Testing the Therapist:

An Analysis of the Patient's Attempt to

Direct Treatment

Carmel Fahey

Department of Psychology

Victoria University

STUDENT DECLARATION

"I Carmel Fahey, declare that the PhD thesis entitled 'Testing the therapist: An analysis of the patient's attempt to direct treatment' is no more that 100,000 words in length, exclusive of tables, figures, appendices, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other degree or diploma. Except where otherwise indicated, this thesis is my own work."

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Carmel Fahey   Date

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ABSTRACT

Much research has been conducted that explores the process of psychotherapy and psychoanalysis; however, there is little that provides an illustration of what actually occurs between patient and therapist. This research is an explanatory and descriptive study of testing, which Weiss (1993; Weiss et al. 1986) links to the transference. An analysis of the process of testing is presented from two theoretical perspectives drawn from the theories of Joseph Weiss (Control-mastery theory (CMT)) and Sigmund Freud and Jacques Lacan (Freudian-Lacanian theory). The primary research question asked: what is testing? CMT, based on the higher mental functioning hypothesis (HMF), proposes that testing is a phenomenon based on an assumption that the unconscious can think, plan and make decisions in the same way as the conscious mind. Freud's later theory relating to the ego provides a theoretical framework for CMT and Freud's early theory is used by Joseph Weiss as an alternative theoretical hypothesis to the HMF hypothesis. This thesis presents a comparative analysis of both theoretical positions, which revealed that testing was consistent with an unconscious transference demand. Two propositions were examined at a clinical level using data from a multiple-case study in which transcripts of the first ten sessions of each of three patients' psychotherapy were analysed. The propositions were examined according to Yin's rival theory and analysed according to the logic of pattern matching. The first proposition stated: (1) The Freudian-Lacanian theory of the transference would provide a fuller explanation of testing episodes than CMT. The second proposition related to what the patient wants of the therapist in testing and proposed that: (2) The patient wants the therapist to occupy the position of his parental object, which is the position of an identificatory

object. Theoretically, testing in control-mastery theory is consistent with the Freudian preconscious but inconsistent with the Freudian unconscious. At a descriptive level testing was consistent with aspects of the psychoanalytic processes of acting out, projective identification, and repetition but inconsistent with these processes at a theoretical level due to differing conceptualisations of the unconscious. Clinically, testing as an unconscious process was most consistently explained in the case studies by Freudian-Lacanian theory in which it was viewed as the patient's demand that the therapist occupy the position of the parental objects. This finding opposes the CMT assumption that in testing, the patient does not want the therapist to occupy the position of the parental objects. The opposing positions were explained by the different formulations of the unconscious, either admitting or omitting the drives, which underpinned different therapeutic aims in the two theories. As a theory of conscious and preconscious functioning CMT has merit, but the thesis concludes that it is not a theory of unconscious functioning. The implications of these findings for clinical practice and research are discussed.

INTRODUCTION

The Spotlight: Testing the Therapist

Testing is common in most aspects of social life, whether at school, in psychological assessment, or achieving a driver's licence. Testing usually has a tester and a person being tested, but, for instance, in the early stages of romance, both participants are likely to test each other. Similarly at the beginning of psychotherapy, the therapist has to examine the prospective patient's distress and motivation to attend regularly and the prospective patient will check the therapist's credentials formally and informally. "Credentials" in this sense includes more than professional qualifications or word-of-mouth reputation; the patient wants to know what it feels like to be in the therapist's presence, how the therapist responds to the patient's questions, anxieties and evasions. Such behaviour can continue well into the work of therapy and it is this sort of testing that is explored in this thesis.

Dora's Test of Freud

During Lacan's re-reading of Freud's (1905/1964) case study of hysteria, the case of Dora, he observed that Dora had tested Freud. It was in this case study that Freud first began to formulate the concept of the transference, and Lacan returned to it in his endeavour to tease out the case study by tracking the transference process. Lacan (1951/1982) set out this process in his paper, *Intervention on Transference*.

Dora's test is to determine if Freud will be the same as her father who was less than truthful. He had denied his affair with his lover, Frau K, and Dora seeks to determine if Freud, too, will deny her father's affair. The friendship of Freud and

Dora's father has raised Dora's suspicion that Freud will protect her father instead of demonstrating to Dora his search for her truth. If he does protect her father, he will demonstrate complicity with her father's lie. But, as Freud pointed out, Dora herself was complicit. She had accepted the advances of Frau K's husband which had included much attention and gifts, up to the point where she was faced with the reality of a clandestine sexual affair – the well known scene by the lake- at which point she stops Herr K's advances. She not only tested to see if Freud would be the same as her father, but the same as she. As Lacan pointed out, this example demonstrated Freud's adherence to his stance of seeking the patient's truth in speech. That is, the necessity of establishing within the relationship with the patient that the analyst always seeks the truth in the speech of the patient, regardless of who this might affect or concern. Lacan located Dora's test in the first stage of the transference. He identified a direct relationship between Freud's non-compliance with her attempt to see if he was also hypocritical and her recall of memories displaying examples indicting others. Lacan referred to this as a first development:

> …which is exemplary in that it carries us straight onto the plane where truth asserts itself. Thus, having tested Freud out to see if he will show himself to be as hypocritical as the paternal figure, Dora enters into her indictment, opening up a dossier of memories whose rigour contrasts with the lack of biographical precision which is characteristic of neurosis. (p.65)

Lacan made no further mention of the test, which leaves one surmising that perhaps it was such a commonplace phenomenon that no further explanation was required. Freud appears to treat it similarly even though it has clearly played a part in the development of the theory of the transference and is possibly what triggered in Freud the notion that the patient was assigning the analyst a role from her past. In the

excerpt below, one notices Freud's comment on the way the patient made him feel. This became known as counter transference and although it took on a central focus in a number of post-Freudian theories it was not further developed to any great extent by either Freud or Lacan. What Freud did describe in relation to being tested was a sense of being put on the spot by Dora. He wrote:

> When a patient brings forward a sound and incontestable train of argument during psychoanalytic treatment, the physician is liable to feel a moment's embarrassment, and the patient may take advantage of it by asking: 'This is all perfectly correct and true, isn't it? What do you want to change in it, now that I've told it [to] you?' (Freud, 1905/1964, p.35)

Freud recognised the test, which appeared as a trap that made him uncomfortable. On the one hand Freud believed Dora was accurate in her description of her father, "I could not in general dispute Dora's characterization of her father…" (p.34). But, on the other, he recognised that in the accuracy of her reproaches something more was concealed. In speaking of technique Freud stated that each reproach was a self-reproach and could be turned back on Dora. In this way, as Lacan (1951/1982) pointed out, he pursued Dora's truth; the truth she wished to conceal from herself and from Freud. The complicity and hypocrisy she tested in Freud are functioning patterns not only of her father but also of herself. In other words, they are traits Dora has identified but which she can only recognise as belonging to someone outside of herself.

When Freud demonstrated his belief in Dora with respect to her father's affair with Frau K, she gained access to the memories Lacan referred to. These came in the form of reproaches of her father and Frau K. At a certain level Dora knew that she was testing Freud and in this she expected a particular response, a response similar to

her experience of others – her father, Frau K, her mother perhaps, but also a response that would have shown Freud as complying with Dora's own hypocrisy. In other words, Dora's sensitivity to complicity and hypocrisy was not only due to her experience of others close to her with the same traits, but because these traits were part of her functioning. The test therefore is risky. Whilst she wanted Freud to believe the accusations she hurled at her father, in her articulation she was brought a step closer to recognising her own hypocrisy and complicity - the part she played in the reproaches she delivered. It is this recognition that she wanted to avoid and she had therefore employed the reproaches as a cover, as Freud (1905/1964, p.35) wrote, "…for the purpose of cloaking others which are anxious to escape from criticism and from consciousness." Freud had pointed to Dora's use of defences to push from consciousness those aspects of herself of which she had accused others. Considered in this way, it appears that Dora's investment in the test is to conceal her hypocrisy, which is possible if Freud showed himself to be hypocritical and complicit like both herself and her parental objects. In other words, if Freud complies she can continue to live according to her intentions, which will remain hidden. The reproaches Freud referred to have a defensive function whereby they conceal Dora's role in the whole affair by focussing on the behaviour of others. Dora summoned these defences when Freud did not comply, thus suggesting this was the moment in which she experienced exposure. In this formulation the installation of defences was preceded by the test.

Along with the enactment of defences after a test as is evident in Freud and Lacan's explanations, the test is also a reproduction of previous relationship interactions. Dora had attempted to elicit from Freud the same position in relation to herself as she had experienced with her father, and possibly with others. As Lacan observed, the test related to the transference, which is evident in Dora's attempt to

position Freud in a part consistent with her parental objects. The playing a part from the patient's history was Freud's view of the transference. Likewise, it was this aspect of the transference referred to as a test by Joseph Weiss. Weiss was another theorist who noticed the patient turning the spotlight on the therapist by testing, but Weiss approached the theoretical explanation for the concept differently from Lacan.

Testing in Control-Mastery Theory

During the same period that Lacan, in France, was immersed in Freudian theory, a group of North American ego psychologists were similarly focused. Joseph Weiss and Harold Sampson, with Weiss as the instigator, developed the San Francisco Psychotherapy Research Group (SFPRG). Their charter was to develop an empirically measurable theory of therapy that had predictive power. During this process they identified an event in the therapy session that they named testing. This was incorporated into a new theory called control-mastery theory (CMT) which Galatzer-Levy, Bachrach, Skolnikoff and Waldron (2000) identified as having its roots in ego psychology. The literature of both Weiss and Lacan refers to Freud's early theories but for very different reasons. As pointed out by Mitchell (1982) Lacan's aim was to re-examine and develop a greater understanding of Freud's early theories which resulted in him retaining them. In contrast, Weiss used particular aspects of Freud's early theory as a contrast to CMT, which meant the early theories were discarded for the later work on the ego.

CMT rests on the proposition that the patient is actively planning, managing and directing his therapy at both a conscious and unconscious level. This proposition consistently underpins CMT across Weiss's (1971; 1990; 1993) publications and those of his collaborators, such as, Weiss, Sampson and the San Francisco Psychotherapy Group (1986). That this occurs at a conscious level does not raise

questions because planning, managing and directing various aspects of one's life are processes that occur every day. However, the notion that planning and managing occur at an unconscious level is antithetical to the Freudian unconscious[1]. The CMT proposition presupposes an operational level of higher mental functions operating at an unconscious level. The inclusion of organised, rational processes including decision-making, in the processes of the unconscious as CMT does raises a functional question of how processes usually considered conscious might operate in the unconscious. CMT's answer to this is the ego, specifically, the unconscious ego. There is a presupposition implied in this formulation that enables the unconscious ego to be thought of in this way. The theory presupposes that the unconscious part of the ego can access higher-level mental functions that are also considered ego functions. In this way the patient is able to unconsciously assess the therapist through testing, an idea that pivots on Weiss's (1993; Weiss et al., 1986) theoretical proposition that the patient has an unconscious plan for getting well, of which testing is a part. Just as the psychologist gathers information from the patient when he administers psychometric, neuropsychological and projective tests, so too, the patient gathers information about the therapist.

Testing is viewed as a central, not incidental, part of therapy (Rappoport, 1996; 1997; Weiss, 1971; 1990; 1993; Weiss et al. 1986). In the cognitive-behavioural based therapies the therapist is seen as the active agent of change in the passive patient, but with testing Weiss pointed to the patient's unconscious activity. In this consideration Weiss has shifted the focus of what has become the standard reading of cognitive-behavioural based therapies to a reading that includes the unconscious. By positing a theory of the unconscious that includes planned and decisive activity he

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[1] It is the unconscious aspect of testing that is the subject of this research; the conscious aspect will not be followed beyond this mention. It is hardly mentioned further is Weiss's main publications.

adds a new dimension to the unconscious, the agency of the patient. The theoretical formulation of the unconscious in CMT will be the subject of the next chapter, but before exploring this, one needs to know how testing manifests in a CMT formulation. Is it, for example, consistent with Dora's test of Freud?

When Freud (1905/1964) realised that Dora was actively testing him he referred to a feeling of embarrassment. A similar affective quality was also evident in the examples of testing proposed by control-mastery theorists, even though each test varied idiosyncratically. Although the theoretical accounts of testing differ, this suggests that tests in both theories have the same quality at a descriptive level. The following series of quotes were provided by Weiss (1993, p.95) as examples of the way in which testing is formulated in CMT. Here, Weiss described the patient's effect on the therapist as occurs during testing:

> Patient arouses powerful feelings in the therapist by, for example, being provocatively boring, contemptuous, seductive, or impossible.

> Patient attempts to force the therapist to act by demanding the therapist behave in a particular way, for example, being silent for an extended period, making false or absurd statements, non-payment, feeling highly insulted when the therapist says something clearly intended to be benign, suddenly angrily threatening to stop treatment, and insisting the therapist step out of his role as therapist.

> Patient makes use of provocatively wild exaggeration.

> Patient displays behaviour that is out of keeping with his usual behaviour, that is, more foolish, or self-destructive.

Other CMT proponents have provided further examples of testing. For example, Curtis, Silberschatz, Sampson and Weiss (1994, p.201) provided the following detailed hypothetical list of how a specific female patient might test her therapist:

> She will try to deny or rationalise her problems to see if the therapist needs or wants to deny issues.

> She will take control of the session to see if the therapist is bothered by her strength and direction.

> She will act vulnerable, needy, and/or seductive to see if the therapist will take advantage of her.

> She may invite the therapist to exploit her in some way, or to take charge of her (e.g., tell her what she should or should not do) to see if his/her intentions are truly in her best interests.

One can see from the affective component in Weiss's (1993) examples the similarity with Freud's feeling of embarrassment. It is clear from these examples and from Freud's response to Dora that testing aims at the elicitation of a response in the therapist. This was evident in the examples provided by Curtis el al. (1994) also, and even though they are hypothetical they demonstrated the way tests were structured in the CMT formulation of clinical material. This formulation was part of a larger overall hypothetical plan that was developed according to CMT principles. The plan was proposed as a model consistent with the patient's unconscious plan for therapy.

The examples Curtis et al. (1994) provide are structured in two parts and therefore give more information about the formulation of tests in CMT. The first part of each sentence is observable. It tells of the way the patient will be, or is, toward the

clinician. Some are clearly recognised as defences, for example denial and rationalisation. The second part of each account is a hypothesis based on CMT. Curtis et al. speculate, based on this hypothesis, on the patient's unconscious motivation as stated in the first part of the sentence. In these examples, like Freud's embarrassment when Dora attempted to manipulate him into behaving hypocritically, the degree of activity in the patient and the invitation, even expectation that the analyst act according to a preconceived notion on the patient's part, is evident. CMT has attempted to explain this preconceived notion through the unconscious.

Although the examples above enable one to develop an idea of what tests might look like from a CMT perspective, a closer examination of the theory itself is required to answer questions such as: Why are the tests considered to be unconscious? Also, is it possible to determine what response the patient wants from the therapist when he tests? These questions will be broached in Chapter Two, but before that, an overview of testing in relation to CMT and to Dora in Freud and Lacan's work is provided.

The current research

After noting testing in the case of Dora little more is made of it. Certainly, neither Freud nor Lacan explore it further as a theoretical construct. The case had, however, played a crucial role in Lacan's understanding of the transference, which leads one to suspect that testing might be implicit in the Lacanian conceptualisation of the transference. Considering this, it is most likely that testing was not viewed as a separate process but absorbed into an existing one. When one revisits Lacan's reference to testing it is evident, although unstated, that both Freud and Lacan read the interaction between patient and analyst as a demand on the part of Dora. It was

this concept of demand in the transference that Lacan went on to develop further. He believed it to be so important that eventually he assigned it a position of centrality in his theory of the transference. The transference in Lacanian theory is discussed in detail in Chapter Four.

The possibility that testing was incorporated into demand would explain why Lacan did not develop testing further. In contrast, Weiss's (1993) development of testing as a separate construct included the transference but was not specific to it. Weiss's test had a cognitive component; it was a test of an unconscious belief enacted in the relationship with the therapist. Its endeavour was to disconfirm a belief considered harmful to the patient's psychological functioning. The concept of testing, where noted by Lacan and Weiss, has developed along separate theoretical trajectories, even though Lacan and Weiss have a shared history in Freudian theory. There is a commonality, however, which is evident at the level of description and concerns the patient's demand.

If one proposes that in testing the aim is to elicit a response, or its counterpart, no response, then testing could be considered a demand in both theories solely on this basis. It would be a demand to see or hear what occurs in relation to the test. Weiss (1993) acknowledged the link between tests and demands in a way that enabled the elevation of the cognitive aspect of tests in favour of the drives. This reversal of the usual structuring of psychical functioning and its vicissitudes in a theory that acknowledges the Freudian notion of the unconscious makes it difficult to understand what Weiss actually meant by testing. This is made even more difficult because so many of the patient's interactions are incorporated into testing.

The CMT literature on testing reads like a "grab bag" of everything the patient does in psychoanalysis that calls on the therapist to respond. In this it is hard to find a

clear demarcation between the conscious and unconscious which makes it difficult to understand how a theory of unconscious processing with an emphasis on cognitive aspects would distinguish between unconscious and conscious testing. Such a theory would be more comprehensible if unconscious processes were used to explain unconscious testing and cognitive processes called on to explain conscious testing, but this does not appear to occur; instead, the unconscious and conscious are combined. There is a curious disjunction at this point that leaves one questioning the notion of the unconscious according to Weiss and the unconscious according to Freud.

It is this disjunction which drew interest, and in the early stages of examining both Freud and Weiss's theoretical propositions relating to what occurs in therapy sessions, this interest naturally led to the case of Dora, where Lacan had also referred to testing. The differences in the two theoretical explanations around the notion of testing then became the focus of the research. Thus, this thesis sets out to explore the different explanations for the kinds of behaviour described by Weiss as testing. It has aspects of the Freudian psychical operations of projective identification, acting out, repetition and transference, and would appear to contribute to the formation of the therapeutic relationship and therapeutic alliance.

The questions that arise in explaining testing are best addressed by combining a theoretical and clinical methodology. This forms the later chapters, but first, the broader psychoanalytic and psychotherapy research literature as it pertains to the relationship between patient and therapist is reviewed. Particular emphasis is placed on the distinction between the conscious and unconscious in research which will enable a contextualisation of clinical patient-therapist relationship research within the contemporary dominant research paradigm. The focus of this paradigm is conscious

content and behaviour. Considering that descriptions of testing are consistent with a number of existing psychical concepts, these will also be reviewed.

Plan of thesis

The thesis is divided into two parts Part A is theoretical and Part B clinical. First, testing by the patient is reviewed theoretically. Second, clinical data will be presented. Finally, the findings of the two initial explorations are integrated. Each part has several chapters. The first of the four theoretical chapters locates testing within the patient-therapist relationship conceptually and within the research literature. The second provides a background to the development of control-mastery theory and testing. It also presents the control-mastery theoretical arguement and explores fundamental elements of the theory relating to testing. The third chapter presents the Freudian theory of the unconscious and the fourth introduces relevant Lacanian theoretical concepts. The final stage of the fourth chapter describes and discusses the relationship of testing to existing clinical constructs and in doing so draws together Freudian and Lacanian theory as it relates to clinical phenomena. Subsequent chapters are related to clinical data. The fifth chapter presents the methodology, the sixth, seventh and eighth are each a single clinical case study. The ninth chapter presents the conclusions and implications of the thesis.

Throughout the thesis the person undergoing psychotherapy will be referred to as the patient and with the pronoun 'he' inclusive of all patients. This is consistent with the psychoanalytic tradition of reporting case material and theoretical investigations. In Lacanian literature the terms analysand and subject are used as homologous with patient and will not be replaced in any quotation of this literature. Unless otherwise clarified where the word unconscious appears it is assumed to be the unconscious as written of by Freud.

PART A: EXAMINING TESTING THEORETICALLY

CHAPTER 1: THE PATIENT-THERAPIST RELATIONSHIP IN

RESEARCH

An abundance of empirical research exists about the relationship between

therapist and patient within psychotherapy. The vast majority of this research focuses

on conscious processes relating to how well the patient and analyst get along and

utilises a variety of methodologies. However, there is also a growing body of clinical

research that, to a varying degree, explores unconscious processes in relation to the

relationship between analyst and patient (Bornstein & Masling, 1998; Masling,

1986). An overview and critique of treatment research follows.

1.1 CONTEMPORARY PSYCHOANALYTIC AND PSYCHOTHERAPY TREATMENT RESEARCH

Both process and outcome research have attempted to determine the correlation

between events in therapy and the patient's symptoms. In outcome research the aim

is to demonstrate the effectiveness of specific treatment models and in process

research it is to determine how the treatment works. Process-outcome research

combines the two and there is now an abundance of studies in all three research

methodologies (see Goldfried & Wolfe, 1998; Greenberg & Pinsof, 1986; Greenberg,

Rice & Elliot, 1993; Hartley & Strupp, 1983; Honos-Webb, Styles & Greenberg,

2003; Honos-Webb, Lani & Styles, 1999; Masling, 1986; Shapiro & Stiles, 1994;

Toukmanian & Rennie, 1992). Reviews and meta-analyses of psychoanalysis,

psychodynamic psychotherapy and counselling research have resulted in a variety of

conclusions (see Crits-Christoph, 1992; Galatzer-Levy et al. 2000; Lazar, 1997) Some, such as Roth and Fonagy (1996) attempted to match patient types and therapist types in a, "who suits whom" investigation. However, in his review of the meta-analyses, Fonagy (1999) concluded that no treatment model was superior. Yet, superiority, or at least efficacy of treatment models appears to be the driving force behind research studies. This drive to find a single, best-practice model stems from the physical health paradigm of evidenced-based medicine. As Fonagy pointed out, this paradigm has forced mental-health practitioners to adhere to research models that predict outcomes for interventions in the same way as occurs in the physical sciences, such as medicine. Treatment of the mind is considered synonymous with treatment of the body and in this, physical and psychical are not distinguished.

Just as contemporary research does not generally question its underlying research paradigm, neither is the lack of fit between the current process and outcome models of research and intrapsychic processes questioned. The lack of fit, however, exists and points directly to the unconscious. The dominant nomothetic research paradigm was designed to investigate physical functions and can be extended to conscious mental functions through language, but not to the unconscious. The reason being that the unconscious manifests in language in a distorted or disguised form. This was Freud's thesis and is the basis of his theory of the unconscious. It was taken up by Lacan and can be identified across the body of both their life's works. Instead of acknowledging this lack of fit and the difference between the physical and psychical, the call has been to improve the 'rigour' of research models within the same paradigm. This occurred in the efficacy research studies that emerged in the 1980s and 1990s. In this research different treatment models were compared and found to be equivalent which resulted in a scrutiny of research studies that uncovered

numerous methodological flaws (For a review of this area see Charman, 2003). A call for greater scientific 'rigour' in research resulted (King & Ollendick, 1998; Lampropoulos, 2000) not a call to acknowledge the limits of researching the unconscious using an empiricist tradition. (This lack of fit is discussed further in the next section.)

A further point concerns the type of data used to research conscious and unconscious psychical content and processes. The data might include therapy session transcripts, observation, or some form of self-report, the latter drawing from various inventories, scales and questionnaires, developed to measure particular aspects of therapeutic treatment. Research into the therapeutic alliance appears to be the most often conducted and this has utilised all of these methodologies. Surprisingly, Martin Garske and Davis's (2000) meta-analytic study of alliance research found that the measure used in the research was not a factor that influenced alliance-outcome findings. This means that regardless of the way the information is gathered the results are the same. Perhaps this is not so surprising when one considers that the vast majority of this body of research uses a method of self-report. The patient's ability to comment on the effectiveness of the relationship suggests that the data gathered is conscious. Increasingly researchers of a cognitive orientation are researching what they describe as unconscious content and processes. This is particularly evident in Ryle's (1990; 1994; 1995) cognitive-analytic approach but extends to the cognitive-behavioural approaches in which unconscious processes such as the transference are now incorporated into psychotherapy treatment (see Arnow, 2005; Sareen & Skakem, 2005). Generally, these studies do not distinguish between conscious, preconscious and unconscious content or processes, even though the unconscious is implied each time phenomena such as the transference is referred

to. The accepted, although unstated, assumption in mental health research is that conscious material and processes are under investigation unless otherwise specified. This is problematic when the research comments on what is generally considered unconscious material and processes, without consideration of the conscious-unconscious system that Freud defined. Some, such as the authors of papers that appear in Bornstein and Masling's (1998) *Empirical perspectives on the psychoanalytic unconscious* series have attempted to research the unconscious but consistently misinterpret Freud's distinction between the conscious and unconscious. Certainly the problem of distinguishing objectively between the data of the conscious and the unconscious has not found a simple solution.

Perhaps such a question is unfashionable and there is no longer a need for researchers to understand the conscious-unconscious system: the psychoanalysts can work with the unconscious and the cognitive-based therapists can remain with the conscious mind. But even a solution such as this is inadequate because the problem concerns the distinction between the conscious and unconscious, not who works with what. The distinction has been obscured and researchers attempting to explain the inconsistencies that appear in research of psychical processes have blurred the boundaries of the traditional conscious-unconscious system. This is a two-way shift, with psychoanalytic theories now being explored through cognitive-based research models and the cognitive-based theories and research models attempting to explain conscious thoughts and behaviour using the terms and processes of the unconscious. The latter has been referred to as the 'psychoanalytic drift' in cognitive therapy, which is likened to the previous 'cognitive drift' in behaviour therapy (Power, 1991). The former is a result of the pressure on analytic models to simplify and speed up, for purposes of therapeutic convenience, which pushes them into cognitive

modes. Milton (2001) discussed this trend comprehensively. The lack of fit between the Freudian unconscious and the nomothetic research paradigm means a failure of the unconscious to be 'proven' in the empiricist's tradition. Given that in contemporary psychological research 'proven' evidently means observed, the Freudian unconscious appears to have been elided.

1.1.1 Research and the unconscious: A question of fit

The question of observability has become increasingly important in mental health research. Observers of the unconscious, however, know that it is not directly observable in the same way that conscious material is. This is not to say that Freud's research on the unconscious was not empirical, but that the unconscious must be observed via indirect means. Freud did this by developing a theory that explained the manifestations of the unconscious as they appeared in disguised form. These were the metaphorical and metonymical manifestations of the unconscious appearing in jokes, dreams, slips and so on. Despite these forms theoretical approaches that utilise metaphor and metonymy as a means of describing the existence of indirectly observable material are criticised. In the reference to it being unfashionable to call this research empirical, Nobus and Quinn (2005) optimistically suggest that it might be temporary. Regardless of whether change is on the horizon the current outcome has been to change the unconscious into something more directly observable, which then becomes a question of definition.

Much of the current psychoanalytic and psychotherapy research is conducted through large research institutes, often university based, and many in the United States and has therefore fallen under the dominant ego psychology model of psychoanalysis and its descendants. Ryle's (1990) cognitive-analytic model,

although developed in Britain, has an analytic focus but is based on the ego psychology model. In this model the unconscious is defined loosely by all that is out of awareness. This contrasts with the Freudian unconscious which was defined by specific laws and principles and the mechanism of repression. Furthermore, much of this research has used the cognitive theories as a comparative point to support research claims, thus suggesting an underlying motivation to compete with the empirical claims of these theories. For example, the conversion of Freudian theory into cognitive models is evident in language where fantasies become schemas, defences are self-representations, and so on (see Singer, 1998). This appears to bring contemporary research a level of credibility that it would not otherwise receive. It is the problem that faces the Freudian case study methodology when compared with the new cognitive methodologies and has shaped the way psychical functioning is viewed in contemporary clinical research. This is particularly so where it concerns the relationship between patient and therapist. It is into this contemporary research paradigm that testing fits. This is due to CMT being a part of the research that straddles Freudian and cognitive theory. What is unknown is where in the existing conceptual literature testing fits.

1.2 CONCEPTUAL-THEORETICAL LITERATURE AND RESEARCH

A number of psychoanalytic and psychotherapy concepts have been developed to explain what occurs within the relationship between therapist and patient. In the literature the term therapeutic relationship encompasses all that takes place in the therapy session between therapist and patient and includes the more specific terms of the therapeutic alliance and the transference. Each of these is heavily researched at process and outcome levels. Some are directly referred to in CMT literature. In

reviewing these concepts and the research pertaining to them the aim is to determine where the concept of testing can be located within established psychoanalytic concepts.

1.2.1   Therapeutic relationship

The relationship between therapist and patient has been extensively researched. Much of this research has focused on the failure of the establishment of a therapeutic relationship. While this is generally attributed to an unsuccessful beginning of therapy it is also attributed to occurrences in the relationship called ruptures (Safran, Crocker, McMain & Murray, 1990) and impasses (Arnow, 2005). The degree of importance placed on the relationship as a factor in treating symptoms varies and is dependant on the theoretical principles guiding the treatment. For example, Kahn (1991) specifically referred to therapists of the psychodynamic therapies, including, object-relations, self-psychology and gestalt therapy as advocating that the therapeutic relationship was crucial to their practice. In psychoanalysis for example, the symptom is viewed as representative of something unconscious that is yet to be discovered by patient and therapist, but which can be discovered and treated through the relationship. In contrast, Egan (1994) noted that the behaviourally based therapies viewed the therapeutic relationship as an impediment to the patient's achievement of goals. Traditionally, the behavioural therapies considered the patient's goals as separate to the relationship, whereas more recently the dynamics between therapist and patient have captured the interest of some behaviour therapists (Raue & Goldfried, 1994), who have moved toward a cognitive-behavioural model. The cognitive-behavioural therapies in general are even more interested in the therapeutic relationship than the behaviourists and are increasingly elevating the importance of

relationship factors in treatment (see Arnow, 2005; Safran et al, 1990). This recent shift has resulted in an abundance of research studies on various aspects of the therapeutic relationship within cognitive-behavioural theory (see Milton, 2001).

There is also a growing body of research in therapies where the transference relationship itself is considered curative. In this research the therapeutic alliance is viewed as facilitating the instalment of the transference (see Bailey, Wood, & Nava, 1992; Kahn, 1991). Lester Luborsky has been an influential researcher in the transference as a process. He began with explorations of the therapeutic relationship and the therapeutic alliance (see Luborsky, 1976). Luborsky's research utilised what is considered highly empirical methodologies, and, along with Weiss's research is typical of the methodological approach exploring psychical processes considered to be out of awareness. Such approaches generally rely on the descriptive model of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association, 1994). However, there are limitations to using research based solely on a descriptive model as illustrated in the following example.

Luborsky and his colleagues (Luborsky, Crits-Christoph, Alexander, Margolis & Cohen, 1983) proposed that the patient's ability to trust was required for the development of a therapeutic relationship. The capacity to trust influenced the type of "helping alliance" formed with the therapist, and the researchers identified two specific types of alliance. The first was called Type one and was developed by dependent patients who expected a "supportive and helpful" therapist and the second, Type two was developed by less dependent patients who saw themselves, along with the therapist, as active agents in working towards understanding and conflict resolution. Although not stated, one would expect a significant difference in the level and type of psychopathology in the types of patients forming these alliances. The

patient who is more severely disturbed would be expected to experience more difficulty trusting. But, also a consideration of the structural determinants of psychical functioning would enable a differentiation between, for example, two types of neurosis - obsessional and hysteric - or psychosis, each of which present differently in terms of what the patient wants and needs from the therapist. Luborsky et al.'s conceptualisation of the alliance is reminiscent of what emerged into the conflict and relational research in the 1990s.[2]

While these models are useful in understanding the psychical processes of the patient, they consider conflict solely from the perspective of the patient's experience in relationships and in doing so focus on the external aspect of the patient's conflict. This means that little, if any, attention is paid to the internal drive as a factor in the conflict. In a structurally determined model the drives would be considered. Attention to the relationship between patient and therapist and the transference within this relationship is vital to treatment and is not in question here. In fact, those clinical researchers who have broached this area through transcript-based data have made a valuable contribution to clinical process research. Weiss (1993) is among these. The problem is that the unconscious as Freud described, which included the drives, is missing from the current body of research. Nevertheless, in an increasing number of theoretical approaches successful treatment of the patient is recognised as dependant on the relationship between therapist and patient. Any discussion of this relationship, however, introduces the therapeutic alliance, which is often considered the measure of successful treatment.

A comprehensive review of the therapeutic alliance and therapeutic relationship literature is beyond the scope of this research, however it must be pointed out that the

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[2] Luborsky and Crits-Christoph (1998) went on to develop the Core conflictual relationship theme method (CCRT) which had considerable influence on both clinical research models and the understanding and depiction of the transference.

two terms, relationship and alliance, are both used in relation to the therapy session and at times they appear in the literature synonymously. Not surprisingly, this has created confusion about the exact meaning of the terms (Stiles, Shapiro & Elliott, 1986). It is generally understood, however, that the therapeutic alliance plays a specific role in the therapeutic relationship. Due to the importance placed on the therapeutic alliance in certain psychoanalytic and psychotherapeutic approaches it will be discussed separately here.

1.2.2   Therapeutic alliance

The therapeutic alliance is a particular kind of arrangement between therapist and patient. It has the subject of much recent psychotherapy research across a number of orientations. Meissner (1996) studied the therapeutic alliance from a contemporary psychoanalytic perspective and, in tracing the concept historically, found that the early proponents related it directly to the ego. Sterba's (1934) formulation of the ego included what he referred to as a therapeutic split. This split created a division in which one part of the ego worked directly with the analyst. Bibring (1937) is recognised as the earliest proponent of the therapeutic alliance, which Zetzel (1956; 1958) further explored. Greenson (1965;1967) referred to a working alliance in which the patient's ability to work with the analyst was emphasised over the relationship factors central to the therapeutic alliance.

Meissner's review of the literature pointed to the vastness of the therapeutic alliance as a concept; it incorporated everything from collaborative relationships to the transference. On the basis that any expectations or perceptions about the therapist can be considered transferential, some, such as Bird (1972) and Brenner (1979) argued that the therapeutic alliance and the transference were connected. They cautioned, however, that a focus on the therapeutic alliance in therapy could interfere

with the transference and the therapist's attention to it. One can imagine the pitfalls of being seduced into colluding with a patient and consequently losing track of the transference.

Although the consistently held view of the therapeutic alliance is that the analyst and patient's ego's become allied through a process of identification, not all agree that this should occur. For example, Lacanian theory opposes this view. This is not to say a relationship should not develop, on the contrary, the relationship in Lacanian theory is considered essential, but it is the type of relationship that is crucial to progress and this is linked directly to the aim of treatment in the various models. It is discussed further in Chapter Two.

Meissner (1996), consistent with Luborsky et al. (1983), proposed that trust was a necessary preliminary step in developing an alliance. He linked the capacity for trust to the patient's ability to build the identifications necessary to sustain the alliance. He called this the narcissistic alliance, which was consistent with what Erikson (1950) and later Zetzel (1958) referred to as 'basic trust', or the protective function of the patient's relationship with the analyst. As Meissner pointed out, Zetzel's early work located the formation of basic trust in the infant-mother object relationship. Clinically, an attempt is made through the therapeutic alliance to provide the patient with a new experience that mimics the original infant-mother relationship, but in the relationship with the therapist this provides a sense of safety and installs trust. Theoretically, a new identification will then replace the earlier pathological identification.

The ego's concern for safety during the development of the therapeutic alliance is reminiscent of descriptions of testing and in line with the CMT view of ego functions. Theoretically, one could ask if it is possible that testing is an attempt to

build a therapeutic alliance within the therapeutic relationship, and if so, is the therapeutic alliance considered to function at a conscious or unconscious level? The research depicting self-report data presented in Section 2.1 highlighted the conscious aspects of the psyche that forms much of the data relating to the therapeutic alliance. However, Meissner's interpretation of the therapeutic alliance and its relationship to identifications in the ego suggest a connection to aspects of the psyche that are out of awareness.

Meissner (1996) concluded that the therapeutic alliance had both conscious and unconscious aspects but in research there is little distinction between the two. With regard to the consciousness system Meissner related the building of the alliance to the patient consciously evaluating the analyst through judging his ability to be, "constant, confident, reasonably optimistic, and professionally competent." (p.237). The search for such qualities, which might be considered necessary to any professional practice, reflects the direction of psychotherapy research that dominated the 1980s. The focus was around attempts to identify predictors of outcome, and numerous measures of the alliance, mostly self-report, were developed to do this (see Horowitz, Marmar, Weiss, DeWitt & Rosenbaum, 1984; Luborsky et al, 1983; Marziali, 1984) As Honos-Webb, Stiles, & Greenberg (2003) reported, the findings of such research supported the view that the alliance could be used to predict psychotherapy outcome. Typically, although not always, this research linked the alliance to the patient's achievement of goals, which necessarily are consciously stated goals and often inconsistent with unconscious motives. Furthermore, the link between the patient's view of the alliance and successful treatment outcomes indicated the therapist and patient's ability to get along well, whereas this is not always a realistic view of therapy. The defences and difficult transference

phenomena such as the negative transference do not always display a positive relationship. More recently researchers such as Siefert, Hilsenroth, Blagys and Ackerman (2006) have begun to examine the connection between the negative manifestations in sessions and the alliance.

Karen Walant's (1995) book, *Creating the Capacity for Attachment,* provides a patient's retrospective view of the relationship with the therapist and offers the reader an opportunity to observe unconscious content. This is more consistent with the case study approach used by Freud in which the reader learnt a great deal more about the patient from the dialogue presented than what existed at face value. The excerpt highlights the different stages of the patient-therapist relationship which impacts on what might be considered a good or bad therapeutic alliance at any given time. Walant's research provided a remarkable first hand view of the patient's perspective in regard to his inability to verbalise thoughts at one level, but at the same time knowing that the therapist had become part of his pattern of relationship functioning. Through a letter written in response to the patient's reading of his own case study (part of Walant's dissertation) the reader, as a third person, is privy to the patient's reflections:

> I knew, though I could not verbalise, what I needed. …. For me, not getting one of **those**, but rather a young woman who is **oddly sure of herself** around me, the one person who most people were **NOT** sure of themselves with. …. I've always found it amazing how in touch you were with me. I tried so very hard to **piss you off**, to shock you, to scare you, to basically make you **blush** in some way. …. I knew, in time, I'd have you switching with another doctor or therapist since you couldn't deal with this **loony**. Just looking for the obvious rejection soon to come. The sturdy, rigid Therapist (**who came off awful coy, I might add**) I really wanted to spit on in that room **EVERY** time I saw her, is and still is, one of the only people who stands up to me. An

important difference between **You** and **everyone else** (1995, p.152-153).
Style variations in original).

The patient speaks here about the therapeutic relationship and although he acknowledges his antagonism toward the therapist, it is through her tolerance of this that a relationship has been built. The transference is also revealed by the patient's reference to his attempts to induce a rejection. Depending on the model used to research the therapeutic alliance, a passage such as this could be construed as either a well established or poorly established therapeutic alliance. For example, a report on the relationship given by this patient during the occasions that he referred to in the passage would likely show him speaking disparagingly of the therapist, and this could be interpreted as a poor therapeutic alliance. Yet, as the passage illustrates, a therapeutic alliance using Meissner's (1996) definition of an unconscious ego process built on identifications appears to be working well. The therapist and patient have developed a relationship in which the patient can experience another person as calm and reliable rather than aggressive and rejecting, as anticipated based on previous relationships.

The excerpt above depicts elements similar to those of testing in CMT. Within these components one can observe the concurrently operational levels of conscious and unconscious functioning. For example, Walant's (1995) patient did not understand his motivation for behaving as he described, other than to determine whether the therapist would help or reject him. In this, he searched for a relationship different from past relationships, as he pointed out. He was aware that his test was to see if he frightened his analyst enough for her to reject him and his ability to describe this demonstrates a conscious process. Beneath this, however, is the content of which he was unaware but is evident in his description of wanting to spit on the therapist.

Thus, multiple layers of material drawn from the conscious, preconscious and unconscious and likely stemming from an early experience with a hated object, are reflected. Although this excerpt was used to demonstrate attachment theory,[3] the description was consistent with testing and the therapeutic alliance.

Despite the focus on the unconscious aspect of the therapeutic alliance, Weiss et al. (1986) believed it to be more frequently considered a conscious rather than unconscious process. Weiss et al. used the following quote to demonstrate how an apparently poor therapeutic alliance is viewed in CMT as concealing an underlying unconscious process:

> "Her threats to stop treatment marked considerable progress in her analysis. She could permit herself to make these threats only after she had, as a consequence of analytic work, developed a certain degree of trust in the analyst. By making these threats, Miss P is working more directly and ultimately more successfully than earlier to test her beliefs that she did not deserve help from the analyst and would, by demanding help from him, drain him." (p.331)

Weiss et al. described the manifest feelings and behaviour of Miss P as clues to the testing of her underlying unconscious beliefs. Miss P expressed a wish to terminate therapy, which Weiss et al. interpreted as a conscious expression of hate for the analyst. The theorists state that if conscious processes only are considered this example would be described as a poorly established therapeutic alliance. But, when viewed in line with CMT, the expression of hate is seen as an example of the patient unconsciously working closely with the analyst. The conscious expressions of hate and rejection are tests based on unconscious beliefs connected with these emotions.

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[3] Attachment theory is an extension of object-relations theory. It stemmed from the theoretical approach of John Bowlby and was extended by Mary Main and Mary Ainsworth.

Weiss et al. believed that if the therapist passed the above tests, Miss P would experience a deepening or qualitative positive shift in the therapeutic alliance.

In CMT testing is believed to influence the therapeutic alliance, which in Meissner's (1996) formulation amounts to the ego of the patient and that of the analyst being allied through the process of identification. Thus, the alliance is strengthened when the patient believes he and the analyst are more in tune, or more alike. A relationship between safety and identification is implied in the alliance and suggests that the patient will feel safe when he believes the therapist and he are alike; or, that the therapist is like someone familiar to the patient, such as his parents, which introduces the transference. This is returned to below. By implication there is a fear of difference in the relationship. This is the area of Lacan's notion of alienation and separation and Freud's primary narcissism. Theoretically, therefore, testing can be understood as a process that facilitates the therapeutic alliance, possibly through identification, but this is inconsistent with the patient wanting the therapist to be different from his parents which is the premise on which testing is based in CMT. The problem is that identification is not a conscious process; however, where the conceptual literature considers the alliance alongside identification, the research literature tends to focus on conscious aspects of the alliance in relation to the ego. This mostly occurs through the use of rating scales such as the widely used Working Alliance Inventory (WAI) (Horvath & Greenberg, 1986; 1989) which is used to gather data in much of the contemporary psychotherapy research that explores relationship factors in treatment. There is an abundance of research that uses this scale and all of it makes the assumption, regardless of the theoretical orientation, that high scores on alliance scales are an indicator of successful treatment. This is an artefact of assuming a correlation between high

scores and successful treatment. It reduces complex psychical functioning to a simplistic level in which the unconscious has no part. The building of an alliance through testing either means that the patient wants the therapist to be the same as his identificatory objects, which are usually parents, or, testing is purely a conscious process that can be investigated through alliance scales. If this were so, the unconscious and its manifestation in therapy through the transference would play no part in testing. According to CMT however, the transference, the unconscious and testing are interrelated which necessitates further consideration of the transference.

1.2.3 Transference

In CMT the transference is not viewed as a phenomenon in itself despite its incorporation into the concept of testing as a term that denotes a particular type of test. In this respect CMT differs from most other post-Freudian psychoanalytic models.

Freud (1900/1976) initially used the term transference solely in relation to the transfer of affect, but, as Evans (1996) pointed out, the wider psychoanalytic view of the transference refers more generally to the relationship of the patient to the analyst within the analytic setting. The relation is a re-enactment of early relationships, with the analyst representing various people originally present in the patient's early experience. Freud (1905/1964) initially considered the transference to be a resistance to treatment, an idea generated by the inhibiting effect of the transference on the emergence of repressed memories. However, as Freud's ideas developed he realised the transference was also an asset to treatment. Freud (1914b/1964) believed the transference represented infantile conflicts manifesting as neurotic symptoms within the relationship with the analyst. He called this the transference neurosis and realised

it was the position from which change was possible. The manifestation of the patient's history of significant relationships arising within the relationship with the analyst enabled new sense to be made of relationships via the new experience. Laplanche and Pontalis (1988) believed Freud referred primarily to the transference of unconscious wishes and their related fantasies, which were connected to Oedipal material. Freud (1905/1964), was clear that transferred content was symbolic, not verbatim repetition. He wrote, "What are transferences? They are new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician." (p.116). In terms of the curative aspects of the transference, Freud explained that sometimes the transferred content is a replica of the original content imprinted onto the analyst, and at other times it undergoes moderation during the process of attaching itself to the new object. This is explained in greater detail in terms of a movement of energy in psychical processes in the following chapter. The new object is the analyst and through this process the original content is revised. This suggests two possibilities for the unconscious material, one in which the content is altered and one wherein it remains the same. In the former, where there is a revision, there exists the potential for change. This means the therapeutic relationship provides an environment of possibility, in which the patient can make progress without interpretation by the therapist or analyst. It was the recognition of such progress that propelled Weiss into his original exploration of testing. As mentioned in the Introduction, Weiss endeavoured to explain how and why progress occurred without interpretation, beyond Freud's existing explanation. Weiss was not alone in

attempting to pioneer an explanation of the transference beyond the existing Freudian view.

The use of the term transference in the psychological literature has expanded outside of a purely Freudian construction and is now used to describe anything concerned with the relationship between the patient and analyst (Laplanche & Pontalis, 1988). Luborsky and Crits-Christoph (1998)[4] produced a comprehensive review of the literature on transference. A reading of this review confirms Laplanche and Pontalis's (1988) view of the breadth of the term in contemporary literature. Although Luborsky and Crits-Christoph's assumptions remain closely aligned with Freud's they do not attempt a definition of the transference. Similarly, Weiss et al. (1986) did not provide a clear definition, but they did describe the patient as re-enacting a previous interaction so as to test an unconscious belief. The reason some theorists steered away from a definition could concern the changes Freud made as he developed the concept. As Evans (1996) pointed out, Freud's view, that the transference was both an asset and a detriment to the analysis appeared contradictory until Lacan clarified the apparent paradox and an understanding of the transference became clear. (A separate section on Lacan's notion of the transference appears in Chapter Four.) Weiss's references to Freud in regard to the transference focus on the transference neurosis.

Weiss (1993; Weiss, et al., 1986) acknowledged the consistency between CMT and Freud's theory of the transference neurosis even though he did not state that testing was transference phenomenon. For example, he located the gradual disconfirmation of pathogenic beliefs and the consequential confidence in the analyst and eventual control over unconscious beliefs, within the Freudian stages of the

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[4] Luborsky and Crits-Christoph operationalised and empirically demonstrated the manifestation and pervasive nature of the transference in *Understanding Transference* (1990).

formation and resolution of the transference neurosis. Weiss (1986) explained that 'formation' was the stage in which the patient became confident in the analyst and realised that his or her pathogenic beliefs were false. Consequently, the patient felt safe enough to allow feelings of love for the analyst to develop (a positive transference), which enabled him further to test his beliefs and gather more evidence of the falseness of the beliefs. During the 'resolution' of the transference neurosis the patient purportedly reduced his testing. The belief, at this point, is realised as false and maladaptive, therefore the patient no longer requires testing as a check of this (Weiss, 1993).The patient's activity in this regard is possible because of the assumption that the patient has control over his unconscious.

Weiss et al. (1986) had earlier suggested that Freud described the conception and resolution of the transference neurosis as separate stages. Weiss used the model of separate stages as a contrast for the CMT proposal that the two processes were located on a progressively operating continuum, "…in which the patient progressively disconfirms his pathogenic beliefs and so progressively gains control over the unconscious transference." (p.327). In this formulation, the testing of pathogenic beliefs was a way of not only controlling the transference, but controlling it to the extent of deciding when to enact it. Weiss wrote that the patient, "… becomes able not to express the transference when it is inappropriate and to express it when it is appropriate." (p.327). This was at odds with the Freudian understanding, as Weiss acknowledged. In Freudian theory one does not choose the appropriateness of expressing unconscious psychical content, as is explained fully in Chapter Three. At the level of description, however, the patient in both Weiss's testing and in Freud's transference demand continues in the same activity until a change occurs. For example, the patient continues to test until the therapist responds in a particular

way and he no longer needs to test. In Freudian theory the patient continues to enact the transference until the unconscious material is successfully attached to a new object and modified. Furthermore, in both accounts the patient relates to the therapist as if he was someone else. Observationally and descriptively therefore, testing is consistent with the enactment of transference material. However, this similarity only applies to one type of test, and Weiss identified two – the transference test and the passive-into-active test. Furthermore, this second test is observationally different from the transference test and not linked by name to the transference, which suggests that Weiss considered them to be different at the level of the transference. This raises a question of the nature of the two tests. How are they different, and how does the second test, if at all, relate to the transference? These questions will be addressed through a detailed explanation of CMT in the following chapter. For now it suffices to point out that the passive-into-active test is played out from a position that reverses the parent/child parts enacted in the transference.

Thus far, testing has been located in the relationship between therapist and patient and questions have been raised about the relationship between testing, and the therapeutic alliance and the transference. These questions will be returned to in Part B of the thesis. The existing clinical research pertaining to the relationship between therapist and patient was examined and identified as having made significant steps in mapping the process of psychoanalysis and psychotherapy. Furthermore, the lack of fit between unconscious processes and current clinical research was pointed out. It was suggested that researchers had elided the unconscious in order to fit clinical research into the dominant research paradigm. This point is returned to in the following chapter where it relates specifically to CMT. The role of the unconscious in contemporary psychoanalytic and psychotherapy theories, and along with this

testing, becomes clearer through a tracing of the history of the development of CMT.

This history begins the following chapter.

CHAPTER 2: THE THEORETICAL BASIS OF TESTING: CONTROL-MASTERY THEORY

The chapter begins with a focus on the work of Joseph Weiss and the San Francisco Psychotherapy Research Group (SFPRG), followed by a discussion of the mental health environment within which the SFPRG developed. This is followed by a clinical description of those elements of the theory that are fundamental to testing. Thus, the chapter provides a clinical and theoretical context for the discussion of the Freudian concepts of the ego and the unconscious.

2.1   THE SAN FRANCISCO PSYCHOTHERAPY RESEARCH GROUP

Broitman (1999) provides an overview of the history of the development of CMT. She notes that the original idea for the theory came to Joseph Weiss in 1958, when, whilst studying therapists' process notes, he noticed that patients developed insight independent of interpretation from the analyst. He was intrigued by this finding and began researching the circumstances under which this occurred. In 1965 Hal Sampson joined Weiss in his research, and in 1972 Weiss and Sampson formed the Mount Zion Psychotherapy Research Group, now known as the SFPRG. Since this time the SFPRG has produced an abundance of empirical research-based publications supporting CMT. The group is made up of statisticians and various health professionals - including psychoanalysts, psychiatrists, psychologists and social workers (Weiss, 1986).

Although the psychoanalytic orientation of Weiss and Sampson is unmistakeably an extension of ego psychology (Galatzer-Levy et al., 2000) a progressive move toward a cognitive model of theory and psychotherapy is evident

in the publications of the SFPRG. On their website *Behaviour-on-line*, the group includes an extensive list of research papers and publications. The use of the word behaviour in the name of this website offers some indication of the shift away from the psychoanalytic model. Weiss (1993) himself explained the origins of his theory in terms of borrowing from object-relations theory, self-psychology, Alexander and French's (1946) corrective emotional experience, developmental psychology and cognitive psychology. All of these influences have contributed to a theory that has amalgamated specific Freudian psychoanalytic principles with specific post-Freudian ideas and non-Freudian cognitive ideas to produce a theory now referred to by some clinical researchers, such as Collins and Messer (1991) as a cognitive-psychoanalytic theory.

With the development of the SFPRG, Weiss's aim has gone beyond the solution of his original theoretical question of how insight occurred without interpretation from the analyst (Broitman, 1999). The question resulted in the development of CMT, the foundations of which were set out in Weiss's (1971) early paper, *The emergence of new themes: A contribution to the psychoanalytic theory of therapy.* As the theory developed the primary aim appears to have become the establishment of CMT as predictive science, an endeavour acknowledged as accomplished by the SFPRG.

2.1.1 Empirical aims of the SFPRG

Weiss and the SFPRG set themselves the task of synchronising psychoanalysis and empiricism. A difficult task given that psychoanalysis has at its core the unconscious and, as pointed out in Chapter One, the conscious/unconscious distinction is inherently subjective and therefore does not fit with empirical models

of measurability and prediction as do other models. Models built on conscious thoughts and beliefs, such as behavioural and cognitive-behavioural theories, have a better fit with formal empirical research due to the data being more readily articulated. For example, one takes at face value the answers given on a research questionnaire, but when dealing with the unconscious, face value is deceptive. Nevertheless, in their endeavour Weiss et al. (1986) pushed ahead acknowledging their difficulties along the way. At one point the SFPRG described their research as, "one of all-too-few attempts to test and support a particular psychoanalytic theory by formal empirical methods… and it has been relatively successfully" (p.4). Their stated purpose in continuing to pursue the goal of conducting and encouraging replicable psychoanalytic research was directed toward progressing what has been an ongoing dilemma for psychoanalysis. They researched so that "psychoanalysis can mature as a science." (p.4). Their investigations have been intense and their production of research-based publications prolific. Clearly the goal of providing a replicable theory with predictive value has shaped the methodology of the research group. Sampson (1976) highlighted this when he referred to the group as, "… carrying out systematic research studies to verify these observations in a more formal, reliable, and objective way." (p.255). What began for Weiss, as an exploration of how insight occurs without interpretation, grew into a quest to establish an empirical model of psychoanalysis.

The question arises as to why Weiss's research group was so strongly invested in pursuing an empirical methodological approach to their work through establishing the predictive ability of their theory, rather than remaining with the previous psychoanalytic method of presenting theory through case studies. Freud (1925/1964) had argued for the place of psychoanalysis as science and used the case study method

to illustrate his theory. This is an issue that has remained contentious despite Freud's method of continually returning to and amending his theories as he tested them, which has been strongly defended as a highly rigorous approach (see Nobus & Quinn, 2005).

Historically, the debate on the scientific nature of psychoanalysis has centred on the constitution of science. For example, the positivists rejected psychoanalysis on the basis of Karl Popper's argument that analysts were unable to demonstrate the necessary condition of falsifiability (Leahey, 1994). This condition was a precondition of positivist science. But this is not the only angle from which to assess the 'science' in science. As Nobus and Quinn (2005) pointed out science does not claim to be complete knowledge which is the premise upon which Freud intentionally presented psychoanalysis as science[5]. Nobus and Quinn went on to explain that something is always left unknown, a gap in any body of knowledge that necessarily exists because of the limits of space and time. Freud was able to identify psychoanalysis with science because he recognised this element as common to the two. Nobus and Quinn pointed this out when they wrote, "…psychoanalysis and science share the same truth notably that their knowledge is limited and must reckon with an unknown, perhaps potentially unknowable element." (p.18). It is precisely this element that psychoanalysis reckons with in working with the unconscious.

Nevertheless, the SFPRG believed that, for psychoanalytic theory to progress, a predictive theory that adhered to formal empirical principles was preferable to the traditional interpretive method. Some theories of psychical functioning were better placed to be investigated using empirical principles; the behavioural theories had the closest fit, but also the incoming cognitive psychology was able to be researched

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[5] For a comprehensive discussion of Freud's argument see Nobus and Quinn (2005), *Knowing nothing, staying stupid: Elements for a psychoanalytic epistemology*.

using formal methodologies, therefore the SFPRG attempted to bring together psychoanalysis and cognitive psychology through research. Weiss identified the problem of turning clinical process into empirical research. Freud's theory had been developed through anecdote and case study, but Weiss wanted a more structured approach and CMT gave him this.

2.1.2   The SFPRG: A historical contextualisation

In the early 1970s, at the time of the development of the SFPRG, there was a cognitive revolution in psychiatry in North America (Leahey, 1994). A cognitive-based psychology that relied on a positivist notion of science fitted the predictive and outcome-based model that measures results quantitatively, whereas psychoanalytic theory and the seemingly unobservable unconscious did not. The SFPRG proceeded to develop a theory from specific psychoanalytic principles that met the same measurement principles as the cognitive-based theories. There was a benefit to doing this. The demonstration of measurable results over a specific time period was an emerging requirement of the public and private health plans in the United States. The plan managers required proven evidence of treatment outcomes because they would not pay for "quackery" (Leahey, 1994, p.363). The SFPRG was part of a growth of psychotherapy research institutes and projects that provided such research outcomes, these included the Columbia Psychoanalytic Centre, the Boston Psychoanalytic Institute, the New York Psychoanalytic Institute and the Menninger Foundation (Galatzer-Levy et al., 2000). Whilst these research studies have produced the evidence required for health plans and other purposes driven by economics, they can be criticised for their tendency to research shorter-term therapies, which, whilst having the advantage of the completion of the project in a fixed term usually running

to weeks, rather than months or years, report the outcomes of symptom change over a limited period. It is well known that observable symptoms can be 'removed', or, at least the intensity reduced during the life of a short-term research project; the 'flight into health' is just one way of explaining such phenomena. Also, it is only recently that research, such as that of Brockmann, Schluter and Eckhert (2006), has included long term (seven years in this research) follow-up methods to identify the possibility of a re-emergence of symptoms over time and/or the emergence of new, replacement symptoms. These are points that the longer-term focus of psychoanalysis understood and relayed through case-study methodology, as seen in the Freudian case studies.

Members of the SFPRG have attempted to straddle both cognitive and psychoanalytic models. They, and others such as those connected to the large research institutions mentioned above, have found a way to utilise the scientific research models that enabled the cognitive-behavioural therapies to demonstrate they could match outcomes with pre-established criteria. Whilst this has not been the primary aim of the SFPRG, in order to legitimise their findings and to add further weight to the legitimacy of psychotherapy and psychoanalysis as a science they have felt the need to demonstrate the fit between their theories and empirical research models. Sampson (1992) described the aim of the SFPRG in his paper, *A new psychoanalytic theory and its testing in research,* in *Interface of Psychoanalysis and Psychology*:

> …my colleagues and I have demonstrated that rigorous empirical research using ordinary scientific methods may be carried out systematically on broad, fundamental psychoanalytic hypotheses about unconscious mental functioning, psychopathology, and the treatment process. It can be carried out using the data of the psychoanalytic situation as well as of other psychotherapies. It can yield findings that disclose lawful relationships,

challenge some long-established beliefs, and have implications for both theory and practice. In these ways, the work I report helps to make psychoanalysis less of a separate discipline based exclusively on a unique methodology. (p.586)

That these theorists have demonstrated that psychoanalysis and psychotherapies stand up to scientific rigour is commendable. The researchers have met quantitative research criteria such as inter-rater reliability, which are referred to in the above quote as 'ordinary scientific methods', however, what these research models lack is the provision of detailed phenomenological illustrations of the processes under research. This is possible through qualitative methods and case studies, which enable access to a different level of knowledge about psychical processes and functions. This has not occurred in the CMT notion of testing and it is possible that it is the research methodology that has contributed to the unconscious in CMT appearing somewhat different from the unconscious in Freudian theory. What actually drove the shift in methodologies for the SFPRG is unknown but the shift is consistent with a change in clinical research paradigms that fitted with broader systemic changes.

In an environment that became hostile toward psychoanalytic principles the SFPRG, along with many of the other large research-based institutions attempted to demonstrate the scientific credibility of CMT in current acceptable methodologies. At a fundamental level they were caught in an incoming tide of rationalism that gathered up economic, social, scientific and intrapsychic models. The non-rational unconscious was sunk and a model of a rational mind took its place. Unfortunately, in the United States it seems that this tide is yet to recede and instead of psychoanalysis remaining a separate discipline with its own methodology, it became a discipline with a surface, or rational unconscious, readily accessible to the scrutiny

of 'scientific' research models. The Freudian unconscious however, was never understood as readily accessible, it was always hidden and its detection dependent on following the unique instructions Freud provided for this very purpose. This made researching the Freudian unconscious, which existed amidst deception and disguise, difficult.

With a more empiricist methodological approach, the emphasis on the cognitive aspects of CMT increased, which lessened the emphasis on the drives. This shift away from the drives was not isolated to psychoanalysis in the United States, but was consistent with a more generalised shift in focus from the id to the ego in post-Freudian psychological and psychoanalytical theories and therapies. It is extremely difficult to accept that one is at the behest of irrational unconscious processes, and much easier on every level, research, intrapersonal, interpersonal, cultural, social and so on, to have an unconscious that fits a rational model than to subvert the model of rationalism. Repression, which is a fundamental mechanism of the unconscious, appears to extend to the broader conceptual level of the unconscious which leaves one asking, is it possible that the unconscious has fallen prey to its own mechanisms, so that the Freudian unconscious has been repressed? The rationalist argument is consistent with this, as those aspects of psychical functioning operating at the level of the unconscious, such as the drives, are ignored. This was the case with ego psychology, which was the original theoretical orientation of CMT

Ego psychologists believed that Freud's later theory of the ego was an abandonment of the drive theories (Evans, 1996; Fink, 2004). Others did not abandon the drives but re-emphasised them. For example, the object-relations movement considered the relationship between subject and object or infant and mother as primary (Evans, 1996). This created a shift from the Freudian one-person psychology

to a two-person psychology. In relation to psychical functioning, this theoretical shift elevated the importance of experience and interaction in the external world. Intersubjectivity therefore became vital in both psychical development and in clinical treatment. CMT is more similar to the object-relations two-person psychology than it is to the Freudian one-person psychology, however there is a fundamental difference. Weiss's theory is one of adult functioning with a focus on pathogenic beliefs developing in childhood, whereas the object-relations theorists considered infancy and the pre-verbal period as formative of mental functioning. This emphasis on the verbal state locates CMT in the cognitive psychologies and explains why it has become known as a cognitive-analytic model of the mind.

Weiss's version of psychoanalysis was shaped by the rationalist environment in which it developed, which in turn fitted well with the cognitive psychologies and enabled the production of much research and greater understanding of the process of psychotherapy and psychoanalysis. This has fostered a particular theoretical formulation of the unconscious within which testing is located as a process. In order to explore the relationship between testing and the unconscious, further understanding of the fundamental elements of CMT is required. These elements, namely pathogenic beliefs, testing and repression, are now considered.

2.2   FUNDAMENTAL ELEMENTS OF CMT RELATING TO TESTING

Two fundamental psychoanalytic ideas central to CMT have been retained from classical Freudian psychoanalysis (Weiss, 1993; Weiss, et al., 1986) - the impact of relationships, particularly childhood relationships, and the unconscious repression of beliefs about one's relational functioning in the world. The classical psychoanalytic notion of the conflict between drives and defences is not part of the CMT model of

the mind. Weiss and his colleagues argued that CMT was consistent with Freud's later work regarding the ego, which emphasised the more sophisticated, thinking function. Based on this area of Freud's work, Weiss proposed that the patient controlled his therapy by testing certain beliefs developed in childhood. These beliefs, called pathogenic beliefs, are predominantly unconscious and held in place by the mechanism of repression.

2.2.1 Pathogenic beliefs

Pathogenic beliefs develop in childhood and are referred to as pathogenic because of the negative influence they have on the patient. Weiss wrote, "They impede or prevent normal functioning and so may be called pathogenic." (Weiss, 1990, p.105). In the opening paragraphs of his book, *How psychotherapy works,* Weiss (1993) described their function:

> …the patient's problems stem from frightening unconscious maladaptive beliefs, here called "pathogenic," that impede his functioning, adversely affect his self-esteem, and prevent his pursuit of highly adaptive and desirable goals (e.g., happiness, success, or a good relationship). The patient suffers from these beliefs and is powerfully motivated both consciously and unconsciously to disprove them… (p.3).

Weiss et al. (1986) described the development of pathogenic beliefs as sequential. They form through an attempt by the individual to gratify an impulse or reach a goal. In this attempt the child experiences a traumatic event that he uses as a point of reference to inflict self-blame, which in turn prevents him from further

attempts to gratify the impulse or reach the goal that was originally pursued. For example:

> … a boy may conclude after his father's death that he caused the death by his hostility to his father or his competitiveness with him. The boy may come to believe that by being hostile or competitive he may bring on another catastrophe analogous to the death of his father (Weiss et al., 1986, p.71).

Weiss (1993) believed that such subjective traumatic experiences of childhood make the child feel unsafe, and thus initiate the development of a protective system that is carried into adulthood. This, Weiss proposed, is the origin of the pathogenic belief and thereafter it directs the thoughts, feelings and behaviours of the individual. Despite being uncomfortable, the belief prevents the individual from re-experiencing a trauma, which may occur if he were to pursue his goals or impulses. The belief, therefore, must operate at the same level of consciousness as the goal or impulse because goals in CMT include both consciously stated goals and unconscious goals, meaning that in the CMT formulation of psychical activity the patient has the ability to perform the same mental activities unconsciously as he can consciously, and he does this via the ego. The protective function of the pathogenic belief suggests a defensive function, but Weiss makes no reference to pathogenic beliefs as defences, instead, the nature of the belief as pathogenic holds that it is the belief itself that must be defended against.

2.2.2   Pathogenic beliefs as defences

Weiss's (1993) reference to a protective system strongly suggested a synonymous relationship between a pathogenic belief and a defence, but Weiss wrote

little of the relationship between them. He did, however, refer to defences and the capacity of the ego to master and control them in the same way that he described pathogenic beliefs being controlled through assessments made by testing. For example, he wrote, "The ego's control of its defences is regulated by certain judgements that it makes unconsciously concerning whether particular impulses are a threat or whether it is safe to experience them." (Weiss, 1971, p. 459). This was Weiss's thinking in the early stages of the development of CMT. At this time he believed that defences operated in conjunction with a pathogenic belief and the judgement of safety occurred through the test. This assertion is strengthened when one considers that Weiss originally described CMT as a theory of defence. He wrote, "Let me present a theory of how defence analysis works that is based on recognition of the role of the ego." (p.461). Further evidence that Weiss linked defences to pathogenic beliefs is found in the example of a test provided by Curtis et al. (1994) and presented in the Introduction, "She will try to deny or rationalize her problems to see if the therapist needs or wants to deny issues." (p.201) Here, the patient employs the defences of denial and rationalisation which Curtis et al. call tests. The pathogenic belief forms the second part of the example wherein the patient believes the therapist will deny issues. The pathogenic belief is the thought the defence works in relation to, not the defence itself, and in combination they have a protective function. This formulation of defences and beliefs stems from Weiss's theory of the ego in which the defence responds to beliefs rather than to drives as would be the case in a Freudian formulation of defences. The focus on cognitive beliefs rather than drives indicates the direction of CMT vis-à-vis the ego's relation to the external world and away from its relation to the id, which is consistent with the cognitive aspects of the theory.

Weiss's reluctance to use the term defence after the early developments of his theory, likely reflects the shift in the dominant orientation of CMT from its beginnings in psychoanalytic theory to a more cognitive based theory. Certainly Rappoport (1996) used the language of the cognitive-behavioural theorists when he referred to *cognitive constructs* and normalised the development of pathogenic beliefs as part of the child's adaptation to the world. The child's experiences, Rappoport explained, result in conscious and unconscious cognitive constructs that direct thought processes and behaviour and, when an experience is traumatic, a pathogenic belief can result. This explanation is consistent with Weiss's description of pathogenic beliefs and is also understandable in the language of cognitive-behavioural psychology.

Traditionally in psychoanalysis the term defence implied a connection to the drive. Given that the drives are not the domain of cognitive psychologies, it is likely that it is the connection of CMT to the cognitive theories that has resulted in the shift away from any reference to defences. Such a connection would not fit with the CMT hypothesis relating to the ego (This is described in detail further on in this chapter). Having said this, however, there are aspects of the theory relating to pathogenic beliefs that at times resemble fantasies.

2.2.3 Pathogenic beliefs as fantasies

In some of the descriptions Weiss (1993; Weiss et al., 1986) provides of pathogenic beliefs they can be divided into two parts, a goal and an associated belief in relation to the goal. In the excerpt below an example of castration anxiety is used to demonstrate a pathogenic belief. In this example the child believes that if he or she maintains a sexual interest in the mother the father will castrate him. Weiss et al.

(1986) hypothesised that the patient, in, "… expressing the impulse or pursuing the goal, he would either provoke punishment or rejection from the parent, or worry, injure, or even kill the parent." (p.8). Evident here is what, in CMT, is viewed as an impulse or goal, and an associated belief. In Freudian terms the belief described here would be referred to as a fantasy or a defence and the work of analysis would determine which, but in CMT the belief is based in reality not fantasy. Weiss et al. wrote, "Pathogenic beliefs and fantasies bear certain resemblances to each other. …However, pathogenic beliefs are not fantasies." (p.324). In the CMT formulation the child has developed the belief of castration because the father has been a punishing figure and has likely hurt him or threatened to hurt him in actuality. Weiss's theory approaches psychopathology at this level, not at the level of fantasy present in relation to the child's sexual interest in the mother.

Interestingly, some proponents of CMT link wishes to pathogenic beliefs through fantasy (Gassner & Bush, 1998) although Weiss et al. (1986) do not. Still other readers of CMT interpret pathogenic beliefs as fantasies that have a negative impact on the patient (Galatzer-Levy et al., 2000, p.201). Weiss's argument for distancing pathogenic beliefs from fantasies is based on Freud's definition of fantasies as a source of pleasure, whereas Galatzer-Levy et al. point to the possibility of fantasies resulting in displeasure, thus alluding to fantasies belonging to the system of conscious-unconscious rather than existing separately in either the conscious or the unconscious. Nevertheless, Weiss (1993) is clear that pathogenic beliefs result from displeasure not pleasure. They are based on what a child experienced as frightening and traumatising actual event, which occurred simultaneously to the child having certain wishes in relation to his parents. Weiss provided further examples of the child's wishes to achieve "normal, desirable goals"

(p.6), the pursuit of which resulted in a disruption of his relationship with his parents.

For example, the child who might wish that his parents were dependable,

trustworthy, give him independence, and allow him to compete and identify with

them might feel "fear, shame, remorse, or self-torment, or that he will bring about a

serious disruption in his relations with his parents. He may expect to hurt them or to

be rejected or punished by them." (p.7). Such experiences and thinking is capable of

installing unconscious pathogenic beliefs which the patient is motivated to

disconfirm, and this process of disconfirmation occurs through testing.

2.2.4   Testing

Weiss (1993) conceives of the test as an attempt by the patient to rid him of the

debilitating and uncomfortable effects of a pathogenic belief. The test is designed to

establish a safe environment in which to expose repressed or warded-off [6]

unconscious content. To paraphrase, Weiss et al. (1986) wrote of the test as a reliving

in the therapy session of a particular event in the original relationship with the

parents in which, as a child, the patient attempted to satisfy an impulse or seek a

goal. The patient fears that he or she will damage the current relationship with the

analyst in the same way as the original relationship with the parents was damaged

and therefore is motivated to overcome this fear. Such motivation, Weiss suggested,

is predominantly unconscious, in the sense that the patient is unaware of the belief

and largely[7] unaware that he is testing the therapist.

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[6] The term warded-off is used interchangeably with repressed throughout CMT literature. A discussion of this appears in the following section.
[7] The use of the qualifier 'largely' with the word unaware is deliberate. It denotes a discussion in the following section in which I question the use of the terms unconscious and conscious in relation to processes as used in CMT.

Weiss (1993) assigned to testing a place in both conscious and unconscious functioning. He proposed that testing could be located in the normal everyday process of reality testing, but that it is mostly an unconscious process and, as such, out of the awareness of the patient. Other CMT researchers have pondered the question of whether testing is a conscious or unconscious process and, like Weiss, concluded that it is primarily unconscious. For example, Gassner and Bush (1998) believed that the location within other unconscious processes, such as the transference, acting out, and resistance meant that it was primarily unconscious. All of these processes occur without the patient knowing that something, other than their conscious thoughts, is driving their thoughts and actions.

It is time to explore testing in more detail beginning with the relationship of testing to the transference referred to above by Gassner and Bush (1998). Weiss (1993) described the transference as a particular type of test, not a psychical phenomenon encompassing testing. In this radical formulation Weiss subordinated the Freudian transference to testing, so that the transference is part of testing rather than the inverse. He described two types of tests - transference and passive-into-active. The former is a direct repetition of a previous traumatic experience and the latter a reversal of the positions of the patient/child and the parent/analyst. The reversed position is described as the patient taking control of the relationship between therapist and patient by mimicking the parental object. In CMT the former is considered a transference phenomenon, and the latter, a replication of the parent's behaviour. The CMT formulation of the passive-into-active test does not relate to the patient's drive related psychical processes, but to the parent's as experienced and/or perceived by the child.

Some publications by proponents of the SFPRG show an extension of these two types of tests. Rappoport (1997) proposed that transference tests could be divided into compliance and non-compliance tests. In compliance tests the patient accommodates the presumed needs of the therapist, whereas in non-compliance tests the patient intentionally opposes the therapist. Rappoport suggested that the aim of a compliance test is to determine if the therapist will be gratified by the patient's behaviour, and the aim of a non-compliance test is to see if the therapist is threatened. This fine-tuning of transference tests was not adopted in CMT literature and Rappoport himself appears to have abandoned the idea of exploring testing further at this level. In a later publication Rappoport (2002) he referred only to what he called the two main types of tests, the original transference and passive-into-active test.

From these descriptions it is clear that testing is a repetition of a past pattern of behaviour, as Weiss (1993) asserted, but Weiss made the point that this explanation is too simplistic for what is an extremely sophisticated process. Weiss and other proponents of CMT identified two other processes that occurred in relation to the patient's testing. These concerned the passing of tests and were referred to as a modification process and a coaching process, both of which assisted the analyst to pass the test if he or she had previously failed (Gassner & Bush, 1998; Rappoport, 1997; Weiss et al., 1986). Rappoport (1997) believed these processes demonstrated the patient's determination to disconfirm pathogenic beliefs, but also, the need to assess the safety or danger of releasing the beliefs. The tests he noted are a controlled way of determining if it is safe to do so. This raises the question of how one knows if a therapist has passed a test. What does the patient do or say that enables the therapist to know? Rappoport provided a detailed account of how this worked by noting what

occurred immediately after a passed test. He believed that these were signs of the patient's feelings of safety. The patient, Rappoport wrote, will show the following:

> …greater physical relaxation (e.g., more relaxed posture, deeper, more even breathing, more graceful movements), less vocal stress, more fluid use of language, decreased defensiveness, increased self-acceptance, self-confidence, and/or self-esteem, increased emotional expressiveness, the introduction of new, significant material into the therapy (e.g., dreams, memories, associations), the appearance of insight, and increased boldness of testing. To the extent that testing is unsuccessful, the patient immediately feels less safe, and the opposites of the above responses will be apparent. (1997, p.253).

An example makes it is easier to understand the form a test might take in the actual dialogue of patient and therapist. The following examples are some of the few published clinical excerpts of tests from session content using CMT. They enable one to identify how passed and failed tests appear in a clinical setting, and were part of a study by Silberschatz (as cited in Gassner & Bush, 1998).

Example of passed test

> **Patient:** (Silence) It's funny. I just, when I finished saying what I said about um, the way I'm emphasizing what, what the trouble is or what's important, last night when I was thinking about it, it just seemed such an important thing to have realised. And now today when I think about it, it, I just sort of feel, well, of course, there's no point in even saying it. Or perhaps I'm feeling that's what you're thinking.

> **Analyst:** Ah (patient laughs) I was going to just say that here you are again sort of taking away from yourself, degrading it immediately. It can't be worth much if you thought it, that kind of feeling.

Example of failed test

> **Patient:** (Silence) Is it better to force yourself to say something that you feel sort of not ready to say?

> **Analyst:** Well, what is the rule I told you? Or what did I say is your job?

Silberschatz provided the following explanation of the testing:

> In the passed test, the patient is attempting to disconfirm her pathogenic belief that she had to diminish herself to make the analyst (and others) feel superior to her. The analyst's response implied that he did not need her to belittle her ideas for him to maintain his sense of authority. In the failed test, the patient is attempting to find out whether the analyst could tolerate her being in control in the sessions. The analyst's response conveyed a demand that she submit to his authority (p.283).

Alternative explanations for Silberschatz's analysis will be as numerous as there are psychoanalytic and psychodynamic orientations and will not be broached here. These examples demonstrate the subtlety of testing and the way it is formulated in relation to the ego using a CMT approach. Given that the analyst is being tested, it makes sense that he or she would experience some form of request to respond or remain silent. In both the examples above the request from the patient is evident, a question is asked. In the first example it appears as, "Or perhaps I'm feeling that's what you're thinking." In the second, "Is it better to…"? On both occasions the patient has asked a question, either directly or indirectly, and the analyst must choose a response.

In testing the patient considers his therapeutic goals, pathogenic beliefs, ideas about his and the therapist's strengths and weaknesses, and consequently the therapist's capacity to help him (Weiss, 1993; Weiss et al., 1986). All of this presupposes a sophisticated level of thought, planning and motivation, the premise on which CMT is built. But more importantly, CMT is built on the proposition that these processes operate at an unconscious level, which is also the level of the original repressed material that was felt to be dangerous and resulted in the pathogenic belief. From a CMT process perspective the following occurs. Content is repressed in the unconscious where a part of the ego makes it less dangerous to the patient through testing. The aim is to lift the repression thus allowing the potentially dangerous material into consciousness. Weiss's (1993; Weiss et al., 1986) primary hypothesis is that the test regulates repression unconsciously by the criteria of safety and danger. He also proposed that the ego and the unconscious worked together, which implies that Weiss had a specific interpretation of the Freudian defence mechanism of repression and assumed something of the nature of repression.

2.2.5   Repression

At a functional level CMT refers to repression as the mechanism by which content such as memories, impulses, affects, ideas and transferences is kept out of consciousness (Weiss, 1993; Weiss et al., 1986). Although this interpretation is consistent with the traditional Freudian view of repression, it differs in the formulation of the way the unconscious content emerges into consciousness. Weiss (1993) identified repressed content as emerging into consciousness in an unconflicted manner when the therapist enables the patient to feel safe. He wrote:

The patient in therapy exerts control over his repressions. He may and often does lift his repressions and bring previously warded-off mental contents to consciousness without these contents having been interpreted. He brings them forth when he unconsciously decides that he can safely experience them. Thus, their emergence may be undramatic and nonconflictual (p.168).

Here, Weiss spells out his conceptual understanding of repression and this proposition forms the basis of CMT research (Weiss, 1993). It is consistent with Hartman's (1958/1992) concept of the *conflict-free ego sphere* described previously. In this conceptualisation the patient can release the repressed material into consciousness from a site in the ego that is not under the influence of the defences and drives. As already pointed out, Weiss et al. (1986) did not refer to defences post his early 1970s publications and although he used the term repression, he did not call it a defence. Instead, he defined it as a function of the unconscious that was controllable through the ego. Rather than believing that where there are symptoms, defences and drives are in conflict and the mechanism of repression is operational, Weiss (1993; Weiss et al., 1986) understood repressed content as maintained in obedience to a pathogenic belief. As Laplanche and Pontalis (1988) noted, for Freud repression was one stage in a complex defensive operation, but he mainly used the term in relation to the unconscious. It was the mechanism that separated the unconscious from the conscious. In this sense Weiss's idea of repression is consistent with Freud's; however, Freud (1926/1964) was clear that the material repelled by repression into the unconscious was bound to the drives. It was the ideational representatives, or ideas and images of the drives that were repressed in the unconscious. This connection to the drives along with Freud's specification that repressed ideas, "… escape the control of the subject…" (Laplanche & Pontalis, 1988, p. 393), contrasts with Weiss's proposition that the ego can control repressed

content. If Freud's view that it is impossible for the subject to control repressed content, is accepted, a question is raised as to what might the ego have control over in Weiss's formulation? Logically, this must be content that is not, or at least no longer, repressed. This might be, for example, material subject to non-pathological defences, such as avoidance, which, as Laplanche and Pontalis (1988) point out, is much more readily accessible to consciousness, if not already conscious. It might also be material located in the preconscious which is also more readily accessible to consciousness. Regardless, Weiss differs with Freud on the point of having control of repressed content. Weiss is clear that the ego has the ability to plan and decide when to bring forth repressed material. This is a point that Weiss believed Freud changed his mind about in the latter formulations of the ego wherein Freud attributed much greater control to the ego. It is this aspect of the theory of the ego that Weiss followed in the development of CMT.

2.3   CMT: A SPECIFIC INTERPRETATION OF FREUDIAN THEORY

Weiss and the SFPRG focused on the early, 1911 -1915 Freudian theory as a point of difference in the development of CMT. Their argument sat in opposition to what they referred to as Freud's early drive-defence theory in favour of specific aspects relating to the ego in Freud's later theory. Two contrasting hypotheses formed the basis of CMT and set the scene for the specific use of repression and the unconscious in CMT. These were the automatic functioning hypothesis and the higher-mental functioning hypothesis. The former is based on Freud's drive theory and the latter on the ego's functions. The difference between the ego /cognitive analytic theory of control-mastery, and Freudian theory, is the varying emphasis on the ego and the id, and the workings of the unconscious. As the name suggests ego

psychology's primary focus is the ego. Freud (1923/1964), however, believed the

ego developed out of the id and that the id, ego and superego were interrelated. The

theoretical literature reviewed now introduces Weiss's hypothesis, which underpins

CMT and sets out his argument in favour of this hypothesis. A critical review of

CMT in relation to Freudian theory forms the subsequent section.

2.3.1 The automatic functioning and the higher-mental functioning hypotheses

The central argument that permeates CMT relating to Freudian theory concerns

Weiss's interpretation of the Freudian unconscious. Weiss believed that Freud

changed his mind on the unconscious with his later developments of the theory of the

ego. In the *Interpretation of Dreams* Freud (1900/1976) emphasised the function of

the drives. Weiss and his colleagues (1993; Weiss, 1986) pointed out that Freud

originally believed instinctual drives and defences interacted automatically, without

being organised by thought or plan. As a result mental life was organised by the

dynamic interaction of psychic forces outside of the conscious control of the patient.

In Weiss's (1993; Weiss et al. 1986) theory this automatic defence-drive interaction

of early Freudian theory was referred to as the automatic functioning hypothesis

(AFH). Weiss's reading of Freud's (1940/1964) later theory assigned to the

unconscious the ability to control mental life through the regulation of unconscious

thoughts, beliefs, and reality checking. Weiss (1993; Weiss, 1986) called this the

higher mental functioning hypothesis (HMF). He argued that the unconscious

introduced thought and planning into a defence-belief interaction functioning at the

level of the ego. The HMF hypothesis also proposed that warded-off or repressed

unconscious content could enter consciousness without being interpreted (Gassner &

Bush, 1998) and Weiss believed that this was made possible because the patient conducted his own thinking, planning and decision making before deciding to let unconscious content into consciousness. Galatzer et al's (2000) description of the two hypotheses as they relate to repression provided a good indication of CMT's idea of the decision making function of the unconscious:

> The hypothesis of higher mental functioning assumes that previously repressed mental contents emerge because the patient unconsciously decides that they may be safely experienced for the purpose of working out the difficulties they pose. The hypothesis of automatic functioning, by contrast, assumes that repressed mental contents are pushed through by the drives to consciousness. (p.199)

In CMT, the purposeful, decision-making functions of the mind operate from both consciousness and the unconscious. The argument supporting this is predicated on Weiss et al's. (1986) belief in an unconscious that has access to the same ego functions as the conscious. This is consistent with Freud (1940/1964) in some of the operations of the ego, for example, ego defences operate outside of consciousness, but inconsistent in relation to the unconscious performing conscious functions, that is, functions Freud restricted to consciousness, such as rational thinking which involves a degree of planning. This argument will be covered thoroughly in the following section. Functionally, the CMT of unconscious planning implies a fusion of the unconscious with the ego.

Weiss was not the first to integrate Freud's two tripartite models. Sterba (1934), prior to Weiss, formulated a directional model of the ego in which he attempted to overlay the two models. In terms of the ego, one part faced the id and therefore belonged to the unconscious, a second part faced reality or the external world, and

was therefore in consciousness, and the third part belonged between the other two and formed the site of the interplay between the inner and external conflicts. Sterba's conceptualisation allowed for the functioning of both the id and the ego in an interrelated manner, which contrasted with Weiss's (1993; Weiss et al., 1986) model of the mind in which the id played no part. Instead, the emphasis was on the ego and the external world as functioning outside of the influence of the id, but still in relation to the unconscious.

In the development of CMT Weiss has provided a way of understanding mental processes that allows the individual control over his unconscious. His solution was to assign to the unconscious the functions of the ego. In CMT the mind works in the following way: repressed unconscious content (pathogenic beliefs) can pass into consciousness when unconscious processes in the ego (unconscious planning) initiate specific experiences with objects in the external world (testing the analyst). Testing, as a function of the ego, therefore, is the mechanism through which Weiss linked the unconscious with the external world. This view of the ego and the unconscious is highly specific to CMT and, whilst it is at odds with classical Freudian theory in which content in the unconscious, apart from the affects, cannot pass directly into the conscious, it has much support from a rigorous research base.

2.4   REVIEW AND CRITIQUE OF CMT RESEARCH

As well as developing CMT the SFPRG have been prolific in their production of research in support of the theory. In doing so they have produced a theory with a strong empirical base and advanced the understanding of psychoanalytic process and psychotherapy methods. The focus of much of CMT research is on a method devised

for the formulation of cases that assists the therapist to treat the patient. This method is known as the Plan Formulation Method (PMF).

2.4.1   Plan formulation method

The PFM is "…a procedure for developing comprehensive clinical case formulations" (Curtis et al., 1994, p.197). It was specifically designed to conduct empirical clinical process and outcome research and is underpinned by an assumption that the patient has an identifiable, predominantly unconscious plan for working in therapy. The "plan" is a predictive method of case formulation for a patient's therapy that is developed out of information derived in the initial sessions of therapy. The objective in identifying the patient's unconscious plan is to provide the therapist with a patient-specific model to work from in sessions, including predictions of the types of tests the patient will use on the therapist. The researchers claimed that the patient's progress was influenced by the response of the therapist to the tests (Curtis et al, 1994; Weiss, 1993; Weiss et al., 1986). The patient would improve if the analyst responded according to the predictions of the plan (Curtis et al, 1994). Additionally, patients were viewed as 'coaching' the analyst to pass tests (Weiss et al., 1986; Rappoport, 1996; Rappoport, 1997), which supported the CMT view that the patient plans his therapy.

The process of developing a patient's plan is a dynamic one wherein the therapist continually forms hypotheses that are tested through interventions with the patient. Initially, the therapist identifies key traumas reported by the patient and then hypothesises the kinds of problems or obstructions the patient is most likely to experience. From this point the therapist infers the patient's goals and the tests he is likely to use. If these correspond to the behaviours or thoughts the patient displays or

describes, the hypothesis is retained, where not, it is refined, taking into account the way the patient responds (Collins & Messer, 1991; Curtis et al., 1994; Curtis & Silberschatz, 1996; Rappoport, 1996; Rappoport, 1997; Weiss et al., 1986). The plan formulation is conceptualised by the following four sections:

> "(a) *Goals* unconsciously planned by the patient; (b) *Obstructions*, or unconscious pathogenic beliefs that block the patient's healthy functioning; (c) *Tests*, or unconsciously planned experiments in which the patient will seek to disconfirm his or her pathogenic beliefs within the therapy relationship; and (d) *Insights* that will be helpful to the patient in achieving his or her goals." (Collins & Messer, 1991, p. 75).

Although the goals referred to here are unconscious Weiss (1993) believed that they were derived from "normal and reasonable" consciously stated goals (p.71). This deduction was the task of the therapist who inferred from both the patient's conscious goals and from something within himself. As Weiss put it, the therapist deduced the patient's unconscious goals from "…well-developed intuitions based on everyday experience." (p.71). The process of hypothesis testing was then applied to clarify the accuracy of the inferences and modify where necessary.

2.4.2 CMT research methodology

Numerous studies have been conducted using this plan formulation method, all of which support CMT's hypothesis of the ego's higher-mental functioning. The research achieves extremely high rates of reliability in a mixture of settings from private practice to university clinics. It includes both short and long-term therapy and encompasses various theoretical models, including psychodynamic psychotherapy, psychoanalysis, interpersonal psychotherapy, and cognitive-behavioural therapy

(Collins & Messer, 1991; Curtis et al., 1994; Persons, Curtis & Silberschatz, 1991). The studies are conducted by researchers producing case formulations developed from the transcripts of as little as a first interview and up to the first ten hours of psychoanalysis (Curtis et al., 1994). Research studies using the PFM have demonstrated both reliability and validity in terms of the therapist's plan-based interpretations predicting the patient's progress (Silberschatz, 1986; Silberschatz & Curtis, 1993; Silberschatz, Curtis, Fretter & Kelly, 1988). Furthermore, they have shown adaptability to perspectives other than the cognitive-analytic[8] orientation of CMT, for example, object-relations theory (Collins & Messer, 1991). Reliability rates are conceived within a closed theoretical system which becomes apparent when reviewing this research. While this is not unusual in research, it raises questions when claims of superiority are made about specific therapies based on reliability rates in research. This criticism not only applies to CMT but broadly to clinical research that focuses on reliability and includes much of the research presented in Chapter One.

Such research works by training independent raters who determine from therapy session transcripts, relevant material to use as data. As Honos-Webb, Stiles & Greenberg (2003) point out, the use of raters enables claims of increased reliability and validity. In the CMT research, raters range in levels of clinical experience and are either familiar with the model of therapy used in the research, or are trained through a manual and under supervision to detect the items sought in the tradition of empiricism, which they do (see Collins & Messer, 1991; Curtis et al, 1994). The latter method provides a higher rate of reliability than the former and was introduced to deflect the criticism of researchers such as Shapiro and Stiles (1994) who pointed

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[8] Since Weiss referred to his theory as a new type of defence analysis in 1971, it has been referred to in a number of ways. In recent publications the researchers refer to CMT as cognitive-psychoanalytic. This likely reflects the development of the theory.

to the former model's moderate rates of reliability. While the model enables high rates of inter-rater reliability, it does not solve the problem of such research being a function of an algorithmic system. What it actually reflects is thorough training in a specific model. Nevertheless, the resulting research is prolific. While it meets the criteria for "scientific" research it is problematic because it utilises a newly constructed version of the unconscious, without making this clear. This is a question of validity, which appears to be subordinated to reliability in this and much of the contemporary psychotherapy research.

In CMT studies, where validity is claimed it is mostly predictive validity. This is established through the use of outcome measurement instruments with high rates of internal validity such as the Morgan Patient Insight Scale, and various other symptom checklists and rating scales (see O'Conner, Edelstein, Berry, & Weiss, 1994). The problem with such outcome measures is that they are based on descriptions of symptoms, or of the desired outcome predicated on an objective assumption of what the patient wants. The assumption is that the patient wants the imposed CMT view of health, which is based on consciously stated goals, without consideration of the influence of suggestibility as a confound in the research. Suggestibility can create a goal in the patient's mind that is reflected back in speech in the session, or on post-session checklists. A typical example is where directive or coaching styles of therapy are used. In one CMT research study, the treatment went as follows:

> *… in addition to directly challenging pathogenic beliefs (by interpreting them and negating them), the therapist advised and encouraged Maria to seek roles outside of motherhood. He encouraged her to fulfil her ambitions, supported her when she did, and helped her realize how her guilt and worry*

about others kept her from pursuing her goals (Pole, Ablon, O'Conner & Weiss, 2002, p.4) (Italics in original).

In 16 weeks of psychotherapy this patient shifted from a DSM-IV diagnosis for major depressive disorder, with a Beck Depression Inventory (BDI) score placing her in the 'moderate-severely depressed' range, to the 'asymptomatic' range. She no longer met the criteria for major depression. This result remained stable at six, twelve and 18-month follow-up (Pole et al., 2002). These are extraordinary results that suggest that the patient responded well to supportive encouragement and suggestibility, in the form of advice. What must be questioned here is the level at which this patient was treated. This excerpt, whilst only one out of many over 16 weeks of treatment, shows the patient's treatment at the level of the conscious mind as registered by a descriptive measure, the depression inventory, which is not a device designed to access unconscious material. This points to the same problem identified in Chapter One, where the incongruence between current research models and the unconscious became evident. Here it is evident that the validity of the research is most problematic where the theoretical propositions studied are concerned with the Freudian unconscious. There is no easy solution to such a dilemma, if there was, researchers such as the SFPRG would have solved it. The unconscious studied in the research mentioned so far is different from the unconscious articulated by Freud. In the following chapter, the unconscious as proposed by Freud will be explained.

On a final point in regard to CMT research and validity, it is surprising that a retrospective study has not been conducted to determine whether the hypothetical list of goals, obstructions, tests and insights produced by the PFM eventuate in sessions.

Such a study would provide a valid measure of the plan formulation method according to empirical theory. Correspondence with Weiss's research group ascertained that, whilst this research had not been conducted, the researchers would welcome it.

CHAPTER 3: THE FREUDIAN UNCONSCIOUS

In the previous chapter Weiss's CMT was contextualised within post 1950s
North American psychoanalysis. In the following chapter Freudian theory is
presented as it pertains to the theoretical base of CMT. In this, the focus is
specifically on the two tripartite models: the unconscious, preconscious and
conscious, and the id, ego and superego.

3.1 FREUD REVISITED: THE EGO AND THE UNCONSCIOUS

In Freud's theory of the mind both tripartite models exist and function in an
interrelated manner. In *The ego and the Id* Freud (1923/1964) explained that the ego
emerged out of the id: "The ego is not sharply separated from the id; its lower
portion merges into it" (p.24). He also explained that the id-based drives, although
unconscious, have access to the ego through this connection, as does repressed
material, but as Freud clarified, when the resistances operate they refuse the ego
contact. In this explanation Freud pointed out the way unconscious material becomes
conscious via the ego, and also the way unconscious material is blocked, or cut off,
from the ego and therefore from consciousness. The resistances have a blocking
effect on the ego's access to unconscious content.

In Freud's (1940/1964) posthumously published work, *An outline of
psychoanalysis*, he made it clear that the tripartite model of consciousness did not
supersede the first model of the id, ego and superego. On a number of occasions
Freud set out his ideas on the relationship between the two models but also pointed to
those aspects that remained unclear. For example, he formulated the difference
between ego and id, and preconscious and unconscious, in terms of quality, "The

sole prevailing quality in the id is that of being unconscious. Id and unconscious are as intimately linked as ego and preconscious: ...." (p.163), but at the same time acknowledged the limitations of his understanding of this quality; he added, "...this quality is to be regarded only as an *indication* of the difference and not as its essence, ..." (p. 163) (Italics in original). He was sure, however, that the answer to the difference between the two systems lay in the dynamic relation of energy *states*, which explained the movement of content from one state to the other.

The movement of energy in mental functioning was a continuing theme across Freud's works beginning in the *Interpretation of Dreams* (Freud, 1900/1976). He understood psychical energy in terms of two forms, mobile and bound. The transformation of the former into the later represented a movement from the unconscious to the preconscious and could occur either spontaneously or through the relation with the analyst (Freud, 1940/1964). This relation with the analyst was the transference and is discussed in detail in the following chapter. The movement of energy is elaborated in regard to repetition in Chapter Four.

In *An Outline of Psychoanalysis* Freud (1940/1964) set out what he believed to be a new discovery. Until this point his explanations for the movement of energy states in psychical functioning were based upon the existing knowledge of the natural sciences. Now he proposed that processing laws provided a basis from which to distinguish between the two systems. Freud wrote,

> Behind all these uncertainties, however, there lies one new fact, whose discovery we owe to psycho-analytic research. We have found that processes in the unconscious or in the id obey different laws from those in the preconscious ego. We name these laws in their totality the *primary process*, in contrast to the *secondary process*, which governs the course of events in the preconscious, in the ego. (p. 164) (Italics in original)

The introduction of the laws of processing enabled Freud to distinguish between the preconscious and unconscious, but they also revealed Freud's understanding of the close connection between the two systems. This is evident in the linking of the preconscious and ego in reference to the preconscious part of the ego in the quote above, which enables one to see that Freud required both tripartite models for his theory of the mind. Further evidence that he retained the concept of the id throughout his life's work is found in his many references to the id in his writings in *The Outline*. Additionally, Freud's construction of two principles of mental functioning, the pleasure and the reality principles, enabled further distinguishing between the systems conscious-unconscious. The pleasure principle related directly to the id and the reality principle to the external world.

In *The Ego and the Id* Freud wrote of the id being guided by the pleasure principle in the satisfaction of the drives, "The id, guided by the pleasure principle - thus, by the perception of unpleasure - fends off these tensions in various ways" (Freud, 1923/1964, p.47). However, as Evans (1996) pointed out, Freud's reality principle aims to satisfy the drives just as the pleasure principle does, and supports rather than replaces the pleasure principle. "…the substitution of the reality principle for the pleasure principle implies no deposing of the pleasure principle, but only a safeguarding of it" (Freud, 1911/1964, p.223). When Freud introduced the reality principle and along with it the repetition compulsion, some, as Cameron and Rychlak (1985) noted, read this as a demotion of the pleasure principle as a major concept, but Freud never abandoned the notion of the pleasure principle, not even in his later works. As the title *Beyond the Pleasure Principle* implies, he extended his understanding by introducing factors *beyond*, not *instead* of, the pleasure principle.

Nevertheless, the introduction of the reality principle enabled the assignation of a position of centrality to the ego, which formed the basis of ego psychology. Throughout Freudian theory, both these principles function in relation to the processing laws referred to above.

Freud's distinction between primary and secondary processing is fundamental to a differentiation of the conscious, preconscious and unconscious systems. In *The Unconscious,* Freud wrote: " …processes in the one system, the *Ucs.*, show characteristics which are not met with again in the system immediately above it." (1915/1964, p.186). He listed the characteristics of unconscious processes as: wishful impulses, primary process, timelessness, and that which is subject to the pleasure principle, that is, not heeding reality. Freud, in the same paper, regarded the processes of the preconscious as displaying "…an inhibition of the tendency of cathected ideas towards discharge." (p.188). In this sense, an idea is not completely out of conscious awareness but inhibited when in the domain of the preconscious. The 'idea', as it is used in Freudian theory, refers to representatives of the drives and derives from Freud's term *Vorstellungen*, which Strachey translated as both ideas and as presentations, which can be words (Rodriguez & Rodriguez, 1989). When in the preconscious, the idea is available to consciousness because some cathexis remains attached as the idea shifts and a part of the original idea is displaced. This is the process by which material comes into consciousness. Ideas in this system communicate with each other through links binding them together, unlike in the unconscious system. Functions that do not occur in the unconscious, that is, attention to time, censorship, and reality testing, do occur in the preconscious and conscious systems. Freud (1915/1964) was clear that the preconscious functioned with the characteristics of the conscious; he frequently represented the preconscious as

attached to the conscious by writing (pre)conscious. In contrast, Freud did not draw a likeness between the conscious and unconscious systems.

In these explanations Freud was motivated to distinguish between the conscious and unconscious by explaining how they operate differently. In developing the theory of the unconscious he provided a frame through which to understand what was not understandable to the conscious mind. The higher mental functioning hypothesis, with its emphasis on the ego, is antithetic to this; it proposes an unconscious that understands as the conscious mind does, which enables the release of repressed content into the conscious. This occurs through the ego. Freud, however, explained the passage of unconscious content to the conscious via the preconscious, which operates as an essential medium through which content must pass prior to entry into consciousness. In Freud's theory such connections occur through speech, or word-presentations as he called them, and were connected to the movement of bound and unbound energy. Psychoanalysis, as the 'talking cure', facilitated the movement of energy from the unconscious to the preconscious and conscious by connecting material in its symbolic form, that is jokes, dreams, symptoms, slips and so on, to speech. Lacan, consistent with Freud, repeatedly pointed out that speech was the mechanism through which the unconscious content is detected and able to be brought into consciousness. In contrast, CMT rejects the dynamic unconscious, but retains a desire for a theory of the unconscious. Which leads again to the question proposed in the Introduction - what is the unconscious of CMT? The answer to this is assisted by a consideration of the ego psychology roots of CMT.

3.1.1 Ego psychology

In his book, *Ego Psychology and the Problem of Adaptation,* Heinz Hartmann (1958/1992), following from Anna Freud's *The Ego and the Mechanisms of Defence* (A. Freud, 1936/1966), *wrote* of his conceptualisation of a "conflict-free sphere" in which the ego could attain mastery over reality. His aim was not to disregard the drives, although ostensibly this was the result, it was to explain, "…how human rational behaviour could arise out of a drive psychology." (Schwartz, 1999, p.190). Hartmann's inquiry went to those areas of functioning that were not in conflict and therefore not subject to intrapsychic oppositions, such as infantile wishes and reality. Instead, he focused on broader external factors, such as the way the individual adapts to the social and cultural environment.

Ego psychology, as Schwartz (1999) pointed out, was a way of bridging the classical one-person drive theory with two-person relational theory. All of the functions and processing required for rational functioning could henceforth be assigned to the ego, thus the higher-mental-functioning hypothesis proposed in CMT. Rational functioning, however, is the antithesis of the drives, which were downgraded in favour of the relational aspect of psychical functioning. Relational theories, in contrast with drive-based theories, did not conflict with the higher mental functions of the ego. In this sense ego psychology along with CMT is inconsistent with those aspects of Freudian theory in which the ego is viewed as a mediator between, as Fink (2004) wrote, the "id's drives and the superego's judgements, or between id impulses and the demands of external reality." (p. 40). Psychopathology in CMT, therefore, appears to be located in the realm of the superego's judgements and external reality, and whilst these judgements are consistent with pathogenic beliefs, little reference is made to the superego in CMT. It is difficult to understand

why the superego is given so little attention in CMT. One possibility is that the inclusion of the superego in CMT would require a dialogue about the id with the ego as the mediator, and CMT relates only to the ego. It is also possible that the complexity of Freud's theory of the ego created theoretical dilemmas that were inconsistent with the control-mastery theory of the ego.

As Fink explained, Freud did not develop a single theory of the ego, instead he had a number of different accounts: four as Fink pointed out, two that are object focused and two agent-like. In other words, many different functions fell under the auspices of the ego, which created a paradox that represented the complexity of the ego. Fink argued that ego psychologists came to the conclusion that Freud had made an error in his formulation of the ego, and instead of "pondering the paradox of active and static sides or aspects of the ego…" (Fink, 2004, p.42), the ego psychologists attempted to synchronise Freud's theory of the ego. This created theoretical propositions inconsistent with Freud's teachings and misrepresented vital aspects of his theory.

As Fink (2004) pointed out, for Freud, the id was always the home of the drives and the unconscious the site of the repressed. In psychopathology it is the representations of the drives that are repressed, therefore, both tripartite models are required to adequately account for psychical functioning. In any reading of CMT or ego psychology literature, the desire for an unconscious is evident, for example, Weiss called CMT a theory of unconscious planning, but because the nature of the drives is inconsistent with planned activity, the unconscious required a reformulation in order to fit with a conflict free ego that could operate at a higher level of functioning, as Hartmann formulated.

Lacan's fierce criticism of the ego psychologists' specific reading of Freud is widely acknowledged (see Fink, 2004; Mitchell, 1982; Nobus, 2000). This criticism is relevant to CMT, which is based on Freud's later works, particularly the *Outline*, in which the ego's higher-level functions were more fully developed. The most damning criticism of ego psychology concerned the notion that Freud's later theory superseded the earlier. In this idea the three levels of consciousness were eliminated (Fink, 2004; Miller, 1996). Whilst this criticism applies to CMT, one can be even more specific and propose that in CMT the Freudian formulation of the preconscious has been titled unconscious. This is a phenomenon that stems from an ego psychology base. Miller (1996) believed that the demise of the three levels of consciousness related to the ego psychologist's formulation of the ego. He argued that in elevating the ego to a position in which it was viewed as "the truest agency", as ego psychology did, was to dispense with the unconscious. (p.307). In doing so, the forces of the id-based drives and along with them desire, were not considered. Fink (2004) argued along the same lines and added the higher-level functions favoured by the ego psychologists over the drive-based functions, which is a view that is particularly relevant to the CMT explanations for psychical functioning that included a new theory of the unconscious.

3.1.2   The making of a new unconscious

The reconstruction of theory usually begins with a process of deconstruction, then a rebuilding phase, and to some extent this is how the unconscious in CMT developed. The laws and principles Freud set out as governing the unconscious were set aside to make way for the new unconscious. The rebuilding, or reconstruction incorporated the mechanism of repression from the Freudian model, but this appears

to be the sole element included from the Freudian unconscious. Other functions that constitute the CMT unconscious are the higher-level functions of planning and decision making, which Weiss argued are functions of the ego. Whilst this is consistent with Freud, Weiss added that they exist in the unconscious ego, which is inconsistent with Freud. Whilst Freud's later theory focussed on the ego he never assigned secondary processing, such as is required for these higher-level functions, to the unconscious. This suggests that the CMT unconscious contains elements of those levels of consciousness operating in accordance with secondary processing. The new unconscious is not a new theory of the unconscious but a borrowing from and repackaging of the original three-level, conscious-preconscious- unconscious system into a two-level, conscious-preconscious system that does not include the Freudian unconscious.

In Section 3.1.2, the historical context for the development of CMT was presented. This highlighted the social conformity ideology that fitted with the incoming conflict-free cognitive ideology that was the dominant influence on the control-mastery theorists in post 1950s North America. Such an ideology promoted the notion of the individual's control over the id and the unconscious, which enabled certain psychologists and psychoanalysts to imagine that the patient could have a life without conflict. To make this work, however, required the abolition of the unconscious as it was known. It was within this context that the restructuring of Freud's three-level system of consciousness occurred with the result being a replacement of the Freudian unconscious with the Freudian preconscious. Along with disregarding the id, CMT also disregarded the preconscious, but only in name. At a functional and process level the preconscious was retained and the unconscious processes and functions disregarded. The Freudian preconscious was renamed the

CMT unconscious but included the mechanism of repression, also, in name only. A final query remains regarding the post Freudian CMT and Freudian theory. This pertains to the location in Freudian literature of material that supports the idea of an unconscious that can think and plan in the same way as the conscious mind. From where in Freudian literature did Weiss draw to connect his idea of the unconscious to the Freudian unconscious?

The answer to this is apparent in a comparison of Weiss's reading of Freud's text and that of the text itself. The following quote from Weiss forms the basis of his thesis of unconscious planning. Weiss's page references to Freud are included to enable a direct comparison of Weiss's interpretation and Freud's actual text. In relation to Freud, Weiss (1993) wrote:

> Certain concepts scattered in passages throughout Freud's late works are the starting point for the present theory. These concepts assume the patient's capacity to make use unconsciously of higher mental functions, and so may be referred to as constituting the 'higher-mental-functioning hypothesis' (HMFH). In parts of his late theory, Freud assumed that a person might suffer unconsciously from a pathogenic belief (e.g., the belief in castration as a punishment). There Freud assumed, too, that a person exerts some control over his repressions (1940a, p. 199), and that he can unconsciously think, test reality and make and carry out decisions and plans (1940a, p.199). (Weiss, 1993, p.17).

This refers to Freud's (1940/1964) chapter *The External World* in *An Outline of Psycho-analysis.* In this work Freud did not assign the role of either reality testing or decision making to the unconscious as Weiss interpreted; instead, Freud was writing about the ego. To illustrate, the passage from *The outline* that Weiss referred to above is included. Freud wrote here of the ego and the external world:

Its psychological function consists in raising the passage [of events] in the id to a higher dynamic level (perhaps by transforming freely mobile energy into bound energy, such as corresponds to the preconscious state); its constructive function consists in interpolating, between the demand made by an instinct and the action that satisfies it, the activity of thought which, after taking its bearings in the present and assessing earlier experiences, endeavours by means of experimental actions to calculate the consequences of the course of action proposed. In this way the ego comes to a decision on whether the attempt to obtain satisfaction is to be carried out or postponed or whether it may not be necessary for the demand by the instinct to be suppressed altogether as being dangerous. (Here we have the reality principle.) Just as the id is directed exclusively to obtaining pleasure, so the ego is governed by considerations of safety. The ego has set itself the task of self-preservation, which the id appears to neglect. It [the ego] makes use of the sensations of anxiety as a signal to give a warning of dangers that threaten its integrity (p.199).

There are a number of points to be made about Weiss' interpretation of Freud's writing. First, when Freud hypothesised how one learns to handle the drives he referred to the preconscious not the unconscious. He described this as a process of restraining unrestrained energy, which is a transfer of energy from id to ego. In this, Freud was explaining the movement of content from primary processing to secondary processing. Second, in the passage above Freud did not speak of the unconscious. Yet, by assuming that Freud's reference to the ego includes the unconscious, Weiss concluded that Freud was writing of the unconscious. These functions are ego functions and not part of unconscious processing. Furthermore, the functions mentioned by Weiss are in relation to reality, and in this they are consistent with the purpose of the ego of which Freud was writing. Last, Freud referred to

suppression not repression. Suppression being the term used in relation to conscious and preconscious mechanisms and differentiated from repression (see Laplanche & Pontalis, 1988). Clearly, the ego according to Freud operates the functions Weiss noted, but they were not, in Freud's writings at least, attributed to the unconscious system. Weiss has adopted specific aspects of Freud's theory of the ego and located them in the system of the consciousness, instead of locating these higher-level functions where Freud did, in the preconscious where they operate according to the laws of secondary processing. In the CMT model the patient has some control over this 'new' unconscious because it is not subject to primary processing or to the drives. As Mitchell pointed out, the ego in ego psychology was one that understood conflicts and could control them. In CMT this ability is assigned to the unconscious ego but in Freudian theory from both a theoretical and clinical perspective, such abilities would be assigned to the preconscious and conscious states of the ego.

Having said this, it must be added that whilst the unconscious in CMT is proposed to operate using the mechanism of repression, this is a mechanism under the patient's control. Repression in this description appears to be a conflation of suppression and repression. A constant and fundamental principle running throughout Freud's writings is the discrepancy between one's actual motives and what one believes them to be. One's actual motives are driven by repressed material in the unconscious; therefore, one does not know consciously what one's unconscious motives are. This is fundamental to an understanding of the unconscious and in contrast to the CMT notion of unconscious motivation or planning being under the individual's control in the sense of the patient's ability to bring forth unconscious material at will. The motives of the unconscious, the drives and wishes

in Freudian theory, to which Lacan added desire, are unknown due to repression; a realisation of this unconscious content is the work of analysis.

The aim of psychoanalytic treatment, therefore, differs in the two approaches. In CMT the aim is to identify and dispel a debilitating and repressed pathogenic belief developed in childhood in relation to the patient's parental objects. In doing so the patient will be relieved of guilt and enabled to pursue his goals. In terms of testing, the patient wants the therapist to act differently from his parental objects, which presupposes knowledge of the repressed pathogenic belief the patient is working toward dispelling. In contrast, Freudian theory supposes that what is repressed is something the patient still wishes for but is unaware of and is evident in unconscious wishes and other formations of the unconscious. Lacan calls this desire. An understanding of such wishes and desires is the aim of treatment. Because the assumption in Freudian-Lacanian theory is that the content of the unconscious is unknown the motivation for the re-enactments of previous relationships in testing would not be as they appear. In other words the CMT notion that the patient wants the therapist to do the opposite of what the parents did may be incorrect and the patient may be motivated to have the therapist act the same as the parents did even though this is at odds with his consciously stated goals. The CMT view of the unconscious supports the former proposition, whereas the theory of the Freudian unconscious supports the latter.

Thus far it has been argued that the unconscious of CMT is inconsistent with the Freudian unconscious but consistent with the Freudian preconscious. At a systemic level the reason for the substitution and reconstruction of Freud's levels of consciousness was posited as an answer to the North American rationalist movement that absorbed psychology and psychoanalysis. At a subjective and intersubjective

level Lacanian theory provides an alternative framework to CMT in understanding the psychical processes at play in the therapy session. The theoretical direction now shifts to the Freudian unconscious and its manifestations in relation to the concept of demand as understood by Lacan. Lacanian theory also provides a clear exposition of the patient's psychical processes as they appear clinically, in treatment. This moves the direction of the thesis toward the clinical manifestations of testing which are explored in the data chapters in Part B.

CHAPTER 4: CLINICAL MANIFESTATIONS OF THE UNCONSCIOUS

4.1 LACANIAN THEORY

"There are contradictions within Freud's writings and subsequent analysts have developed one aspect and rejected another, thereby using one theme as a jumping off point for a new theory." (Mitchell, 1982, p.1).

Mitchell could have been writing about Weiss in this passage. The adoption of specific points from one theory to develop a new theory is not necessarily problematic, indeed, in certain discourses it is called progress and in others development. In Lacanian theory where Freud is concerned, it is sacrilegious. The problem for Lacan is not so much the development of a new theory, but more the misunderstanding and misinterpretation of Freudian theory as was highlighted in the previous chapter. The current chapter revisits Freudian theory via Lacan. It was pointed out in the Introduction that testing at a descriptive level was consistent with a demand and this was illustrated through the case of Dora wherein Dora wanted Freud to adopt a particular position and tested him to see if he would do so. The formulation of the test as a demand is returned to in this chapter through a Lacanian understanding of the Freudian unconscious, which enables an expansion of the concept of demand into the realm of the unconscious. In this way, testing can be explored from the position of the Freudian unconscious.

Lacan was fiercely loyal to Freud's theoretical texts and within these he found a consistent 'linguistic framework' that became the bedrock of his own contributions. To explain Lacan's view of treatment and the interaction between therapist and patient requires an understanding of a number of specific Lacanian concepts. How an infant develops psychically and in relation to others is described through the *mirror-*

stage, and the *Other* and the *other*. To grasp what drives a patient to engage in any

particular way in relation to others an understanding of *Object a* is required, and to

understand Lacan's view of the position from which the analyst must work in the

analytic setting the two schemas, *schema L* and the *inverted 8* assist. Finally, any

understanding of Lacanian concepts necessitates an explanation of Lacan's tripartite

model of the *symbolic, imaginary* and the *real*. Due to the interdependence of

Lacan's system it is difficult to present aspects of his theory in a discrete sequential

manner. Nobus (2000) points this out, and it is for this reason that there is some

backtracking in the following presentation of concepts.

4.1.1   The Mirror Stage

The mirror stage was a major contribution to psychoanalytic thinking about the

development of the individual as a subject. Lacan located the stage at somewhere

between six and 18 months. The infant, during this time comes to recognise his

image reflected in the mirror, or in someone he has identified with. In his seminal

work, *The mirror stage as formative of the I function as revealed in psychoanalytic*

experience, Lacan wrote, "It suffices to understand the mirror stage in this context *as*

an identification, …" (Lacan, 1949/2006, p.76). As Lacan pointed out in *The mirror*

stage, and, again in *The formations of the unconscious* (1957-58), identification with

the reflection in the mirror alienates the infant because he sees himself as a singular

and separate entity, and until this time, Lacan argued, the infant believes he and the

mother[9] are one. The infant's previous experience was of a fragmented self, born

prematurely for survival, but the mirror image presents an integrated whole. Lacan

(Lacan, 1949/2006) termed this the specular image. The discrepancy means that,

whilst the infant could no longer imagine that he and mother are one, he could begin

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[9] The mother here is the primordial mother, who, if not the birth mother, is the primary caregiver.

to emerge as a subject, which is facilitated through language. There is a cost, however, in becoming a subject, which is the alienation and eventual separation from the mother (Benvenuto & Kennedy, 1986). In Lacanian theory, psychopathology is linked to problems in what is considered a fundamental stage of development.

In terms of the ego, the mirror stage is that stage of development when the infant appropriates an image of another within his own ego. In Lacan's formulation, the ego is therefore built on identification with something exterior. Initially there is a primary identification with the primordial mother, which, through the relationship to language leads to secondary identifications. Lacan wrote: "the I is precipitated in a primordial form, prior to being objectified in the dialectic of identification with the other, and before language restores to it, in the universal, its function as subject." (Lacan, 1949/2006, p.76). As Evans (1996) pointed out, the relationship between the ego and the specular image was what Lacan called the *Imaginary;* it is the place where the infant/patient holds his image of himself as an object. Whilst identifications are occurring in the mirror stage, symbolisation is also being initiated.

Leader (2000) delivered a concise but resonant description of this process when he explained that as the mother holds the baby in front of the mirror, she uses signifiers from speech to comment on the infant. For example, commenting to the infant that he has his father's eyes shapes his conception of himself, which is why Lacan (Lacan, 1953/1977) believed the subject was the effect of speech. The symbolisation of speech enables one to find his identity within it. Lacan believed that language shifted the subject from the Imaginary order to the Symbolic wherein he could function as a subject (Lacan, 1949/1977). Thus speech is the mechanism in which the subject can enter the symbolic dimension of language, which is the signifier. While trying to develop laws to explain meaning, Lacan realised that

meaning was developed by a specific combination of signifiers that relate to one another – a chain. Furthermore, these combinations had two possible structures, metonymy and metaphor.[10]

Through the laws of metonymy and metaphor, which correspond to Freud's concepts of displacement and condensation, a link between unconscious and conscious content is made possible. These language structures are functions of primary processing and therefore of the unconscious. The laws governing them are different from the laws of secondary processing that govern the conscious mind. This was explained in Chapter Three and contrasts with the CMT idea that the unconscious and conscious mind can process material in the same way. In the CMT notion of unconscious planning and pathogenic beliefs, the unconscious, through the ego, has access to the same processes as the conscious mind, which makes the connective function between unconscious and conscious content of processing structures such as metonymy and metaphor, redundant. In CMT it is the ego that manages all of these processes.

The Real is inextricably linked to Lacan's registers of the Imaginary and Symbolic. Benvenuto and Kennedy (1986) described the Real as that which could not be symbolised and was thus outside of one's reality and without meaning. Jaanus (1996) explained that Lacan located the Real in the domain of objects, thus suggesting that the Real is not subjective but, as Ragland (1996) pointed out, it is not an object either, it "…does not refer to reality, objects in the world, the body, or some phenomenological thing-in-itself" (p.192). She went on to point out that in psychosis the Real could emerge as an external reality, but not one that is shared by

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[10] The two fundamental combinations of signifiers for Lacan are metonymy and metaphor. Both consist of a specific combination of signifiers. Metonymy means connected or related to, and metaphor a substitute for. (For a complete expansion of this area of Lacan's work see Dor, Gurewich and Fairfield (1998).

anyone other than the subject. Lacan described it as a pre-symbolic reality that returned to the same place in the way hunger does. Ragland wrote that it is characteristic of repression in that it too returns to the same place.

Although there is much more to the Real than said here the main points to be made for the purpose of this discussion are that the real is different from external reality, it is outside of symbolisation and, most importantly, although it returns, the subject does not understand it. In conceptualising the Real, Lacan set into a structure the notion that the subject does not and will never understand or know everything about himself. In Freudian theory the difference between knowing and not knowing is depicted in the division between the conscious-preconscious and the unconscious. It is also depicted in the division between the id, ego, superego and external reality, and is represented in what Lacan called the divided subject (Rodriguez, 2001). These explanations for psychical functioning point to a marked difference between what is possible and what is not possible in terms of knowing and understanding, and are consistent with the previous discussions that focussed on the difference between the conscious and unconscious.

4.1.2   Identification

In his chapter *Identification* in *Group Psychology and the Analysis of the Ego,* Freud (1921a/1964) pointed to the importance of identification in relationships, asserting that identification was the earliest form of emotional bond with another, which is consistent with Lacan's descriptions of the mirror stage. Freud also noted that identification was ambivalent, in that it could "turn into an expression of tenderness as easily as into a wish for someone's removal." (p.105). To explain this Freud used an example from the oral phase in which the infant, in consuming a

longed for object, annihilates it. Lacan explained this intrapsychic opposition in terms of the aggressivity that arises because the ego identification has an exterior source. This produces an internal rival for the subject in the sense that what was an external rival becomes internalised through identification (Lacan, 1948/2006).

In the same chapter Freud (1921a/1964) introduced the idea of an 'ego divided' (p.109). The two parts, consisting of a lost object and a conscience that he named the ego ideal (super-ego), conflicted. Freud explained that in cases of melancholia a real object has been lost and the patient will characteristically turn his reproaches and disparagements on himself, but these disparagements represent the ego's revenge on the lost object which is also an object of identification. In Lacan's (1953/2006) teachings the ego-ideal was both Symbolic and Imaginary. This was due to its dual role as the position the subject adopts in order to be looked at, at the same time as he imagines someone looking at him. The latter is what Freud referred to as one's conscience. The image one actually adopts is the ideal ego, which represents the person with whom one has identified. Glowinski (2002) expressed this clearly when she explained "…the ideal ego is the ego which is loved by the other."(p.83). But, as she also pointed out, the implication in Lacan's formulation was that the ideal ego must satisfy the other, with the subject feeling "…both satisfactory …and loved, as long as it fulfils the demands of the other." (p.83). The subject's ego is therefore made up of objects that seek to satisfy or fulfil the imagined demands of the other. These can manifest as aggressive or loving demands, both of which are ultimately demands for love because they depend on what one perceives the other wants. Considering the ego's identifications in this way points to the difference between the conscious and unconscious and draws attention to the discrepancy between one's actual wants which are held in the unconscious, and what one believes one wants.

Such attention to the wants of someone other than the self maintains the subject in a state of ignorance in relation to his own wants and desires, and blankets his subjectivity.

Lacan (1949/2006) proposed that the subject's entry into language, which the mirror stage predates, has the capacity to restore the individual's function as an integrated subject, and is part of the Symbolic order. He proposed that language facilitates the subject's separation and whilst the effect is a loss, the loss involved in being separated from the Other (capital O is defined in the following section) through speech, it also opens a space for the emergence of the subject. Due to the loss, however, something is installed as missing. This is an object that causes desire and therefore motivates the patient to search for what is missing. Lacan called this the *agalma* which represents *object a,* "the missing object that is sought in the Other" (Marks, 2002, p.126). Although object *a* is not a CMT concept it shares similarities with certain aspects of the CMT explanations of testing. Specifically, it resembles the motivation for testing insofar as it is reasonable to assume that testing must be set in motion by something. In CMT, this something is the patient's desire to disconfirm the pathogenic belief that interferes with the patient achieving what he wants in life, which equates to the patient searching for something missing, as in the agalma; but also, the motion is triggered by the possibility of locating object *a*. The aim of testing is addressed in CMT but the triggering of testing is not. Testing is described as a therapy event that occurs in relation to a belief, but nothing is known of why a patient tests at a particular moment in therapy. Thinking of testing in terms of object *a* might offer an explanation. For now, this remains a theoretical question, but it can be further examined through the clinical manifestations of testing, which will occur in the clinical case studies of Chapters Six, Seven and Eight. Before continuing the

discussion of Object *a* it is necessary to distinguish between the two (O)thers; that is, capital O (Other) and small o (other), which are crucial to object *a*.

4.1.3 Other and other

In the seminar of 1954-55 Lacan (1978/1988) distinguished between what he called 'the big Other' and 'the little other'. He proposed a relationship between the big Other and the mother which was based on language, and explained that the mother's interpretation of the infant's cries was what became the Freudian unconscious. The big Other can therefore be understood as representing the mother as she was toward the infant prior to speech. It is because the big Other represents a discourse that predates the subject that this discourse becomes the unconscious (Pereira, 1991). Furthermore, this is why Lacan (1949/2006) believed that speech originated in the Other, and why he wrote, "the unconscious is the discourse of the Other."[11] (Lacan, 1964/1998, p.131). As Evans (1996) explained, the little other, "is the other who is not really other, but a reflection and projection of the EGO." (p.133. Style change in original). The little other, therefore, has a much more literal meaning of being something other. It is something other that is understandable as an otherness because it is formed from identifications even though it is not recognised as other by the subject; whereas the big Other presents problems for the subject in that one does not realise the otherness because of the inarticulacy of its origin. Nobus (2000) explained the difference between the two concepts in the following way, "the other represents the addressee in so far as she is recognised and known (as another self, an alter ego) by the speaker, whereas the Other entails the recognised, yet never fully

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[11] The preceding words to this quote are, "I say somewhere that…", which refers to Lacan's 1954-55 seminar. In this he uses the small other not the big Other. Evans (1996) pointed out that Lacan differentiated between the big and little others in 1955, and this appeared after the original statement, meaning that Lacan's intention was likely the big Other on both occasions.

ascertained aspect of this addressee." (p.12). The Other and other are implicated in analytic work because they are built on relationships and language, both of which are fundamental to treatment in the Lacanian method.

Clinically, insofar as the transference is concerned, the analyst must attend to the positions both he and the analysand occupy. These positions relate directly to the Other and the other. Lacan (1981/1993) was adamant that the analyst must be somewhere in the position of the big Other in order for the unconscious of the analysand to be revealed. If he adopts the position of small other, an intersubjective relation between the ego of the analyst and that of the patient will ensue. Lacanian psychoanalysts work from the premise that the analysand always attempts to position the analyst as the other within the transference and therefore relates to a past relationship. But, in not adopting the position, but being mindful of it and observing the patient's attempts to do so, the analyst comes into contact with the patient's imaginary objects and identifications, including the object *a* mentioned earlier. Rodriguez and Rodriquez (1989) explain the implication for the analysand when the analyst occupies the position of small other. The analysand believes that in the analyst he has "grasped the meaning and object of his desire: the figure, persona or ego of the analyst" (p.171). The outcome is a failure of the patient's ability to recognise his own desire; a desire obfuscated by what he perceives is the desire of the Other. This position limits the development of the analysand's subjectivity because he is blocked from learning about his relation to the Other. Rodriguez and Rodriguez elucidate this idea when they write: "The discourse of the analysand, which is addressed to the Other, encounters, on his way to the Other, the small other, the ego of the analyst, which acts as a barrier, a true resistance against discourse." (p.171). In attending to the speech directed to the Big Other, the analyst can identify

the symbolic point from which to intervene. The analyst who works in this way

offers the possibility of taking the analysand beyond the identificatory position in

which he is stuck; he does this through a process of working in the Symbolic rather

than the Imaginary. Lacan devised a schema to represent how this worked.

4.1.4   Schema L: The Analyst's Position in Relation to the Other and Other

     Lacan's schema L enabled a representation of the Imaginary and Symbolic

positions in the transference. It showed the Symbolic position Lacan proposed

between subject and Other (Evans, 1996), and the Imaginary position he believed the

ego psychologists ascribed to (Nobus, 2000).
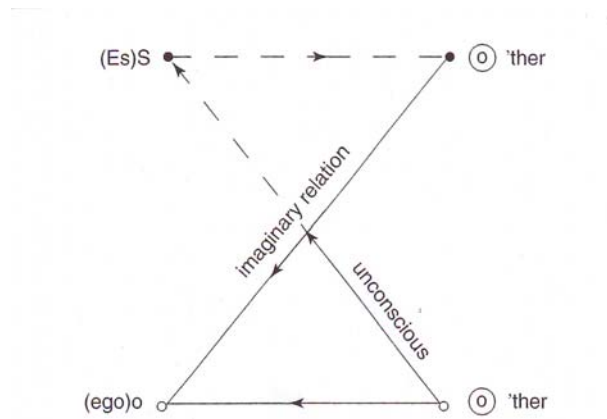
Figure 1. Schema L
Source: J. Lacan, *The Seminar, Book 111, The Psychoses*, New York
W.W. Norton, 1993, p. 14.

     Nobus described the schema as follows: "the subject (S) is identified with the

Freudian Id (Es) and the unconscious is emanating from the Other according to a

symbolic vector which crosses the imaginary axis." (p.65). One observes in the

schema the Symbolic connectedness of the unconscious to the Other, and also, the

separateness of that which pertains to the Imaginary field, that is, the ego and its

identifications. Lacan referred to the analyst's position in the analytic session as follows:

> If one wants to position the analyst within the schema of the subject's speech, one can say that he is somewhere in A. At least he should be. If he enters into the coupling of the resistance, which is just what he is taught not to do, then he speaks from *a'* and he will see himself in the subject (Lacan, 1981/1993).

In Schema L the capital A[12] is the Other and the lower case *a* is the other. In this passage Lacan pointed to the potential of the analyst to occupy a position in which the analysand would identify with him and he referred to this as a resistance on the part of the patient that the analyst colludes with. Lacan used Schema L to describe the relations between the characters in the case of Dora. Here it is also possible to understand these relations in terms of testing.

Recall that Dora sought to determine if Freud would deny her father's affair with Frau K and it was this that Lacan described as her test. To take this further in terms of ego identifications and the Imaginary axis of Schema L, one observes Dora's identification with certain of her father's traits. Her test of Freud can be considered an attempt to determine whether he shared these traits, but Freud would not adopt the position she attempted to induce. Whilst he remained in the position of someone unfamiliar, somewhere in the realm of the Other, (position A in Schema L) rather than like her previous objects (position *a* in Schema L), she spoke and directed her speech to the Other. This was evident in the reference Freud (Freud, 1964/1905) made to the reproaches that followed this interaction (quoted in the Introduction). Dora addressed her reproaches of others to Freud and as such they can be viewed as

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[12] The A represents the French word for Other which is Autre, and *a* is French for other, autre.

spoken to the Other. They resulted from Freud's refusal to adopt the position of the other and not play the role of one of Dora's past objects. Insofar as the reproaches described the jouissance - the way the patient enjoys the object - Freud was in a position to hear and learn of Dora's relationship to her objects. This brought Dora a step closer to recognizing herself, because, as Freud reported, he turned each reproach back on her. In other words, he pointed out that in talking about what she hated in others, she was talking about what she hated in herself. Her attempt to locate another identificatory object within the transference led directly to Dora stating the traits of her existing identificatory objects. The Imaginary realm, in which Dora operated in order to seduce Freud into occupying the position of the other was evident, but instead of doing so, Freud declined, which led Dora to speak of the position she had attempted to elicit.

There is an added stimulus to Dora's attempt to position Freud as the other, which is explained by the relationship between the other and object *a*, which is now returned to.

4.1.5   Object a

As explained above, the *objet (petit) a* or object *a* as it has been translated, is the lost object. It is represented by the *agalma*, which is the desired object that Lacan (1991) referred to in his reading of Plato's symposium in his 1960-61 seminar on the *Transference*. To explain, Lacan used the story of Socrates and Alcibiades. Alcibiades believed that there was something precious and fascinating but hidden inside Socrates's body. This hidden object (agalma) had long fascinated Alcibiades, thus, he revered Socrates's hideous body as one that was attractive (Nobus, 2000). The hidden object represented the missing object, object *a*, and, as Marks (2002)

pointed out, that missing object by its nature of being missing, signified lack. In Lacan's formulation this is a lack in the Other which has the effect of stimulating desire.

Object *a* is thus the object cause of desire; it is not what is desired, but a constantly shifting object that sets desire in motion. Lacan described it as metonymical (Marks, 2002) insofar as it re-locates to a new object as soon as the subject believes he has located it. Object *a* is also partial and represented by various partial objects located in partial drives. In this way any 'thing' that becomes object *a* for the analysand only ever bears a resemblance, it is never complete. The subject is attracted to it because there is something about it that resembles something else that was lost and is experienced as missing; in this sense it causes a perpetual desire. The constant motion is an ongoing attempt "at a recounter with what has been lost through this object *a*" (Harrari, 2004, p.26). In returning to Dora and her attempt to determine if Freud would act in a particular way, it is evident that Freud is for Dora what Socrates was for Alcibiades. Dora has imagined that Freud might hold the key to unlock the answer to what she believes is missing. Although Dora does not realise it, all of this occurs in her imagination, just like Socrates whose actual body was hideous but in Alcibiades's mind was beautiful, Freud is the being who contains within him Dora's father's attributes, which include a hypocrite who is able to be seduced into colluding with Dora. Clinically, it is vitally important that the analyst does not collude with the patient and become what the patient wants him to be. This was a point Lacan made very clear and represented in schema L, which can be read as depicting the transference as the forum in which this is played out.

In the transference the analyst occupies the position of Socrates, but this is not an actual occupation. As Lacan (1964/1998) warned, the occupation must only ever

exist in the mind of the analysand, but he added that for the transference to be operational it was essential that the analysand did believe that the analyst coveted something desired. Insofar as the analysis relates to knowledge, Lacan suggested that in the transference the analyst is considered the holder of knowledge regarding the patient. This position Lacan called the *subject supposed to know*. It is an assumption on the part of the analysand that the analyst is someone who knows, but this assumption signals the beginning of the transference. Lacan (1964/1998) wrote: "As soon as the subject who is supposed to know exists somewhere … there is transference" (p.232). The question here is, what is the supposed knowledge? Evans (1996) interpreted Lacan's answer to this as the analyst knowing, the "secret meaning of the analysand's words, the significations of speech of which even the speaker is unaware" (p.197). Knowledge therefore becomes the partial object, the object *a*, that the patient believes the analyst has contained within him. For the patient it is the answer to what is missing. It is imperative in the early stages of treatment that the patient believes that the analyst has this knowledge; without it, there is no impetus for treatment; object *a* causes desire.

So far object *a* has been explained in terms of setting in motion one's desire for the return of something lost. Williams (2005), in writing on anxiety, pointed to the connection between object *a*, aggression and the real object. For Williams, the real objects are those composed prior to the mirror stage, and are therefore incomprehensible as lost objects. In such cases the object of anxiety can appear in either the ego or object *a*. This appearance in either the subject or the other is due to identification. When the real object returns in object *a*, it produces anxiety and a consequential attack on the object by the patient. In such circumstances aggression is directed toward whatever occupies the position that resembles object *a*. Williams

explained that in the analysis of neurotic patients, one observes continual angry reproaches of others prior to the analysand recognising himself in the reproaches. She added that the circumscription of the real object by speech was what enabled the analysand to eventually recognise himself. This process was evident in Dora's interaction with Freud when she tested him to see if he was hypocritical. When he refused to behave in keeping with her identifications, that is, as a hypocrite, she, through her reproaches, attacked others who had occupied this position. It is at this point that the analyst learns about the patient's objects, but he must learn by occupying the position of an observer not a participant. To depict this, Lacan devised the schematic *Interior 8*.

4.1.6 Interior 8

As just explained the analyst is called on to occupy the position of object *a* and to hear of the reproaches of others who have adopted this position, but Lacan (1964/1998) warned against actually occupying this position. The reason for this relates directly to the aim of treatment. In both Freudian and Lacanian theory, the aim of treatment was to uncover the patient's desire or wants, and for this to be successful a process that occurs within the transference must be followed. This begins with the patient making demands and is facilitated by the position the analyst occupies, enabling the patient to go beyond demand to desire. Lacan said:

> In so far as the analyst is supposed to know, he is also supposed to set out in search of unconscious desire. This is why I say … that desire is the axis, the pivot, the handle, the hammer, by which is applied the force-element, the inertia, that lies behind what is formulated at first, in the discourse of the patient, as demand, namely, the transference. (p.235)
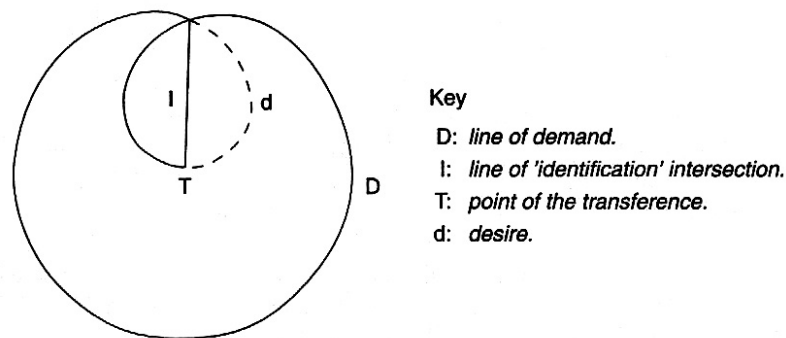
Figure 2. *The Interior Eight*

Source: J. Lacan, *The Four Fundamental Concepts of Psycho-Analysis*, New York W.W. Norton, 1981, p. 271.

To paraphrase[13] Nobus (2000), the patient makes demands on the analyst in the early stages of analysis, which lead to the transference. This coincides with the installation of the analyst as subject supposed to know. From this point, T on the schema, the analyst can direct the patient along either the line of identification or the line of desire. If the analyst fulfils the demands of the patient he will direct the patient along the line of identification. From this position the patient will identify with the analyst and, "enter an endless cycle of identical demands" (p.132). The alternative route proposed by Lacan was made possible when demands were not satisfied, an example of which is to find a way of enabling the analysand to answer his own questions. In this sense the analyst dodges the role of "subject supposed to know" and the analysand can proceed down the line of desire instead of identification. Ultimately, in the schema, he ends up back at the point of demand; so one might ask, what is the difference if the end point is the same? The difference lies in the patient's experience and verbal exploration of the terrain traversed on route. In

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[13] Lacan demonstrated the function of the analyst in the transference through the Interior 8 Schema, but as this originally appeared as a paper model which Lacan demonstrated, Lacan's commentary makes it difficult to understand. Nobus provides an explanation of the Schema which I have used here.

other words, the patient is in a position to become aware of himself (desire), more so than his previous position as depicted on the line of identification wherein he is very aware of other's desire (identification).

Nothing is really said about what the patient does if he ventures down the recommended path according to Lacanian theory. Freud wrote that Dora entered her series of reproaches, which was consistent with her being faced with the real object reappearing, but he reported little in terms of further demands. Nobus pointed out that in an analysis that moves along the path of identification one will observe continual identical demands by the patient. One might assume therefore, a change in demands when the patient heads along the path of desire. This would enable progress, but not the stuckness of repeated identical demands. The aim, eventually, as Lacan (1964/1998) noted in the preceding quote, was to cease demanding and thus expose the hidden desire.

Many of the examples Weiss (1993; Weiss et al. 1986) provided of testing were in the form of a question, which in itself is a demand. Weiss (1993) also made direct reference to demands in his hypothetical examples of testing. He wrote that the patient may, "force the therapist to act by demanding the therapist behave in a particular way" (p.95). When tests are considered demands, it is feasible that the descriptions of tests in CMT would apply to demands, and vice versa. In the CMT examples tests continue until a pathogenic belief is disconfirmed, and, according to the examples provided, the tests change. For example, Rappoport (1996) noted that a passed transference test resulted in more vigorous passive-into-active testing, which suggests the analyst has headed the patient along the line of desire. However, that the patient continues to test until the pathogenic belief is disconfirmed suggests the patient might be stuck in the "repetitive cycle of demands", and therefore on the line

of identification. Because there are no actual examples of tests tracked across sessions it is not possible to determine which line the patient was travelling along in any of the examples provided in the CMT literature. The exact nature of the test and its demand remains unknown in terms of the progress it takes. One of the aims of this thesis is to provide actual examples of tests across sessions which will address the gap exposed here between theoretical explanations for testing and adequate clinical examples of testing. This gap makes it impossible to determine, other than hypothetically, what tests actually are at a clinical level. In the case studies that form the second half of the thesis the process of testing and of demand will be examined through the words of the patient and therapist in the same way as in the case of Dora.

For the moment the schema of the Interior Eight depicts, along with demand, identification and desire as they manifest in the transference. The link between identification and desire is now considered.

4.1.7   Identification and Desire: What does one want of another?

Lacan continually reiterated the importance of not allowing the patient to identify with the analyst, but his constant return to this point suggests that it might pose some difficulties in analysis. That this is a difficulty for the analyst suggests that motivation for the patient is directed toward identification with the analyst. According to Lacan, and based on Freudian theory, this is so; the patient seeks to identify. Lacan pointed this out after he visited a schema Freud (1921/1964) had presented in his chapter *Being in love and Hypnosis* which appeared in *Group Psychology and the Analysis of the Ego*. In examining this schema Lacan brought together the meaning of object identification, desire, demand, and the position of the analyst, all of which relate to the pull of the patient to form an identificatory

relationship in the transference. Lacan's theory of the aim of a Freudian-Lacanian analysis and the demand of the patient is evident in this passage:

> If the transference is that which separates demand from the drive, the analyst's desire is that which brings it back. And in this way, it isolates the *a* places it at the greatest possible distance from the I that he, the analyst, is called upon by the subject to embody. (Lacan,1964/1998, p.273)

Lacan referred here to the call upon the analyst to adopt a position in relation to the subject, but this is more than a position, it is an embodiment as Lacan said, which is a personification of the subject. In this the analyst is asked to become an image of the patient. In this passage Lacan pointed to the requirement that the analyst not take the patient in his own image, and when this is considered alongside Lacan's constant reminder that the analyst must prevent the patient from identifying with him, the dual process of identification becomes evident. This duality highlights the origins of identification in the mirror stage and the pervasiveness of the wish to identify with the other. It has existed at least since biblical times, when references were made to God making man in his own image. "Then God said, 'Let us make man in our image, after our likeness…'" (Genesis 1:26, The New Jerusalem Bible: Study Edition). Such a belief aims to facilitate identification, but, unlike religion, the aim of the analyst or the analyst's desire pertains specifically to the analyst working against identification. Lacan was adamant that the analyst must always work toward his own desire, and for analysis Lacan insisted that this desire must be to bring about separation, which is the antithesis of identification.

In the above quotation Lacan referred to the drive, which in Lacanian theory connects demands, drives and identification. Rodriguez (2001) pointed out that

Lacan believed the drives[14] were subject to the Other's desire as communicated through the Other's demands. "The demands of the Other become the subject's drives and inscribe the signifiers that constitute the traits which form the subject's identifications" (p.195). Answering one's drives therefore becomes a question of, what does the Other want (of me)? The answer to this question is sought through a demand. Clinically, this is a demand for the analyst to want of the patient the same as the parental object wanted, that is, to desire the same. But, as Lacan stated above, the demand and the drive must come together, which is possible only after relinquishing the desire of the Other, which exists in identifications. When this occurs the patient has crossed the "plane of identification" (Lacan, 1964/1998, p. 273) and can enjoy his own desire, which is the end of a successful analysis. This is the ideal, but it is not so easy to bring about clinically. Although Lacan set out guidelines in places such as the schemas illustrated above, about what he believed the patient would do and what the analyst should do in terms of identification and demand, one is still faced with the practical clinical challenge of the demand of the patient. How does the therapist avoid being sucked into the patient, literally? How does the therapist avoid the patient's demand to enter an identificatory relationship? Lacan provided the guidelines to avoid this but in order to apply them one must first recognise the demand. The clues to recognising demand have not been well illustrated but they relate to an understanding of the relationship between desire, need and demand.

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[14] Drive is now accepted as a more accurate translation of the German Trieb, than is instinct, which was Strachey's translation in the Standard Edition of Freud's works. The German word for instinct is Instinkt.

4.1.8 Desire, Need and Demand

Desire, need and demand all describe positions of lack in the subject. Lacan used a matheme to show the relationship between the three (demand – need = desire). Desire is left over when need is subtracted from demand; it is what the subject does not have and it relates specifically to the early relationship with the mother. In this relationship the infant must signal to the mother his need to be fed, which is a demand by the infant that is responded to by the mother in terms of her desire. For example, does she attend to the infant immediately or when she completes whatever else she is doing? Due to the infant having to recognise discomfort and make a demand in order to have the discomfort relieved, the infant experiences lack. Thus the mother's desire and the infant's lack are connected. Lacan wrote,

> "In short, nowhere does it appear more clearly that man's desire finds its meaning in the other's desire, not so much because the other holds the keys to the desired object, as because his first object(ive) is to be recognized by the other." (1959/2006, p.222).

This is why Lacan stated that desire is the desire of the Other. Verhaeghe (2004) described the interrelationship between demand, desire, the drive and lack through the infant's search for the answer to his lack in someone else which progresses the child toward the Oedipal triangle.

> Because demand and desire never fully complete each other each demand for an answer to the drive will be inadequate. The subject goes looking elsewhere for a complete answer and he or she turns to the one whom the first Other desires. This one must have the answer. Here lies the Oedipal triangle and

within it, the subject supposed to know; the one assumed to have the answer. (p.169)

The one who knows, initially, is the father, the object of the mother's desire. As pointed out above, the analyst occupies this place as the *subject supposed to know* in the transference.

Beside the demand to have needs met, the infant also desires love. As Nobus (2000) explained, each demand to have a need met has along with it a question about the Other's love. At a fundamental level love is always desired and one wants this sustained. "Objects functioning in the realms of need and demand have an assuaging, quenching effect, whilst objects in the realm of desire only serve to sustain it." (p.72). Demands in the clinical session are no different; the patient through his demands will attempt to determine something about love, but the treatment must head in the direction of the patient determining something about desire.

At a clinical level the analyst's aim is to go beyond demand to desire which is a point Lacan repeatedly stressed. He believed that the patient automatically functions at the imaginary level, which brings about demand. But, in Lacan's schema L, the analyst's aim is to relate in a way that accesses the unconscious and the desire contained within. This is possible when demands are not met because the frustration creates a space for desire. The therapist's task is to find a way to provide this space. Lacan stated that demand was to be supported by the analyst and that the intention of the analyst was "not, as people say, to frustrate the subject, but in order to allow the signifiers with which the latter's frustration is bound up to reappear" (Lacan, 1958/2006, p.516). One must find a way to neither frustrate the subject nor satisfy his demands. This is the difficulty in clinical work. The clue as to how this might be accomplished is elucidated by Nobus (2000) who wrote that a response to the

patient's demands that is unexpected, opens the door to the unconscious. In this way demand is sidestepped and the patient is headed toward desire. To transfer this to testing, one asks, is it possible to sidestep the test? This seems possible if one considers Weiss's (1993) adage that the patient's tests should be responded to differently from the way the parental objects responded. That tests are built on unconscious pathogenic beliefs suggests there is an expectation on the patient's part that the analyst will give the same response as the parents gave, therefore any different response could be considered unexpected. On this point it appears possible that Lacanian theory and CMT might have something in common. On the topic of what the patient wants by testing and what the patient wants by demanding, it appears the two theories differ. In Lacanian theory the patient wants the therapist to adopt the identificatory position he attempts to elicit, whereas in CMT the patient does not want the therapist to adopt the position he attempts to elicit. This question will be returned to in the case studies.

To this point the literature specific to CMT, Freud and Lacan, has been presented and explored in relation to testing. At a conceptual level testing as a CMT construct was examined amidst the therapist-patient literature specifically pertaining to the therapeutic relationship, the therapeutic alliance and the transference. The clinical research into these concepts was presented and critiqued, as was the specific CMT clinical research. At a descriptive level, testing shares the characteristics of other psychoanalytic phenomena observable in the therapy session. Some of these have already been discussed but there remain some that were developed theoretically by both Freud and Lacan but not by Weiss. The following section will present and discuss repetition and the repetition compulsion, acting out, and projective identification. The transference forms part of all three theories but has less emphasis

in CMT than in either Freudian or Lacanian theory. In Lacanian theory it has a particular meaning that goes beyond Freudian theory and for this reason and for its relevance to testing, it is returned to here and discussed from a Lacanian perspective.

4.1.9   The Transference in Lacanian Theory

Where the usual Freudian understanding of the transference is limited to the patient's re-enactment of early significant relationships with the analyst, as if the analyst was a person from his past, Lacan went further to relate this directly to the assumed knowledge of the "subject supposed to know". Like Freud, Lacan's thoughts on the transference meandered through a number of incarnations until eventually he produced his final theorisations on the concept.[15]

In his attempt to understand the meaning of Freud's writings on the transference Lacan needed to address the paradoxical functions of the transference which held it as both a resistance and an assistance to the progress of treatment (Evans, 1996; Nobus, 2000). Evans explained that this related directly to the repetition compulsion and the re-enactment of love and aggressive affects that Lacan understood in terms of the Symbolic and the Imaginary. The Symbolic involved the repetition of unresolved conflict occurring in the transference, and the Imaginary, the emergence of love and hate. The Symbolic aspect revealed the signifiers and assisted progress, whereas the Imaginary aspect was a resistance to progress. Lacan revised this view and eventually decided that repetition and the transference were separate (Nobus, 2000). In his seminar on the *Transference* Lacan (1960-61/1991) determined the dominance of the affective aspect of love in the transference. In this explanation the *object a* and

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[15] For a full tracing of the development of the concept of the transference in Lacan's work see Nobus, (2000). Evan's (1996) offers a condensed historical tracing.

agalma discussed earlier relate directly to the transference. Eventually, the transference became defined as the "enactment of the reality of the unconscious" (Lacan, 1964/1998, p.149), which is played out in a relation between patient and therapist. Finally, as mentioned above, Lacan articulated the driving force of the transference as a demand for knowledge. Weiss et al. (1986) noted Freud's link between demand and the transference but never developed it theoretically, which left the connection implicit in testing.

Insofar as the transference as an enactment is a response to the patient's unconscious, the act requires a response by the analyst in the form of an act rather than an interpretation. The interpretation or signifying function comes later. Fink (1997) explained that for change to occur two processes are required, symbolisation of the unsymbolised content and a re-experiencing of the affect and dynamics connected to the underlying libidinal conflict that operates in relation to an other. The analyst therefore performs a function, actually two in Lacanian theory that correspond to two aspects of the transference; the signifying function, and the purpose served by the presence of the therapist as an erotic object (Rodriguez, 1989). These functions correlate with the patient's speech and enactment. The former relates to the *subject supposed to know*, and the latter to *objet a*.

Erotic expressions, which Freud (1912/1964) called transference-love, require that the analyst place limits on the patient (Rodriguez & Rodriguez, 1989). Apart from the obvious ethical reasons for limiting and handling carefully the erotic manifestations of the unconscious, these manifestations act as a resistance and if not handled well, will impede progress. When the patient is enjoying imagining the analyst as an erotic object, the unconscious is closed. The erotic objects represent the lost *object a*, which can be "oral, scopic, vocal, masochistic, sadistic, anal, urethral,

phallic" (Rodriguez & Rodriguez, 1989, p.173). As Freud noted, the finding of lost objects is a re-finding, therefore a situation, which might seem fortuitous is motivated by unconscious desire. Whilst the patient describes the jouissance relating to these objects both he and the analyst are in a position to learn much about all that concerns love and enjoyment for the patient (Rodriguez & Rodriguez, 1989). Although this aspect of the transference is more concerned with an act, and this act comes in the form of a demand, the act is actualised in speech. For example, the analyst does no more or less in the session than speak or be silent.

To return to Lacan's final view of the transference and the attribution of knowledge to the Other, Lacan (1964/1998) wrote, "As soon as the subject who is supposed to know exists somewhere … there is transference" (p.232). In the transference the patient demands this assumed knowledge. The genesis of this process lies in infancy as explained at the beginning of this chapter in the section on the mirror stage, wherein the basis of demand was explained in terms of the infant's survival. To take this further, the demand becomes more than the attempt to satisfy a need, it is also a demand for love. In fact Lacan believed that a demand was always a demand for love (Lacan, 1958/2006). Fink (1997), in keeping with Lacan, explained that psychoanalysis must shift the subject from he who demands to he who desires, to he who enjoys. In Lacanian theory, when one reaches this point, one is free to enjoy because enjoyment is no longer subject to the Other.

The transference constitutes the manifestation of unconscious material in the form of an enactment that begins with demand, and ultimately relates to love. The CMT examples of testing provided in the Introduction take the form of a demand and Weiss observed a relationship between demand and love. In writing about the transference Weiss et al. (1986), described the patient making, "…a powerful

implicit or explicit demand on the analyst for love, guidance, praise, special

treatment, and so on" (p. 234). In CMT testing is viewed as a repetition of the trauma

stemming from a loss of parental love in childhood when the child was of a verbal

age, whereas in Lacanian theory the repetition of trauma in relation to the loss of

love is believed to result from an earlier developmental stage.

In CMT trauma and a demand for love are amalgamated in a causal relationship

in the development of childhood pathogenic beliefs. These are built on a traumatic

encounter that threatened the child's perception of parental love. Inherent in this is

anxiety, yet there is little reference to anxiety in CMT. Where it is employed it

utilises Freud's concept of castration anxiety to counter the Freudian idea of the

pleasure principal, without acknowledging Freud's progressions when he introduced

the reality principle. Weiss wrote, "…unconscious guilt and unconscious castration

anxiety do not fit the automatic functioning hypothesis in that they are not pleasure-

seeking motives. They may be directed to self-torture, not to gratification." (Weiss et

al, 1986, p.27). Weiss et al stated that castration anxiety was not a defence nor an

impulse, but a belief based on a real fear, and whilst testing was referred to as the ego

performing trial actions to determine safety, it was not employed as a test related to

anxiety as it might be envisaged in, for example, signal anxiety, but a test of a belief.

In CMT anxiety is directly substituted by beliefs. Freud (1920) however, believed

that anxiety arose in relation to the compulsive repetition of trauma. One can observe

here the different focus in approach of the two theories. The CMT approach moves

from the trauma toward a cognitive model of constructed thoughts, whereas the

Freudian view moves from trauma to anxiety. As Williams (2005), explained, Lacan

in his 1962-63 seminar on anxiety linked the compulsion to repeat, transference-love

and acting out, to anxiety. Acting out was a substitute for anxiety, the compulsion to

repeat was signalled by anxiety, and transference-love or narcissistic-love was an attempt to avoid anxiety. In the Freudian and Lacanian theories the connection between these three concepts and anxiety is clear but in CMT a connection between anxiety and trauma is not made. Trauma in CMT begins in childhood and is the basis of the fear based pathogenic beliefs, whereas anxiety in Freudian and Lacanian theory has an earlier pre-verbal ontology which sets a prototype for further traumatic encounters.

4.2   FREUDIAN-LACANIAN THEORY

Considering the descriptions provided in the CMT literature, testing is consistent with a demand enacted in the transference. Lacan's formulation of the transference provides an explanation consistent with both transference and passive-into-active tests as belonging to the transference. This leaves a further question, relating to the transference, that involves the repetitive nature of testing. Although in CMT the repetition of the traumatic encounter with an external object, usually parental, is not viewed as repetition in the Freudian sense, Weiss did refer to some repetition as testing and testing displays the same descriptive characteristics as episodes of repetition. The following section explores the psychical concepts observed in the clinic that share the same characteristics as testing, namely, repetition, acting out and projective identification and determines the nature of any relationship between these concepts and testing.

4.2.1   Repetition

Benvenuto and Kennedy (1986) provided an example of a patient's repetition enacted in the transference that displays the same characteristics as the CMT descriptions of testing. They wrote "They might try to get the analyst to treat them

coldly, so that they feel once more scorned, or they find objects for their jealousy similar to those of their own childhood, etcetera" (p.92). The episode itself, whether considered theoretically as repetition or as testing, is the same; the patient in exhibiting this behaviour makes no pre-emptive decisions. The question concerning testing as a demand goes beyond the childhood developed pathogenic belief that was established as preconscious in the earlier chapters; it goes to the unconscious and offers an explanation for the clinical observations of testing from this perspective. This brings together the theory relating to repetition and the transference and also integrates Freudian and Lacanian theory.

In *Beyond the Pleasure Principle*, Freud (1920/1964) wrote of repetitions of traumatic experiences appearing in the analytic relationship. As these were not situations in which the patient was avoiding unpleasure or producing pleasure, he decided this phenomenon belonged to the unconscious repressed, which pushed to the surface seeking expression. This idea was further elaborated in *Inhibitions, Symptoms and Anxiety* (Freud, 1926/1964) as unbound energy. Here again, Freud attempted to understand the repetition of unpleasure, or trauma. He explained how the memory or traces of the trauma are separated from a complete idea, through the mechanism of repression, and therefore exist in an unbound form. The repetition is an attempt to bind to something pleasurable, for example, to wishes in dream content, which explains how attempts to satisfy the drive can at the same time be experienced as unpleasure. This is the movement of unbound energy described in Chapter Three. Williams (2005) in her exposition of anxiety across Freud's body of work, explained how, for Freud, the narcissistic wound in itself is not pleasurable when repeated, but if a re-experiencing binds the excitation to an idea, as Freud proposed, it could result in pleasure. The binding in the example of a narcissistic

wound is to a masochistic idea or representation; thus the combination of pleasure and unpleasure. One experiences a 'compulsion to repeat' where binding has been unsuccessful, where there is no representation and so one continues to seek this. As Benvenuto and Kennedy (1986) pointed out, Lacan linked Freud's repetition of unconscious material to the insistence in the signifying chain. In this, Freud's description of the unconscious as dynamic is evident. As Rodriguez and Rodriguez (1989) explained the dynamic unconscious referred to the constant search by the representatives of the drives for a new representative to attach to. Here, Lacan's idea of repetition and the transference as separate changes to one in which they are integrated through the insistence of the signifying chain.

In CMT (Weiss, 1993; Weiss, et al. 1986) the repetition compulsion was acknowledged insofar as it was contrasted with CMT. The contrast was made between the higher mental functioning hypothesis and Freud's early theory, in which repetition was viewed as an attempt (unconscious) by the patient to receive gratification, or to protect gratification through resistance. CMT proposed that "transference repetitions", were purposeful and served to unconsciously test pathogenic beliefs resulting from trauma (Weiss, 1993, p.18). In this formulation the repetitive component was believed driven by the patient's desire to change a belief held at an unconscious level. This is a completely constructed belief developed in childhood, but one that is incorrect and serving a defensive function against a childhood trauma. Whereas in both Freud and Lacan's formulations the trauma that is repeated has an earlier ontology and repeats in the hope of making understanding complete by attempting to attach to new material. It does this by moving along the signifying chain. Both concern a lack of understanding, one incorrect and one incomplete.

There is an element of pleasure, or jouissance, in the search but there is also a jouissance that is beyond pleasure. Here there are two forms of jouissance, one that can be integrated into the signifying chain and one that cannot. The former jouissance is derived from the patient longing for what he thinks will be answered by an object, this is the object *a* explained in Section 4.1.5, which relates to desire. The latter is traumatic and, as William's (2005) explained, is designated by the Lacanian Real and can take the form of either a lack or excess. The former relates to the lack in the subject and the latter the lack in the Other, the latter representing what is unknown for the subject about the Other. In drawing from Lacan (1964/1998) Williams explained how the signifying chain always had something at its core that was and always would be missed, therefore, in repetition there would always be a loss of jouissance. This translates into a traumatic experience that is at the core of every subject, but it is a very different trauma to that described in CMT as causally connected to pathogenic beliefs. For Lacan it was a signified jouissance that is repeated, and it did so when triggered through, for example, a scent, a sound or an image (Williams, 2005). In other words, the repetition was an automatic, perhaps even opportunistic, attempt to link to something that has an element of familiarity. There is a fundamental difference between repetition in this explanation and testing and this concerns pleasure. The repetition described in testing is explained as an attempt to rid oneself of beliefs that cause discomfort, which inhibits the patient's achievement of his goals. Where the CMT focus is on familiarising the patient with the unpleasurable or painful aspects of his functioning, Freudian-Lacanian theory focuses on familiarising the patient with those aspects of unpleasure of which he is unaware. These are the pleasurable aspects.

At a descriptive level testing installs the same function in the analyst as Freud described in repetition and implicates the transference at a functional level. That is, the analyst is an actor playing the role of the parent within the conflicts of neurotics. Theoretically, Weiss distances CMT from the repetition compulsion because testing, as a repeated unconscious process, cannot be fully accounted for without considering the manner in which the unconscious content comes into consciousness. Freud explained this in terms of the flow of energy through representations or ideas, and depending on whether this is successful or not the patient responds to his own attempts in various ways. These manifestations are evident at a descriptive level in the behaviour of the patient. Furthermore, the unconscious in Freudian theory presupposes the existence of the drives, which is inconsistent with the CMT higher-mental functioning hypothesis. The descriptive similarities that exist in testing and repetition also exist in acting out and in the defensive mechanism of projective identification. The wide-ranging descriptions of testing encompass elements of all of these processes and mechanisms. For this reason, the literature on acting out and projective identification is examined to determine the nature of any relationship between these processes and testing.

4.2.2   Acting Out

There are two main questions in the literature pertaining to acting out: First, whether acting out is solely a function of the therapy setting, and second, whether it is confined to an action. Some of the examples of testing provided by Weiss are termed acting out in the generalist psychoanalytic and psychotherapy literature. For example, refusing to pay for sessions, not attending sessions, and attending sessions late or early are typical but both Freud and Lacan had specific ideas about acting out.

Freud (1940/1964) viewed acting out as a particular form of repetition in which the patient acts rather than speaks. Freud also described the transference as acting out, but extended this view beyond the transference when he referred to certain of the patient's behaviours that were not confined to the psychoanalytic session. In terms of what the patient acted out, Freud believed it was a reliving of unconscious wishes and fantasies but with an impulsive immediacy (Laplanche & Pontalis, 1988).

Descriptively, the more extreme examples of acting out beyond those listed above include suicidality, murder and sexual assault (Laplanche & Pontalis, 1988). Deutsch (1963) adopted a universal view in which she believed everyone acted out at some point. She included obsessionals' ceremonies, conversion symptoms in neurosis, and the hallucinations and delusions present in psychosis. Chasseguet-Smirgel (1990), like Freud, believed acting out occurred both within and outside of analysis. She included the addiction-based symptoms of drug-addiction and alcoholism, and also delinquency and quarrels with motorists. She argued that acting out represented the oppositions of "psychic elaboration on the one hand and a saving of the process of working through on the other." (p.77). This suggests that acting out is an attempt to communicate internal content but through a means other than thinking and speaking, consistent with Freud's belief that acting out substitutes an action for speech. Laplanche and Pontalis (1988) pointed out that acting out generally manifests in aggressive behaviours, and is also easily distinguishable from other psychical phenomena because it differs from the patient's usual functioning. Weiss (1993) noted that testing could also be detected on the basis of it differing from the patient's usual functioning. Testing, however, bears no resemblance to the examples above of drug-addiction and alcoholism, nor is there any mention in the CMT literature of the extreme forms of acting out given above, such as murder. All

of these have an aggressive component, either toward others or in the case of addictions, toward the self, which is not highlighted in CMT. If one adopts the Freudian view that acting out is the manifestation of unconscious wishes and fantasies, then it is possible that the aggressive wishes and fantasies have not been successfully communicated to the analyst or therapist and are therefore acted out. This is consistent with Greenacre's (1950) view in which she located the genesis of acting out in the frustrations of a preverbal stage of development.

Greenacre described the muscular function of acting out and in doing so related it directly to motility. She proposed that the preverbal child, frustrated by the inability to verbalise, communicated through his body. If acting out is the reliving of unconscious wishes and fantasies either within or at least in relation to the transference, can it be said that acting out always relates to the body in the form of an action, or, might it also be a repetition expressed without actions? For example, Deutsch's reference to hallucinations and delusions, and Freud's (1940/1964) idea that the transference itself is a form of acting out, suggest a more loosely constructed definition of action that does not necessarily include motility. When Freud described acting out as an action that replaced speech, it did not mean that speech had not occurred, but that as a communication it was inadequate, either in terms of delivery or in the listener not having heard. Under such circumstances the patient finds a form of expression other than speaking to address the analyst. This alternative is the body.

The reason why the patient acts instead of speaking is important here. The commonality between the aforementioned theorists' descriptions and explanations for acting out relates to communication. Lacan (cited in Fink, 2004) in his 1962-1963 seminar on anxiety, formulated acting out as a communication that occurred when the analyst had not heard, which implies the patient's frustration at having made an

unsuccessful attempt to communicate. Lacan used the example of a man who believed he was a plagiarist. This man ate fresh brains in a delicatessen upon leaving his sessions of psychoanalysis. This case was a reformulation of a case reported by Ernst Kris (1975) and in it Lacan pointed out that the eating of the brains was a display of the patient's frustration with the analyst for interpreting that he was not a plagiarist, when the correct interpretation would have been to acknowledge that the patient desired to be a plagiarist, but because he was not, he desired nothing. This is consistent with Greenacre's (1950) explanation of acting out, which extends beyond but always with a link to the session. "As long as the emotional centre of the activities is connected with analysis, we can speak of "acting out."" (p.364. Emphasis in original). For Lacan, acting out related directly to the analyst not hearing the patient, which amounts to a demonstration to the analyst of the patient's unknown desire. The aim of the acting out is to elicit from the analyst information about the patient's desire, which can occur through an interpretation (Lacan, cited in Fink, 2004). In the case of the man who ate fresh brains, the patient did not understand his desire, and it was this that was more important than merely pointing out that he was not a plagiarist. Acting out, therefore, in Lacan's view, is a reflection of the patient's frustration with the analyst whom he expects to make sense where he cannot.

Acting out is not mentioned in CMT and this is likely due to the incompatibility of certain aspects of acting out with the theoretical assumptions underpinning CMT. This is most evident in the impulsive immediacy referred to by (Laplanche & Pontalis, 1988). Like the compulsion referred to in the discussion of repetition, impulsivity is the antithesis of the theoretically derived higher mental functioning hypothesis on which testing is based. For Freud, acting out was an attempt to

communicate unconscious wishes and fantasies, which for Lacan was desire. In CMT testing is an attempt to determine the safety of releasing repressed content which will enable pathogenic beliefs to be disconfirmed. From the literature presented here it appears that acting out is a communication or message that is indirect in both the mechanism it utilises, that is, an act rather than speech, and the person addressed. The message is directed to the analyst but not always acted out with the analyst in person. Whilst it is said to differ from the patient's usual behaviour, as does testing, and replace remembering, it does not have the manipulative quality wherein the analyst is required to play a part that is present in testing and also in the transference. The manner in which acting out brings the past into the present is different from the way this is said to occur in testing. In acting out it is an interpretation that is required, whereas Weiss developed testing in response to the progress he noted from the interaction between therapist and patient when interpretation did not occur. At a theoretical level acting out and testing differ, but at a descriptive level, the same behaviours may constitute either acting out or testing, and knowledge of the particular patient would determine which. For example, attending sessions late could fit either. Projective identification also shares similarities with some of the descriptions of testing.

4.2.3   Projective Identification

Projective identification was considered a primitive defence mechanism when first described by Klein. Where identification is the absorption of components of a person outside of the self, projection is the ejection of inner components of the self to the outside.

Klein's (1946/1977) concept of projective identification is described, along with splitting, as the major defence of the psychotic personality structure. This is consistent with a connection Freud made in Draft K (Freud, 1896/1950), when he linked projection to paranoia. Bion (1959) made clear the effect on the analyst of projective identification when he described a feeling of being manipulated, as in playing a part; the 'part' was the patient's fantasy. Betty Joseph (1997) similarly described the patient's attempts to have the analyst act in a specific manner consistent with the projection. Ogden (1979) described experiencing a feeling of being pressured to think, feel or act. The projection as described by Ogden, also represented the patient's fantasy of taking over the other by evacuating parts of the self into another, consistent with Klein's view. Spillius (1988) interpreted Klein's notion of the motive for projective identification as representing the patient's wishes, perceptions and defences. She also likened it to Bion's concept of the container/contained, although Bion (1959) himself did not. Laplanche and Pontalis (1988) focused on the destructive element originally described by Klein in which the subject fantasises that he or she has inserted himself, wholly or in part, into another with the purpose of harm, possession or control. For the patient this enables the possibility of reinternalising a modified version of the ejected feeling.

In Lacanian terms it is the drive that is ejected. Verhaeghe (2004, p.343), described projective identification as a defensive attempt to control the drive by externalising it and in this process it was imagined as controlling the other. Verhaeghe wrote, "The nature of projective identification is such that the other becomes reduced to it and seems to be left with only two possibilities: she or he can either behave in that way, or pull out entirely." (p.343). Verhaeghe also described two forms of control the patient used in relation to the analyst. These two forms

mirror the patient's original experience of the patient-parent relationship which in the case of borderline patients, was, "aggressive punishment or overconcern." (p.343). Verhaeghe pointed to the separation of identificatory states that is indicative of projective identification that results in the patient experiencing relationships in terms of polarities such as, positive or negative, or intimate and rejecting. Because the identificatory layers have not integrated in the ego they remain separate, or split off.

Similarities between descriptions of testing and descriptions of projective identification are confined to the effect the patient has on the analyst. Both are generally, although not exclusively in the case of testing, considered unconscious processes (this was challenged in the earlier chapters) motivated by a desire to influence the behaviour of others. At a theoretical level, however, testing is inconsistent with a primitive defence mechanism. The Kleinian view of projective identification locates it ontologically in infantile fantasies where hated parts of the self are split off and projected into the other, but the genesis of the pathogenic belief, the trauma that underpins testing, occurs at a later developmental stage than infancy. This indicates a fundamental difference between the two in terms of theoretical explanations. Furthermore, in CMT pathogenic beliefs do not represent hated parts of the self. Although the patient wants to be rid of the beliefs the theoretical explanation for the aggressive component consistent with projective identification, differs to explanations in CMT. Foreman (1996) specifically drew attention to the similarities and differences between Ogden's (1979) view of projective identification and passive-into-active testing. The similarities he pointed to related to the way the analyst was made to feel, consistent with the patient's own feelings, and the patient's re-internalisation of a modified form of this experience. Foreman differentiated the two on the basis of defences. Passive-into-active was not a defence against

aggression, but rather an attempt to change a pathogenic belief through re-enacting the traumatic experience that was the catalyst for the belief. In the absence of a consideration of defences aggression is attributed solely to an external source and not to the patient. In this sense, Foreman's explanation is consistent with CMT.

Fundamentally, the difference between testing and projective identification concerns the levels of consciousness. Although testing is predominantly an unconscious process it is also located in the normal everyday process of reality testing (Weiss, 1993; Weiss, 1986). In contrast, projective identification with its roots in infantile fantasy is an unconscious process, and most easily observed in highly damaged patients such as is seen in psychosis and the category of borderline personality disorder Verhaeghe (2004) referred to. Where in CMT it is stated that testing can at times be 'normal everyday reality testing', projective identification, in Verhaeghe's view, is a result of an inability to adequately construct social reality. In this formulation testing appears to have a closer link to external or social reality than projective identification.

Both projective identification and testing involve the attempt to manipulate the analyst. However, whilst this similarity exists at the level of clinical description it does not hold at a theoretical level. In CMT the test relates to a highly functioning unconscious ego. Such an ego can plan and construct a situation in which the analyst can be manipulated into a position so as to disconfirm a belief, whereas projective identification is the result of an ego that cannot adequately process reality, and which leaves the affects and drives in an unintegrated state. Certainly, the CMT hypothesis of planning and decision-making conducted by the unconscious ego in testing is inconsistent with the fragile unintegrated ego that utilises the fantasy involved in projective identification. This leads one to believe that testing would not occur in

psychosis. However, Weiss (1993) believed testing occurred in highly damaged patients and gave an example of a woman he described as experiencing schizophrenia and suffering from hallucinations and paranoid ideas. In the example provided, the therapist told the patient he would not charge for sessions in order to alleviate the patient's concern that she was receiving more than she should from the 'state' through which her therapy is funded. She implied that she would discontinue therapy. The therapist felt under pressure to solve this, which indicated the test. After telling the patient she did not have to pay she appeared reassured and for the first time she brought a dream to the following session.

As with all case material the analysis and interpretation of a case occurs within a specific tautology, which, as pointed out in Section 2.1.1 is usually unstated when empirical claims of psychoanalysis as science are made[16]. Nevertheless, there are two points to be made in relation to the case just reported. First, even though the test is said to occur in a woman with psychosis it is inconsistent with the highly affective and manipulative nature of projective identification. This test is presented by Weiss as a subtle test but the nature of psychosis or projective identification is not subtle. And second, assumptions about the functioning of the ego in a psychotic structure are not made explicit in the CMT literature. In proposing that testing occurs in a psychotic structure assumes that repression is a function of psychosis whereas in Freudian theory the mechanism of repression is exclusive to neurosis. There is a further point to be made that relates to the undeveloped ego and the preconscious system.

Klein is criticised for not differentiating between unconscious and preconscious processes (Mitchell, 1986). Her technique of directly interpreting unconscious

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[16] See Nobus and Quinn (2005) for a discussion of this.

phantasies is seen as implausible given Freud's view that access to the unconscious is through the preconscious system (Gammelgaard, 2003). This is not so implausible, however, when one considers that Klein observed the primitive processes of very young children. Much of her work was with an ego still in the process of forming, therefore it was the id-based drives that she observed and an immature ego. Freud (1940/1964) considered the ego and the preconscious system as working together, which makes it reasonable to assume that the preconscious would progressively develop along with the ego and with language. This is consistent with Freud's view of the absence of the system preconscious in psychosis, which was why the unconscious was said to appear in consciousness in the form of hallucinations in psychosis. The repressing mechanism was not in operation due to poor, if any, ego function, and either the lack of or an undeveloped preconscious intermediary state.

On a further point, it is plausible that fantasies and pathogenic beliefs are connected. As Freud (1908/1964) explained, fantasies are the mind's way of fulfilling an unsatisfied wish, a way of returning to an earlier state of satisfaction. Somewhere the ideal that the child/adult seeks but no longer experiences, retains a potentiality that exists as a wish fulfilled in fantasy. Freud wrote that satisfied people have no need for phantasying[17] therefore phantasies are the method of satisfaction used by unhappy people. He described fantasies as, "unsatisfied wishes, and every single phantasy is the fulfilment of a wish, a correction of unsatisfying reality." (p.146). The fantasy or daydream represents the past, present and future. Freud proposed that the fantasy is provoked by an event in the present that draws attention to a major wish. This wish is then associated with a memory of a time when the wish

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[17] The Freudian and Kleinian use of phantasy with a 'ph' denotes the unconscious. It is used in this way to differentiate with conscious or preconscious fantasy. I will use the term fantasy to mean unconscious fantasy and daydream where preconscious fantasy is meant.

was fulfilled, Freud stated this was usually an infantile experience, and the thoughts in the fantasy returned the individual to a state of fulfilment of the wish in the future.

The patient searches to disconfirm pathogenic beliefs so as to fulfil his goals. In other words, to get what he wants. The difference between stated goals and unconscious wishes is the difference between conscious and unconscious processes. The higher level thought processes required for the development of a pathogenic belief and the testing of such a belief are inconsistent with the primitive splitting and projective mechanisms operational in projective identification; however, as with the other constructs discussed here, there is a discrepancy between the descriptive and theoretical levels of testing that emerge under a theoretical examination of alternative constructs, such as the transference, acting out and projective identification.

4.3   SUMMARY OF THEORETICAL SECTIONS

In summary, each of the alternative constructs discussed displays components identical to descriptions of either testing or pathogenic beliefs, yet all are underpinned by Freudian wishes and fantasies. As such, they result from the drives and are connected to unconscious desire. On the surface, therefore, acting out and projective identification describe some of the same phenomena as testing, but depending on the theoretical position and the underlying assumptions from which such descriptions are viewed, the conceptual, functional and ontological explanations differ. For example, at a functional level acting out relates to repetition and the transference, but not to testing, yet at a descriptive level testing and acting out share commonalities. Ontologically, the Freudian constructs differ markedly to testing and the underpinning pathogenic belief and conceptually, testing is a new term

encompassing existing behaviours that are assigned a newly formulated theoretical explanation.

Testing, as a newly constructed concept, does not consider the difficulties inherent in the patient recognising his wishes as his own and the restrictions external reality places on one's wishes. These factors implicate the mechanism of repression as it is known in Freudian theory. In CMT, repressed content does not include forbidden wishes or forbidden desire, instead, it stems from external reality, and the mechanism itself serves as a protection against pain stemming from an external source. Although this reading locates pathogenic beliefs as defences they are not acknowledged as such in CMT. Possibly, this is due to the need to acknowledge what is defended against, which is the drive in Freudian and Lacanian theory. In Chapter Two the assumption that the unconscious in CMT is the same unconscious Freud proposed, was questioned. Chapter Three presented the Freudian unconscious and the drives, and the current chapter, based on the Freudian unconscious, explained Lacan's ideas on the manifestations of the unconscious in the therapy session, and explored the similarities and differences of specific psychoanalytic constructs that share descriptive characteristics with testing. Theoretically, thus far it has been argued that the unconscious in CMT does not include the drives, instead it is rational and operates on secondary processing. In this, it is consistent with the Freudian preconscious. This leads to a further question. Can CMT, with its notion of the unconscious, adequately explain clinical data without acknowledging the drives? This question will be approached in the case studies, first, from a CMT perspective during the process of tracking tests, and second, by analysing the same material from a Freudian-Lacanian theoretical perspective wherein the tests are observable as demands, as proposed in part A of the thesis. The most interesting question to be

addressed in the case studies relates to the aim of testing which implicates the positioning of the therapist and the direction of treatment. In CMT, the test is considered an attempt to position the therapist differently from the position the parental objects occupied, whereas in Freudian-Lacanian theory the demands are consistent with patient attempts to have the therapist occupy the same position as the parental objects. Addressing these questions forms the second half of the thesis.

PART B: EXAMINING TESTING CLINICALLY

CHAPTER 5: RESEARCH DESIGN

This chapter details the research design chosen to direct the current

investigation. It begins with a rationale supporting the research design, then presents

the multiple-case study strategy and design following Yin's (2003) model of case

study research. The last section presents the process involved in the analysis of the

data, and the findings. Finally, the difficulties encountered in this type of research are

addressed.

5.1   CRITERIA GUIDING THE CURRENT RESEARCH FOCUS

This research aims to expand the limited knowledge of testing provided by the

current model. The limitations were addressed in the current research by (a) the use

of a qualitative multiple-case study methodology to provide a detailed description of

the process of testing through context-rich case discourse, and by, (b) employing a

Freudian-Lacanian theoretical basis as an alternative understanding to the existing

CMT understanding of testing.

5.2   RATIONALE FOR THE METHOD

The current study departed from previous investigations of testing at both a

theoretical and a methodological level. At a theoretical level it aimed to locate testing

in relation to existing psychoanalytic concepts by examining the concept from a

Freudian-Lacanian theoretical perspective. This meant a focus on the Freudian

unconscious, the drives, and desire as proposed by Lacan in his extension of

Freudian theory. At a methodological level it aimed to provide a phenomenological view of testing that would enable a comprehensive description of testing by tracking its occurrence and effects over a limited time period, using transcripts of clinical sessions. Predominantly, it was the limitations of the CMT model of testing that guided the methodological decisions for the current research.

5.2.1 Limitations of the CMT Model: Theoretical

The thesis began by presenting testing as an enactment occurring in the relationship between patient and therapist that was introduced by the patient, as in the case of Dora. Little theoretical attention has been paid to testing in the general literature of psychology and psychoanalysis, but it was explored specifically within CMT. It was also argued that the CMT model of ego-psychology/cognitive analytic psychology was limited in the understanding it provided of the concept of testing because of the assumptions of the theoretical framework it was based on. The assumption of the CMT higher-mental functioning hypothesis was that the unconscious functioned and processed in the same way as the ego. A further related assumption held that the unconscious was not subject to the drives. CMT's model did not locate testing within other pre-existing Freudian psychical concepts, but it did differentiate other psychical concepts from testing in order to support the higher-mental functioning hypothesis. Furthermore, a number of theoretical errors in Weiss's interpretation of Freudian theory were located in the arguments used in the development of CMT. For these reasons the current research employed a qualitative methodology, which enabled an in-depth textual analysis of testing across the first ten sessions of three individual case studies. Given that CMT is based on ego psychology, which is underpinned by particular aspects of Freudian theory, a

comparative analysis at a theoretical level within each of the case studies, utilising Freudian-Lacanian theory, was employed. This provided an alternative illustration of the concept of testing.

5.2.2   Limitations of the CMT Model: Methodological

From a methodological perspective it was argued that CMT was influenced by a research paradigm dominant in North America that evolved under broad systemic pressure to produce a specific theory of psychical functioning consistent with this paradigm. It seemed of vital importance to the SFPRG that they develop a theory that had predictive value, which they did. In contrast, the current research was primarily an investigation of testing as a concept. It was not constrained by the development of a new theory of psychotherapy and therefore could be studied through an alternative theoretical model. Because it was a singular construct under investigation, testing was explored in greater depth than had previously occurred.

The readability of the findings and accessibility of the subject represented within the data was a consideration in the design and presentation of the research. In the clinical research literature there are a number of studies that explore the process of psychotherapy – including CMT - and in particular the transference (Gedo & Schaffler, 1989; Hill, 1990; Hoffman & Gill, 1988; Luborsky & Crits-Christoph, 1998). In presentation these studies frequently promote methodological rigour over readability, which is necessary for the purpose of the particular researches. However, in the process the patient's words are often lost, at times they are converted to statements of statistical significance, and the research participant as a particular subject forsaken. The reader is left without a sense of the ebb and flow of the session and along with this a sense of the transference as it developed. The rich clinical case

material that enables the reader to contextualise the process of the sessions and get to know the patient though his discourse, which was the method of presentation Freud used, is abandoned, and replaced by statements of validity, reliability and predictability. To avoid such pitfalls the current study employed a multiple-case study approach wherein three cases were presented in a way that enables the reader to understand something about each individual's manner of engaging in the phenomenon under study. In this, the research aims to produce three clinical cases in the form of textual discourse, through which the concept of testing can be better understood and represented for the purpose of enhanced clinical knowledge. The cost is, arguably, the rigour of the method, although Yin (2003) argued that to presume case study or qualitative research is less rigorous than quantitative methods is to confuse the aims of case study research with the aims of other forms of research.

5.3   RESEARCH STRATEGY FOR THE CURRENT STUDY

The present research is qualitative in its evidence base and utilises a multiple case study research strategy. Whether research constitutes a qualitative or quantitative methodology is dependent on the way the data is explored and presented. Yin (2003) argued that this distinction should be based on the type of evidence gathered and produced. He pointed out that a case study research strategy "is a way of investigating an empirical topic by following a set of pre-specified procedures" (p. 15). It uses either qualitative or quantitative evidence.

Case study describes complex phenomena, and it does so using a methodology that has as its goal, "…making the epistemological status of the investigation clear" (Galatzer-Levy et al., 2000, p.230). Given the history of clinical case study as the method used to develop the theory of psychoanalysis and many subsequent

psychological theories, it is not surprising that with the recent systematisation of case study research it is said that "single-case methods are the most promising line of approach to exploring the efficacy of psychoanalysis" (Galatzer-Levy et al., 2000, p.230). This view however has only recently arisen. The Freudian case studies, for example, were often criticised for a lack of rigour. Such debate largely reflects the quantitative/qualitative research debate that existed in psychology until recently. Now case study research has been developed and, as Yin argued, by following a systematised research model the credibility and reliability of case study is enhanced.

The current research aimed to examine in detail a complex clinical phenomenon through two existing theories in order to provide a comprehensive explanation of the phenomenon. An illustration of the phenomenon across time and within the context of the therapy session provided clinical value. This aim qualifies the current research to meet the three conditions Yin (2003) proposed as necessary for case-study methodology:

(a)   the type of research questions asked,

(b)   the extent of control over behavioural events, and

(c)   the degree of focus on contemporary over historical events.

The research questions inquired about the circumstances surrounding testing in the relationship between therapist and patient. These are detailed in the following section. Case-study research is best applied in a naturalistic environment where the researcher observes phenomena but does not directly intervene to control or influence behavioural events, or in this case, the discourse between patient and therapist, for the purposes of the research. In the current study the researcher had access to transcripts of therapy sessions but was not present in the sessions and did

not direct either party. The therapy proceeded as it would usually. The impact of the research is considered in Chapter Nine in the section on limitations of the research. On the final condition, the discourse in the sessions was the main component of the data. Minimal information relating to the patient's history was derived from the therapist's assessment. The therapist's process notes were drawn directly from the therapy session and written after each session.

Case study methodology enables a detailed examination of the context-determined meaning of patient and therapist actions in relation to testing. In this sense it is concerned with idiographic knowledge (Willig, 2001), which allows the uniqueness of the phenomenon under investigation to be observed. This research used a multiple-case study strategy rather than a single-case strategy. In general Stake (1994) differentiated between three methods of study that attribute varying emphases to the case chosen for study in relation to the phenomenon under study. These are intrinsic, instrumental and collective case studies. The intrinsic case study places greatest emphasis on the case itself. It is chosen because the case is of particular interest. Theory building or understanding a construct is subordinated in this type of case study to the actual case. Instrumental case study is used when theoretical questions are of primary importance, and the case is of secondary interest. The collective case study places the least emphasis on one case. Cases are not chosen because they exhibit whatever is common to the research, but because in exploring them a better understanding will be gained at either a phenomenological or theoretical level, about further cases. In the current research the researcher did not select the specific cases. CMT proposes that all psychotherapy cases should exhibit the phenomenon under study. Therefore it was an essential part of the research that cases were not specifically chosen, but accepted as they became available. The

theoretical propositions (detailed below) therefore directed the design choice of collective or multiple-case study[18] as the most appropriate vehicle from which to explore testing.

Two further reasons influenced the choice of multiple case study as the design for the research. One was the impact of the research on the patient, and the other was to use more than the single case approach of the original SFPRG research. The impact of the research on participants where psychotherapy and psychoanalysis is under study is a highly sensitive area. Taping and observing sessions through one-way mirrors has long been an accepted part of the training of psychologists and psychiatrists, but the actual impact on the patient remains unknown, and this is true of the current study. Although the taping of sessions was an accepted part of attending the University Clinic where the research was conducted, and in the community setting being asked to participate in research, with the right to decline, was accepted, the participant numbers were kept to a minimum. This is an ongoing dilemma in psychotherapy and psychoanalytic research.

The number of cases studied also had practical implications. Each case produced an abundance of data that was analysed by one researcher. Although originally it was planned to use more, three cases were analysed (see Section 6.7.1). A driving factor in the current research was an interest in testing generated by the SFPRG's work, but this exploration of testing raised for the researcher more questions than it answered[19]. For this reason a multiple-case study strategy with a different design, as described

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[18] Although Stake (1994) uses the term collective case study to describe studies that use more than a single case, the more commonly used multiple-case study was employed in this research. This provided consistency with Yin's (1993)language, given the study was designed according to his overall research strategy.
[19] It must be noted that the aim of the SFPRG was not to explore testing in isolation as occurred in the current research.

below, was employed and enabled an in-depth investigation of the concept of testing across time.

5.4   RESEARCH DESIGN

The systematic comprehensive approach to case studies formulated by Yin (2003) guided the current study. It began with an overall research design dictated by the need to link the research questions to the data, and in turn to the conclusions. This required a logical plan that incorporated collecting, analysing, and interpreting the data. Yin listed the following five components of research designs:

- A study's questions;
- Its propositions, if any;
- Its unit(s) of analysis;
- The logic linking the data to the propositions, or strategy of analysis; and
- The criteria for interpreting the findings, or techniques of analysis.

Each of these components will be addressed in detail.

5.4.1   The Research Questions

Yin (2003) stated that case study research is used where *how* and *why* questions are to be answered. *How* is a question of process and *why* a question of theory. The CMT literature provided numerous examples of how a patient might test, but few examples or descriptions of how a patient actually tested. The current research shifted the existing knowledge of testing from a predictive model to a descriptive one. Although CMT has a view of why the patient tests, in that the test determines the safety of bringing forth pathogenic beliefs so as to disconfirm those beliefs,

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which would enable the patient to see the therapist as different from his parental objects, this research re-analysed the question of "why" from an alternative theoretical model, in an attempt to further the current understanding of testing. Because of the existing work conducted by Weiss and the SFPRG, testing in sessions was considered axiomatic.

CMT proposes that all patients test the therapist which led the researcher to consider why the concept was not more widely known in psychoanalytic and psychological literature. Why, for example did Lacan refer to it in the case of Dora but not take it further? Such a question led to the idea that testing may already exist as a psychical concept occurring in therapy, but under a different name. In the preceding chapters a theoretical argument was forwarded that addressed this question and resulted in the development of a proposition to be examined through the clinical case-study data, to determine if the theoretical argument was supported. This proposition is stated in the following section. Analysing the clinical data from an alternative theoretical model also enhanced the theoretical understanding of testing. The question of process - how are tests enacted? - provided the starting point for detecting the tests. A description of this process appears below in Section 6.5.2. From this point the tests were tracked across sessions to identify patterns within the data. It was anticipated that this method would enable the answering of questions of process such as: how do tests relate to each other; how is the test initiated; and, how do tests affect the therapist and the patient? The purpose of testing will be addressed through the question of why the patient tests. An explanation for all of these questions will produce a case description based specifically on testing.

5.4.2 Propositions

The purpose of the case studies was first, to illustrate the process of testing in a clinical setting. This was a necessary preliminary step, as the existing CMT descriptions of testing were limited due to the prospective nature of the "plan" in which they were incorporated. Furthermore, they formed a small part of the development of CMT. The patient's tests contributed to an individual plan of how each patient might work in psychotherapy. The CMT model was designed to produce a comprehensive theory of psychotherapy that fitted with the current empiricist style of research models. In contrast, this thesis aimed to provide a retrospective description of the process of testing. The CMT analysis furthers the understanding of testing in its current form, and the Freudian-Lacanian analysis provides an alternative explanation for testing. Both aims address the questions of how and why the patient tests.

Two propositions were examined in the current research as rival accounts of CMT's explanation of testing. They arose after theoretical comparisons of the descriptions given in the CMT literature with both the general psychoanalytic literature and the specific Freudian-Lacanian literature identified that testing was a transference demand. It was therefore proposed that a drive-based theory offered a consistent explanation for both passive-into-active and transference testing. This idea was examined in the data and formed the first proposition: (1) The Freudian-Lacanian theory of the transference would provide a fuller explanation of testing episodes than CMT. The second proposition related to what the patient wants of the therapist in testing. CMT proposed that the patient does not want the therapist to occupy the position of parental object, whereas in considering Freudian-Lacanian theory the converse is proposed and formed the second proposition: (2) The patient

wants the therapist to occupy the position of his parental object, hence an identificatory object. This proposition was also examined in the clinical data.

Case studies require a design that fits with the direction and aims of the research. Yin (2003) described three case study designs: exploratory, explanatory and descriptive. Exploratory designs form questions for further research, explanatory designs explain cause and effect relationships and descriptive designs involve the in-depth description of a case. The current study was both explanatory and descriptive.

5.4.3   Unit of Analysis

The unit of analysis forms the *case* under study. It can be an individual, an organisation or an event (Yin, 2003). For this research, the phenomenon of testing within the therapy session formed the unit of analysis. The data constituted the transcripts of the therapy sessions, the therapist's process notes, and a minimum of background information from the therapist's assessment of the patient. The therapy sessions consisted of three individual cases of ten sessions each. Within the therapy session transcripts, the material analysed followed an orthodox interpretation of tests consistent with CMT. In this, material appearing after the test was considered an effect of the test. This followed the CMT assumption that an increase in the flow of discourse or the introduction of memories was an effect of a passed test. By implication, increased anxiety or the absence of memories or increased discourse were effects of failed tests (This is explained in Section 6.6.3.). Only discourse that related directly to, or provided information about the test, was analysed.

The participants were three psychotherapy subjects, two men and one woman, recruited by the therapists who agreed to participate in the project. No direct contact

occurred between the researcher and the patients. When the participating therapist saw a new adult patient at either the Victoria University psychology clinic or the participating community counselling service, she explained the research project and invited them to participate (consent form and plain language statement are included in Appendices B-G). The timing was at the therapist's discretion provided it occurred during the assessment phase prior to the commencement of therapy. Those who agreed were included as participants. The exclusion criteria were as follows:

- individuals who had a neuropsychological disorder,
- individuals who would not be understandable on tape for transcription purposes,
- individuals with paranoid tendencies (established during the assessment phase).

All therapist participants were trainees in the Doctor of Psychology degree at Victoria University. This course of study had a psychodynamically orientated theoretical and therapeutic base. It focussed strongly on Freudian theory and the post Freudian schools of thought. These included a range of theorists including, Winnicott, Klein, Fairbairn, Stern, Bowlby, Anna Freud and Lacan. Students were also familiarised with the cognitive-behavioural theories of therapy but to a much lesser extent than to Freudian theory. Six trainees participated, of these, two female therapists with three patients formed the final number of case studies analysed.

The data consisted of both verbatim transcripts of therapy sessions and the process notes of the therapists conducting the therapy. The data from two therapists was collected via video-taped therapy sessions conducted at the University clinic. In this setting, inconspicuous taping facilities are built into the ceiling of the therapy rooms. Data from the third participant was gathered via audiotape. The transcription

of tapes formed the data set of therapy session transcripts. Each set contained the first ten sessions of therapy.

The second source of data was the therapist's process notes. These acted as markers of specific moments that occurred in the sessions between therapist and patient that, based on CMT, represented the phenomenon under investigation. They also provided information that enabled the initial detection of the tests. The researcher asked the therapists to note in their process notes any emotive or unusual content that occurred during the session. The therapists also provided the researcher with the presenting problem and the patient's goals or goals for therapy. The therapist had gathered this information during assessment, which occurred prior to the therapy phase that constituted the period of research.

The tapes were transcribed by one person who signed a confidentiality form and was recommended to the researcher by a non-government, not for profit research organisation, familiar with handling sensitive data. Transfer of the videotapes to audiotape occurred in the University audio unit. Again, this occurred after the signing of a confidentiality form and one individual handled all tapes. The video monitor was off throughout this process to protect the anonymity of the patient. The therapist's process notes and the therapy session transcripts were then analysed.

5.4.4   A Note on Validity

Historically, the case study method has attracted criticism but, as Cook and Campbell (1979) assert that this was mainly due to a misunderstanding of the aims of case study and concerned generalisability, or external validity. A case study methodology enables the researcher to make analytic generalisations about theoretical propositions rather than populations (Firestone, 1993; Yin, 2003). Yin

argued that multiple cases enable "analytic generalizations" wherein an existing

theory acts as a template for comparison of the case study results beyond a single

case. Generalisability in qualitative case studies occurs through this link to prior

theory (Miles & Huberman, 1994), and is made more robust by a multiple-case study

design. Where two or more cases support the theory underpinning the research,

replication can be claimed, and where a rival theory is introduced but not supported

by the data, greater potency in replication can be argued for. In the current research

the rival theory was used to determine which theory produced the best explanation of

the phenomenon described in CMT as testing. Yin argued that the development of a

systematic case study methodology addressed the criticisms of external validity in

case study research. Galatzer-Levy et al. (2000) compiled a comprehensive series of

psychoanalytic research studies which illustrated generalisations across cases in the

study of the process of therapy. Consistent with Yin, Galatzer-Levy et al. believed

that a systematised approach to case study was vital to external validity. Yin set out

clear guidelines to achieve this which he based on his early research and that of

others researching in the area (see Kratochwill, 1992; Nachmias & Nachmias, 1976;

Philliber, Schwab, Samsloss, 1980).

The explanatory design used in the current research enabled there to be causal

inferences about relationships between events in the therapy sessions, based on

theoretical propositions. As Yin pointed out, internal validity is relevant only to

explanatory case studies, not descriptive research. The establishment of internal

validity was necessary in the current research because it combined both explanatory

and descriptive designs. The causal inferences made about testing in the current

research did not introduce an intervention. Instead, a tracing of the natural

progression of the therapy sessions occurred, with the therapist told a minimum

about the phenomenon under study, and the patient told only that the research explored the process of psychotherapy. (Plain language statements are in Appendices B-G) Due to the discursive nature of the therapy sessions, the particular event under study was not directly observable but evident through the discourse and its interpretation. This is consistent with interpretive studies that provide understanding of a phenomenon through the interaction of the phenomenon and its context (Williamson, 2000). The interpretation was highly contextualised and based on the propositions of the two rival theories.

Firstly, validity was addressed through triangulation of the data. The components were the therapist's process notes, the theoretical propositions and the researcher's interpretive analysis of the data. Next, the findings were presented as *thick*, context-rich descriptions of the cases. By presenting the data and the findings in this manner the reader could determine, at face value, whether the findings made sense, and were credible based on the theoretical propositions presented. By retaining the context in the description of the case the ability to make both internal and external validity claims about the research was enhanced. This was consistent with both Denzin's (1989) and Geertz's (1973) views on validity in case study research.

Although internal validity is not applicable to the descriptive case study, in this research the use of the descriptive study in combination with the explanatory study assists in establishing internal validity. As Williamson (2000) explained, "The interpretive researcher is presenting their interpretation of the interpretations of others, and the strength of analysis derives from the strength of the explanation of the phenomena based on the interpretation of data" (p.100). By basing the research on CMT's interpretation of therapy sessions, then re-analysing or re-interpreting the

sessions using an alternative theoretical model and describing this within the context of the session, internal validity was enhanced.

5.5   ANALYTIC STRATEGY AND ANALYTIC TECHNIQUES

The purpose of an analytic strategy is to demonstrate a logical link between the theoretical propositions and the data collected (Yin, 2003). Yin proposed three general analytic strategies he believed suitable to case study research. The first two, relying on theoretical propositions and thinking about rival explanations, are theory driven. The third, developing a case description is a way of organising the data along descriptive lines. Consistent with *rival explanations* the current research relied on the theoretical propositions of Freudian-Lacanian theory as an alternative or rival explanation to the existing CMT propositions. The process the analysis followed was consistent with Miles and Huberman's (1994) three-stage design of data reduction, data display, and conclusion drawing and verification.

5.5.1   Data Reduction and Organisation

A number of methods have been described that enable data reduction (Miles & Huberman, 1994; Yin, 2003) This was a vital step in the current research due to the abundance of data produced by the multiple case study design. Each case consisted of ten, 50 minute therapy sessions. In each session the test was tracked over time; for this reason Miles and Huberman's method of reducing and organising data according to its chronological sequence was employed. This temporal scheme enabled each segment of data nominated for analyses to be studied within the context of, and in

relation to, the previous nominated segment. The nominated segments were identified using Patton's (2002) *sensitizing concepts*.

5.5.2   Sensitising Concepts

Patton (2002) identified analytic induction as a technique for analysing qualitative data when the analysis is based on theoretical propositions. Patton suggested that analytic induction could occur alongside what he referred to as an inductive analysis in which patterns or themes are identified. Patton referred to "theory-derived sensitizing concepts" as a method of focusing the analysis (p. 454). These *sensitizing concepts* provide an external point of reference from which the researcher can look at the data in search of specific patterns or events. The *sensitizing concepts* used in this analysis were constructed from CMT descriptions of the effects of tests on the therapist. These effects were identified in the therapist's process notes and matched to data segments in the transcripts. This process is detailed in the following section. After data segments were identified through the process of *sensitizing* they were organised in chronological sequence and tracked across the ten sessions. This was consistent with pattern matching (Yin, 2003). From this position, and again driven by CMT, the tests were analysed in terms of causal links. This process was displayed in stage two of the analysis where each test segment was presented then followed by the dialogue relating to the effect the test had on both therapist and patient. This occurred with both CMT and Freudian-Lacanian theory. This type of analysis most closely follows Yin's *explanation building*, which is a type of pattern matching. It requires a set of causal links to be specified that will 'explain' the phenomenon. The tests were linked according to the relationship pattern they formed based on the patient's history and on the data. An iterative process

occurs where "the case study evidence is examined, theoretical positions are revised, and the evidence is examined once again from a new perspective …" (p.122).

5.5.3   Data Display

The discourse relating to the test was displayed in a contextually-rich manner. Presented in this way the reader is able to develop an understanding of the case prior to the interpretation stage of the analysis. In clinical case presentations it is usual to provide a background history on the individual case prior to reporting the material relevant to the phenomenon being presented. This model of presentation was adhered to in the current research, followed by an interpretive analysis. First, the sections of session transcript relating to the test were presented with minimal interpretation and linked with the discourse from the therapist's process notes that formed the sensitising concepts. The sensitising concepts were placed in a text box and positioned with the session transcript data to which it corresponded. In each of the three case studies this appeared as *Interface of Therapist and Patient Data*. The therapist and patient discourse is differentiated by style. The therapist text appears in the same style in both the text box and the display of session content. Where either therapist or patient discourse appears within the body text it does not vary in style from the surrounding text and is differentiated through quotation marks with the speaker nominated. Where the quotation is large it is separated from the text. Second, the discourse from these sections was woven into an interpretation of the discourse based on the principles of CMT and named *Control-Mastery Theoretical Analysis*, then repeated with an interpretation based on Freudian-Lacanian theory and named *Freudian-Lacanian Theoretical Analysis*. This form of presentation, while necessary for the adequate discussion of the two theoretical models as discrete interpretive

analyses, has entailed the repetition of data. The reader is asked to bear this in mind
wherever repetitions occur within these sections of the thesis.

5.6   INTERPRETING THE FINDINGS

The interpretation of the data involved a five-step process of analysis. It began
with a preliminary analysis designed to familiarise the researcher with the data and
was followed by an examination of the therapists' process notes. The next stage was
a theoretical analysis using CMT then Freudian-Lacanian theory as separate analyses
of the same data. A comparative analysis of the two theories was then conducted and
followed by a cross-case analysis. Each step is detailed in the following section.

5.6.1   Preliminary Analysis - Familiarisation of Transcript Data

Each case was worked on separately. The transcripts of the ten sessions were
read and re-read in an *iterative* process until the researcher was satisfied that she had
an understanding of the case (Miles & Huberman, 1994). As suggested by Miles and
Huberman memos enabled the identification of repeated material or concepts in the
transcripts, but the main aim at this point was familiarisation with the case and its
content. It was crucial to develop familiarity pertaining to the patient's presenting
problem and material relating to the patient's relationships, particularly parental
relationships as presented in the history section of the patient's psychological report.
The next step was an analysis of the therapist's process notes.

5.6.2   Therapist Process Notes - Sensitising Concepts

Each set of the therapist's process notes was reviewed for content referring to emotive or unusual occurrences consistent with CMT's description of the effect of testing on the therapist. All passages meeting these criteria were extracted and matched to the moments they referred to in the corresponding session material of each transcript. This process created an interface of process notes and transcript data, which formed the basis of the next step in the analysis. (These are displayed in each separate case study with the process note passages in text boxes) The process of *sensitisation*, which was initially informed by theory, took the form of a building process. Theory sensitised the researcher to material in the process notes, which in turn was used to sensitise the researcher to material in the transcripts. In this manner specific paragraphs were extracted, although the nature of the tests and the links between the test events were unknown at this stage.

5.6.3   Second Stage Analysis: Theoretical

Once material was matched to the process note data the surrounding discourse was reviewed. All material considered relevant to the test was extracted from the transcripts. The relevance of the material was based on CMT descriptions of a patient's discourse following a test, and discourse that contextualised the test. An iterative process was again utilised to compare the process note and transcript segments where the researcher constantly cross referenced between the two, and described the verbal interaction in each segment. This created a 'patient said, therapist said' flow of material. All data considered relevant to the test, causal or effectual, was displayed chronologically. The discourse was then reduced to patterns that enabled links to be identified between separate occurrences of tests. These

relationships were based on a theoretically driven interpretation of the data that represented the test and the surrounding discourse. First, the CMT analysis was conducted and then separately the Freudian-Lacanian analysis. The CMT analysis was conducted by interpreting the test and related discourse in terms of the patient's attempts to disconfirm a pathogenic belief . The Freudian-Lacanian analysis was conducted by interpreting the test and other related discourse in terms of the Freudian-Lacanian concept of demand and Lacan's notion of desire.

CMT predicts that a passed test should affect the patient in ways that represent the patient feeling safer in relation to the therapist. He or she may introduce memories or may display a greater flow of discourse than previously. These two effects were sought in the discourse following the tests and were used to infer a passed test. Little was said about failed tests in CMT, but by inference the opposite, that is, a stuckness or signs of anxiety, would be expected from the patient.

The specific nature of each test and its relationship to pathogenic beliefs and to the concepts of demand and desire were described in the analysis and presentation of the case studies. The causal links between the tests and their theoretically proposed effects were illustrated. These effects consisted of memories and an increased flow in the discourse. Each case study formed its own chapter. In empirical analysis the researcher describes the performance of the patient when the event under study occurred and attempts to identify the steps involved in the event (Yin, 2003). This process was illustrated in each individual case study by presenting the flow of discourse in terms of the patient's actual words in its natural or chronological sequence and interpreting this according to each theoretical model. This process was strengthened by the analysis of the patient and the therapist's responses to each other.

5.6.4   Cross-case Analysis

The multiple-case study design enabled the completion of a cross-case analysis, which increases the generalisability of the research findings. As Miles and Huberman (1994) pointed out, the process and outcome level of the study can be viewed in different environments, which provides greater descriptive and explanatory power. Whilst in the current study the cross-case analysis enabled *replication*, this was not the major consideration in deciding on the research design. The aim was not to compare the cases so much as to compare the two theoretical approaches used to interpret the data. However, conducting the interpretive analysis on more than one case did enable *replication*. Yin (2003) described this approach in terms of an initial case being examined and subsequent cases analysed to determine if the findings of the first case are also found in later cases. This research used a modified version of replication. The analysis of the first case was theory-driven and it was found that tests could be identified and patterns detected that represented a cause and effect relationship. The two subsequent cases were approached in precisely the same way to determine if the theoretical findings held across more than one case.

5.7   COMPARISON OF THEORETICAL INTERPRETATIONS

The final stage of analysis was a comparison of the two theoretical interpretations. The aim of this comparison was to identify similarities and differences found in the explanations each analysis offered. This enabled the researcher to answer the original questions of how and why the patient tests the therapist. It enabled an alternative perspective to be considered which broadened the current understanding of testing. During this stage anomalies in the two theoretical analyses were re-examined in order to determine, if the alternative theory could

provide a greater understanding of what occurred in the sessions, and to determine if this understanding of testing was consistent with the theoretical analysis of the relationship between testing and existing psychical constructs conducted in Part A.

5.7.1 Difficulties Encountered in Recruitment

For the researcher, the recruitment of participants for the study was the most difficult stage of the project. It resulted in a variation to the initial design. Originally, the multiple-case design was to include a greater number of participants. This number fell to six cases when unexpected difficulties were encountered recruiting therapists who were required to seek consent from the patients. The choice of this method of recruitment was to minimise the impact of the research on the therapy process. The research was therefore presented to the patient by the therapist during the assessment phase. All participants approached by their therapist consented to the research but approximately 15 therapists across two agencies, a university clinic and a community clinic, were approached, with only four agreeing to participate.

The collection of data took an extremely long time with the researcher spending many hours trying to meet the requirements of, in particular, the community organisation. Many meetings, examining fine detail in the protocol, occurred with supervisors of the therapists. The researcher rewrote the protocol pertaining to the research many times. Other material describing the process of the research was prepared at the request of specific individuals in the organisation. All of this material was already available and acceptable to the university clinic and the ethics committee but specific changes were required by the community organisation. At no time did the members of this organisation, who required the changes, state that they did not want the project operating through their facility. The project was presented to the

therapists as a group then again individually in an informal manner by the researcher who attended the counselling service one night per week for more than six months. During this time no therapist stated they would be uncomfortable participating, which is why the researcher continued to attend, but no data was collected. There was an overt agreement to participate but an actual non-participation. Eventually, one therapist who was collecting data at the University clinic was on placement at the community clinic and collected from both settings. This meant effectively, that no counsellors collected data. What was of most interest was the passive form of the counsellor's refusal to participate. Why they did not state their intention not to participate was and remains unknown, and is likely specific to each individual, but alerts one to the difficulties inherent in collecting psychotherapy session, transcript data.

Six cases were collected, five through the university clinic and one, as just stated, through a university candidate in a community setting. Of these six cases, three were analysed. The reduction in the number of cases analysed occurred because of the vast amount of data produced by each case, and the amount of data considered relevant to each test within each case. After analysis of the first three randomly selected cases, the researcher realised that the greatest contribution to the study of testing would be gained by focusing in-depth on fewer cases, rather than analysing more cases. The analysis of a greater number of cases would mean reducing the material to a conceptual level that would compromise the presentation of the discourse and the clear description of testing that emerged from it. The cases enabled a clear picture of process using the voices of the participants and this was considered invaluable in providing understandable case material. The discourse enabled the process of testing to be understood and illustrated. Although further conclusions

might emerge after analysing the remaining three cases, it was beyond the scope of

this study to do this at such depth.

CHAPTER 6: CASE STUDY 1 - DAVID

6.1   BACKGROUND

David was a 36-year-old man who experienced relationship difficulties and had recently separated from his second wife. He was curious to understand a discrepancy he identified between how he perceived himself, and how his wife understood him. He had an extensive medical history beginning at the age of three months when he was hospitalised for a significant intestinal tract operation. Further hospitalisations occurred over the next few years for related problems. Ten years prior to presenting for psychotherapy an accident had resulted in back and leg injuries. Five years later he was diagnosed with epilepsy. David described experiencing medical professionals as inadequate.

At the time of therapy he had returned to living at his parents' home. He experienced his mother as dominant and was both obedient to, and fearful of her. He described her as …"very hard, very determined, unforgiving", " Inflexible to a large extent.", "… she still has that streak of self-determination, domination …" The absence of any mention of his father was noticeable although his father in law, whom he referred to as the patriarch of his wife's family, was described as authoritarian and controlling; a similar description to the one given of his mother. David himself displayed the same traits he described in his mother. He recalled rebelling against her attempts to force him to attend a function when he was 16 years old. The result was a physical battle, which ended in him attending the function but walking in one door and out the other. Even though such functions were a regular part of family life he reported that he never again attended.

Throughout David's therapy a pattern typical of psychosomatic illness emerged wherein the patient sought help for psychological distress, within medical settings. Causality of the physical symptoms displayed is frequently unexplainable by medical models, thus leaving the patient experiencing, along with his or her symptoms, a continuous state of dissatisfaction. In David's case, this was all the more complex because psychosomatic illnesses were present alongside the physical disability he experienced and was treated for as a baby. The pervasiveness of illness in David's life masked the psychological level of his functioning and was evident in the excerpts from his sessions presented below.

6.2 STAGE ONE ANALYSIS: INTERFACE OF SESSION TRANSCRIPT AND PROCESS NOTE MARKERS

The following section located the therapist's process note markers within the dialogue directly related to each marker. The aim at this point is to familiarise the reader with the session content and to provide an orientation within the context of surrounding material. A minimal level of interpretation of the data is presented in this first stage of analysis

Session 1 Segment 1 (D1.1)

The following excerpt was from the beginning of David's first session of therapy. It followed a series of assessment sessions covering history taking, the administration of formal and informal psychological assessment tools, and a feedback session in the week prior to the session depicted below. At the time of these sessions David was not given a DSM-IV diagnosis. He did however, display characteristics of psychosomatic illness and in a Freudian structural diagnosis his presentation was consistent with neurosis.

Session 1 Segment 2 (D1.2)

The following segment was not marked by the therapist but was included because it demonstrated the importance of illness to David and a metaphoric link to loss. It occurred later in the first session.

David began a process of teaching the therapist about how he wanted to be treated. In the previous segment she had not answered his questions. In this segment he told her, via the example of an experience with another health professional, that he expected answers to his questions. David told a story of an experience of a dog bite which resulted in his presentation at a medical clinic. In the following excerpt, which was in relation to his visit to the doctor, David alluded to the satisfaction he derived from a visible illness. Instead of being upset at the doctor for not preventing an infection, he was pleased. The therapist, by commenting on his satisfaction, created an opening for David in which he spoke of the connection for him between acknowledged, visible, pain and discomfort, and the satisfaction of a need. David felt satisfied when his bodily ailments were named.

> David: He – from my point of view he's not acknowledging what I'm coming to him with. Okay? He's not acknowledging what I came to him with. I go to a doctor, right - For argument's sake when the animal bit me, right? Go to the doctor, right, he jabs me with antibiotics right – and he doesn't stitch it up. And I say to him 'well, you're not stitching it up.' And he says 'well we are not going to.' Right? And if I say to him, 'why?' He says 'well I'm just not going to.' What's that? What's that scenario to you?
>
> *Therapist: His professional judgment is that it's not necessary.*
> David: Okay. I say, 'why not?' And he says 'well I'm just not going to.'

Therapist: So the issue is in fact with his way of relating to you as another person?

David: Yes. Right? Now, all right? I in actual fact did ask the question and I got an answer to my question. I prefer having answers to my questions, right? answers to my questions, right? He says 'well look nowadays we don't do that because with animal bites it's been found basically that if you suture the wounds, right, the germs etcetera, what have you that are in most animals mouths, right, fester in the wound and by suturing the wound, right, you lock them in there and the level of antibiotics may not be enough to basically fight the level of infection present because of the high concentrations of bacteria in the normal mouth, whether it's a human, animal etcetera' – I've got an answer to my question.

Therapist: And you were satisfied with that?

David: I am satisfied with that – because – three days later I was in hospital undergoing surgery, even having seen my doctor the next day and him doing another swab out of the wound, more antibiotics, pills, antibiotic pills etcetera, to boost it, it did in actual fact become highly infected and I nearly lost my leg. Nice, right? But I at least got an answer to my question, right?

In what followed David spoke of a further experience of dismissal by a medical professional. This sense of being dismissed was played out within the context of physical illness where David's physical ailments were dismissed. Dismissal pervaded his style of relating to others, and was illustrated when reporting memory problems and a troublesome wrist. "Yes. It was dismissed – same way as my wrist was dismissed. I hate it." He complained that the specialist doctor did not suggest he explore alternative reasons for his memory difficulties, "But I have had to come here by myself and say – well I'll investigate this possibility". During David's assessment at the psychology Clinic a neuropsychological assessment was conducted that showed he functioned at a high level overall with no deficits in memory function.

David's frustration with his failure to find answers to his discontent was evident in these excerpts. He began to ponder his own failings along with the failure he reported in others.

David questioned his ability to adequately communicate the distress he represented at the level of the body. Unfortunately for David, real physical illness such as the animal bite mentioned above, became entwined with his search for answers in medical settings. In the following excerpt, which followed directly from the above dialogue, David expressed this frustration by asking the therapist directly about his communication style. In this, his difficulty with communicating was verbalised. The therapist acknowledged David's difficulty rather than dismissing him as not having a legitimate problem, which was his complaint of doctors and perhaps, given that this was a repeated pattern of relating, a position his parents had also occupied.

> David: You tell me (therapist's name), am I - am I – how is my capability of making what I require understood?
>
> *Therapist: I'm not talking about on a cognitive level; I'm talking about on an interpersonal level. And I'm not saying that it's your fault, you didn't make yourself understood. I'm saying that perhaps he didn't have the skill to see what you were actually looking for. And that's a skill that you could expect somebody in the caring professions to have but unfortunately often is not the case.*
>
> David: Very often it's not the case actually. But – I can – see I don't understand why. Okay that's basically the question – I don't understand why. Why would it be so difficult for him to understand that, …? What is so hard about that? I don't understand that.

Session 1 Segment 3 (D1.3)

In the following exchange, David's uncertainty about his identity was evident in his request that the therapist give her impression of him. At one level he appeared to recognise that his physical illnesses were symptomatic of something not understood. Again he questioned his part in his failure to have what he wanted, which he experienced as a withdrawal or failure of others to help him. At one level he knew his failure was a direct result of his anger and resentment and in wondering about whether as a consequence others saw him as unworthy of help, he pondered his inadequacy. In the following exchange, the therapist's reference to infancy was destabilising as evident in his comment about clutching at straws. His intention appeared to be for the therapist to comment on her experience of him, but despite his attempts the therapist did not speak of her impressions of him. Even when he asked directly she did not respond, instead she turned the question back for him to ponder.

> David: …am I such an arsehole in my dealings with doctors? No, I don't think so. I mean – well you *tell me. Am I – am I – well was I so bad as an initial patient?*
>
> *Therapist: Were you so bad as a three month old?*
>
> David: No, no. Is it perhaps – see – I'm clutching straws at all sorts of stuff. But in my dealings, for argument's sake, in the medical profession, right, I go to them and I want to have something done or looked at etcetera – am I so bad as a patient that I engender a sense of anger, resentment or what have you that they perhaps don't consider me worthwhile as a patient? That's why I was asking you. When I initially came to see you, was I so bad in my initial dealings with you that that was a scenario?
>
> *Therapist: So, as if it's possible that you are too demanding?*

David: Yep, perhaps too demanding or impolite, all the rest of it, in sort of dealing with somebody with regard to business or interpersonal relations. Am I so bad that – as I say – that I create an environment where rather than doing something for me they will do as little as possible because of the way I treat them? Now – I came to see you with an issue, right? And the question I am asking is – am I so bad in my initial – was I so bad in my initial dealings with you that that was a scenario?

Therapist: You are asking me did I think you were bad?

David: Yes, that's the question. I am asking you a question.

Therapist: Well I don't make judgements about people like that.

David: All right.

Therapist: You are asking me did I feel too demanded of by you?

David: Not as a – no.

Therapist: Well how would you answer your own question then? I mean we've got these ideas here, what do you think about them?

David: I personally don't think so.

Therapist: Then I wonder what other explanations there could be.

David: All right. That's a good point. I don't know, I don't know. I mean I hate the idea that I keep on picking crappy doctors. (laughter) It's a really sort of bad scenario from my point of view, that I constantly get lumbered with a crappy doctor. It's rather depressing.

David relaxed and laughed. Whilst the therapist frustrated his attempts to glean answers she did not frustrate David as the doctors he reported had done. He relaxed and ceased demanding answers under the conditions of her tolerance and her request that he speak.

Session 2

Therapist process notes did not indicate a test. David used the session to show his disquiet about his ex-wife. He disparaged her then presented a diatribe of supporting examples. He verbalised his sense of her controlling him and his life and gave examples through describing the events surrounding his marriage breakdown. David also described 'falling apart' in relation to feeling controlled and directly related this to his physical illnesses.

Session 3 Segment 1 (D3.1)

David began the following session by stating that he had to move from the house he was renting from his sister-in–law. Consistent with the location of his symptoms in his body, he described this as a painful physical attack, 'a kick'. Both David and the therapist were surprised by the information he presented. She that he had not told her, and he, that she did not know and/or that he had not told her.

> *He said he'd received notice from his sister-in-law to move out of the house he was in. I asked where, as I thought he was still at his parents'.*

David: Let me think. Got a bit of a kick the other day. My sister-in-law rang me up and said, 'well look, right, you are going to have to move out in March.'

Therapist: Move out from where?

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David: The house that she owns.

Therapist: So you are not at your parents' house now?

David: No. Hadn't I mentioned that?

In this and subsequent sessions, David's assumption that the therapist knew the content of his thoughts was evident. Additionally, in speaking from an assumed position, David highlighted the therapist's inadequacy. This position indirectly pointed out what she did not know by creating an expectation that she should and gave her the experience of not knowing, which is a lack but also an exclusion. In doing this, David let the therapist know something about his own sensitivities.

Session 3 Segment 2 (D3.2)

This dialogue related to Madeline, his most recent wife, and Marion, his first wife.

> *I was stunned to hear this and asked "so she knew Madeline". No, this was his first wife. I had never heard of this before and said so. David was surprised but basically kept the conversation going so I could not immediately enquire further.*

Therapist: I don't think I have heard about her.

David: Oh haven't you? Second marriage now.

The segment above was a further example of David's expectation that the therapist knew what he knew. In this sense David's fantasy of himself and the therapist as one pointed to the experience of early separation difficulties leaving a symbiotic merger. Interestingly, David had referred to his first wife in the previous

session, but it was amidst other material and went unnoticed by the therapist. He seemed genuinely surprised that the therapist did not know of her. As in the previous example David's assumption that the therapist knew about him, whether he told her or not, placed her in a position of failure in the sense that he expected her to know. Furthermore, as the therapist pointed out, this gave her an experience of exclusion, in this case, the exclusion of information. David described the same sense of exclusion in relation to his sister-in-law 'kicking' him out.

The remainder of this session consisted of David describing his sense of exclusion from his family, particularly his children, at the instigation of his ex-wife. He described visiting the family on the previous weekend, "just dropped in", he said, and was angry that Madeline had a neighbour attend whilst he was there.

> "… Bill didn't spend any time, very little time saying hi to me but he spent a lot of time being where I was. … Madeline decided, oh well we are going to go somewhere for lunch, kids. So that basically curtails the visit. They said, 'oh can Daddy come?' And she pipes up straight away, 'no Daddy's got something else to do.' Not very happy about that, not very happy about the whole situation in actual fact."

Whilst the exclusion David felt was no doubt real, given his separation from his family, he seemed reluctant to acknowledge that this was exacerbated by 'dropping in' unannounced to see his children. Turning up unannounced would provoke discontent in an already conflicted relationship and so potentially set up a forum for experiencing exclusion. David's unconscious recreation and re-experiencing of a situation in which he was likely to be excluded was indicative of his relationship pattern. It was played out with the therapist as well as within other significant relationships.

Session 4 Segment 1 (D4.1)

Much of the content of this session was about failure in relationships in David's family. Most of his siblings' marriages had either failed or were unhappy, according to David. He spoke of his relationship with his mother, which he reported was marked with hostility. David reported that he and his mother argued frequently over seemingly meaningless topics, like the colour of the couch. He described her as dominant and someone whom he was both obedient to, and fearful of.

This segment appeared at the end of session four, and in it David insistently pursued the therapist for answers to his questions about her training.

David: So how long is a student, how long are you here for?

Therapist: Oh that varies. Four to six years in the post-graduate course.

David: Gees, really?

Therapist: Mm.

David: I wouldn't have thought it was that long.

Therapist: Mm, a long time. What do you think about that?

David: Oh, I thought it would have been three, maybe four years – as a post-graduate?

Therapist: Mm, that's on top of four years.

David: Yeah, that's on top of your four years initially.

Therapist: Mm.

David: So you've got your degree and you're going for doctorate, doctorate is that right?

Therapist: Mm. Oh that's not the case for everybody. People who are full-time it would take them three to…

(inaudible comment and response)

David: So how long? Did you do full-time?

Therapist: No.

David: No.

Therapist: No.

David: Oh, you did part-time, okay. There are advantages to that though – but still four to six years, yeah.

David: (laughter – two voices together) "Well I'll play 20 questions with you sometimes."

> *I felt rather uncomfortable with the questions but did not know how not to answer, so I was deliberately vague.*

David's awareness of the therapist's reluctance to answer his questions was clear in his comment about playing 20 questions. The therapist wanted to resist the demanding quality of his questions but David persisted. In doing so, he reversed the usual therapist/patient position and attempted to take control of the session. In this he detected the therapist's resistance, which appeared to stimulate him into continuing to demand answers to his questions. Instead of the cessation of questioning which would usually be adopted when social cues indicate the speaker's reluctance to

proceed, David continued, even answering his own question when the therapist did not. The sequence of "no, no, no," and David deducing, "Oh, you did part-time," clearly demonstrated this. In an earlier session David had commented that he liked his questions answered, suggesting that attempts by another to evade his questions was a repeated experience for him. David's experiences with rejection must also be considered in this interaction. The therapist had informed him that she was leaving the clinic and could not continue to be his therapist. His response to this was to ask questions about the length of her training, as if perhaps he did not trust that determinants outside of him had brought about her pending departure. It is possible that in doing so, David had tried to determine if he had caused the therapist to leave. This was the question he had asked her earlier when trying to identify why medical doctors dismiss him.

Session 5

The therapist's process notes did not indicate a test. David spent the session retrieving memories of his mother's disciplinary action when he was a child. He reported his challenges to her authority and her lack of affection and emotion. David ended the session questioning his memory of material he had presented as factual.

Session 6 Segment 1 (D6.1)

In session six David again disclosed information he believed the therapist knew, but which in fact she did not. The meaning of this for David became clear in the following excerpt in which he spoke of his illnesses. Just prior to this excerpt the therapist inquired about David's arrangements for getting help, if needed, over the Christmas break when the psychology clinic was closed. He replied that he would see his general practitioner because he had another lump requiring excision. The

therapist was unaware of his 'lumps' and questioned. "Another lump?" David

replied, "Yeah, lumps, they are a worry. …I'll go and see him and sort of get another

slice-and-dice". Upon the therapist's inquiry, David reported, "One was benign, one

was just a cyst, this – I don't know, might be another cyst but it's getting bigger. So

yeah a bit of a worry from my point of view…" This dialogue led to the segment

below wherein David attempted to convince the therapist that he could not prevent

his illnesses from occurring and in the process reported another ailment. As in the

aforementioned segments this was information David expected the therapist was

already aware, yet again it was information he had not told her.

> *He also said that he'd had a "stroke" and was very surprised that I had not heard about this.*

David: … I mean I've had enough things sort of going wrong that – yeah I don't see proforma why it should – would – change, right. I mean I'm starting to get lumps and sort of things on a regular basis. I would imagine that that's going to sort of continue. The epilepsy is there forever, the stroke well I'm going to have to be a little bit careful.

Therapist: A stroke, what do you mean by that?

David: Didn't I mention that, that I had a minor stroke.

Therapist: I don't think so. When was this?

David: It's a couple of weeks ago now.

Along with the expectation that the therapist knew of his 'stroke', this excerpt

illustrated David's dependence on illness. The slip he made (above) when he said

'should' instead of 'would' indicated his investment in illness and suggested illness

played an important role in his functioning and would be difficult to give up. This

was further elucidated in the material surrounding the dialogue about the stroke in which David reported that a formal diagnosis of stroke had not been given, "Yes they did investigations and they didn't come up with anything either." Despite this he continued to refer to his 'stroke'. The therapist asked him a question that directed him to speaking about work but he returned to his illnesses. "So where were we going? Right, body, right. So there's the stroke, the epilepsy, sort of lumps, sort of organ failures. I'm having a good run as far as that is concerned. Yes it is starting to become a very big worry." David's need to present himself as a failed body was evident, but also evident was an element of pleasure he gained from presenting his illnesses. The parapraxes of his speech revealed this as evidenced in the aforementioned slip, but also, he commonly spoke in a facetious manner as shown above in his reference to the illnesses as, "…a good run…". The literality of such comments revealed David's unconscious.

Session 7

The therapist's process notes did not indicate a test. David spoke of his upbringing and his parents' marriage, which he had not done previously. He also spoke about other family members and used them as examples of custody access and post break-up interactions. This was evidence he used in support of reproaches he delivered of his ex-wife. In this session, however, David also spoke of himself and appeared to come closer to hearing himself in the reproaches of his ex-wife.

Session 8

The therapist process notes did not indicate a test. David spent the session reproaching his nephew. He focused on his nephew behaving childishly and dependently, which extended to his stealing from David.

Session 9 Segment 2 (D9.1)

Most of this session was spent with David again concentrating on a series of reproaches of his ex-wife. On two occasions he asked the therapist if she had any suggestions for a dilemma that related to his children. He described what he believed to be his wife's stringent control of his access to his children. "…it's six months down the track. Things have not changed a great deal. How much time does it need? Do you have any ideas?" On the second occasion he reported a conversation he had with his nephew in which he referred to 'active disobeying' in regard to what he perceived to be his wife's control of his child access visits. The active disobeying related to David entertaining the possibility of deliberately ignoring an intervention order his wife had taken out on him.

> David: Do I leave it run the course that it's currently running, or do I take into the realms of active sort of – yeah – active disobeying of what she wants, which, as I say would probably take it into the realms of having police on my doorstep, right, with accusations of kidnapping et cetera et cetera. I mean it won't stand up anywhere but its still `not funny – police on your doorstep, right? I've had it with the intervention order, wasn't really impressed with that. Anyway.

> *Therapist: Time to finish.*

> David: Do you have any suggestions?

> *Therapist: No.*

> David: I love that. (inaudible sentence in relation to staying safe).

> *When walking out he asked if I had any suggestions. I (stupidly) said just "No" which he took to be witholding and accused me jokingly of just staying "safe". It felt like (and was) a mistake.*

In the previous segment David grappled with either accepting, or rebelling against his situation and saw himself as having two options – passive or aggressive. He was fully aware of the law as he pointed out in his comment about the police, but wishfully toyed with the notion of transgression. His attempt to provoke the therapist into introducing the law, or a battle over the law was evident when he referred to her as 'staying safe'. Much of the remainder of the session was spent mulling over this notion.

> "I look at it from the point of view that about the only resolution to this would be just pick them up, right, when I feel like it from school, piss everybody off, create a big hullabaloo and basically say, 'well, hey, they are my children, there are no bloody court orders. I have every right to see my children and I'll pick them up whenever I feel like."

David's masochistic wish to be the victim was also evident in this session. Although he toyed with the idea of taking control of his family situation, it was evident that he actually preferred to see his wife as powerful and in control because this installed him as a victim. "I'm not a perfect person but – it – yeah – it feels like I am accusing all the time and sort of dumping but the bottom line is I'm really a victim…". This position was further evidenced in the description of his wife beating him while he hid behind his child, …"her bashing me around the head and shoulders while I was holding Andrew …". He made no mention of defending himself which would present him as an able male, instead he allowed himself to be beaten, again representative of a masochistic position and perhaps a sado-masochistic relationship with his wife. This session also included David reporting his wish to apply for a

disability pension. In his request to be acknowledged as ill by the State, David's wish for a symbolic recognition of a dependent position was evident.

Session 10 Segment 1 (D10.1)

David began the session describing a new illness, a painful mouth. Like his stroke this illness was not formally diagnosed. "Yeah. I went to the doctor last week; had x-rays done … they don't show any abnormalities." From describing the effects of this infliction he associated directly to the disability pension. "Yeah, eating. If I yawn, right. I have to sort of consciously sort of pull the muscles together to hold … that's a very painful experience. So, anyway, yeah, … life remains interesting on a regular basis. Right, right. I've decided that I am going to retire, with …(inaudible word)…disability pension." He then spoke of another illness, a seizure:

> *He said that this year he had had two epileptic seizures and was surprised that I didn't know – he thought he had told me.*

David: That's mainly what I've been doing yeah. In the last fortnight – I did mention that I had a seizure didn't I?

Therapist: No, no you didn't?

David: I didn't? Are you sure? You would be more sure than I would but – ah – not last week but the week before. Not a really huge seizure but – sort of I was conscious but couldn't speak properly, hot and cold sweats, staggering all over the place, hyperventilating to a certain extent, very tired after it and I had one a week before that one.

Therapist: So that's in this New Year period?

David: Yes, yes. So, right, I – that – that's sort of – my knee is waking me up again with the level of pain in it, right. I mean I – apart from accepting the

reality of my condition I have to accept the reality of the consequences, have to act on the reality of the consequences that I have to live with, right. And I can't continue to do what I'm doing, well it doesn't appear that I can continue to do what I'm doing.

Here David questioned whether he had told the therapist about a seizure he experienced. This signalled a small shift in his position from assuming the therapist knew to questioning whether she knew. But he added that she, "…would be more sure than he…", and in doing so indicated the position he assigned the therapist in relation to himself, which was one in which she knew him better than he. His lack of subjectivity was represented in his body.

6.3   STAGE TWO ANALYSIS: THEORETICAL

The following section presents the discourse of the three occasions on which David tested. They were identified by markers in the therapist's process notes and presented in chronological sequence. Dialogue surrounding each test was commented on at an interpretive level. During the analysis of the sessions certain material was identified that related and informed the test but did not fit the CMT criteria for a test. This material was included where it enabled the reader a better understanding of David and therefore the test. The analysis of the tests follows a two-phase interpretive format, the first phase is conducted using a CMT perspective, and the second follows that of the alternative Freudian-Lacanian analysis.

6.4   CMT ANALYSIS OF THE TEST

In the examples David reported of his interpersonal interactions with others he consistently portrayed himself as subservient and passive with others controlling

him. Within a CMT framework David lived his life believing he was without control and consequently experienced others as dominating and controlling. From this perspective the material was viewed as David testing to determine if the therapist would try to control him, or be threatened by his attempts to take control. The session material, however, showed David functioning in direct contrast to this view. He placed the therapist in the position in which he described himself, which in CMT is considered a test of the therapist. From David's reports of his interactions with his ex-wife he placed her in the same position as he played out with the therapist, which resulted in a misconception of how he portrayed himself as relating to others. This was consistent with his desire to know why his ex-wife perceived him as different from how he perceived himself. David's test was designed to identify if the therapist would dominate and control him. His test reversed the position of which he complained and David was viewed as attempting to control the therapist. Frequently, he disparaged his ex-wife, citing examples of her controlling him particularly in relation to access to their children. The pervasive nature of his experience within relationships was further indicated in his description of his mother, whom he described as controlling and whom he obeyed through fear. Passing his test, according to CMT, would entail the therapist tolerating his attempts to control her and not reject him. Working in relation to his ego in this way would, at the level of the ego, enable him to build satisfactory non-conflictual relationships in which he did not experience others as wanting to control and reject him.

6.4.1   David's Pathogenic Belief and Test

David's history and the experiences he reported in relationships suggest that his pathogenic belief would dictate that if he attempted to take control of his life others

would become angry and reject him. His test therefore would attempt to determine if the therapist was dominating and controlling.

This was played out verbally and in relation to knowledge insofar as David wanted particular answers from the therapist. In CMT terms this constituted a *passive-into-active* test in which he placed the therapist in the position he occupied as a child. It was the relentless and insistent style David used to try to elicit the information he wanted rather than the actual questions he wanted answered that had a controlling quality. Passing the test involved the therapist tolerating his attempt to force her to say what he wanted her to say. If she felt threatened she might respond defensively and retaliate in an attempt to prevent his bullying. The ensuing battle for domination or control is consistent with David's description of his relationship with his mother as told through an event occurring whilst he was a teenager. On this occasion David reported having fought with his mother and defeated her after she was physically aggressive toward him.

David's provocative and forceful style was repeated in three of the first ten sessions – session one, four, and nine. On each of these occasions the therapist commented in her process notes of being uncomfortable. The test was designed to determine how the therapist would respond to attempts to control her.

6.4.2   Episode One

At the beginning of the first session (D1.1) David launched into determining how the therapist would respond to force. This test of the therapist is consistent with a *passive-into-active* test in which David played the part of his parental object, likely his mother given the history he provided, with the therapist placed in the position David occupied as a child. He asked, "I'm sure that – part of the structured testing

I've had with you is designed to elicit that sort of information. So, how is that going?" In the week prior to this session the therapist had provided feedback on the results of David's formal assessment and had responded by reiterating his symptoms. He continued, "That's what I've been telling you. What do the test – what do the tests see? I mean – weren't the tests designed to sort of finding out information along those lines?" The therapist, in not answering his question had provoked further pressure, which had an insistent and forceful quality. Instead of retaliating she invited him to speak further, and more specifically. She asked him what he wanted from her and commented that he expected her to know what he did not. She remarked that he "…hoped to find out things he did not already know." Before responding David paused, as if her response was unexpected. He replied in a disjointed way, "Yes, whether there was any – sort of – I was hoping to find sort of things like the test – mental stability and grip on reality and type – things like that. I was thinking that perhaps the tests were designed to sort of elicit information such as that." The therapist then stated that she was unsure of what he wanted her to say and in saying this indicated to David that he wanted her to say something specific, of which she was unaware. In response, David replied, "Well okay, I suppose I'll have to settle for what I've got for the time being." He appeared dissatisfied with the lack of a diagnosis. The therapist again prompted David to articulate precisely what he wanted to hear by asking if he expected something hidden would emerge, a response that was again unexpected, and as it required that he think and speak about what he wanted, he became confused. His confusion was evident in the following contradiction, "… is there anything that I don't know about myself … . I mean I came in here knowing everything I needed to know about myself in the first place. … I mean what else is there? I mean what else is there?" This interaction placed David

in an unfamiliar position in relation to the therapist and indicated that he might have begun to question that his idea of knowing everything was delusory.

Effect of the test on the therapist

In her process notes (D1.1) the therapist commented that the session felt difficult to contain at times. She was irritated and defensive in response to David's persistent questioning. In saying this, the therapist highlighted her awareness of David's attempt to force her to respond in a particular way. If successful, an angry retaliation might follow which would fit with his description of the way his mother responded. In terms of CMT he required that she tolerate this attempt to control her. David's progress depended on the therapist not entering the battle he provoked. She must not respond with anger, or reject him.

Evidence of a passed test

In CMT the test episode described above (D1.1) was considered a passed test based on the criteria nominated in Chapter Five that determined tests as passed when the patient accessed memories after the test. David's memories consisted of examples of interactions with others, which matched precisely the test he had just enacted. His memories were of the recent past and were confined to health professionals and linked to his illnesses. They consisted of a series of disparaging diatribes about medical doctors intermixed with examples of his illnesses which alerted the therapist to the extent of the role illness played in his life. Eventually these disparaging remarks led David to speak of his difficulty communicating which in turn led to him testing the therapist again, but in a more subtle manner.

Effect of the test on the patient

In the series of reproaches of health professionals that followed David's test he expressed anger toward those who had not allowed him to speak. He hated the health professional who remained superior and in control.

> …at least if he had sat down and we had of had a discussion about it, all right, then I would have felt that he had at least acknowledged that 'yes you do have concerns, let's talk about something you have a concern about, in my area of expertise.' Right? And he can tell me why. He says, 'well, no, it's not a possibility.'

David's sense of not being acknowledged, which for him was metaphorically linked to his body in terms of having his illnesses acknowledged, was significant. The point at which he experienced a doctor as hearing him was the point at which he connected physical illness to subjectivity. This followed his disparaging remarks about medical professionals. (D1.2) "I nearly lost my hand. Nice, right? But I at least got an answer to my question, right?" The therapist's response to David's test had enabled him to shift to expressing the difficulty he had communicating within the medical setting and whilst doing so he checked with the therapist for the effect he had on others. He asked her of her experience of him. (D1.2) "You tell me (therapist's name), am I - am I – how is my capability of making what I require understood?" He repeated this shortly after when he asked.

(D1.3) But in my dealings, for argument's sake, in the medical profession, right, I go to them and I want to have something done or looked at et cetera – am I so bad as a patient that I engender a sense of anger, resentment or what have you that they perhaps don't consider me worthwhile as a patient? That's why I was asking you. When I initially came to see you, was I so bad in my initial dealings with you that that was a scenario?

In this material the effect of the earlier passed test in which the therapist did not enter David's battle for control was evident. David demanded answers of her but not in the same bullying style. He continued, "Yes, that's the question. I am asking you a question." to which the therapist responded, "Well I don't make judgements about people like that." This interaction had the quality of both parties attempting to understand. The therapist's response was to tell him that she would not answer his question, which as he stated earlier, was important to him. She continued by asking him how he would answer his own question. In asking him to speak further, to explain what he wanted, as in the first example above, she did not dismiss him.

6.4.3 Episode Two

In the fourth session (D4.2) David repeated the test from session one (D1.1) in which he tried to determine if the therapist would dominate and control him. As with the previous test, the current one was consistent with a *passive-into-active* test. This time the test was enacted at the end of the session rather than the beginning. He asked the therapist a series of questions about her training. "So how long is a student, how long are you here for?" David asked. Such a question is reasonable but the quality of his interest showed an underlying meaning in addition to his interest in her

training. The catalyst for his questioning was something the therapist said. She had informed him of her pending cessation of practice at the clinic, which was due to the completion of her training. David responded by asking questions about the length of her training, as if perhaps he had some doubt as to the truthfulness of her response. It is possible that David was trying to determine if the way he had been toward her was the cause of her leaving. This is consistent with his report in segment (D3.1) wherein he experienced health professionals as not wanting to help him and questioned if this was due to his manner of communication. Even so, once David began his questioning his detection of the therapist's resistance to his questions stimulated further questioning. Social cues usually dictate a withdrawal of questioning once a retreat has been detected, but David questioned further even though he was fully aware of the therapist's resistance, as noted in his statement at the end of the session. (D4.2) "Well I'll play 20 questions with you sometimes." This statement had a game-like quality, suggesting perhaps some enjoyment by David. It is possible that he believed his mother enjoyed her bullying interactions with him, but also, the sense of withdrawal experienced by the therapist was consistent with David's experience of his mother, and also, his wife's experience of him, and had resulted in her separation from him.

Effect on the therapist

In her process notes (D4.2) the therapist reported feeling uncomfortable, deliberately vague, and thought David experienced her as withholding. Whilst this was a subjective impression of David it indicated that her response was to withhold. In this interaction David adopted the position of his mother placing the therapist in his childhood position. The repetition of a previous interaction in which David as a child became angry and withholding in response to his mother's insistence, was re-

enacted as a passive-into-active test with David adopting the position of his insisting mother. The therapist was assigned the role of the child David, who felt bullied, angry and consequently withholding.

Evidence of passed test

Determining whether this test was passed or failed was not straightforward and complicated by the timeliness of the test occurring at the end of the session without any immediately following dialogue. There were two factors, however, that indicated it was passed. One was the material in the session that followed and the other was David's comment at the end of the test. In the session immediately after, David spoke about the pattern of failed relationships in his family and particularly of his memories of his relationship with his mother, which he had not done before. The new material indicated a passed test in CMT terms, however, due to the test occurring at the end of the session, the material relating to memories was reported one week later, in the next session. One cannot be certain, therefore, that the material relating to memories was a direct result of the test but it was consistent with the test. Furthermore, David's comment on playing 20 questions indicated two things, an awareness of the therapist's discomfort during the test and his own enjoyment. The series of interactions in this episode raise a question about whether the test is passed or failed. The therapist responded in a manner that she described as withholding, which is considered a failed test if David also experienced her as withholding. He would have recognised his own childhood want to withhold from a demanding mother. The therapist, however, did not become angry and try to fight with him, which was his experience of other relationships since the relationship with his mother. Instead, she tolerated his questions which provided him with a new

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experience. If one works from the premise of a passed test being one that gives the patient an experience different from that of the parental object then this test was a passed test.

Effect of the test on the patient

Session five followed immediately after the previous test. In this, David recalled childhood instances of his mother's disciplinary action. He reported challenges to her authority, and what he perceived to be her lack of affection and emotion. At the end of the session, David questioned his memory of material he had previously presented as factual. As in episode one of the tests, David spoke of experiences with others that were the same as the experience the therapist had in the test. In episode one these were experiences with health professionals, in episode two they were experiences with his mother.

6.4.4   Episode Three

In session nine (D9.1), there were two interrelated test episodes only one of which was referred to in the therapist's process notes. The sensitising concept referred to in the notes came at the end of the session, but an earlier, similar interaction in session nine was indicative of a test very similar to the latter one. By describing it one can see how David gathered information about the therapist that led to the later test. For this reason, it was considered a preliminary step to the latter test and therefore included.

As in the previous tests, David again tried to see how the therapist would react to his attempts to force her to respond according to his wishes. His mother had used

this method and it had resulted in conflict and his mother's eventual domination of him. On this occasion, instead of provoking a battle so as to force the therapist to adopt the position David usually occupied, he checked first to determine if she would give advice. Then, when she did not, he tested more aggressively (in the second part of the episode) to ascertain, if by offering her a choice of positions, she would adopt one. Either of these positions would trap the therapist in a situation that would then enable David to try again to provoke conflict.

Preliminary test

In the preliminary episode (D9.1) David asked the therapist for suggestions about how to handle what he described, as his wife's stringent control of his access to their children. "…its six months down the track. Things have not changed a great deal. How much time does it need? Do you have any ideas?" The therapist responded that she did not know. Unbeknown to David he followed this complaint of 'things not changing' with an example of change that occurred in his relationship with his wife. In reporting this David inadvertently revealed his contribution to his relationship difficulties. Earlier he had complained of the requirement that he give notice prior to visiting his ex-wife and children. On the occasion reported below he arrived unannounced, rationalising that he would be expected on his son's birthday. His wife's civility surprised him. David remarked:

> (D9.1) …she was probably expecting me yesterday because it was Andrew's
>
> birthday so I had no argument about the fact that I hadn't made an
>
> appointment, right? We spoke civilly to each other basically, 'hi, how are you

going?' 'Oh okay' and that was the extent of the conversation apart from her offering me a cup of tea, me accepting it, thanking her for it…

David's comments suggested he expected an argument from his unannounced arrival, and he had his counter argument ready. He did not want to abide by the rules established in relation to access and therefore risked sabotaging time with his children and potentially further damaging the relationship with his wife. Even though he was unable at this point to realise his provocation of his wife, he did not act out this process with the therapist as he had in earlier examples; instead, he spoke of provocation via a past experience, in itself indicating a level of recognition on David's part. Instead of giving him advice, or an answer he did not want to hear, the therapist let David know that she did not have answers. From this position he became more articulate in relation to reproaches of his ex-wife, which brought him a step closer to hearing his self-reproach.

Effects of the preliminary test on the patient

Much of the session after the preliminary test was spent with David continuing to complain about his ex-wife, Madeline, for being the one in full control of the children. Amidst this he reported a feeling of being without control in relation to his ex-wife and children. He informed the therapist that his parents gave him advice, but he recognised this as bad advice and did not implement it. This was consistent with the preliminary test in which he attempted to elicit advice from the therapist. In not giving advice the therapist had enabled David to recall and articulate an instance of advice giving. Would she, like his parents, give him advice that he could then reject due to feeling the advice giver was controlling him? His parents suggested he take

over the house he had shared with Madeline and the children and change the locks to exclude her. He would then have his children, they reasoned. He realised this would be unfair to the children, but still toyed with the idea of taking them from school to, "see what would happen." Again, he presented a quandary and looked to the therapist for advice, but in doing this, he attempted to see if she, like his parents, would collude with him against his wife. He described his lack of control and Madeline's complete control, again in relation to child access, which also highlighted his wish to transgress boundaries.

I don't go around there because I'm told to piss off because I haven't had appointments. I ring and the times that I've rung to say, 'look I want to be coming around' – 'oh we are going out.' Well where do I stand? If I ring to say 'well look I want to come around' 'oh look we are not going to be home' what's the point of ringing, right?

David did not identify that his opposition to the rules of access exacerbated his lack of access. But he did begin to hear himself in his complaints of his wife. "I'm not a perfect person but – it – yeah – it feels like I am accusing all the time and sort of dumping but the bottom line is I'm really a victim…" His reference to his position as a victim marked considerable progress, as he could hear his complaints of his ex-wife. Eventually, if he was to cease placing his ex-wife in the position he believed his parents occupied when he was a child, he might become aware of his role in perpetuating his position as the one who feels like a controlled and powerless victim.

6.4.5   Episode Three: Main Test

At the end of the session (D9.1) David tested again by attempting to manipulate the therapist into one of two positions. He gave her a choice of either colluding with him against the legal system and his wife, or advising him to remain in his current position wherein he felt powerless and controlled. David said:

> Do I leave it run the course that it's currently running or do I take into the realms of active sort of – yeah – active disobeying of what she wants, which as I say would probably take it into the realms of having police on my doorstep, right, with accusations of kidnapping etcetera etcetera.

The therapist did not respond, instead she signalled the end of the session and David added, "Do you have any suggestions?" "No." replied the therapist." David concluded with, "I love that."

Effect on the therapist

The therapist was aware of David's attempt to manipulate her into giving advice. In her process notes (D9.1) she reported, "When walking out he asked if I had any suggestions. I (stupidly) said just 'No' which he took to be withholding and accused me jokingly of just staying 'safe'." David's reference to staying safe indicated his familiarity with having drawn others into a precarious position from which there was the possibility of regret. By inviting the therapist to tell him what to do, he relived the position he complained of in his relationship with his mother. He spoke of obeying her out of fear until he reached a point of disobeying her, wherein he fought her and won. His examples of his ex-wife's behaviour also demonstrated

his wish to disregard the access arrangements, which would potentially incite conflict. In order to provoke the same with the therapist he must entice her to instruct or advise him so that he can disregard or oppose this. The therapist, however, did not do so and he accused her of remaining safe, thus acknowledging the dangerous position he tried to elicit.

Evidence of a passed test

Like the previous test, this test occurred at the end of the session where there was no immediate subsequent material to establish the test as passed or not, according to the CMT guidelines. The following session (D10.1), however, began with David talking about illness and contained an episode wherein he revealed an illness of which he expected the therapist knew. It is explained in detail in Appendix A. In CMT terms this could be considered new material but it was not of the nature of the memory-based examples of reproaches that followed the previous tests. Although similar to the previous tests this test was more subtle. It could constitute a passed test in that the therapist did not react in the way his parents had done in David's early life, or as his wife did in more recent interactions. David's wife did not attempt to dominate or take control even though he attempted to elicit this. Presenting these tests at the end of the session may be significant but one would need more than the ten sessions available in this study to determine this. It may be a safety mechanism for David in that the *passive-into-active* test was risky and so if it went awry he could escape, literally, out the door. Opportunism was also a possibility. In vigilantly detecting the therapist's resistance toward his asking of personal questions, he reacted, just as he described his mother had. But also, the pursuit of answers to

questions at the end of the session extended the session. The questioning, therefore, could be perceived as difficulties David had with separation.

Effect of the test on the patient

At the beginning of session 10 (10.1), which followed the previous test, David described his mouth as a new source of pain. No formal diagnosis was obtained for this illness, "Yeah. I went to the doctor last week; had x-rays done … they don't show any abnormalities." David detailed his symptoms along with emphasising the pain his mouth caused him then informed the therapist of his plan to cease work and apply for a disability pension. Illness dominated this session with David also reporting a seizure he had experienced recently, and at one point he presented a list of the illnesses and pains he lived with. By showing David that she would not try to dominate and control him, the therapist had provided David with a new experience. The result of this appeared to be an attempt on David's part to let the therapist know about the extent of his pains. It is possible that he attempted to determine if the therapist was someone who could tolerate his inept body because she had tolerated his attempts to dominate and control without becoming dominating and controlling, or dismissive as he reported others having done.

6.4.6 CMT Summary

This series of tests showed David's attempt to determine if his exertion of strength threatened the therapist. Consistent with a CMT formulation he did this to determine if she, like his mother, would fight to dominate and control him. His experience of others in control, such as doctors, was of a dismissal, often before

acknowledging his illness or pain through which his self-identification as a 'failed body' was represented.

At a process level the first test, a *passive-into-active* test, when passed by the therapist resulted in David recalling memories. These were recent memories of his experiences with doctors and were exhibited in the form of reproaches. The sessions between this and the following test were filled with descriptions of his illnesses and examples that depicted him as a man dominated by his ex-wife which enabled him to subsequently portray his sense of victimisation. The next time David tested, another *passive-into-active* test conducted in precisely the same way as the first test, it was possible to identify a manufacturing of the test. He asked a direct personal question of the therapist and as soon as he detected her hesitancy, or as she reported, her withdrawal, he became insistent and doggedly pursued her for answers. David appeared to believe that he was in a dominant and controlling position in relation to the therapist. The following sessions were spent speaking of illness, and of his ex-wife's domination of him.

A third, *passive-into-active* test, was enacted, but this time David varied it slightly. In the two previous tests David's experience with the therapist was different from his usual experience in relationships, in that neither a battle nor a rejection ensued, although a retreat was evident. On the third occasion, he employed a more sophisticated version of the test. Even though he tried to manipulate the therapist into choosing to support him, or oppose him by supporting his wife, the test did not have the bullying quality of the previous two tests. Also, the therapist stopped any further questions by saying 'no' to him.

The progress evident in tracking the tests showed a shift from the initial bullying style of testing, to a more sophisticated form. Both styles appeared to have the same

aim, which was to dominate and determine the therapist's response. Consistent with CMT, David retrieved memories after each passed test. Table 1 summarises the effects of passing David's passive-into-active tests. Interestingly, the retrieval of memories began with recent memories and, as the sessions and the testing progressed, he moved to earlier memories. The content of the memories described precisely the position he had attempted to bring about in the test, but the role of David was played by a sequence of other people just as he had assigned the therapist this role. That is, his reproaches of others that followed the tests were unrecognised descriptions of himself. The others included his ex-wife, doctors, his nephew and his siblings. His mother also belonged to this category but at this early stage in the therapy he was disparaging of her.

Table 1. The effects of David's tests

EPISODE	SESSION/ SEGMENT	TEST	THERAPIST RESPONSE	PATIENT RESPONSE
1	1.1	Passive/active	Passed	Expresses memories/reproaches
2	4.2	Passive/active	Passed	Expresses memories/reproaches
3	9.1	Passive/active	Passed	Expresses memories/reproaches

Overall the process of testing in the case of David was as follows:

- Tests could be tracked throughout sessions and were repeated across multiple sessions.

- No two instances of a test were identical but all had an underlying theme that could be linked to the patient's pathogenic belief. Each test had an idiosyncratic presentation that utilised the specific content of the session.

- Tests utilised the *passive-into-active* test mode. No use of the *transference* test occurred.

- *Passive-into-active* testing was aggressive and used when the patient wanted to provoke conflict.

- When the test was passed, new, more manipulative versions were enacted.

- Passed tests produced an articulation of the test episode in the form of reproaches of others.

- Tests were either set up by the patient or triggered by session content in relation to the therapist's words.

- The therapist was verbally *coached* through examples of others' responses as to how to respond to the test in the way the patient wanted.

6.5   FREUDIAN-LACANIAN ANALYSIS OF THE TEST

The following section presented an alternative interpretation of the transcript data using a Freudian-Lacanian analysis. In this analysis the episodes that were determined as tests by the sensitising concepts described in Section 6.5.2, were consistent with demands in the transference. It is from the perspective of demand that the following section is analysed. At the risk of repetition the data will be returned to in order to connect with Freudian-Lacanian ideas.

6.5.1   Episode One

David, in the first session (remembering this is not the first contact given the assessment process that preceded therapy) demonstrated the beginning of the transference in terms of the subject supposed to know, as described by Lacan (1964/1998). He demanded the therapist release what he suspected she knew about

him. He expressed disappointment when she told him there were no significant impairments other than those of which he was already aware. David was not satisfied with this response and perceived the therapist to be withholding information. At the very moment he heard what he did not want to hear, he launched into a series of questions. (D1.1). "That's what I've been telling you. What do the test – what do the tests see? I mean – weren't the tests designed to sort of finding [sic] out information along those lines?" David persisted and pressured the therapist but was unable to say exactly what he wanted from her. She invited him to speak further, and more specifically. She asked him what he wanted from her, and he repeated, "What else is there?" He seemed to want a diagnosis, or at least a description of an illness, but could not articulate precisely what he wanted only that it was something he believed he did not already have.

The therapist's experience of the transference demand

The therapist commented in her process notes (D1.1) of feelings of irritation and defensiveness in response to David's insistent questioning. Difficult as it was she did not respond with anger, nor reject him, which, as he had pointed out, was his usual experience - the therapist's response to David's test appeared to offer him a new experience, which was of someone who would be neither threatened nor bullied, nor fight him. Instead, she would listen and ask him to speak. Functioning in the transference, David had checked to see if she too was a bully like he described his mother, and like he had been with the therapist.

The effect on the patient of a frustrated transference demand

After the therapist stated that she did not know what he wanted her to say he

ceased his demand which he signalled by stating, "Well okay, I suppose I'll have to

settle for what I've got for the time being." The therapist's response appeared to be

unexpected and resulted in a cessation of his insistent questioning. This was

significant in that his demand, constructed as both persistent and insistent

questioning, was designed to find out something about the therapist and asking David

what he wanted of her reversed this position thus ceasing his demand. The therapist

had jolted David into a subjective position of considering what it was that he wanted

and this brought about a cessation of questioning.

As a result of the therapist frustrating David's demand that she argue with him

over his symptoms, he ceased his demand which led to him verbalising a series of

reproaches, and, through a series of reproaches of health professionals after the test,

he verbalised his usual experience. Amidst this, he acquainted the therapist with the

vital role illness played in his life, thus connecting illness to identity. He reproached

those who he believed did not enable him to speak, such as the doctor in the

following passage:

> …at least if he had sat down and we had of had a discussion about it, all right,
> then I would have felt that he had at least acknowledged that 'yes you do
> have concerns, let's talk about something you have a concern about, in my
> area of expertise.' Right? And he can tell me why. He says, 'well, no, it's not
> a possibility.'

David's sense of subjectivity was registered at the level of the body and he had

learnt that the only form of recognition of his pain was obtained through the

validation of his illnesses. He was therefore furious with medical professionals who did not acknowledge his pain or illness. In the following example (D1.3), the importance of linking physical illness with speech in defining David, in giving him a sense of identity, was evident. "I nearly lost my hand. Nice, right? But I at least got an answer to my question, right?" This material was available after the therapist tolerated his demands rather than reacting angrily or dismissively to his persistence.

6.5.2   Episode Two

A further development occurred toward the end of the session wherein the requirement for David to speak elicited a consideration by him of his own part in his discontent with doctors. This had the same insistent demanding nature of the first moment and began with David trying to force the therapist into stating her experience of him. David showed clearly that he had a level of awareness of his effect on others. He asked, (D1.3) "am I so bad as a patient that I engender a sense of anger, resentment or what have you that they perhaps don't consider me worthwhile as a patient? ". When the therapist responded, "You are asking me did I think you were bad?" David insisted, "Yes, that's the question. I am asking you a question." Clearly, David had placed the therapist in a difficult position by insisting she report to him her experience which was exactly as he stated, he had engendered anger and clearly many of his physical ailments were psychosomatic, therefore one could identify with the medical doctors who treated him the way he reported. The therapist did not answer his question, but again asked him to speak.

The effect on the therapist of the transference demand

After attempting to identify precisely what David wanted her to say, the therapist turned the question back on David, "Well how would you answer your own question then? I mean we've got these ideas here, what do you think about them?", he responded that he did not agree and the therapist asked, "Then I wonder what other explanations there could be." In the therapist's response she asked David why he thought doctors treated him the way he reported them doing. Thus, his demand for answers from her was unmet or frustrated.

The effect on the patient of a frustrated transference demand

As in the first test, this question to David resulted in a cessation of his demand that the therapist answer him and he responded, "All right. That's a good point. I don't know, I don't know, I mean I hate the idea that I keep on picking crappy doctors. (laughter)" David's laughter indicated that he enjoyed this interaction; however there was no laughter from the therapist. It was a one-sided enjoyment. Although this test was presented in the same manner as the previous test, the content showed David's awareness of the demands he had made of others. He had verbalised his effect on others whilst enacting this with the therapist. It was possible that his experience in the first test, wherein the therapist failed to act according to his repertoire of experience, meant a space had opened for him to consider his part in such interactions. This test had occurred at the end of the session. In the following session David disparaged his ex-wife and delivered examples of her controlling him and his life by describing the events surrounding his marriage breakdown. David also described 'falling apart' in relation to feeling controlled and directly related this to his physical illnesses.

6.5.3　Episode Three

In session four, the sense David had of others resisting his questioning was relived. David, at the end of the session asked the therapist questions about her training which had the same quality of insistent demands described in session one. David was aware of this pattern of questioning and of the therapist's resistance as evidenced in his comment (D4.2) "Well I'll play 20 questions with you sometimes." As soon as he detected resistance, which informed him of what the therapist did not want, he sprang to life trying to thwart this. Instead of trying to satisfy the therapist by retreating, he did the opposite. This was reminiscent of a fight he described with his mother in which he rebelled against her wish that he attend a family function. Here again, David tried to determine if the therapist was like his parent which was also the way he was. If he could provoke the therapist he would be pleased, but this had generally led to his dismissal, or at least not having his questions answered. He assumed the therapist wanted him to oppose her and create conflict as he believed his mother had wanted, and as he wanted. Again, he did the opposite of what he believed she wanted, which was to stop asking questions. If he determined what she wanted, he could withhold it from her, which would, he believed, provoke a fight. In David's mind, this was equivalent to giving her what she wanted. The transference demand therefore was to determine if the therapist would withdraw from his questions, questions he wanted answered, but more importantly, the withdrawal would signify that she did not want what he demanded: a response that would also signify the potentiality for conflict.

The therapist's experience of the transference demand

The therapist reported in her process notes (D4.2) that she had experienced discomfort at David's insistence and was deliberately vague and withholding. Her discomfort and resistance to David indicated that he had attempted to force her into responding to him in a particular way. That she resisted this, prompted David to state that he was playing with her, which was evident in his '20 questions' comment. In this interaction, the therapist did not respond in a way that invoked a cessation of David's demand but she did not battle with him either. Because this segment occurred at the end of the session, what followed remains unknown.

The patient's response to the transference demand

David's response to the therapist's resistance was to deliver the '20 questions' comment, which stated that he detected her resistance. It also suggested that he had enjoyed himself with her and would return to this type of interaction. In session five, which was the next contact with the therapist following his '20 questions' comment, David spoke about his mother in terms of the battles they had over discipline. He particularly recalled an episode that resulted in physical aggression, but which he stated he had won. He also described his relationship with his mother as built on arguments over meaningless matters. Whilst engaged in verbalising previous experiences of argumentative interactions that likely stemmed from David and his mother's demands of each other, David did not make further demands of the therapist. It appeared that the ability to verbalise the earlier event with his mother was enabled by the therapist's response to the previous transference demand and transcended the need further to enact the demand in the session with the therapist. That the therapist did not fight or argue with David appeared to be the significant aspect of this demand. This was what he described in his relationship with his

mother; it suggested that David's demand to have his questions answered was combined with a demand to fight.

6.5.4 Episode Four

In session nine, David made two transference demands, both of which ceased to have the overt aggressive quality of the earlier occasions. As mentioned in the CMT analysis of the tests, only the latter of these two episodes was referred to in the therapist's process notes. This was likely due to the former, although clearly related to the latter in content, was subtle and therefore did not have the same effect on the therapist as the other episodes. It was mentioned here mainly because of the material that followed it.

In session nine, David shifted to employing a more sophisticated, albeit manipulative manner of determining if the therapist would respond to him in the same way as his mother had. He attempted to elicit suggestions or advice on the management of his access arrangements with his children. (D9.1) "…it's six months down the track. Things have not changed a great deal. How much time does it need? Do you have any ideas?" In this presentation, David had requested an opinion from the therapist, which would tell him something about her. His usual mode of relating to others had not enabled him to identify the therapist as someone the same as those in his previous relationships, which he extended to medical professionals, and this appeared to bring about a change in the quality of the demands evidenced in this session. The therapist responded to David's request for ideas about relationship breakdowns by stating that she did not have an answer to his question, "Well I don't know" she responded. Had the therapist offered suggestions, she would have

revealed something of herself and given him something to work against in the same way as he had worked against his ex-wife, as he revealed in the material that followed immediately from the therapist stating she had no suggestions.

The material that followed clearly depicted David's investment in provoking conflict. (D9.1) He described how he had arrived unannounced at his ex-wife's house and was surprised when she was civil to him, even offering him a cup of tea. Knowing that his child-access arrangements required that he give notice prior to seeing his children, he flouted this and arrived, armed with the excuse that it was his son's birthday. David's surprise that his ex-wife was civil indicated his expectation that his behaviour would produce a different response. The previous experiences with the therapist that differed from his expected responses seem to have enabled David to recall an occurrence with his ex-wife that was also different from what he expected, which was her civility. He then entered a series of reproaches of his ex-wife that continued for much of the rest of the session.

David focussed on disparaging his ex-wife for what he perceived as controlling his access to their children. He delivered further examples of his provocation in his 'kidnapping' fantasies (D9.1), but then began to hear himself. Initially he toyed with the idea of kidnapping his children from school, to, "see what would happen." In delivering these fantasies he could disparage his ex-wife for not enabling him access. But his reproaches, as unrecognised reproaches of himself, were evident in the qualification he gave, "I'm not a perfect person but – it – yeah – it feels like I am accusing all the time and sort of dumping but the bottom line is I'm really a victim…" Evident in this statement was David having heard himself in his accusation, but also evident was his desire to be the victim. The demand the therapist

reported in her notes consisted of a return to the same kidnapping fantasy reported here.

As in the previous '20 questions' episode, David again enacted the transference at the end of the session. He tried to have the therapist choose between siding with his ex-wife against him and colluding with him in his thoughts of ignoring access rules around his children. (D9.1) David began this episode by presenting the therapist with two options and whilst doing so, inadvertently revealed his investment in conflict. He called this, "active disobeying" and the reference was made to him disobeying his ex-wife. It was an enlightening comment in regard to the position David had occupied in relation to his ex-wife as the word disobey is not usually used between peers, but reserved for parent-child type of relationships. David had related to his ex-wife as he had to his mother, and as he was trying to relate to the therapist. The therapist did not respond, instead she signalled the end of the session and David added, "Do you have any suggestions?" "No." replied the therapist. David's immediate response to the therapist's 'no' was, "I love that." At this point, the therapist and David were walking from the room and David added accusingly that the therapist's 'no' represented her staying safe. In this, David had acknowledged the compromised position he was trying to elicit from the therapist. The demand was a demand to tell him what to do, which he could then disobey.

The therapist's experience of the transference demand

The therapist in her process notes (D9.1) identified David's provocation. She reported, "When walking out he asked if I had any suggestions. I (stupidly) said just "No" which he took to be withholding and accused me jokingly of just staying "safe"." Evident in this report was the pleasure David obtained in provocation. Furthermore, he was fully aware of the therapist remaining outside of his

manipulation. The therapist's reference to feeling stupid in this interaction is also indicative of David's attempt to manipulate her and play with her as one would an object.

The patient's response to the transference demand

This episode was the last in the series of ten sessions included in this research. It was not possible therefore to know what occurred subsequently.

6.5.5   Freudian-Lacanian Summary

Two significant points arose in relation to the enactment of the transference demand. They related to the beginning and the end of the enactment. First, David began to make demands of the therapist when he either imagined something in the interaction with the therapist that was familiar, or actually detected something in the interaction that was familiar. Second, he ended the enactment when he experienced the therapist as unfamiliar. Like an automaton his perception of the therapist as withholding triggered his demand that she reveal whatever he believed she had. Also, when he was asked by the therapist to reveal what he wanted his demand ceased.

At the level of process the demands showed David attempting on three occasions to determine something about what the therapist wanted; what would please her. On the first two occasions he showed that he was overtly bullying in the hope that, paradoxically, by doing what the therapist did not want, she would conflict with him; which, based on descriptions of his relationships with significant others, was what he believed she wanted. This was a pattern in David's functioning constructed from his relationship to his mother. Upon detecting the therapist's resistance, which represented her wish that he cease questioning, he did the opposite

and pursued questioning in an insistent manner. He did precisely what the therapist did not want. This same pattern was evident outside of the therapy session. From what he had said of his experiences with medical doctors, he was unhappy when they did not listen to him and he often felt dismissed. He complained that his questions were not answered. From his enactment in the therapy session one could see how this eventuated. David's aim was to thwart both the therapist's and the medical doctor's desire, which he had mistakenly believed were the same as his mother's desire. At the level of fantasy, it is possible to consider that David imagined the therapist wanted to be angry and displeased with him, and therefore enter a fight with him. He then set about fulfilling this wish by providing himself as someone to fight with.

On the first occasion of David's demand, his questions were about his person and he wanted to hear something particular about himself. Asking him to think about what this was had the effect of ceasing the questions. On the second occasion, the questions were about the therapist. He wanted her to reveal something of herself. David's enactment was opportunistic in the sense that he bullied the therapist as soon as he detected her hesitation, which was his signal that she might be the same as his mother. On these two occasions, he was unsuccessful in eliciting a conflictual relationship with the therapist.

By the third occasion, he had changed the manner he used to invoke conflict, likely because by now he had established that she would not conflict with him in response to his bullying. This time he attempted to manipulate her into a conflict in a more subtle manner by giving her a choice of siding with him, which would have been to collude in breaking the law, or against him, which would have given him the opportunity to conflict. Had this occurred David would have identified that perhaps after all he could identify his mother in her.

The enactment of the transference demand was therefore conceptualised as a method used to determine if the therapist was the same as David's mother, and hence the same as himself. He expected she was, and provocatively attempted to manipulate the sessions to have her reveal this. When she did not comply, thus, when there was no preconceived pattern of relating, but something different, David spoke through a series of reproaches of the very situation he had attempted to provoke. He spoke of conflict in a number of relationships: with his wife; within his extended family; with his nephew with whom he lived; and with his mother in the past. He also informed the therapist through his stories of dissatisfaction with his doctors of what it was like for him in interactions with others, wherein there was no acknowledgement of him, and consequently felt dismissed or rejected. Evident at one level was the failure of the medical doctors to recognise the psychological basis to his continual presentation in medical settings, and at another, his investment in physical illness through a link to a failed sense of acknowledgement. This was a failure of subjectivity at a fundamental psychical level.

From David's description of his mother as someone whom he obeyed out of fear, one could assume his fear stemmed from experiences of the effects of disobedience, thus suggesting a sadistic component to his mother's relating. His description of his mother dragging him down the stairs by his hair at age 16 was further evidence of this. David's mother appeared to derive some pleasure from battles with her children and David assumed the therapist also wanted this. What he was yet to comprehend was the sadistic pleasure he derived from this position and its masochistic counterpart of the helpless victim to another's domination. Each time he was unsuccessful in bringing about the position in which the therapist did not dismiss him or enter a battle with him, he was able to go further in describing his experiences

and he began to hear himself and question his role in the predicaments in which he found himself within relationships.

David's demand related closely to desire. By nature of his attendance in therapy it was known that the position David occupied in relation to the Other, caused him unpleasure as well as pleasure, for example, his failed marriage and the loss of his children were disappointments to him. Paradoxically, this was the very position David wished to maintain because in it, he could believe his infantile wishes were realised. Although these were wishes relating to him and his mother being the same in terms of identificatory objects, the maintenance of such wishes was at the expense of enjoyment in adulthood. Whilst he wanted therefore to see if he could adopt the same position with the therapist as he did with his mother, his progress, as evident in the analysis above, was in experiencing the space that existed between himself and the Other, which emerged when the position he attempted to bring about did not eventuate. In this space David had room to think and speak. For David, however, the wish that he and his mother, and in therapy the therapist, were identified with each other suggested a failure at the level of separation, which was extreme. An analysis of this area of David's functioning appears in Appendix A. It is included because it adds to the understanding of David as a patient who experienced significant difficulty at the levels of alienation and separation.

6.6   COMPARISON OF CMT AND FREUDIAN-LACANIAN THEORETICAL ANALYSIS

The main difference between the two models was evident in the theoretical explanations of David's provocative behaviour. In CMT his provocation was considered a test to determine if the therapist was harmed when he displayed

strength, which manifested in conflict. He therefore needed the therapist to tolerate this provocation so that he could see that his strength did not harm her. In Freudian-Lacanian terms his provocation was an attempt to fulfil an unconscious wish relating to desire in which he believed that he was the one who could please or satisfy his mother by giving her what he imagined she wanted. He believed she enjoyed conflict; therefore, he enjoyed deliberately provoking conflict so as to please her, hence himself. David attempted to recreate this position in others. Whilst David had an investment in this pattern of functioning, he was miserable and discontented with his life, which was why he sought help in a clinical setting. The dual operations of investment and misery that David lived with reflect the duality of the psychical functioning of conscious and unconscious processes. They also reflect the opposition of the two theories used to analyse David's sessions. CMT focused on the misery and discontent, but not the investment, whereas Freudian-Lacanian theory acknowledged the misery and discontent but focused on the investment.

In Freudian terms the CMT formulation of testing is consistent with a defence against the wish to conflict, which is a defence against the aggressive drive and against knowing one's desire. That the formulation of a case using a theory of defences sits in opposition to a formulation based on a theory of drives and desire is therefore no surprise. This is not to say that one theory encourages gratification of the drives, only that the aim of the therapy is the discovery of one's own drives and, also, of what one wants. This is not to say that satisfying or meeting those desires is emotionally, physically, or socially healthy, but that one is responsible for one's choices and not led blindly by one's defences.

CHAPTER 7: CASE STUDY 2 - BOB

7.1   BACKGROUND

Bob was a man in his 50s who had separated from his wife of over 20 years. They had four children in early adulthood. During the course of the therapy he lived with his new partner but maintained the pretence of living in accommodation at his workplace. He wanted to fulfil his responsibilities to his family and continued with full financial support, although he was beginning to resent this. Bob presented in psychotherapy wanting to take control of his life. He was bemused as to how his relationships with his wife and children had disintegrated, particularly when he still made all attempts to be helpful, participate and to attend generally to his family responsibilities. Despite these attempts, he felt ineffectual in his relationships, both within and outside of the home, and was concerned that his current relationship would also fail. Bob described his father as an alcoholic and Bob himself drank to excess. His mother raised her children with little support from his father.

7.2   STAGE ONE ANALYSIS: INTERFACE OF SESSION TRANSCRIPT AND PROCESS NOTE MARKERS

The following section presents excerpts of the dialogue between Bob and his therapist at those points in the session where the therapist's process notes indicated the presence of an emotive or demanding moment in the session. Material from the therapist's process notes were italicised and placed in a text box to distinguish them from the surrounding dialogue. The aim at this point was to familiarise the reader with the session's content and orient within the context of surrounding material. This involved, where necessary, the inclusion of further relevant dialogue not used as part

of the test sequences, but essential for background to the dialogue appearing in those sequences. A minimal level of interpretation of the data occurred at this first stage of analysis.

Session 1 Segment 1 (B1.1)

> *It felt as though he wanted reassurance from me that he was in an acceptable 'category'. I resisted this at the beginning.*

Bob: And I want to remember. I want to remember and I suppose concentrate on the parts where, I don't know, I didn't sort of reach standard or something or, was different or out of sync. So why did that happen?

Therapist: I don't quite follow. Things that.

Bob: I'm trying to remember.

Therapist: Some things didn't quite feel right is that what you're saying? Ok

Bob: Yeah, yeah, yeah. And I just can't recall what they, which ones they were. Like dealing with the stress, I know I get stressed, but only one person can fix it and that's me. I know that, I recognise that. I have to deal with that situation. um, I suppose, oh, what did you say a couple of weeks back, (long pause) Maybe we'll look at me. I think it was words to those effect. Yeah my answer was, well I don't think I've ever looked at me. And I want to look at me to say well, will that help me understand why I am, the way I am, sort of thing, and what's been worrying me.

Therapist: What's been worrying you?

Bob: Well the fact that I still don't know what I am, or who I am. Or why I am, why have I done this, how did this happen, what made this happen? And you know, I've made me do this after all this time.

Here, at the very beginning, Bob presented the perpetual question relating to one's being commonly pondered by the obsessional neurotic- what, who and why, am I. The questioning of his existence was provoked by the breakdown of his family life. In this, he believed he had provided them with everything and although he worked hard to justify his existence, he believed he still failed. He asked "So why did that happen?"

The therapist, in stating her resistance (in her process notes), pointed to Bob's demand of her. Bob demonstrated the neurotic's position of attempting to adopt the Other's ego-ideal in his pursuit of what the therapist wanted of him before he responded. If she answered, he would know something about what she wanted of him.

Session 1 Segment 2 (B1.2)

> Bob: Look I felt I had more power because I was really … the family, I was the head I was, don't know, certainly not (pause).

> *Therapist: Then what happened?*

> Bob: We just coasted along I suppose until my son was born.

> *Therapist: We're on the train of you trying to figure out how you got yourself in this situation.*

> Bob: Definitely, sorry I'm going to have to take my jumper off

> *Therapist: In terms of a budget.*

> Bob: Sorry, so yep.

> *Therapist: So you weren't feeling powerless at this point in terms of the money.*

Bob: Nup, nup, I think I can go back to about 17 years ago when we'd paid the house, we'd actually paid the house. And I remember saying to one of the managers I was talking to and I said, now maybe we'll have a little extra cash to enjoy a bit of a thing, fruits of life for a while. Before we do anything else.

> *Bob indicated that he was getting hot – as I got up to turn heater off, Bob took off his jumper (he's never done this before). I noticed he looked really good. Later on in session he talked about how he'd struggled with himself to buy the new shirt because it wasn't absolutely necessary to buy it.*

One of Bob's major complaints was the paucity of money available to him throughout his marriage. He had handed his wife control of the finances to avoid a repeat of his mother's situation within his own marriage. He explained,

"I suppose it goes back to many years ago where I said where we watched our parents and we said we'd never let that happen to us. So therefore the trust was I gave her all my money in that return for that I would expect certain things. But I never made those demands."

His mother was allocated a small percentage of his father's wage each week to manage the house and his father retained the rest of the money. "Dad would say here's a fifty dollars, manage for the week. The fact that he made 400 that week was Dad's concern…. He was constantly able to flash cash." In handing his wages to his wife and receiving back a modest spending allowance, Bob reversed the parental roles familiar to him. In doing so, however, he identified with his mother and consequently focused on his financial deprivation as a problem within the marriage. In the above excerpt, he spoke of not being able to do extra things. During this, he commented on being hot and removed his jumper to reveal a new shirt. The shirt was

not mentioned until later in the session but the therapist commented in her process notes that he had never removed his jumper before and that she was aware of a difference in his appearance. Here, two methods of communication are operating simultaneously. He reveals his new shirt while attempting to convince the therapist that he is not a spendthrift. He tells her that he was deprived of spending the money he had planned to spend, "now maybe we'll have a little extra cash to enjoy a bit of a thing, fruits of life for a while", but was prevented from doing so by his wife, "… she started talking about buying more and doing extensions and everything else like that which we couldn't afford. Oh well actually no, we did. That was also when her mother became gravely ill. And we did build a property but we couldn't proceed with it. So we had to forfeit that; we didn't lose anything on it."

In the session, Bob spoke as though he had no agency in the decisions about spending money. In doing so he was setting the scene for the revelation of his spending on the shirt and needed to ensure that the therapist did not see this as fulfilling his own desire. It was essential he keep this hidden if the therapist was to believe he was someone who fulfils other's needs. The deprived position he presented reinforces his belief that he provides others with everything they need, and enabled him to maintain a masochistic position.

Session 1 Segment 3 (B1.3)

> Bob: Well, new shirt, I've got a new shirt the other day. And I felt guilty about it for nearly half a day. And then I felt I couldn't wear it. And then I thought this is stupid. So I'm wearing it. You know.
>
> *Therapist: How's it feel?*

Bob: To be quite honest going to work this morning it didn't feel anything at all. It felt quite, here we go, here we go. And after 2 or 3 people commented on how well I looked and how, wow that's a nice shirt, I felt good. That's what it's about. And I'm still feeling guilty about it and I won't rush out and buy another five shirts so everybody can say well that's a nice shirt too. But I'm sort of putting up with it thinking well (sigh).

Bob said while he felt guilty re buying the shirt, he was very pleased to get the compliments it evoked from work colleagues who said how good he looked (obviously I was supposed to too).

The dialogue about the new shirt occurred about half way through the session, much after he initially removed his jumper. He commented on feeling good when others admired him and his shirt, but also that he felt guilty about the shirt. Freud called this way of speaking *negativism*. By deliberately framing his thoughts in the negative Bob denies the truth, which is opposite of what he has said. In other words, Bob did feel something when going to work. His apprehension was evident when he said, "here we go, here we go." Furthermore, it was likely that he wished for a continuance of admiration, as was suggested by his comment, "That's what it's about."

The therapist sensed that Bob wanted her to compliment him on his appearance, which suggested that his guilt related to seduction. She had not revealed anything of her thoughts on the shirt or his appearance; therefore, he could feel guilty that he tried to seduce her into admiring him. In the transference, this was a relationship like the parental relationship forbidden to him. He could not seduce his mother, nor could he seduce the therapist, and an attempt at this would provoke guilt. It is also possible that, for Bob, the purchase of the shirt symbolised something forbidden that required hiding and therefore the exposure elicited guilt. It was no accident that his purchase

was hidden prior to his removal of the jumper. Whatever the reason, Bob became angry with the therapist as is evident in the next sequence.

Session 1 Segment 4 (B1.4)

In the psychology training clinic where Bob's therapy took place the usual process was a series of assessment sessions in which both formal and informal assessment occurs. The informal assessments include clinical interview with history taking and listening to the style of the patient's relating. The formal assessment includes both projective and cognitive tests. At the completion of this part of the assessment a feedback session is held in which the therapist reports to the patient his or her findings. A comprehensive psychological report is written at the conclusion of the assessment phase. If psychotherapy is indicated, it commences after the feedback session. The following excerpt related to the assessment and material discussed in the feedback session.

> Bob: No, no no no What I'm saying is that I've given you a picture of me that you've been able to go to a book and open that book up and say that's as near as Bobby falls into.

> *Therapist: That's not what's happened.*

> Bob: Well that's what I perceive what's going on.

> *Therapist: Ok*

> Bob: Ok and that's what I'm saying is, I suppose what I'm asking is what did you find? What did you find out about me? Yes ok I've acknowledged the stress one because that's the only one I could remember. …. I was happy with my life. (sigh) Now, what's happened? So if we'd done those tests 5 years ago I think you'd have got a different view. And that what I'm saying to

myself, am I still back there secretly or have I just closed myself. And I know I might have minimised a lot of my communications with things. I'm very controlled with what I say and I don't want to get involved if you like as I did in the past. And they're the sort of things, and that's what I'm saying is that's what I think I was asking when we first started was, what have you seen in me that I haven't seen?

The therapist followed this with a summary of the previous feedback session. After which she commented in her notes that she felt rapport had deepened.

> *After I gave Bob the summary it felt as though our rapport had deepened – as though I'd satisfied a need somehow.*

Therapist:… I didn't go back to a book and secretly say to myself Bob fits here or here

Bob: No, no, no, no, no

Therapist: Um, I don't work like that

Bob: Oh no, I didn't mean it that way, I meant that

Therapist: Well that's what you said so I'm just responding to that

Bob: Yeah sorry

Therapist:…disparity, really. Um, we were talking a lot about your difficulty with authoritarian relationships …um that you didn't feel like you're a rigid thinker, that you didn't feel like you're quite fixed in your opinions and it's difficult to shift them. The testing showed that that's how your thinking is and your way of dealing with problems is. And you weren't quite sure whether that was really you or not…

Bob: Yep

> *Therapist: And we've been talking about that again tonight really. That you've allowed your ex-wife to put herself in a position of authority*

> Bob: Have the power

Bob had fixated on his belief that the therapist knew something about him and in this segment he returned, angry, to this theme. Previously he attempted to seduce the therapist into commenting on his appearance, but when she did not respond he attacked her credibility, as evident above. She responded by giving him information about himself but this only satisfied him temporarily as it was information he had already received in the feedback session. Whilst his quest was to know what he believed the therapist knew about him, he was at the same time provocative and challenging. Seemingly, he tried to identify what the therapist would do if he questioned her ability and made her feel inept. Ironically, when the therapist defended herself Bob retreated and became apologetic. He attempted to revoke or undo his statement and experienced guilt when the therapist did not allow his retreat. Again, the guilt indicated that Bob was aware of his injurious intentions toward the therapist. On this occasion, his apology made his intention to hurt clear, whereas in the previous episode, seduction and the purchase of the shirt brought on feelings of guilt.

Session 2 Segment 1 (B2.1)

The following excerpt is not presented within a text box because it was referred to in the therapist's process notes. It is included because it relates to a segment presented later in this session. It also highlights Bob's need to create distance from his feelings, which he does by denying the therapist's importance to him.

Bob: I'm sorry I'm trying to put it into a context of this weekend we did some really exciting stuff.

Therapist: The thing where you're going to go on and tell me lots and lots and lots of stories and not tell me how you felt.

(laughter from both)

Bob: ok, after the weekend you come home and you're absolutely bursting, bursting with the pride that, yep, pretty good stories to tell ya, um met a politician, ta da, ta da, ta da, ta da, ta da, sat down and had coffee with him you know and talked. Um and you, (pause) I could tell you a story from that time but I'm not going on about the politician tonight and what I did and it's really quite a funny story. And nobody believes me.

Therapist: Hang on, she shut you out. She didn't want to hear it.

Bob: Yeah that's right.

Therapist: How did you feel?

Bob: Dreadful. Just like you just did then.

Therapist: Yep. Yeah.

Bob: I think well if you don't want to hear my story.

Therapist: Tell me tell me, you don't want to hear the story.

Bob: I felt hurt, not from you, don't get me wrong.

Therapist: Well you did hear it, I did hear it.

Bob: I felt it I had a spontaneous split second but you're not, you're not as important to me as my wife was (laugh). All right.

Therapist: Yeah, yeah, but you did feel it, then; how did you feel?

Bob: No, I just wanted to tell you, forget it.

Therapist: So then you withdraw, is that it.

Bob: Yep yep.

Therapist: That's what you're doing, how are you feeling?

Bob: I'm boiling inside.

Therapist: Boiling!

Bob: Yep

Therapist: With anger?

Bob: Um, disappointment and anger, yeah.

Therapist: Ah hm, tell me more about the anger, like rage ?

Bob: Oh no, no no. It's well I'll just have to wait until tomorrow when I can tell somebody else (laugh) some body who will listen to me.

Therapist: Do you feel as though the person, or in this case (ex-wife), wasn't interested in you.

Bob: I think she was interested in me as a person, but not interested in what I'd done.

….

Therapist: That makes you feel really hurt, angry,

Bob: Angry, disappointed, hurt, reclusive I want her to back off. I don't want to hear about the soup, but don't, and the anger, the angry reaction is, well don't let her ……… but she would force me to hear her. Well my weekend was like this.

This excerpt showed Bob's first real expression of his feelings in front of the therapist. He spoke directly of what he had just experienced with the therapist and drew a parallel with past experience, in this case, with his ex-wife. Bob's negation of the importance of the therapist in comparison to his ex-wife illustrated a level of recognition on his part of the repetition occurring in transference phenomena. In realising a similar experience evoked similar feelings, he needed to distance the past from the present at the level of emotion and whilst doing so he delivered a blow to the therapist in pointing out her lack of importance. After he spoke of the difficulties he was experiencing in his relationships, he pondered whether he could love two women.

Jenny, in the following dialogue is a friend of his ex-wife.

Therapist: Then you felt forced to listen and how did that feel.

Bob: Like waves, waves of information, today, oh Jenny did this and then the lawns need grading …….and then the back yard you know, and you weren't home of course. Of course you weren't home you were out there with them.

Therapist: How do you feel then?

Bob: Ha ha ha well how would you feel? (laugh) when you've been told how disastrous things were and you weren't there.

Therapist: Did you feel like you've failed.

Bob: Yeah, dramatically, so you just close down more, close down more and close down more.

Therapist: And is that what happened over the years, Bob closed down?

Bob: Yeah that's what happened, I think that's what happened, I haven't, look I've been mulling over this really seriously the last 2 or 3 days, and I'm still asking the question: can you love two women? I'm really in dire straits with that because I still think I do really care enough to say to (ex-wife) I love you, but again I've got (new partner) there but ….. I can say that to (new partner). I don't know. And that sort of I suppose where we go back to where it started tonight, how long can I go on with this? How long can I keep it up? Not even keep it up, how long can this go on. How long, I don't ask myself how long I keep it up, I think I can probably keep it up forever no matter what the damage comes out to be eventually to a point to where I just will fall over, that's what's worrying me. Right, 'cause I've got high blood pressure now, not high but it's gone up.

Here, Bob showed his tendency to introduce a third person into his relationships. He believed he was unable to give up either of the women and spoke of being incapable of thinking about his life without one of them. He believed he was essential to both women. To give up his wife would be to give up part of his role in the family and thus become a fallen father, which contrasted with his view of himself as the essential father. His façade was evident when he questioned how long he could keep it up. At a conscious level, he was referring to how long he could continue with the two relationships; but at an unconscious level, the sexual metaphor was unmistakeable.

Session 2 Segment 2 (B2.2)

Therapist: What are you doing here?

Bob: I suppose trying to get guidance.

Therapist: Guidance?

Bob: So that I don't have to go there.

Therapist: But you just said you did have to go there.

Bob: Oh, yeah I don't want to go there. (laugh) That's the part, I know I've got to go there but I don't want to go there. Does that make sense?

Therapist: No

Bob: No, I'm sorry

> *When Bob was talking about the need for him to collapse before he will confront/ really change anything-I confronted him by asking why he's here. "To get guidance" – as if he were not getting it. Bob looked extremely puzzled and very surprised that I'd confronted him so strongly. I felt the need to retrieve the situation.*

In this excerpt Bob told the therapist that he wanted guidance from her. He wanted her to advise or instruct him on living, which would enable him to determine what she wanted of him. Her notes suggested that his comment accused her of not providing guidance. Furthermore, the therapist again noted that she was active in the session. This was at the point where Bob spoke of his inactivity by stating that he knew he must do something but did not want to. The therapist's active and confronting response appeared to result from Bob's passive accusation that he had not received the guidance he expected. This could be viewed as a sadistic response to Bob's masochistic passivity. It was evident that the therapist noticed her response to Bob and questioned this. She described a want to repair a perceived rupture on her part, but, interestingly, Bob apologised as if he believed he had something to repair. It is also possible that Bob's apology was an attempt to deflect the therapist's

defensive hostility rather than repair. Whichever the case this interaction was a repeat of the previous sequence wherein Bob verbally attacked the therapist's credibility. On that occasion, also Bob apologised because she would not passively agree with him.

Given that apology commonly follows remorse, it indicates that Bob believed in his wrongdoing and experienced guilt as a result. When the therapist did not automatically agree with Bob and questioned him, thus requiring him to think further about his words, he became confused.

In the following sequence, Bob returned to his concern that the therapist knew more than she had revealed.

Session 2 Segment 3 (B2.3)

He looked at me as if I have all the answers and that I'm hiding them from him.

Bob: I don't think I know myself to be honest. Honestly don't, I'm sorry. That's what I was coming here today to ask. What am I? That was going to be my key question today. Because I was running late I was a bit phased.

Therapist: What am I?

Bob: Where am I, What am I, who am I? I don't think I know.

Therapist: Very big questions.

Bob: Um, that's what I think I came to ask. I got a bit late and then sort of phased and (laugh).

Therapist: Well we have to find them in you.

Bob: I know this and I'm having difficulty looking at me. And going back to what you said a couple of weeks ago. Which has really opened my eyes I think. When you said something about, when you did your analysis you said we might find out really who Bob is. And I think I said to you some words, well I don't know who I am. I don't think I've ever looked at myself.

Whilst ruminating over his existence Bob demonstrated his desire to identify if the therapist had answers to his questions. The uneasiness involved in asking such questions was evident in Bob's admission that he was late, thus leaving the questions until late in the session. Following from this admission, he recognised his failure to consider his motivations. Also, Bob's reference to "looking" pointed to a scopophilic focus that was also evident in his requests for the therapist to tell him what she had "seen" in reference to him. The same focus existed in his shirt exposure. Bob appeared much more comfortable knowing about others than knowing about himself and was extremely uncomfortable with the thought that someone might know about him.

He followed this with an explanation of his feelings of guilt, which he noticed arose when considering himself. He reported, "But you also have to consider that every time Bob has thought about Bob he's been made to feel guilty." By questioning his words, the therapist triggered his feelings of guilt, which forced him to think about himself, as he reported. Bob related the guilty feeling to his want of something, possibly something he was not supposed to have. He explained the fear that emerged when the therapist questioned him,

"Frighten me with it because I think, if I give the wrong indication here, guilt, if I don't get this right, guilt, you know. And if I have to think about Bob, Bob puts a connotation on Bob, Bob wants something, Bob wants something. Well who said he could have it. Sort of thing I think, (gasp) ooh".

If he slipped he may reveal what he wanted that he believed he should not have, and this he feared. He might also have something already that he believes he should not have, which would elicit feelings of guilt along with the fear that he might reveal this. All of this is held at an unconscious level. At this stage in the treatment it is unlikely that Bob could articulate what it was that he wanted but could not have.

At the very end of the session, Bob reported a story that he had earlier referred to but not told. The therapist was aware of his need to tell this story. She noted, "Bob had an insatiable need to tell me a story about an awkward/embarrassing meeting with a public figure." Bob said, "Before you go… work ditto…". He relayed the story in which Bob was in the bathroom at a public function and was called on by a well known older public figure who had caught himself in his trouser zipper. Bob described himself as being down on his knees attending to the man. Metaphorically, the story tells of an older man in an impotent state who Bob rescues. Unmistakeable is the libidinal homosexual investment in the father figure who Bob enjoyed rescuing. Bob was compelled to relay this story that earlier in the session he had withheld. He presented it as an extremely entertaining experience.

Session 3 (B3)

The therapist process notes did not indicate a test. Bob spent the session complaining about money and about how much he was needed by his family in a practical sense, for example, for repairs to the house. He also complained about not pleasing his father.

Session 4 Segment 1 (B4.1)

Preceding this session Bob had been away for the weekend in a work-related capacity. In the following comments, he referred to driving back from his weekend away, which, as he pointed out, also meant returning to the same relationship dilemma he had left, the dilemma being his inability to break away from his wife even though he had a new partner. He presented this as a torturous position and in the telling he made a slip that revealed a masochistic relation to the position he held himself in. The therapist noted her frustration in listening to Bob's exposition of his dilemma.

My countertransference was to feel frustrated with Bob.

Bob: The remorse, and the fact that I was driving back into a situation, well it was still there. The situation was still there. Was I dealing with it appropriately, and I suppose that was my reward (slip) remorse, I doubt I …if I was or wasn't and I felt pangs of guilt, sadness, and disappointment. All of those. And sort of, could I have done things better, can I still do things better or is it too late now. …

Therapist: When you say is it too late, what do you mean by that?

Bob: I don't know, I have to think about that in as much as, what do I want to do better, you know what I mean. I suppose to be able to communicate to the boys better, just how much I do care for them and love them, and even for that matter (ex-wife) but it's just, it's, it's a, it's very difficult. And … have that problem with (new partner) as much as I'd like, I have difficulty … how much I do care. And I'm trying to balance everything. I do care for both.

Therapist: Sounds like you feel like you're letting everyone down.

Bob: Yeah,

Therapist: The boys, ex-wife and new partner.

Bob: That's probably it. Actually that's probably that's putting it in true context that's probably what I was feeling when I was driving back, that I had let, or was letting everybody down. That I was far better staying away. Because in that week staying away I didn't have that problem.

Therapist: Better for you?

Bob: Well for my feelings, yeah.

Therapist: You had a break from those feelings.

Bob: Yeah, shut down. … animals do this job and they still bark. (Pause)

Therapist: How do you get yourself into this situation though where you're letting everyone down, all the people who are dearest to you. The boys, ex-wife and new partner? How is it that you're there?

Bob: Oh, I think I'm starting to realise that I'm trying to please everybody but I can't. And that within them must create some frustrations like, it doesn't come out the way I want it to come out if you like, because I have to modify, people have an expectation of um, of a situation and because I'm trying hard to please everybody in that situation I don't please my target.

Therapist: Which is who, which is what?

Bob: Well it might be (ex-wife), it might be the boys. Whoever I'm trying to please, or to make them feel that yes I do care that I am trying to give them a little bit more but not all 'cause I'm trying to share all that around to everybody so that everybody's got the picture of, and that's what I think I'm, and that's what I think keeps happening, I'm trying to, and as a result the target that I aim for to please, I can't, so I become frustrated …

During Bob's depiction of his attempts to please his family, the therapist noted in her process notes her frustration with him. Finally, he articulated his own

frustration at what he believed was his failure to please. He explained this failure being due to his attempts to please everyone at once. His description of this dilemma revealed his belief that he could please everyone, if only there were fewer others. Interestingly, in recognising and articulating his problem he also recognised the frustration he projected onto the therapist that was evident from her comment in the text box. In this excerpt, Bob's progress was evident. He had shifted from giving the therapist the experience of frustration to acknowledging his inducement of this feeling in others, to feeling it himself.

Session 4 Segment 2 (B4.2)

> *I felt quite different here – it felt as though Bob needed to preserve me – that, he thought that if I thought he were arguing with me that he'd offend/lose me/whatever (and he'd feel guilty); and so he retracted the statement so as to rebuild his connection with me.*

Bob described his relationship with his children. He believed that he currently gave them what they ask for and spoke of giving them money, including loans to buy cars, with the knowledge that he would not receive repayments, which meant that he was without money for himself. He thus presented himself in a deprived position that highlighted his masochistic view of himself.

> *Therapist: Yeah yeah, and get things right as well. So if your kids come to you and you're willing to say yes to anything, how's that helpful to them?*
>
> Bob: Well it's not, it's giving them the easy way.
>
> *Therapist: Yeah*
>
> Bob: It clearly is. But my argument to that is, well not argument, my statement to that is, they've had it so hard for so long why shouldn't it be easy for them now. It's like me, I've had it, and (ex-wife) had it hard for so

long that I couldn't cope with it being hard for so long anymore so I went out and made life easier.

Therapist: So it's actually about your needs?

Bob: Well I think it's the needs for the lot. Not just me.

The therapist commented here on Bob's retreat from the word "argument" which invokes a more aggressive form of discussion than the word "statement". Arguing is active and supposes reciprocity as one cannot argue unless there is a counterargument. This brings the other to life, something Bob does not want in the therapist. In contrast, a statement does not presuppose a response from the other. Here, the therapist noted Bob's passivity, which displayed his way of relating to her that concealed his need to control. The dialogue also revealed Bob's inability to acknowledge his wish to please himself; instead, he only detected his attempts to please others. Thus, challenging his view that martyrdom is altruistic, as the therapist did, left him defending himself.

Session 5 Segment 1 (B5.1)

> *Bob gave a wry smile and blushed as if to say – you're onto me. It felt as though he was pleased that this was the case and that I had challenged his position.*

Bob: …. Everybody has power, its how we use that. I don't want to be seen to be using my powers, abusively. I want to enhance those powers so that I can be shown to be positive.

Therapist: One can also put oneself in a position of being abused.

Bob: By withholding those powers or suppressing those powers I believe that to be quite true. And that was something, you know, I was never able to

grasp, I suppose, was that knowing that I have power of some form, using it appropriately. I sat on it and I still do so because I don't know how to do it. …

After the session was spent speaking of money and power and linking knowledge to power, Bob delivered a long lecture in which he informed the therapist of his knowledge of women. He reported reading the *Feminine Mystique* and, through the knowledge gained from this book, he believed he had acquired power in relation to women. He had learnt of post-natal depression and hormonal changes and prior to this newfound knowledge, as he reported, his philosophy was "get on with your life woman." Bob's search to identify what women want was evident here. He moved to speaking of powerful world figures and questioned leadership and power and whether leaders abuse their power. The therapist did not interject but at the end she commented on the masochistic state of placing oneself in the position of the abused. Ironically, in her notes she stated that Bob seemed pleased by this. His pleasure, however, might be connected to his belief that he had seduced the therapist into agreeing that it was he who gave up all for others' pleasure; a position that concealed the narcissistic pleasure he derived from his belief that he could fulfil others. Both laugh at the end of the session, which could also suggest to Bob that he pleased the therapist.

Session 6 Segment 1 (B6.1)

Bob arrived at this session late and immediately delivered his reason for being late. His son had phoned him and needed advice. Bob reported that he had to take the call because his son would be in a class until late therefore Bob could not speak to him after his psychotherapy session.

Bob 25 mins late because he had a phone call from his son wanting advice.

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Bob: He had some questions about work. He's got some more important things to try and sort out.

Therapist: More important than your time?

Bob: Well the way I see it, yeah. Pardon? Sorry, it is more important did you say?

Therapist: Yeah.

Bob: Yeah, yeah, it's good to hear from them sort of thing, know that they appreciate your advice, so.

Therapist: I don't know much about B?

Bob: … he's very much in control of B. … And he says what he needs to say, … he doesn't put up with any rubbish. …in a relationship for instance, it's very interesting to watch um, he just tells her straight out …

Therapist: Hm ,hm. You describe him in contrast with the way you describe yourself.

Bob: I think his self … Um, very much one who lays down the ground rules and will abide strongly by them, but one who can also be very um, will take on an issue and fight it black and blue. Very strong in his own belief of an issue, of right and wrong. …

Therapist: So you don't lay down the ground rules and stick to them.

Bob: I probably do but I don't stick to them. I'll bend them and shift the boundaries to suit the needs I suppose. Whether I shouldn't shift the boundaries at all, to stand firm I would probably have had a better outcome perhaps in the past on reflection.

> *Therapist: So you lay down the ground rules and then instead of sticking to those rules?*
>
> Bob: I stick to them but I modify them to meet needs.
>
> *Therapist: Whose needs?*
>
> Bob: Perhaps those from others but certainly not myself. But I don't think of myself but in the end it suits me because it takes away less rigidity, …

The therapist commented on Bob making someone else's time more important than his time. He then lowered his voice whilst agreeing and musing over the importance of feeling appreciated. Again, Bob appeared to imagine that he had fulfilled the needs of someone who needed him. What remained unspoken in Bob's dialogue was the message he communicated to the therapist in arriving late, which was that she was unimportant to him. This was noted when Bob asked questioningly, 'more important did you say? Bob's dialogue suggested that he expected her to say something other than this, perhaps that the therapist's time was most important. The negativism Bob used in the last phrase was a telling indication of his transparent depiction of himself as a man who only thinks of others, never himself. Bob spent the session speaking about his children and their lives, all of which was presented in a superficial descriptive manner.

Session 7 (B7)

The therapist process notes did not indicate a test. Bob spent the session complaining about money and at one point revealed that as a 13 year old he had watched his mother and an uncle in an embrace, through a crack in the door.

Session 8 (B8)

The therapist process notes did not indicate a test. The session was spent with Bob complaining of not being included in his family's everyday activities and particularly complaints about his wife. He also focussed on feeling tired and intolerant.

Session 9 (B9)

The therapist process notes did not indicate a test. Bob spent the session speaking of the anxiety he is experiencing because of his wife's pressure for him to decide if he wishes to remain married or not.

Session 10 Segment 1 (B10.1)

In this segment, the therapist experienced the same frustration that she had previously during Bob's ruminations over his dilemma of not being able to extract himself from meeting everyone's needs. She also experienced him wanting something from her.

> *There was a long pause in here where I felt Bob was very expectant of me to do something. It felt awkward.*

Bob: No, I think there's my own. And I suppose I don't know what a perspective is – is it a view or – there's my own views. It's my own views but I mean like I can modify them. And also I think, there's (new partner's) perspectives and views as well that I have to consider.

Therapist: Sounds like you find it very, very difficult to see your views, needs, wants independently of everybody and anybody else's. Sounds like they all overlap with each other and you find it impossible to see yours in this circle – and (ex-wife's) in that circle – and (new partner) is in that circle, instead they all overlap.

Bob: Yeah.

Therapist: Interdependent.

Bob: I think my views are dependent on those two. And that sort of – I'm not sure I'm heading the right way. I'm not sure, I just can't think of that.

Therapist: So that's difficult to think about?

Bob: Well it's difficult, I suppose I'm not understanding the question if you like. When you say 'it's difficult to think about' yes I think about both and I sort of think, inside myself I think, well I have no needs apart from that.

Therapist: Apart from?

Bob: From those both. I mean – I don't know how you put it. What needs have I really got? To be flexible enough to be able to attend meetings, to enjoy my daily chores, to be acknowledged, occasionally to have sympathy for me, irrespective of what it might be, try and understand me. And try and understand me, no matter whether – whether you disagree or agree with me – understand why I took that path, whatever.

Pause

Same countertransference as before.

Again, the therapist sensed that Bob wanted something from her. In this excerpt, he recognised his inability to think and act outside of the needs of others, but also, he alluded to the confusion and uncertainty that emerges when one constantly strives to know what others want. This is a position that relies on imagination and contrasts with the clarity of recognising what he might want. Although it was clearly a struggle, Bob attempted to articulate his own needs and in doing so he focused on

superficial everyday annoyances that he would like to change. Bob waited for the therapist to tell him of his needs, which was a repetition of the very dilemma he had just described in not being able to think outside of the needs of others. Here he looked to the therapist to tell him what she thought so that again he could think and act within the perceived needs of someone else. In therapy it was the therapist he looked toward to fulfil this defining role.

Later in this session Bob told the therapist of his ex-wife's recent ultimatum – either, he decide whether he returns to her, or she will end the marriage. Again, he looked to the therapist for answers and appeared to be unaware of his life with another woman. His wife's ultimatum suggested that Bob had led her to believe there was a possibility of his return to the family home, but his pondering in the therapy sessions had not suggested this. Bob gave his solutions as, "One is to run. And the other is to say; well I'll just live on my own. (sigh) Are they the answers?"

> *It feels like Bob is freely associating much more – although he struggles with it. Sometimes he looks to me to do something with the problem/issue he's brought to deal with in that session. I feel that Bob feels quite uncomfortable at these times – that he cannot bear any silence and that he's desperate for me to pick up and carry his burden – I try and resist and could resist some more.*

The therapist provided a summary of the sessions in her process notes that implied her sense that Bob was progressing. She noted Bob's ongoing pull for her to be active and provide something for him. She also made a final entry in her process notes that stated, "I was a little surprised at how open Bob was to my tough questions." This comment suggested a passive, masochistic position adopted by Bob in relation to her. Such a position was consistent with an obsessional neurotic structure and Bob displayed a number of other traits suggestive of this structure. For example, his attempts to push thoughts out of his mind that insist on returning, and

his thought of fleeing and of isolating himself by living on his own in an attempt to rid himself of the difficulties he has in relationships.

7.3   STAGE TWO ANALYSIS: THEORETICAL

The following segment tracked the progress of Bob's tests identified via markers in the therapist's process notes. Dialogue from the sessions, when viewed in chronological sequence, showed the pattern of testing interspersed throughout the sessions. Initially the tests were separated thematically into two separate test patterns. However, it became clear that total separation of the tests was not possible because of the interrelationship between the testing episodes. For this reason, one pattern of testing was presented in chronological sequence. As with the previous case of David, an analysis was conducted from two perspectives. First, a CMT perspective where the tests were located at the level of the ego and viewed as tests designed to disconfirm pathogenic beliefs. Second, from a Freudian-Lacanian perspective whereby the tests were viewed as demands that had as their aim the determination of desire. The data was organised into test episodes. After the presentation of the test, each episode was divided into three segments: the effect the test had on the therapist; evidence of the test being passed or failed; and the effect the test had on the patient. A summary of the sequence of test episodes concludes the section. The same episodes were presented in the Freudian-Lacanian analysis and structured the same as the CMT analysis, but conceptualised and named as demands.

7.4   CMT ANALYSIS OF TEST

From a CMT perspective, Bob tested to determine if the therapist would make him feel inadequate, inferior and guilty. Within this framework Bob was viewed as

having experienced feelings of inadequacy in relation to his parents. Bob had spoken of this during some sessions. His expectation, therefore, was that the thoughts and feelings from his early relationships would be re-experienced in the current relationship with the therapist, and he unconsciously set up situations in which this belief could be tested. Passing his test, according to CMT, would entail the therapist reassuring him of his adequacy. Working in relation to his ego in this way would, at the level of the ego, enable him to believe in himself as an adequate person, and he would feel better via this reassurance. He might come to realise that others would not be deprived if he met his needs, because, as adults, he was not responsible for what they may or may not think or feel. Bob's frustration with the therapist for not reassuring him was evident throughout the testing sequences. Also evident was Bob's continuance of testing on the same theme until he spoke of what, at a conscious level, had been driving the test. This was something she had said in the feedback session prior to psychotherapy. Once he had articulated this he no longer needed to try to extract the information he imagined she knew, and he ceased testing in relation to this. However, he did continue to try to determine if she was bothered by his displays of knowledge, which were considered representations of inadequacy.

7.4.1   Bob's Pathogenic Belief and Test

Bob's history and the experiences he reported in relationships suggested that his pathogenic belief dictated that a meeting of his own needs would deprive others and he would feel guilty. As a result he attempted to meet others needs but felt inadequate when unsuccessful at this. His test therefore attempted to determine if he experienced inadequacy in relation to the therapist.

7.4.2   Episode One

From the beginning of therapy Bob made repetitive attempts to test his pathogenic belief that it was his inadequacy that resulted in him not being able to meet completely others' needs and that the therapist would not tolerate his competence. This first test was a *transference test*. It was a re-enactment of the parent/child relationship, with the therapist occupying the position of parent and Bob remaining in his own childhood position. In seeking to dispel this pathogenic belief Bob sought reassurance by requesting the therapist assure him of his adequacy or acceptability (B1.1) "I didn't sort of reach standard or something or, was different or out of sync. So why did that happen?" The risky nature of testing was evident because the question could result in either the therapist responding reassuringly or by telling him his failings.

Effect on therapist

In her process notes (B1.1) the therapist reported feeling a demand to reassure Bob of his acceptability, which she resisted, but at the same time she asked him to clarify what he specifically wanted. Bob had attempted to place the therapist in the same position he described his father as occupying. He wanted reassurance from his father that he was as adequate as other family members and had illustrated this through an example wherein he had visited his elderly father, only to have him comment on the success of Bob's brother. This was upsetting to Bob who believed that he could not please his father. In the current interaction with the therapist, Bob replayed his childhood belief that he was inadequate and attempted to determine if the therapist also believed him to be inadequate. In CMT Bob needed the therapist to

assure him of his adequacy. She did not offer reassurance, but neither did she point out his failings, in fact, she maintained a position of neutrality in relation to his test that resulted in Bob recalling something she had said previously.

Evidence of passed or failed test

Bob replied to the therapist's question by recalling a comment she made during the feedback session. "Maybe we'll look at [me]. I think it was words to those effect. …well I don't think I've ever looked at me." He followed this by musing; "…I still don't know what I am, or who I am. Or why I am,…". These are fundamental existential questions raised in Bob by thinking about himself as the subject of the therapist's focus. It was difficult to determine if this test was passed or failed, but the recall of the material that had prompted the test suggested it was passed. Furthermore, the immediacy of the recall suggested that this test was more likely a conscious than unconscious test. Bob based his test on something the therapist had said in the feedback session and he tested in direct relation to this. His testing attempted to determine if she would respond judgementally in relation to his failings. After the test he was able to state directly what she had said that was on his mind. Thus, Bob's assumption that the therapist would respond as his parental objects had was triggered by something the therapist said of which Bob was conscious.

Effect of the test on the patient

Bob followed the test with memories of having deprived himself by providing for others. He presented a series of examples of this that mostly related to the parenting of his children, which he believed was too permissive. In other words, because Bob and his wife gave too much to their children, Bob had to go without.

7.4.3 Episode Two

The second episode (B1.2) of testing followed from the dialogue referred to directly above. Bob wanted to know if the therapist would make him feel guilty for buying for himself. If so, this would add to his sense of inadequacy because his pathogenic belief predicted that if he satisfied himself others would be deprived and therefore dissatisfied with him. In this test, Bob removed his jumper thus exposing a new shirt. In the history he gave of his parents, he described his father as a man who kept most of his wages. His mother raised the family on the meagre amount given to her by her husband each week. Bob's father retained the remaining money, which he spent on alcohol. In his marital relationship, Bob placed himself in his mother's position insofar as he gave his wages to his wife each week and she returned to him a small amount of spending money, never enough, from his report. Throughout the sessions, he disparaged his wife for controlling their finances and intimated that she was to blame for him having so little. He reported handing control to her. At one point, he disclosed a second job, the money from which he kept secret from his family.

Preface to the test

Bob exposed his shirt well before he spoke of it, thus locating the beginning of the test at the point where he removed his jumper (B1.2). In the middle of speaking about feeling power within his family prior to his marriage breakdown and complaint of not having enough money to do extra things, Bob removed his jumper and exposed the new shirt. The therapist was aware of a difference in his appearance, although she was unaware that his shirt was new. She wrote in her process notes (B1.2):

Bob indicated that he was getting hot – as I got up to turn heater off, Bob took off his jumper (he's never done this before). I noticed he looked really good. Later on in session he talked about how he'd struggled with himself to buy the new shirt because it wasn't absolutely necessary to buy it.

The therapist did not comment on Bob's appearance and he continued to speak of being deprived of purchasing but of having planned to spend after the couple's housing mortgage was paid. He then blamed his wife for his lack of spending money. He complained:

… she started talking about buying more and doing extensions and everything else like that, which we couldn't afford. Oh well actually no, we did. That was also when her parents became gravely ill. And we did build a property but we couldn't proceed with it. So we had to forfeit that, we didn't lose anything on it.

The removal of Bob's jumper was a preliminary test in which he disguised the exposure of his shirt behind the practical matter of the room temperature. It was a safe step that culminated in his speaking about the purchase of the shirt. As well as this preparatory act, Bob verbally prepared the therapist for his revelation by delivering further examples of financial deprivation in his marriage. Bob needed to assure himself that the therapist would not make him feel guilty and counteracted this possibility by reporting examples of deprivation. He also pointed out the feelings of guilt he experienced when he was successful in getting what he wanted and used this as a way of introducing his new shirt (B1.2). "Well, new shirt, I got a new shirt the other day. And I felt guilty about it for nearly half a day. And then I felt I couldn't wear it. And then I thought this is stupid. So I'm wearing it. You know." In response, the therapist asked how it felt to be wearing the shirt. He replied,

"To be quite honest going to work this morning it didn't feel anything at all. It felt quite, here we go, here we go. And after two or three people commented on how well I looked and how, wow that's a nice shirt, I felt good. That's what it's about. And I'm still feeling guilty about it and I won't rush out and buy another five shirts so everybody can say well that's a nice shirt too. But I'm sort of putting up with it thinking well (sigh)."

In exposing his shirt Bob set up a potential re-enactment of his childhood dilemma wherein he felt guilty when he got what he wanted. Viewed in CMT terms he wanted to know if the therapist would make him feel guilty for spending money on himself. In the relationship with his mother, likewise the one he created with his wife, he described experiencing guilt at the time of asking for what he wanted, as well as upon receipt of what he wanted. Bob spoke of this in relation to the limited money available to meet the needs of a number of people, suggesting a belief that someone would be deprived. If he did not experience guilt in relation to the therapist he could progress toward dispelling the childhood pathogenic belief that influenced his current thinking. Instead of believing that getting what he wanted deprived others and therefore induced guilt, he had the possibility of an experience in which he could have what he wanted, the therapist would encourage this and guilt would not be experienced.

Effect on therapist

In her process notes the therapist reported feeling pressure to comment on Bob's appearance. "Bob said while he felt guilty re buying the shirt, he was very pleased to get the compliments it evoked from work colleagues who said how good he looked

(obviously I was supposed to too)." The therapist's failure to comment incited Bob's anger.

Evidence of passed or failed test

It was difficult to determine whether the therapist's response qualified as a passed or failed test. Her only comment about the shirt was to ask how it felt to wear. She did not offer any opinion on Bob's appearance in the manner of his work colleagues. Bob's immediate anger toward the therapist was consistent with the CMT assertion that passed tests could be followed by the more aggressive *passive-into-active* test. According to the CMT formulation of Bob's pathogenic beliefs, he would have expected the therapist's response to be consistent with that of his parents and ex-wife, which had resulted in guilt feelings. Instead of this the therapist was neutral.

Effect of the test on the patient

The neutral response to the shirt exposure resulted in a *passive-into-active* test, which took the form of an attack on the therapist's competence. This suggested that her response had provoked Bob to question his beliefs about his own inadequacy and his deprivation of others. When the therapist did not judge his decision to spend money he tested her response to feelings of inadequacy, which formed the next test episode. The effect of the *transference* test on the patient was another more aggressive *passive-into-active* test wherein the patient placed the therapist in his childhood position.

7.4.4   Episode Three

The next episode (B1.4) was a *passive-into-active* test that resulted from the previous *transference* test. In this episode Bob returned to the theme of the first test

episode in which he endeavoured to establish what the therapist knew about him from the psychological assessment. Here, he reversed the parent/child position and provoked feelings of inadequacy in the therapist by accusing her of matching his information to a textbook description of mental functioning. He played the role of parent in eliciting feelings of inadequacy. Rappoport (1996; 1997) believed this type of aggressive testing mostly occurred in later sessions when the patient felt more comfortable with the therapist, but here it was evident in the first session. The therapist defended herself from Bob's attack in which he stated, "So if we'd done those tests five years ago I think you'd have got a different view. And that what I'm saying to myself, am I still back there secretly or have I just closed myself." He insisted on pressing the therapist for an answer, "…what have you seen in me that I haven't seen?" Bob attempted to undo the attack when the therapist responded defensively, "Oh no, I didn't mean it that way, I meant that", but she insisted, "Well that's what you said so I'm just responding to that". Bob apologised, "Yeah sorry". In this interaction the therapist's challenge provoked an instant retreat. She restated the findings that he had requested and he relaxed which was consistent with a passed test.

Effect on therapist

Although the therapist did not comment in her process notes about Bob's aggressive attack, both the attack and her defence were evident in the dialogue. Furthermore, she wrote in her process notes of the relief that Bob appeared to experience after she delivered the summary of the feedback session. She commented that, "…it felt as though our rapport had deepened – as though I'd satisfied a need somehow." This suggested that the therapist was also somewhat relieved that the hostility she had been drawn into had ended.

Evidence of passed or failed test

The complexity of this episode made it difficult to determine whether the therapist passed or failed the test. Bob's experience of guilt suggested the test was failed. Moreover, this test had the quality of a retaliatory battle. According to CMT the therapist must withstand the aggressive attack and not defensively counterattack, as occurred. Bob had likely responded to his parents in the same way when he was made to feel inadequate; therefore, in response to the therapist's defence against attacks on her credibility, Bob's pathogenic belief that he was inadequate was strengthened rather than disconfirmed. The result was feelings of guilt, which were evident in his apology, "Yeah sorry". There were no memories or evidence of greater relaxation following this test. Neither was it immediately followed by a further passive-into-active test, either of which is consistent with a passed test in CMT. This test was therefore considered a failed test.

A further possibility is that this test might be considered a *compliance test,* as described by Rappoport (1997) and presented in Section 3.2.4. In such a formulation Bob's aggression would be considered an attempt to determine if the therapist was threatened by his attack. He complies with her need to defend herself to avoid his belief that he has injured her and that negative consequences, such as punishment or blame, will ensue if he does not. In Bob's case it was guilt that constituted the negative consequences and his compliance in this case his retreat, resulted in defence against emerging guilt.

Effect of the test on the patient

After this test, Bob retreated and became apologetic. The hostile interaction produced feelings of guilt. In addition to the therapist showing that she would defend herself against attack, she repeated the material from the feedback session, which

seemed to temporarily satisfy Bob's quest for an answer to his question "What did you find out about me?" (B1.4). During her recital of the assessment information the therapist had reminded him of the difficulty he had with authoritarian relationships and linked this to his discussion of his wife in the current session. During Bob's description of handing the position of authority to his ex-wife during their marriage the therapist reiterated this, and he interpreted her reference to authority as power. He said, "Have the power", in regard to his wife's position. It appeared that Bob had experienced the therapist also as having power and needed to strip her of her credibility so as identify how she experienced feeling inept and inadequate, and likely powerless.

7.4.5   Episode Four

At the beginning of the next session (B2.1) Bob was disparaging of his ex-wife for not listening to him. He began a story but the therapist interjected and pointed out that he was about to tell stories but not speak about his feelings. From the therapist's remark, it was clear that Bob's tendency to speak in this way had been previously discussed. In telling the story Bob attempted to determine if the therapist would tolerate his story telling and he became angry when she stopped him. Consequently he retaliated. He attempted to stimulate interest in the story whilst at the same time telling her that he was going to withhold it. (B2.1) "I could tell you a story from that time but I'm not going on about the [public figure] tonight and what I did and it's really quite a funny story. And nobody believes me." Bob had disparaged his ex-wife for not listening to his stories then attempted to determine if the therapist would do the same. When she stopped him, he articulated the anger he had experienced when both she and his ex-wife had not listened to him. In withholding, he became the therapist who he believed was withholding information about him. He wanted her to

have the same experience he had of being withheld from. (He told the story at the end of the session). Whilst expressing his own difficulty of listening to his wife, he posited the question of whether he could love two women. He pondered over this as if it was possible that he could remain married and keep his new partner without damaging his relationships. Bob then returned to his concern that he had revealed something of himself in the assessment and again reported that he wanted answers to his existential questions. He asked, (B2.3) "Where am I, What am I, who am I? I don't think I know." The therapist's response was to say, "Well we have to find them in you", which initiated in Bob the recollection of material that provided evidence for his belief that the therapist knew something about him, "…when you did your analysis you said we might find out really who Bob is." Bob again returned to his idea that he had revealed something to the therapist that she was concealing.

Although this material is presented as one test episode, it could also be considered two tests, or perhaps a twofold test. The therapist did not refer to the first test in her process notes, which was the reason for not illustrated them separately here. The first test, in which Bob expected the therapist to listen and then withheld his story when she interrupted him, was a *transference* test followed by a *passive-into-active* test, the withholding segment being the *passive-into-active*. The second was another *transference* test. The flow of testing therefore was as follows. Initially Bob attempted to determine if the therapist would tolerate listening to him, and, when she did not, he tried stimulating interest by withholding. This led to a re-emergence of the questioning of his identity, which he believed the therapist knew the answers to.

Effect on therapist

In her process notes, the therapist reported (B2.3) "He looked at me as if I have all the answers and that I'm hiding them from him." Consistent with Bob's history he hoped she might tell him he deserved to satisfy himself just as he hoped his parents would tell him and as he hoped his wife would treat him. He felt adequate when he thought he pleased others and this occurred when they tolerated listening to him.

Evidence of passed or failed test

If the therapist's response was considered reassuring in its neutrality then this test was passed. There was no doubt that the interaction with the therapist had prompted Bob's memory of what she had said in the feedback session. This was the second time Bob had raised this, which indicated that it was troubling him. Bob did not follow this interaction with any other memories, or any other evidence of a passed test, but neither did he display characteristics of a failed test. However, he did return to speaking about guilt feelings, therefore the response of the therapist appeared to create a space in which Bob could speak of his guilt. The recent memory of the material from the feedback session also indicated a passed test.

Effect of the test on the patient

The guilt Bob spoke of (B2.4) related directly to the thoughts he had after testing in the previous session. He had described feeling guilty upon purchasing what he wanted. This time he described feeling guilty when thinking about himself. At such times, he realised that he may not be able to have what he wants. Bob reported that he felt guilty each time the therapist challenged him. He said,

> "Frighten me with it because I think, if I give the wrong indication here, guilt, if I don't get this right, guilt, you know. And if I have to think about Bob,

Bob puts a connotation on Bob, Bob wants something, Bob wants something. Well who said he could have it. Sort of thing I think, (gasp) ooh."

Although Bob's feelings of guilt directly related to his satisfactions, in the above excerpt this was shown to extend to pervasive thoughts of revealing something that he did not intend. In considering Bob's belief that the therapist had concealed something she knew about him, Bob's concern made sense. He seemed to believe that he had inadvertently revealed something and that guilt would result. Bob ended this session by insisting on telling his public figure story from earlier (B2.5). In this he depicted himself as a person who had helped the man out of a compromising sexually laden situation and he was therefore essential to alleviating any embarrassment the esteemed public figure might otherwise have experienced. In other words, his story depicted him as adequate insofar as he was capable of assisting the incapable public figure. Through this example, Bob reported his adequacy to the therapist.

7.4.6   Episode Five

In session four (B4.1) Bob verbalised his recognition of the frustration he caused others. He then articulated his own experience of frustration, which resulted from his attempts to meet everyone's needs. In this recognition, Bob began verbalising his repeated relational position that consisted of a cycle of frustration and guilt. In the midst of examples of his attempts to meet others' needs, he reported a work related weekend away in which he had enjoyed being free of the demands of others. The others he referred to were his children, his ex-wife and his new partner. Whilst reporting his thoughts Bob slipped and said 'reward' instead of 'remorse', thus indicating that at an unconscious level he experienced some gain from the situation he found himself in. Bob reported:

"The remorse, and the fact that I was driving back into a situation, well it was still there. The situation was still there. Was I dealing with it appropriately, and I suppose that was my reward (slip) remorse, I doubt I, if I was or wasn't and I felt pangs of guilt, sadness, and disappointment. All of those. And sort of, could I have done things better, can I still do things better or is it too late now."

Although CMT does not offer an explanation for unconscious material, such as slips, one cannot help but notice the connection between Bob's focus on guilt and the unconscious connection to reward that occurred in the slip. (This is returned to in the Freudian-Lacanian section.) Bob was able to articulate that he frustrated others by trying to please everyone. He stated,

"Oh, I think I'm starting to realise that I'm trying to please everybody but I can't. And that within them must create some frustrations like, it doesn't come out the way I want it to come out if you like, because I have to modify, people have an expectation of um, of a situation and because I'm trying hard to please everybody in that situation I don't please my target."

During a speech about the feelings of ineptness that he experienced when unable to please all of his loved ones, Bob tested the therapist's response to frustration. His sense of inadequacy was enhanced by his belief that he could please all and the impossibility of this created both a sense of failure and guilt. Bob further described the manner of his frustration directly after the above quotation.

"Whoever I'm trying to please, or to make them feel that yes I do care that I am trying to give them a little bit more but not all, 'cause I'm trying to share all that around to everybody so that everybody's got the picture of, and that's

what I think I'm, and that's what I think keeps happening, I'm trying to, and as a result the target that I aim for to please, I can't, so I become frustrated …

This excerpt made clear Bob's cycle of frustration. The more he attempted to please others the greater their frustration, which in turn frustrated him. The test fits with a CMT transference test because Bob placed the therapist in the same position he described when frustrated by his inability to please all. These were his parents initially, but then his ex-wife and children.

Effect on therapist

In her process notes (B4.1) the therapist reported frustration, "My countertransference was to feel frustrated with Bob". In this interaction, Bob adopted a position in which he portrayed himself as ineffectual and remorseful because he was not as successful at attending to others' needs as he wished. However, instead of feeling empathy for Bob's position, the therapist experienced frustration, thus suggesting that there was a lack of the usual emotion elicited when one speaks of failure and guilt. The therapist was in a position that one could only imagine was Bob's childhood position. One in which he was frustrated by his inability to accurately ascertain what his mother wanted of him. Little was known of Bob's mother as he only referred to her a few times, twice within the context of what his father failed to provide to her – money, and sexual satisfaction as deduced from his mother's straying to the man in the kitchen incident he observed, and again in relation to his continual pattern of failing to complete activities. This was significant in that Bob believed that he should be capable of providing for, hence satisfying others, but clearly was unable to do so. It was likely that these others represented his mother and she was the original one he believed he should satisfy, but was

unsuccessful. The therapist, therefore, played the part of the mother frustrated by her child who began, then abandoned, whatever he commenced. Bob failed when he attempted to do what he wanted, only to find that it was not what he wanted. He had previously recalled that when he wanted to join a boys' activity group his mother threatened that if he did not continue with the group he would not commence other activities. This resulted from his pattern of beginning then abandoning activities. Bob needed the therapist to tolerate the frustration of his musing over not knowing what he wanted and not knowing how to please others so that he could disconfirm his pathogenic belief that getting what he wanted deprived others.

Evidence of passed test

Bob followed this test with memories of further examples of the same material in which he frustrated others. This indicated a passed test. This time, however, the therapist did not comment on feeling frustrated. It is possible that this represented a shift in Bob's position, in that he was able to speak of the frustration better without actually frustrating the therapist. He combined this material with examples depicting both his family and new partner needing him and relayed the difficulties he had in addressing their needs. This highlighted the connection between Bob's attempts to address others' needs and the frustration of his failed attempts to do so.

Effect of the test on the patient

Further material in which he portrayed his behaviour as altruistic arose as a result. He described himself in a masochistic position whereby he gave money to his children, which deprived him, and this he rationalised on the basis of his children having been deprived in the past. His use of these further examples, extending his thoughts about his feelings of deprivation, was consistent with a passed test.

7.4.7   Episode Six

Bob spent Session Five speaking about power, money and knowledge. He used historical examples, such as the power he believed Mahatma Ghandi had, to explain his notion of a link between knowledge and power. Bob's delivery had the quality of a lecture. In the previous session, he spoke of frustration and the therapist became frustrated with his passive presentation of attempts to please others. In this episode (B5.1) he delivered a speech on women, a 'what women want' lecture. It seemed that Bob was continuing to let the therapist know the lengths he would go to in order to please women and in doing so, he reverted to story telling. The test was a *transference* test and an extension of the adequacy test in that Bob tried to determine if the therapist would accept or challenge his display of knowledge. In other words, did he, as a knowledgeable person, threaten the therapist? In this new instance of story telling he anticipated that the intellectual content he delivered would be of interest to her and she would therefore listen. If she listened, he would feel that he had pleased her, but if she did not, he would feel inadequate. This time the therapist listened to his story and in it (B5.1) he told of his understanding and attentiveness to women's needs and of not abusing power. The therapist challenged Bob by commenting on his dialogue when she asked, "One can also put oneself in a position of being abused." In saying this, she encouraged him to continue his speech. Until this point, she had passively listened to his protracted story, which gave him an experience he had not had in relation to his wife or the therapist in previous sessions. Bob and the therapist laughed together upon her closing the session with, "there's a lot more there." This indicated perhaps to Bob her readiness to hear more of his intellectualisations. Bob's laughter suggested his relief, which was consistent with a passed test in CMT terms.

Effect on therapist

In her process notes (5.1) the therapist commented that Bob appeared pleased that she had challenged him, and he blushed. While the therapist did not comment on the way she felt when Bob delivered his lecture, her comment suggested that she experienced a desire to interject in Bob's lecturing and challenge the content of his argument. She did this in a way that enabled Bob to continue to speak and whilst her statement had challenged him it also provided him with fuel to continue, as he did. Effectively, the therapist acknowledged the position Bob believed he could occupy, as someone who was acceptable to others and who could please them. When his stories were not listened to, and particularly when he was required to listen to others' stories, he felt abused. In articulating this, the therapist had pleased Bob. Her response was the opposite of how others had responded, in particular his father, whom he described as someone he could never please and, also, his mother whom he described as being frustrated by his lack of satisfaction.

Evidence of passed or failed test

Because this episode occurred at the end of the session it was difficult to determine if it was passed or failed according to the material that followed the test. Bob's immediate response was laughter, which indicated a passed test. He wanted to know if the therapist would listen to, or dismiss him, as he believed others had done; she listened and he felt better, as noted in the relaxed mutual laughter, which suggested little, if any, anxiety. In the next session, however, Bob arrived late, which could be viewed as an act of aggression toward the therapist, but in CMT such an act following a passed test could also be viewed as an extension of the previous test whereby Bob tested again in a more vigorous manner. The re-testing is considered a check to ensure that the therapist really could tolerate someone being more important

than she. *Passive-into-active* testing after the *transference* test may be required as a means of confirming the test result. Considered in this way the test was viewed as passed.

Effect of the test on the patient

In this example a re-test resulted from the previous test.

7.4.8   Episode Seven

Bob's late arrival at the next session (6.1) was considered a further *passive-into-active* test designed to ensure that the therapist could tolerate waiting for him just as she had tolerated sitting through his stories in the previous session. This indicated that the therapist could tolerate someone else's needs being met, which could be perceived as others being more important than she. This test could also be constructed as a transference test in which Bob presented himself as inadequate because he could not meet everyone's needs. In meeting the needs of his son he disappointed the therapist.

Effect on therapist

The therapist did not report an affective experience in relation to Bob's lateness.

The patient's response to the therapist

When Bob arrived late and delivered his reason for being late, which was a telephone conversation with his son who needed him, the therapist commented that his son's time was more important than his time. This was unexpected to Bob who was surprised, and after a momentary delay, asked, "More important did you say?" The therapist's unexpected response resulted in Bob speaking about the flexibility he

drew on to meet the needs of others. Here he attempted to demonstrate to the therapist the very position he had found himself in when attempting to meet everyone's needs - someone was disappointed. He followed this comment by reporting that he never met his own needs and gave some examples of his son whom he believed did meet his own needs. Despite describing his son as arrogant and inflexible, Bob viewed these characteristics as positive. He spent the rest of the session speaking about his children.

Evidence of passed or failed test

Bob followed this test by speaking about his flexibility in meeting others' needs and then spoke about his children and their lives in a descriptive manner. There was no evidence that this test was passed although Bob did spend the session speaking, which could represent a passed test. The content of his speech, however, was more consistent with a social engagement than with material representative of the work of psychotherapy. There was no depth and no affectivity. Furthermore, Bob's clarification of the therapist's statement was not explainable in CMT terms. One would have expected Bob to agree with this statement, not be surprised by it, as it was exactly the position he was presenting - his son's needs were more important than his.

7.4.9   CMT Summary

Bob's tests illustrated his attempt to determine if the therapist would make him feel guilty for meeting his own needs. Consistent with a CMT formulation he did this to determine if she would respond in the same way as his mother who had been deprived by a selfish husband who met his own needs and left her to meet inadequately the needs of her family. Bob's experience of others constituted a cycle

of frustration in which he became frustrated attempting to meet the needs of others and they became frustrated with his failure to do so.

At a process level, the first test was a *transference* test. Bob played himself as a child who attempted to gain reassurance of his adequacy or acceptability so as disconfirm his pathogenic belief that he was inadequate. The therapist was neutral in her response and Bob set up the shirt test, which was another *transference* test. Again the therapist was neutral, neither assuring him of his adequacy, nor making him feel guilty. He recalled memories of experiences of his own deprivation, then immediately followed this with a *passive-into-active* test in which he played the role of his parents in whose company he experienced inadequacy. This was consistent with CMT wherein a *passive-into-active* test could be used to test more aggressively after a *transference* test was passed. Bob returned to a *transference* test and again a *passive-into-active* test then finally another *transference* test. Throughout this process he became increasingly more articulate about the motive for his attempt to pressure the therapist into revealing what she knew about him. All of the tests displayed a link to Bob's pathogenic belief. Table 2 (below) provides a summary of the effects of Bob's passed and failed tests and highlights the absence of memories pertaining to the test when a test is failed.

A statement the therapist made in the feedback session triggered the testing process. As Bob was fully aware of the information that formed the basis for the test it was a conscious test, but at another level, it was connected to Bob's feelings of inadequacy of which he was somewhat, but not fully, aware. For example, he was not aware of the link between his tests and his relationship to his parents and the repetition of the pattern displayed in the tests in other relationships, such as with his ex-wife and children. Whilst out of awareness, this material was accessible to Bob.

The testing episodes enabled him to link his current experiences in therapy with others in his life, particularly his ex-wife. This suggested the material was preconscious. Something the therapist had said which triggered the testing sequence was conscious and had played on Bob's mind. When Bob finally articulated this he ceased testing on this topic (it is unknown whether he returned to this after the ten sessions presented here) and spoke of the guilt he experienced in satisfying himself.

Although Bob continued to revisit the theme of inadequacy, he changed the approach slightly each time and became more articulate in regard to his own thoughts. In most of the examples, the therapist remained neutral in relation to the test material, which resulted in him becoming more articulate about his dilemmas, and more insightful. On the occasion the therapist became defensive Bob experienced guilt and retreated in the manner he had likely behaved as a child and, also, described himself as behaving in response to his ex-wife. He recovered, however, and tested again in the following session, thus illustrating resilience on the part of the patient, which allowed for the therapist to make mistakes. This showed that making mistakes was not irretrievably detrimental to the therapy.

This formulation of Bob's case illustrated the manner in which Bob intermittently drew on the therapist to assist him in disconfirming his pathogenic beliefs about pleasing others, deprivation and inadequacy.

Table 2. The effects of Bob's tests

EPISODE	SESSION/ SEGMENT	TEST	THERAPIST RESPONSE	PATIENT RESPONSE
1	1.1	Transference	Passed	Expresses memories
2	1.2	Transference	Passed	Expresses memories and displays anger
3	1.3	Passive/active	Failed	Apologises/ Submissive
4	2.1	Transference	Passed (followed by passive/active)	Retaliates, tests again then expresses memories
5	4 .1	Transference	Passed	Expresses memories
6	5.1	Transference	Passed (followed by passive/active)	Laughs and enjoys
7	6.1	Passive/active	Passed	Expresses surprise, then expresses memories

Overall the process of testing was as follows:

- Tests could be tracked throughout sessions and were repeated across multiple sessions and/or throughout one session.

- Some tests were triggered by session content that appeared in two forms. One form was based on words the therapist spoke which were readily recalled by the patient and therefore constituted a conscious test. The other was a response to the therapist's reaction to a previous test, which the patient was unable to articulate directly, thus suggesting an unconscious or preconscious test.

- No two instances of a test were identical but all had an underlying theme that could be linked to the patient's pathogenic belief. Each test had an idiosyncratic presentation that utilised the specific content of the session.

- Mostly tests were of the *transference* test mode but on some occasions a *passive-into-active* test was used as a confirmation of a previously enacted *transference* test.

- *Passive-into-active* was used in the first session after an attempt at transference.

- Passed tests produced an articulation of the test episode in the form of reproaches of others.

- The therapist was verbally *coached* through examples of others' responses as to how to respond to the test in the way the patient wanted.

- Failing a test was not catastrophic to the therapy. Where the therapist returned to a neutral stance the patient recovered and continued testing.

7.6   FREUDIAN-LACANIAN ANALYSIS OF TEST

The same segments used in the CMT analysis were analysed according to a Freudian-Lacanian theoretical formulation. Some additional segments were added that were not part of the CMT analysis but did appear in Stage One of the analysis. Episodes considered tests in the previous section were considered demands in the following section.

8.6.1   Episode One

Bob began the session in a manner consistent with Lacan's notion of entering the transference. He demanded the therapist tell him what he believed she knew, as deduced from her formal assessment. He asked, (B1.1) "…. I want to remember …where … I didn't sort of reach standard or something or, was different or out of

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sync. So why did that happen?" The therapist did not repeat the information she had already delivered in the feedback session and was therefore neutral to his demand for information. She did, however, attempt to determine more precisely what he wanted of her by asking further questions, to which Bob recalled something he believed the therapist had said during the feedback session, he reported, "Maybe we'll look at me. I think it was words to those effect." He followed this with, "Yeah my answer was, well I don't think I've ever looked at me. And I want to look at me to say well, will that help me understand why I am, the way I am, sort of thing, and what's been worrying me." At a conscious level, this request concerned what the therapist had deduced from the formal tests. But, also, it was evident that Bob wanted to know how he could meet the other's needs, and he believed the therapist could answer this, even though to him this aspect of the question was unconscious. His question therefore related to determining what he must do, or who he must be to please others. There was a further level to this demand. Bob stated that he wanted to 'look' at himself. His demand therefore was a demand that the therapist also look at him. When Bob's two requests were combined the purpose for 'looking' became evident. Bob's looking to the therapist to tell him his flaws, or conversely, that he was without flaws, was a demand that she 'look' at him. To study him was to look at him and in doing so Bob might see himself.

The therapist's experience of the transference demand

The therapist commented in her process notes (B1.1) that she resisted Bob's plea for reassurance that he "…was in an acceptable category…". In stating this, the therapist pointed to Bob's demand to be told about him, which as she noted, elicited a sense of resistance in her. She tried to deduce precisely what he wanted her to say given that his question was unclear. This lack of clarity likely stemmed from Bob's

demand that she tell him something she had not already, as if what she said was not enough and he wanted her to focus more on him, to 'look' at him some more. This, the therapist resisted, which frustrated Bob's demand.

The patient's response to the therapist/transference demand

Bob's immediate response to the therapist's frustration of his demand was, as noted above, that he wanted to look at himself because, he believed, he had not done so. He followed with evidence for this statement in which he delivered examples of giving to his family, which resulted in his own deprivation. In other words, Bob presented his argument for looking at what others' want at the expense of what he wants. Amidst this account, Bob removed his jumper, which formed the basis for the next demand.

7.6.2   Episode Two

This demand was enacted through seduction and followed from the therapist's frustration of the previous test. It began with Bob removing his jumper under the pretext of being hot (B1.2). The therapist wrote in her process notes of her awareness that he looked good. She also noted that he had never before removed an article of clothing, but made no comment, instead she responded in a practical manner by turning the heater off. He continued to speak about his wife and parents, and the feelings of guilt that arose in the past when he asked for things he wanted. As an example of the changes resulting from not getting what he wanted since leaving his wife, he pointed out his new shirt – he had bought himself something he wanted. He commented on previously felt guilt the present guilt associated with having made a purchase that resulted in admiration.

The therapist's experience of the transference demand

In her process notes (B1.3) the therapist wrote of her sense that she was supposed to comment on Bob's shirt. She did not and instead asked him, "How's it feel?" In doing this she frustrated Bob's demand that she comment and he responded by describing how others had commented. Her failure to respond left him with no indication of what she thought. Whereas if she commented on his appearance, as others had done, Bob might have believed that he could seduce her and that he was desirable to her, which might tell him something of her desire in relation to him.

The patient's response to the therapist/transference demand

Bob had initially exposed his shirt while delivering historical examples supporting his position of not satisfying himself. When the therapist did not comment, but was aware of the seductive aspect of removing one's jumper in session, Bob continued with his supportive examples then verbally presented his new shirt. The therapist still did not comment and Bob delivered examples of how he wanted her to respond. He explained, "…after 2 or 3 people commented on how well I looked and how, wow that's a nice shirt, I felt good. That's what it's about. And I'm still feeling guilty about it and I won't rush out and buy another five shirts so everybody can say well that's a nice shirt too." The therapist was not seduced into commenting in the same way that he described others having done, therefore Bob did not know what she 'saw' in him and he became angry. Furthermore, in the transference Bob attempted to seduce the therapist who stood in for the parental object, a figure necessarily forbidden to him, and in being unsuccessful, he experienced guilt.

7.6.3   Episode Three

Bob returned (B1.4) to his demand that the therapist tell him what she had seen that he had not, but on this occasion Bob was angry and he attacked the therapist's professional credibility. He accused her of basing her assessment on the details he provided then cross matching these with profiles in a book. Bob used the word "picture" to describe how he had depicted himself, which was consistent with his wish to be looked at. The shirt episode was an unsuccessful attempt at seducing the therapist into looking at him and resulted in his accusation that she had looked at a book, not at him. After defending herself, he asked about what she had seen that he had not. She reiterated her defence and Bob retracted his accusation and apologised. This time the therapist restated her findings, repeating information of which he was already aware. Bob's response to the frustration of not being told who he must be or what he must do was evident in the sense of inadequacy he projected onto the therapist in his attack on her credibility.

The therapist's experience of the transference demand

The therapist's response to Bob's demand was defensive, thus highlighting the hostility in Bob's attack. She made no comment in her process notes but did comment on a deepening of rapport and a sense that she had satisfied a need by restating the psychological assessment findings. In this episode Bob's demand was not frustrated, it was met with reciprocal hostility, which suggested that this was a familiar interaction. In restating the assessment findings, the therapist pointed out the difficulty he had with authoritarian relationships and particularly his placement of his ex-wife in a position of authority. On this occasion the therapist responded to Bob's attack by adopting the same position he attributed to his wife; she became the authority and Bob retreated.

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The patient's response to the therapist/transference demand

Bob responded by withdrawing and apologising, and then referring to his ex-wife as (B1.4) "having the power". Although he provoked hostility and defensiveness, his withdrawal upon the realisation that she would defend herself rather than be submissive or hurt, was unexpected. A possible explanation for this was found in Bob's background. He had a history of violence and his children had called the police on an occasion when he became aggressive. This incident precipitated his marital breakdown. The thought of the therapist knowing something he had revealed was more than he could bear and returned him to a position in which he felt inept, thus he attempted to provoke the therapist into 'looking' at him, and what she saw was his aggression. Until this point, Bob had presented himself as a passive man who gave up all for others. This interaction revealed something different and he retreated.

7.6.4   Episode Four

In session two Bob prepared to relay a story in which he was portrayed as useful to a man of importance. When he commenced his story, the therapist interjected, reminding him of his repeated pattern of story telling (B2.1). Bob responded by promoting interest in a story, which he said was both funny and unbelievable, then retracted, stating he was not going to tell it to the therapist at that time. He then described the anger he experienced when his stories were not listened to and paralleled his experience with the therapist, with his wife's response to him. Eventually, he posed the question "…can you love two women? For Bob this was a real dilemma, he appeared to believe that it was possible to have both his ex-wife and his new partner and was puzzled by his inability to solve this. The therapist's failure to be satisfied by his stories had prompted his thoughts on the impossibility of

adequately satisfying his loved ones, but he continued to believe that this was possible and all he needed was to be told "how" by the therapist. She asked him why he had attended therapy and he responded that he was "…trying to get guidance". A little further on Bob's demand for answers emerged again and he asked, "Where am I, what am I, who am I? I don't think I know?" The therapist's failure to reveal herself upon his seduction, in both the shirt episode and in his story telling, had frustrated his attempts to know what pleased her and placed his whole existence in question. He ended this session by telling the story he had begun earlier. It was a story that highlighted the lengths he went to in order to please others, and a story also about being the privileged one chosen to assist a public father figure. In the story Bob was placed in a position metaphoric of a passive homosexual position wherein he got down on his knees, literally, to please another man. His enjoyment was evident.

The therapist's experience of the transference demand

At one level Bob's demand for answers was driven by a belief that the therapist had answers. In her process notes she commented, (B2.3) "He looked at me as if I have all the answers and that I'm hiding them from him." At this point Bob pondered his existence, hence his question, "who am I". In response, she stated "Well we have to find them in you". This response resulted in Bob revealing conscious material that had driven his idea that she could answer his questions. He articulated evidence that confirmed his suspicion that she knew something about him of which he was unclear. This was something the therapist said during the feedback session.

Although the therapist failed to answer Bob's question, her acknowledgement of the possibility of answers prompted his recall of what she said previously that was on his mind. He replied, (B2.3) "…you said we might find out really who Bob is." (Bob's memory of what she said). Alongside the assumption that another person had answers to his troubles, which had brought him to psychotherapy, Bob feared that he had inadvertently revealed something to the therapist. Exactly what was unknown, however, the comment above demonstrated that what the therapist said had triggered a fear that she might know something he preferred to keep hidden. At a conscious level, Bob continued to pursue this until he revealed the source of his angst, which he did by reminding the therapist of what she had said. He then spoke of feeling guilty when he "looks" at or "thinks" about himself and articulated his fear of inadvertent exposure (B2.3). He stated, "…giving the wrong indication here, guilt, if I don't get this right, guilt…". This statement revealed both Bob's fear and his need to disguise himself, which linked his fear with guilt. In Bob's case, the feelings of guilt were consistent with his unconscious desire and these formed the basis for his demands. The therapist, in frustrating his demand, had opened a door that exposed fear; fear that was acknowledgeable at a conscious level but also had an underlying unconscious component.

7.6.5   Episode Five

A couple of sessions later, at the same time as Bob slipped when referring to remorse as reward (B4.1), the therapist noted her own frustration. Bob recognised that he frustrated others (during the time that he was frustrating the therapist) and then articulated his own frustration in trying to meet everyone's needs. In this recognition, Bob began to verbalise the relational position he repeatedly encountered.

This segment was absent of a direct demand of the therapist such as a question, but Bob did demand that she listen to him, which she found frustrating. His recognition that he frustrated others whilst simultaneously frustrating the therapist was a significant step forward in "seeing" himself. It was likely prompted by his own frustration in not being able to determine anything about the therapist. His demands had been for her to reveal her desire and in the absence of this he became frustrated which resulted in him acknowledging himself as the one who frustrated others.

Bob's slip was enlightening insofar as it exposed the source of the therapist's frustration and indeed the frustration of others Bob referred to. The slip revealed unconscious material that related to the guilt Bob spoke of. This was noticeable in his substitution of the word remorse with reward, which revealed that at one level his way of relating was a gain, or at least he expected to be rewarded. The therapist's frustration can be understood as a response to the disingenuous quality of Bob's representation of himself. His failure to recognise the extent to which he pleased himself hidden behind his presentation of himself as someone deprived who constantly tried to please others, was indeed frustrating. Although knowledge of his pleasure was unconscious as revealed in the slip, his recognition of frustrating others had emerged from the preconscious.

7.6.6   Episode Six

In the following session, Bob delivered a lecture on women (B5.1). He told of how he understood women and their problems and progressed to speaking of power and leadership and the abuse of power in the political arena. This speech had an intellectualising quality and despite appearing to require nothing of the therapist other than that she provides him with an audience, as she did, he had, in fact demanded that she passively receive his discourse.

The therapist's experience of the transference demand

The therapist had listened attentively and when an opportunity arose she introduced the notion of Bob's masochistic pleasure. She commented, "One can also put oneself in a position of being abused." To which, Bob responded by speaking of power in relation to his own functioning. "By withholding those powers or suppressing those powers I believe that to be quite true. And that was something you know I was never able to grasp I suppose, was that knowing that I have power of some form, using it appropriately. I sat on it and I still do so because I don't know how to do it. …". The therapist believed she had challenged Bob with her statement, and commented that he gave a wry smile. It was difficult to determine the meaning of the smile; for example, it could mean displeasure, or that the meaning of what Bob or the therapist had said was distorted. Whatever the smile meant, Bob continued without stopping to ponder the therapist's words.

The patient's response to the therapist

In response to the therapist's comment Bob twisted her statement in order to retain his belief and convince the therapist, that he gave up all to please others, thus concealing the narcissistic pleasure he derived from his masochistic position. This he was yet unable to tolerate. His pleasure came from retaining his belief that he was the one to fulfil the Other (this is the representative of the mother in Lacanian theory) and his pain from placing himself under the control of the Other's desire without recognising that this was his chosen position, his desire. The therapist, in passively listening to his lecture, had provided the impetus for him to continue, which he did. This segment occurred at the end of the session and the therapist commented in

closing, that there was "…plenty more for us there", to which Bob replied, "ooh yeah." And, they both laughed.

In an earlier session Bob complained of not being listened to by his wife, who insisted on being heard. In Episode Six he tried to determine if the therapist would passively listen to him and be fulfilled intellectually. In her parting comment she seemed to say yes, which revealed her enjoyment and consequently pleased him. The encouragement he gleaned from her parting comment was enlivening, as noted by his laughter.

Interestingly, it was the therapist's passive receipt of Bob's lecture that pleased him. To a vigilant observer such as Bob this was all he required as evidence that this woman would also relate to him as others had. In other words, he believed he could determine how to please her. This, however, left him in a position of having to work in relation to this, meaning that he must produce what she wanted which was the position he repeatedly found himself in. The information he had worked so hard to identify placed him in the very position of which he complained. That the therapist listened to him appeared to provoke a further demand, which occurred at the beginning of the following session.

7.6.8   Episode Seven

Bob arrived 25 minutes late for the next session (B6.1). He told the therapist that a telephone call from his son, who needed his advice, had delayed him. Again, he demonstrated his experience of trying to meet the needs of everyone and failing. Arriving late gave the therapist the experience of being let down, perhaps even of failure if, in waiting, she wondered whether or not he would attend. Yet again, it was her who was given the experience of inadequacy or inferiority; this time because someone else was more important - his son who phoned and asked for advice. His

son's direct request meant Bob knew exactly what he must do to please him because he had asked. The pleasure Bob gained from the feeling of having answered the demand of the Other superseded any prior commitments he might have had and hence any disappointment he might cause the therapist. This set in motion his cycle of not being able to please everyone.

The therapist's experience of the transference demand

In responding to Bob's lateness the therapist commented that someone else's time was more important than his own, which he had not expected. "More important did you say?" Bob seemed to expect her to comment that someone else's time was more important than hers, which would have revealed a wound. Had she done so she would have shown the disappointment of rejection. In arriving late he had attempted to provoke the therapist into showing more of what she wanted, which was a way of coercing her into making a demand of him in the form of requesting that he attend promptly. This demand could then be read in terms of the therapist's love and desire.

The patient's response to the therapist

The therapist's unexpected response resulted in Bob returning to her statement and asking, "Pardon? Sorry, it is more important did you say?" His surprise prompted him to speak about rules and boundaries and in doing so he described precisely what he had just done by arriving 25 minutes late. He stated, "I'll bend them and shift the boundaries to suit the needs I suppose." The therapist's failure to respond to Bob's demand in a predictable way in keeping with the responses of those in his past, which would have been to become frustrated and make demands of him, elicited Bob's articulation of his own desires. He framed the above comment in terms of his flexibility and provision of his children's needs, whereas his shifting of

boundaries to suit his own needs was also represented in the ambiguity of the phrase. This was a similar response to earlier, when the therapist pointed to his masochism which he heard in terms of his defences; here again, he believed that what he had said supported his defences, but it also revealed his desire.

7.6.9   Episode Eight

Finally, in Session 10, Bob again displayed his expectation that the therapist would provide him with something. He spent the session ruminating over his failure to meet everyone's needs, and, as with previous occasions, the therapist became frustrated. He spoke of having no needs in a manner that portrayed him as meeting others' needs but not his own. He said that his views were dependent on the views of his ex-wife and his new partner and he believed he could not think independently of the two women in his life; of having no needs separate to these two women. He had articulated his dilemma of not being able to function outside of the desire of the Other. Bob experienced this as extremely frustrating and believed that, "…well I have no needs apart from that." He then said that he wanted others to understand him, "whether you disagree or agree with me – understand why I took that path …" but made no mention of understanding others. Again, Bob's narcissism and his defence against any knowledge of this were evident. His message to the therapist, that she needed to understand him, was accurate therapeutically but said nothing of what he could understand at this point.

The therapist's experience of the transference demand

In her process notes the therapist wrote, "There was an uncomfortable pause in here where I felt Bob was very expectant of me to do something. It felt awkward." (10.1). The therapist also noted her frustration.

In the perceived inability to think outside of the views of the women in his life, Bob demonstrated here that he was lost until the therapist gave him something that might indicate her views. As he just stated, he did not mind whether she agreed or disagreed.

The patient's response to the therapist

The therapist responded to Bob's pause by asking questions. He answered, but stumbled at times when she pointed out inconsistencies in his argument and when she demanded that he think about what he was saying. Later in the session, he said that his ex-wife wanted him to return home and that she had nominated a deadline within which he was to make his decision. This suggested that he believed a return to his family was possible and that he led his ex-wife to believe this also, whereas his session material was inconsistent with any such intention. Furthermore, the notion disregarded completely his life with his new partner. Thus, Bob, who believed he lived his life meeting the needs of others, showed that his own needs were far too pressing to do so. The presentation of such transparent material highlighted the therapist's frustration in working with Bob.

7.6.10   Freudian-Lacanian Summary

The case of Bob illustrated both the conscious and unconscious aspects of the demand. The conscious aspect was based on something the therapist said, "we'll find out who Bob is?", and the unconscious aspect was an attempt to determine something about what the therapist wanted, based on a familiar prototype set by his relationship with his parental objects. The demand that the therapist report what she knew about him ceased after he clearly verbalised to the therapist, what he wanted

and why. This was the basis of his demand at a conscious level. She was then in a position to respond directly to his request, which allayed his fears and corresponded with a cessation of demand based directly on this episode. (At least in the ten sessions presented here) He did, however, continue to make other demands based on concealed but related content that were not at a conscious level. These demands ceased when the therapist responded in an unfamiliar way.

At a process level, on two occasions Bob attempted to determine what the therapist knew about him, which related to his attempts to determine something about her desire. First, he asked her directly for the results of the formal testing, thus believing that she was concealing something. Second, he wanted to know something about her, therefore he attempted to seduce her into commenting on his appearance. The shirt hidden beneath the jumper was metaphoric of Bob's pattern of functioning. He needed to believe that he was deprived and gave up all for others, which was the story he presented between the exposure of his shirt, and pointing out that it was a new purchase. This was consistent with an identification with his mother whom he presented as deprived. It was also likely that he believed he could seduce his mother. When the therapist was not seduced into revealing anything about her desire, Bob became angry and aggressively attempted to determine what she knew about him. At this point the therapist retaliated with hostility, which resulted in a retreat and apology from Bob. The therapist had revealed something of herself but it was not what he wanted; Bob wanted her to admire and be impressed by him, not hostile. His unsuccessful attempt to seduce her was not the experience he wanted.

The ten sessions depicted here revealed only some aspects of what Bob hid. There would be numerous aspects to this content extending across all three levels of consciousness. For example, at a conscious level he articulated that he hid the money

he earned from his extra job. At an unconscious level, he hid his desire to have what he wanted behind his belief that he deprived himself because he gave to others. He also hid the masochistic pleasure he derived from believing he was deprived and the narcissistic pleasure he derived from believing that he could fulfil others when in fact he was fulfilling himself by demanding a listener and an observer who would not demand the same of him. For example, he did not want to listen to his wife's stories yet demanded she listen to his and demanded the same of the therapist. The seductive methods he used to elicit the therapist's desire would likely have links to infantile sexual material that had resulted in frustration.

Bob's pattern of relating was frustrating to others and evidenced most clearly on the occasion that he managed to believe that he had fulfilled the therapist by talking about his knowledge of women. They had both laughed which showed their pleasure. Bob was clearly pleased with this response because she had satisfied his demand to listen, but this resulted in him attending the following session late. Whilst this could be viewed as a punishment of the therapist and, indeed, it was a further demand, her response to his lateness facilitated the exposure of further material. He had not expected her to respond by saying someone else's time was more important than his. When this demand was connected to his wish to determine the therapist's desire, it became clear. Bob, in believing he had identified how to please her, or at least something about her desire, then had to destroy that desire. His late attendance would have been frustrating for the therapist as were the experiences he described as provoking in his family. He likely expected disappointment, anger or frustration in response to his late attendance or at least a request that he attend on time. Either would have revealed to him more about her desire, but she did neither. Instead her unexpected response jolted his assumptions about her desire and frustrated him.

Because she responded in an unfamiliar way, Bob was able to recognise himself in his speech, thus in the presence of the therapist he revealed something of himself. His need to believe that he met others' needs as he could not function outside of the knowledge that the Other desired him, but as soon as he detected desire in the other he destroyed it, which restarted his existence within an endless cycle of frustration.

7.8 COMPARISON OF CMT AND FREUDIAN-LACANIAN THEORETICAL ANALYSIS

The differences between the CMT and Freudian-Lacanian models were evident in the theoretical explanations for Bob's seductive behaviour. In CMT, the tests were constructed to determine if the therapist believed him to be inadequate. In Freudian-Lacanian terms, this was a demand for the therapist to acknowledge his adequacy and importance. This belief in one's importance, which encompassed a sense of privilege, related directly to desire in the Lacanian sense of the word, and underpinned the demands that manifested throughout the sessions. For example, his attempt to determine if the therapist would make him feel guilty for purchasing his shirt was connected to seduction, which was the mechanism he used to elicit a desirable response about his appearance.

The CMT formulation contrasted with this and required that the therapist respond in the opposite way to Bob's mother, who had experienced deprivation and in whose company (either real or imagined) he experienced guilt when he pleased himself. He needed the therapist to accept that he had made purchases and not make him feel guilty for doing so. In Freudian-Lacanian theory Bob was viewed as

depriving himself at a conscious level, but this was a defence against a narcissistic sense of privilege that became evident in the data.

Far from depriving himself Bob was indulgent, but his sense of privilege and entitlement was held at an unconscious level and therefore inaccessible to him. His hidden income, his excessive drinking, and his two women were all examples of his indulgence. Whilst Bob was invested in keeping hidden, both from himself and others, that which he defended against, he realised the impossible and frustrating position he continuously occupied and constantly created in others. The defensive aspect of his functioning was located at conscious and preconscious levels, which were evident in his ability to verbalise his sense of inadequacy and also his guilt. However, the underlying drive which incorporated the scopophilic drive as evidenced in Bob's focus on what had been 'seen' by the therapist and being 'seen' in his shirt exposure, and his drive to satisfy himself, were located at an unconscious level and not accessible to Bob.

CMT focused on Bob's unhappiness and his inability to be pleased, whereas Freudian-Lacanian theory viewed this as a defence against the drives he wanted satisfied and his infantile wishes and desires. Bob's investment in maintaining his defences, particularly his feelings of guilt were revealed in the unconscious slip. His manner of relating in the transference revealed his unconscious wish to occupy a position of importance in relation to the therapist.

Whilst there are a number of ways of interpreting this material, the CMT formulation focused on the strengthening of the ego. Such a method enables patients to feel better after sessions, but as was evidenced, where the test/demand was frustrated, the patient became more articulate regarding his thoughts and feelings.

Frustration of the demand meant the patient began putting into words the unconscious material that he was enacting. At times, this material was disguised within the words spoken but assigned to someone else, such as his ex-wife, and mostly it was in the form of reproaches and disparagements. The satisfied transference demands left unconscious material unspoken and hidden.

To respond only to the defensive aspect of the ego, in this case the test, assumes that what the patient wants is to feel adequate and important and, whilst this was evident, Bob would continue his attempts to maintain the illusion of this position. Unfortunately, this was only possible when he caught a glimpse of the therapist responding like his parental other, which reminded him of the desire of his mother. He would continually encounter feelings of inadequacy because of the relationship between his defence of inadequacy, his actual inadequacy and his unconscious demand for the reassurance of his imagined position of privilege. To cope with all of this he must continually try to determine what sort of person to be to please others and ultimately fulfil them, which assured him of his position. The problem for Bob, however, is that as soon as he detected that he had fulfilled or pleased someone, the therapist in this case, which assured him of his position, he could not tolerate this and set about destroying it. This was evident when Bob arrived late to the session following the episode in which the therapist and he laughed. His impossibly frustrating position was one in which a glimpse of the therapist's desire equated to him having to meet the assumed forthcoming demands that would follow from knowing something about that desire. The CMT construction of Bob's late attendance would be a further attempt to determine if the therapist could tolerate his failure to meet everyone's needs.

Whether the content of the sessions was considered demands or tests both theories illustrated the following: the repetition of the episodes; the patient's attempt to elicit a specific position in the therapist; and, frustration when this did not occur. Bob's response to being frustrated was also evident, as was the effect of the frustration, which was an articulation of his dilemma in relation to other experiences of the same. This circumscription in speech of his dilemma enabled him to progress toward identifying repeated aspects of his functioning.

CHAPTER 8: CASE STUDY 3 – ANNETTE

8.1   BACKGROUND

Annette was a 32-year-old married mother of two young children. She sought psychotherapy because of marital difficulties. Most commonly, she complained of a pervasive feeling of discontent. In attending psychotherapy Annette stated that she feared discovering that she did not want to be with her husband, but that she did not want to leave him, instead, she wanted to be happy with him.

Throughout the sessions, Annette frequently discussed a boyfriend with whom she had had a relationship prior to her marriage. This relationship was spoken of in a wishful and longing manner as if it had satisfied her. Annette explained that her previous boyfriend was someone who initiated and organised their lives and had a clear purpose. She had felt like she was married and pressured him to settle down and begin a family. She regarded her attempt to force this position as the precipitant for the demise of the relationship. Annette observed that with her husband she had adopted the opposite role to the one she had occupied with her previous boyfriend – she was the organiser and controller. Annette believed the couple's marriage difficulties were a result of her husband jealously fixating on her previous relationship. She felt responsible for the relationship problems and believed her husband was a good man who deserved more than she gave.

When Annette spoke of her mother, it was of a woman she believed to be ambivalent toward her children, which left Annette questioning whether or not she was wanted as a child. She also described her mother as distracted. "I think she felt she did not want to be there ... She used to say 'I wish I hadn't had you bloody kids'." Annette had difficulty coming to terms with what she described as an

unexpected pregnancy soon after her marriage, which she reluctantly terminated due to pressure from her husband and his mother. She reported that she had never understood her husband's reaction to this pregnancy.

Annette attended many of the psychotherapy sessions with her young son who made considerable noise, banging toys. (Some dialogue was lost because of this.) Despite Annette attending alone for a couple of sessions following the therapist raising this and Annette talking openly about her fears of what she might discover in psychotherapy, Annette returned to attending with the child. A number of times she did not attend sessions and did not contact the therapist but arrived for her usual appointment the following week. Eventually, sometime after the ten sessions reported here, Annette abandoned individual psychotherapy and attended couple therapy with her husband.

8.2 STAGE ONE ANALYSIS: INTERFACE OF SESSION TRANSCRIPT AND PROCESS NOTE MARKERS

The following segment located the therapist's process note markers within the corresponding dialogue. As with the previous two case studies, the aim at this point was to familiarise the reader with the session's content and to provide an orientation within the context of surrounding material. A minimal level of interpretation of the data was conducted at this first stage of analysis

Session 1

Although Annette's child was not in this session, the therapist's process notes indicated that the session felt significantly different to the previous assessment sessions. The therapist partly attributed this to her waiting for Annette to speak rather

than asking specific questions as she had during the assessment sessions. The therapist stated, "It felt odd in some way, perhaps because I was no longer taking the lead role, perhaps Annette is reluctant to take the lead role and would rather accommodate me." This comment was indicative of how uncomfortable Annette was when she was required to initiate speech, and became typical of the sessions she attended with her son.

Session 2 Segment 1 (A2.1)

Throughout this part of the session Annette's child Adam banged a toy. Whilst some of the dialogue was lost the essence was retained.

> *Child in the session. Strong resistance from Annette re: being wanted by her mother. She'd stated a number of times that she was unwanted by her mother but at this point was not able to.*

Annette: ……whether I was wanted or other …..(inaudible)…..obviously if she didn't want me she would have had a termination.

Therapist: Would she?

Annette: She did have one prior….. I didn't know that until I was pregnant…..(inaudible). …….and she said, 'well yes I did have a termination before I met your father.' …..(inaudible sentence). Dad helped her through that. I mean she had the termination so what made her think…..(hammering).

Prior to this dialogue Annette had spoken of a sense she had during childhood that her mother did not want her. Her mother, she reported, questioned why she had her children, and had stated that she would have been better off if she had not had them. But, as pointed out by the therapist (in the text box above), when this was put

to Annette directly, she disputed it, possibly revealing both her and her mother's tendencies toward ambivalence.

Of particular note in this session was the attendance of Adam, Annette's small child. This created a distraction, which made the session difficult for the therapist, but it also placed restrictions on the content discussed. Throughout the session, Annette focused on whether she was wanted by her mother or whether her mother would really have preferred to be doing something other than caring for her children - she gave work as an example. This was precisely the experience she set up for the therapist; she was the one called on to tolerate Annette's child in the sessions and although difficult, at this point the therapist did so without speaking of it.

Bringing the child to sessions can also be seen as a difficulty Annette had in being separated from her child. This was consistent with the dependence she described in the first session in relation to her previous partner. She spoke frequently throughout the sessions of her husband's preference for attending activities with her, rather than alone. She stated that he wanted them to be together, not separate, and at one point included herself in this by stating that she also wanted to attend events and functions with him, rather than alone.

Session 2 Segment 2

At the end of the session Annette reflected that she found gaining the understanding of the impact of losing her ex-boyfriend's family very helpful. She's feeling a lot better after each session – less preoccupied and happier.

Annette made the comment about feeling less preoccupied and happier at the end of the session. It was inaudible due to the noise created by the child in the room,

and therefore unable to be represented here other than in the text box as taken from the therapist's notes.

The theme of dialogue throughout this session related to Annette's feelings of being unwanted by her mother and her belief that her mother preferred paid work to raising children.

> Annette: I think she felt a little bit like me to a certain degree, you want some peace in your life, sometimes it's easier to go to work than look after the kids at home, with all the fighting and carrying on. So I think she felt a bit trapped at times.
>
> Annette: A little bit in the way. A little bit not wanted, but only slightly from what I can gather from that time really. Because I didn't think much about it, I was pretty young.

Whilst there are a number of reasons why Annette might feel better after attending psychotherapy (for example, the experience of someone to speak to) there was an element of her trying to please the therapist that includes the reciprocal assumption that the therapist was pleased with Annette. This contrasted however, with Annette dividing her attention between the therapist and the child she brought to the sessions. She stated that since attending the sessions she was less preoccupied with her previous boyfriend. By bringing her child, however, she created a triangular relationship in which one person is separated. Annette appears to have carried her previous boyfriend into her current marriage just as she brought her child into the therapy sessions.

Session 3

Annette's child was not in the session. She stated that she wanted to speak about her husband whom she spent much of the session reproaching. She particularly focussed on his complaint and dissatisfaction with their life including their sexual life.

Session 4 Segment 1

> *Child in the session. I sensed at the beginnng of the session when Annette was complaining about the reason for Adam's presence – that she wanted my approval for her avoidance/sabbotaging the therapy.*

Annette: Adam hasn't been very well.

Therapist: Oh hasn't he?

Annette: Diahorhea and vomiting….(inaudible few words).

Therapist: So what is it that you'd like to bring to the work today?

Annette: I'm not really sure, haven't thought to think about it, a blank.

Therapist: A blank? I wonder what that means?

Annette: I'm feeling pretty content.

In the text box above the therapist reported her sense that Annette was jeopardising the therapy and wanted her to collude with this. Annette's comment that she felt content, conflicted with having an unwell child, that is, unless one considers that something about an unwell child gave Annette a feeling of contentment. What that might be is unknown at this point.

Session 4 Segment 2

> *Also ½ way through session (during silence) Annette used Adam's presence to absorb her attention in the silence, I felt stuck.*

This comment followed from the above dialogue in which there was a discussion about Annette and her husband attending couple therapy. Throughout the sessions the therapist found herself working in a supportive way with this patient. She initiated dialogue and encouraged the patient by reminding her of the progress she had made. This part of the session was spent talking about Annette's interest in couple therapy and resulted in the therapist encouraging Annette to continue with individual work which was a position likely prompted by her impression that Annette may cease her individual work. The therapist adopted a supportive, encouraging position, telling Annette that she was working well. Annette's responses to the therapist's questions enabled a history of Annette's life to be developed, but this occurred in a responsive way rather than new material emerging as initiated by Annette in the form of associative material. There was an implicit demand on Annette's part for the therapist to act.

Session 5

> *At the end of the session I acknowledged Annette's courage in coming to the session without Adam.*

Therapist: ... you for giving yourself the space to do this today without Adam here.

Annette: Yeah well that's right. ….both sick, both kids.

Therapist: Are they?

Annette: Time of the year yeah.

Annette's child was again present in the session and the therapist's comment demonstrated the impact of this. It reflected the doubt she had about the patient's motivation for attending with her son. The therapist's need to support and encourage Annette indicated her preference for the child not be in the sessions but she did not state this clearly, as if any demands made of Annette might result in her abandoning the therapy. Furthermore, in reporting the children's ill health, Annette implies that they might have attended had they been well.

Session 6

> *Interpretation re: the newness of her feelings of power and confidence.*
> *Annette showed delight; said she felt overwhelmed, not frightened.*

Annette did not bring her child to this session and disclosed a physical assault by her husband that had occurred the previous evening and resulted in Annette making a report to the police. The session mostly consisted of Annette's description of the sequence of events surrounding the assault. The therapist was supporting in her comment that Annette had exhibited feelings of power and confidence by reporting the incident. Interestingly, Annette viewed her reaction to the assault as overwhelming rather than frightening which was inconsistent with an assault and therefore leaves the meaning it had for Annette unclear at this point. Overwhelming feelings are usually associated with something being too much, as in beyond. This is

interesting in light of Annette's feelings of never satisfying her husband and suggestive perhaps of a sense that either she or her husband, or both, went too far.

Session 7 (A7.1)

> *Child in the session. When Annette said that she wanted answers from me (after being challenged)- the session freed up. Prior to this I wonder if Annette was trying to abdicate her newly found position of power to me. I resisted it strongly, felt uncomfortable in the countertransference before I identified the expectation.*

Annette pondered her role in her husband's angry attack and the therapist posed the following question.

Therapist: So, wondering how you contributed, whether it's your fault?

Annette: Yes.

Therapist: And what about (husband)?

Annette: Well I can see it wasn't my fault, that his behaviour is not my fault – and how he reacts but, you know, I suppose I could have contributed to him being angry but I'm not responsible for how he reacts.

….

Therapist: You've used the word 'supposed' to a lot as if there's some fixed rights or wrongs – I don't know what you mean by that but you've used it a number of times about yourself.

Annette: I suppose I've never been in the situation before. (inaudible sentence – background noise). How are they supposed to feel?

Long pause

Therapist: Are you asking me those questions? Or are you musing out loud?

Annette: Probably a bit of both.

Long pause

Therapist: I was thinking about your childhood and the responsibility you had to be Mum to your brother and sister and how you were behaving how you were supposed to behave, that your Mum expected that you would.

In this session Annette verbalised material (above) which was more challenging and appeared more honest than previously. She questioned her part in the angry attack by her husband and pondered over the way she dealt with such attacks, wondering how one is supposed to respond. She questioned why she did not resent her husband as much as she had expected, which suggested an element of anticipation in relation to the assault and, also, expressed a wish to be angrier than she was. As demonstrated in these sessions, Annette exhibited a passive form of aggression that was concurrent with a physical acting out of aggression in her husband. She seemed to be asking here to speak about this aspect of herself that at one level she recognised, but yet to understand.

Just after this segment, the therapist focused on the word "supposed" which Annette frequently used in describing her tendency to be subject to others' wants or expectations. This highlighted the difficulty Annette had in seeing herself as separate to others. This difficulty pervaded her relationships and was further evident when Annette pondered over not knowing how she should feel and relate to her husband intimately after the assault. She spoke about how she communicated indirectly by giving him signals. For example, the therapist asked if he knew what she wanted and Annette replied, "non-verbally he does but not verbally." Annette appeared unaware

of the difficulties inherent in her assumption that her husband was able to know what she wanted without her verbalising this.

The effect on the therapist of having the child in the session was also made clear in this dialogue. The therapist worked in a style that is indicative of her feeding Annette and Annette mostly agreed with the therapist. The therapist was aware that Annette attending to the child would fill silences, rather than her speaking of what entered her mind. In the previous session, the therapist noted that she initiated dialogue, thus moving Annette onto a specific topic of her choosing, and she questioned why she did so. Here, she repeated this when she focused on the word supposed. Annette had attempted to speak of her sense that she played a part in her husband's violence, but the therapist, responding to the 'passive victim' position Annette had adopted, became supportive of her, thus ending Annette's attempt to explore her motivation. She described being left with a sense of confusion about how she should think and feel.

Session 8 (A.1)

> *Child in the session. There were lots of uncomfortable pauses in the session today. While I'm normally very comfortable sitting in silence, my countertransference was unease, not that I wanted or needed to say something-but unease. I felt Adam filled a lot of pauses/gaps for Annette.*

Again the therapist in her process notes pointed out the difference in her work with Annette and with other patients. She acknowledged the difficulty she had being silent and not initiating dialogue with Annette. In the earlier sessions the therapist took the lead, supporting and interpreting. In this session Annette appeared to expect this but the therapist did not respond. Instead, the presence of Adam meant that Annette did not have to experience the silences and instead waited for the therapist to

speak. The therapist noted her own anxiety during the silent periods. The discourse focused on Annette's pregnancy termination when the couple were first married. This was revisited throughout the sessions. As in other sessions with the child in attendance, much of the dialogue could not be transcribed. For example, Annette's verbalisations about her termination did not appear in the transcript but the therapist had noted them in her process notes. The transcribed segments contained fluid passages in which Annette spoke of aggression in her children, in her husband and in her husband's family, and gave descriptive examples of specific incidents. She reported changes in her husband since his first psychotherapy session, and spoke of being surprised at her mother's angry response to her intention to leave home to attend tertiary training. After this session, Annette did not attend for a couple of sessions then returned with her son.

Session 9 (A9.1)

Annette attended with her child. She had not contacted the therapist for the previous couple of weeks.

Child in the session. Was I trying to punish her for her cancellations … Not consciously but why did I not stay with Annette's response to my interpretation? Or, perhaps I'm picking up on her transference about punishment. She said she is not trying to punish her partner – perhaps she is and transferred it to me??

Annette: And I didn't want to do it but I had done it.

Therapist: So it scared you a bit?

Annette: Yeah. I don't know whether it's transposing from – you know – what happened with me and my husband and that's sort of transposing, that's sort of coming back on to me.

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Again, Annette tried to speak of her part in the angry physical outbursts of her husband. She referred to her daughter whom she hit when she would not do what Annette wanted. Her ability to link the fights between her husband and herself, and her angry response to her daughter suggested she had an awareness of her own aggression. Despite this link, the therapist did not explore Annette's aggression, but questioned herself as to why she had avoided it. The therapist noticed her own pattern of focussing on the husband's part in the violence rather than Annette's. Instead of staying with Annette speaking of her own contribution, the therapist moved to speaking about Annette's husband's anger and appointments for anger management classes, which negated Annette's attempts to address her own motivation.

> Annette: Yeah. Like I'm not trying to punish him, I'm really not. Because you know I'm just as sensitive to the termination – I'm part of it. I'm not trying to do that. I sort of feel like I've moved on from that, I really have, but I don't know whether he is feeling very guilty about it.
>
> *Therapist: Do you?*
>
> Annette: I did feel a little bit guilty but – I don't think about it a lot. Wish it never happened but it did so.

A little further on Annette employed a negativism in her speech that was consistent with the therapist's sense that Annette was angry and wanted to punish her husband for the terminated pregnancy. This raised a question about the source of her guilt as her wish at the time was to go through with the pregnancy. It was possible that the guilt related to her intention to be pregnant against her husband's wishes and the consequential termination, which represented her own conflicted wishes. Again,

the possibility of her part in the dilemmas she complained of, was alluded to, but not explored at this stage.

Session 9 Segment 2 (A9.2)

> *We became distracted with Adam. I asked Annette how the session had been for her. (it felt like there had been a rush of issues – all connected but not connected.) Annette said that she had found it useful to make the connections/see a new pattern in her relationships that she had not thought of before. (ie. Above interpretation)/her contribution.*

> *Therapist: To me the session today feels like you've been all over the place, danced across a whole lot of different issues and that's probably because we had a break – so sort of re-establishing the continuity. Again sometimes it can feel quite splattered after a break.*

> Annette: Yeah, that's right.

> *Therapist: And that's fine. Often breaks are very helpful.*

> Annette: Yeah, because I remember the last session, I was like – oh I didn't have anything in particular that I wanted to start.

Here the therapist spoke more than usual. She responded to the passivity in the patient by initiating dialogue in which she asked questions and made supportive statements. This was the first session after some missed sessions on Annette's part. The therapist was drawn into being the one who took control of the session, perhaps so as to keep Annette engaged for fear of losing her. She appeared to need to keep her engaged in the sessions. Annette was extremely passive which appeared to produce a frustration and anger in the therapist indicative perhaps of Annette's husband's response to her. The therapist was drawn into colluding with Annette about her absence. First, she reprimanded Annette by stating the session was all over

the place, but then stated that breaks were helpful, perhaps trying to retrieve the reprimand. Annette agreed with all of the therapist's comments. As the therapist pointed out in the previous week, she may have wanted to punish Annette for bringing the child. She appeared to do the same here. The therapist avoided addressing the fact that the child was a distraction in the session, instead framing this in terms of a break from sessions. Annette's indirect mode of communication had become the mode of the therapist.

Session 10

Annette's child was not in the session. She began by reporting that her week had been disappointing which related to a family member's hospitalisation. She spent most of the session speaking of illness and the difficulties this created for her.

8.3   STAGE TWO ANALYSIS: THEORETICAL

The following test was identified according to markers in the therapist's process notes and, consistent with the previous two cases, was presented in chronological sequence. The form of the test necessitated differences in the presentation of material in this case compared to the cases of Bob and David. The test was non-verbal and took the form of an act rather than a dialogue. The material included here was referred to in the therapist's process notes and, whilst it did not represent the test itself, it highlighted the effects of Annette's attendance with her child. In this, it illustrated a failed test. As with the previous cases the analysis of the tests was conducted through a CMT perspective, followed by an alternative analysis from a Freudian-Lacanian perspective. The data is organised and presented in the same manner as before. The same session material was covered in each analysis and formed episodes that were arranged by session and segments within each session.

8.4 CMT ANALYSIS OF THE TEST

Annette provided examples of occurrences, which portrayed her in a passive position in which she did not get what she wanted and was a powerless victim. Annette's pathogenic belief was based on her belief that she was an unwanted child and that while raising her children her mother preferred to be doing something else. She worked, leaving Annette to attend to her siblings until she returned home. Annette also believed that her mother had a better relationship with Annette's younger sister, whom she believed she preferred. In relationships, Annette believed that others imposed their wishes on her. Based on this material Annette tested to see if, when she attempted to do what she wanted, the therapist would try to force her own wishes on her. The session content, however, told a different story. An active side to Annette's passivity was evident. In effect it reversed the position she complained of and showed the therapist in a position wherein she accepted Annette's wishes against her own. Having reversed her childhood role in relation to her mother by playing mother, Annette had enacted a passive-into-active test. The therapist's response did not assist her to disconfirm her pathogenic belief and was therefore a failed test. To disconfirm the belief would have required the therapist to show Annette that, as an adult, she did not silently have to do as others wanted when this was at her own expense. This case demonstrated the effects of a consistently failed test.

8.4.1 Annette's Pathogenic Belief and Test

Annette's history and the experiences she reported in relationships suggest that her pathogenic belief would dictate that she would be rejected if she expressed her

wishes. She therefore did what others wanted which resulted in feelings of unhappiness. Her test was a silent test in which she attempted to determine if others (the therapist) would tell her what to do, hence force their wishes on her.

Annette's test was a non-verbal *passive-into-active* test that had two elements, first, the bringing of the child, which was tolerated by the therapist and which facilitated the second element, which was Annette's focus on her child during the sessions. While the child in the session might be viewed in terms of separation difficulties, Annette's ability to attend some sessions and, also, her placing him in a crèche whilst attending fitness classes, suggested another motive. Annette attended with her child in five of the ten sessions. When she attended without her child Annette had a predetermined topic to speak about, all of which cast her in the role of a victim. Topics consisted of: her unsatisfactory sexual life insofar as she had no wish to fulfil her husband's sexual demands; an experience of becoming pregnant and of terminating at her husband's insistence; an assault by her husband; and the final session in which she focused on the demands on her time of an ill member of her husband's family. During all of these sessions, the therapist supported and encouraged her.

8.5.1   Episode One

In the preceding session, the first, the therapist commented in her process notes of many uncomfortable silences during which Annette seemed to expect the therapist to lead. Her child was not present in this session. She attended the second psychotherapy session with her son and was frequently preoccupied with him. The child created such noise that much of the tape was inaudible for transcription. During the session Annette spoke about her mother and her childhood memories. Throughout this her child cried and noisily banged toys whilst she identified with her

mother's experience of raising her children. Annette was concerned that her mother regretted having children but unconvincingly assured herself and the therapist, that she was a wanted child. (A2.1) "…..obviously if she didn't want me she would have had a termination." The therapist maintained a continuous dialogue by mirroring or asking clarifying questions. Annette frequently answered with one-word responses, mostly, yeah or yep. Occasionally she corrected the therapist.

Effect of the test on the therapist

In her process notes (A2.2) the therapist commented, "At the end of the session Annette reflected that she found gaining the understanding of the impact of losing her ex-boyfriend's family very helpful. She's feeling a lot better after each session – less preoccupied and happier." This indicated the therapist's awareness of Annette's wish to offer encouragement, but it also displayed Annette's attempt to shift the focus of the session onto the therapist, which might encourage her to continue in the same manner as in this session.

From this early stage, the therapist noted that Annette expected her to be active. This had the added impetus of Annette's need to attend to the actual demands of her child, but also flowed from her tendency to focus on him when he did not demand this but when there was silence. This added to the therapist's attempts to keep Annette focused on dialogue. Thus, the pattern of the therapist maintaining the flow of dialogue was set. In this session, the therapist tolerated the child, but she altered the way she conducted the session because of his demands and Annette's style of waiting for the therapist to initiate speech. The session took on a directive, question and answer character.

Evidence of a failed test

In CMT, the test episode described above (A2.2) was considered a failed test due to the session being empty of any flow of dialogue, or any new memories. Annette did not initiate dialogue other than her statement to the therapist about the success of the therapy.

Effect of the test on the patient

Attending the session with Adam resulted in Annette distracting herself with him rather than focussing on her thoughts and engaging in the work of the session. This also appeared to enable Annette to escape from the anxiety of exploring her thoughts.

8.5.2   Episode Two

In the fourth session, Annette again brought her child and explained, "Adam hasn't been very well." The therapist sensed that Annette was sabotaging the therapy by bringing the child. In response to her asking what Annette wanted to speak of, Annette replied, "I'm not really sure, haven't thought to think about it, a blank." Annette then added, "I'm feeling pretty content." The session was mostly spent talking about the possibility of Annette and her husband attending couple therapy, which conveyed a sense that she may abandon the individual sessions, a sense that was also implicit in the attention she paid to her son during the sessions. The therapist encouraged her to continue individual therapy just as she encouraged her to maintain a dialogue by asking questions and generally keeping the session moving. When the therapist did not do this, Annette focussed on her son.

Effect of the test on the therapist

The therapist commented in her process notes (A4.2) on the difficulty of conducting therapy with Annette whilst her son was present. She wrote, "Also ½ way through session (during silence) Annette used Adam's presence to absorb her attention in the silence, I felt stuck." Evidently, Annette subtly manipulated the therapist into the role of the one who directed the session. When the therapist did not do so and remained silent, she lost Annette's attention. Apparently, this did not impact on Annette because she could, as the therapist noted, absorb herself in her son. The therapist was left in a position of having to conduct the session on Annette's terms and appeared powerless to do anything about this. Her attempt to wait for something to emerge from Annette rather than directing the dialogue resulted in feelings of stuckness. This was the very position Annette complained of in her relationships when she was forced to accommodate others' wants.

Evidence of a failed test

The therapist played Annette's childhood role of doing what others wanted rather than what she wanted. In this case, what the therapist wanted was to perform her role as therapist which she was prevented from doing because of the child's presence. There was no material to indicate a passed test.

Effect of the test on the patient

Annette focused on her son and answered the therapist's questions, however, she did not produce any spontaneous dialogue.

8.5.3 Two Sessions between Test Episodes

Brief summaries of sessions five and six are included because they provided examples of the role Annette enacted with the therapist. Of particular interest was Annette's knowledge, at one level, of her contribution to the position she placed others in. This was consistent with her experience of her mother and therefore a test of her pathogenic belief. She verbalised memories of experiences in which she accommodated others' wishes but to her detriment. In both sessions, Annette had something specific to speak about that involved reproaching her husband for his part in bringing about her discontent. In these reproaches, she highlighted the position she complained of, wherein she did not get what she wanted. Most of the session was spent talking about Annette's pregnancies and birthing experiences, including her terminated pregnancy shortly after marriage. At one point she commented on feeling as though she had trapped her husband, thus suggesting she was, at some level, invested in becoming pregnant knowing her husband was not ready for children. Annette's discourse was much more fluid in this session, and at the end, the therapist congratulated her for attending without her child.

The following session, session six, was the one in which Annette disclosed the assault by her husband. The therapist's response was supportive and encouraging, particularly in relation to Annette's response which was to report the assault to the police. She had not done this before even though her husband had assaulted her before. She described feeling overwhelmed but confident that she had made the report. As with the previous session, she again attended without her son and, there were few silences in her unusually fluid speech.

8.5.4   Episode Three

In the next session (A7.1) Annette again brought her child. The session proceeded in the same manner as the previous sessions in which the child had attended. The therapist mostly initiated and maintained the discourse, but Annette did produce some spontaneous material. She questioned her part in provoking her husband's aggression. This questioning appeared stimulated by the therapist's refusal to adopt the position Annette had previously placed her in. This interaction had begun with Annette speaking of her responsibility for her husband's aggression. Annette stated, "Well I can see it wasn't my fault, that his behaviour is not my fault – and how he reacts but, you know, I suppose I could have contributed to him being angry but I'm not responsible for how he reacts." She then asked the therapist about how she should feel, having spoken of not being as angry with her husband as she anticipated. The therapist responded with a question to Annette that highlighted her request for the therapist to tell her how she should feel. She had not answered the question but demanded that Annette do so by asking, "Are you asking me those questions?" and Annette replied, "Probably a bit of both". The therapist responded, "I was thinking about your childhood and the responsibility you had to be Mum to your brother and sister and how you were behaving how you were supposed to behave, that your Mum expected that you would." This interaction appeared to be a further test of the therapist to determine if she would tell Annette what she should feel along with telling her what she should do.

Effect of the test on the therapist

The therapist commented in her process notes (A7.1). "When Annette said that she wanted answers from me (after being challenged)- the session freed up. Prior to this I wonder if Annette was trying to abdicate her newly found position of power to

me. I resisted it strongly, felt uncomfortable in the countertransference…". The therapist noticed and resisted Annette's style of positioning her as the initiator, or the one in power, as the therapist referred to it. It made her uncomfortable but on this occasion she believed she had challenged Annette, who had not previously asked the therapist a direct question but instead had been silent. Although the silences were tests that followed from the test of bringing the child, they made it impossible for the therapist to respond, she always had to initiate. The question, however, enabled her to respond and as she pointed out, the session freed up.

Evidence of a failed test

Although after this test Annette was more verbal than in other sessions, she still left long silences that were eventually interrupted by the therapist paralleling Annette's current experiences with her childhood. Whilst the test appeared to be passed, given that the therapist did not answer Annette's question but requested she answer it herself, Annette maintained her silence, which after sitting through extended pauses the therapist eventually filled. The same cycle of the therapist initiating when Annette became silent, was repeated.

Effect of the test on the patient

The test appeared to have little effect on Annette. She continued her silence intermixed with answering the therapist's questions and mostly agreeing with interpretations.

Missed in this was Annette volunteering that she played a part in her husband's aggressive outburst. Although she proposed this, the supportive style she elicited from the therapist, under threat of losing her attention either to her son in the session or in general in abandoning therapy, had set a pattern that prevented the therapist

from enabling Annette to explore her own aggression. Annette had effectively sabotaged any progress the therapy could make in this exploration through the very test she enacted with the therapist.

8.5.5   Episode Four

Annette attended the following session (A8.1) with her child, which was another *passive-into-active* test. The therapist noted further uncomfortable silences in the dialogue and the child was noisy to the point that a great deal of dialogue was lost. The therapist highlighted in her process notes that Annette again spoke of her termination. The segments able to be transcribed were more fluid than Annette had shown on other occasions when her child was in the session. Her focus was on aggression and particularly on the positive changes that had occurred in the way her husband handled aggression since his first psychotherapy session. They included examples of aggression in her children, in her husband and in her husband's family. She also spoke of her mother's anger in relation to her intention to leave home to attend tertiary training. Her mother had not spoken of her feelings toward Annette's decision, instead, she handled this by walking home leaving Annette to walk on her own. This was indicative of Annette's retreats into silence, which left the therapist in the position of trying to extract speech from Annette. After this session, Annette did not attend for a couple of sessions. When she returned, her son accompanied her.

Effect of the test on the therapist

In her process notes the therapist commented on the many uncomfortable pauses in the session. She wrote (A8.1) "While I'm normally very comfortable sitting in silence, my counter-transference was unease, not that I wanted or needed to say

something- but unease. I felt Adam filled a lot of pauses/gaps for Annette." One can determine from the therapist's comment the dominance of the silence combined with the noise produced by Annette's child. Both the silence and the child were deafening and appeared to create an environment in which it was almost impossible for the therapist to think and therefore function effectively.

Evidence of a failed test

Again, Annette left many long silences in this session and, although there was some change insofar as she combined the test with speaking about aggression, this was limited to the aggression of others. The examples were memories and in each case they were used to illustrate an improvement in her husband's manner of controlling his aggression and were presented in a way that was encouraging of his attempt to address his problem. While in CMT memories after a test generally indicate a passed test, it was difficult to determine how this test could have been passed given that the child had been allowed to disrupt the session. Furthermore, the same pattern of Annette focusing on her child during silence occurred, but this was combined with the fluidity with which she presented her memories of instances of aggression. In this episode, the CMT evidence of a passed or failed test was inconsistent with the theory and with previous examples.

Effect of the test on the patient

The test could be considered to have led to Annette's fluid recall and presentation of memories but this must be considered alongside the silences that punctuated it. Also, Annette missed two subsequent sessions and failed to advise the therapist of her non-attendance, which could be considered a further *passive-into-active* test. There were, however, inconsistencies in this session that were

unexplainable by CMT. Given that there was considerable lost dialogue, the solution to the riddle of this session might be lost in the missing dialogue.

8.5.6   Episode Five

Annette attended again with her child (A9.1). This constituted another *passive-into-active* test. As in the previous sessions, the therapist noted the uncomfortable silences combined with the child's noise that were typical of sessions with Annette. The therapist was aware of her relation to this patient being inconsistent with her usual work and was also aware of her rising anger and frustration in relation to Annette's brutal, yet silent, tests. Both her absences and attendance with the child were in direct opposition to the usual protocol of psychotherapy sessions, of which Annette was aware. She therefore continued to test the therapist in exactly the same manner without any variation and this was beginning to be more than the therapist could bear. At the beginning of this session Annette did not mention her absences and when the therapist commented that she had phoned several times, Annette responded, "yeah". The therapist then stated that she had phoned to check if Annette was all right given that she had not attended. Annette stated that everything was all right at home and that there had been school holidays. She offered no reason for her absences.

Effect of the test on the therapist

The therapist questioned the way she worked with Annette. This questioning indicated her sense of having been manipulated by Annette and her consequent uncertainty of her position. She wrote, (A9.1) "Was I trying to punish her for her cancellations… Not consciously but why did I not stay with Annette's response to

my interpretation? Or, perhaps I'm picking up on her transference about punishment. She said she is not trying to punish her partner – perhaps she is and transferred it to me??" Annette had used a negativism, which was indicative of her intention to try to punish her partner for not allowing her to go ahead with her first pregnancy. "Yeah. Like I'm not trying to punish him, I'm really not. Because you know I'm just as sensitive to the termination – I'm part of it. I'm not trying to do that. I sort of feel like I've moved on from that, I really have, but I don't know whether he is feeling very guilty about it." The therapist focused on whether Annette felt guilty, and she replied, "I did feel a little bit guilty but – I don't think about it a lot. Wish it never happened but it did so." Here the therapist was able to elicit something from Annette that had some depth, but the dialogue ceased with neither the therapist nor Annette pursuing this. The therapist reported in her process notes that she was conscious of the content of the sessions throughout all of those the child attended and therefore opportunities such as Annette speaking in the way she had here were lost. The content of the sessions the child attended, was predominantly presented in a descriptive, pragmatic style, devoid of any emotional content.

Toward the end of the session the therapist's frustration and anger toward Annette was evident. She asked Annette how she experienced the session and then gave her own impression, which was covertly disparaging. The therapist stated, "To me the session today feels like you've been all over the place, danced across a whole lot of different issues and that's probably because we had a break … Annette responded in her usual agreeable style, "Yeah, that's right." To which the therapist continued, "And that's fine. Often breaks are very helpful." Annette responded, "Yeah, because I remember the last session, I was like – oh I didn't have anything in particular that I wanted to start." This comment was telling. In it Annette

inadvertently articulated her pattern of not having begun the discourse in the session and instead, having expected the therapist to do so. The therapist accommodated this because Annette occupied herself with her child. She also highlighted her attendance with the child when she did not have anything planned to speak about, unlike the occasions when she left the child at home and reproached her husband in the sessions.

Evidence of a failed test

As with the previous tests, Annette spent the session responding to the therapist rather than initiating dialogue or spontaneously recalling memories. She did recall childhood material but it was in direct response to the therapist's questions and was not linked to the test.

Effect of the test on the patient

As with the previous test, this test had little effect on Annette; her silences were intermixed with answering the therapist's questions and mostly agreeing with the therapist's interpretations.

The impossibility of accessing the unconscious under circumstances such as this is evident here. There is no space in which unconscious material could emerge in discourse and be worked through, meaning that the sessions flow along dealing mostly with conscious material. This is not to say that unconscious material is not present, but that it is expressed indirectly in action rather than in speech. The failure of the test is shown to limit the work to the conscious mind.

8.5.7   CMT Summary

The most striking aspect of Annette's therapy was the child's regular presence in the sessions. Even though this was discussed with Annette in terms of it being a defensive function, which resulted in her attending alone for three sessions, she reverted to bringing the child. The repeated failure of the test resulted in a stuckness in the sessions in which both Annette and the therapist became bound.

The failure of the test also produced an identical repetition insofar as the test was presented without variation each time it was enacted. It was only presented as a *passive-into-active* test, never as a *transference* test. Furthermore, the consistently failed test resulted in change, but this was not in the patient, it was in the therapist. As the sessions continued, the therapist became increasingly more active in response to Annette's passivity, a passivity epitomised by the focus she cast on her son during silences. The test had manipulated the therapist into the active position required to keep Annette actively engaged in the process of therapy. This became a reversal of the mother-daughter relationship she described, in which, as a child, Annette found herself acting against her wishes in order to maintain her mother's focus. As Annette's childhood belief dictated, the therapist found herself in an undesired position; precisely the position Annette described experiencing. The child's physical presence made the therapist's work difficult if not impossible to perform, not only because he was a third party but he was also a noisy distraction. She also commented on feeling stuck.

Although the therapist realised she was stuck the child was already in the session, creating a pattern that became difficult to change. To pass the test at the outset would have been extremely difficult because of the risk of Annette abandoning therapy. The therapist would need to tell Annette that she could not bring

the child to sessions, but do so in a way that would not be interpreted as a rejection.

If it was possible for Annette to accept the therapist's terms and attend the sessions

without her child, she might see the possibility of asking for what she wanted, and

placing limits on what she would accept. It was likely that, as a child, she could not

do this. She would then work toward disconfirming the pathogenic belief that getting

or asking for what she wanted would be at the expense of another, who would then

tell her what to do, and possibly reject her. This was precisely the experience that the

therapist repeated and, although she did not reject Annette, she did conduct sessions

under conditions she would not usually allow. The therapist became more directive

than usual, in the sense that she continually asked questions and introduced topics.

She found herself resisting this and questioning why she was conducting the sessions

in this way. Furthermore, the therapist noted her anger toward Annette. As Annette

reported, her husband took this a step further and acted out his anger by assaulting

her.

As CMT maintains and this case supported, the spontaneous emergence of new

material was dependent on a passed test. In this case, Annette at times presented new

material but it was generally the result of the therapist's questions rather than a

spontaneous association. When the child was in attendance Annette reported having

little to speak of. Had Annette attended without her child, it might have been possible

for her to test the same pathogenic belief in another way, or put into words what it

was she needed to communicate, which would enable her to disconfirm her

pathogenic belief. But, in this case, there was no variation in the test, it continued,

unchanged and unspoken, as depicted in Table 3. It appeared that the repeated failing

of a test and subsequent confirmation rather than disconfirmation of a pathogenic

belief, resulted in a repetition of the relationship patterns of which the patient complained.

Table 3. The effects of Annette's tests

EPISODE	SESSION	TEST	THERAPIST RESPONSE	PATIENT RESPONSE
1	2	Child Passive/active	Failed	Silence/ Pragmatic responses to therapist
2	4	Child Passive/active	Failed	Silence/ Pragmatic responses to therapist
3	7	Child Passive/active	Failed	Silence/ Pragmatic responses to therapist
4	8	Child Passive/active	Failed	Silence/ Pragmatic responses to therapist
5	9	Child Passive/active	Failed	Silence/ Pragmatic responses to therapist

Overall the process of testing in the case of Annette is as follows:

- Tests can be tracked across multiple sessions.

- All tests were failed and each presentation of the test was identical to the previous.

- Tests utilised the *passive-into-active* test mode. No use of the *transference* test occurred.

- Failing the test repeatedly, resulted in repetition of the test.

- Repeated failing of passive-into-active tests resulted in the patient manipulating the way the therapist works.

- Failing the test repeatedly resulted in the therapist changing out of her usual role.

- Failing the test enabled progress but it was extremely slow.

8.7   FREUDIAN-LACANIAN ANALYSIS

This series of tests are framed in terms of the Lacanian concept of demand, which has as its aim the determination of desire. Annette's demand was silent. Despite her knowing the individual psychotherapy sessions could not be conducted with a third person present, she brought her son, expecting the therapist to tolerate the distraction he caused, both by his noise and by Annette's attendance to him during the sessions. When formulated in terms of desire, Annette was doing precisely what she knew the therapist did not want. The motivation for her style of relating can be explained from both preconscious and unconscious levels.

At a preconscious level, Annette's resistance to therapy was evident. It was at this level that the therapist intervened and Annette did not bring the child for a couple of sessions. This was presented at the beginning of this chapter (Section 8.1) where it was noted that Annette was concerned that she may discover in psychotherapy that she did not want to be with her husband, a proposition she found unacceptable and was fearful of learning. Paradoxically, in articulating this and by attending therapy, she demonstrated that this was existing knowledge she had access to but of which she had limited understanding. At an unconscious level, she thwarted the therapist's wish that she engage in the work of psychotherapy. This paradox reflected the conflict between her conscious and unconscious wishes. She wanted to be happy and make her husband happy, but was driven to remain in a state of dissatisfaction.

The case of Annette was organised somewhat differently from the previous two cases. This was necessitated by the consistently failed test. Because each demand

occurred at the beginning of each session and was silent there was not the usual material that enabled the reader to locate the relevant episode within the surrounding dialogue. Each section therefore is brief in comparison to the previous cases. The section *The therapist's experience of the transference demand*, has been changed to *The effect of the transference demand*, which more accurately reflected the impact of the failed test being on the therapist rather than the patient. In the section, *The patient's response to the transference demand* additional material has been included to highlight the position the patient adopted in the session.

8.7.1   Episode One

The second session began with Annette bringing the child and attending to him throughout. The discourse is patchy with many missing words and sentences due to the child's noise.

The effect on the therapist of the transference demand

The effect of Annette's demand to have her child in attendance was evident in the therapist's raised level of activity in the sessions and the inconsistency between this and her usual method of working. She adopted a questioning and clarifying style. As noted above, Annette responded to this way of working with a "yeah", or "yep". Most of the sessions had this quality of Annette responding to the therapist's initiation of dialogue.

The patient's response to the therapist/transference demand

At the end of the session Annette spontaneously reassured the therapist of the helpfulness of therapy. (This material was only represented in the process notes due to the inaudibility of the audio-tape. See A2.2) Annette's attempt to please the

therapist by telling her what she imagined she wanted was evident but depicted a conflict. At the same time as she told the therapist how helpful therapy had been she had brought the child, which thwarted the therapist's ability to conduct further work. The subtle manipulation of the therapist into working in a particular way combined with the flattery that sustained the therapist's supposed belief that she was pleasing Annette, functions to keep the therapist's desire alive but unsatisfied. This was the same position that Annette displayed in the second session where she stated that the first session had been helpful but arrived to the second with her child, which prevented any further progress. Annette's thwarting of the therapist's desire was also a thwarting of her own progress.

8.7.2   Episode Two

In the fourth session, Annette brought the child again, but on this occasion she provided an excuse for bringing her child, (A4.1) "Adam hasn't been very well." In this, she attempted to elicit a response from the therapist but the therapist made little comment.

The effect on the therapist of the transference demand

The therapist resisted engaging in dialogue about the health of Annette's child and instead signalled the beginning of the session by asking Annette directly what she wanted to speak of. Annette replied (A4.2) to the effect that she had not "… thought to think about it" and that she felt "…pretty content". Then furthered this by reporting that she was no longer so focussed on her ex-partner. Again, she was flattering toward the therapist's work in her report of being happier and more content in her relationship, and having more energy. She spoke pragmatically of her husband

wanting therapy and the possibility of couple therapy, and about her children and her birthing experiences. The therapist asked for further detail to extend the sterile detail she presented and was supportive and encouraging as if she sensed that Annette might not continue with individual therapy. The therapist also commented on the child appearing tired which illustrated the impossibility of retaining a therapeutic focus on Annette. Instead, the therapist found herself adopting a mothering role toward the child. She commented in her process notes (A4.2). "Also ½ way through session (during silence) Annette used Adam's presence to absorb her attention in the silence, I felt stuck." Annette, in attending with her child had re-enacted the positions she and her mother had occupied. The therapist was in a frustrated, stuck position in relation to Annette who reported that everything was going well.

The patient's response to the therapist/transference demand

The superficial descriptive nature of the content of these sessions pointed to Annette's resistance to think further about the material she brought. Due to the child's presence there was no frustration experienced by Annette and hence no space for the emergence of material from any level other than consciousness. Because the first demand (to have the child in the session) was satisfied, a spiral was motioned in which the therapist was held in a position of frustration. The therapist's frustration also represented a lack of satisfaction, but one that was confusing, given Annette's reports of her satisfaction with the therapy. She was stuck, as she pointed out, just as Annette was, but for Annette this was familiar; it was the same frustrated position she occupied in relation to her mother.

The satisfaction of dissatisfaction: An example from Annette

Annette attended sessions five and six without her child. In both, and consistent with session one, which she had also attended alone, she had specific material to speak of that involved reproaches of her husband and the verbalisation of this enabled her to focus on and present examples of her own dissatisfied state.

In session five she spoke of being forced by her husband to terminate a pregnancy conceived shortly after they married. She also mulled over her unrequited wish to marry her previous boyfriend whom she believed she pushed away because of her urgency to marry and have children. In session six she spoke of an assault by her husband that left her feeling overwhelmed but confident because she had reported the assault to the police. These experiences were presented in a descriptive style, vacant of emotionality. The therapist's support and encouragement of Annette's reproaches of her husband missed her attempt to introduce her motivation into the discourse. Exploring this would have linked the conscious material to the preconscious material and eventually enable access to the unconscious. Annette had presented two statements that signified her motivation. In session five she said that she felt she trapped her husband when she became pregnant after they had discussed waiting for children. And, in session seven (below) she questioned her part in provoking her husband's violent attack. Session seven will be discussed in the next section.

Annette's report of feeling she had trapped her husband reflected the therapist's experience of her in the sessions. The therapist described this as "stuck". It was due to this stuckness that the therapist either missed or chose not to explore this comment. The latter was most likely, given Annette's presentation of herself as a fragile woman, victimised after constant attempts to please others. She had

manipulated the therapist into a supportive role in which she would not be challenged; therefore, the exposition of her knowledge of the entrapment of her husband through pregnancy, was left unexplored and an opportunity was lost.

This material was available when Annette attended alone and reproached others. While making her complaints she heard something in her reproaches that enabled her to question her own position. This was not possible in the stuck position she occupied in the sessions where she attended with the child. Preconscious material that was not defensive was accessible via the reproaches.

Much of the dialogue in session six was inaudible due to Annette speaking extremely quietly. She spent most of the session in a quietly spoken victimised position discussing her husband's assault and its associated details. She explained that she had been hit before but this time it was worse. Interestingly, she did not need her child with her on the very occasion one would expect her to require comfort.

8.7.3   Episode Three

In session seven Annette reverted to attending with her child.

The effect on the therapist of the transference demand

The same pattern existed in this session as in those previous sessions in which Annette's demand was met. The therapist actively maintained the dialogue and Annette responded intermittently throughout silences. Interestingly, the therapist began to identify that Annette was positioning her in an uncomfortable role and resisted filling the silences. She pushed Annette to articulate more clearly rather than in the vague manner she often used. (This is referred to in more detail in the

following passage) She commented in her process notes (A7.1). "When Annette said that she wanted answers from me (after being challenged) - the session freed up. Prior to this I wonder if Annette was trying to abdicate her newly found position of power to me. I resisted it strongly, felt uncomfortable in the countertransference…". The difficulty of these sessions was evident.

The patient's response to the therapist problematic quote bits

Annette questioned her part in provoking her husband's aggression (A7.1). "Well I can see it wasn't my fault, that his behaviour is not my fault". Although she admits that, "I suppose I could have contributed to him being angry". The question she asked of the therapist about how she should feel (referred to above in the therapist's notes) was occasioned by her bemusement over her response to her husband's aggressive attack; she had not been as angry as she had anticipated. Although this was the first direct question Annette had asked, she presented it vaguely. In responding to the question, the path of the discourse shifted from Annette venturing to think about her part in the aggression that manifested in her relationship, to one in which she was portrayed as succumbing to another's direction. "Are you asking me those questions? asked the therapist. "Probably a bit of both." replied Annette. We recall that in this session the therapist responded after a long pause, "I was thinking about …the responsibility you had to be Mum to your brother and sister and how you were behaving how you were supposed to behave, that your Mum expected that you would." This dialogue illustrated the pervasive nature of the effect of meeting Annette's demand to have the child in the session. On each of these occasions the therapist shifted into a supportive and at times directive mode of relating. While this responded to Annette's passivity it also demonstrated a positioning of the therapist that mimicked the position evident in the descriptions of others, such as her husband.

Her husband, however, had eventually responded with aggression. This was a relational pattern familiar to Annette, she returned to passively answering the therapist's questions so that the therapist was doing the work in the sessions rather than Annette, and increasingly the therapist became frustrated and angry in this stuck position. Annette manipulated others into a position in which they made demands of her and she could then perceive herself as a victim to those demands. The manipulation of the therapist into a particular position in the sessions was consistent with Annette's sense that she had contributed to her husband's behaviour, but this remained unspoken because of the ongoing meeting of her demand.

8.7.4 Episode Four

Annette attended again with her child (A8.1).

The effect on the therapist of the transference demand

Again, the therapist was acutely aware of the uncomfortable silence in the session and commented in her process notes that she felt uneasy (A8.1). She was also extremely aware of the child's presence and that he played a role for Annette that made therapeutic work extremely difficult.

The patient's response to the therapist

Although Annette brought the child to this session she also had items she wished to speak of that concerned indirect reproaches of her husband. For example, reporting that he was much better able to manage his anger after his first session of psychotherapy enabled her to focus on his anger. She could not ignore the passive aggression she showed in attending with her child, which effectively forced the therapist into the position of "worker" in the sessions. Although Annette attended

sessions, she did little work other than respond to the therapist's questions. However, when she reported her husband's failings in the form of what he needed to do to solve the couple's discontent, she was able to initiate dialogue. Without such content to report she retreated into attending to her son and waiting for the therapist to work.

8.7.5   Episode Five

Annette did not attend for a couple of sessions and did not contact the therapist. She then returned, bringing her son with her.

The effect on the therapist of the transference demand

In Session Eight the therapist's rising frustration was evident. As in the previous session, she questioned her responses to Annette (A8.1). She was particularly cognisant of the transference and the possibility of her own wish to punish her. The therapist realised that she was pulled out of her therapeutic role and was responding aggressively to Annette's positioning of her in a role from which there appeared no escape. If she insisted on Annette not attending with the child she risked her not attending at all, but in its present form there was a risk of the therapist acting out and little if any chance of working with any unconscious material. The unconscious material was evident in the transference enactments but unavailable to the therapy work because the satisfied demand acted as a resistance to the emergence of the unconscious in speech. These sessions also showed that there was very little preconscious material emerging into consciousness during the therapy.

The patient's response to the therapist

Annette's unconscious intention was revealed in this session by her negativism. At a conscious level, she believed what she reported but her need to convince the

therapist was instructive in its concealed intention. Annette spoke of the termination she believed her husband had insisted she undergo. (A8.1) "…I'm not trying to punish him, I'm really not. … but I don't know whether he is feeling very guilty about it." The therapist inquired about the feeling of guilt, inviting Annette to speak of her own feelings rather than her perception of her husband's. She replied, "I did feel a little bit guilty …." The child was noisy throughout this dialogue but the therapist managed to keep Annette speaking about the termination. The therapist's desperate attempts to hold Annette's attention was particularly evident when she spoke of a topic in which the unconscious was exposed, and was reflective of the omnipresent threat of exclusion in Annette's sessions. Annette retreated again into periods of silence that magnified her resistance to an exposure of herself. Instead, she required the therapist to act in order to retain Annette's focus.

8.7.6   A Final Note on a Satisfied Demand

The difficulties encountered by the therapist in sessions such as Annette's were most evident at the end of session nine where the therapist's increasing frustration with repeated passive aggression was highlighted. Annette continued to bring her son to sessions, which made them almost impossible to tolerate. She missed sessions without notice and although she was often silent, she did not experience the silence; instead, she occupied herself with her son, leaving the therapist to experience the frustration of the sessions. The therapist asked Annette for her impression of the sessions to which she responded that they were useful. The therapist however, tried to explain how she was experiencing the sessions. She stated, (A9.2) "To me the session today feels like you've been all over the place, danced across a whole lot of different issues and that's probably because we had a break – so sort of re-

establishing the continuity. Again sometimes it can feel quite splattered after a break." The therapist was pointing to Annette's approach to the sessions, which consisted of superficial pragmatic descriptions with only momentary glimpses of depth or emotion. But, when she broached the missing sessions she did so in a disguised manner as if she needed to protect Annette. Annette responded in her agreeable style, "Yeah, that's right." To which the therapist replied, disingenuously, "And that's fine. Often breaks are very helpful." Of course, breaks of the type Annette took are not helpful and could be construed as acting out. The therapist had already mentioned the absences at the beginning of the session but Annette had ignored this. Here again the therapist raised the same issue but under conditions of anger, responding in the same passive-aggressive manner as Annette did. The lack of clarity meant that the therapist's anger was unrequited and Annette responded, "Yeah, because I remember the last session, I was like – oh I didn't have anything in particular that I wanted to start." This was a telling comment as the phrase, "I wanted to start" was ambiguous. At a conscious level, this alluded to Annette's expectation that she only need attend when she had something particular to speak of. It is, however, also a phrase used when speaking of 'starting a fight'. This was what Annette had attempted to speak of in an earlier session in which she questioned her provocation of her husband's aggression, thus at an unconscious level Annette was driven to provoke the therapist. Indeed, this was the therapist's experience of Annette. Her attendance with her child when she did not have anything planned was consistent with the pattern observed across the ten sessions. She did not bring the child when she spoke of her unsatisfactory sexual life, the assault and the termination. In these experiences, Annette cast herself in the role of victim.

The therapist's position in the sessions was one of a third party to Annette and her son, which created a sense of dissatisfaction in the therapist. This was the position Annette complained of in her relationships. Her previous partner would not marry her, and her current partner would not agree to her having a child before he was ready. Also, her husband, with whom she was dissatisfied but wanted to remain married, assaulted her. Annette did what she knew the therapist did not want which orchestrated the therapist's shift out of her usual therapeutic role. This was the bringing of her child, which paradoxically, rendered the therapeutic work ineffective, thus leaving Annette in a position of dissatisfaction; the very position she complained of. Annette had set up a position in which she would not be "helped" and in doing so, the therapist was placed in the same frustrated and dissatisfied position from which she did not feel she was of help.

8.7.7 Summary

The ten sessions reported here demonstrated Annette's positioning of herself in relation to the therapist for the purpose of determining something about the therapist's desire. In this, Annette was successful and it placed her and the therapist in a position that was familiar to her; she could imagine the therapist's desire was the same as her mother's.

Interestingly, the therapist's positioning was the result of a non-verbal orchestration. Despite the lack of speech, Annette's demand was vociferous. She entered the sessions with her son and expected tolerance of this, an expectation that was in fact, met. Due to this tolerance, Annette was in a position to re-enact a relationship pattern familiar to her and which became more entrenched as the sessions continued. Through the introduction of the child in the sessions, the

necessary two person therapeutic relationship became triangular and an exclusionary relationship between mother and son dominated. This resulted in the therapist's inability to function in her role and forced her into an active role. This position was held in place throughout the sessions by both Annette's passivity, and by the attention she paid to her child when, through silence, a demand from the therapist for her to speak, was invoked. In this position, the therapist's activity fluctuated between support, direction and, also aggression insofar as she noticed her wish to punish Annette for her failure to work and abide by the rules of the session. Similarities were evident here with the descriptions Annette gave of her husband's jealousy of her previous boyfriend. Annette reported on her husband as the one who continually brought her ex-boyfriend into their relationship, with the result of aggressive outbursts on her husband's part. Annette's investment in producing a triangular relationship was evident in the transference. She had stated at one point she no longer focussed on her ex-boyfriend, suggesting it was the therapist who had maintained the preoccupation with her previous relationship.

Where Annette presented examples of her dissatisfied, victimised position she attended alone seemingly without the need to position the therapist and identify with her dissatisfaction. During the four sessions, she attended without her son she spoke fluidly of her termination, the assault, her father-in-law's illness, and her and her husband's unsatisfactory sexual life. This pattern suggested that whilst she could verbalise her own dissatisfied state she had no need to recreate this with the therapist. At such times, the discourse surrounding dissatisfaction was active and initiated by Annette whereas this contrasted with the therapist being required to initiate material at other times. Paradoxically, but consistent with Freudian-Lacanian theory, in Annette's position of dissatisfaction, satisfaction was also evident. Hence, she was

content, as she commented in the session after the assault, and wondered why she was not angrier toward her husband than she felt. This aspect of her functioning she did not understand.

Due to the positioning of the therapist as the one whose desire was active in the session, a reversal of the process necessary for the emergence of the patient's desire occurred. It was the therapist's desire that was Annette's focus; in fact, as pointed out above, she was effectively master of it. The position she elicited, however, mimicked an identification and whilst she was master of the therapist's desire, she was also enslaved by it. She was enslaved in the position of denying herself enjoyment because it enabled her to fulfil an unconscious wish; a fantasy the precise nature of which was unknown, but was related to an assumption that her mother enjoyed being unhappy or dissatisfied. In positioning the therapist as her mother, which she did by attending with the child, she in fact became the cause of the therapist's dissatisfaction. Through an identification with her mother, Annette ensured her own dissatisfaction. As she stated, she was fearful that if she understood herself better she might discover the discontent in her marriage and abandon it. In sabotaging the psychotherapy sessions, she could remain in her unhappy state within the marriage.

Although the unconscious was rarely evident in the dialogue from Annette's sessions, there were a couple of moments that provided a glimpse of Annette's unconscious wish and the manner in which this was played out in her current relationship with her husband. These were moments when she questioned her contribution to her abuse by her husband, and her sense that she trapped her husband when she became pregnant. In these examples, she revealed an unconscious wish connected to the experience she managed to effect. Her husband reported both events as examples of her being in a state in which dissatisfaction was imposed on her, but

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this view left unattended her unconscious wish to occupy this position; knowledge she was yet to have access to and in the present context had resisted knowing.

8.9   COMPARATIVE ANALYSIS OF CMT AND FREUDIAN-LACANIAN THEORY

At a descriptive level, the therapy was at an impasse due to Annette's manipulation of the sessions. Theoretically, in CMT terms the tests were repeatedly failed. In Freudian-Lacanian terms the patient's demand was satisfied thus closing the door on the unconscious. The difference between the two models is explained in terms of defences and drives.

The main difference between the two models was evident in the theoretical explanations for Annette's child in the session and her consequential silence. In CMT, her silence was considered a test to determine if the therapist would tell her what to do, which would result in her experiencing unhappiness. Annette needed the therapist to show her that she could ask for what she wanted without rejection and without causing unhappiness. Achieving this, required the therapist to inform her of the impossibility of her undertaking psychotherapy with the child present and would give her the experience of the therapist articulating her own wants. The therapist did not tell Annette that she could not attend with her child and therefore failed the test, and Annette did not learn that she could ask for what she wanted. In Freudian-Lacanian theory Annette's attendance with her child and consequential silence was viewed as an unconscious wish to do the opposite of what she believed she knew the therapist wanted. She sought to reproduce with the therapist her relationship with her mother in which she had experienced her mother as dissatisfied. She, therefore, set

about opposing the therapist so that she could engage in a familiar relationship built on mutual dissatisfaction.

Both theories adequately accounted for the data until the point where Annette expressed her feelings of not knowing how to feel and not being as angry as she believed she should after the assault by her husband. The assault, paradoxically, brought an element of satisfaction by enabling a position of dissatisfaction, which was consistent with her comment that she feared knowing that she did not want to remain with her husband. This was knowledge she had but did not want.

Freudian-Lacanian theory enabled a consideration of the literality of what Annette said and matched this to what she did in the transference. This accounted for what Annette wanted at the level of desire. She demanded the therapist tolerate her child, which made the therapist's work impossible. When the transference was considered and the therapist stood in for the maternal object, it was evident that Annette believed her mother was dissatisfied. The descriptions of her mother confirmed this. She therefore created an environment in which her mother/therapist was dissatisfied. In fact the therapist was frustrated and angry which was consistent with descriptions of others in her life. Annette's mother was her primary identification and Annette sought to determine if the therapist would take on this identification. Because the transference demand was satisfied and the therapist did take on the position of Annette's mother, Annette's unconscious was effectively closed which resulted in her repeating what she already knew and not learning anything about her unconscious.

Furthermore, Annette was most fluid when speaking of examples where she did not get what she wanted. On these occasions, she portrayed herself as a victim, either directly when she was assaulted and when she was a child caring for her siblings, or

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indirectly through reports of her child being unwell or injured. This was consistent with the Freudian-Lacanian theory pertaining to Annette's desire to be dissatisfied but inconsistent with CMT, which dictated that she wanted to ask for what she wanted so that she could be happy and satisfied. Both theories offered explanations for the sessions but where CMT focussed on Annette as a victim and her inability to effect what she wanted, Freudian-Lacanian theory viewed the conscious portrayal of what she wanted to be a defensive response to her drive and desire for dissatisfaction.

CHAPTER 9: CONCLUSIONS AND IMPLICATIONS

9.1   AN OVERVIEW OF THE RESEARCH

Weiss's (1986; 1993) notion of the patient performing unconscious tests of the therapist formed the basis of this research. The initial research question asked "What is testing?" This and subsequent questions related to the process of psychotherapy and were specific to CMT descriptions of the phenomenon. These questions asked: "How are tests enacted in psychotherapy?" and, "How do tests relate to each other?" They were answered through an illustration of testing in the CMT section of each clinical case study. The search for an explanation for testing outside of Weiss's theory led to Freud's case of Dora and the concept of demand. Based on Weiss's descriptions of tests, it was found that each test episode could be successfully analysed as an unconscious transference demand. This was illustrated in the case studies in Chapters Six, Seven and Eight.

A further research question emerged from Weiss's higher- level functioning hypothesis in which it was stated that the ego functions of planning and managing operate at both conscious and unconscious levels. This inquiry went to the nature of the unconscious and its processes and asked: "What is the unconscious in Weiss's theory?" This question and that of how testing fits with broader existing psychical concepts were examined in the first part of the thesis in Chapters One to Four where it was argued that the Freudian unconscious had been elided and the unconscious referred to in CMT served the function of the Freudian preconscious.

At a clinical level, two propositions were examined through case-study data using Freudian-Lacanian theory as an alternative to CMT. The first proposition was that a drive-based theory of the transference (Freudian-Lacanian) would provide a

fuller explanation of testing episodes than an ego-defence based theory (CMT). This

proposition was supported.

The second proposition was based on the Freudian-Lacanian theory of

identification and proposed that the patient would attempt to position the therapist as

an identificatory object. This contrasted with the CMT proposition that in treatment

the patient wants the therapist not to respond as the parental objects responded. This

proposition was also supported.

9.2 PROPOSITION ONE

The Freudian-Lacanian theory of the transference will provide a fuller explanation of testing episodes than CMT.

The first proposition was supported. Freudian-Lacanian theory was able to

account for the patients' displays of aggression and repeated enjoyment of the

therapist where CMT explanations were incomplete. These displays were consistent

with the therapist being treated as an erotic object in the transference. As pointed out

in Chapter Four, CMT explains aggressive acts as passive-into-active tests and

therefore as a re-enactment of the parent's aggression (Foreman, 1996; Rappoport,

1996; Weiss, 1993; Weiss et al., 1986). This is in the manner of Anna Freud's

(1936/1966) defence of *identification with the aggressor.* This attribution of the

patient's behaviour to a defence necessitates a departure from the transference as

occurs at the point of passive-into-active testing. In contrast, the Freudian-Lacanian

explanation maintains a connection to the transference through the drives. In this

explanation, the patient enjoys his treatment of the therapist as an erotic object in the

same manner as past objects.

The two functions of the therapist in the transference, according to Lacanian theory, were evident in the data. As explained in Chapter Four, these are the *subject supposed to know* and *object a*. Both relate to the patient's attempts to position the therapist in an imaginary role affected by attempts to foreclose the position of someone unknown, the Other, and install someone known like the patient and like the parental objects.

As was found in the cases in this research, this process is stimulated by a demand of which the patient awaits a response. When the expected and anticipated response to the assumption that the other knows something did not eventuate, the patient's drives emerged from the unconscious and the patient's way of enjoying his objects became evident. In the cases of Bob and David, the initial demand within the session was consistent with the "subject supposed to know" and provoked by the psychological testing. In turn, the therapist's resistance provoked her installation as a potential erotic object and, to use an example from the first case study, David began his incessant aggressive style of relating. For David, resistance represents a potential object *a* and stimulates an aspect of the drive, which consistent with jouissance, the subject enjoys in its unbearable way.

All three cases displayed examples of the patient's use of the therapist as an erotic object, an object that resembled object *a,* and, in these cases one that had an aggressive component. Each patient spoke of others they had used in the same way; namely ex-wives, husbands and mothers. Annette's relations to her erotic objects were evident in the passive manner in which she presented herself with her child. This meant that the therapist demanded of her and also experienced anger toward her. On the occasions she attended alone she presented herself as the victim of her husband. Her presentation as a victim disguised the sadomasochistic relation she had

with her husband. David described hating the situation he was in with his family yet it was a situation he was driven to exacerbate and perpetuate. Bob lived with another woman (kept secret from his children) but continued to hand his weekly pay cheque to his wife, which enabled him to complain of deprivation regarding money. The sense of deprivation, however, is a defence against the enjoyment he experiences from his secret bank account – Bob enjoyed, enjoying in secret. Furthermore, he attempted to seduce the therapist into admiring him via his new shirt. At the same time, he annulled his own desire by presenting the purchase as something needed rather than desired. The therapist, as with other women he spoke of, became the new version of his lost object (object a) and, as such, she set desire in motion only to have it annihilated as soon as Bob detected it. He enjoys concealing, both from himself and from others, his narcissistic position, as revealed in his covert drinking, secret money and his two women.

At noted in these examples, when repeated destructive elements of the patient's functioning are not attributed to the patient's drives, the benefits of such functioning are impossible to account for and cannot be done through higher-level rationalisations and other defences. This is particularly evident when the patient enjoys in the manner of simultaneous happiness and unhappiness. The second proposition relates to what the patient wants of the therapist in testing.

9.3   PROPOSITION TWO

The patient attempts to position the therapist as an identificatory object.

This proposition was supported and Freudian-Lacanian theory was found to offer a more complete explanation of the data in terms of the patient's continuing

attempts to re-create his past objects in the therapist. The findings reflect a fundamental difference in the two theories regarding what the patient wants at conscious and unconscious levels, and the direction of therapy.

According to Freudian-Lacanian theory the patient seeks familiar objects, which are imaginary identifications installed in the ego. The attempt to position the therapist is consistent with the patient's endeavour to bring about a match between an identificatory object and a new object – the therapist. In this sense, the patient tries to install the therapist as someone imagined to act in a certain way. As is evident in the data, this is an extremely active process, even in the case of Annette who appeared to do no more than bring her child to sessions then remain silent. She continually attempted to re-establish the parental object, which is possible if the therapist adopts the position of the other. In this position the therapist embodies the "I" (Lacan, 1964/1998, p.273), the specular image, which reflects back something familiar. It provides an explanation for why David, Annette and Bob continued to demand when the outcome was complaint and disparagement directed toward those who adopted this position. The patient wants and does not want simultaneously, which is a conflicted position. In Freudian-Lacanian theory, the repetition that occurs in conflicted positions indicates something at the level of the unconscious that is not understood. The CMT explanation is the reverse; the patient wants the therapist to be different to the parental objects. In this model, ongoing testing occurs because the therapist has not passed the test enough to convince the patient that his pathogenic belief is untrue. In CMT, defences replace desire, leaving no room to discover what the patient actually wants as opposed to what he says he wants. This is the difference between unconscious and conscious desire.

The patients' attempts to recreate identificatory relationships were evident throughout the cases both in the style of relating between the therapist and patient, and in the patients' descriptions of their relationships. David described his mother as controlling, bullying and bossy; the very traits he displayed in relation to the therapist and likewise complained of in his ex-wife and in most of his dealings with medical professionals. Bob described his mother as a deprived woman at the mercy of her husband who controlled the family money. He presented himself as financially deprived by his wife but spoke of a bank account he kept hidden from her. He also complained that his wife deprived him of her listening, an accusation he also levelled at the therapist. Annette described her mother as largely absent, of not wanting to be in the home raising children, and more attentive to Annette's sibling than to Annette. In attending with her child, Annette treated the therapist in the same way and descriptions of her husband's complaint of her mimicked her own complaint of her mother. While these examples clearly illustrate the patient's identification with paternal objects, they also display the function of the pathogenic belief as a defence. Bob's vocalised deprivation alongside his hidden bank account provided just one example. The patient wants a new identificatory object but one that will enable unconscious wishes to come true, rather than experiencing the trauma associated with them not coming true. In the Freudian-Lacanian model of the mind this is why defences are constructed.

Defences were most clearly evident in the reproaches and disparagements that showed the patients blaming others for their discontent when in fact this served the purpose of hiding their part in the interactions of which they complained. Lacan's (1951/1982) way of raising the patient's awareness of his defences against his drives was to implement the dialectical reversal. This was identified in Freud's (1905/1964)

case of Dora. The reversal is of the positions of self and other in speech and is specific to the transference. It was quoted in the Introduction. All three cases display the same characteristic of reproaching those who adopt the position of the other that was present in the case of Dora. Bob, for example, begins story telling and when the therapist interrupts, he is reminded of his wife's inattention. He then recalls being forced to listen to her stories. David, similarly, attempted to trap the therapist into giving advice. Later in the session he disparaged his parents for giving him "bad" advice. Although the therapists in this research did not implement the reversal as Freud did, the patient's desire in relation to the drive and the defence against knowing this, is still evident. The implementation occurs when the patient is in a position to acknowledge this information. To do so prematurely will frustrate the patient. The reproaches, therefore serve a defensive function as displacements employed when the therapist refuses to become the patient's object.[20] Ultimately, when the patient can tolerate the reversal he learns about himself. When the therapist adopts the position of the patient's parental object, as occurred in the case of Annette, there is maintenance of the two positions.

9.3.1   Failed tests: A case of identical demands

The case of Annette illustrates the lack of movement in the transference that results from a series of failed tests. In Lacanian terms Annette managed to position the therapist as the other (small o) with whom she could re-enact her relationship with the Other. She recreated in the therapist the same position she described her

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[20] This is not solely a function of the psychoanalytic session as reproaches occur in everyday conversation outside of the session. Nor is it solely a function of having enacted something of the unconscious in the transference. When it appears in the session, however, it offers the opportunity of connecting, or at least bringing closer, the verbalised content of the reproach with the patient's enactment in the session. This is described further on in sections 9.3.1 and 9.4 in terms of the role of the transference in the movement of content from the unconscious to the preconscious.

husband as occupying, which was consistent with the jealousy and absence that marked her relationship with her mother.

Theoretically, the case of Annette is represented schematically in Lacan's figure of *The Interior Eight* (Lacan, 1964/1998, p.271). As pointed out in Chapter Four, this is a schema describing the relationship between the transference and the direction of treatment. According to Lacan the two paths available for treatment are identification and desire. Annette takes the path of identification rather than the recommended path of desire. As a result the sessions proceed in line with what Nobus called "an endless cycle of identical demands" (Nobus, 2000, p.132) Unfortunately, in satisfying Annette's demand to attend with her child, the therapist presents herself as an ego ideal. In this role, the therapist is a caring person who tolerates an impossible therapeutic situation. From this position, Annette sees herself as the therapist's reflection, she is an alienated figure trying desperately but unsuccessfully to accommodate the Other. While this is consistent with the CMT formulation of the relationship between Annette and her mother, what Annette sees is the defence she has constructed against her desire. In Lacanian theory, it is the specular image she sees, which is an image that blinds her from seeing her own masochistic drive and the unbearable enjoyment (jouissance) she derives from it. When considering Lacan's diagram, the therapist, in occupying the position of other, progresses toward becoming an object of identification, which is a step along the line of identification.

In these ten sessions, Annette shifts further away from recognising her part in her discontented life. Her comment, 'I think she felt she did not want to be there', spoken about her mother but clearly a speech about herself, was exactly the way she presented in therapy and consistent with the masochistic drive. Annette's likeness to

her mother originates from her mother's demands that represent her drives and it is through these demands that emerge the traits of identifications that become objects. Annette's masochism is an identification with her mother's masochism and if she can turn the therapy into a masochistic exercise for the therapist, she will not see herself as separate but together with her mother and her masochistic objects.

The case study of Annette illustrates the process of psychotherapy when the therapist occupies the position the patient attempts to elicit. The therapy hits an impasse in which it is stuck in repetitive demands. In contrast, where the therapist does not take up the position of the other and therefore does not play the part of a parental object, the patient ceases his enactment, speaks of the situation based on his memory of an associative experience, and the demands change. This process was evident in the cases of Bob and David.

9.3.2   Passed tests: Changes in demands from enactment to speech

An examination of the dialogue delivered after passed and failed tests revealed that when the therapist did not adopt the position of other as demanded by the patient, the patient articulated this position. The articulation relied on an example from other experiences in which the demanded role was adopted. The cases of David and Bob illustrated how the patient shifts from enactment to speech. This is a slow process and although in the ten sessions presented here the demands do not cease, they do change. David consistently demanded answers to his questions but he changed from wanting answers to direct and at times blunt questions, to presenting options from which the therapist could choose. In effect, he was subtler in his attempt to trap the therapist into responding favourably and although the interaction

was manipulative, it lost some of the aggression of the previous demands. David appeared to learn that the therapist would not play in the way his mother had.

In CMT, the satisfaction or frustration of demands is viewed as the passing or failing of tests; passing being the mechanism that enables the patient to bring forth previously repressed unconscious pathogenic beliefs (Weiss, 1993; Weiss, 1986). Likewise, Freudian theory generally states that frustrating demands enables access to the unconscious. As pointed out in Chapter Four, Lacan was more specific. He believed that by responding to demands in a way that was unexpected to the patient, the door to the unconscious opened. This opening was evident in the cases of Bob and David.

David immediately ceased demanding upon an ambiguous response by the therapist in which she said that she did not know what David wanted her to say, which surprised him. In other relationships David has argued and is therefore unlikely to be listened to, whereas the therapist did not argue, instead she asked him to speak, which was also unexpected. The same function was evident in the case of Bob when he arrived 25 minutes late for the session and the therapist responded unexpectedly. The therapist's response resulted in Bob revealing more than he expected. He spoke of bending and shifting boundaries to suit needs, but quickly denied that he did this, suggesting that he did not like hearing what he had just said. In this, the opening to the unconscious was evident.

An unexpected finding of this research pertained to the patient's progress in the sessions. It illustrates the movement of ideas through the conscious-unconscious system resulting from frustrated transference demands. The illustration requires a return to the examples of disparagements and reproaches presented in the

Introduction, but this time the focus is on the temporal position of speech in relation to the transference act.

9.4   AN UNEXPECTED FINDING: THE TEMPORAL RELATIONSHIP BETWEEN SUBJECT AND OBJECT IN SPEECH

Freud described the mechanics of the movement between states of consciousness in relation to the patient's experiencing in the transference. As pointed out in Chapter Three, Freud (1900/1976) wrote of the need to connect the unconscious representatives of the drives to something held in the preconscious system in order for the content to come into consciousness. This could occur through the new relationship, if all goes well, when previously indescribable unconscious content is enacted with the therapist in the transference. The preconscious idea, as Freud pointed out, could be left either unmodified or modified by the transference. When David states - after a number of occasions of attempting to argue with the therapist, followed by disparagements of those with whom he has argued - that he feels like he is always accusing, the modification although slight at this point, is detectable. This modification is also evident where demands are varied, which relates the modification or movement from the unconscious to the preconscious, directly to the demands (tests).

This distance between the preconscious material and the transference demand was greatest when the transference demand was satisfied and, at times simultaneous, that is, without a temporal separation from the demand when the demand was frustrated. In the case of David, when each transference demand was frustrated he articulated the therapist's experience of him in the form of disparaging comments about others. This was a description of his use of another as an object in the same

form he had just attempted to enact with the therapist. In the unsuccessful substitution of one object for another, David, as the subject of his unconscious, came face to face with the object of his unconscious. This proximal relationship enabled him to recognise himself in the object and illustrated the beginnings of the circumscription in speech of unconscious desire.

Prior to this movement, the patient is unable to recognise his participation because he only sees what is reflected back to him in the form of the other person. Each new person who takes up the identification re-enacts an existing experience and further blinds the patient to his own drives and desires, which is what occurred in Annette's case. She never attained this proximal relationship and the subject and object of her unconscious desire remained distanced. Her reproaches and disparaging comments were articulated in the sessions between the demands, not in the same sessions as had occurred with Bob and David. For example, she attended with her child, which is a demand that the therapist accommodate rather than frustrate. It resulted in no associations to those objects with whom she had previously satisfied her drives and her desire. Bob displayed some of both. His demands were mostly frustrated but some were satisfied and where frustration occurred, disparaging comments followed.

The temporal and proximal relationship of subject and object illustrates the movement of material between the states of consciousness and returns the discussion to the purpose of the current research. This was to explain testing through a theory of the drives. As an unconscious concept, testing is a transference demand in which the unconscious is displayed. As a preconscious concept, it shows the movement of content from the preconscious to the conscious, which is evident in the disparagement through which the patients complain. In the disparagements, there is a

movement of ideas and the energy attached to them, from distant relationship objects toward the subject. When there is no distance between the ideas and the subject, they become conscious.

Freud's (1900/1976) formulation that something must be experienced for it to move from the unconscious to the conscious is consistent with CMT. What is missed is that this occurs through connections in the preconscious system. The tests identified in this research as demands follow the process from the unconscious to the preconscious, whereas descriptions of pathogenic beliefs, as pointed out in Chapter Three are consistent with the 'ideas' including defences, located in the preconscious, not in the unconscious as assigned in CMT.

9.5   SUMMARY

Finally, the clinical case studies showed that Freudian-Lacanian theory more consistently explained the patient's demand that the therapist occupy a particular position in relation to the patient. The two theories offer opposed explanations of the position the patient attempts to elicit. CMT views the patient as attempting to have the therapist occupy the opposite position of his parental objects whereas Freudian-Lacanian theory views the patient as attempting to have the therapist occupy the position of the parental objects. Both theories adequately explained the clinical data but when the patients' displayed aggression and enjoyment in the relation with the therapist the Freudian-Lacanian theory was able to account for this by unconscious drives and wishes. Without recourse to the drives, CMT did not adequately explain masochistic or sado-masochistic interactions with the therapist. The opposing positions are explained by the different formulations of the unconscious, which underpins different therapeutic aims, hence different treatment directions, in the two

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theories. In CMT, the aim of treatment is to build a therapeutic alliance, whereas in

Freudian-Lacanian theory the aim is to deter the building of a therapeutic alliance in

order to uncover the patient's unconscious desire.

The researcher's original contribution was the illustration of the transference

and within this, the patient's attempt to elicit from the therapist a particular position

consistent with his parental objects. This enabled an illustration of clinical processes

with original data.

9.6   LIMITATIONS AND STRENGTHS OF THE RESEARCH.

In this section, the research design is evaluated in terms of its limitations and

strengths.

9.6.1   Limitations of Theory-led research

The current research attempted to provide a balanced interpretation of the data

through the comparison of two theories. Claims of objectivity consistent with

positivist research are not possible with theory-led research, but bias exists in all

methods and paradigms, therefore, it is transparency that is vital to the heuristic merit

of the research. While the interpretation of the data is theory-led and open to the

assumptions of the two theories utilised, the presentation of the raw data in a highly

naturalistic form enabled transparency. In presenting the data in this manner, critics

can form a view of the researcher's findings, thus offsetting the limitations.

9.6.2   A lack of empirical clarity in Weiss's model

A problem in using Weiss's model of testing was that, as Weiss (1993) himself

admitted, there was no common definition for what constituted a test. The same

problem existed for identifying tests as passed or failed. Because of the lack of definition, commonalities that emerged from Weiss's descriptions of tests were used in the analysis of the data in this research. The basis of the analysis amounted to the therapists carefully noting their own affective state, which is often loosely termed the countertransference. This method is not without problems given the therapist's subjective state being present in the countertransference, however they were directed to highlight in their process notes specific occurrences, such as an emotional pull from the patient, or the patient doing something different to usual. This method, while not previously documented by Weiss, proved highly effective, and, through highlighting countertransference phenomena, the therapists were able to point directly to the patients' tests. In determining if tests were passed or failed, the most consistent events that emerged from Weiss's descriptions were again used in the analysis of the data. These were the recall of memories and an increased flow of dialogue, which was considered in CMT to represent a lessening of anxiety.

9.6.3 Selection bias of patients who agree to participate in research

No participant asked to participate, declined. Therefore, the usual assumptions regarding sampling bias require consideration. First, the willingness of those patients who agreed to participate in the research might place them within a specific cohort of psychopathology that would bias the findings. However, this did not appear to be the case in the current research, as each of the three participants proved to have relatively distinct patterns of symptoms.

9.6.4   The impact of recording on patient's behaviour

The influence of taping sessions on the patient's presentation of material cannot be known, it can only be minimised by the unobtrusiveness of the recording equipment. In two of the cases, the recording was videotape and located unobtrusively in the ceiling of the room occupied by the patient and therapist. The third case utilised a small wallet sized tape recorder that sat on a side table in the room. Kachele, Thoma, Ruberg and Grunzig (1988) explored the impact of recording psychoanalytic sessions and concluded that the effect on the patient was minimal. Kachele et al's. research identified references to the recording made by the patient during the course of his treatment. The references, which were few over the course of the treatment, related to being observed and were either direct or indirect. Kachele et al. were of the view that, where the patient's awareness of the recording was evident it produced a positive effect on treatment because it enabled an exploration of the subjective meaning of being observed.

Taping sessions is predominantly an ethical issue in which one weighs up the value of accurate data against the impact on the patient's psychotherapy. Kachele et al. proposed that, as an ethical issue, recording had a favourable effect on the patient because, in being recorded, the patient knew the therapist was under scrutiny. Furthermore, they believed that through consent forms and other information provided when taping was to occur, the presence of a third party was made explicit. This was contrasted with the accepted practice of presenting cases to a third party, in the form of supervisors and those present at case presentations, which was not always made explicit to the patient. The plain language statements made the taping explicit and explained the manner in which confidentiality and anonymity was to be

handled. It was decided that this method was the least intrusive and most transparent way of obtaining verbatim discourse.

9.6.5 The limited experience of trainee therapists

Basing research on psychotherapy conducted by therapists in training has both strengths and limitations. In the endeavour to explore a process in which the patient attempted to have the therapist act a particular part or adopt a particular position, it was more likely that both the success and failure of this, could be observed with training therapists. The inexperience of the therapists, which might otherwise be considered a limitation for the progress of therapy, in fact proved to be invaluable for the findings of this research. The occasions where the therapist's response was less than perfect enabled data to be gathered that not only illustrated the successes of psychotherapy on a moment-by-moment basis but also the failures. A further point concerns the desire of the therapist. In this research, student appeasement was evident in some of the approaches to the patients. Students in training want the therapy to continue. This was evident in the conscious supporting of the patient, which is more consistent with the CMT model than the Freudian-Lacanian model. To some extent, this offsets the researcher bias pointed out below.

9.6.6 Researcher Bias

The researcher is a clinical psychologist, who throughout the time of this research project increased her understanding of Freudian and Lacanian theory through reading and by attending seminars and reading groups on the subject. The researcher's clinical training was in a Masters program informed by Freudian theoretical models. This considered to create a potential for bias given that CMT

began as a post-Freudian theory. Understanding of CMT however, was limited to the literature available on the theory, which was not as abundant or inclusive as the Freudian and Lacanian theoretical literature. CMT literature is heavily weighted toward research publications of psychotherapy rather than a comprehensive theory of the mind, whereas the Freudian and Lacanian publications are the converse. However, knowledge of both theories did develop over the time of the project (six years). The possibility of subjective bias was taken into account and although the use of the two theoretical methods assisted in reducing this, it must be acknowledged that toward the end of the research the researcher had experienced greater exposure to Freudian-Lacanian theory than CMT. It could be argued therefore that there was some bias toward the Freudian-Lacanian theoretical model in the latter stages of the research. The researcher attempted to make any bias transparent by displaying the raw data in its pure form, in doing so the reader can draw his own conclusions without any interpretation by the researcher. This form of data display was a strength of this research that, for ethical reasons, is rarely found in psychotherapy research. All care was taken to ensure that identifying material was changed or removed in order to protect the identity of the participants.

9.7   IMPLICATIONS FOR FURTHER RESEARCH

The current study draws attention to models of psychoanalytic and psychotherapy research where there has been a replacement of the Freudian concept of the unconscious with the Freudian preconscious. Where this has occurred the unconscious as Freud set out has no separate existence. This creates a problem for research. It calls into question the validity of research that makes claims about the unconscious where underlying assumptions are not stated. Readers, and particularly

researchers, of this literature are mislead. This is a particularly prevalent

phenomenon in some of the more contemporary cognitive based research that has, as

pointed out in this thesis, moved toward attempting to explain the mind through

existing psychoanalytic concepts. This is an unfortunate position given the paucity of

research conducted on the content and processes of the Freudian preconscious.

Whether inadvertent or intentional, Weiss and the SFPRG have made a start in this

area but their work is let down by the failure to acknowledge the existence of the

Freudian unconscious. Although not without further problems, the use of the term

subconscious, as exists in some literature, would not confuse Weiss's theory with

that of Freud's and therefore not be misleading. The problems identified here have

implications for psychotherapy practice.

9.7.1   Applications of the research for training psychotherapists

As a training therapist, the transference is arguably the most difficult concept to

grasp, since it is best understood through practice. This research has highlighted that

transference phenomena occur at the outset, that is, from the first session. The

therapist is faced with managing the transference as soon as the session begins,

although, by its very nature, it may not be easily recognised. This research offers an

experience of the interaction between therapist and patient that is not available

through the reading of theoretical and general texts on the subject. Unlike existing

research models (including Weiss el al., 1993 and Luborsky & Crits-Christoph, 1998,

for example), this research illustrates the process of testing at a fundamental level in

the context of the clinical interaction. During the reading of the data the reader

experiences, to some extent, the frustrations and other thoughts and feelings inherent

in any session. This has clear applications for the training of psychotherapists who only have this experience when they enter the session.

A further implication of this research is the highlighting of the significance of the early sessions of therapy. Both the CMT and the Freudian-Lacanian theoretical models call attention to events in psychotherapy relating to the interchange between patient and therapist that is of critical importance and must be attended to. Whilst this interchange relates to speech it is at the time of its enactment beyond speech, which is a vital point in training and one, which therapies that only focus on speech do not consider. At the level of language, the match between the patient's demands and the reproaches of others reveals significant information about the patient's functioning. The training therapist would benefit from the knowledge that from the beginning of psychotherapy he or she is not only under as much scrutiny as he puts the patient under, but he will also be called on to relate in a particular way that is idiosyncratic to each patient, and this must be resisted. Attention to these factors directs the therapist toward what is important thus supporting what is already known of the transference. As became evident in this research a model that does not consider the Freudian unconscious does not capture the full experience of both therapist and patient and what occurs in the space between the two.

9.7.2   Implications for future research

The main point emerging from this research is a need to be specific about what the researcher means when referring to the unconscious in research. Also, as the researcher, the most interesting outcome of this research was inadvertent. This was the depiction of the movement of psychical content between the enactment of the unconscious in the transference and speech. Psychoanalysts are fully aware of this

movement and it is well described in both Freudian and Lacanian transference literature, however, during the session, one is focused on managing the transference and therefore an objective view of this movement often does not occur until post-session reflections. More seasoned psychoanalysts and psychotherapists get better at this. It was the transcript data that enabled the precise depiction of the role the transference plays in the patient's progress. For the development of theory and practice, the close examination of transcript data is essential. In this research, such an examination validated the theory Freud illustrated through the case of Dora just over a century ago. Even though researchers have long been critical of the method Freud used to support his theory, here, through the rigorous and transparent analysis of original transcript data, Freud's theory of the transference with its connections to the unconscious drives, holds.

REFERENCES

Alexander, F., & French, T. M. (1946). *Psychoanalytic therapy: Principles and application.* New York: Ronald Press.

American Psychiatric Association. (1995). *Diagnostic and statistical manual of mental disorders. International version with ICD-10 code* (4th ed.). Washington, DC: Author.

Arnow, B. A. (2005). Cognitive behavioural analysis system of psychotherapy for chronic depression. *Cognitive and Behavioural Practice, 12*(1), 6-16.

Benvenuto, B., & Kennedy, R. (1986). *The works of Jacques Lacan.* London: Free Association Books.

Bion, W. (1959). *Experiences in groups.* New York, NY: Basic Books.

Bird, B. (1972). Notes on transference: Universal phenomenon and hardest part of analysis. *Journal of the American Psychoanalytic Association, 20*, 267-301.

Bornstein, R. F., & Masling, J. M. (Eds.). (1998). *Empirical perspectives on the psychoanalytic unconscious* (Vol. 7). Washington, DC: American Psychological Association.

Brenner, C. (1979). Working alliance, therapeutic alliance, and transference. *Journal of the American Psychoanalytic Association, 27*, 137-157.

Brockmann, J., Schluter, T., & Eckert, J. (2006). Langzeitwirkungen psychoanalytisher und verhaltenstherapeutischer Langzeitpsychotherapien: Eine vergleichende Studie aus der Praxis niedergelassener Psychotherapeuten. [Long-term effects of long-term psychoanalytic and long-term behaviour therapy: A comparative study from the general practices of psychotherapists] [Abstract]. *Psychotherapeut, 51*(1),15-25.

Broitman, J. (1999). San Francisco psychotherapy research group: Clinical primer of control mastery theory.   Retrieved 24/06/99, http://www.behavior.net/orgs/sfprg/ControlMastery.html

Cameron, N., & Rychlak, J. F. (1985). *Personality development and psychopathology: A dynamic approach* (2nd ed.). Boston: Houghton Mifflin Company.

Charman, D. (2003). Paradigms in current psychotherapy research: A critique and the case for evidence-based psychodynamic psychotherapy research. *Australian Psychologist, 38*(1), 39-45.

Chasseguet-Smirgel, J. (1990). On acting out. *International Journal of Psycho-Analysis, 71*, 77-86.

Collins, W. D., & Messer, S. B. (1991). Extending the plan formulation method to an object relations perspective: reliability, stability and adaptability. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 3*(1), 75-81.

Cook, T. D., & Campbell, D. T. (1979). *Quasi-experimentation: Design and analysis issues for field settings.* Chicago: Rand McNally.

Crits-Christoph, P. (1992). The efficacy of brief dynamic psychotherapy: A meta-analysis. *American Journal of Psychiatry, 159*, 325-333.

Curtis, J. T., Silberschatz, G., Sampson, H., & Weiss, J. (1994). The plan formulation method. *Psychotherapy Research, 4*(3&4), 197-207.

Curtis, J. T., & Silberschatz, G. (Ed.). (1996). *Plan formulation method*. New York: Guildford.

Denzin, N. K. (1989). *The research act*. Englewood Cliffs, NJ: Prentice Hall.

Deutsch, H. (1963). Acting out in the transference. In J. D. Sutherland & M. M. R. Khan (Eds.), *Neuroses and character types (1965)* (pp. 363-373). London: The Hogarth Press.

Dor, J., Gurewich, J. F., & Fairfield, S. (1998). *Introduction to the reading of Lacan : the unconscious structured like a language*. New York: Other Press.

Egan, G. (1994). *The skilled helper: A problem-management approach to helping*. Pacific Grove, California: Brooks/Cole.

Erikson, E. H. (1950). *Childhood and society.* New York: Norton.

Evans, D. (1996). *An introductory dictionary of Lacanian psychoanalysis*. London: Routledge.

Fink, B. (1995). *The Lacanian subject: Between language and jouissance*. Princeton NJ: Princeton University Press.

Fink, B. (1997). *A clinical introduction to Lacanian psychoanalysis: Theory and technique* (1999 ed.). Cambridge, MA & London: Harvard University Press.

Fink, B. (2004). *Lacan to the letter: Reading "Ecrits" closely*. Minneapolis, MN: University of Minnesota Press.

Firestone, W. A. (1993). Alternative arguments for generalizing from data as applied to qualitative research. *Educational Researcher, 22*(4), 16-23.

Fonagy, P. (1999). *The process of change and the change of processes: What can change in 'good' analysis.* Paper presented at the Keynote address to the spring meeting of Division 39 of the American Psychological Association, New York 16th April 1999.

Foreman, S. A. (1996). The significant of turning passive into active in control mastery theory. *The Journal of Psychotherpay Practice and Research, 5*, 106-121.

Freud, A. (1966). *The ego and the mechanisms of defence*. New York NY: International Universities Press. (Original work published 1936).

Freud, S. (1950[1896]). *Extracts from the Fliess Papers* [1887-1902]. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 1, pp. 175-280). London: Hogarth Press.

Freud, S. (1976[1900]). *The Interpretation of Dreams* (J. Strachey, Trans. Vol. 4). London: Penguin.

Freud, S. (1964[1905]). Fragment of an Analysis of a Case of Hysteria. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 7, pp. 7-122). London: Hogarth Press.

Freud, S. (1964[1908]). Creative writers and day-dreaming. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 9, pp. 141-154). London: Hogarth Press.

Freud, S. (1964[1911]). Formulations on the two principles of mental functioning. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud,* (Vol. 12, pp. 215-226). London: Hogarth Press.

Freud, S. (1964[1912]). The dynamics of transference. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 99-108). London: Hogarth Press.

Freud, S. (1964[1914a]). Papers on technique (1911-1915). In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 85-108). London: Hogarth Press.

Freud, S. (1964[1914b]). Remembering, repeating and working through (Further recommendations on the technique of psycho-analysis II) (J.

Strachey, Trans.). In J. Strachey (Ed.), *Standard Edition,* 12, pp. 145-156. London: Hogarth Press.

Freud, S. (1964[1915]). The Unconscious. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 159-215). London: Hogarth Press.

Freud, S. (1964[1920]). Beyond the pleasure principle. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 18, pp. 1-64). London: Hogarth Press.

Freud, S. (1964[1921a]). Identification. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 18, pp. 105-110). London: Hogarth Press.

Freud, S. (1964[1921b]). Being in love and hypnosis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 18, pp. 111-116). London: Hogarth Press.

Freud, S. (1964[1923]). *The Ego and the Id.* In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 19, pp. 1-66). London: Hogarth Press.

Freud, S. (1964[1925]). An autobiographical study. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 3-41). London: Hogarth Press.

Freud, S. (1964[1926]). Inhibitions, Symptoms and Anxiety. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 87-172). London: Hogarth Press.

Freud, S. (1964[1940]). An outline of psycho-analysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 141-207). London: Hogarth Press.

Galatzer-Levy, R. M., Bachrach, H., Skolnikoff, A., & Waldron, S. J. (2000). *Does psychoanalysis work?* New Haven & London: Yale University Press.

Gammelgaard, J. (2003). The unconscious: A re-reading of the Freudian concept. *Scandinavian Psychoanalytic Review, 26*(1), 11-21.

Gassner, S. M., & Bush, M. (1998). Research on unconscious mental functioning in relationship to the therapeutic process. In R. F. Bornstein & J. M. Masling (Eds.), *Empirical relationship to the therapeutic process* (pp. 259-301). Washington, D.C: American Psychological Association.

Gedo, P., & Schaffler, N. (1989). An empirical approach to studying psychoanalytic process. *Psychoanalytic Psychology, 6*, 277-292.

Geertz, C. (1973). Thick description: Toward an interpretative theory of culture. In C. Geertz (Ed.), *The interpretation of cultures*. New York: Basic Books.

Glowinski, H. (2002). Ideal ego. In H. Glowinski, Z. Marks & S. Murphy (Eds.), *A Compendium of Lacanian Terms* (pp. 83-86). London: Free Association Books.

Goldfried, M. R., & Wolfe, B. E. (1998). Toward a more clinically valid approach to therapy research. *Journal of Consulting and Clinical Psychology, 66*, 143-150.

Greenacre, P. (1950). General problems of acting out. *Psychoanalytic Quarterly, 19*, 455-467.

Greenberg, L. S., & Pinsof, W. M. (Eds.). (1986). *The psychotherapeutic process: A research handbook*. New York: Guildford Press.

Greenberg, L. S., Rice, L. N., & Elliott, R. (1993). *Facilitating emotional change: The moment-by-moment process*. New York: Guilford Press.

Greenson, R. (1965). The working alliance and transference neurosis. *Psychoanalytic Quarterly, 34* (1), 158-181.

Greenson, R. (1967). *The technique and practice of psychoanalysis* (Vol. 34). New York: International Universities Press.

Harari, R. (2004). *Lacan's four fundamental concepts of psychoanalysis : an introduction* (J. Filc, Trans.). New York: Other Press.

Hartley, & Strupp. (1983). The therapeutic alliance: Its relationship to outcome in brief psychotherapy. In J. Masling (Ed.), *Empirical studies of psychoanalytical theories* (Vol. 1, pp. 1-37). Hillsdale, NJ: Analytical Press.

Hartmann. (1992/1958). *Ego psychology and the problem of adaptation* (D. Rapaport, Trans. 13th ed.). Madison, CT: International Universities Press, Inc.

Hill, C. E. (1990). Exploratory in-session process research in individual psychotherapy: A review. *Journal of Consulting and Clinical Psychology, 58*, 288-294.

Hoffman, M., & Gill, M. (1988). A scheme for coding the Patient's Experience of the Relationship with the Therapist (PERT): Some applications, extensions, and comparisons. In H. Dahl, H. Kachele & H. Thoma

(Eds.), *Psychoanalytic process research strategies* (pp. 67-98). Berlin: Springer-Verlag.

Honos-Webb, L., Lani, J. A., & Stiles, W. B. (1999). Discovering markers of assimilation stages: The rear of the marker. *Journal of Clinical Psychology, 55*, 1441-1452.

Honos-Webb, L., Stiles, W. B., & Greenberg, L. S. (2003). A method of rating assimilation in psychotherapy based on markers of change. *Journal of Counseling Psychology, 50*(2), 189-198.

Horowitz, M. J., Marmar, C., Weiss, D. S., DeWitt, K., & Rosenbaum, R. (1984). Brief psychotherapy of bereavement reactions: The relationship of process to outcome. *Archives of General Psychiatry, 41*, 438-448.

Horvath, A. O., & Greenberg, L. S. (1986). The development of the working alliance inventory. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 529-556). New York: Guildford Press.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223-233.

Jaanus, M. (1996). Civilisation of hatred: The Other in the imaginary. In R. Feldstein, B. Fink & M. Jaanus (Eds.), *Reading Seminars I and II: Lacan's return to Freud* (pp. 323-355). Albany, NY: State University of New York Press.

Joseph, B. (1997). Projective identification: Some clinical aspects. In R. Shafer (Ed.), *The contemporary Kleinians of London* (pp. 100-118). Madison, USA: International Universities Press.

Kachele, H., Thoma, H., Ruberg, W., & Grunzig, H-J. (1988). Audio-recordings of the psychoanalytic dialogue: Scientific, clinical and ethical problems. In H.D.H. Kachele & H. Thoma (Eds.), *Psychoanalytic process research strategies* (pp. 179-193). Berlin: Springer-Verlag.

Kahn, M. (1991). *Between therapist and client: The new relationship*. New York: W.H. Freeman.

King, N. J., & Ollendick, T. H. (1998). Empirically validated treatments in clinical psychology. *Australian Psychologist, 33*(2), 89-95.

Klein, M. (1977[1946]). Notes on some schizoid mechanisms. In *Envy and Gratitude & other works 1946-1963* (pp. 1-24). New York: Dell (Original work published 1946).

Kratochwill, T. (1992). Single-case research design and analysis: An overview. In T. Kratochwill & J. Levin (Eds.), *Single-case research design and analysis: New directions for psychology and education* (pp. 3-14). Hillsdale, N.J.: Erlbaum.

Kris, E. (1975). *Selected papers of Ernst Kris*. New York: Yale University Press.

Lacan, J. (1957-1958). *Seminar Book V: 'Formations of the unconscious'* (C. Gallagher, Trans.): Unpublished.

Lacan, J. (1982[1951]). Intervention on Transference (J. Rose, Trans.). In J. Mitchell & J. Rose (Eds.), *Feminine Sexuality: Jacques Lacan and the Ecole Freudienne* (pp. 61-73). London & Basingstoke: The Macmillan Press Ltd.

Lacan, J. (1988[1978]). *The Seminar of Jacques Lacan Book II: The Ego in Freud's Theory and in the Technique of Psychoanalysis 1954-1955* (S. Tomaselli, Trans.). Cambridge, Great Britain: Cambridge University Press.

Lacan, J. (1991[1960-61]). *Le Seminaire, Livre VIII, Le transfert [Transference] 1960-61* (J.-A. Miller, Trans.). Paris: Seuil.

Lacan, J. (1993[1981]). *The Psychoses: The seminar of Jacques Lacan book III 1955-156.* (R. Grigg, Trans.). London: Routledge.

Lacan, J. (1998[1964]). *The Four Fundamental Concepts of Psycho-Analysis* (A. Sheridan, Trans.). New York & London: W.W. Norton & Company.

Lacan, J. (2006[1949]). The mirror stage as formative of the function of the I as revealed in psychoanalytic experience (B. Fink, Trans.). In *Ecrits: The first complete edition in English* (pp. 75-81). New York & London: W.W. Norton & Company.

Lacan, J. (2006[1948]). Aggressivity in psychoanalysis (B. Fink, Trans.). In *Ecrits: The first complete edition in English* (pp. 82-101). New York & London: W.W. Norton & Company.

Lacan, J. (2006[1953]). The function and field of speech and language in psychoanalysis (B. Fink, Trans.). In *Ecrits: The first complete edition in English* (pp. 197-268). New York & London: W.W. Norton and Company.

Lacan, J. (2006[1958]). The signification of the phallus (B. Fink, Trans.). In *Ecrits: The first complete edition in English* (pp. 575-584). New York & London: W.W. Norton & Company.

Lampr opoulos, G. K. (2000). A re-examination of the empirically supported treatments critques. *Psychotherapy Research, 10*, 474-487.

Laplanche, J., & Pontalis, J. (1988). *The language of psychoanalysis*. London: Hogarth Press.

Lazar, S. G. (Ed.). (1997). *Extended dynamic psychotherapy: Making the case in an era of managed care.* Hillsdale, NJ: Analytic Press.

Leahey, T. H. (1994). *A history of modern psychology* (2nd ed.). Englewood Cliffs, USA: Prentice-Hall.

Leader, D., & Groves, J. (2000). *Introducing Lacan*. Duxford, UK: Icon Books.

Luborsky, L. (1976). Helping alliances in psychotherapy. In J. Claghorn (Ed.), *Successful psychotherapy* (pp. 92-116). New York: Brunner-Mazel.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding transference: The core conflictual relationship theme method* (2nd ed.). Washington, DC: American Psychological Association.

Luborsky, L., Crits-Christoph, P., Alexander, L., Margolis, M., & Cohen, M. (1983). Two helping alliance methods for predicting outcomes of psychotherapy: Accounting signs vs. a global rating method. *Journal of Nervous and Mental Disorders, 171*, 480-492.

Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from psychotherapy: Predicting therapeutic outcomes.* New York: Basic Books.

Marks, Z. M. (2002). Agalma. In H. Glowinski, Z. Marks & S. Murphy (Eds.), *A Compendium of Lacanian Terms* (pp. 1-4). London: Free Association Books.

Martin, D. J., Garske, F. P., & Davis, M. K. (2000). Relationship of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.

Marziali, E. A. (1984). Prediction of outcome of brief psychotherapy from therapist interpretive interventions. *Archives of General Psychiatry, 41*, 301-304.

Masling, J. (Ed.). (1986). *Empirical studies of psychoanalytic theories* (Vol. 2). NJ: The Analytic Press.

Meissner, W. W. (1991). *What is effective in psychoanalytic therapy: The move from interpretation to relation.* Northvale, NJ & London: Jason Aronson Inc.

Meissner, W. W. (1996). *The therapeutic alliance*. New Haven, CT: Yale University Press.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks: Sage Publications CA.

Miller, J.-A. (1996). An introduction to seminars I and II. In R. Feldstein, B. Fink & M. Januus (Eds.), *Reading Seminars I and II: Lacan's return to Freud*. Albany: State University of New York Press.

Milton, J. (2001). Psychoanalysis and congnitive behaviour therapy - Rival paradigms or common ground? *International Journal of Psycho-Analysis, 82*, 431-447.

Mitchell, J. (1982). Introduction -1 (J. Rose, Trans.). In J. Mitchell & J. Rose (Eds.), *Feminine Sexuality: Jacques Lacan and the Ecole Freudienne* (pp. 1-22). London and Basingstoke: Macmillan Press.

Mitchell, J. (1986). Introduction (J. Rose, Trans.). In J. Mitchell (Ed.), *The selected Melanie Klein* (pp. 9-32). Harmondsworth, UK: Penguin.

Nachmias, D., & Nachmias, C. (1976). *Research methods in the social sciences*. New York: Martin's.

Nobus, D. (2000). *Jacques Lacan: and the Freudian practice of psychoanalysis*. London: Routledge.

Nobus, D., & Quinn, M. (2005). *Knowing nothing, staying stupid: Elements for a psychoanalytic epistemology*. East Sussex: Routledge.

O'Conner, L., Edelstein, S., Berry, J., & Weiss, J. (1994). The pattern of insight in brief psychotherapy: A series of pilot studies. *Psycyhotherapy, 31*(3), 533-544.

Ogden, T. (1979). On projective identification. *International Journal of Psycho-Analysis, 60*, 357-373.

Patton, M. Q. (2002). Two decades of developments in qualitative inquiry: A personal, experiential perspective. *Qualitative Social Work, 1*(3), 261-283.

Pereira, D. (1991). Inhibition, symptoms and act; from the moment of occlusion to the moment of conclusion. In O. Zentner (Ed.), *Lacan and the object in psychoanalysis* (pp. 21-32). Melbourne: Papers of the Freudian School of Melbourne.

Persons, J. B., Curtis, J. T., & Silberschatz, G. (1991). Psychodynamic and cognitive-behavioural formulations of a single case. *Psychotherapy, 28*, 608-617.

Philliber, S. G., Schwab, M. R., & Samsloss, G. (1980). *Social research: Guides to a decision-making process.* Itasca, IL: Peacock.

Pole, N., Ablon, J. S., O'Conner, L., & Weiss, J. (2002). Ideal Control Mastery technique correlates with change in a single case. *Psychotherapy: Theory, Research, Practice, Training, 39*(1), 88-96.

Power, M. (1991). Cognitive science and behavioural psychotherapy: Where behaviour was, there shall cognition be? *Behavioural Psychotherapy, 19*, 20-41.

Ragland, E. (1996). An overview of the real, with examples from seminar I. In R. Feldstein, B. Fink & M. Jaanus (Eds.), *Reading seminars I and II: Lacan's return to Freud*. Albany: University of New York Press.

Rappoport, A. (1996). The structure of psychotherapy: Control-mastery theory's diagnostic plan formulation. *Psychotherapy, 33*(1), 1-10.

Rappoport, A. (1997). The patient's search for safety: The organising principle in psychotherapy. *Psychotherapy, 34*(3), 250-261.

Rappoport, A. (2002). How psychotherapy works: The concepts of control-mastery theory. *Bulletin of the American Academy of Clinical Psychology., 8*(2), 10-14.

Raue, P. J., & Goldfried, M. R. (1994). The therapeutic alliance in cognitive-behavioural therapy. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 131-152). New York: John Wiley.

Rodriguez, S. A. (2001). Subject. In H. Glowinski, Z. Marks & S. Murphy (Eds.), *A compendium of Lacanian terms* (pp. 192-197). London: Free Association Books.

Rodriguez, S. A., & Rodriguez, L. S. (1989). On the transference. *Analysis, 1*, 165-185.

Roth, A., & Fonagy, P. (1996). *What works for whom: A critical review of psychotherapy research*. New York: The Guildford Press.

Ryle, A. (1990). *Cognitive Analytical Therapy*. Chichester, UK: Wiley.

Ryle, A. (1994). Psychoanalysis and cognitive analytic therapy. *British Journal of Psychotherapy, 10*, 402-404.

Ryle, A. (1995). Psychoanalysis, cognitive-analytic therapy, mind and self. *British Journal of Psychotherapy, 11*, 568-574.

Safran, J. D., Crocker, P., McMain, S., &, & Murray, P. (1990). The therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy, 27*, 154-165.

Sampson, H. (1976). A critique of certain traditional concepts in the psychoanalytic theory of therapy. *Menninger Clinic Bulletin, 40*, 255-262.

Sampson, H. (1992). A new psychoanalytic theory and its testing in formal research. In J. W. Barron, M. N. Eagle & D. L. Wolitzky (Eds.), *Interface of Psychoanalysis and Psychology* (pp. 586-604). Washington, D.C.: American Association.

Sareen, J., & Skakum, K. (2005). Defining the core processes of psychotherapy. *American Journal of Psychiatry, 162*(8), 1549.

Schneiderman, S. (Ed.). (1980). *Returning to Freud: Clinical psychoanalysis in the school of Lacan*. New Haven, CT & London: Yale University Press.

Schwartz, J. (1999). *Cassandra's daughter: A history of psychoanalysis in Europe and America*. London: The Penguin Press.

Siefert, C. J., Hilsenroth, M. J., Blagys, M. D., & Ackerman, S. J. (2006). The relationship of patient defensive functioning and alliance with therapist technique during short-term psychodynamic psychotherapy. *Clinical Psychology and Psychotherapy, 13*(1), 20-33.

Silberschatz, G. (1986). Testing pathogenic beliefs. In J. Weiss, H. Sampson & The Mount Zion Psychotherapy Group (Eds.), *The psychoanalytic process: theory, clinical observations, and empirical research* (pp. 256-266). New York: Guildford.

Silberschatz, G., & Curtis, J. T. (1993). Measuring the therapist's impact on the patient's therapeutic progress. *Journal of Consulting and Clinical Psychology, 61*, 403-411.

Silberschatz, G., Curtis, J. T., Fretter, P. B., & Kelly, T. J. (1988). Testing hypotheses of psychotherapeutic change processes. In H. Dahl, G. Kachele & H. Thoma (Eds.), *Psychoanalytic process research strategies* (pp. 128-145). New York: Springer.

Singer, J. L. (1998). Daydreams, the stream of consciousness, and self-representations. In R. F. Bornstein & J. M. Masling (Eds.), *Empirical perspectives on the psychoanalytic unconscious* (Vol. 7, pp. 141-186). Washington DC: American Psychological Association.

Spillius, E. B. (1988). Introduction. In E. B. Spillius (Ed.), *Melanie Klein today: Developments in theory and practice* (pp. 5-16). London: Routledge.

Stake, R. E. (1994). Case Studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 236-247). Thousand Oaks, CA: Sage.

Sterba, R. (1934). The fate of the ego in analytic therapy. *The International Journal of Psycho-Analysis, 15*, 117-126.

Stiles, W. B., Shapiro, D. A., & Elliott, R. (1986). Are all psychotherapies equivalent? *American Psychologist, 41*(2), 165-180.

Toukmanian, S. G., & Rennie, D. L. (Eds.). (1992). *Psychotherapy process research: Paradigmatic and narrative approaches*. Newbury Park: Sage.

Verhaeghe, P. (2004). *On being normal and other disorders: A manual for clinical diagnostics*. New York: Other Press.

Walant, K. B. (1995). *Creating the capacity for attachment: Treating addictions and the alienated self*. Northvale, NJ: Jason Aronson.

Weiss, J. (1971). The emergence of new themes: A contribution to the psychoanalytic theory of therapy. *International Journal of Psycho-Analysis, 52*, 459-457.

Weiss, J. (1990). The nature of the patient's problems and how in psychoanalysis the individual works to solve them. *Psychoanalytic Psychology, 7*(1), 105-113.

Weiss, J. (1993). *How psychotherapy works: Process and technique*. New York: The Guildford Press.

Weiss, J., Sampson, H., & The Mount Zion Psychotherapy Group. (1986). *The Psychoanalytic Process: Theory, Clinical Observations, and Empirical Research*. New York: The Guildford Press.

Williams, M. (2005). *The subject of anxiety: A comparison of the theories of Sigmund Freud and Jacques Lacan.* Unpublished PhD, Monash University, Melbourne, Australia.

Williamson, K. (2000). *Research methods for students and professionals: Information management and systems.* (Vol. 16). Wagga Wagga, Australia: Centre for Information Studies, Charles Sturt University.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and practice.* Philadelphia: Open University press.

Yin, R. K. (2003). *Case study research: design and methods* (Third ed.). Thousand Oaks, CA, London & New Delhi: Sage Publications, Inc.

Zetzel, E. (1956). Current concepts of transference. *The International Journal of Psycho-Analysis, 37*(4), 369-376.

Zetzel, E. (1958). Therapeutic alliance in the analysis of hysteria. In E. Zetzel (Ed.), *The capacity for emotional growth* (pp. 182-196). London: Hogarth Press.

APPENDICES

Appendix A: An Interaction of Note in the Case of David

David's sessions were interspersed with events from his life that he presented as if the therapist knew of them. Each time he spoke of one of these events he was surprised that she knew nothing of it. In her process notes the therapist drew attention to these events in the same way as she had the tests. She wrote that these were important events, for instance, a stroke, and a first wife were two of those mentioned. Throughout these episodes she had the impression that she had been excluded from the information. David's expectation that she should know what he knew even though it had not been told to her, induced discomfort in the form of an inadequacy, or lack. In this sense, it could be viewed as a transference test wherein David played the part of his early self – someone who expected his parental object, likely his mother, to know his thoughts and hence his needs. The expectation that she knew the content of his mind without him speaking was consistent with a pre-verbal developmental stage; well before the childhood stage that the CMT belief system was built on. For this reason the sequence of interactions was not included in the CMT analysis. Furthermore, the event could be viewed from two perspectives which meant that it could be explained as either a transference or passive-into-active test. From a Freudian-Lacanian perspective it did not have a demanding quality. David did not appear to want anything from the therapist in these episodes; on the contrary, he had a fundamental assumption that she knew about him. Although the analysis was possible without including the material, its absence limits the reader's understanding of a large aspect of David's functioning, which was not entirely separate to the test material. This points to a limitation of the CMT explanation of

patient-therapist interaction. The material is included in the following section titled 'Symbiosis'.

Symbiosis

David assumed the therapist knew information about him that he had not previously told her. Mostly, this related to the body in the form of illnesses, but it was also represented in other contexts. The first example occurred in Session Three wherein David complained of being asked to move from the house he was renting. David had not notified the therapist of his move from his parent's house to rental accommodation, but assumed she knew of this. (D3.1) "Hadn't I mentioned that?" Later in the same session he made a similar assumption in relation to having been twice married. The therapist stated (D3.2) "I don't think I have heard about her" to which David replied, "Oh haven't you? Second marriage now." Despite a full history being collected in the assessment phase of David's treatment, he had not mentioned his first marriage. Further assumptions evident in other sessions related to David's physical illnesses. He referred to the removal of lumps and the therapist commented (D6.1) "Another lump?" to which David replied, "Yeah, lumps, they are a worry." In the same session, amidst other material, he referred to a stroke and was surprised that she did not know of this. (D6.2) "A stroke, what do you mean by that?" asked the therapist. David replied, "Didn't I mention that, that I had a minor stroke." The therapist asked, "I don't think so. When was this?" "It's a couple of weeks ago now." responded David. Similarly he mentioned a seizure. "… I did mention that I had a seizure didn't I?" " No, no you didn't", replied the therapist. Interestingly, on this

last occasion David questioned whether he had mentioned the seizure, which he had not previously done.

On each of these occasions the therapist was left with a sense that David expected her to know what he knew, and he was surprised when she did not. Considering that David located his mental torment at the level of his body this material suggested that he did not believe himself to be entirely separate to the therapist. It was possible to identify here David's expectation that the symbiotic link he had to his mother, existed with the therapist. He had likely expected his mother to know of his thoughts, hence his needs, and therefore did not need to speak of events for her, or the therapist to know of them. While the material pertaining to this did not constitute a test of the therapist in a CMT formulation, for instance, he did not appear to be attempting to elicit a response from the therapist; David did appear to be learning about a need to speak. When considered alongside his complaint of medical professionals wherein he believed he had difficulty being understood, a twofold problem was evident. First, David assumed health professionals knew what he knew without necessarily telling them; and second, David's antagonistic style likely resulted in health professionals dismissing him. Much of David's communication was confined to his body and therefore his psychological symptoms became physical symptoms. David's pain, which represented an inability to successfully negotiate the early development stages of alienation and separation, had left him in this symbiotic relationship. His pain was not symbolised in language and therefore remained an enigma to both himself and those who tried to address this at the level of his body. These were the medical professionals he was constantly dissatisfied with. The reason he gave for attending therapy which was that he wanted to know why his wife saw him differently from the way he saw himself, was consistent with this.

This symbiotic state belonged to a pre-verbal merger of psyche and soma at a developmental stage prior to that of separation. At a psychological level David was merged with his mother and had not learnt to adequately represent himself as separate to her. This was evidenced in the expectation that others knew what he knew, and also in the representation of his symptoms in his body. A representation of this fundamental problem was evident also when considering this material from a CMT perspective.

Within the transference David was both he and his mother simultaneously. Instead of playing his part or his mother's part he played both as inseparable. There are two related explanations for David's fixation on having his questions answered. First, his inability to effectively communicate due to an early failure to symbolise had resulted in his search for answers. Also, his mother had likely assumed she knew the answers to David's questions prior to hearing him vocalise. At the pre-verbal level the question is represented in the form of a demand, for example - can I have a drink? - becomes a cry of thirst. David had significant difficulty at this early stage due to his intestinal problems. The second explanation stemmed from this demand. David's tests, along with wanting answers, had a bossy, demanding quality. He insisted the therapist answer him. While this can be likened to the anal stage of development in which the mother and child battled over control during the mother's attempts at toiled training, it was also intimately connected to desire. David's demands provoked the therapist because at the moment he detected her withdrawal, he insisted. This had the effect of retaining her connectedness via dialogue, but in a way that repeated his relationship with his mother. Unfortunately, when David re-enacted this relationship

in medical settings, he felt dismissed. The medical professionals were not interested in tolerating the insistence he demanded when he detected resistance or a withdrawal, nor were they interested in an argument.

Appendix B: Plain Language Statement for University Clinicians

The Psychology Clinic at Victoria University is participating in a research project that aims to explore the relationship between client and therapist within therapy. It is anticipated that this research will provide further information about the way client's progress in therapy. Increased knowledge in this area can assist in the effective and efficient treatment of clients during therapy.

Your part in this research involves you providing access to process notes pertaining to clients involved in the research, and possibly being interviewed in regard to the emotions you experience during therapy.

Duplicate copies of process notes and of the video and/or audiotapes of therapy sessions you participate in will be made and used for the purposes of the research. They will be kept under lock and key and destroyed five years after the completion of the research. Your identity will remain anonymous at all times. When the tapes are transcribed for analysis your real name and the client's real name will be substituted by aliases so as to protect your identity. At no time will the therapy transcripts appear with your real name.

Your participation in this research is voluntary. You may withdraw from the project at any time by notifying the researchers listed below. Reasons for your withdrawal are not required. The researchers do not foresee any associated risks with your participation in the research.

If you have any further questions about the project, please contact the researchers, either Carmel Fahey on 95312971, or Associate Professor Ross Williams on 92168107.

Appendix C: Consent Form for University Research participants

Name of participant _____

Project: Client-Therapist interactions in early sessions of therapy

Principal Researcher: Student Researcher:
Associate Professor Ross Williams   Carmel Fahey
Victoria University   Victoria University
Werribee   St. Albans

I consent to participate in the above named project which is being conducted at
Victoria University. I have had explained to me and I have read and understand the
general aims, methods, and demands of the research as outlined above, and have
received a copy of this document.

I certify that I have had the opportunity to have any questions answered and that I
understand that my participation in the research is voluntary, and that I am free to
withdraw at any time and that this withdrawal will not jeopardise me in any way. I
have been informed that the information I provide will be kept confidential at all
times.

Signed: ....   }

Witness other than the researcher: }   **Date: ....**

...}

Any queries about your participation in this project may be directed to the researcher
(Carmel Fahey: ph 95312971). If you have any queries or complaints about the way
you have been treated, you may contact the Secretary, University Human Research
Ethics Committee, Victoria University of Technology, PO Box 14428 MCMC,
Melbourne, 8001 (telephone no: 03-9688 4710)

Appendix D: Plain Language Statement for University Clients

The Psychology Clinic at Victoria University is participating in a research project that aims to explore the relationship between client and therapist within therapy. It is anticipated that this research will provide further information about the way clients progress in therapy. Increased knowledge in this area can assist in the effective and efficient treatment of clients during therapy.

Your part in this research involves you consenting to the researchers having access to the first ten of your video taped therapy sessions at the Victoria University Clinic. These tapes will not be viewed by anyone other than clinicians and the researchers. Copies of the tapes of the therapy sessions you participate in will be kept under lock and key and destroyed five years after the completion of the research. Your identity will remain anonymous at all times. When the tapes are transcribed for analysis your real name and the clinicians' real name will be substituted by aliases so as to protect your identity. At no time will the therapy transcripts or tapes appear with your real name.

Your participation in this research is voluntary. You may withdraw from the project at any time by notifying the researchers listed below. Reasons for your withdrawal are not required. The researchers do not foresee any associated risks with your participation in the research.

If you have any further questions about the project, please contact the researchers, either Carmel Fahey on 95312971, or Associate Professor Ross Williams on 92168107.

Appendix E: Plain Language Statement for Counsellors

Counsellor Invitation to participate in a research project

Project: Counsellor/client Interactions in early sessions of counselling

[Community counselling service] is participating in research by Victoria University. The aim of this research is to explore the early stages of counselling. It is anticipated that this project will provide further information about the way clients progress in counselling. Increased knowledge in this area can assist in the effective and efficient treatment of clients during counselling.

Your part in this research involves the following:

1. asking your client for consent and taping the counselling sessions
2. providing access to notes pertaining to some of your client's sessions
3. being interviewed about your experience in some counselling sessions

In regard to point 3 above, you will be asked a couple of questions at the end of the counselling session that will take only one or two minutes to answer. Dependent upon the particular session, you may be interviewed for your reflections upon the session. It is anticipated that this will take approximately 30 minutes and will be conducted as soon as possible after the session, given the counsellor's availability.

Duplicate copies of notes pertaining to clients who participate in the research will be made and used for the purposes of the research. Interviews you participate in will be audiotaped. All data will be kept under lock and key and destroyed five years after the completion of the research. Your identity will remain anonymous at all times. When the tapes are transcribed for analysis your real name and the client's real name will be substituted by aliases so as to protect your identity. At no time will the transcripts appear with your real name.

Your participation in this research is voluntary. You may withdraw from the project at any time by notifying the researchers listed below. Reasons for your withdrawal are not required.

If you have any further questions about the project, please contact the researchers, either Carmel Fahey on 96884334, or Anne Graham 93658159 (until December 2000), Associate Professor Ross Williams 92168107 (from December 2000).

Appendix F: Consent Form for Counselling Research Participants

Consent form for persons participating in research

Name of participant _____

Project: ***Counsellor/client interactions in early sessions of counselling***

Principal Researcher: Student Researcher:
Associate Professor Ross Williams   Carmel Fahey
Victoria University   Victoria University
Werribee   St. Albans

I consent to participate in the above named project, which is being conducted at Victoria University and [Community Counselling Service]. I have had explained to me and I have read and understand the general aims, methods, and procedures of the research as outlined above, and have received a copy of this document.

I certify that I have had the opportunity to have any questions answered and that I understand that my participation in the research is voluntary, and that I am free to withdraw at any time and that this withdrawal will not compromise my position at [Community Counselling Service]. I have been informed that the information I provide will be kept confidential at all times.

Signed: ....…………}

Witness other than the researcher: Date: ....

....}

Any queries about your participation in this project may be directed to the researcher (Carmel Fahey: ph 96884334). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University of Technology, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03-9688 4710)

Appendix G: Plain Language Statement for Counselling Clients

Client Invitation to participate in a research project

Project: Counsellor/client Interactions in early sessions of counselling

[Community Counselling Service] is participating in research by Victoria University. The aim of this research is to explore the early stages of counselling. It is anticipated that the project will provide further information about the way clients progress in counselling. Increased knowledge in this area can assist in the effective and efficient treatment of clients during counselling.

Your part in this research involves you consenting to have your counselling sessions audiotaped, beginning in the second session. It also involves your consent for the researchers to have access to notes and discussions about your counselling. The researchers anticipate this study will not have a significant impact on your counselling. The audiotapes will not be heard by anyone other than the researchers. The data will be pooled so that no individual assessments will be made. Instead, patterns and themes emerging across many participants' sessions will allow the process of counselling to be better understood. The tapes of the counselling sessions you participate in will be kept under lock and key and destroyed five years after the completion of the research. Your identity will remain anonymous at all times.

Your participation in this research is voluntary. You may withdraw from the project at any time by notifying your counsellor or the researchers listed below. Reasons for your withdrawal are not required.

Your counsellor will discuss this project with you. If, at any later stage you have any further questions about the project, please contact the researchers, either Carmel Fahey on 96884334, or Anne Graham 93658159 (until December 2000), Associate Professor Ross Williams 92168107 (from December 2000).