enough therapies there had been moments of negation where a participant had somehow felt let down by the therapist. This was often accompanied by a sense of insufficient attunement, of being “missed” in some way, that is, being misrecognised. Recuperation from such moments could come about through the therapist’s capacity and willingness to acknowledge and recognise the validity of the patient's experience and to change while “surviving” this (even if only temporary and momentary) dismantling of his power. This did not necessarily mean the therapist’s giving up his own viewpoint, but rather the participant’s becoming aware that he had somehow affected the therapist; that is, had been recognised by him. In this context difference could be negotiated without its degenerating into an impasse situation.

After about a year of seeing him, I felt that he was focusing very strongly on my thoughts and was not really providing much kind of attention to my feeling life. I actually just said that to him. What was interesting is that he didn't interpret that to me as if it was about me. He took it in and changed the way he was working, ja. That was great, because it meant that he valued my therapeutic opinion as a patient. And I think that's also why I felt safe enough to say that to him. And I think, in retrospect I was correct, because he's changed his language. So he'll say: "Do you have any thoughts or feelings about that?" And he used to say: "Do you have any thoughts about that?" When I came in once, he was reading. And there's a chapter in that book "Forms of Feeling" called "Feeling". And he was reading that chapter, like two weeks later. So my fantasy is that he was reading that chapter to kind of remind him, because it is a really good chapter and it really is just about focusing on feeling in the room.

Now, that is just a fantasy of mine and I have no clue at all whether that's true, but it's true for me that he did that. He didn't challenge me in any way; he thought about it and kind of agreed. Kind of said: "Okay, so perhaps there is something about me not looking at your feelings that we have to think about." And so, actually, the irony is that that's different.

"In the end the patient uses the analyst’s failures, often quite small ones ... and we have to put up with being in a limited context misunderstood. The operative factor is that the patient now hates the analyst for the failure that originally came as an environmental factor, outside the infant’s area of omnipotent control, but that is now staged in the transference ... So in the end we succeed by failing – failing the patient’s way" (Winnicott, 1963a, p. 258). Self psychologists, especially Kohut (1971, 1977, 1984) highlighted the value of “optimal frustration”.  

100
I focus a lot on how the person's feeling. I can sit here and think that maybe my therapist actually didn't shift in his focus on my feeling at all. Maybe he just didn't challenge me on it and he thought about it. And that was enough for me to think that he was doing that. (B)

He did not own up (laughs), but almost by not owning up, it was like a silent acknowledgement of what was said. I feel free in the relationship to have a difference of opinion and to counter and I feel incredibly safe that that's possible and that I can talk about it and he can hear it and maybe it remains in some instances an ongoing dialogue. (BP)

There was an occasion where I became so hurt and angry with him that I actually decided to leave therapy. We had some exchanges on the telephone and he persuaded me to come back to at least resolve something. And when I went back there he said he'd been responding to something else, not necessarily to me. He is a very cagey man!

But I took that as an apology. And I went back to the therapy. (D)

Sometimes there will be this jarring feeling of: "I can hear an interpretation that's come from a book-understanding." She'll pick it up, she'll say: "Okay, something was wrong there." And we can go back to it and we can talk about it and we can go back to what is the experience. And maybe she's right. (F)

The participant could come to identify with the therapist’s undefended openness in being willing to “admit” his mistakes (albeit not in a submissive or self-effacing way) or to at least consider his own part (and not just as a transferential figure) in what had gone wrong. This “admission” may or may not have been verbal. Sometimes it was inferred from the way the therapist acted, or, more correctly, from the way that the participant perceived, imagined and felt that he (the therapist) acted.

There could be some relief in having somebody less than perfect to identify with: it could whittle away some of the participant’s own unrelenting expectation of himself to be an omniscient and omnipotent “perfect” therapist.

My therapist sometimes has made mistakes. Sometimes those have been the most useful part of my therapy. And she's actually been wonderful in that she's ridden through that. She's been able to just sit with that and acknowledge it and talk about it and that's been with me very strongly. Like sometimes when I have responded to a patient or I've done something wrong, done something that's been wrong for that person, she's been there with me. I thought: "You know, I don't have to cover this up, I don't have to, even though I feel so ashamed of what I've just said or just done or it's been wrong."

And you have those sessions where you know you've just missed the person. I mean, you haven't broken any major rules or had sex with your patient.

As can be seen in the examples, the extent of this “undefendedness” varied.
or anything like that, but even a little missing, being unempathic, being unattuned, saying the wrong thing, you can come out of a session feeling really awful.

I can say to myself: "But it's okay; I don't have to protect myself, I don't need to be defensive; it's okay, I can survive this; she's survived making mistakes, she's survived me being disappointed or angry." (F)

There had also been the kind of situations where the therapeutic third had become tinged with a distinctively destructive, negative quality, and where there had been a fierce, but unacknowledged jostling for power about whose reality should prevail. This was typical of what Benjamin describes in her notion of complementary twoness. In the participants’ thinking about their therapists’ mistakes, this was about the therapeutic pair’s collapsing into the unnegotiable and concrete polarities of one being at fault, and one not, where symbolic thinking and difference cannot exist.

Although the therapist could apparently emerge as victorious aggressor (to the participant’s submissive and vanquished victim), the participant could also empower himself by seeing the therapist as a weakened and no-longer-to-be trusted transgressor who defensively needed not to surrender her position of power. In Participant B’s descriptions of the process that had led to his terminating a therapy, the reversals of dominance and submission that mark such a continuing and intractable impasse could be glimpsed.

Where the therapist’s unacknowledged negation of the participant (usually in the form of frame breaks or boundary violations) had been of an enduring and/or destructive nature, this had usually signalled the irretrievable breakdown of the therapeutic third and even the precipitate termination of therapy.\(^{102}\)

\(^{102}\) This had not happened in any of the participants’ present therapies.
It also felt as if the therapist's own needs were quite clear. For instance, it was part of our agreement that his children could interrupt a session. So they were allowed to come into the therapy room when they wanted to show him a photograph or a picture or whatever and that was part of the therapy (laughs). So it didn't feel like a safe space to really let go and at the time I didn't really know it. I just thought well, once again therapist knows best and I'll try to accommodate within those boundaries. (BP)

And he was an incredibly quiet therapist, would literally not speak for weeks. And I remember the first time after two years when I actually got frustrated with him and said so about his silence, he became very punitive. And I think that was the end of that. I remained in therapy for a while, but I never trusted to actually speak again in the transference. So from then on the therapy moved out of the transference. I would not again get close to him to work at that level. It became speaking about things, not about the relationship. (BP)

Although it may leave him with the burden of an unfinished process, unilaterally terminating therapy is a last-resort choice that a patient always has. It may be an unavoidable way of fleeing a situation which seems irrevocably detrimental and/or may be a very effective means of retaliating (and thus reversing the power distribution) for what the therapist has inflicted on the patient or has not provided him with. Every therapist knows about the sense of failure he is left with if a patient (especially a therapist-patient) leaves in such a way.

4.3.2 Disidentification and learning from experience

When a participant had been able to think about these kinds of events as possibly being mistakes his therapist had made (that is, had been able to trust his own perceptions of what had happened and to reflect on this), a conscious decision about whether or not they were serious and important enough to take note of not to repeat, that is, to disidentify from (in the sense of becoming aware of their possible existence in his own work and endeavouring to act from this sensibility), thus learning from experience (Bion, 1962), was possible.

Because I know that if I had done that in my practice, that I've made a mistake, that the person's come and I haven't been here or something, I feel regret about that.

If I make a bungle-up of some kind, I will immediately apologise for it if I feel that way.

I don't apologise inauthentically if I'm not sure.

Then I'll just say: "Well, I'm not sure how this happened. Let's think about it, [omitted]." (B)
Grand (2003, p. 492-493) makes the interesting comment that regret, in contrast with the “paranoid-schizoid guilt which operates by the talion principle, … turns us inward in self-reflection and outward in recognition of the other”.

A participant could certainly use theoretical knowledge (which a lay patient would more often than not lack) to give validity to and back his conviction that his therapist had transgressed or failed him, and thus doing, empowering himself. However, even for these therapist-patients, unacknowledged negation of an enduring or destructive nature could be debilitatingly disempowering. It was almost “easier” not to feel “lesser” (in the sense of knowing what had happened) if what the therapist had done concerned some kind of relatively crude and unmistakable transgression (like an obvious boundary violation).

In participant E’s hesitant description of a particularly turbulent and disturbing time in her therapy, where her therapist had temporarily not contained E’s feelings of disintegration and abandonment (and where her therapist had for a time probably been what has previously been described as a negative container), E’s disempowerment could be patently sensed and found specific expression in her ambivalent feelings about whether or not her therapist had actually been at fault. Although E’s relationship with her therapist had recovered and survived that time, E’s account of it was suffused with the lingering and painful traces of her identification with that experience (that is, with the total intersubjective experience) of feeling so harshly negated.

Fuss (1995, p. 7) makes the thought-provoking point that what may appear to be a “refused identification” (that is, a disidentification), may sometimes rather be a “disavowed one”, that is, “an identification that has already been made and denied in the unconscious”. This resonates with the notion that, just as in the case of identification, acts of disidentification are “unavoidable and unthought” (Benjamin, 1998b, p. 20).

In the case of E’s therapy there had (at that point in time that she was discussing) not been the constitutive elements of the first and second clusters of thirdness (affective attunement, holding and containing) on which symbolic thinking is predicated. In the interview E had therefore uneasily grappled with reflecting on what had happened in her therapy and with not feeling so compelled, in her work, to do exactly the opposite to what her therapist had done (and thus perpetuating the renounced identification with her own experience of therapy); that is, to shift beyond just “unthoughtfully” disidentifying from that experience.

127 E: [Omitted] I really feel that I've been through the fire [omitted].
128 I'm also aware that I'm terrified of my clients' disintegration [omitted].
I think that one of the problems is that I don't know if I was particularly well held in that place.

*R: It was quite a frightening experience for you?

E: Absolutely terrifying.

I think that something very destructive was constellated in the space.

I think I needed reassurance, which I didn't get.

And I think that, in a sense, that in itself informs my work, because I think that I err on the other side.

I think that I am too reassuring as a result of having had the experience of not being reassured.

I think it's in the place of disconnection that I felt utterly abandoned and I think that, maybe, in my work, I'm sometimes not able to be sufficiently kind of distant, because I don't want my clients to feel abandoned and I think that sometimes that's anti-therapeutic, but I am conscious of it and I have begun to work on it.

I think that my analyst feels that it was a place that I had to go and I think that in hindsight, I would agree with that.

In a sense, there was no other way, but I think it was a place I could have gone to with a greater sense of feeling connected or held or understood or something ...

I think there's been an acknowledgement that my feeling abandoned was not just my stuff.

*R: So afterwards the two of you actually discussed this?

E: Oh, ja, at GREAT length.

*R: You're talking about a difficult experience in therapy; maybe of a mistake made by your therapist?

E: Ja, I don't know that I'm in a place where I could call it a mistake.

It felt like a mistake and I am aware that I have a diffidence about this.  

This can be contrasted with Participant F’s description of how, within the context of feeling recognised and empowered, it had been possible to use her therapy, including her therapist’s momentary failures, as a Third to think about her own work. F’s description speaks of the kind of symbolic therapeutic third described in the third cluster of the trajectory of thirdness, which is characterised by mutuality and a fluid back-and-forth movement of reciprocal identifications and disidentifications between therapist and patient.

There was a model of how sometimes to respond to people in a positive way as well as kind of the other side.

I remember sometimes hearing her say things and thinking: "I don't like that; why don't I like that?"

And then being aware of how I was responding to my own patients and trying to imagine how it might be sounding to them.

Just thinking about what it might be sounding like.

The easiest example to give you is kind of those times when you sit there and you hear an interpretation coming at you.

And it just doesn't, it just sounds as if it's out of a book, doesn't just quite make it.

I mean, I've heard those and I've said them to people.

It just made me like stop a little bit more, not always, not easily, because it's always a process of struggling, but just made me stop and think: "Okay, hang on, I've heard this and I know how false this sounds or how far from my experience this sounds when I hear it in my own therapy. Hold on a minute. How is this going to sound to this person? Is there any other way I can say it?"  

(F)
Iatrogenic (or even just disappointing or indifferent) therapy experiences had certainly contributed
to participants’ knowledge about what not to do in therapy and what therapy should not be like.\textsuperscript{104}

Those are things that I wouldn't like to repeat in my own therapy. And I'm sure I do it. I'm sure we all do it. But, you know, it is something I would like to guard against. (D)

I have OFTEN, often confronted my analyst on feeling that there's been a lack of responsiveness. I have often said that it feels as though I talk into the air and my words just hang in the air (laughs). I do think that one needs to be very conscious of one's responses, but to not respond, I think, is just inhuman... So lack of responsiveness is something that I think I don't want to repeat. (E)

However, these kinds of experiences had sometimes wrought real losses, which had left participants with regrets for forgone opportunities and a sense of mourning for what could have been different in their lives.

There were [omitted] occasions when W lost it with me. And I believe that had he reacted differently, the consequences to my life would have been different. I think he missed something at the time. And he got very angry with me for [omitted]. And I rebelled. So I went RIGHT into [omitted]. And I think if he'd been more gentle, if he'd been more empathic at the time, I wouldn't have [omitted]. And I'm always sorry I did. (D)

In contrast to these negative and even harmful therapy experiences, participants had also emphasised the abundance of goodness that they had received during the course of their therapies and how this had enabled and motivated them to share this with their patients.

I think my own experience of analysis has been a deeply respectful attitude to my faith and journey and defences, and that has been a very powerful model, I think, for me. (E)

I think that I largely feel incredibly respected in my therapy; I feel contained and I feel I'm not being rushed and because it feels so good for me and because I feel contented within that, it's almost like the contentment spills over and it's not an effort to give what I'm receiving. (G)

4.4 THE BRIDGE OF IDENTIFICATION

The participants’ accounts contained descriptions of what could be understood and interpreted as identificatory processes which were present both in their therapies and in their work. While examples of these identifications were primarily found in the manner in which participants thought

\textsuperscript{104} This is similar to what Macran, Smith and Stiles (1999) found in their study.
about and understood their experiences of the processes whereby aspects of their therapies were transposed to their work as clinicians, they also described identifying with their patients.

In their findings, Macran, Smith and Stiles (1999, p. 428) conceptualise personal therapy as being linked to clinical work via processes that they denote by using “the metaphor of translation”. According to them (Ibid., p. 429), “much of the translation seemed to involve tacit or procedural knowledge”. They contrast this with the imitations which also sometimes took place. Although they do not use the term “identification” in this part of their discussion, they do seem to imply the presence of processes of identification. More explicitly they (Ibid., p. 429) do write about “two important mechanisms that contributed to the translation”. In the first place, “the translation involved exploring and gaining insight into [the therapists’] personal problems and personal growth” (Ibid.). And secondly, “the translation involved the learning of reciprocal roles”; that is, what it is like to be both therapist and patient and using the knowledge of the patient role in working as a clinician. In this latter instance they also seem to be writing about some kind of involvement of identification, although, again, the term as such is not used.

Identification is often described by Benjamin as it pertains to parent and child. For the purposes of this study, identification was only considered as it concerned participant-patient and therapist, participant-therapist and patient(s), and this was done in terms of “ungendered” dyads. This means that the “gendered angle” of the participant-therapist and participant-patient dyads was not taken into consideration. That would have required specific questions in the interviews and a much longer and more complex analysis, which could be the topic of further research.

The desire and need to choose a therapist to emulate and to idealise were already evident in some of the participants’ descriptions of how they went about selecting a specific therapist. The participants described their experiences of identifying with their therapists: they noted similarities between themselves and their therapists, as well as between their own experiences of therapy and their work as therapists, and were also sometimes aware of their therapists’ internalised presences when they were working. As was previously discussed, they also described disidentifying from their therapists. The participants had also retained identifications (and disidentifications) from previous therapies and from earlier times in their present therapies. This supports the ideas of plural identifications (Benjamin, 1995) and of sustained identification involving both identifications and disidentifications (Pizer, 1998).
Benjamin’s thinking around identification and mutual recognition was dialogued with the interview material. This made it possible to conceptualise the nature of the participants’ identifications as varying between being more concrete and taking place at a more symbolic level. This had happened alongside the evolvement of the therapeutic third and/or according to the specific cluster of thirdness that was foregrounded at a particular time, and also in terms of where and how the participants had felt located in terms of the power differential between themselves and their therapists.

4.4.1 Choosing the therapist to emulate

Participants had been aware of the serious implications of their choice of therapist for their work.

257 And perhaps there was a certain degree of conscious modelling because I knew, I knew the therapist I was going to go to, I’m going to absorb that way of being in the room. (B)

182 I think that I will become and I will do therapy very much like my therapist. (G)

The significance of the choice of therapist had become more prominent as they themselves had gained experience and developed professionally:

254 So out of the three therapists, the first therapist was just on recommendation that I went to, because of my own personal hurts.
255 There was nothing there about me being a therapist that chose her.
256 But the second two were chosen in part because of the kind of therapist I want to be. (B)

Often the participant-as-patient’s therapist had been circumspectly and variously scrutinised and evaluated before the participant had felt ready to take the plunge into therapy:

101 I went to a conference and I watched senior people contributing and doing workshops and having talks and this particular therapist, there was something in the way that he was so incredibly clear about what he was saying and he was incredibly clear when he countered anybody in discussions.
102 So I suppose I was quite impressed with his intellect, but there was something in his clarity that also felt very containing.
103 It felt as if there were not too many grey areas.
104 He felt like a very containing, stable person.
105 So I think I felt safe to go to him as a therapist. (BP)

As expressed by Participant B, this often meant that an idealising transference had been set up even before the start of therapy.

247 I saw in this man a combination of deep intellectual and theoretical rigour, like he knew what he was talking about way beyond where I was theoretically, combined with depth, with great depth and feeling and at the same time, a spiritual trajectory in life.
248 I identified those strong features in him, and so I sought him out.
249 I said: "This is the person I want to go to therapy with."
250 So that transference of "these are the attributes that I want to be, these are the things that I want to have as a therapist myself" and me seeking him out as a therapist were there from the start. (B)
The assumption that the therapist has had or is having his own therapy, is one of the “givens” when one chooses to go to a psychodynamic therapist. The participants had found it meaningful and reassuring to think or to “know” that their therapists had also had the experience of analysis or therapy. That meant that they (the therapists), as well as knowing what it is like to do the work of therapy, could also identify with the participants’ experiences of being-patients and that also made them more equal partners in the therapeutic endeavour.

519 But it does still happen where something one of my patients is going through really touches something deep inside of me that is not necessarily negative, but I would like to share with somebody who would understand why it touched me so deeply.

361 So it's someone who has also been through their own analysis. (A)

As has been previously discussed in the section on therapist “mistakes”, the therapist’s identifications with a participant could also sometimes become problematic and compromise subject-to-subject relating within the therapeutic third.

4.4.2 The participants’ experiences of identifying with their therapists

The participants described their experiences of identifying with their therapists and how these had become links between their being-patients and being-therapists.

130 *R: So what do you do with what you experience in your own therapy?
132 B: I internalise it and I model, I model. (B)

90 I think I'm very consciously aware of going to my own therapist, seeing how he is able to contain me and allow me to get in touch with certain feelings or issues; not allowing me to veer off.

91 I would say that I model that behaviour when I go back to my own therapy, in my own practice.

94 I think it gets processed; gets internalised; it becomes mine. (BP)

306 Because of my experience with her, I watch her; I see how she does it and I like what she does, so I kind of internalise it.

307 I mean, it's not like I go to the next session and do that.

308 It is something that I have then internalised.

309 Then it just becomes awake again; one day in a session when a person may bring up something and then quite all of a sudden it flows out of me, as if I've internalised it.

310 So my learning has not been theoretical, it has been experiential. (C)

248 The way you were looked at and the way you were taught to look at yourself becomes the way that you begin to look at other people and look at yourself with other people. (D)

98 I've always thought of it like the parenting thing.

99 It's like a model of parenting.

100 You take on parts of it, you reject parts of it, you reflect on it and it becomes part of who you are.

101 My therapist is very different from me, but in a way she's become part of me.

469 Sometimes it's her words or I hear her way of phrasing. (F)
They were aware that this had happened in the context of their relationships with their therapists.

691  If the trust happens; you are much, much more open.
692  So I think it is almost like a kind of imprinting that happens, like with a baby.
694  And to make that process more conscious is a lot more difficult than maybe with supervision.
695  Therefore, again, the delicacy of that relationship is quite huge, the power ... (A)

240  But if I just want to sit here and be myself I'd say that I look at and I exist in relationship with this person, my therapist, and I find myself doing what he does.
241  He is a role model for me. (B)

The participants considered their identifications with their therapists as a fundamental part of learning “to do” therapy, rather than learning “about” therapy, that is, “learning from experience” (Bion, 1962).

178  In fact, I would say that my functioning as a therapist is ninety per cent due to the modelling that I have had on my three therapists that I have had and ten per cent due to my training ... (B)

Participant B further elaborated on what “doing” therapy would be like for a therapist who had not had a sufficient experience of his own therapy.

204  It's like saying you get your driver's licence, but you've never been in a car until you've got your licence and then you can get in the car, but you've read an incredible amount about what it's like to drive.
205  So you know everything about the car.
206  You can name all the things; you know how they work.
207  You might even know how the engine works, but it's COMPLETELY F****** IRRELEVANT, totally irrelevant, until you've been in the car behind the wheel and your body, your body has had to function there, what you know is really just fleeting, it's fleeting bits of knowing and huge amounts of information.
208  Whereas I've a huge amount of knowing and oftentimes fleeting bits of information (laughs). (B)

4.4.3  Identification at an unconscious/non-conscious level

Generally the participants had not consciously or deliberately “imitated” their therapists. One could expect that the conscious and purposeful imitation of the therapist would be more common in paradigms (such as cognitive-behaviour therapy) where the emphasis in bringing about change is less on the therapeutic relationship than on the use of specific techniques which need to be theoretically and practically taught and learned.

Although the participants had an awareness that that what they were doing as clinicians was related to what they had experienced in therapy and to what their therapists had said or done, these identifications were often unconscious/non-conscious.

134  It's sort of preconscious and partly unconscious, I think.
In their work as clinicians, participants had found themselves doing or saying what they had experienced as their therapists’ acts or words and had realised that that was what was happening, but they usually had no awareness of a conscious intention to repeat their own experiences in therapy in their work. This “awareness” may be seen as being constituted by the many and different occasions when a participant had noticed what he or she had done or said or thought during or after such an event. Wiseman and Shefler (2001) also mention this in the findings of their study.

Sometimes, although a participant would find himself repeating something deriving from his therapist (like a gesture or a sound), he would struggle (or find it impossible) to repeat this consciously and deliberately. This type of non-conscious identification seems to be more based on procedural knowing or memory and less on declarative or explicit knowing or memory.

4.4.4 What participants identified with within the context of recognition

Put into rather simplistic and colloquial terms, one could say that when a participant had experienced his therapist as recognising him (and this could happen in different ways and on different levels) and/or what his therapist did as ultimately beneficial and in his best interests, this was frequently identified with and used in his (the participant’s) own work. The benefits the participant would experience from such a process would also often include becoming freer of the difficulties that had been addressed in his therapy.

Whatever makes sense to you, you pass on.
And that’s the process of integrating ...

So if I see my therapist doing something and it works for me, I model it.
Sometimes I might hear myself saying something that my analyst has said and then I recognise it and I am very conscious of using interpretations and insights gained from my own process.
I am very aware that, interpretations, insights that have made sense to me, they kind of wake me up to something new that I will use.

These are concepts deriving from attachment theory: within that context their use represents an attempt to integrate cognitive science and psychoanalysis. According to the Change Process Study Group of Boston (Fonagy, 1998; Lyons-Ruth, 1999), attachment research has recently provided consistent support for the idea that significant dimensions of relational behaviour are grounded in relational history. This process results in meaning systems that include procedural forms of knowing or memory (which include implicit relational knowing) that do not rely on verbal forms of thought. It is, of course, a controversial issue whether or what aspects of infant functioning, as depicted by infant research, should or could be extrapolated to adult functioning (Flax, 1996; Wolff, 1996; Green, 2000; Ryle, 2003).
Mackey and Mackey (1993, p. 108) describe how personal therapy had helped their participants “to nurture knowledge, values and skills by way of identification with psychotherapists who became models of professional practice”. According to them (Ibid., p. 103), this modelling has to be understood as happening within the context of a “mutual and collaborative” therapeutic relationship. This resonates with Benjamin’s ideas around the kind of therapeutic relationships characterised by mutual recognition.

In the following excerpt Participant B described his use of a specific interpretation made by his therapist (96-97). This interpretation had both been accurate (or “fitted”) and had been presented in such a way that he had felt recognised (104-119). It had also led to a shift “out in the world”, so it was obviously something that worked and made sense on an experiential level (121–122).

96 And I still, actually, now in my own therapy, when I see that dynamic in someone, use the exact same words that she used to me ...
97 And so I don't know what's that about, but there's no question that that was directly picked up, that I use that as a therapist, that particular interpretation of being discovered.
104 She didn't say "you get caught" or something like that.
105 It changed it for me.
106 It described it perfectly, but in a way that I could accept as being okay.
112 It described the experience accurately, but described it with words that had a positive connotation and indicated that she could see me.
119 So I had that experience in the room by virtue of her making the interpretation and just being fine with it and just waiting for me now, you know.
120 And, secondly that meant to me that, actually, maybe there was nothing to discover, that it was an anxiety itself.
121 Then so out in the world, when I felt those feelings, [omitted] somehow that insight shifted the anxiety.
122 And I don't have that anxiety any more, at all. (B)

In this excerpt it seemed that Participant B had used his therapist’s interpretation directly (“the exact same words”) without really making it his own, but he qualified this:

129 The way it worked, or the way that it does work is when I recognise the neurosis, my own neurosis of that time in a patient I am working with, when I get that sense of, okay, I know this, because I've been in this, okay, then I'll offer the same interpretation, obviously adjusted for the uniqueness of that relationship, but basically the same interpretation that my therapist offered to me, now it would be six years ago. (B)

The existence and nature of what has previously been denoted as the moral third (Benjamin, 2001, 2002), or the therapist’s agapaic attitude towards his patients, may often be traced back to his experience of his own therapist’s steady, reliable and concerned presence (Lambert, 1981). What a participant identified with therefore encompassed both the actions of the therapist, as well as the therapist’s attitudes towards the participant and the values held by the therapist that the participant perceived those actions to be embedded in.
I think maybe the most important thing for me has been - what I've picked up is a sense of complete respect, interest in the patient.

It feels as if I'm working with somebody who is completely there, completely interested, completely respectful of the process.

I think his immense patience in therapy has taught me something about respect for the patient. (BP)

*R: Having had that kind of experience of trust in your own therapy, I wonder what of that you take to your work?

C: I'm able to portray to my patients trust and patience and a non-judgemental attitude and being aware that it's OK, if you've got a secret and you're not ready to tell me yet, then don't, but it will come out if you want to.

So, in other words, I don't say that, but that's psychologically what I bring across to them.

If somebody had given this to me theoretically, it wouldn't have come as alive to me as the therapy way. (C)

I think my own experience of analysis has been a deeply respectful attitude to my faith and journey and defences and all of that, and that has been a very powerful model, I think, for me. (E)

These experiences of his own therapist and the therapy process could therefore, in an experiential and very personal way, significantly contribute to the participant’s own ideas and convictions about what kind of therapist behaviour, attitudes and values are useful, ethical, responsible, creative and so forth. This consequently pertains to what it is that is required of the therapist, both in overt behaviours and implicit attitudes and values, to render therapeutic space both safe and generative of new meanings for the patient. In its turn, disidentification would (as previously discussed) often happen in the converse way.

4.4.5 The “presence” of the participant’s therapist in the clinical third

At times, especially when feeling uncertain or doubting his own abilities as a clinician, a participant would, either unintentionally or more deliberately, evoke and use his therapist’s presence in a way that was reminiscent both of what Casement (1985, 1990, 2002) calls the “internalized supervisor” and what he denotes as the “internal supervisor”. Ogden (1988, p. 652) comments on how analytic and psychotherapy trainees unconsciously identify with an idealised version of their analysts/therapists (“an omniscient internal object”) as a defence against their own anxieties of “not knowing”.

106 When the evoked therapist presence was used quite concretely and directly, this would be similar to what Casement (2002, p. 47) calls the “internalized supervisor” (which in this case would be the “internalized therapist”). The notion of the “internal supervisor” refers to the therapist’s own capacity to be reflective (that is, to sustain his own autonomous thinking) when doing the work of therapy (also see p. 142). When the participant, rather than making concrete use of his therapist’s presence (for example, the therapist’s actions and words), employed it to inform his own thinking, that would thus be more comparable to the notion of the “internal supervisor”. Casement (Ibid.) comments that both the “internalized supervisor” and the “internal supervisor” are important: the former plays a pivotal role in the development of the latter and the “internalized supervisor” is often drawn upon at moments of uncertainty. He (Ibid.) describes a dialogue between these positions as being essential in order to process and make appropriate use of the “internalized supervisor’s” thinking in the immediacy of doing the work of therapy. This is similar to what these participants described in relation to their use of their therapists’ presences in their work.
A participant would find himself imagining what his therapist would have thought, said or done in a similar situation and use this as a directive for his own actions. Such a participant might also have become aware that because what he was doing was similar to (or even “exactly like”) his therapist’s words or actions, he was creating what one may call a “mimetic resonance” (Benjamin, 1998b, p. 97) with his therapist’s actual presence.

Sometimes I will find that I will laugh, not laugh, I will smile a certain way and I'll sit in a certain way.

And I'll think to myself: "Why am I sitting like this, what is it that I'm doing?"

Then I catch myself wanting to be like JJ. (C)

I've actually heard myself using some of the same kind of grunts.

He has a particular thing, I don't know what it means for him, but if you're talking and he's obviously thinking or he's writing, he'd say something like: "Hmmm" in about that kind of tone.

And I find myself actually saying: "Hmmm" (laughs)!

And then I think: "That's W!"

So that's one of the ways that I experience him present, almost as an identity, which I have taken on. (D)

When the participant’s anxiety was linked to a feeling of his being, to a greater or lesser degree, not as competent a clinician as his therapist, the “internalised therapist” could, on the one hand, be experienced as a benignly helpful and supportive figure whose clinical expertise and thinking the participant could attempt to emulate. This idealisation would usually diminish when a participant was (or became) aware of and able to think about what was happening.

Sometimes I will think: "What will JJ do now?"

But then I'm just like: "But why am I thinking what JJ would do, what would I do?" (C)

However, participants had also sometimes experienced a critical “inner voice” about not being as capable as their therapists.

It's quite, quite feelable, in the sense that I would at times of feeling inadequate think that they should rather go and see P; or J would know what to say under these circumstances ...(A)

She [the therapist] also sometimes is there: "You know, maybe this patient should rather go to JJ, because she can do a better job than I can do." (C)

One way to think about this critical “inner voice” would be in terms of its being an unmediated merger between an internalisation of the therapist’s (real, perceived or fantasised) critical attitude towards the participant’s abilities as a clinician and the participant’s own critical and punitive “inner voice” (that is, in Freudian terms, a punitive superego, or, in Jungian terms, what Participant E, 403, called a negative animus).

This raises the important issue of how a therapist may be self-critical without being paralysingly judgemental of himself. The therapist often moves on the slippery slope between being responsibly
self-scrutinising and reflective of his own work and being unproductively and harshly judgemental of it. While it has been found that more effective psychodynamic therapists are more self-critical (Najavits & Strupp, 1994), Benjamin (2001, p. 14) also cautions that when there is a conflation of self-observation with submission “to a person or an ideal”, judgement of oneself (rather than a Third to use for thinking) ensues. While such a person or ideal may serve as a Third that structures the dyad, the therapist’s submission renders this an antitherapeutic dyad rather than a “true” Third. Not only does this submission expunge the therapist’s subjectivity, but his ability to engage in subject-to-subject relating with the patient also becomes compromised. Frankel (2003, p. 513) remarks on how the therapist’s attempts “to salvage some feeling of psychic existence” in such a situation may actually lead to misdemeanours on his part.

As previously discussed in Section 4.3, the participants had, within the context of not feeling significantly negated by and/or feeling disempowered in relation to their therapists, identified with the (their therapists’) attitudes, thinking and acts that had accompanied and followed such therapists’ “mistakes”. This had provided a reassuring and useful way to think about surviving being less than perfect and had placed therapists and participants on a more equal level.

To return to the participant’s evocation of his therapist’s presence: it was also a means by which a participant could employ the emerging therapeutic third as a Third to contain disturbing affects, such as anxiety, which had originated in the clinical third.

266 I've experienced him present when suddenly something a client is doing, is quite similar to something that I've done or he's interpreted.
267 You know, actually feeling him present.
268 I had a case today, in fact.
269 A guy is [omitted], as I am.
272 Which was the process that I had with [omitted].
273 And then as this was sort of becoming clearer and I could see the similarities.
274 I could actually feel myself back in my session, and remembering some of the things that W had been saying, you know, around that.
275 And that was then very useful to be able to formulate interpretations for this guy.
276 I felt contained still by W in working with this chap. (D)

Such identifications could, when “played” with and made the participant’s own, be a useful way to think about his own work and could thus be conceptualised in terms of the therapeutic third being a Third to the clinical third.

626 What I like about JJ, is that she can be in the room and she trusts the process and she does it with her beingness, her presence and I use that with my clients, but not that I'm JJ.
627 I've internalised that and I've made it my version. (C)
478 It was just these odd little experiences, every now and then of, particularly, I think, sometimes when I was lost.
Like: "Okay, I can draw on something I've heard somebody else say."
Like it broadened my repertoire rather than changed it or captured it or closed it down.
I could still use all of who I was and how I would respond, but sometimes when I was stuck I could borrow a phrase from her. (F)

The participants' accounts had therefore depicted identificatory processes marked by specific experiences of evoking, becoming conscious, or making use of the internal representations of their therapists in such a way that the therapists became actual imagined presences in the participants’ own therapist-patient dyads. Such a therapist presence could be a useful Third to participant-patient dyads or form an antitherapeutic dyad with a participant.

This phenomenon could pertain to the “presence” of one therapist or to an awareness of the availability of a composite figure, constituted over time by identifications with various therapists. The participants recounted retaining identifications with their present therapists, as well as with therapists from other and previous therapies. This is similar to Wiseman and Shefler’s (2001, p. 138) finding that there may be an “internalization of a number of therapists … at different stages of professional life”.

For example, Participant B described how his inadvertent identifications with his therapists had caused the actual physical space of his own therapy room to become permeated with the echoes of the presences of his current and past therapists and therapies.

They are always present in the room; all three of my therapists are present in the room in every session that I do and that I'm conscious of.
I mean, even the room, even my therapy room here, when I look at it, I'm amused, because I can see, I can see my first therapist in this room, like this here (points) is my first therapist, the candle is my first therapist.
I can also see my current therapist strongly in the room.
All the figurines, even this carved bookcase, the couch, even the covering on the couch, to some extent.
And here with the physicalness of the room, I'm literally internalising, even the leather chairs. (B)

This had extended to words and gestures.
She did this (moves head) with her head, it's a kind of lift of the head, I can't even do it, but I do it ...
And when I do it, I know that that's S.
And I know that I do things that work, because when she used to do that, I used to feel like: "Okay, she's got it."
I've said something and she's understanding me because of this particular kind of nod of the head.
Like my current therapist, he uses certain words.
He uses the word “tricky”.
Now, I never used that word “tricky” before.
So that is quite tricky or this is tricky.
And it's a very good word, because again, it's like a non-judgemental, descriptive term that is incredibly useful, because it indicates a
struggle and some difficulty, but it also indicates the possibility of resolution, at the same time and an acknowledgement of complexity ... .

I use that word all the time, now. That's my therapist's word. (B)

The cumulative effect of this phenomenon could be described as the participants’ over time having gathered a kind of reservoir of useful identifications (and disidentifications), deriving from previous therapies, as well from their present therapies.

So over time you collect a lot more of those experiences. And I actually have in fact experienced several different therapists with different approaches and different natures, so that also broadens my own experience base of different kinds of relationships that can work ...

Ja, so they become a constant presence in me. The longer I work, I've got more than one person to call on. (A)

And in earlier therapies that I've been in, at times things happened that were profound for me and which would still be part of what I would do in my own therapies. (BP)

This forms a central part of the therapist “tool kit” (A, 281), which consists of the various resources on which a therapist may draw during the course of the work of therapy.

4.4.6 The changing nature of participants’ identifications with their therapists

Participants described identifying with their therapists in a variety of ways. These different kinds of identifications may be considered by first taking into account their contents. These had ranged from being quite concrete and simple to abstract and symbolic: from attributes of the therapist like clothes, the furnishings of the room, to gestures and sounds made by the therapist, to specific words spoken and specific interpretations given by the therapist, to dealing with certain situations or issues in therapy in the same way as the therapist. Finally there was a sense of sharing a state of being with the therapist.

Even when participants had repeated the actual acts and words of their therapists, this had not seemed like conscious imitations, but rather as deriving from identification at a concrete level. This differs from the results of the other qualitative studies (Mackey & Mackey, 1993; Macran, Smith, & Stiles, 1999; Wiseman & Shefler, 2001) in that they described their participants as both imitating and identifying with their therapists. Although the participants in this study had sometimes apparently imitated their therapists, this was usually not done consciously or deliberately, and had often involved therapist acts that they would find themselves spontaneously and easily replicating in their work, but would struggle to repeat intentionally. As Benjamin (1998b, p. 20n2) points out, the “act of identification” is not deliberate, but “unavoidable and unthought”. These participant acts had furthermore appeared to be based on procedural rather than declarative memory, which would
also be indicative of the involvement of identification (Pugh, 2002) rather than imitation. I think that one needs to be careful not to conflate imitation and identification, nor to confuse imitation with imitative acts deriving from identification at a concrete level.

Participants had found themselves engaged in or had become aware of speaking or acting in ways in which they had recognised specific words, acts or characteristics of their therapists.

141 And interestingly enough, that wall hanging there, which I unconsciously bought when I was overseas ...
142 When I went and I put it up, when I went back to my therapist's room, I noticed that he had that same wall hanging. (B)

227 There is a pair of shoes that I bought.
228 I didn't even realise, but they're the same shoes as those of my therapist.
229 And then when I went to therapy, I could see that he was wearing them, and I clicked.
230 And I speak about this in my own therapy. (B)

92 So I do find myself using similar ideas, words, it's true, definitely, and they're very useful. (BP)

73 I remember those first couple of years, being in my therapy and hearing my therapist say things and hearing her respond in certain ways and then doing it myself and hearing sometimes my own, you know, her words coming out. (F)

These could also be thought of as mimetic identifications whereby a sense of the therapist's presence and the shared affective connectedness, such as the “loving tie” (Benjamin, 1995, p. 7) between participant and therapist or the participant’s relatedness to the therapist as the literal embodiment of the ideal other, may be invoked.

There were also those instances where a participant’s identifications with his therapist were marked by the feeling of sharing a state of being, that is, the same particular co-created intersubjective space, with the therapist. This appeared to indicate a more evolved level of identification than the more concrete identifications.

145 It's like I'm internalising a way of being. (B)

638 I mean, JJ will sit, and I've learned that from her, to be comfortable, and her whole manner, the way she sits.
639 It's not the way she SITS, it is the way she IS, that's what I've adopted from her [omitted], because I feel comfortable with it, so I'm not in the room wanting to be JJ, I've internalised her being, but through me, if that makes sense? (C)

192 I would say that it's the way of being that I have experienced and that way of being comes through in the way of being in my own therapy room and I think I give permission to my patients to be in a different way to before. (G)
These kinds of identifications would be typical of what one could expect when the quality of the emerging therapeutic third is like that described in the symbolic third, that is, the third cluster of the previously described trajectory of thirdness. This is where reciprocal identifications and disidentifications between therapist and participant would be taking place in the natural and fluid rhythm of the therapy. At such times participants were able to think reflectively about what they had experienced in their own therapies in relation to clinical situations, rather than specifically just repeating what they had experienced themselves. There was also the feeling that if what a participant did or said in his work, was linked to his therapy, this no longer just “belonged” to his therapist and had been appropriated as such, but rather that it had become part of the shared thirdness that is “beyond identity” (Benjamin, 1998b, p. 74) between participant and therapist, as well as becoming uniquely his (the participant’s) own. The idea that what was identified with, paradoxically both belonged to and did not belong to the participant, could furthermore be understood as these identifications serving as transitional objects in the potential space (Winnicott, 1971) between participant and therapist (where symbolic thinking becomes possible) and also bridging the therapeutic and clinical thirds.

The ways in which a participant had identified with a therapist at a particular stage of therapy, appeared to depend on both the participant’s sense of his own worth and competence as a therapist in relation to that of his therapist, and on the quality and stage of emerging mutual recognition or thirdness in the therapeutic third.

In the beginning you're like a sponge; you take it all in and pass it on. Later on, when you get your own shape a bit more, you become a bit more discriminating around what you take in and pass on. You become more sure of how you would do things as opposed to how this person would do things. In the beginning you think that nobody should see you; everybody should go and see somebody else rather than you: some wiser, older person. (A)

D: So there was an idealisation of W and there was the introjection of him as an identity, as an entity that I would then piggyback on. *R: That piggybacking would appear in your work? D: Yes, yes, less and less now, but certainly back then, quite a lot. Even my initial using the couch and I've had a couch for years, but my initial using the couch was part of that introjection. Initially I used the couch in exactly the same way as he does. Then I wanted to put everybody on the couch. Now I am very circumspect about whom I have on the couch. (D)

When I first came into it, I just sort of grabbed it and gobbled it. Now I sort of say: "Do I really want to do this; does it make sense to do it?" (D)

Sometimes it's her words or I hear her way of phrasing. That was much more in the beginning, when I was a beginning therapist and tried to find my own identity as a therapist.

And I think I'm secure enough in that now that it's my words ... (F)
In these descriptions of how the nature of their identifications with their therapists had “developed” over time, it is clear that the participants had often experienced the more concrete and less evolved identifications as entailing a sense that aspects of the therapist or the therapist as a whole had been indiscriminatingly incorporated and had been merged with rather than becoming their own in a more thought-through way.

In further reflecting on the ways in which the participants had identified with their therapists, one may therefore consider the contents of identifications against the backdrop of the power balance between participant and therapist. This, in its turn, could be connected to where the therapy was (in its history and at that particular moment) in terms of the (earlier and later) clusters in the trajectory of thirdness. When the participants were feeling “lesser” than their therapists as therapists, identifications tended to be more concrete in nature; when there was more mutuality, identifications would move towards being increasingly abstract and symbolic. How a participant had experienced the distribution of power within the therapeutic third, was therefore a central factor in the constitution of the nature of identifications with his therapist at particular times.

The participant’s identifications with his therapist could be understood to have different functions within the therapeutic third. It could be the participant’s “lived practice” (Harris, 1998, p. 46) of the longing to be like and to be closer to the one who knows how to be a therapist and/or a way of submitting to this ideal other. Identificatory processes could also be ways to become closer to and forge the emotional connection with this ideal other within a process where recognition by the one who knows how to be a therapist had gradually transformed the participant’s ideal love (Benjamin, 1988, p. 100) for this powerful other to an increased “sense of mutuality” (Gerhardt, Sweetnam & Borton, 2000, p. 27). Within this context of growing mutuality, the nature of these identifications would, in its turn, also tend to move from being concrete to more symbolic.

These identifications with their therapists were evident in and became part of the participants’ manner of relating to patients in the clinical third. How these identifications were used by participants in the clinical third, was not just determined by the therapeutic third, but rather by an intricate interweaving of the therapeutic and clinical thirds. For example, a participant could, when feeling unsure of himself as a therapist, attempt to manage his anxieties by unthinkingly and concretely using his therapist to shore up his sense of himself a therapist. This holds the danger of the therapeutic third forming an antitherapeutic dyad with the clinical third. On the other hand,

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107 This is somewhat similar to Mackey and Mackey’s (1993) finding that students and novice therapists are more inclined to imitate and idealise their therapists.
evoking a sense of his therapist’s presence by (sometimes even concretely) identifying with him, may render the therapeutic third into a containing Third for the participant’s anxieties and, as such, instead of his being subsumed by these, enable him to become free to engage with patients in a subject-to-subject manner and to recuperate the ability to think about what is happening in the clinical third.

If the nature of the participant’s identifications with the therapist is regarded against the template of the evolving trajectory of thirdness and the accompanying (intrapsychic and intersubjective) changes that are wrought during the course of this process, I would further propose that the “earlier” identifications are generally qualitatively different from “later” ones. In this I differ from Wiseman and Shefler (2001, p. 138) who describe their participants moving “through complex processes of imitation and identification towards individuation”. I would rather not put the participant’s identifications with his therapist and his individuation as the beginning and culmination of the participant’s progression towards individuation, but would see the identifications themselves as being located on a continuum ranging from being more concrete to symbolic, and changing in tandem with a movement towards individuation (or the participant-therapist’s becoming increasingly able to engage in subject-to-subject relations with patients).

4.4.7 Identification in the space of mutual recognition

There were examples of how the subtle interplay of reciprocal identifications and mutual recognition could free a participant from his own issues, thus enabling him to work from his own subjectivity without losing sight of his patient’s subjectivity and to usefully draw on his identifications with his therapist (by whom he felt recognised) and his (the therapist’s) way of working in doing his (the participant’s) work as clinician.

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108 I use the term generally, because, as previously discussed in the section “The trajectory of thirdness and clusters of thirdness” (p. 75), although the process of therapy and evolving thirdness implies a certain developmental progression, this is not linear or sequential.

109 This resonates with Casement’s (2002, p. 47) distinction between the “internalized” and “internal” supervisors and the ongoing dialogue between these two positions. See also p. 142 and p. 165.
He just offered some observations about it ...  
But I could feel that he was not, I could feel that he was not trying to make me come.  
And up until that point I used to fall into that trap in therapy if I had patients that were doing that kind of push me pull you.  
I'd confront them; I'd feel a little bit angry.  
I would be attached to whether they were coming on not.  
I'd be invested in them coming or not in a neurotic way ...  
The reason that changed was not because of supervision, although I was in supervision.  
It wasn't because of anything.  
It was because I somehow got through something in my own therapy and that stopped that whole thing of like not wanting to go, wanting to come, that whole struggle, you know, just spontaneously just sort of dissolved into a different place, never to return since then.  
And that's been about three years.  
And in my own therapy, I mean, when I was doing therapy, then patients of mine that were doing this, I'd just let go of right away INSIDE.  
I let go INSIDE in the same way that he did.  
And that was not a verbal thing.  
That was more like a feeling thing.  
That's been great.  
*R: Something very important happened there.  
B: That was critical.  
And when I look back at my early days of working, I just see endless mistakes of that.  
Endless mistakes of losing, of patients terminating when they actually wouldn't have, because I was holding on too tight and they had to actually get away.  
*R: What is that holding on too tight about?  
B: It's an anxiety ...  
For me, it's partly about abandonment.  
It is a bit of a theme in my life, in my early history.  
My patient wants to leave, so they are abandoning me, you know ...  
There were a number of reasons.  
But it didn't actually matter, because in the end I simply modelled on how my therapist works, even though those issues are still there.  
It's not as if I don't have abandonment issues, I don't have financial anxiety, or I don't feel that the person's work is not complete yet.  
I still might have all those, but because of the way he was with me around that and I saw how that worked out, because I saw what happened to me as a patient, I choose that way to be.  
*R: One could say that you had some kind of issue of your own that came alive when you were working.  
B: Exactly.  
I had a neurotic matrix, if you like.  
There was a little abandonment neurosis, you see, of my own, which I hadn't finished working through and all the patients that I saw, until I had finished working through, had stepped into that matrix with me and those therapies failed.  
And once I had worked through it in my therapy, since then, when most patients step into that neurosis with me, when I get into that countertransference, if you like to use that term, I succeed largely, because I'm not stuck to it, I can see it and I hold it and I can move with it.  
*R: So it's not that it's not there ...  
B: It's totally there.  
Those things come up for me but I'm not attached to them; I'm not in automatic mode; I'm in manual mode.  
I hold them and I don't allow them to ...  
I don't take the bait, even though I can see the part of me that wants to.  
I can say: "Just hang on here one second."  
I can contain my own anxiety.
For me, that particular little neurosis means grief work. It means that I have to let go of the person, that’s what I have to do. That’s MY work, which was modelled by my therapist, who used to let me go. And so I didn't then have to push him away. That's crystal clear for me.

This is the kind of situation that Russel (cf. Slavin & Kriegman, 1998b) aptly called a therapeutic crunch. It could easily have degenerated into a power struggle between participant and therapist, which could have propelled the therapy into the complementary twoness of an impasse leading to a collapse of thirdness. As B himself indicated and had himself experienced (307-310), what B did could threaten his therapist's feelings of worth as a therapist and evoke issues of abandonment. However, the therapist did not get caught up in his own desires (299-302), but was attuned to B (317-318), held and contained him. That is, the therapist recognised B and even introduced some difference (304). The accommodation by the therapist (306) meant that B did not need to resist and oppose him (391). The therapist’s recognition of B (and, by implication, his identification with B), also made it possible for B to think and feel differently about his own “dim spot” or “wound” (327-330, 377-378), to be less consumed by it (313) and to become able to contain it himself (379, 382-387). In his turn, B was able to recognise (303) what the therapist had done, to identify with that (316, 340, 390), and to think about this identification in relation to what he was doing in his work (341-342). Thus the therapeutic and the clinical thirds had become linked (390).

This extract contains many of the elements constituting the unique way of “learning to do therapy” (rather than “learning about therapy”) that the therapist's personal therapy offers. It is also about becoming enabled as a therapist. This becoming is an ever-continuing process of growth and development in the face of one’s own limitations. The Third provided by the clinician’s personal therapy in this way is different from the third perspectives provided by theoretical knowledge or supervision, but is also linked to those Thirds, and is as such both informed by them and informs them.

This is the point in the therapy of a participant (usually when the nature of the therapy is as it is described in the third cluster of the trajectory of thirdness) who is both patient and clinician, where one may conceptualise identifications as fluid processes linking the therapeutic and clinical thirds which continually shift together and move apart in a rhythm that is constituted by the many complexities involved. In this instance, the participant’s therapy was a Third that opened up a space for thinking and reflecting, rather than forming an antitherapeutic dyad (which, by implication, could have excluded the participant’s patient) with the participant.
4.5 THE PSYCHOANALYTIC CONSCIOUSNESS AND UNCONSCIOUS AS EMERGING THERAPIST SKILLS

During the course of the data analysis it became evident that it was necessary to create a theoretical context in which the therapeutic skills that the participants had developed owing to their therapies could be described, understood and thought about. These skills specifically concerned the ways that a participant was increasingly able to use his own subjectivity as a basis for knowledge that could inform the tasks set by the endeavour of psychodynamic psychotherapy. The use of the existing notions of a psychoanalytic consciousness and unconscious to denote such therapist skills therefore ensued from the nature of the results of the earlier phases of the data analysis. In this section the conceptual elaborations of these notions were dialogued with the data to make sense of the way that the participants were thinking and talking about their therapies and work during the interviews and also to understand certain aspects of their descriptions of their therapies, work and the links between those. Because the theoretical background used in this section is based both on relevant literature and the prior discussions of theory and interview material, it is presented here rather than as part of the previous chapter about the conceptual underpinnings of the textual analysis.

4.5.1 Personal therapy and the notions of a psychoanalytic consciousness and unconscious

In psychoanalytic theorising there has been and is an emphasis on the notion of the therapist’s engendering the creation and continued existence of analytic space. Analytic space, the variant of potential space (Winnicott, 1971) that emerges between therapist and patient, is an “invitational space” (Ivey, 1995, p. 367), which is initially established by the frame or ground rules of therapy (Langs, 1982). The frame demarcates the world of symbolic communication from ordinary life; establishes the unique quality of patient-therapist relating and provides a bounded space in which it is safe enough for patient and therapist to do the work of therapy and for thirdness to emerge. Therapeutic space can be viewed as “an extension of the maternal body container” (Benjamin, 1998b, p. 26), where holding (Winnicott, 1960b, 1960c) and containing (Bion, 1959) give “coherence to the self” (Benjamin, Ibid.) and consequently make reflective and symbolic thinking possible.

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110 See also p. 56.
111 In this case potential space (Winnicott, 1971) is usually considered as the interpersonal and transitional area of experiencing, a shared “state of mind” located between individuals “based upon a series of dialectical relationships between fantasy and reality, me and not-me, symbol and symbolized, etc.” (Ogden, 1986, p. 231). “Potential space furthermore refers to that kind of mental organization in which the precursors to symbolization find their shape – where ‘me’ is barely differentiated from ‘not-me’…” (Freedman, 1994, p. 99).
112 Although the notion of analytic space resonates with that of co-created thirdness, it is not exactly the same. It is also part of more general analytic thinking, while thirdness is a concept that is usually found in intersubjective theorising. Analytic space could further be understood as a prerequisite and container for emerging thirdness.
113 I am using the terms analytic space and therapeutic space interchangeably for the purposes of this study.
A viable therapeutic space is marked by a sense of generative creativity: it is an intersubjective as-if place of difference and motion, where both therapist and patient come into being as subjects (Ogden, 1994) and are free to roam metaphorically. It is “the space between certain knowledge and unthinking action, the space of negative capability that is thought” (Benjamin, 1998b, p. 34). Here “meanings can [imaginatively] be played with, considered, understood” (Ogden, 1986, p. 233) without the “constraints of some objective reality” (Bram & Gabbard, 2001, p. 693). It involves the “deconcretizing” of meaning (Bromberg, 1998, p. 253), becoming able to entertain “contradictory intentionalities” (Freedman, 1994, p. 99), and the acceptance of paradox (Winnicott, 1971).

Like thirdness, therapeutic space is never finally established, but is continually being lost and found. While generated by both therapist and patient, the asymmetry of the therapeutic relationship holds the moral and ethical implications that the therapeutic space belongs to the patient and that both its creation and its continual coming into being is ultimately the therapist’s responsibility. And if working as a therapist means “that you use yourself as a tool” (A, 529), this foregrounds the part that the therapist’s own therapy plays in keeping this “tool clean and sharp and bright and shining” (A, 538).

Some of the findings concerning the ways in which personal therapy enhances the therapist’s being-a-clinician have already been discussed in terms of the participants’ increased capacity for sustained subject-to-subject relating with patients and how this changes the nature of their empathy and ways of identifying with patients. The nature of the Thirds that therapeutic thirds had formed in relation to clinical thirds in the participants’ management of the ongoing demands of actually doing the work of therapy, has also been considered. In this section the focus is more specifically on how the participants’ therapies had facilitated the development of what one could call therapist skills, that is the “tool kit” (A, 281) that is needed for undertaking the tasks set by psychodynamic therapy. Within the psychodynamic paradigm such therapist skills particularly concern the therapist’s ability to make use of his own subjectivity in such a manner that his presence could become a “third mediating voice” (Gerhardt, Sweetnam & Borton, 2000, p. 8) that triangulates the dyadic encounter and opens up possibilities for further analytic work.

One could expect the potential for these therapist capacities (to a greater or lesser extent) to already be present in the trainee or novice therapist. Their evolvement also concerns other aspects of the therapist’s professional development, such as supervision and theoretical knowledge. As

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114 According to Winnicott (1971, p. 152), “‘I am’ must precede ‘I do’, otherwise ‘I do’ will have no meaning.”

115 Bion (1970, p. 125) borrowed the term “negative capability” from Keats (1817). It refers to the capacity to tolerate uncertainty and ambivalence without prematurely “reaching after fact and reason”.

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supervision and theoretical knowledge are largely outside the scope of this study, they will only be discussed as they relate and may be compared to personal therapy.

And since they pertain to psychodynamic psychotherapy, these therapist skills do not concern mere technical abilities or could be considered as being finally established, but are situated and come alive in a variety of ways within the complexities of many different and ever-changing therapist-patient relationships. This begs the question of what the “frameworks” (Flax, 1996, p. 590) are that psychodynamic therapists draw upon in their day-to-day operation as clinicians. Experience is generated, perceived and interpreted, and meaning and “truth” are created through these “frames” that are sometimes evident and explicit, but more often than not preconscious or unconscious (Ibid.). Each therapist-patient dyad mutually and newly creates and determines the nature and “frames” of each individual therapeutic intersubjectivity. However, the intention of this study was to unravel some aspects of the therapist’s contribution to this. In addition to considering how the organising principles underpinning and guiding the clinician’s functioning may change as a result of his personal therapy, the aim of this study was also to explore how the therapist’s therapy may provide a space in which these (often unarticulated) assumptions may be examined and questioned.

For the purposes of this study, the already-mentioned therapist skills are conceptualised in terms of a psychoanalytic consciousness and a psychoanalytic unconscious. These are intricately linked, because, as Ogden (1994, p. 14) points out, the subject of psychoanalysis is not constituted by either consciousness or unconsciousness, but is rather to be found in the relations between consciousness and unconsciousness; that is, in the “dialectical interplay of consciousness and unconsciousness”\(^\text{116}\). Although the psychoanalytic consciousness and unconscious are, for reasons of clarity, discussed separately, they are interwoven, with the one informing and defining the other. These therapist capacities, while not exactly the same as the previously described increased therapist ability to engage in subject-to-subject relating, are also underpinned by that.

In this section I have therefore considered some of the ideas that may be usefully employed to describe and understand both the participants’ reflective thinking about their work and their use of the more opaque and intuitive aspects of their experience in engaging with clinical work. This was employed to explore how being-a-patient had “cultivated” and changed these aspects of the participant’s being-a-therapist. Although the main theoretical focus of these discussions was on

\(^{116}\) This resonates with Loewald’s (1978, p. 31) suggestion: “The richer a person’s mental life is, the more he experiences on several levels of mentation, the more translation occurs back and forth between unconscious and conscious experience. To make the unconscious conscious, is one-sided. It is the transference between them that makes a human life, that makes life human.”
relational/intersubjective theory, I have not confined myself to these perspectives and did, when necessary, also include more general psychoanalytic thinking. Some of the aspects of the psychoanalytic consciousness and unconscious have also come to the fore in the earlier discussions of data and those, as well as relevant excerpts from interviews, have also been referred to in this section.

4.5.2 Personal therapy and a psychoanalytic consciousness

One of the expectations underpinning the idea that a therapist’s personal therapy has an impact on his work as a clinician is that this (his own therapy) would have an effect on the way he thinks-in-action during the course of his work and on how he thinks in reflecting on his work. This foregrounds the question of how a therapist needs to think in order to be able to do the work of therapy. “What are the qualities of thought [especially on the part of the therapist] that allow patient and [therapist] to think their way through transference and countertransference interlocks, impasses and stalemates?” (Benjamin & Aron, 1999, p. 1). In terms of this study, one could therefore ask what role the therapist-patient’s personal therapy plays in his becoming and remaining capable of “thinking-in-action” (Aron, 2000, p. 675) at these turbulent and taxing times when the negotiation of difference has become fraught with impending or actual breakdown. Further relevant questions would be about how the Third of the therapist’s own therapy could also become a space of thirdness in his mind (Benjamin, 2001) within and across the varying and shifting relational configurations of the different therapist-patient dyads of his being-a-clinician and also about how this contributes towards what is commonly thought of as the therapist’s reflective and symbolic capacities.

4.5.2.1 The role of theory within the context of the acknowledgement of the therapist’s subjectivity

As previously discussed, contemporary relational and intersubjective theory supports the idea that the influence of the therapist’s subjectivity should be acknowledged and even embraced (Mitchell, 1997). According to Renik (1993, p. 565), the therapist is “someone who allows himself or herself to be acted upon by powerful forces, knowing that they are to be managed and harnessed, rather than completely controlled”. The therapist is indeed always both subject of and subject to the process of therapy (Kennedy, 1998). Anonymity, abstinence and neutrality have consequently become viewed as impossible (and even undesirable) ideals (Mitchell, 1997). But what about the therapist’s deployment of theory in his thinking about his work? Does this not (at least to some extent) imply an “objective” stance?
Theoretical knowledge is certainly an indispensable part of the therapist “tool kit” (A, 281) and may usefully inform the therapist by providing a framework for what is experienced in the space of therapy. Any “facts” that the therapist “knows” about the patient will inevitably be “soaked” in the therapist’s theoretical perspectives (Stein, 1991, p. 326). However, the therapist’s allegiance to a specific theoretical orientation is often based on highly subjective considerations that are far from being primarily cognitively based or “objective”. The therapist’s very choice of a specific theoretical perspective may be linked to his personal life (for example, with the nature of his early relationship configurations) (Spence, 1993). Aron (1999, p. 20) accordingly suggests that many therapists use theory “as a form of self-regulation”. A particular theory may fit a specific therapist because it is concordant with or because it complements whom the therapist is. “Analysts with a propensity for exhibitionism may choose a theory that encourages self-disclosure because it matches their own personal proclivities; other analysts with the very same proclivities may choose a more conservative theory of technique precisely in an effort to modulate those tendencies” (Aron, 1999, p. 21).

The therapist’s choice and use of theory may therefore sometimes have more to do with meeting his own needs than with facilitating his thinking and understanding. Lindon (1991) points out how theory is at times used defensively to contain the therapist’s anxiety at not “knowing”. The way that the therapist relates to theory may also locate it within the discourse of power between him and the patient. In this case theory may form a Third that contributes to the therapist’s “privileged relation to interpretation” to which the patient may feel obliged to submit (Benjamin, 2001, p. 6). Here theory is not necessarily a “true” Third that opens up a space for thinking, but may form an antitherapeutic dyad with the therapist. An example of this may be found in an interpretation given by Participant C’s therapist.

In the case of the therapist-patient, the treating therapist’s theoretical knowledge and the therapist-patient’s lived experience of the well-considered and fine-tuned application of this in clinical work could provide a useful model to emulate. As was described by some of the participants, the treating therapist’s real or imagined theoretical “superiority” may also feature prominently in the therapist-patient’s idealisation of and submission to the one who knows how to be a therapist.

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118 For example, see B, 247-250, p. 146; BP, 101-105, p. 160.
4.5.2.2 The therapist’s capacity to sustain paradoxical and dialectical thinking

Incorporating the idea of the therapist’s subjectivity therefore means accepting that whatever knowledge the therapist has of the patient is refracted through his (the therapist’s) intrapsychic prism and the therapist’s having “entered into a realm of knowledge based on identifications” (Benjamin, 1998b, p. 25). What is asked of the therapist, is to engage in the play of multiple identifications and disidentifications with the patient, to tolerate the ambiguity and uncertainty of moving among and straddling many different and often contradictory subjective positions and not to remain identified with any one of them. This means the therapist’s being able engage with and entertain the experience of multiple self-states, while preserving a subjective sense of his own “going-on-being” (Winnicott, 1963b, p. 86), and consequently implies his being able to think paradoxically. The idea of the “accommodating asymmetry” (Benjamin, 2001, p. 22) of the therapist’s recognition of the patient as a different other ushering in and being fundamental to the development of mutual recognition (Benjamin, 1988, 1995), also highlights the importance of this therapist capability.

Paradox is inherently heuristic: it takes the mind beyond the familiar and invites us to transcend that which is already known (Ghent, 1992). This capacity of the therapist to have many “voices” rather than one (Kennedy, 1996) and to “engage in the internal dialogue of the multiple voices of subjectivity” (Aron, 2000, p. 672) has been variously described as sustaining paradox (Winnicott, 1971); movement through opposition (Benjamin, 1998b, p. xix); standing in the spaces between realities (Bromberg, 1998); tolerance of multiple gaps within and between subjects (Flax, 1996, p. 588); building bridges (Pizer, 1998); and thinking dialectically (Hoffman, 1994; Ogden, 1994, 1997, 2001; Benjamin, 1999b). In Kennedy’s (1998, p. 82) words: “In this sense, the analyst is poised at the point at which the paradox of human subjectivity arises.”

When the terms paradox and dialectic are used to describe the process whereby the tension between opposites is sustained rather than resolved, there does not appear to be an essential difference between them. However, dialectic does elucidate the relationship between polarities further: as well as the idea of the oscillating movement between polarities, it also pertains to the interactive dynamic between opposites.

The therapist’s own therapy could render him freer to both move among and become immersed in different vantage points or positions; that is, to allow a kind of free play and a holding of the tension between different ways of being-a-clinician, such as being open to his own reveries and being consciously self-reflective; practising analytic restraint and being spontaneous; focusing on
what emerges from him as an individual and what arises from the intersubjective dimension, and so forth. This enhances the possibility of the creation of new and generative intersubjective third spaces where thinking and self-reflection are possible at a meta-level.

An example of these kinds of therapist thought processes may be found in the therapist’s efforts to represent “a double-sided perspective” (the patient’s and his own) by engaging in the “play” of identifications and disidentifications (Benjamin, 1998b, p. 25). This is fundamental to the establishment of the “dialogic space of the third position” (Benjamin, Ibid.). Presenting the patient with the thought processes involved in this (or even being perceived to be thinking in this way), conveys the therapist’s intent to recognise the patient. This may be just as useful as the therapist’s getting it exactly “right” and is an invitation to the patient to (even if just in fantasy) collaborate in the meaning-making process. In the section “Therapist’s ‘mistakes’ and the dialectic of recognition and negation”, participants had described how they and their therapists had survived moments of negation in this manner.[119]

4.5.2.3 Aron and Benjamin’s intersubjective rendition of reflective thinking

If misrecognition is an inevitable part of the therapist’s efforts to “know” and recognise the patient, it does not follow that “anything goes”. Mitchell (1997) consequently warns against simplistic relativism and absolute subjectivism. This returns us to his previously mentioned suggestion[120] that the therapist’s methodology be shaped by a “self-reflective responsiveness of a particular (psychoanalytic) sort” (Ibid., p. 193).

This could be considered a central component of the psychoanalytic consciousness. For the purposes of this study, this term is used as an overarching concept for the thought-related processes in which the therapist engages when participating in the mutual and asymmetrical creation of evolving thirdness. These processes are also sustained by the values and attitude that the therapist brings to his work, that is, the previously discussed moral third and agapaic attitude[121] “This kind of analytic participation is neither simple nor naïve … [but] a highly cultivated skill … The analyst … learns to track and engage in, simultaneously, different lines of thought, affective response, self-organization … There are, therefore, in the same analyst, many kinds of analytic minds” (Ibid., p. 194). This emphasis on “the conceptual power of multiplicity” brings contemporary relational/intersubjective theory in line with postmodern thinking (Harris, 1996, p. 537).

[120] See also p. 50.
Contemporary psychoanalytic thinking highlights the importance of the patient’s developing a capacity for reflective thinking, that is, of becoming increasingly able of “making meaning of [own and] interpersonal experience and of thinking of self in relation to others” (Bram & Gabbard, 2001, p. 686). Rather than just being a new term “for what have heretofore been called insight and expanded awareness”, this concept represents “an incremental advance in the precision by which the therapeutic action of psychoanalysis is understood” (Aron, 2000, p. 671). Aron (Ibid.) points out that while psychoanalysis may be “uniquely suited” to improve this “self-reflective capacity”, this is not only true for those severely disturbed patients who are usually lacking in this respect. In the case of “healthier patients” (and one hopes that this would include therapist-patients), their reflective function may also be impaired in areas in which they have difficulties (for example, when therapist-patients’ own “woundedness” and/or desires for power are evoked).

One of the fundamental issues that psychoanalytic theory has long grappled with is how therapist and patient may both become involved participants in and observers of the analytic process (Benjamin & Aron, 1999). The traditional approach saw these stances (participant and observer) as complementary positions that were respectively taken up by patient and therapist (Ibid.). Sterba’s (1934) further “solution” is to conceptualise a dissociation of the “experiential and observational aspects of the ego” between which it is possible to oscillate (Aron, 2000, p. 672). Through identification with the therapist’s observing ego, the patient also becomes capable of moving to and fro between these experiencing and observing positions. However, this idea of oscillation is still not a real double-sided perspective and holds the possibility of complementarity, splitting and projection (Benjamin & Aron, 1999). A further deconstruction of the opposites of feeling and thinking is therefore necessary.

Aron and Benjamin’s (Benjamin & Aron, 1999; Aron, 2000) notion of self-reflexivity highlights the capacity to transcend the dichotomous thinking involved in complementary relations and thus pertains to the ability to simultaneously hold multiple and even contradictory perspectives in mind, that is, to be able to sustain the tension inherent to paradoxes or dialectical relationships. Aron (2000, p. 668) emphasises that his use of this concept refers both to “an experiential and affective function” and “an intellectual observational function”. These functions are conceptualised as being linked via a dialectic or a “higher integration of the oscillating function, characterized by the capacity to move back and forth smoothly” (Benjamin & Aron, 1999, p. 4). This dialectic is therefore between “experiencing oneself as a subject [the ‘I’ of subjective self-awareness], as well as reflecting on oneself as an object [the ‘me’ of objective self-awareness]”, that is, between

122 Ferenczi (1919) and Freud (1932[1933]) had similar ideas about this.
experiencing and observing oneself (Aron, 2000, p. 668). However, self-reflexivity does not just mean being able to think about one’s own experience, participation or point of view, but also to think about the other as subject and object and keep his point of view in mind.

“Reflexive self-awareness is [therefore] both an intellectual and emotional process; involves conscious and unconscious mentation; draws on symbolic, iconic, and enactive representations; and involves the mediation of the self-as-subject with self-as-object, the ‘I’ and the ‘me’, the verbal and the bodily selves, the other-as-subject, and the other-as-object” (Aron, 2000, Abstract). This consideration of the relationship between perspectives of self and other may be further expanded to include “thinking about thinking”, that is, to think at a meta-level (Benjamin & Aron, 1999, p. 2).

The therapist’s reflexive or reflective capacity offers a way out of the dyadic entanglements involved in identificatory processes and complementary twoness, where the therapist could otherwise be “destroyed” (Winnicott, 1969) by either submitting to or resisting the patient. It could therefore function as a third in the therapist’s mind (Benjamin, 2001) and could also contribute to the “expansion of triangular mental space in which self-reflexivity is possible”, both in the co-created third and in the patient’s mind (Aron, 2000, p. 675).

Reflexive thinking clearly has both intrapsychic and intersubjective dimensions. However, in relational and intersubjective theorising, the Cartesian belief that “one could know one’s own mind via introspection, without the mediation of dialogue with an other” is largely rejected (Auerbach & Blatt, 2001, p. 436). Aron (2000, p. 668) further sees introspection as being based “on the dubious assumption that the self has privileged access to its own internal states”. The development of reflexive thinking is therefore seen as being intricately connected with mutual recognition and evolving thirdness; that is, it concerns “a triangular space emergent from within an interpersonal dyad” (Aron, 2000, p. 672) where meanings are exchanged and thinking becomes possible. Reflexive thinking is consequently fundamentally intersubjectively based.

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123 Although her theoretical perspective is somewhat different, Coltart (1996, p. 28) also writes about the “inherently paradoxical … psychic manoeuvres” of the therapist, who is “intricately related to the patient and his inner-object world, yet … also detached in order to be able to reflect on them, and on [him]self both as subject and as the patient’s object”.

124 According to Aron (2000, p. 668), he speaks about a self-reflexive rather than a reflective function, because, for him, the latter connotes only examining oneself in a more intellectual and distant way, that is, as an “object of thought”. I prefer to use the terms reflective or reflexive (rather than self-reflexive), because these seem to encompass the notion of the capacity of reflecting both on self and other and I shall use them as such (except when quoting text in which the term self-reflexive is used).
Benjamin and Aron (1999, p. 6) further suggest that we denote “two distinct [but linked] features of intersubjectivity”, both involving the idea of a triadic structure. *Epistemological intersubjectivity* pertains to the relational viewpoint of multiple and even paradoxical perspectives being present. *Affective intersubjectivity* concerns mutual recognition and identification (which may be contrasted with projection and splitting). One way of conceptualising the collapse of the third space is not only as a failure of these two intersubjective dimensions, but also as the loss of their connectedness. In the case of enactments or impasses, “observation and participation typically are split apart” (Ibid.). The therapist may become so submerged and entrapped in his own experience of the interaction that he can no longer think or can only think by becoming detached from the patient (that is, by disidentifying from the patient) (Ibid.).

### 4.5.2.4 The therapist’s symbolic capacity

Within the therapeutic context symbolisation is generally understood as the process whereby unthought or unintegrated experience is transformed “into communicable, understandable, ‘thinkable’ thought” (Frankel, 1998b, p. 157). Ogden (1986, p. 213) conceptualises the potential space constellated by the symbolic function as arising out of the triangular relation between the thinker (who is an “interpreting subject … generating his own thoughts and interpreting his own symbols”), “the symbol (a thought)” and that which is being symbolised (being thought about).

For triangularity to be a feature and to have *symbol formation proper* rather than *symbolic equation* (Segal, 1957) taking place, it is necessary that the mediating subject, symbol and symbolised be differentiated; that is, that symbol is not seen as being the same as symbolised, but as standing for that which is being symbolised. This process of symbol formation makes *thinking about feelings* and *understanding* them possible, “because understanding involves a system of layering of meanings” (Ogden, 1986, p. 217). For example, experiences like the past, the present, dreams transference and so forth contextualise one another and have meaning in terms of one another. Understanding the other by having *empathy* also becomes possible within the context of the potential space generated by “a dialectic of being and not-being the other” (Ogden, 1986, p. 227). This resonates with the previously discussed notion of the therapist’s empathy with the patient involving his identifying with as well as disidentifying from the patient.

The therapist’s ability to think symbolically is related to (and overlaps with) his functioning reflectively and is also linked to his capability of generating therapeutic space. The meaning of the term symbolic capacity, specifically used as it concerns the therapist, is complex, multifaceted and cannot be reduced to a simple definition. Intrapsychically the therapist's symbolic capacity pertains
to the therapist's having something of a stable ability for “playing” and “to-ing and fro-ing” (in the Winnicottian sense); for thinking metaphorically and for tolerating the anxiety (and sometimes guilt) of the Kleinian depressive position (Klein, 1988a, 1988b). It also concerns the therapist’s remaining reflective of himself, the patient and the process; responding rather than reacting reflexively and engaging in “tension-dissipating action” (Ogden, 1997, p. 25); when necessary, being able to be “actively passive” (Freedman, 1994, p. 105); and allowing meanings to accrue over time rather than foreclosing the meaning-making process with premature certainties.

The idea of the therapist’s having a certain “symbolic capacity” does not mean that everything that happens in the therapeutic space will (or should) be seen as being symbolic: the therapist can collapse the space both by taking everything as symbolic or by naively assuming the literal. There needs to be an openness to both possibilities; that is, the tension needs to be held between what is literal and what is symbolic.

Reflective thinking about self and others is primarily deployed by using words. Because words “carry the capacity for abstraction”, “they allow us to consider experiences in the framework of a past and a future and to imagine categories, hypotheticals, ideals and alternatives” (Frankel, 1998b, p. 159), that is, to enter the symbolic play with meanings. While the patient may not be lacking speech as such, Benjamin (1998b, p. 26) points out that the patient’s “symbolic capacity”, that is, his ability to “use” the therapist (Winnicott, 1971) and the space of therapy for symbolic thinking, cannot be taken for granted. This often only develops within the context of the therapeutic relationship and space, that is, within the previously described trajectory of thirdness. Benjamin (1999a, p. 206) further posits that although “symbolic capacities are associated with thirdness”, one cannot say that the one results from the other, but rather that they are both the “effects of the mental work of containing and communicating affect”; that is, they result from the nature of relating within the analytic dyad.

The literal concreteness of complementary twoness is often constellation through the enactment of that which cannot be represented and thought about. Symbolisation may emerge when the therapist survives his “inevitable involvement” in this “by making use of identificatory responses that bypass or dissolve it” (Benjamin, 1998b, p. 25). In this way the apparently irreconcilable and dichotomous

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125 Ogden (1986, p. 219n3) refers to the interesting point (made by Lacan) that while the capacity for symbolisation frees the individual from being imprisoned by “unmediated sensory experience”, he then becomes subjected to the symbolic order. Here “language provides us with symbols that long preexisted us and in that way determines our thought, even though we labor under the illusion that we create our own symbols” (Ibid.).
polarities of twoness may incrementally be transposed into metaphor and symbolic thought (Benjamin, 1998b).

The therapist’s symbolic capacity and his (the therapist’s) ability to think reflectively invite the patient to function in a similar manner and provide him (the patient) with a powerful model (with which he may identify) of how to think “analytically”. This is especially important in the case of the patient who is also a therapist. Examples of this phenomenon may be found in some of the excerpts already used in the earlier discussions of the interview material. The excerpts that had specifically pertained to these kinds of identificatory processes had concerned those instances when participants had felt recognised by their therapists being and remaining finely attuned, even when this had been in the face of their (the participants’) negative and contradictory aspects. The participants had also experienced some therapist alterity and occurrences of momentary misrecognition by the therapist being recuperated and subsumed in the dialectic of recognition and negation rather than leading to rupture. Participants had accordingly also become more able to tolerate and recognise their patients’ otherness and to work with that.

4.5.2.5 Britton’s notion of triangular psychic space

Benjamin and Aron’s ideas about reflective and symbolic thinking and the nature of the symbolic third resembles Britton’s (2003, p. 98) notion of triangular psychic space. For Britton (1998, p. 42), who writes from a Kleinian perspective, this triangular space refers to “the mental freedom” where a third position comes into being from where it becomes possible to observe object relationships, to envisage oneself being observed, interacting with others and ideas, to contemplate other points of view while retaining one’s own, and to reflect on oneself while being oneself.

Britton (1989, 1998, 2003) sees the establishment of this symbolic space as resulting from the resolution of the Oedipus complex. In the therapeutic situation this concerns the therapist’s taking up a third position by linking his subjective “empathic understanding” (the maternal container) and the more objective otherness of his “intellectual comprehension” (penetrating phallic knowledge) (Britton, 1998, p. 43). This can only happen successfully (as when the therapist makes an interpretation) if the maternal containment is adequate enough so that the feared catastrophe of the patient’s subjectivity and reality being obliterated or replaced by that of the therapist does not take place.

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126 See B, 96-122, p. 164.
127 See BP, 312, 316, p. 139.
Benjamin and Aron (Benjamin & Aron, 1999; Aron, 2000; Benjamin 2001) conceptualise the way towards symbolic space somewhat differently. They emphasise that the symbolic third is founded on the earlier clusters of thirdness marked by the therapist’s attunement and affective resonance with the patient. The therapist’s use of interpretation does therefore not necessarily institute or signal the presence of a symbolic third unless it is predicated on the existence of those clusters of thirdness. In their absence the therapist’s “holding on” to interpretation may subvert the very “thirdness it aims to preserve” (Benjamin, 2001, p. 21). The therapist therefore becomes “a persecutory invader rather than an instigator of symbolic functioning” (Ibid., p. 14), that is, he brings about Britton’s (1998) dreaded catastrophe. This is similar to Britton’s (1998) notion that the therapist’s third position of “paternal” interpretation could threaten or usurp the connectedness within the therapist-patient dyad when “maternal” containment is already shaky. An example of this was previously discussed in Participant C’s description of her therapist’s interpretation of an act of C’s which had not been in line with what the therapist as “one who knows” had wanted her to do and to be.

Aron and Benjamin give Britton credit for his thinking (Benjamin & Aron, 1999; Aron, 2000; Benjamin, 2001), which, although couched in somewhat different terminology, is very similar to their own. As they (especially Benjamin) do, Britton (1998) describes grappling with holding on to his own subjectivity through and together with the differing degrees of alterity that the patient is able to tolerate. He further writes about the reversible hierarchical binaries that get constellated in the power struggle about whose feelings, perspective or reality should prevail. This was also depicted by Benjamin (1998b, 2001) in her previously discussed notion of complementary twoness.

However, Benjamin and Aron (Benjamin & Aron, 1999; Aron, 2000; Benjamin, 2001) also comment that as in the case of Lacan, Britton is too insistent on an Oedipal “solution”. They contest the idea of the Oedipal as the “singular metaphor for the triadic structure”, but rather “value it as one way of conceiving of that structure” (Benjamin & Aron, 1999, p. 4). According to them, thirdness is not just instituted through the third position of the symbolic father, and Britton therefore “bypasses the important forerunner of triangular space that emerges from within the [therapist-patient] dyad” (Ibid., p. 5). Britton’s descriptions of his clinical work should consequently also be conceptualised as the triadic being generated within the dyadic, that is, in terms of evolving thirdness. There the “paternal” is seen as emerging from and based on the “maternal”, rather than as an Oedipal link bringing these aspects together and integrating them.

132 See also pp. 69-70.
4.5.2.6 Reflective and symbolic thinking and metacommunication
The therapist’s capacities for reflective and symbolic thinking both feature in and facilitate his use of metacommunication in relating to the patient. Metacommunication “consists of an attempt to disembed oneself from the relational configuration that is being enacted by taking the current interaction as the focus of communication” (Safran, 2002, p. 181). Metacommunication plays a prominent part in the relational therapist’s attempts to dissolve the impasses created by the oppositional binaries of complementary twoness. The therapist communicates from his own experience of the paradox about it (Ringstrom, 1998).

Metacommunication on the part of the therapist may involve countertransference disclosure, but this concept is broader than just that and may also include other ways of sharing the therapist’s thinking, for example, the therapist’s speculating, making observations and asking questions in the presence of the patient (Safran, 2002). Metacommunicating has the potential of restoring collapsed thirdness “and in so doing lends itself to increments of new intersubjective structure formation” (Ringstrom, 1998, p. 287). Metacommunication features in the previously described, improvisational moments (Ringstrom, 2001a), now moments (Stern, 1998) and dialectics of difference (Bollas, 1989, 1992). Such metacommunications may locate the communications of therapist and patient at “a metalevel of discourse” (Ringstrom, 1998, p. 291) where they “are able to relate in a more subject-to-subject manner” (Ibid., p. 287).

4.5.2.7 Discussion of interview material
4.5.2.7.1 Personal therapy and some facets of an evolving psychoanalytic consciousness
As could already be seen in some of the excerpts used in previous discussions, the participants’ manner of engagement with thinking and talking about their therapies and their work in the interviews was indicative of their (to a greater or lesser extent) being able to reflect on and think symbolically about their work. Participants also understood both their thinking-in-action when working and their thinking-in-reflecting on their work as having changed and developed as result of having been in therapy. What had started off as the psychologically-mindedness (Appelbaum, 1973; Farber, 1985) of the wounded healer had accordingly evolved into a powerful therapeutic tool.

Personal therapy had offered a containing Third which had allowed the participant-therapists’ thinking to move towards including themselves and patients, both as subjects and as objects. This had been especially useful when the participants had been novice therapists. Their own therapies had made it possible for them not becoming submerged in their own feelings and to shift between
their own experience of the clinical third and that of patients’, that is, their therapies had facilitated the prospect of a triangular thinking space (Britton, 1998) or thirdness in their own minds (Benjamin, 2001).

113 That you can feel contained enough for your attention to be able to rove, able to flip between yourself and the patient and the interaction and just be able to work.
114 I don't think it's about taking your feelings about what's happening in your life and packing them away and hiding them somewhere, but just that you're not so caught up in it that you can't kind of be responsive to the patient or the process that the two of you are going through.
115 So that was very important in the beginning.  (F)

In time the initial containing Third of therapy had also become a relied-on space of thirdness in participants’ minds, that is, an accustomed way of engaging with the process of doing therapy or part of the participant’s implicit or procedural knowledge of therapy.

542 So initially it's a bit like you're hanging onto those tools, concentrating like mad on everything and trying to keep a hold on everything, whereas later you really can let go of that stuff, put it there and be there for the person; be available completely, because this other conversation is going on more by itself and when needed you can go and tap into that one.  (A)

The participant’s being contained by his own therapy had meant that the space of therapy could actually belong to the patient rather than being suffused with the participant-therapist’s anxieties, needs and wants. For the patient this had offered the presence of the participant-therapist as “someone available, someone present without making demands” (Winnicott, 1958, p. 34). It had further meant the participant-therapist’s not having to take refuge in premature certainty and closure, but being able to “slouch towards” (Coltart, 1993a) the making of co-created meaning. This had been underpinned by his being able to continue thinking about the patient, with his own experience of and feelings about the shared third informing the process of therapy.

146 A: I think that what that [therapy] also has also helped me with is to listen better, obviously, to sit back and listen and put on a hook more what I am feeling and seeing and so it's a process that goes on over there while I'm engaging here.
147 And waiting more before I would offer an intervention or a comment or a reflection.
149 *R: It's a bit like listening and thinking or reflecting at the same time? What were you doing?
152 A: That thing that Winnicott talked about of being alone in the presence of another.
153 It's a bit like that.
154 There is an internal dialogue going on with myself, which is on the back burner.
155 It's not in the forefront ...  (A)
169 My therapy gives me much greater tolerance for matters that are unresolved, for spaces in therapy and it allows me to move far deeper within each therapy session.  (G)
Thinking about patients had also meant keeping different (and sometimes contradictory) aspects of them in mind.

What I'm finding more and more exciting is where I can begin to see the pain and the growth happening together and so I keep my one eye on the pain, so I'm there, but with the other eye you can see the face beginning to break open or you hear that there are other things happening behind the pain that is new growth, it's new something and ... (A)

The paradox is in that the one eye is on the child side of the patient and the other eye is on the adult, the capable adult.

And if you don't keep your eye on both, you are going to injure something.

You will injure the adult if you only keep your eye on the child.

And that will become really offensive, eventually, to both, I think.

It's patronising to just look at the vulnerability and ignore the strengths. (A)

The determination to sustain self-observation and “thinking about feelings” (Shuttleworth, 1991, p. 6) had marked the capable and responsible participant-therapist who had valued and respected the patient as an equal but different other.

You become an observer of your own emotional life virtually constantly ...

But it's not a burden; it's a pleasure, it's interesting, because all of that becomes part of your virtuoso, your capacity to be with other people and other people's emotions without feeling frightened of it. (A)

So I think that everything just feels more rigorous in terms of thinking about how many patients, how often, why have they cancelled, why am I getting irritated, can I see a patient or am I too tired, can I take on another patient or not, selection processes, all of that.

It just feels like a much more serious business to me and with that I can see the benefits to my patients and to myself, because I am enjoying my work more, a lot more. (BP)

Sometimes the attempt to think about oneself in the process of doing the work of therapy had resulted in what Benjamin (2001, p. 14) sees as the conflation of self-observation with submission “to a person or an ideal” or grappling with what Participant E (403, 406) described as a “negative and destructive Animus”.

And that destructive voice can be very undermining of my work.

I think, as I reflect on my work, I often feel that I don't have enough understanding of what's going on.

In the face-to-face space I don't often experience that, but as I reflect, I feel that I don't have enough understanding and that, I think, sometimes is absolutely valid, but sometimes there is this destructive voice.

I mean, obviously there is a place for being critical of my work, but it's not that kind of objective critical, it's the laying waste, you know, of stuff that is of value, as well. (E)

The establishment of a triangular psychic thinking space had meant the participant-therapists’ scrutinising and questioning their own work in terms of themselves, patients, transference, and
especially, countertransference; that is, thinking about the nature of and their own contribution to the clinical third without being so persecutingly judgmental of themselves.

339 One of the things that I want to talk about in having my own therapy and working as a therapist is that one of the things I have been aware of and that I think that I watch out for and just am aware of is that I think sometimes therapy can negatively influence your work in that when I'm sometimes going through a process in my own therapy and I'm excited about it: "Wow, you know, gosh, look at how I'm doing that" or: "Oh, yes, you're right", my therapist has picked up on that or: "Oh yes, gosh, I hadn't realised I do that or feel that way or think that way!"

340 I will be sensitive to it and maybe looking out for it unconsciously.

344 I don't think it's about whether it is or isn't here in the patient, because I think there's often so much there, but maybe what I have been aware of sometimes is when a patient gives me six cues to things, rather than picking up on the one that is foremost for that patient at that moment, I'll pick up on the one that is foremost for me, because I've just had a wonderful therapy session (laughs)!

348 And I think I just have to be aware of it, because it's going to happen anyway.

366 It [therapy] brings into your life a general attitude of self-reflectiveness that enables you then to, in therapy, out of therapy, actually say: "Hang on a minute; why am I seeing that issue in the last three patients; why am I picking up on this aspect of experience in all of my patients today?" (F)

Participant F had been discussing the possibility of seeing the patient in terms of her own desires, that is, as an object rather than a subject who is a different other. She had been considering how her impinging use of the patient’s therapeutic space might potentially come about as a result of her own therapy. Without F’s having and clinging to the certainty of being the one who knows exactly what the truth was, this had become a playing with ideas and meanings around this issue.

This may be contrasted with Participant G’s discussion of the same topic. While both F and G’s ways of understanding such a situation could have been be valid, G showed a certain lack of playful reflectiveness and much more of a sense that her interpretation and understanding had been the correct one.

76 I also find, very interestingly, that the things that I focus on in my own therapy, very soon, within a week or so of me exploring a certain area, it will come up.

77 Suddenly my patients seem to have issues and problems in those areas ...

82 I feel that the reason that I can deal with those things, is because they provoke less anxiety in me now and because I'm more consciously aware.

88 And I also believe that on an unconscious level, somehow, it gets communicated to the patient.   (G)

The frame is a fundamental aspect of psychodynamic therapy and needs to be respected as such. However, the participant-therapist’s being reflective had also meant his having the confidence and the openness to think beyond the reassuring certainty of just “following the rules”.

630 B: I have to admit that I break the rules.

633 And I think that any therapist who doesn't ever break the rules, doesn't ever, I mean, is missing something.

634 Because they're not really rules.
I think they're more like guidelines.
But they are important guidelines, very important guidelines.
The frame is a very important guideline.
But it's not a rule, it's a guideline.
*R: What does that mean, not a rule but a guideline?
B: It means you don't have to follow it.
It's only a guide, but you follow your own path.
*R: So you interpret it, basically?
B: Ja.
It's the map, not the territory.
And the territory and the map are not the same.
But the map is a good guide for traversing the territory.
Therapy happens in the psychic space of the room.
The frame is a kind of synthetic guideline that needs to be translated into lived experience in the room to be helpful. (B)

This translation of the notion of the frame into the “lived experience in the room” had involved some “hard thinking” rather than just “correct actions” (Mitchell, 1997, p. 268).

I had a patient, two weeks ago, who challenged me, directly challenged me. Said something like: "I'm not one of your average patients and basically I'm a special boy."
"I'm a special boy and if you want to work with me, you are going to have to pull finger; you're going to have to change; you're going to have to give me something of yourself."
I think that any good therapist can work with that.
It's lovely material to work with.
It's not easy, but it's great when a patient offers that kind of narcissistic fantasy and one can step into vulnerability about that.
What I did with him, I was able to, at the same time as interpret the importance that he not be seen as just a regular patient; talk about what that might mean if he was just a regular patient and how that might feel to him.
At the same time that I did that, I was also able to think about some of his criticisms of my lack of self-disclosure.
As a therapist I could say: "Now, I'm not supposed to self-disclose" or something like that.
But I actually thought about it and I offered him self-disclosure, but I offered it therapeutically.
So I offered self-disclosure about how it felt to be in the room with him, for me, which was self-disclosure, but was not historical or factual self-disclosure about me.
It was still really about him.
And he really took to that very well, because ...
And I don't think I would have done this if my therapist hadn't had taken my feedback.
I can sit here and think that maybe my therapist actually didn't shift in his focus on my feeling at all.
Maybe he just didn't challenge me on it and he thought about it.
And that was enough for me to think that he was doing that.
I don't know, because it's a fantasy.
But there was definitely a connection there. (B)

This patient's “challenge” had been both an expression of his narcissistic grandiosity (and implied hidden vulnerability) and an invitation for B to enter into a power struggle about what therapy should be about, whose reality should prevail, who should dominate and who should submit (599-601). B’s surrender (rather than submission) to this had started off by exploring what this had meant to the patient (605-608). If this had been all that B had done and he if had also “refused” to
self-disclose, the patient could have felt that B was distancing himself, attempting to force him (the patient) into submitting to his (B’s) theoretical loyalty, and an antitherapeutic dyad and negative intersubjective third could have ensued. One may, of course, interpret this therapeutic “tale” differently. But what does stand out with indisputable lucidity is that, rather than just keeping to the rules (611), B had been able to remain thinking about what was happening (609, 612). B had consequently responded in a way that had reflected the patient’s impact on him; that is, his identification with and recognition of the patient and his (B’s) holding on to his own separate and different subjectivity (612-616). B had further connected his ability to do this to his own experience of therapy. One could therefore understand B’s actions in the clinical third as his identification with his therapist’s way of thinking and working when he (B) had felt recognised in the therapeutic third (618-623).

The significance of the therapist’s holding on to his subjectivity by thinking reflectively and symbolically is highlighted at such uneasy times when impasse and breakdown loom. This is when the therapist’s only choices seem to be giving up his own version of what is happening or compelling the patient to submit to his authority, for example, by means of making only a transference interpretation. And any therapist would be sorely tempted to do just that if his own idea of himself as a therapist were sufficiently threatened and the wounded healer constellation with its impaired capacity for subject-to-subject relating came to the fore.

In the following excerpt, Participant B described his thinking in and about such a challenging situation (781) where he had not hidden behind a transference interpretation (782-783), but had also recognised the validity of the patient’s experience (784) without submitting to her demands. This had taken the therapy beyond the possibility of potential collapse into the concrete polarities of complementary twoness to the level of the symbolic third (786)

781 I have one patient who has a very strongly erotic transference with me, who challenges the boundaries here; directly challenges the boundaries.
782 I don't interpret to this person like ...
783 I don't sort of volley the challenges away, like throwing it back at them.
784 What I say is: "Look, there is something very frustrating and synthetic about the relationship here: that I'm getting from you. We meet at a certain time and it is all controlled and structured. Here you are having these feelings and meanwhile we are stuck in a therapy relationship. I mean, that is F****** frustrating and B***** hard."
785 So I get that.
786 It works extremely well, because the person gets that they actually don't need to break the boundaries to get intimate. (B)

Thinking had also been part of participant-therapists’ engagement with those aspects of the clinical thirds that were non-conscious or unconscious. This did not pertain to the rather archaic and
simplistic notion of making the “unconscious conscious”. It rather had to do with the participant-therapist’s thinking being brought into his encounters with the shadowy adumbrations of what is generically described as the unconscious. By implication this had also involved the participant-therapist’s developing awareness of, open receptivity to and ability to sense and experience the unthought, unarticulated, unformulated and intuitive aspects of experience. There had thus been a movement between thinking and experiencing, with one informing the other. Experience had illuminated, opened up and disseminated thinking, and thought had organised and brought understanding to experience.

315 E: I am aware that I can sometimes be extremely intolerant of fundamentalist kinds of viewpoints and need to be very conscious of that intolerance and walk very respectfully around what other people come with, because I think that triggers a kind of complex reaction in me. And ja, so to come back to how my own therapy informs my work, I am SO much more aware of my own complexes and what to watch out for.

317 *R: It's brought that kind of awareness?

320 E: I am much more attuned to affective changes in myself in the therapeutic setting and know when, I can't say it's absolutely, but I'm much more attuned to when a complex has been triggered in me.

321 That is absolutely a result of having been in therapy.

322 *R: What does it mean in your work to have an awareness of a complex that has been triggered?

325 E: I maybe feel an increase in my pulse rate or I'm aware that there's a visceral response to something that's been said and I need to be very conscious of, I mean, even though my client may pick up something in me, in my body language or whatever, I need to be very conscious of anything I might articulate at that point.

326 I need to be very careful of how I respond rather than react, you know, as I might in just an ordinary conversation.

327 *R: You seem to be saying that you cannot just react, but that you need somehow to reflect on or have an awareness?

329 E: Ja, you know, I think, Casement's "supervisors" ...

330 Ja, for sure, I am more, as a result of having worked with my complexes and shadow and inferior function or whatever, much more conscious of when those sorts of responses are evoked in me in therapy.

331 I mean, not that they are evoked, you know, endlessly, but when they are.

332 And it often is with, it's always where there is more of an intensity of connection with clients ... (E)

Sometimes a patient's face will be in a dream and then, in talking about that, I might say; "Who is this patient? What is she representing to me? Who is she to me? What are my feelings about her? Did she say something that connects with what I'm talking about?" (F)

4.5.2.7.2 Personal therapy and the interplay of identification and disidentification, reflective and symbolic thinking in the clinical third

The following excerpt highlights some aspects of the role of Participant F’s personal therapy in her moving towards thinking reflectively and symbolically about her work. She described the presence of identificatory processes that had involved both identification and disidentification. The excerpt also shows how F’s therapy had formed a containing Third to her work, and as such had also been a
Third from which to think symbolically and reflectively, and had contributed to a triangular psychic space or a space of thirdness in her mind (218).

218 F: But the other kind of place that I've really appreciated the therapy is, it's really helped me sometimes to work with some of my patients; just to be more responsive to them and to hear what they are saying and hear the symbolic part of it; to hear their story in an open way and kind of understand, kind of more metaphorically, what they are meaning.

219 I am thinking of a man whom I found difficult to like, initially ... He was, he just represented things that I didn't, I just didn't appreciate, I didn't like.

220 It was hard to listen to him.

221 I thought him to be quite callous and self-centred and very patronising towards women.

222 I thought that he treated women very badly.

223 It was hard to listen to him.

224 I really found my therapy at that point to help me just to not assume that that was who he was or all he was, but that was where he was at that point in time and what he needed to project at that point in time about himself, what he felt like in relation to me or to women at that moment in time.

225 *R: What about your therapy enabled you to do that?

227 F: Part of it was just being able to use the therapy as a container in a way for some of my own feelings about men in general, which I might have had at that time with that man and could have used that to kind of push him away, because at that time I was [omitted] and I was angry at men.

228 And here is this man coming in telling me about abusing his wife and being incredibly thoughtless and he had no sense of who she was.

229 The way he was talking, he had no sense of who she was or no consideration for her whatsoever.

230 It might have been very easy, because at that particular point, I had my own set of issues around relationships and men and it might have been very easy just to see him as another thoughtless man who kind of paid no attention to his wife and had no idea who she was.

231 *R: What about your therapy enabled you to do that?

233 F: Part of it was just being able to use the therapy as a container in a way for some of my own feelings about men in general, which I might have had at that time with that man and could have used that to kind of push him away, because at that time I was [omitted] and I was angry at men.

234 And here is this man coming in telling me about abusing his wife and being incredibly thoughtless and he had no sense of who she was.

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236 It might have been very easy, because at that particular point, I had my own set of issues around relationships and men and it might have been very easy just to see him as another thoughtless man who kind of paid no attention to his wife and had no idea who she was.

237 *R: What about your therapy enabled you to do that?

239 F: Part of it was just being able to use the therapy as a container in a way for some of my own feelings about men in general, which I might have had at that time with that man and could have used that to kind of push him away, because at that time I was [omitted] and I was angry at men.

240 And here is this man coming in telling me about abusing his wife and being incredibly thoughtless and he had no sense of who she was.

241 The way he was talking, he had no sense of who she was or no consideration for her whatsoever.

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Initially F had had found herself disliking this patient intensely (221, 227). It had been almost impossible to be attuned and responsive to him (223), and she had doubted that she could work with him (228). This may be understood as F’s having made a complementary identification with
the disempowered victim “pole” of this patient’s negating way of relating to women and herself (which was probably also a disowned part of himself) (236-237). This had echoed and intersected with an aspect of her own life that she was struggling with, and about which she had strong and disturbing feelings (235). There had consequently been some confusion between the “other within” and the “other without” (Benjamin, 1998b, p. 108) (238) and the patient had come to represent a hated and incensing “object” (222). This had evoked F’s anger towards and judgement of the patient himself (224-225) and had pulled her towards relating to him as a despised other/object that she desired to distance herself from rather than as a subject (235). At that time F’s negation of the patient had seemed certain and the derailment of the therapy had appeared to be a strong possibility.

However, because her therapy had contained her feelings (235, 239), F had managed not to drown in (Racker, 1968) or to react reflexively to her countertransference feelings towards the patient and was able to use them to inform the therapeutic process. She had consequently been able to disidentify from the “abused victim” pole of the patient’s relating to women and the “as-if” space of therapy could be restored (232). F was able to use her own experience of therapy to identify with the patient’s being in therapy (241-245) and to move towards a more empathic knowing and recognition of him; that is to use identification as a “bridge” towards greater connectedness with this patient. One could also speculate that she had probably been making use of and identifying with her experience of her own therapist’s acting and thinking towards her in similar situations.

At this point F had clearly been able to be “on both sides of the divide” (Benjamin, 1998b, p. 19), to represent a “double-sided perspective” (Benjamin, Ibid., p. 25) and to keep both herself and the patient in mind. She was therefore being reflective in the manner described by Aron and Benjamin (Benjamin & Aron, 1999; Aron, 2000). Her thinking had also moved to a more symbolic level (246-248). The patient was no longer just concretely what he was in a moment: she had come to understand her experience of that period of almost hating him as only representing an aspect of him. Different and contradictory identifications with the patient and a variety of meanings could now be entertained and played with. Her connectedness with the patient could also become an authentic “loving tie” (Benjamin, 1995, p. 7) at a more subject-to-subject level, so that thirdness between them and the real work of therapy became possible (249).
4.5.2.7.3 Personal therapy and the Thirds of theory and supervision

As in the “pure” psychoanalytic and Jungian paradigms, the triad of personal therapy, supervision and theoretical knowledge is also considered essential in the training and ongoing development of the psychodynamic psychotherapist. Just as Wiseman and Shefler’s (2001) participants, the participants in this study had considered their therapies as having been more fundamental to their development as therapists than either theoretical knowledge or supervision, and also that their therapies had enabled them to make better use of those. Of course the kinds of Thirds provided by theoretical knowledge and supervision are also essential aspects of being-a-therapist, inform personal therapy and are also informed by that. However, as Macran, Smith and Stiles (1999) point out, personal therapy has a unique place in the development of the therapist that cannot be filled by knowledge or supervision. In the following sections there is a discussion of the participants’ views and experiences of how the Thirds offered by theoretical knowledge and supervision had related to those of their therapies and how this had influenced their thinking, both about and in doing therapy.

4.5.2.7.3.1 Personal therapy, thinking about clinical work and theoretical knowledge

The term “psychodynamic psychotherapy” is understood as encompassing a variety of therapies. While there are different ways of viewing and describing the same psychological phenomena within this paradigm, psychodynamic psychotherapy is theoretically grounded, rather than being technique-driven.

268 I am strongly located within a theoretical discourse and so what I'm saying comes from that.
282 It's like you cannot have a conversation without using language.
284 It's there, it's embedded in every single thing you do, it's embedded in every thought you think.
285 Even if you're not using terms like countertransference or projection or whatever your terms might be, you're coming from a model of understanding human beings and relatedness and how we function.
579 One of the things it's particularly clarified for me today, which is interesting, I know where I come from, I know that I come from a very strong belief that therapy is important and one of the things that I've just had to acknowledge is that is where I come from, it's about my theoretical model. (F)

The participants had viewed their own therapies as being more fundamental than their theoretical knowledge in constituting their functioning as therapists.

8 In my opinion, actually, one's own therapy is the core of the effectiveness of your own work. (A)
212 The theory is always secondary in my judgement and each year that I've worked, that realisation has been amplified exponentially.
213 I mean, I wouldn't have said theory is secondary three years ago.
214 I would have said it's a balance between theory and authentic knowing of yourself in the room and relating.
215 And there is a relationship between them that's a kind of give and take.
216 And each year that has passed, that scale has tipped totally. (B)
Taking conceptual knowledge to one’s work as a psychodynamic psychotherapist means thinking about and responding to patients in specific ways that are based on “a frame that you are bringing into the therapy” (D, 232). What is meaningful is therefore not so much “based on a perception and that's what captures me in the field right now” but rather on “thought-through understanding ... that may only become relevant after a fair amount of dialogue and a fair amount of sensing where that actually fits into” (D, 232).

According to the participants, theoretical knowledge could only become a “living phenomenon” (D, 220) in the context of the therapeutic relationship, where the “anchorage for the therapist is in the transference and countertransference” (D, 208). The actual experience of personal therapy renders theory “alive” in a way that goes beyond the limitations of just having cognitive understanding.

I can't see that you can actually help anybody from a theoretical place. (B)
You can give them words, but I think that is just so many words, it's not really going to help. (B)
I think that how that kind of work subsequently has influenced my work has been profound, because it is not just a theoretical understanding of the structure, of the depth psychology or the roots of your psyche. (B)
It is experiencing it. (A)
That is the experiential side: then I can see it, I can feel it, and it's not just the theory. (C)

The connection between theoretical knowledge and personal therapy had been especially important when participants had been trainees or novice therapists. Over time theory had become part of whom they were as clinicians.

We'd be in a lecture and there would be a theory; or I'd be in therapy and there'd be a process happening in the therapy of some kind and I would just absorb it and just get it. (B)
I think you've got to have the theory, you've got to learn, you've got to have it there at the beginning and it's then nice when you can then just let it go, but understand where you've come from. (F)
So I think I work a lot harder in therapy, but it's different from when I was a young therapist, where one almost felt that you had to prepare and you had to come with the answers.
It's not that kind of thing.
It's much more processing it in myself.
Ja, ja it's not an intellectual thing.
It's that, too, but it's a proper processing of countertransference issues, of feelings that patients elicit in me, what it means, and really having to think about it properly. (BP)
Theory had therefore not been “objective”, but also part of whom the participant had been, that is, his subjectivity.

And it does not really matter what method, I think, but it has to be something that's compatible to one's own nature. (A)

It never felt really like I was learning something that I never ever knew and now this is the first time I'm learning it.

And when it does feel that way, I've come to realise for myself that is not valuable to me, that information.

Because if I can't feel like I'm remembering it, it's not really about me.

And if it's not about me, it's not about anybody, really, because I'm a human being and I have a psyche.

And so if it's not connecting it to my psyche somewhere, well, then that's not really about the psyche. (B)

I think that my theoretical orientation helps me and guides me in creating boundaries and creating structure and a frame within which I work, but ultimately it is me who is the therapist and I don't think I'm going to be like Jung or like anyone that I have studied.

There's going to be an interface between me and my theoretical orientation, which is uniquely me and cannot be replicated by any other therapist. (G)

Participant E found being able to relate to and identify with the experiences and thinking of other therapists particularly useful to make sense of her own processes.

*R: Do you sometimes use theory, somebody else's writing, to get an understanding of your therapy?

E: Oh, absolutely, I have an absolutely driving need to understand what I'm experiencing in therapy and at the time of all this kind of disintegration I was much more immersed in psychoanalytic stuff and Francis Tustin I found very meaningful; Winnicott I found very meaningful.

I read a lot of kind of biographical stuff.

I read Coltart and Nini Herman, I think and then there's psychoanalytic writers who wrote of their own kind of disintegration ... the woman who saw Winnicott, Little, I think.

So those I also found kind of thoughtful in terms of trying to make sense of my own process.

The therapist’s perceived intellectual prowess and conceptual proficiency had often played a part in the participant’s choice of him as therapist. This had partly been based on the reality of the participant’s being knowledgeable enough about therapy to look for a therapist who was known as being competent, preferably excellent, in the community of fellow therapists, that is, a “therapist’s therapist” (Norcross, Geller & Kurzawa, 2001). On the other hand, such a view of the therapist’s supposed intellectual superiority was also suffused with the idealisation of the one who had been chosen to be like.

I saw in this man a combination of deep intellectual and theoretical rigour, like he knew what he was talking about way beyond where I was theoretically, combined with depth, with great depth and feeling and at the same time, a spiritual trajectory in life. (B)
Nonetheless, it had also been important for the participants to know that the chosen therapist had had his own *experience* of therapy or analysis.

181 I, myself, wouldn't go near a therapist who hasn't been in therapy themselves.
182 I can't see how they can be working in the room.
183 They'd be working through a textbook ... (B)

Participant A described how theory had provided names and concepts for what she had experienced in therapy.

264 A: Well, it's a combination of experience and then the naming of it.
265 The theory for me would come after, more as a description of what you experienced.
266 And then it really becomes a tool.
267 If you then have a name for that experience, you know what's inside the box, whereas if you just see the name and you can read what is inside the box, you still don't know anything about the experience and you can't really use it.
268 *R: So you can then go to theory?
270 A: Yes, theory for me would have to come after experience, but it's also as necessary as the experience, because the theory gives you a label. (A)

Therapy had also informed conceptual understanding.

540 But then you would read about something and really can't quite get your head around it until that particular pattern has slotted into place in your own psyche and you can really see it: "Oh, okay, now I understand that particular pattern." (A)

Sometimes the experience of therapy had led to a change in theoretical paradigm.

239 D: I think it's about a shift in a paradigm.
240 There's been a shift; it's like a quantum shift.
242 I think that's what happens in therapy.
243 Once you've had that experience, there's a shift in the way you think of things, the way you see things, the way you conceptualise things.
246 *R: So something about your own experience changes...
248 D: The way you were looked at and the way you were taught to look at yourself becomes the way that you begin to look at other people and look at yourself with other people. (D)
In the following excerpt Participant D emphasised that theory had not been foregrounded in his reflecting on the patient he was talking about. But his thinking about her, whether or not one agrees with his specific understanding of the patient or the relationship, had certainly been psychodynamic in nature in the focus on the transference-countertransference and unconscious communications and meanings. What D described could also be understood as his identification with his therapist’s way of working. This had not remained at the level of concretely repeating words or actions, but had included the more abstract level of coming to share a way of thinking about doing clinical work.

178 What I found is that I began to reflect a lot more during the therapy and my reflections would not be of a theoretical nature.
179 Occasionally I would sort of break into theory if I was really confused: "What on earth is this person trying to say," but generally it would be, as I said, more of a reflection.
180 And out of that reflection I would be reflecting on what I was feeling and what I was understanding was coming through.
181 Then what would happen, is meaning would start to emerge out of the way certain things that the client had said in coming into therapy later on in therapy.
182 Through those reflections I'd be able to gather them.
183 So, to give an example.
184 A client came waltzing in one day and she says: "Those bottles you've got on the lawn, are they supposed to stop the dog s******* on the lawn?"
185 And I said: "Yes."
186 I couldn't quite understand what that was about.
187 She flounced in and sat down and then she began to talk about a relationship she was having and the difficulties in this relationship.
188 And then she began to talk about anxieties she had around her therapy, because she wanted to travel to the place where this relationship was taking place.
189 And then it became clear what this meant, with the bottles.
190 What she was anxious about was whether I was going to s*** on her for wanting to leave the therapy to go to the relationship.
191 And I could make that interpretation for her, but that wasn't the end of it, and because as we explored that a little bit more, what became another level was in fact her being the dogs, s******* on the lawn of the relationship and the lawn of the therapy, and because she was very angry with this man for living so far away and not being available to her, as I wasn't always available to her.
192 But those kinds of thoughts wouldn't have happened for me as a [omitted] therapist.
193 So what I learnt in my therapy was the way something I said here and something I said there and something I said then could be collected by the therapist into the meaning that I was bringing to the therapy on that particular day.
194 It's a particular way of thinking, which I think was one of the first things that actually influenced me in my actual therapeutic work. (D)

In a similar vein, Participant BP described how her own experience of feeling contained by her therapist’s “theoretical rigour” had led to her making this part of her being-a-clinician.

64 I think that he is extremely rigorous in terms of his theoretical background; he is extremely containing in terms of boundaries and I think that that is what is helpful.
148 And in the process feeling myself more contained, because there is more of a theoretical rigour, which immediately contains me more and helps the therapy.
147 So I think as part of that, since I have been in therapy, I've done a lot
The experience of therapy and the gaining of further theoretical knowledge had mutually
influenced, informed and enriched each other and as such had contributed to the participants’ being
able to keep on thinking about their work.

Participant F highlighted the importance of examining and questioning the place and use of one’s
actual theoretical framework. The therapist may use theory defensively, for example, by
dominating the patient from the position of being the *one who knows* and as such attempting to
replace the patient’s version of reality with his own.

The therapist’s theoretical knowledge is a necessary background frame to his responses to the
patient. For Participant F it had been important *not* to be aware of her therapist’s theory, but rather
to feel recognised through being heard and understood in a way that had conveyed authentic and
vital connectedness. She could then take this way of working to her own work.

Participant F accordingly described how she had used her own experience of her therapy and
therapist as a Third to listen to herself responding in a session with a patient and to think about the
possibility that she could be using theory in a negating way.

*more theoretical reading, courses, support, because I am becoming much
more aware of my responsibility as well, I suppose.*

187 The theoretical rigour which I’ve experienced in my own therapy, I’m
bringing into my practice, and it’s very helpful.  (BP)

The experience of therapy and the gaining of further theoretical knowledge had mutually
influenced, informed and enriched each other and as such had contributed to the participants’ being
able to keep on thinking about their work.

*Theoretical rigour which I’ve experienced in my own therapy, I’m bringing into my practice, and it’s very helpful. (BP)*

482 I do a lot of thinking about things that have come up that are
meaningful, and, I suppose, from my reading as well.
483 I often have one mind on my practice when I read and one mind on my own
individual therapy when I read.  (D)

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actual theoretical framework. The therapist may use theory defensively, for example, by
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293 So I think you have to examine your theory.
294 I think that it can be a hindrance.
295 You know, I think it's very easy to hide behind your theory or to use it
in things like interpretations and it doesn't take you to understanding
the experience, the phenomenology of something.  (F)

The therapist’s theoretical knowledge is a necessary background frame to his responses to the
patient. For Participant F it had been important *not* to be aware of her therapist’s theory, but rather
to feel recognised through being heard and understood in a way that had conveyed authentic and
vital connectedness. She could then take this way of working to her own work.

313 My therapist and I are both psychoanalytic, but we're from fairly
different sides and very different theoretical viewpoints.
315 But that's not an issue.
330 But it's the experience that is important and understanding it in the
human way that's important.
331 Ja, the theory is in there.
332 Your theory is in there the whole time.
333 I need my therapist to use it, but I need her to hear ME.
334 I don't want hear her theory, although I know it's in there.
335 And I suppose I try and do the same thing.  (F)

Participant F accordingly described how she had used her own experience of her therapy and
therapist as a Third to listen to herself responding in a session with a patient and to think about the
possibility that she could be using theory in a negating way.

81 And trying to imagine whether it was sounding very theoretical or whether
it was sounding very kind of coldly analytical.
82 Just thinking about what it might be sounding like.  (F)
4.5.2.7.3.2 Personal therapy and supervision

Just like personal therapy, supervision had been one of the Thirds that had enabled the therapist-patients to continue doing the work of therapy.

I think the burnout that happens in this work is quite well known, and can be remedied by your own therapy, by supervision, by frequent holidays and by not having too many people in a day, by balancing your year with holidays in between. (A)

In conjunction with therapy and the gaining of theoretical knowledge, the participants had also considered supervision to be one of the continuing necessary requirements for being an effective and dedicated professional.

I think the more I experience therapy, the more I know of therapy, the more I believe in the work of therapy, but the more I'm also aware of the need for intellectual application, for supervision, and that one has to be completely dedicated and you have to remain in a training kind of a situation where you can keep on kind of sharpening your pencils.

And I think when the therapist becomes too secure in her own knowledge and doesn't make use of these support systems like therapy and supervision and discussion, I think that will always be a danger, because it's an ongoing effort.

It's like having exercise every day of your life.

It's not something that you can learn and you've got the tools now, now you can ride on that.

You have to keep on working at it all the time you are a therapist.

Maybe it's like exercise.

You can't actually get fit and then think you can ride on that.

You have to stay fit ... (BP)

One's own therapy is part of the whole process of therapeutic work.

It's the therapy with a patient, it's the supervision, and it's the own therapy.

It's all of those kind of things that enable you altogether to actually do the therapeutic work.

What you do with it in your hour or your fifty minutes with your patient, that's not the whole of the therapy. (F)

They had also considered supervision to be part of their ongoing development as therapists.

But I really do think it's an inch-by-inch process that happens in therapy, whereby one, both as a result of the reading and the supervision that one is exposed to and one's own process, there is a process of transformation and I am a completely different person from the person who started therapy [omitted] years ago. (E)

In contrast to supervision, the participants had seldom used the space of personal therapy to talk about patients. At earlier stages in their professional lives they had been more inclined to do this.

I actually very rarely talk about patients in my therapy.

I talk about aspects of patients, I suppose.

I talk about what they represent for me.

Maybe what the patient has made me reflect on. (F)

Having supervision helps me to use my therapy time for myself.

So very seldom do I talk about my patients. (G)
The participants had also pointed out the different but overlapping emphases of personal therapy and supervision.

531 You would still talk about how it has affected you, but you won't go into the tale that hangs on that.
532 You would say: "It has touched me" and maybe say how, but then focus on the story of the patient and how best you can position yourself towards that ... (A)

361 It was a theoretical, mostly intellectual process, with occasionally, I suppose, one would touch on unworked-through emotions in oneself, but mostly that was not the pitch of it. (BP)

467 I talk about my clients to my analyst when there has been some kind of impact on me.
468 My supervision is about their process.
469 Ja, so talking about them in analysis is about my process; in supervision it's about their process. (E)

200 I see them very differently.
201 I suppose I would go to supervision with my patient very much in the foreground.
202 I would talk about the patient's narrative.
203 I would talk about my thoughts and my feelings and my responses to that narrative.
204 Occasionally I would touch on how the patient's narrative and my responses to the narrative touch, things I know about myself or unusually strong or disturbing responses in myself.
205 When I go to therapy, my feelings, my experiences, are in the foreground.
206 That's mainly what I'm thinking about.
207 That's where my energy is.
208 Sometimes a patient's face will be in a dream and then, in talking about that, I might say; "Who is this patient? What is she representing to me? Who is she to me? What are my feelings about her? Did she say something that connects with what I'm talking about?"
209 I'm not talking about what it means for her; I'm talking about what it means for me.
210 It's not completely separate.
211 They overlap, but I suppose it's just a different emphasis ... (F)

An important difference between therapy and supervision had been that the supervisory relationship had more of a sense of being one between two professionals. The participant's relationship with his therapist had been one where he could be less of a professional and be known in a more personal way, but also one in which he had been in a more vulnerable and disempowered position.

690 Analysis comes closer, because you do open yourself if you do.
691 If the trust happens; you are much, much more open.
694 And to make that process more conscious is a lot more difficult than maybe with supervision.
695 Therefore, the delicacy of that relationship is quite huge, the power ... (A)

570 And learning from somebody who really knows me and I think that that's the difference between taking my work there and taking my work to supervision, because taking my work to analysis, my analyst REALLY knows my shadow and REALLY knows my vulnerability and my complexes and can see where they interface and so it really is very helpful. (E)

137 My therapy, by contrast, gives me the permission to be small, to be
helpless, to be vulnerable, to expose parts of me that are not part of my professional persona.

And there's been a very clear division there, so that in both I've been able to keep my dignity, the one as a professional, enhancing my professional curiosity and the other as an individual ...

And supervision has never become too intensely personal so that it becomes humiliating.

I'm sure it could if my supervisor felt the need to explore certain areas that I was battling with, because it was my own personal issue.

I believe that it would become humiliating. (G)

4.5.3 Personal therapy and a psychoanalytic unconscious

4.5.3.1 The notions of unconsciousness and a psychoanalytic unconscious

One of the principal underlying notions of psychodynamic psychotherapy is the idea that human experience involves more than “meets the eye”. Therefore the “idea that the self can have transparent access to and be the master of its own processes is no longer tenable” (Flax, 1993, p. 96). There is “an unconscious” which influences our perception and experience of the world, that is, of ourselves and others, and that informs the ideas and organising principles by which we live. It could indeed be said that the unconscious has to do with that which is lived, but not known or thought. There is also the assumption that understanding the unconscious meaning of human mental activity offers a powerful potential for change (Stokoe, 2000). Since what is unconscious is by definition “outside conscious awareness and control” (Flax, 1993, p. 96) and our knowing is subject to the vicissitudes of the same unconscious that we are trying to understand, we have to accept that our understanding will always be partial and provisional (Flax, 1994).

Part of the therapist’s task is help the patient to have more awareness of and confidence in his internal processes. This makes the “collaborative inquiry into the patient’s unconscious life” central to the therapeutic endeavour and requires that therapist and patient mutually create “a language” for experience that is “unsymbolized, disavowed or otherwise repressed” (Zeddies, 2000b, p. 468). The therapist therefore has to be open to and able to trust the deeply intuitive aspects of his own experience in therapy, for example, of the nonconscious or unconscious processes constellated between him and the patient.

This brings us to the kind of working model of “the unconscious” (both their own and that of patients) that therapists hold. Exactly what is meant by the term “unconscious” has become more diverse and controversial in the present-day psychoanalytic and analytic world of post-modern thinking and many and ever-evolving paradigms. Thinking about what is meant by “the unconscious” is indeed very much a “work in progress” (Renik, 2000, p. 4). Things have changed radically since Freud introduced his notion of the dynamic unconscious, by definition the seat of
repressed instinctual drives, a structure (rather than a process) consisting of “a dynamic collection of timeless fantasies and wishes” sealed off within the individual mind (Zeddies, 2000a, p. 61).

For example, theorists from the contextualist or systems intersubjective approach write about “the organizing principles that unconsciously shape and thematize the person’s experiences” (Stolorow & Atwood, 1992, p. 33) and about “emotional convictions that operate automatically”, which may concern relatedness or one’s sense of self (Orange, Atwood & Stolorow, 1997, p. 7). This is compatible with the relational view of the unconscious, with which the contextualist approach further shares the notion that unconscious processes arise out of and are shaped by the person’s intersubjective experience with significant others, especially those early experiences in the family of origin (Zeddies, 2000a). Both the relational view and that of the contextualist intersubjective approach emphasise that what is unconscious and hence “unformulated” (Stern, 1997), “refers not only to an individual’s mental processes, but is also considered to be an inalienable property of interpersonal relationships and dialogue” (Zeddies, 2000a, p. 62). These ideas therefore depict “the unconscious” very differently from when it was first thought about within psychoanalysis.

In conceptualising what he calls the “relational unconscious” as it pertains to the therapeutic situation, Zeddies (2000b, p. 467) posits that it includes the idea that “meaning and understanding are coconstructed and not universal, absolute and performed”. The patient’s “unconscious” is therefore no longer viewed as a “thing” to be excavated, but as “intersubjectively mediated” (Ibid.). Whatever approach the therapist uses to explore the patient’s unconscious material will consequently play a role in how that comes to be understood. Instead of Freud’s repression barrier, there is also “a fluid boundary with consciousness” (Zeddies, 2000a, p. 61).

What the individual therapist expects the “unconscious” to be (both in form and content), and what he infers from this expectation, will depend on the analytic subculture the therapist belongs to and will also inevitably be part of his or her subjectivity (Renik, 2000). Renik (2000, p. 4) suggests that we should think of unconsciousness as a concept or idea that organises our clinical experiences rather than of the unconscious as “an immutable thing-in-itself”. He consequently usefully discusses unconsciousness from a phenomenological perspective in experiential rather than in purely theoretical terms and distinguishes the following ways in which unconsciousness is commonly experienced in the clinical situation.[133]

[133] Although Renik suggests this differentiation as a potential heuristic device in an actual clinical situation rather than as an indication of the existence of separate phenomena, it is likely that even in a clinical situation these aspects of unconsciousness would not be quite so clearly differentiated.
Experiences and thoughts that are being kept out of conscious awareness because of psychological reasons; that is, experiences and thoughts about which the individual is motivated to remain unconscious. Both Freud, and Stolorow and Atwood’s concepts of a dynamic unconscious could be included in this. However, Freud’s dynamic unconscious would be the result of repressed instinctual drives and that of Stolorow and Atwood would pertain to emotional information that “was ‘sequestered’ because it jeopardized needed ties to caregivers or threatened the psychological intactness of the potential knower” (Stolorow & Atwood, 1992; Orange, 1995, p. 80; Renik, 2000). According to Renik (Ibid.), a criticism that can be levelled at Freud is that he overemphasised the importance of the domain of the dynamic unconscious in clinical analysis.

Experiences that remain unconscious because they were never verbally represented. This happens primarily because of circumstantial reasons (for example, because of a lack of the necessary linguistic or conceptual skills) and/or sometimes also because of defensive reasons. Examples of this would be Freud’s descriptive unconscious; Stolorow and Atwood’s prereflective unconscious and unvalidated unconscious; Bollas’s (1987) unthought known and Stern’s (1997) unformulated experience. Implicit or procedural knowing or memory could also be seen as being nonconscious or unconscious in this sense (Fonagy, 1998; Lyons-Ruth, 1999).

Thoughts that the patient has never before entertained; that is, attitudes, ideas and ways of experiencing that the patient becomes conscious of as these are created in the therapeutic intersubjectivity. Mitchell (2002, p. 24) points out that the “Freudian revolution” has asked that one gives up “a certain kind of hubris”; that is the “vision of the human mind as transparent to itself and ruled by conscious reason”. Freudian and Lacanian thinking about the unconscious further means that “the subject is always internally divided” (Flax, 1993, p. 96). Rather than just thinking of these more opaque areas of experience as being limiting, they may also, if one is willing and open to the idea of somehow engaging with this complex and multifaceted dimension, hold the potential of deepening and enriching experience. Therapy is therefore not just about discovering what is already there and becoming freer from limitations, but also about creating new possibilities. (Renik credits the Jungians for being more comfortable with the idea of the analyst’s adding something from his or her perspective in their conception of the clinical methods of analysis.)
Some psychoanalytic thinkers such as Ogden (1997, 2001) and Bollas (1992, 1995, 2001) give evocative accounts of the creative use of the analyst’s unconscious processes and how this informs and shapes the therapeutic process. Using Freud’s ideas around the unconscious as a starting point, both of them have (in their different ways) opened up theorising about the unconscious to include intrapsychic as well as intersubjective processes. They further describe how the therapist’s “active use of countertransference” alters his role from that of “careful observer/listener” of the patient’s unconscious productions to that of “active coshaper/coholder” of the therapeutic pair’s unconscious processes (Bernstein, 1999, p. 280). The therapist’s task of being open and receptive to the patient’s “intrapsychic productions” is accordingly extended to include his (the therapist’s) own “internal free associations” (Ibid.) to his experience of the intersubjective third, and these, for example, the therapist’s fleeting thoughts, intuitions and reveries, are transformed into “intersubjectively generated scripts” for further analytic work (Ibid., p. 282).134

Ogden (1997, 2001) explains how, together with the conversations with the patient, the therapist also has other and private conversations with himself about what is happening and being communicated unconsciously between him and the patient (that is, about the analytic third). He does this by being attuned and open and by associating to his own reveries or waking dreams (Ogden, 2001, p. 5). Those are experienced in the form of mundane, everyday thoughts, feelings, ruminations, daydreams, bodily sensations and so forth, which may, at times, appear to be no more than rather self-absorbed narcissistic musings. The therapist’s “reverie state involves a withdrawal from the logic, demands and distractions of external reality” (Ibid.) Reveries drift in and out of the therapist’s mind intermingled with and shaping self-reflective consciousness136 The openness to unconscious experiences and the therapist’s use of his own reveries requires tolerating the drifting and uncertainty of not knowing and being able to bear the anxiety of letting meanings accrue rather than imposing premature certainties.

Ogden (2001, p. 6) imaginatively uses Freud’s metaphor of the unconscious, preconscious and conscious minds and locates reverie experience on the border between the unconscious and the preconscious. This “frontier” (Ibid.) is the place where playing and creativity originate,137 where

134 Bernstein (1999, p. 280) warns that we should keep in mind that this could provide theoretical leverage for the therapist’s becoming preoccupied with his own “internal echoes at the expense of [the] patient’s intrapsychic conflicts”.
135 In this regard Freud wrote to Lou Andreas-Salomé (Freud & Andreas-Salomé, 1966, p. 45) as follows: “The analyst must cast a beam of intense darkness into the interior of the patient’s associations so that some object that has hitherto been obscured in the light can now glow in that darkness.”
136 Ogden (2001, p. 10) calls this “symbolically mediated self-consciousness” and also underlines (Ibid, p. 107) that “it becomes necessary that the analyst recast his reveries into a more highly organized, verbally symbolized form of talking to himself (and eventually to the patient) about the affective meaning of the reverie experience”.
137 According to Ogden (2001, p. 9), it is “crackling with the impulse toward symbolic expression”.

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Bion’s ß-elements, the incoherent “things in themselves” (Bion, 1962, p. 6) may accrue into meaningful thoughts that become available for self-reflective thinking and the “it-ness” may become the subjective “I” which may become the self-reflective “me”. There is no linear progression: these ways of being ebb and flow and interweave and one has significance only in terms of the others.

Just as reflective consciousness exists in dialectical tension with productions from the unconscious, the unconscious productions from the therapist as an individual (and those of the patient as an individual) are also in a dynamic tension with those that ensue from the unconscious intersubjective analytic third. While the analytic third (partly) shapes the analyst’s reveries, reveries also feature prominently in the analyst’s efforts of “catching the drift” of the unconscious third (Freud, 1923b, p. 239; Ogden, 2001). Ogden (2001) further emphasises that the therapist’s reveries do not indicate that aspects of unconscious experience are being brought into conscious awareness: reveries are newly-created reflections of what unconscious experience is like or metaphors for unconscious experience. This resonates with Bollas’s (2001, p. 96) notion: “This is less often the return of the repressed and more often the evocation of the received.”

Bollas’s ideas about Freudian intersubjectivity (Bollas, 2001) and the therapist’s countertransference dreams (Bollas, 1995) are similar to those of Ogden. However, encountering his beautiful and elegant prose is like entering the “dreamier frame of mind” (Bollas, 1995, p. 1) of the unconscious, which rather obscures a systematic rendering of his theoretical perspectives.

In his earlier work Bollas (1987, 1992) highlights the intrapsychic aspects of the therapist’s task in this regard. He envisages the creation of a receptive space (in this instance belonging to the therapist) that is open to and sustaining of the spontaneous arrival of unconscious derivatives (such as the therapist’s shifting states of mind, fantasies, affects, thoughts, bodily sensations, ruminations, preoccupations, feelings, daydreams, and so forth) that will allow unconscious development without consciousness intruding. This is made possible by the therapist’s receptive capacity, which is marked by the evocation of a certain frame of mind (the therapist’s being actively quiet and meditative), and which is indeed a “mode of deflected attention” (Gerhardt & Sweetnam, 2001, p. 45). Bollas (1987) contrasts this being and experiencing with being self-reflective (and knowing and interpreting).

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138 Unthought emotional experiences and sense impressions devoid of meaning (Bion, 1962).
139 See pp. 194-195 for the discussion of interview material pertaining to this.
140 Bollas (1987) hopes that the patient will internalise this through identifying with the therapist.
Bollas (1992, p. 103) also describes how the therapist brings his “disseminating subjectivity” (a kind of unconscious deconstructive activity) to bear on the patient’s material, making it both his own and part of the therapeutic intersubjectivity; that is, belonging to patient and therapist. What is received from the patient is transformed (and not just contained) by the therapist from being β-based to α-thinking (Bion, 1962) and provides material for further analytic work. The therapist’s conscious reflective capacity becomes foregrounded in the process of organising and conferring meaning on what ensues from this, although the dialectical processes between “the two separate yet deeply involved unconscious subjectivities” remain of primary importance (Bollas, 1992, p. 99).

In his later work Bollas (2001, p. 93) conceptualises the figurations of unconscious communications and processes between therapist and patient as a distinct kind of unconscious intersubjectivity, a “Freudian intersubjectivity” constellation by the “Freudian pair” constituted by “the patient’s free associations and the analyst’s evenly suspended attentiveness”. The analyst listens in such a way that the patient’s speaking “becomes open speech, a discourse driven by the unconscious speaking in the presence of an other newly arrived on the scene” (Bollas, 1999, p. 184). Just as in Ogden’s work (although not so clearly described), there is an interplay of individual subjectivities and intersubjectivity (the “third”) on an unconscious level (Bollas, 1992, 2001).

In Benjamin’s (1988, 1995, 1998b) innovative work on intersubjectivity, where mutual recognition is conceptualised as an essential aspect of the development of the self and intersubjective relatedness, there is a focus on the processes of mutual, reciprocal identifications between therapist and patient as mostly taking place on an unconscious level. Although Benjamin appears to theorise about a “more interactive axis” in psychoanalysis, “the unconscious world is enriched rather than replaced” in her thinking (Gerhardt, Sweetnam & Borton, 2000, p. 40).

Since the unconscious can never be encountered wilfully or directly, cannot be predicted or controlled, our experience of it is only a dim and fragmented outline of its presence. This is true for both patient and therapist and makes therapy a difficult and dangerous undertaking for both of them. Bion (1990, pp. 4-5) speaks of therapists’ and patients’ inevitable anxieties in this regard: “[W]hen approaching the unconscious – that is, what we do not know, not what we do know – we, patient and analyst alike, are certain to be disturbed … In every consulting room there ought to be

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141 For example, between the patient’s transferences and the therapist’s countertransferences; the patient’s narratives and the therapist’s associations, and so forth (Bollas, 1992).

142 See pp. 162-163 and pp. 195-197 for examples of interview material pertaining to this.
two rather frightened people: the patient and the psycho-analyst. If they are not, one wonders why they are bothering to find out what everyone knows.”

The asymmetry of the therapist-patient dyad is based on the formal and contractual aspects of their relationship and on the special expertise and professional training of the therapist (Broucek & Ricci, 1998). By implication the therapeutic space belongs to the patient and the therapist is understood to be the “expert” who is available to facilitate the exploration of the patient’s inner world. This means that therapists should be both intellectually and emotionally receptive to what patients communicate not only consciously, but also unconsciously. Freud (1912, p. 116) therefore warns that a precondition for the analyst’s use of his unconscious as “an instrument in the analysis” is that he “may not tolerate any resistances in himself which hold back from his consciousness what has been perceived by his unconscious” and that every unresolved repression constitutes a “blind spot”.

According to Zeddies (2000a), the therapist’s ability to allow his unconscious to resonate with a patient’s fantasies, conflicts and fears, is crucial in enhancing the therapist’s understanding of patients and in promoting his analytic responsiveness. This implies the therapist’s being sufficiently emotionally available to the patient to be able to listen with the “third ear” (Reik, 1948), and to be open to even the more obscure and intuitive aspects of what is evoked in himself as a result of his experiences in and engagement with the intersubjective third (Bollas, 1992, 2001; Ogden, 1994, 1997, 2001). The evolvement of this kind of “therapeutic” emotional availability was previously described as part of the participants’ increased capacity for subject-to-subject relating, and the concomitant ability to empathically identify with the patient as a dissimilar and separate other and to engage in the play of identifying and disindenifying with the patient and different and contradictory aspects of the patient.

As in all individuals who seek therapy, the therapist’s own therapy brings both the possibility of increased self-knowledge and personal growth, but there is also an added dimension that makes it different from other therapies: the role it plays in the therapist’s development as a professional, which is so inextricably entwined with self-knowledge and personal growth. What the therapist’s personal therapy offers him is also different from the contributions that theoretical knowledge or even supervision makes to his professional development.

143 “[T]his third ear works in two ways. It can catch what other people do not say, but only feel or think, and it can also be turned inward. It can hear voices from within the self that are otherwise not audible because they are drowned out by the noise of our conscious thought-processes” (Reik, 1948, p. 146).
144 For example, see A, 127-448, p. 138; B, 312-342, p. 139; B, 291-392, pp. 173-175; E, 218-249, p. 196.
The therapist’s own therapy could provide him with the awe-inspiring but also humbling experience that he is not omnipotent and omniscient and that, just as in the case of “lesser” mortals, there is “an unconscious” at work in his life and in his therapy. As Racker (1957, p. 306) remarks, “we are still children and neurotics even when we are adults and analysts”. According to Silverstone (1979), the therapist’s experience of the existence of his own unconscious entails suffering a real narcissistic wounding; that is, the acknowledgment of the existence of his own conflicts and psychological limitations.

Some examples of this may be found in the participants’ descriptions of how their therapies had “cracked up” and dismantled what Bollas (1995, p. 222) calls the “arrogance of consciousness”. They had also come to understand their choice of profession in terms of the wounded healer phenomenon and retroactively it had become clear to them that their becoming therapists had been for very different reasons than their original conscious motivations for choosing their profession. The experience of their own therapies had subsequently changed their motivations for doing the work of therapy.

Personal therapy could lead to therapists’ becoming more aware of those unconscious desires that may “push and pull” and sometimes even overwhelm them and more able to contain these so that their own needs are less likely to become enacted in the therapeutic space. Many of these blind or dim spots, may, in fact, never ultimately be resolved with any kind of finality. Therefore, this is not just about therapists becoming diminishingly gripped by and freer of their own issues that are in the process of becoming less powerful, but it is also about their awareness of their own limitations as therapists. Gill (1996, p.132) reminds us that the therapist “should be ready to recognize that while his unconscious may have been explored in some measure, it cannot be expunged”. The therapist’s own therapy therefore does not bring either a “psycho-analytic purification” (Freud, 1912, p. 116) nor a “Husserlian cleansing of pre-suppositions” (Orange, 1995, p. 14).

In the therapist's quest to enhance the patient's self-understanding, there is also a limit to the extent to which this can be informed by thought-related factors or the verbal contents of the encounter. The therapist’s task has to do with working on the edge of what is known; making what is embedded explicit; providing a verbal window on those covert presences which structure the patient's experience, but are obscure and not thought or spoken. The therapist’s therapy should
therefore not just be seen as rendering him more conscious of and less entrapped by his own issues, but also as enabling him to become more attuned to and comfortable with the “deeper”, subjective and more intuitive aspects of his experience in the therapeutic intersubjectivity; to become more able to engage in and facilitate “the dialogues of the unconscious” between him and the patient (Ferenczi, 1915, p. 109).

This can be related to the therapist’s experience in his own therapy of being listened and responded to from beyond immediate and explicit consciousness, and at some level knowing that this is what is happening, even if what is occurring is not yet verbally mediated. This kind of interpenetrating simultaneous knowledge and experience may converge into a different and vital way of being that alters and expands the therapist’s “idiom” of working as a clinician (Bollas, 1992).

Spezzano (1993, p. 212) suggests that every psychoanalytic psychotherapist’s “unconscious” (and consequently the way that therapists treat their own unconscious material as well as that of their patients) is transformed into “a psychoanalytic unconscious” through the combination of his own analysis, supervision and theoretical knowledge. As the therapist’s experiences of being immersed in psychoanalytic language and thought accumulate, the “psychoanalytic unconscious” develops and becomes something he can rely on and use automatically.150

This “interpretive template” (Zeddies, 2000a, p. 63), which may also be understood in terms of the therapist’s “professional” procedural memory or knowledge, underpins the clinician’s work. It does not just reflect the therapist’s personal history, but also contains the therapist’s preconscious and unconscious knowledge and recognition of the therapeutic space and task. It is therefore saturated in psychoanalytic meanings and values; that is, it also mirrors the ways in which the therapist relates to his therapy and supervision, theoretical knowledge, and the therapeutic community.

The therapist’s relating to the psychoanalytic unconscious and the resulting dissemination of the conscious surface into the rich and multifaceted depths of this dimension of experience, can be thought of as one of the vantage points of his being-a-clinician. From this perspective the psychoanalytic unconscious becomes a filter through which the therapist listens, a lens through which he perceives, and a template from which he thinks and interprets.

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150 This resonates with Sachs’s (1947, p. 165) much earlier and rather grandiose idea that the aim of the training analysis is “to make the understanding of the nature, language and the mechanisms of the unconscious sufficiently intimate, profound and intense that it becomes a permanent fixture in the mind and will be fully available when it is needed for sounding the unconscious of future analysands”.

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This plays a significant part in the constellation of the meaning-making “frameworks” (Flax, 1996, p. 590) operating between patient and therapist, which both makes possible and constrains the generation of understanding and “truth” in the therapeutic intersubjectivity. Rather than being primarily “objective” or cognitively informed, the therapist’s attachment to certain ways of approaching and thinking about his work is often suffused with intense and unconscious desires and investments. Personal therapy may help the therapist to be more open to the idea of exploring and even questioning the taken-for-granted and embedded epistemological and ontological assumptions according to which he works.

Another aspect that should also be considered at this point is what the therapist actually does with the experience of what comes from the deeply intuitive “psychoanalytic unconscious”. Here one may think of how beginning therapists often identify with a favoured theory, a supervisor or a therapist quite concretely, unthinkingly and “unconsciously”, and directly transpose these to his clinical work. In more mature therapists, what comes from the psychoanalytic unconscious often appears to be part of their subjectivities, their way of being, in quite a smooth and seamless way; opening up possibilities for thinking and meaning rather than foreclosing them with premature certainties.

The nature of such therapist acts should not be seen just as a function of the therapist’s level of development as a clinician, because the therapist may become more self-absorbed and less available for free symbolic play for many reasons (some may be only temporary and others more enduring) such as countertransference issues, difficult life events, and so forth. It also does not mean that the therapist should not make concrete and literal use of his own therapy, theory or supervision, but rather that it should not happen continually, inappropriately or for defensive or narcissistic reasons and if it happens because of such reasons (which is probably just as inevitable as countertransference enactments), that there is some awareness and conscious scrutiny of the event.

4.5.3.2 Discussion of interview material

The Interview Guide contained no direct questions about those therapist capacities which have been termed the psychoanalytic unconscious and consciousness. The use of these concepts had been suggested by the interview material itself and that had again deepened the understanding of these therapist skills that are so pivotal in doing psychodynamic psychotherapy. Generally, it could be said that the participants’ thinking about their therapies and work had been quite evident in their

[151] See the section “The changing nature of participants’ identifications with their therapists”, p. 169.
accounts and had showed itself in the way that they had talked about many different aspects of their therapies and their work. As has already been referred to in the previous theoretical section, there were unconscious aspects to the participants’ original choice of profession, and their therapies had given them some awareness of this and of how their own unconscious processes had shaped and organised their manner of working. Through their therapies, the participants had developed more of a sense of the “pushes and pulls” of their own unconscious desires and needs in the space of clinical work, but because of their own therapies they had also become less prone to enact these with patients and more able to relate to patients as subjects.

The participants’ reflective thinking was quite apparent in the interviews. However, by its very nature it had been much more difficult to tap into the psychoanalytic unconscious “at work”. In this section there is some further exploration of the rather scanty gleanings of further interview material where the participants had described or specifically referred to unconscious processes in their therapies and work. An aspect of this was previously discussed as part of the way that the participants’ thinking and their openness to the more unarticulated, and intuitive aspects of experience had mutually informed each other in the clinical third.

Participants BP and G’s accounts of how their own “freeing up” as therapists through their own therapies had been unconsciously communicated to their own patients, had highlighted the importance of unconscious communications between therapist and patient.

342 I think up to very recently my patients had been incredibly courteous, nice and well behaved and I find that the more that I feel safe in my own therapy to also get in touch with anger, I find that my own patients to also be more free to get in touch with their anger and to attack me, ja

346 I think it's quite an unconscious thing and I see that just in terms of, as I say, how therapies are beginning to develop, my therapies with my patients, how they are beginning to go further, how I see more anger coming from them, but constructive in terms of the therapy.

347 I see more emotion; I see more tears in my patients.

348 So I think my capacity to hold them is increasing as I am learning or experiencing my therapist's capacity to contain. (BP)

91 I believe that something gets communicated to the patient, who is very often very, very much more in tune to us therapists than we ever acknowledge.

99 I believe that, I see that over and over again that somehow, through not such direct means of communication, somehow cues must be coming from me to the patient, to indicate to the patient to bring up the material.

100 So it's not just my awareness that I can focus on.

101 I almost feel it's on another level: that my readiness to deal with the issue gets communicated to the patient. (G)

As Participant B pointed out, the foregrounding of the “the dialogues of the unconscious” between therapist and patient (Ferenczi, 1915, p. 109) holds the potential threat that the therapist may become entangled in and overwhelmed by the hidden complexities of the transference-countertransference matrix or Benjamin’s (1998b, p. xv) web of identifications. This makes the Third of therapy (or that of supervision) crucial as a container that could render the therapist capable of continuing thinking about what is happening. The Third of the therapist’s own therapy, as well as that of supervision, may therefore be thought of as contributing to the development and continuing existence of what Casement (1985, 1990, 2002) calls the therapist’s “internal supervisor”.

427 There's just you and the patient and you need to have a therapist or supervisor in your life at that time, otherwise you might be possessed, possessed by the unconscious at work, because the other person creates a polarity that allows you to become conscious of that which you cannot see. (B)

Personal therapy had deepened Participant E’s self-understanding and had brought some consciousness to aspects of herself that she had been largely unaware of.

634: It's made me very conscious of how unconscious I was of other people's shadows; not least of all some of my intimate others and it's made me IMMENSELY conscious of how I project, I think, particularly positive stuff, out there, to an extent that in the past I idealised people, particularly intelligent men. (E)

Participant F described how her therapy had contributed towards her growing awareness of her own unconscious processes and how they had affected her presence in the space of the clinical third, as well as influencing the nature of the clinical third.

147 Obviously I have my own unconscious defences of a particular kind, as everyone has, as we all do. I work with those.
148 But because they are unconscious, of course you don't just know them.
134 It's been part of the work, part of understanding the unconscious processes in me and how they are influencing who I am in my life and in my work and actually in the therapy sessions. (F)

Participant C’s experience of coming to trust the process of therapy had enabled her to do work around a particular issue (without necessarily “resolving” it) and also to become able to, when working, to be more open to and aware of her own feelings that were evoked if that matter did arise in a therapy situation. Because of this she had become more able to contain her own feelings and less prone to enact them.

211 Well, to give you an example, I've always had an issue with silences, so when a client is silent, in the past I would have always wanted to fill that time and then in my own therapy, when we've had a silence between me and JJ and then I'd say to her that I'm uncomfortable about it, then we would look at it, what does it mean and as I became more trusting of that process, I have become able to do that with my clients, because I've became a deeper person, more trusting within myself, so now
I can sit with silences and work with it and be comfortable with it. I've become much more comfortable with silence and I would say that I'm more rooted, definitely more rooted and I do know that if I do feel more uncomfortable, I think it's something deeper, more unconscious, and I can take it deeper to whatever comes out. (C)

Through her own experience of therapy, Participant F had become increasingly able to listen with the “third ear” (Reik, 1948). She had become more receptive to and could make imaginative use of her own experience of the intersubjective third, while also being able to “track” the patient both on a verbal and on a more intuitive, unarticulated level. This resonates with the previous discussion concerning Bollas’s and Ogden’s conceptualisations of the therapist’s capacity to be attuned to the unconscious dimension of intersubjectivity and how this may inform and shape the therapeutic process. In F’s account there was also a sense of her moving between experiencing the unconscious intersubjective third and more consciously reflecting on that.

Things like I'll listen to a patient speaking in therapy, I'll be responsive and I will be able to understand and hear some of what they are saying, but some of it I'll be hearing at a different level, maybe unconsciously or something. Because I'll go, afterwards, I'll think and sometimes even things they say will come into my dreams. So I think that the communication is working in me at an unconscious level, at a symbolic level. And I think it's important to be able to work with that as well. And that's sometimes where therapy has helped as well, to be able to make sense of what the patient's saying about themselves and what it's evoking in me, what I am using that for to represent something of myself. The therapy helps me to uncover, to keep on uncovering my unconscious constellations and to be reflective about who I am and how I'm responding to different people, and how I'm responding to my patients. And there are intersubjective conjunctions and disjunctions. It helps me to sort those out and the transference and countertransference and all of that. (F)

153 Some of Macran, Smith and Stiles’s (1999, p. 427) participants also described how their therapies had resulted in their feeling “able to work at a deeper, more unconscious level with their clients”.

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CHAPTER 5

CONCLUSION

5.1 OVERVIEW OF RESULTS

5.1.1 An intersubjective reconfiguration of the therapist as wounded healer

The participants’ descriptions of themselves as wounded healers cohered into an account wherein the future therapist’s woundedness had originated in early experiences marked by the want of felt and specific recognition by significant others. This lack could also be conceived in terms of the absence of a sustained dialectic of recognition and negation or the evolvement of the trajectory of thirdness between the child and primary caretaker(s). Owing to their own neediness and/or narcissistic involvement, these parents were unable and/or unwilling to take care of the child’s needs and primarily related to him in an extractive manner as the object of their own needs and desires. In an attempt to gain some recognition, the child (who probably had an aptitude for this) became sensitive and attuned to being the object of the powerful other's needs and desires in a relationship that lacked any real intimacy and emotional sustenance.

In developing this “picture” from the participants’ descriptions of their early relational experiences, their accounts were taken at face value, that is, as being factual or “historical” truths (Spence, 1982). However, it needs to be considered that the participants’ descriptions should rather be regarded as constructed or “narrative” truths (Ibid.). One may therefore speculate about the role and significance of something like a poor “fit” between parents and a particular child rather than just seeing woundedness simply as an indication of parental failure.

To return to the future therapist: the relationship between caretaker(s) and child thus became marked by a splitting into the polarities of the dominant but needy caretaker(s) and the submissive but caretaking child, who functioned as a prematurely pseudo-independent “false self” (Winnicott, 1960a). In relational and intersubjective theorising, identification is understood to be with the total intersubjective experience, rather than with specific attributes of the other. It is therefore with this relationship, with its movement between two unequal positions, that the child and future therapist identified and that featured prominently in his relating to others.

The would-be participant-therapist was thus left with the ambiguous (and mostly unconscious) ability to be sensitive and attuned to the patient (thus seemingly recognising the patient) so long as the patient played the “good” patient to his role of rescuer or helper, a role which would make him
(the therapist) feel recognised as a therapist and met his needs (rather than those of the patient) in this manner. This meant that he probably was unable to recognise a patient as an other, different and separate from himself, and that problems would arise when a patient threatened his sense of himself as a therapist: for example, by being negative and hostile, by not becoming “better”, and so forth. Because he would have difficulties in differentiating himself from a patient, such a therapist could, when a patient had issues similar to his own, and the “other within” came to be located in the “other without” (Benjamin, 1998b, p. 108), identify with the patient in a manner that obscured what belonged to whom, thus also constellating a subject-to-object rather than a subject-to-subject relationship with the patient.

Together with the more benign and useful desire to understand himself and others, to think about and to make sense of his world and his relationships, his unacknowledged vulnerabilities and neediness also attract the therapist who is a wounded healer to his profession. Being a clinician offers him an unparalleled opportunity, condoned and even sanctioned by his being the therapist, of helping and rescuing that which is disowned in himself in the patient. Such a therapist’s contradictory attributes of being both “sensitive” to others and being prone to becoming unable to engage in subject-to-subject relating when his own needs and anxieties feature too prominently, enable him to do the work of therapy and are potentially dangerous. This is foregrounded at those difficult and precarious moments when the therapist’s identification with the patient is not indicative of empathic connectedness, but rather signals “the inevitable return of the repressed” (Benjamin, 1998b, p. xiv).

5.1.2 Personal therapy facilitating the therapist’s capacity for subject-to-subject relating

The participants understood their therapies as having been (and in some instances as still being) transformative of their professional lives. This also pertained to their personal lives, but that was unconnected with this study. While they did not feel that they had to be in interminable therapy, they also understood that this transformation was no final “psychoanalytic purification” (Freud, 1912, p. 116), but rather concerned the evolvement of a specific sensibility that they could bring to their work.

Through their therapies they had become aware of the existence of their entrapment in their own issues; of how this had become a distorting prism through which they had viewed and done their work and related to their patients. On a professional level, the work of personal therapy had concerned the participants’ unravelling the different strands of their own “blind spots” in their work and becoming able to relate to their patients in a different manner.
A fundamental question in this study was what about the participants’ therapies had brought about these transformative changes. Their accounts of their therapy experiences should not be understood as descriptions of therapy as a so-called *corrective emotional experience* (Alexander & French, 1946), but rather as an intricate interweaving of the *needed* and the *repeated* relationships (Stern, 1994). This resonates with Benjamin’s notion of there being different dimensions or clusters in the evolving trajectory of thirdness.

Within the context of the development of sustained and increasingly trusted co-created thirdness, the therapist’s attuned recognition of and affectively resonant connectedness to the participant were signalled by the appropriate foregrounding of the various clusters of thirdness at different times. Rather than leading to rupture, moments of negation were subsumed in the dialectic of recognition and negation. The participant accordingly became increasingly capable of relating to a different other (as represented both by his own therapist and by his patients) as a subject. These processes were underpinned by the participant’s awareness of the therapist’s loving respect and steady and unflagging presence, that is, the therapist’s agapaic attitude and what Benjamin calls the moral third.

Some of the aspects of the participant-therapist’s augmented capacity for subject-to-subject relating with patients were:

- Being open to and able to contemplate his own experiences, of and about the therapeutic intersubjectivity between him and a patient: for example, his thoughts, feelings, ruminations, bodily sensations, dreams and so forth.
- Being able to engage in the play of thinking about and reflecting on his experiences and acts in a meaning-making way without being unduly self-judgemental.
- Having an adequate sense of being in his “own skin” (A, 129), thus being able to differentiate himself from patients so that the “other without” was less likely to become confused with the “other within” (Benjamin, 1998b, p. 108) and the participant therefore being less prone to negate patients by using them in the service of his own needs and desires or disempowering them.
- Linked to the above was the participant’s ability of being sufficiently able to decentre from his own experience and feelings to engage in processes of both identifying and disidentifying with the patient. This meant the participant’s empathically recognising the patient while holding on to his own subjectivity.
- Being able to think and reflect by keeping both his own and the patient’s perspectives in mind.
Making his thinking available to the patient in a manner that is sensitive and appropriate to where the patient and the therapy are at in a particular moment.

The participants’ experiences of their therapies had thus allowed them to become aware of, to work through and to distance themselves from their difficulties and issues and to become capable of working differently and developing as therapists. The therapeutic third had also served as a container for the difficult and painful affects that were sometimes evoked by doing the work of therapy, thus enabling participants to use it as a third vertex from where they could think about their work. In time this had resulted in the participants developing what has been described as a triangular psychic space or a space of thirdness in their minds.

5.1.3 Relating power and therapist mistakes to negation and mutual recognition

It was evident that even if the “dance” of thirdness between therapist and participant had been co-created and mutual, the asymmetry and accompanying power disparity that characterised the participant-therapist dyads were such that the therapists had ultimately been both in charge of and responsible for “inviting” participants to take part in and to keep the “dance” going (or allowing it to break down). Entering therapy had indeed placed the participant in a position of vulnerability in a relationship where there was an inherent disparity of power. Having some knowledge about therapy had not changed the essential nature of the process, and there was also the added factor that the therapist was generally seen (and had even been chosen) as the one to be emulated; as the one who really knew how to be a therapist.

Therefore the therapist’s (real and perceived) transgressions had the potential of being (and were sometimes) devastating, especially when the therapist had had a need to hold on to his position of power and was negating of the participant’s subjectivity and reality. Sometimes a participant had had no choice but to flee from a previous therapist or therapy. While negative therapy experiences were not the focus of this study, the accounts of such experiences that did emerge during the interviews underlined the vulnerability of patients (even informed ones), the destructive potential of therapy and the enormous responsibility that therapists need to assume. Having such iatrogenic experiences had made participants more aware and sensitive to all of this, but they had felt that this knowledge was not worth the destruction that had been wrought.

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\[154\] This is similar to the findings of other qualitative studies (Mackey & Mackey, 1993; Macran, Smith & Stiles, 1999; Wiseman & Shefler, 2001) on the effects of therapists’ personal therapies on their work as clinicians. See also p. 136.
However, sometimes the therapist’s mistake had constituted a rectifiable moment of negation, rather than breakdown or rupture. It was not always clear whether or not such a “correction” by the therapist had actually happened in “reality” or only in the participant’s fantasies, but that had not seemed very important. What had mattered was the participant’s sense of being recognised through what was perceived as the therapist’s silent or spoken acknowledgment of the impact of his (the participant’s) different perception of what had happened and the therapist’s not becoming threatened and defensive. At times the therapist’s “mistake” was also not experienced as negating of the participant, but rather deemed to be due to the therapist’s idiosyncratic foibles which could be accepted and forgiven. Such incidents had actually served as a means to redress the power disparity and to move the therapeutic dyad towards mutual recognition; that is, towards therapist and participant becoming like subjects.

Precarious moments in a therapy that had included the participant’s sense of somehow having been missed or failed by the therapist that took place in the more general context of the participant’s feeling recognised and empowered, had therefore meant something very different than those instances that had signalled the therapist’s negation of the participant. Such more benign experiences of the therapist’s being “at fault” had often included the therapist’s implicit or explicit acknowledgement of his own contribution to the situation, as well as his being open to the participant’s version of reality and his critical feelings towards the therapist. Sometimes this had been followed by therapist and participant engaging in a mutual consideration of what had happened. These kinds of events had tended to put participant and therapist on a more equal level and had also provided the participant with a useful way of thinking about surviving being less than perfect as a therapist. At times this had meant the participant’s disidentifying from those acts of his therapist which he had considered as being inappropriate or counter-productive, but these disidentifications had been done in a thoughtful manner and were often accompanied by the participant’s identification with the therapist’s attitude, thinking and acts of “rectification” or reparation.

5.1.4 Identification bridging personal therapy and clinical work

The participants described identifying with their therapists' ways of working and with the attitudes that they (the participants) had perceived as underpinning those. As the participants indicated, the processes of identification had often been unconscious: that is, they had mostly taken place at a nonconscious or procedural level. The participants also described how their identifications had ranged from being concrete and literal to being more symbolic. The nature of these identifications
had changed over time and as a therapy had progressed, as well as according to the nature of the relationship with the therapist.

When there was a significant power disparity between therapist and participant, identifications had tended to be more concrete. Although it was not possible to find a kind of one-to-one correlation, it was clear that this was related to the participant’s own sense of self as a therapist in relation to his therapist. When feeling “lesser”, which had either been due to the power disparity in the therapeutic third, or to feeling unsure of himself in the clinical third, or to a combination of these, he had been more inclined to use the attributes, acts and words of his therapist directly and concretely. When there had been more of a sense of therapist and participant being like subjects, identifications had been at a more symbolic level.

If the role of identification was just about (or just stayed at the level of) the participants directly “importing” the idealised and powerful other’s supposedly “superior” version of being-a-therapist and using it as such, it would have meant their subverting rather than developing their own unique abilities as therapists. This is not to say that there is anything inherently detrimental about using identification in this manner at certain points. When identification had been used more concretely, it had often been a means of shoring up the participant’s flagging confidence in himself as a therapist. However, optimally enriching and expanding one’s being-a-therapist does require that identification goes beyond this.

The participants described such optimal moments when more evolved forms of identification had specifically linked what had happened in the therapeutic third to events in the clinical third. This had usually taken place when a participant had experienced a significant shift in himself owing to what he had perceived as a useful and helpful act on the therapist’s part. Such an act would also have been felt to occur within the context of mutual recognition, that is, when the therapist had been both recognising of the participant and also more of a like subject rather than the idealised other. The therapist’s act having been designated as being “useful”, had not always meant the therapist’s getting it exactly “right”, but had also pertained to how he had dealt with those instances when things had gone wrong.

Although such identifications had also been experienced as just “happening”, this had no longer just consisted of the participant’s, during the moment or retrospectively, becoming aware that specific words, gestures, acts or interpretations that he was using or had used had actually been those of his therapist or that he was or had been invoking his therapist’s critical or helpful presence.
The more abstract and evolved forms of identification had often been accompanied by a shared sense of being with the therapist, which was indicative of intersubjective thirdness having developed into there being an “interpersonal symbolic third” between therapist and participant (Benjamin, 2001, p. 16). At this point that which had been useful or helpful in the participant’s own therapy had become part of the in-between transitional space of neither belonging to and belonging to both participant and therapist. It could therefore be thought about, be made the participant’s own, and be appropriately used when needed.

The participants’ accounts were therefore used to gain some understanding of how “a loving tie” (Benjamin, 1995, p. 8) and recognition from the initially idealised therapist could start off the movement towards mutual recognition and participant and therapist becoming like subjects. As described, this was accompanied by changes in the ways that the participants had identified with their therapists: their identifications with their therapists had changed in tandem with their becoming like rather than lesser than their therapists. Rather than making the participants primarily and often submissively therapists just like their therapists, those identifications had become integral parts of themselves, thus adding to, augmenting and deepening their own “repertoires” as psychodynamic therapists.

5.1.5 Personal therapy making a unique contribution to clinical work

While all the participants in the study could be described as wounded healers, this has to be understood as being meaningful within the context of this specific group of therapists and can therefore not be interpreted as signifying that all (or most) psychodynamic therapists are wounded healers. However, it also needs to be considered that although I have, for the sake of clarity, described what could be called “the wounded healer phenomenon” starkly, definitely and in a rather oversimplified way, as though it is or is not present, it should actually be seen as existing in degrees on a continuum. After all, it is only human to have hidden vulnerabilities and unmet needs, and we can never know or control ourselves as much as we would like to think we are able to. Unlike in some other professions, such vulnerabilities and needs are “highly relevant” to the way that therapists engage with and relate to patients and do the work of therapy (Wiseman & Shefler, 2001, p. 137).

Wiseman and Shefler (2001) therefore comment that the personal and professional selves of therapists cannot readily be distinguished from each other and should consequently not be regarded separately. Four of the participants in this study had originally entered therapy for mainly personal reasons and the other four for more professional reasons, but this had not made any significant
difference to the nature or focus of their therapies, because those two domains were essentially interwoven. This was similar to Wiseman and Shefler’s (Ibid, p. 137) participants who “viewed training reasons for entering personal therapy as inseparable from growth and personal reasons”.

As also expressed by the participants in this study, therapists themselves are the “tools” that they use in doing the work of therapy. Currently there are fewer rules and more emphasis on independent thinking as well as on authentic engagement with patients. Therapy can therefore help any therapist to become freer of his own inner entrapments, which may exist to a greater or lesser extent. At the same time it could also strip him of the arrogance of thinking that he is necessarily more “healthy” or “insightful” than the next person.

Doing psychodynamic psychotherapy is also demanding in a very specific way. The interpersonal dynamics typical of the therapeutic dyad when the therapist functions in the “wounded healer mode”, such as the collapse of thirdness and mutual recognition into the power struggle or collusion of complementary twoness, are also what one finds at difficult moments in any good-enough therapy. At such moments the therapeutic third provides a Third outside the interpersonal entanglements of the dyad in the clinical third. The therapeutic third is the therapist’s own space where there is containment, nurturance and where he may regain the ability to think about what is happening in the clinical third. Those features of their therapies had been clearly described by the participants. Of course helpful Thirds may also be formed by the therapist’s theoretical knowledge, supervision, the wider therapeutic community, and so forth, but according to the participants, their personal therapies had played a more fundamental role in enabling them to develop as therapists and had potentiated their capacity to make good use of those other Thirds that sustain and contribute towards the development of a therapist.

To survive the strain of doing the work of therapy and to keep a therapy going, requires, apart from the necessary knowledge and skill, a certain amount of emotional resilience and resourcefulness on the therapist’s part. Personal therapy is therefore pivotal even for the therapist who would not have or who would no longer have deemed personal therapy necessary if he had not been a therapist. Further aspects of the unique contribution of the therapist’s own therapy to clinical work were also discussed by the participants: one cannot do this work unless one has faith in the process of therapy, and this faith can only come from experiencing it oneself; one can also not know what it is like to be a patient and to be disempowered in that specific way without experiencing it.
Taking into account that therapist and patient mutually influence each other and that every event in the therapeutic space is co-created by both of them, one could also, for heuristic purposes, isolate and focus on the nature of the therapist’s contributions to a good-enough therapy. Seen in this light, every act of the therapist arises out of a complex and multi-faceted combination of aspects such as his capacity to engage in subject-to-subject relating, his attitudes, values, theoretical knowledge and professional allegiances, a certain inner freedom, resilience and resourcefulness, and what may be called therapeutic “skills”.

During the course of their therapies the participants had augmented and developed skills which are particularly important for the psychodynamic psychotherapist. The *psychoanalytic consciousness* concerns the kind of reflective and symbolic thinking that the therapist brings to bear on his work. The *psychoanalytic unconscious* is about accepting nothing as a given: this implies the therapist’s being open to and capable of deconstructing the more implicit, unformulated and opaque aspects of his experiences of himself and the patient in the therapeutic space and also being willing to explore and question the actual frameworks that he uses to engage in these processes. These two aspects of the therapist’s functioning are not independent: they exist in relation to and inform one another.

In fact, all these elements that constitute being-a-therapist are intricately linked and cannot be separated. For example, the therapist who is so threatened by a patient’s rage that he withdraws into the fortress of being the *one who knows* and attempts to regain his position of power by subduing the patient in this manner and is therefore relating to the patient as an object rather than as a subject, is unlikely to be able to use the skill of thinking reflectively. However, the therapist may be open to and become aware of his own uncomfortable or disturbed feelings, and manage to right himself sufficiently to regain some ability to think about what is happening, so that his own feelings become adequately contained for him to again relate to the patient as a different and separate other and to continue thinking about what has happened.

It is also hard to imagine *how* the actual praxis of even the obvious characteristics (for example, the analytic frame) and, particularly, the more subtle features of psychodynamic therapy (for example, the therapist’s “living” the knowledge that the therapeutic space is there for the patient and not for himself by keeping the patient in mind and not following his own needs and desires) could actually come about through *only* theoretically knowing about them. “Learning from experience” (Bion, 1962) therefore is highlighted. Another way of thinking about this, which is similar to the notion suggested by Macran, Smith and Stiles (1999), is to posit that the kind of knowledge and skills that is asked of the psychodynamic psychotherapist exists on a verbal and declarative level *and* on a
more procedural and implicit level which cannot be separated from each other. This makes the actual experience of therapy an indispensable part of being-a-therapist.

Although the participants had been requested to give their accounts in terms of their own experience rather than from a theoretical perspective, what they had spoken about had inevitably been steeped in theory. They had evidently known a great deal about therapy and had easily been able to put theoretical meaning to the words, actions and attitudes of their therapists and of themselves. In terms of doing therapy, they were very clear that, within the context of the therapeutic relationships in which they had felt recognised, they had taken over and identified with what they themselves had experienced as being useful or helpful, or had disidentified from what they had experienced as being inappropriate, counterproductive or potentially harmful. These identificatory processes, consisting of identifications and disidentifications with a good therapist who actually does know, were experienced as a pivotal part of gaining knowledge and skills and in developing as a therapist. This does not imply that such skills are entirely absent in the novice therapist; they are probably already present in an incipient form as an aptitude for this kind of work, but they need to be developed and honed for the task at hand.

5.2 AN INTERSUBJECTIVE MODEL OF PERSONAL THERAPY AND BEING-A-THERAPIST

The research participants had provided accounts of their therapies, as well as of their work as clinicians, and had related these to each other. From that it became clear that although initial training may confer the sense of being-a-therapist, the therapist’s continually being present to his patients with integrity, steady dedication and in an emotionally alive and sensitive way, involves a lifelong task of walking the tightrope of both having some awareness and acceptance of his own vulnerabilities and limitations and also striving to develop and reach beyond those. An ongoing identity as a therapist may further be conceptualised as existing in dialectical tension with “the multiplicity of subjective experience[s]” that constitute being-a-therapist (Seligman & Shanok, 1995, p. 558n2). The participants’ accounts had offered a vivid portrayal of the unique role of personal therapy in promoting and sustaining these kinds of therapist attributes and processes.

Very soon into the research process it became apparent that any theoretical paradigm used had to take both the intrapsychic and intersubjective aspects of the participants’ experiences into account. Benjamin (1998b) does precisely this by distinguishing the intrapsychic and intersubjective dimensions from each other, but deeming them as being of equal purport in psychoanalytic
theorising. This is encapsulated in her notion of “the double-sidedness of the relation to the other”, that is, relating to the other both as object and as subject (Benjamin, 1998b, p. 90).

The use of the “lens” of relational/ intersubjective theory, with a particular focus on Benjamin’s work, subsequently led to the emergence of a tentative model, Figure 5.1, that represents the multi-dimensional processes involved in the ongoing development of a psychodynamic therapist.

Figure 5.1

The multi-dimensional processes involved in the development of a psychodynamic psychotherapist
This model aims to articulate both the intrapsychic and intersubjective dimensions of the participants’ experiences and the way in which subjectivity and intersubjectivity are inextricably interwoven in the linked therapeutic and clinical thirds. From this perspective, that which occurs on an intrapsychic level, illuminates that which is intersubjectively constellated, and *vice versa*.

As Figure 5.1 indicates, the development of a psychodynamic therapist concerns much more than just his personal therapy. This model only includes those developmental aspects that appeared generally important; there may be others that are also significant in the development of a specific therapist. Figure 5.1 is a simplified and two-dimensional version of very complex processes that ebb and flow and intersect in three-dimensional dialectical interplays of different positions and where developmental trajectories (and *not* development in the sense of a current or finally achieved position) spiral and recede along diachronic as well as synchronic axes.

These processes take place in the dynamic context and form part of what may be described as an open and complex non-linear system. By conceptualising psychological phenomena simultaneously as emerging at the experiential level constituted by intrapsychic and intersubjective events and in terms of a more comprehensive system (Coburn, 2002), thinking about the therapeutic and clinical thirds may be expanded to encompass a wider spectrum of what is actually involved in being-a-therapist. But does this not constitute a somewhat haphazard mixing of different theoretical viewpoints and models? In this regard, Coburn (2002, p. 657) makes the useful comment that the apparent “conceptual tension” between “understanding psychological phenomena through a one- or two-person model one moment, and then through a systems or contextualist lens the next” is largely due to the “conflation of phenomenological and explanatory levels of conceptualising key concepts”.

In terms of the model in Figure 5.1, this had meant moving from the perspective of the participants’ descriptions of their experiences through those experiences being interpreted via the prism of theory and that leading to a deeper understanding in terms of the interpenetrating therapeutic and clinical thirds. This was followed by yet another and more distanciated viewpoint, which is represented by the model in Figure 5.1, where the therapeutic and clinical thirds may be seen as part of a wider system that includes more facets of being-a-therapist. In the manner typical of the circular, iterative nature of the interpretative processes deployed in this study, the model could then be taken back to the participants’ descriptions and used to inform the way in which those were understood and interpreted.
Thirds are constellated in the dialectics between different points of reference within the system depicted in Figure 5.1 and also between the participant and these vertices. This may open up or truncate possibilities of meaning. Some Thirds may be envisaged as primarily emanating from the therapist, and in this study that had pertained to both the treating therapists and, especially, to the participants-as-therapists. Thirds may be formed, for example, between the therapeutic dyad and the therapist’s relationships with his own needs and desires, his issues and concerns about power, the values held by the wider therapeutic community, different theoretical positions, his supervisor and supervision. This study also highlighted the kinds of Thirds that were formed between the therapeutic dyads consisting of participants and their therapists, and participants and their patients; that is, the Thirds that therapeutic thirds had formed to the clinical thirds.

Such triangularities always involve “a relation of relations” (Muller, 1999, p. 471) or “shifting vectors of relations” (Aron, 1999, p. 8). One could, for example, consider how the therapist’s theoretical stance could become a Third to the therapeutic dyad. But the therapist’s theoretical position is not just that. It is often permeated by conscious and unconscious desires, allegiances and values. It may form part of the psychoanalytic unconscious or the therapist’s reflective psychoanalytic consciousness may be brought to bear on it; it may be transformed by (and be transforming of) the therapist’s supervision, professional affiliation and own therapy. And all of these vertices also relate to one another; create and negate one another. A third point of reference to a therapist-patient dyad does also not necessarily facilitate the evolvement of co-created thirdness between therapist and patient. When such a third vertex forms an antitherapeutic dyad with the therapist, therapeutic space and thirdness may become compromised and might even collapse.

While indications of these processes represented in Figure 5.1 did appear in the participants’ accounts, this study did not attempt to encompass all of these. As shown in Figure 5.2, the focus of this study was limited to, as well as highlighted, the evolvement of the participant-as-patient in the dialectic of the recognition and negation (Benjamin, 1990, 1995, 1998b; Ogden, 1994, 1999) between the participant and his therapist in tandem with what happened, changed and developed within the participant, as well as between the participant-as-therapist and his patient(s).

From a systems perspective and as indicated in Figure 5.2, the therapeutic and clinical thirds mutually influence each other, but the effects of the clinical third on the therapeutic third were, for the most part, outside the scope of this study. Figure 5.2 therefore facilitated thought about how facets of the participant’s being-a-patient could be conceptualised as significant in his work with
patients; that is, how the *therapeutic third* affects the *clinical third* and how the links between these thirds may be understood. In this way this study *framed* (Coburn, 2002) a part of the larger perspective of the development of a psychodynamic therapist. However, this does not mean that other aspects that are involved in developing as a therapist, such as theory, supervision and the therapeutic community, were totally excluded, and when appropriate, they were taken into account and referred to.

### 5.3 SOME REFLECTIONS ON THE RESEARCH PROCESS AND FINDINGS

The purpose of this study had been to gain some understanding of *what* happens when therapists are in therapy and *how* this changes their being-therapists. This led to an exploration of the nature of the participants’ therapies and particularly of those aspects of their own therapies that they had considered as being relevant to their own work as clinicians. The participants’ accounts had also included descriptions of the ways that their therapies had affected their ways of working and being therapists. From these descriptions a “picture” emerged of how the participants had developed as
professionals as a result of their therapies. Although “professional” and “personal” cannot be readily distinguished in the development of a therapist, the emphasis was on participants’ professional development. Of course this had not only been due to their therapies, but the focus was specifically on how their therapies had contributed to their development. In considering the ways in which personal therapy had affected both participants’ manner of working and their development as therapists, and linking these, this study has been different from those by Macran, Smith and Stiles (1999) and Wiseman and Shefler (2001). The Macran, Smith and Stiles (1999) study specifically focuses on how personal therapy affects therapists’ practice and Wiseman and Shefler (2001) explore the impact of personal therapy on therapists’ personal and professional development.

Although the main focus of this research was on the participants’ present therapies, they perceived both present and past therapies as fundamental aspects of their ongoing development as therapists. Participants had been limited to therapists presently both practising psychodynamic psychotherapy and being in their own therapies. In retrospect, I am not sure whether this limitation was really necessary, because it may be that including therapists who have terminated therapy during the last few years may not have made much of a difference. The participants seemed to have ongoing narratives of their own therapies that ran through their lives over many years and in which the significant events remained embedded even after a considerable passage of time. Because of this, I did not confine the excerpts from the interviews to the participants’ accounts of their present therapies, but when appropriate, also used those descriptions which pertained to past therapies.

I have clarified that I was working within a relational and intersubjective model in this study. While I did ask the participants to speak from their own experience rather than giving theoretical explanations of what had happened, their theoretical positions were inevitably part of their accounts, since experience takes place within and from the understanding that one already has. While the participants were all psychodynamic therapists, they did not all come from exactly the same theoretical background. Their theoretical perspectives were also not necessarily purely in one theoretical paradigm. Only one came from an (primarily) intersubjective perspective. In Cape Town, Kleinian theory is probably the predominant theoretical discourse among psychodynamic psychotherapists, and I would imagine that the participants' (even those who described themselves as, for example, “Jungian”) ways of speaking about their experiences would in some ways be influenced by this. Even my own way of asking questions was probably also informed by this. This meant that in thinking about and interpreting the interview material (especially when using the “lens of relational/intersubjective theory), I attempted to “translate” the participants’ accounts into a relational/intersubjective way of understanding.
I have found this research process an exciting, but also a very taxing and demanding one. This was especially true of the process of developing an understanding of the interview material in a manner that was satisfactory in the sense of being coherent and theoretically consistent and comprehensive. When reading about research, there is the rather misleading impression that concepts and theory arise from the data quite easily and spontaneously. In reality I have to agree with Ayres’s (2003a, 2003b) comment that “we tend to write that something ‘emerged’ from the data, which is of course ridiculous because we clawed it out kicking and screaming … ”

There were pivotal moments in the research process, turning points when enlightenment and insight dawned and when some “truth” became evident (often seemingly just by chance). For example, quite early on I conducted an interview with one of the participants in his/her consulting room. As I entered that room, it felt vaguely familiar, but I knew that I had never been there before. Later on, even though the participant never told me the name of his/her therapist, I knew what this familiarity was: I had actually been in the participant’s therapist’s room. Although the two rooms were not exactly the same, there was a subtle but uncanny resemblance between them. This set me wondering what this could mean and I began to listen to this participant (and the others) with a new sensibility, not exactly knowing what it was that I was listening for. This incident led me to issues that are present in all therapies, but that are specifically foregrounded in therapists’ therapies: power, idealisation and identification. Trying to make sense of this took me to Benjamin’s thinking around these matters.

Despite my previously discussed reservations about using Computer-Aided Qualitative Data Analysis Software (CAQDAS), I did employ QRS N6 in the analysis of interview material. Since there were no local training programmes and also no available individual with the necessary skills and knowledge who could help me, my use of N6 was largely self-taught, with the help of the manual, tutorials and by following the QSR e-mail forum. QSR support was ready to lend a hand in providing help with technical problems and did so on a few occasions. Notwithstanding my computer skills being relatively limited, I found the program quite user-friendly and I was able to master its basic use without an undue input of time and effort.

One of my concerns had been whether the use of N6 would lead to a kind of glib and superficial data analysis. This reservation proved to be unfounded, but neither had N6 been much of an actual “theory-builder”. The latter may have been partly due to my lack of training for that purpose, but I would rather ascribe it to the actual and previously described method of data analysis that I used. That had required my repeatedly going back and re-listening to and re-reading the entire interviews.
I had consequently kept in touch with the original interviews throughout the research process. However, N6 did prove itself invaluable in the actual storing and organising of the interview material, that is, the coding and retrieving of excerpts from the interviews and the organising of excerpts into categories (or “nodes”, as this is called in N6 terminology). In the initial stages of the data analysis the use of N6 had also given me a measure of confidence that some order and clarity could be possible in what seemed like an bewilderingly incomprehensible and overwhelming amount of material.

The passion with which the participants had regarded both their personal therapies and their work was something that had struck me quite early in the process of interviewing. This played a role in the emergence of the question of who this group (of mostly self-selected) participants was. They were evidently a particular group of psychodynamic therapists in whose lives their own therapies and their work were of central importance. Subsequently this was used in exploring the further question of why the wounded healer trope had featured so prominently in the participants’ accounts.

I do not think that the emphasis on the participants’ woundedness, which had emerged during the interviews, had simply been the result of my search for confirmation that the idea of therapist as wounded healer is more than just a commonly believed myth among therapists. The participants’ understanding of this aspect of their becoming and being therapists had certainly been given form and meaning by their awareness of this notion, which is generally known among psychotherapists (including myself). However, the participants’ accounts cannot merely be described as stereotyped “press releases” (Wiersma, 1988) which were constructed around their familiarity with the idea of the therapist as wounded healer. The emphasis on the wounded healer trope probably mostly had to do with the nature of this specific group of participants.

While it is possible to be somewhat cynical and to think of the therapist as wounded healer as a rather hackneyed, romanticised and overvalued idea, it was apparent that most of the participants had, in differing ways, indeed come to their work from places of hurt and pain. I found myself moved and touched by their accounts of how they had (sometimes for years) courageously struggled to get beyond their difficult early beginnings, as well as by their generosity in sharing such personally revealing material. They did make the effort of actively engaging in being reflective about both their therapies and their work, but there were times when I could sense a participant’s defensiveness around an area that was particularly sensitive. Some of the participants
also commented on finding themselves giving accounts that were more “personal” than they had anticipated and, probably, had intended.

While the participants’ accounts were not just tales of their “redemption” from being “bad” therapists, it was also clear that their therapies (and also their work) had been pivotal in their becoming “healed” and in coming into their own as human beings and as therapists. This was probably (as was indicated by some of them) the greater part of their motivation for taking part in this study. While the findings of this study may, to some extent, not be true for all psychodynamic therapists, it did mean that what the participants described had “painted” a picture of their therapies and their work in brightly-hued rather than in subdued pastel colours.

This particular group of therapists was somewhat similar to those that participated in the study done by Macran, Smith and Stiles (1999). Just as in the Macran et al. study, these participants were “a self-selected group of therapists who were interested in reflecting on their personal therapy and how it [had] affected their work” (Macran, Smith & Stiles, 1999, p. 430). The two participants in this study who had not volunteered had appeared sufficiently interested in the research topic for me to feel that I could approach them to take part. However, the wounded healer phenomenon did not emerge in the Macran et al. study. That may be indicative of the nature of that particular group of therapist-participants. On the other hand, it may simply mean that the researchers did not enquire about it, as I did, for example, by asking about the participants’ understanding of their reasons for choosing their profession and their motives for entering therapy for the first time.

According to Macran, Smith and Stiles (1999, p. 430), it was more likely that therapists with “relatively positive therapy experiences” had volunteered for their study (even though they had not been sought on that basis) and that this could account for the absence of descriptions of “any substantial negative effects on their practice”. This could indubitably also partly be true of the participants in this study, whose experiences of their present therapies were not just “relatively positive”, but were seen as being transformative of their personal and professional lives. The fact that the participants in this study had experienced themselves as wounded healers could also have contributed to the emphasis they had placed on the importance of their own therapies and to their taking the risk and making the effort to volunteer. They had an awareness of what they could have been like (and had often initially been like) as therapists without the personal change and professional development that had come about as the result of their therapies. They all took their work seriously and were aware of the responsibility that it entailed.
Macran, Smith and Stiles (Ibid.) also raise the questions of whether their participants had presented their therapies in such a positive light because of wanting to please the researchers and/or because of wanting to present their chosen profession positively. These issues did not seem to apply the participants in this study. They did talk quite freely of negative and harmful experiences in previous therapies. Even if there had been negative moments, precarious times and “mistakes” on the therapist’s part in their present therapies, they all emphasised that these took place within the context of therapeutic relationships that were, on the whole, beneficial. This foregrounds the question of the eventual fate of the idealisation of the chosen and, in this case, seemingly benign treating therapist, in a therapist’s personal therapy. While accepting that the participants were actually in good-enough therapies, it has to be considered that their very favourable views of their therapists and therapies may also be indicative of some traces of the initial idealisation of the treating therapist always remaining part of the therapist-patient’s therapy.

This study had commenced with the assumption that personal therapy is a necessary part of being a psychodynamic psychotherapist and this had later also been supported by the findings. However, this idea should not be unreservedly and naively embraced, but warrants and requires further deconstruction and qualification.

Potentially there are negative aspects to the therapist’s own therapy. There could be the possibility of the therapist’s own therapy becoming a kind of initiation rite into an exclusive “elitist” group. Notwithstanding therapists’ being knowledgeable about therapy, there is, as research has indicated (Grunebaum, 1986) and as some of the participants have also described, just as with anyone else, the risk of harmful therapy experiences.

While supporting personal therapy as a prerequisite for doing therapy, Coltart (1996) concurs with Symington (1993) that the therapist’s own therapy could also lead to a greater degree of inward-looking narcissistic involvement, to the detriment of what is outer and other. The outcome of a study by Garfield and Bergin (1971) suggests that personal therapy with trainees or inexperienced therapists may lead to a preoccupation with their own issues as patients and have a deleterious effect on their work with patients. Garfield and Bergin mostly ascribe the occurrence of this to their participants’ inexperience, but that aspect did not feature similarly in this study. Nonetheless, the phenomenon of therapy at some stages being “all-consuming” (E, 117, p. 135) was specifically described by one of the participants and referred to by some of the others. Rather than being ongoing, it seemed to have been part of the intense and often disruptive early phases of therapy, which were also marked by feelings of vulnerability, a significant power disparity between
participant and therapist and evident idealisation of the therapist. It appears that this preoccupation with one’s therapy and oneself could just be part of the process of the therapist’s personal therapy, especially in the initial stages of therapy and more so for the novice therapist or for the therapist who enters therapy for the first time. However, the possible drawbacks of such a temporary “lapse” into self-preoccupation, which could perhaps have some negative effects on the therapist’s work, are far outweighed by the other and more long-term contributions of personal therapy towards his being a sensitive, effective, responsible and ethically aware therapist.

On the other hand, the possibility also needs to be considered that personal therapy may provide an opportunity for this particular variety of narcissism that is sometimes found in therapists to become more entrenched, as well as allowing it to persist in a more “underground” and subtle manner. Whereas an intense interest in personal relationships is often one of the primary reasons why psychotherapists are drawn towards their profession, they are frequently (much to the dismayed surprise of “lay” people) woefully inadequate at “human relations” in the “real world” (Coltart, 1996, p. 32). This is seldom willingly or openly acknowledged or discussed by therapists, but on a professional level the tussles for power, the envy, the petty rivalries and schisms that are often such integral parts of interpersonal relationships and group dynamics within and between psychoanalytic or therapeutic communities, speak of this issue (Kirsner, 2000). One does therefore need to take note of the fact that there may be a connection between personal therapy and what Coltart (1996, p. 32) calls a “redolent possibility of inadequately matured narcissism” in psychodynamic psychotherapists, but this matter and the questions that it raises are beyond the scope of this study.

In a more general sense and specifically pertaining to this study, this redirects us to the question of what kind of effect the therapist’s therapy has on his relating to the patient as a subject rather than in terms of his own needs, desires and interests; that is, how therapy impacts on both the therapist’s “blind spots” and “bright spots”. Does therapy free the therapist from the shackles of his “blind spots” so that when therapeutic work touches on such an area, he remains able to keep the patient in mind as a different other, rather than vanishing “into his own process” (D, 434, p. 150)? Or could the therapist’s therapy also render “blind spots” into “bright spots”, so that the “blind spot”, which had once ensnared him, becomes an area of particular interest that he picks up on, rather than staying with and following the patient when he is working? While there could certainly be truth in both possibilities, this is where the therapist’s capacity to be aware and reflective and to keep such contradictory options in mind, would be foregrounded.
5.4 EPILOGUE

Although it has enriched the detail of the process, this research has also led the way to more questions and potential areas for further research. For example, one could investigate this topic from the “other side”, that is, from the perspective of the experience of the therapist whose patient is also a therapist. In terms of the co-created intersubjective third, one could explore how thirdness would be influenced if therapist and patient came from different cultures, social classes, histories and value systems. How would such diverse and often contradictory Thirds affect the nature of thirdness between therapist and patient? This would be particularly relevant in the multi-cultural South African society.

This research has also highlighted the importance of the particular discourses of power and nature of the kinds of power disparities that get constellated within the therapeutic setting. One way of investigating such power-related issues would be to do so according to their variations within different kinds of therapist-patient dyads, for example, a therapist and a fellow therapist, a therapist and a patient of the same or different gender, a therapist and a patient from very different cultural or economical circumstances, and so forth. While being interesting and certainly worthwhile, any research involving the balance of power in therapy would be a complex task requiring great sensitivity. The same could be said about the exploration of negative and harmful therapy experiences, especially if these involved therapists’ own therapies.

Whatever else may follow, this is the end of this particular research journey that was sparked off by my curiosity about my own experience of being both therapist and patient. The research net has been swept and the catch is there to see. I am aware that the yield has been a very specific view of how the therapist's personal therapy impacts on his work and that somebody else may very well have found something different. Despite the inevitable limitations and flaws of this endeavour, I feel reasonably content that, to whatever extent that is possible, I have finished what I had set out to do. Some of the properties and complexities of that perplexing and thought-provoking mix of being both therapist and patient have been explored and unpacked and I do have a more comprehensive, deeper and richer understanding of the phenomenon that had intrigued me sufficiently to take the leap into the research process. I can only hope that other colleagues will also find this useful to think about and to make sense of their own experiences of being-a-therapist and being-in-therapy.

If (as the grounded theorists suggest one does) I could go back to the participants with further questions at this point in time, those questions would probably be very different from the ones that I had originally asked. Of course, the idea of doing this is nothing but wishful thinking, because it would take this study far beyond the scope of what is an acceptably adequate answer to the research question and, especially, of what is practicable. Then again, during the research process, I
sometimes found myself inadvertently glimpsing some of the more unexpected and most 
challenging aspects of the findings on the fringes of participants’ answers to more obvious and 
straightforward questions. I would have appreciated an opportunity to explore some of those facets 
further and in more detail. For example, how is the experience of therapy and nature of thirdness 
shaped by therapist and patient’s sharing the same profession and how is the power differential 
between treating therapist and therapist-patient influenced by this? I would also have liked to know 
more about how the therapist-patient’s manner of thinking about his work and his way of engaging 
with the unconscious intersubjective therapeautic third are changed by his own experience of 
therapy. However, I also realise that such questions, which now seem so obvious, have only come 
to the fore because of what I have actually learned through engaging in the meaning-making circle 
of this research process.
APPENDIX A

LETTER/E-MAIL INVITING PSYCHOTHERAPISTS TO TAKE PART IN THE STUDY

Dear Colleague

Research on the influence of therapists’ own therapies on their work as clinicians
As part of the Rhodes PhD in Psychotherapy I shall shortly be starting a research project about the impact of psychotherapists’ own psychotherapies on their work. Is analysis or therapy really necessary in order to be a competent clinician? The thesis aims to explore how therapists’ clinical work is influenced by their personal therapies. I am therefore looking for participants who are concurrently in therapy and working as psychotherapists. If you fall into this category, I should like to ask you to give serious consideration to participating in this study.

I shall briefly address two issues that may be of concern to possible participants. The first is that of time (which is a very precious commodity for every psychotherapist!). There will be two semi-structured interviews of one-and-a-half to two hours. These interviews will take place at a time and venue to suit participants and will be about six months apart.

The second issue is that of confidentiality. The data gathered will necessarily be sensitive in nature: participants will not only be talking about themselves, but also about their own therapists and their patients. Therefore, apart from participants’ anonymity and their details being disguised, no actual protocols will be published in the final thesis. These will be kept separate and will only be seen by the researcher, the supervisor and the examiners, all of whom will be apprised of the confidentiality clause. On completion of the thesis, protocols will be shredded, or, if requested, returned to participants.

There is a paucity of research in this area and participants will be contributing to training in psychotherapy, especially in South Africa. The interactive process of the research interviews will afford participants the opportunity to learn more about themselves, both on a personal level and as clinicians. At the end of the study each participant will receive a copy of the thesis.

I should appreciate your help in this matter. Please contact me if you are interested (even if you would just like to know more about the study).

Yours sincerely

Ester Haumann
APPENDIX B

INTERVIEW GUIDE

“WARM-UP” QUESTIONS

Do you have any questions before we start?

Why did you agree to participate in this study?
Or
What motivated you to take part in this study?

Before we proceed to the main question, there are a few details about your present therapy that I’d like to clarify:

(If you want to, you could also fill me in about your previous therapies).

How long have you been in your present therapy?

What is the frequency of your therapy sessions?

What is your therapist’s theoretical orientation?

Does your therapist offer the use of the couch?
Yes / No
If yes:
Could you describe your experience of using the couch?

What were the reasons you had for entering personal therapy?
Or:
What was your motivation for seeking therapy?
Prompt: If it was a formal requirement, ask what other reasons there were.

How did you go about choosing your present/this specific therapist?

Would you like to tell me something about your previous therapies?
Or:
Is there anything specific about your previous therapies that you’d like to share?
PERSONAL THERAPY < WORK AS A PSYCHOTHERAPIST

Could you describe as fully as possible how your own therapy or analysis influences your work as a therapist? Please try to describe this in terms of your own experience rather than just giving a theoretical explanation of what happens. Where possible, could you also try to describe specific instances of this?

Prompt: How does your personal therapy relate to and impact on your clinical work?

Could you describe experiences that you have had in your own therapy that you do not want to repeat in your work?

Please describe how you talk about your patients in your own therapy.

How do you experience the difference between therapy and supervision?

Prompt: When are countertransference issues part of your therapy and when do you deal with them in supervision?

It is often said that doing this work may place a burden on therapists. I wonder what your experience has been in this regard?

Or:

Could you describe the ways in which your work as a clinician affects you personally?

Could you describe the role your own therapy plays in assisting you to deal with these issues?

Could you say something about your experience of the process whereby what you experience in your own therapy is carried over or transferred to your work?

PERSONAL THERAPY

Could you describe the experience of your own therapy?

Prompt: What has been helpful and what are the difficulties and disappointments?

You have talked about what it is like when things go well in your therapy. Could you also describe your experience of the difficult times in your therapy, that is, when there are misunderstandings or disagreements or when you are aware of your therapist making "mistakes"?

Prompt: What is your experience of your therapist's approach to countertransference issues?

Could you describe how, during sessions, it sometimes happens that you do not always share that which comes to mind with your therapist?

Prompt: Your own feelings to and reactions about what is happening in the session; aspects of yourself and of your life. How do you understand this?
PERSONAL THERAPY < SELF-ANALYSIS

How do you continue the work of therapy outside of your own therapy?

THEORY

Could you say something about the role that theoretical understanding plays in your experience of your own therapy and your work?

PARTICIPANT’S “OWN STORY” OR REASONS FOR BECOMING A PSYCHOTHERAPIST

Could you describe how it happened that you became a psychotherapist; that is, came to do this work?
Or
Could you talk about what led you to become a therapist?
Prompt: Please tell me about your family of origin and other circumstances, events and issues in your life, and also about role models/mentors who were important in both your becoming and developing as a psychotherapist.

IN CLOSING

Is there anything else you would like to elaborate on further or comment on? Is there anything we have touched on that you would like to return to?

I wonder how this experience of talking about your therapy and your work has been for you?
APPENDIX C

PRE-INTERVIEW QUESTIONNAIRE

Some basic information about yourself ................................................................. Date..................................

You do not have to answer every question. Please feel free to omit any question you are not comfortable with answering.

Personal details:
Name:
Title:
Tel. no.:
E-mail:
Age:
Gender: M / F

Professional details:
Profession:
Qualifications:

Please describe the theoretical orientation(s) you use in your work as a psychotherapist:

Number of years you have been working as a psychotherapist:
Treatment setting(s) you work in as a psychotherapist:
Private: Yes / No
Other (specify):

Nature of psychotherapy practice (% of modalities worked in):
Individuals:
Couples:
Families:
Groups:
Other (specify):

Age groups of patients worked with (% of those worked in):
12 years and younger:
13-19 years:
20-49 years:
50-64 years:
65 years and older:

Other areas of work apart from practising psychotherapy:

**Supervision**
Do you have supervision?
Yes / No

If yes (please mark what applies to you):
Peer supervision:
Supervision with another psychotherapist:
If yes (please mark what applies to you):
Only when needed:
On an ongoing basis:

If ongoing, how regularly (please mark what applies to you):
Once per week:
Every two weeks:
Once per month:
Other (specify):

**Personal therapy**
Have you (apart from your present therapy) had (a) previous experience(s) of therapy?
Yes / No

If yes, could you briefly describe your experience of this/these (keeping in mind when this took place, your reason(s) for entering therapy, the duration of therapy, etc.), and how you felt about the outcome of therapy.

**Research process**
How do you feel about entering into this research process?

What do you expect the difficulties and satisfactions may be?
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SAFPP see South African Federation of Psychoanalytic Psychotherapists.


