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RESEARCH REPORT

2009

Containment: A training therapist's attempt to apply the construct in a first therapeutic encounter

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

Supervisor: Professor Gillian Eagle

Abstract

This case study presents psychotherapeutic work with 'JD', an African male in his mid-twenties with a history of sexual abuse and early deficiencies in maternal provision. The focus of the study is on the difficulty of attempting to comprehend and provide containment (the operationalization of containment), as a trainee therapist working with this particular patient. 'JD' presented with a number of interpersonal fears, complaints of isolation, an unbearable sense of confusion and uncertainty as well repressed anger and resentment. This clinical combination of difficulties, when mixed in with the author's own challenges as a trainee therapist, made therapeutic work challenging. The therapist employed a broadly defined psychodynamic framework, with a particular emphasis on 'containing' 'JD's unbearable levels of distress and anxiety whilst attempting to aid in the process of ascribing meaning to his confusing and difficult experiences. This undertaking was a challenging task, given that the concept of containment is not necessarily clear-cut (particularly for a trainee therapist) and in addition, that the patient seemingly lacked a sense of containment whilst growing up. The case study aims to illustrate and explore the challenges of operationalizing and providing the function of containment in psychotherapy with due consideration to the contributions of both the therapist's and patient's dynamics. In assessing the difficulties involved in attempting to provide containment in this therapy, it becomes apparent that for a beginner therapist the provision of containment is easily complicated by his/her narcissistic anxieties and countertransference reactions. It is proposed that aspects of containment as elaborated by more contemporary theorists may be possible to provide as a trainee therapist, but that working with projective identification as understood by a more classic Bion informed notion of containment is more difficult to master. It seems that this latter capacity is a skill that develops with time and experience. The provision of a holding environment as a possible precursor to the provision of containment appeared to be what was evidenced in this particular therapeutic interchange.

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To my supervisor, Professor Gillian Eagle, thank-you for your containment, guidance and patience through this journey

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To Erika, thank-you for your love, support and guidance through this process

Declaration

I declare that this research report is my own, unaided work. It is being submitted for the degree of Master of Arts in Clinical Psychology at the University of Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other university.

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Nicole Sun

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Date

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Chapter 1: Introduction

The aim of this research case study was to review the process of psychotherapy between a beginner therapist and a male patient with a history of sexual abuse. The primary focus for the case study is the attempted operationalization of Bion's theory of "Containment".

Part I of the research report will provide the conceptual basis for understanding relational dynamics between a patient and therapist in terms of Bion's concept of containment. The container/contained relationship as described originally within the mother-infant relationship is thought to provide the context for all future relationships, including the psychotherapeutic dyad. The idea of containment within the therapeutic setting will then be explored, including the difficulties that arise in attempting to understand and provide such a function especially as a 'beginner' therapist. The difficulties explored touch on both the therapist's counter-transference and the patient's transference, as well as on intersubjective aspects of therapy.

In Part II, clinical case material will be used to demonstrate a developing understanding of the concept of containment and its application as illustrated in this particular therapy. A central focus of the discussion is the difficulty of distinguishing between those aspects of the case material representing the patient's projections and those aspects related to the therapist's anxieties and insecurities. These relational dynamics - which transferential and countertransferential dimensions create in relation to containment - are explored. A hermeneutic approach will be used to illustrate and interpret these dynamics as the *experiences* of the therapist and the patient are the focus of this research.

1.1 Rationale

Casement's (1985; 1990) books illustrate that theory is not just to be applied in clinical work but is also rediscovered. In his conceptualisation of containment, Bion intentionally provided a tool set 'full of gaps' which he expected to be filled in by an individual's own thoughts whilst learning from experience (Ferro, 2005). Containment can be understood as a concept which Bion felt the analyst could use in forging for him/herself 'a language which he knows' and 'which he knows how to use' with 'the value of which he knows' (Bion, 1976, as cited in Mitrani, 2001). It was the aim of this case study to explore the operationalization of Bion's notion of containment within a first therapeutic experience with a male patient with a history of sexual abuse. The primary focus of the case study is an exploration of the anxieties and difficulties experienced as a beginner therapist in attempting to provide containment for this particular patient. In this light, a somewhat fresh angle of research is attempted in considering the difficulties in operationalizing the notion of containment; a notion which has been experienced as slippery and difficult to define in some respects (Ferro, 2005). The aim is to explore the notion of containment as it appeared to play out (or not) in this particular therapy relationship.

Considerable literature has been directed at assessing the difficulties trainee psychotherapists face during their initial experiences (Brightman, 1984; Bruch, 1974; Casement, 1985; Cushway, 1992; Eckstein & Wallerstein, 1958; Ford, 1963; Glickhauf-Hughes & Mehlmann, 1995; Goretti, 2006; Halewood & Tribe, 2003; Kottler, 1991; Kottler & Swartz, 2004; Mollon, 1989; Schumacher Finell, 1985). The difficulties appear to stem from the pressures trainees place on themselves to be 'good enough'; an expectation that includes an ability to understand and contain a patient's distress (Brightman, 1984). The provision of containment is often expected of trainee therapists particularly those being trained within a psychodynamic modality. The idea of providing containment is seductive for trainee therapists who may attempt to offer containment without necessarily clearly understanding or elucidating what such a function entails, a function which seemingly involves considerable clinical experience and skill. Moreover, although most Kleinian authors acknowledge that the patient's projective identifications need to 'hook' onto a part of the therapist in order to exert emotional influence, these hooks and their relation to the therapist's personal countertransference are generally not discussed in the literature on containment (Ivey, 2008). This research contribution focuses on the individual experiences of a patient and researcher/therapist with a view to understanding difficulties in the operationalization of

therapeutic containment and the role that countertransference may play in such difficulties. This study is thus seen as "an opportunity to follow some of what goes on in the mind of a therapist, as he/she struggles to get to know and to understand the complex mysteries of another person's mind and ways of being" (Casement, 1985, p. x) and to respond accordingly.

In addition, it is worth noting very briefly that a study by Price, Hilsenroth, Callahan, Petretic-Jackson & Bonge (2004) established that psychodynamic therapy for adult survivors of childhood sexual abuse was effective in treating this type of patient. This approach generally includes an emphasis on the provision of therapeutic containment.

1.2 Aims

To illustrate and explore the challenges of understanding, operationalizing and providing the function of containment in psychotherapy by a trainee therapist working with a distressed patient with a history of sexual abuse.

1.3 Research Questions

What difficulties arise for a beginner therapist who attempts to provide the 'role' of or become the container for the contained?

How does the operationalization of Bion's theory of containment interface with aspects of transference and countertransference dynamics with reference to a particular case?

Chapter 2: Literature Review

2.1 Introduction

As this case study aims to explore the operationalization of Bion's notion of containment, it begins with exploring what is intended by this concept. The concept has been ascribed various meanings and a theoretical discussion exploring these meanings will form the second section of the literature review. The concept of containment shall then be debated with reference to the notion of 'holding' as the two concepts are at times mistakenly used interchangeably. This discussion will form the third part of the literature review. The fourth part of the literature review will discuss the provision of containment within the therapeutic setting, specifically when provided by a trainee therapist, and the final part of the discussion will deal with aspects of working with the theme of sexual abuse. The possible contributions of both patient and therapist to interactions to do with containment (or its lack) as well as relational dynamics, will be explored throughout the review of the literature, since this is central to the theoretical understanding of containment as applied to psychodynamic psychotherapy.

2.2 What is Containment?

Wilfred Bion, a post-Kleinian object relations theorist, developed the theory of containment through his observations of schizophrenic patients and how they responded to the analytic space (Waddell, 1998). Bion drew upon Klein's concept of projective identification in his exploration of the container/contained relationship and developed the notion of alpha function and reverie in an attempt to explore the development of thinking. Interestingly, although this theory relates to observations concerning the mother-infant relationship, the principles are relevant to the patient-therapist dyad and have been extended in this regard.

Central to Bion's theory lies the idea of the mother and her infant as the unit in which all mental life is birthed; it is at the heart of this interaction that the conditions for containment are formed (Bion, 1978). Bion's infant is one whose quest is for *truth* - a voyage that requires a capacity to persevere despite frustrating experiences, by undergoing and suffering through such experiences, and tolerating the frustration of the unknown (Bion, 1978, 1993). Thus, parallel to Freud's emphasis on the conflict between life and death instincts, and Klein's emphasis on the conflict between states of love and hate - Bion placed his emphasis on the infant's conflict between desiring to know and understand the truth about his/her experience,

and the aversion to that knowing and understanding (Waddell, 1998). The identification of this conflict as central to psychic development has been labelled 'a radically new conceptualisation' (Waddell, 1998, p. 30).

Bion (1978; 1993) noted that the ability to 'know' experience is not acquired from birth, but through a process called containment, which is required when rudimentary forms of thought are overwhelmed by experiences, or sense data, and evacuated. Bion (1978; 1993) termed these sense data 'beta elements'. The idea of containment is related to Klein's notion of projective identification – a defence mechanism employed to ward off anxiety whereby the infant, in his/her omnipotence, defensively splits off that which is felt to be bad, or unbearable, by projecting it outwards into an 'other' who experiences this through processes of identifications. This addition reflects Bion's position, rather than Klein's. Bion extended this concept to encompass the idea of an attempt at communicating that which feels unbearable and confusing to a putative container - the mother and her 'thinking' breast in the case of early infantile experience (Bion, 1978). Bion's 'thinking' breast acts as a metaphor for the mind, in which the mother metaphorically attempts to add shape to her infant's rudimentary thoughts (Waddell, 1998). Here the mother who nurtures and loves (or '*holds*') her infant, brings along with her a thinking self which allows her to mentally and emotionally grapple with (or '*contain'*) the chaos of her infant's psychic life (Waddell, 1998).

Containment refers to a process in which the infant's own fragmented, disorganised and meaningless sensations and impulses (sense data or beta elements), become thoughts, imagination, dreams or memories able to be borne in mind (Elmhirst, 1980). Thus, the infant's inner, indigestible good and bad experiences, indistinguishable on a psychic and physical level - need to encounter an external object capable of performing this 'thinking' function (the alpha function) as the infant alone lacks this capacity (Britton, 1993). The alpha function allows experiences to become divested of terror and fit for reintegration and emotional growth (Waddell, 1998). Several processes, including the capacity for reverie, the receipt and tolerance of projective identifications, and alpha function, constitute the provision of containment. The transformation of beta elements into alpha elements not only allows for the introjection of tolerable and digestible thoughts but also for the progressive introjection of such functions (Ferro, 2005). Through the experience of being adequately contained, the infant introjects the capacity to contain him/herself over time. Thus the capacity for self-containment is gradually built into the infant's personality, accompanied by an inner strength rather than anxious dependency upon external help (Waddell, 1998).

2.3 An Exploration of the Components of Containment

The interpersonal process of projective identification communicates the uncontained individual's state of mind which is usually one of distress, discomfort, anxiety and/or uneasiness (Britton, 1993). The degree to which the container is receptive to and identifies with what he/she contains, that is with the projected raw emotions, communicates the degree of empathy from the other which allows the contained individual to feel understood and loved, with a sense of achievement, self-esteem and a feeling of belonging (Waddell, 1998). The provision of containment therefore communicates a level of comfort and relief, or a discomfort through a relative failure to do so, by the manner through which raw emotions are handled (Bion, 1978). While the concept of containment cannot be reduced purely to the constructs of projective identification and empathy, this outline paves the way to a greater depth of understanding of the concept of containment.

Bion differentiated between realistic projective identification and excessive projective identification according to the degree of *violence* shown as well as the amount of empathy elicited (Caper, 1999). Realistic or urgent projective identification involves the projection of less pathological aspects of the self which elicit understanding and empathic responses from the container. This occurs as the container's receptive part-object identifies with the uncontained individual's raw projections (Waddell, 1998). Bion regarded this process as important as it also allowed for a greater depth of understanding within the therapeutic setting (Casement, 1985). Excessive or aggressive projective identification, on the other hand, involves the forced projection of split emotions, involving hatred or violence, into an object and has an intrusive, omnipotently controlling quality. This type of projective identification underpins defended or rejecting responses in relation to the object, due to the perception of the object as threatening or envy arousing (Bion, 1984). Thus for example, there are times where the individual being contained may feel envious and full of rage and may attempt to destroy the container's internal reality by generating some sense of ego loss in the container (Bion, 1984). Caper (1999) suggests, though, that the container's capacity to transform introjected states of mind is not dependent upon whether the states of mind have been projected for reasons of urgency or aggression. Rather it is dependent upon the container's capacity to receive, tolerate and transform that which is being projected into him/her. The projector's response to the form of containment offered, however, may be reliant upon his/her motive for the projection (Caper, 1999). Thus even when the container is able to transform

and give back aggressively projected aspects, the one doing the projection may not be able to engage with or receive the digested projection because of their envy or rage.

As states of mind are introduced into the container they represent a 'spilling over' of emotions, which communicates that the uncontained individual is in need of help (Casement, 1985). Accordingly, a process called 'reverie' is employed to aid this 'spilling over'. Bion (1978) defined reverie as the container's capacity to receive and resourcefully think through the concrete chaotic, distressing and confusing beta elements which the individual being contained protests to and tries to evacuate. Reverie can also be associated with the container's empathic concern for what is being contained (Elmhirst, 1980). A capacity for reverie therefore encapsulates the container's process of thinking about what he/she is containing but does not automatically translate into a handing back of these relevant thoughts as they may rather be 'kept in mind'.

A process which does amount to the proffering back of meaning by the container is the alpha function mentioned previously. This particular function occurs as beta elements are transformed into thinkable, storable and dreamable elements which are then proffered back to the individual being contained in these meaningful and bearable forms (Bion, 1978). In addition, the alpha function encompasses an 'active holding' of these beta elements and allows them to function as thoughts or as stored memories (Bion, 1978). In effect, the container contains the uncontained individual's fragmented, disorganised and meaningless psychic experiences by lending shape and form to his/her emotions. This assists the individual towards achieving a better sense of self-integration (Elmhirst, 1980).

Elmhirst (1980) notes that individuals make use of containers in their environment during different stages of their lives – in an unconscious attempt to optimise emotional growth. It is important to note here that containers refer to all objects able to contain and transform that which is being contained, which typically involves observing, clarifying and emotionally resonating with that which requires containment (Sorensen, 1995). Ideally in the therapeutic context, the container is the therapist who receives the projections of the patient; however, the therapist may project into the patient in which case the dynamic container/contained relationship is reversed. In this regard, Bion (1984) argues the importance of entering each session without memory or desire as this prevents the therapist's intrusive assumptions (e.g. supporting a particular view of the patient; attempting to make a patient better in a particular way) from distorting the analytic process.

It is important to keep in mind that the container's ability to connect to and comprehend both beta and alpha elements depends on their level of self-knowledge and awareness (Waddell, 1998). This ability provides the container with discernment about the quality of what is being projected, processed and handed back (Waddell, 1998). In psychotherapy the therapist's state of mind forms an important part of this process; an issue that shall be explored later. Thus the introjected ability to contain oneself is accompanied by self-knowledge as well as the capacity to communicate between different aspects of the self (Britton, 1993).

Bion was aware of the improbability of a perfect fit between the container ♀ and the contained ♂ and therefore developed the notion of different types of containing relationships. The outcomes of these different types of relationships depend on the individual characteristics as well as the inter-relational dynamics of the container (which may be rigid/flexible, fragile/firm) and the uncontained (which may be containable, overwhelming or uncontainable) (Symington & Symington, 1996). Bion identified three possible interactions in containment; two of which are considered mutually beneficial (known as a commensal and a symbiotic link) and the other which is seen as mutually destructive (identified as a parasitic link) (Symington & Symington, 1996). A symbiotic link occurs when the container/contained (♀♂) construct objects which are mutually beneficial to both container and contained, while a commensal link occurs when the container/contained construct objects which produce and enrich emotional development within the container and the contained individually (Symington & Symington, 1996). A parasitic link occurs when the container/contained constructs objects threatening to both container and contained separately (Symington & Symington, 1996).

Containment thus far has been described (in keeping with Bion, 1993) as a process through which an infant projects a feeling, say, that it is dying, into the mother, whose 'thinking breast' converts this fantasy or experience into something more tolerable which is later reintrojected. Accordingly, Bion's beta elements have been defined as rudimentary forms of thought, fragmented, disorganised and meaningless sensations and impulses, indigestible good and bad experiences, indistinguishable psychically and physically; raw emotions which are concrete, chaotic, confusing and distressing; all of which are protested to and evacuated because of their unbearable nature. Likewise, Bion's alpha elements have been defined as thoughts, fantasies, dreams and memories which have been divested of terror due to their transformation into bearable, meaningful and storable ideas, a transformation or conversion

which requires a ‘thinking breast’ to emotionally and mentally shape and form that which it contains.

Although widely used in the field of psychotherapy, these concepts are not always clear-cut. Such confusion has been highlighted by a number of authors (Caper, 1999; Ferro, 2005; Mitrani, 2001; Moss, 2008; Ogden, 2004; Symington & Symington, 1996) who feel that Bion’s concepts lack simplicity and clarity. Although one can attribute this to Bion’s intentional creation of such concepts as ‘unsaturated’ with ‘open spaces’ that are to be filled by an individual’s thoughts when ‘learning from experience’, one still needs to render his ideas sufficiently lucid so as to make them applicable in psychotherapeutic work (Ferro, 2005). While this may involve some degree of simplification or reductionism, it seems important to be able to describe what is meant by containment in psychotherapy if a therapist wishes to operationalize this function in therapy.

Containment has been attributed certain metaphoric qualities: depictions that express and portray a need to elucidate this concept further. One such image is that of an emotional or psychic ‘skin’ that functions in the same way that physical skin does in holding parts of the body together (Waddell, 1998). Bick (1968, as cited in Britton, 1993) similarly equated the experience of containment with having a sense of envelopment similar to a skin that protects and enfolds. Ferro (2005) exemplifies containment as being formed by emotive threads that allow emotional contents to come on stage as if they were trapeze artists who know there is a containing safety-net below them, containment thus being represented as a flexible net. Casement (1985) depicted containment as a rubber band holding and preventing a bundle of sticks from falling apart, whilst Britton (1993) likened this process to a sanctuary providing safety, security and form.

Bion himself referred to the containing function as a kind of mental skin in which the container adds shape to and secures the boundaries of the context brought by the contained (Britton, 1993). These descriptions, seemingly similar, in many respects reveal a concept, the lines of which may become fairly easily blurred with other theoretical constructs: a concept which cries out for some distinction and clarification. The difficulty, however, lies in the fact that Bion preserves a view that concepts such as that of container/contained are representations of an unknowable ultimate reality, a mystery which all conceptualisation is inadequate in representing (Symington & Symington, 1996). Nevertheless, as stated earlier, the project of describing containment in such a way that it becomes possible to practice in

psychotherapy is a useful one, particularly to therapists in training, acknowledging, however, that there are limits to such an endeavour.

2.4 Some Elaborations on the Concept of Containment

Bion (1993) argued that practising psycho-analysts should 'restate' his concepts in terms of empirically verifiable data both in terms of infant observation and therapeutic practice. He therefore left the concept of containment open to be interpreted in different ways. The following section will explore how various authors and psycho-analysts have engaged with his theory and introduced new dimensions and formulations in expanding on the idea of containment.

2.4.1 'Containment' According to More Classic Bion Informed Theorists

Lafarge (2000) suggests that the application of the notion of containment to the therapist-patient dyad involves an understanding of the patient's projection and communication of affect and action that he/she struggles to incorporate within him/herself. The therapist introjects this projection into his/her own emotional life, evoking a pull within the therapist towards action, feeling and fantasy (Lafarge, 2000). The therapist is required to use this evoked 'disturbance' and the knowledge that he/she has developed of the patient, to construct an image of the patient's inner experience, fit enough to be returned to and digested by the patient (Lafarge, 2000).

Mitrani (2001) expanded upon the formulation of the process of containment and reverie by elaborating Bion's notions of transformation and publication. In her understanding, Mitrani (2001) defined reverie as the therapist's (container's) capacity to introject, receive and experience that which is being contained. It thus requires a therapist's openness to his/her patient's projections. Transformation requires the therapist to 'bear' the full extent of the patient's projections upon his/her mind for a period of time long enough to bring understanding and meaning (Mitrani, 2001). Mitrani (2001) argued that it was important for the therapist to interpret in a way that expressed the patient's perspective rather than the therapist's perspective. This is dependent upon the therapist's state of mind and willingness to 'experience' the projections – as noted above. A therapist must therefore be tolerant and patient when trying to make sense of a patient's experience; a notion which echoes Keat's (1817, as cited in Ferro, 2006) concept of 'negative capability', which speaks of the analyst's

capacity to remain in doubt and uncertainty, not needing to find exhaustive answers too quickly. Publication occurs when the therapist proffers back his/her understanding and meaning in its detoxified and digestible state to the patient; in a way that may be of use to the patient (Mitrani, 2001). This is generally conveyed in the form of an interpretation and needs to be provided at an appropriate time. Mitrani (2001) likened containment to 'taking the transference', viewing containment as the therapist's interpretation of their 'felt' sense of the patient's raw sensory experiences.

The therapist's engagement with a patient's distress therefore affords him/her enough space to digest and convert the distress into a 'verbal container' – communicated in the form of an interpretation (Hinshelwood, 1999). In this respect, interpretation has been called 'the vehicle' for containment as the recipient being contained should feel that someone, perhaps for the first time, has been able to bear their intense and difficult feelings without retracting or attacking whilst also making them more aware of their attitudes and behaviours that were previously not well understood (Casement, 1985; Sorensen, 1995). Within such proficient interpretations must therefore be evidence that the patient's material has been taken in and transformed (Lafarge, 2000). Ferro (2005) remarks that such interpretations must be 'hot, cooked there and then by taking into account the ingredients brought by the patient and those available to the analyst, without any smell of either refrigerator or cookery book' (p. 1539), a description which suggests the necessity for interpretations to refer to the patient's immediate dynamics in the room when a publication is made (Casement, 1985; Mitrani, 2001).

Ferro (2005) noted that it is not always easy to determine the extent to which interpretations are helpful or effective, adding that patients are usually the 'best colleagues' at these times as they will communicate how a therapist's interpretations are experienced by the degree to which they grow or feel persecuted (Ferro, 2005). Thus, not only should an interpretation be easily understood, but it should be appropriately timed and communicated (Ferro, 2005). It is therefore important to observe the patient's reactions after the proffering of interpretations as it allows the therapist opportunity to modify his/her communication of his/her understanding in times when it seems containment is not communicated (Ferro, 2005). Containment therefore makes space for a therapist's struggle, allowing for modifications to be made.

Attention has been brought to the constant interplay that occurs between projective identification and reverie, as the essential function upon which analysis hinges (Ferro, 2006). Ferro (2006) concludes that apart from words - *that* which is produced in the consulting room due to the encounter between the patient's and analyst's minds matters the most. He explains

that the encounters that occur between the non-aggregated, raw emotional states of the contained individual and the elaborated, well-defined states of mind of the container - form the basis of the containment (Ferro, 2006). Still, it is important to note that the transformation of raw emotional states does not rest solely upon the provision of verbal interpretation but on a series of emotional and relational dealings too (Ferro, 2005). This is the reason that Bion (1970, as cited in Ferro, 2005) chose to place some emphasis on the analyst's mental state, as a state which, functional or dysfunctional, was used to relate to the patient's own functions and dysfunctions.

Furthermore, Bott Spillius (1992) noted that the patient's object-relationships of the past are revealed as they are lived out in the therapeutic relationship through the patient's projection of his/her internal world. In this manner, the patient's behaviour typically arouses feelings in the analyst through projective identification (Bott Spillius, 1992). Bott Spillius (1992) adds that the analyst's capacity for reverie and alpha function need to be performed without the analyst giving in to the patient's pressures to act something out. What is apparent in many of the assertions thus far is that the capacity for containment requires a tolerance for the receipt of powerful affects and projections and places the therapist in the somewhat precarious position of having to entertain and experience this form of communication without acting out in response. That requiring containment can only be known by feeling it at some level and this requires some courage and maturity on the part of the therapist.

From a somewhat different but complementary perspective, Lafarge (2000) notes that interpretations are typically employed when a patient demonstrates whole-object transference as such transferences involve fantasies that are usually elaborated upon and expressed verbally. Lafarge (2000) adds that containment is typically most needed when a patient employs part-object transferences where the patient's primitive emotional experience is predominantly expressed in affect and action through projective identification (Lafarge, 2000). Although there appears to be a clear distinction here between more or less healthy forms of transference, Lafarge (2000) adds that such transferences are generally intertwined and dominant at different moments in time. As a result, part-objects are never fully identified as unelaborated beta-elements and whole-objects are never fully identified as purely integrated alpha elements described in words. In addition, whole objects comprise of part objects. It is here that Lafarge (2000) notes that interpretation rests upon containment whilst noting that it is also a part of the act of containment. Containment is therefore conceptualised as a mutual and reverberating exchange between patient and analyst in which affects and

fantasies are elaborated and modified as they are transmitted back and forth by projective identification and interpretations and other verbal or non-verbal communication (Lafarge, 2000). With this in mind, the analyst needs to be informed by his/her own affective responses to the patient's non-verbal and verbal communications (Lafarge, 2000).

Bion's idea of containment appears more closely tied to Lafarge's (2000) notion that what requires containment is the projective identification of part-object transferences rather than whole-object transferences, these part object transferences comprising mainly of beta elements expressed as concrete entities. Concrete entities, typically expressed in affect and in action, primitively communicate an individual's needs and wishes that have not yet been captured in fantasy or imagination (Lafarge, 2000). Part-object transferences are therefore communicated predominantly through projective identification, creating a countertransference pull within the therapist, as suggested previously (Lafarge, 2000). The receipt of such projective identifications allows for a potentially constructive process of containment to take place once the patient's raw experience has been transformed and proffered back appropriately without being enacted (Lafarge, 2000). Whole-object transferences are also projectively identified with, but Lafarge (2000) notes that enactments in these cases are more easily kept at bay through the use of more immediate verbal interpretations.

Steiner (2000) argues that successful containment depends upon the analyst's ability to contain his/her tendency to react (enact), as feelings aroused within the therapist should not be viewed as part of the patient's situation that needs to be understood. Steiner (2006, as cited in Ivey, 2008) adds that *thinking* is a central part of containment as it relies upon the analyst's capacity to receive projections, respond to them emotionally and tolerate the tension and frustration they may elicit – without recourse to action. In this manner, a failure in containment may occur when a therapist – rather than thinking about the patient's pain – enacts it, creating a sense of relief for a therapist who is overwhelmed by a patient's pain (Ivey, 2008; Pick, 1985; Steiner, 2000). Failures in containment consequently tend to occur when a therapist fails to acknowledge and separate his/her own countertransference reactions to his/her patient as this may lead to unanticipated enactments.

Ogden (1997, as cited in Lafarge, 2000) notes that during the process of reverie, the analyst's introjection of a patient's emotional experience results in a further incorporation of the experience into his/her own feelings and fantasies; an incorporation which propels the analyst to develop a more coherent understanding of his/her patient. In this way, Ogden's views

differ from those of Steiner (2000) as he makes space for the therapist's countertransference. Ogden argues that containment involves the patient's feelings and fantasies as much as it involves the therapist's feelings and fantasies. Such an understanding, when interpreted, may shift the patient towards a higher level of integration by enabling the reintrojection of more coherent fantasies that can be expressed as words (towards more whole object transferences).

Adding to this, Ogden (2004) views containment as the container's ability to *dream* the unconscious thoughts derived from the lived emotional experience projected by the individual being contained. In this manner, growth of the patient being contained can be reflected in his/her expanded ability to communicate thoughts and feelings (Ogden, 2004). Ogden (2004) feels that the container/contained relationship needs to be mutually beneficial to both the container and the contained as the container's capacity to dream is necessary for therapeutic benefit and requires openness to the possible dream-thoughts that are being contained and the ability to tolerate the projections. Ogden's contribution thus allows for a more inter-subjective understanding of containment and makes a strong argument for the potentially positive contribution of the therapist's countertransference. This is a perspective that supports Bion's (1984) central concern that psychoanalysis not only resolves unconscious conflict but also facilitates the growth of both the container and the contained.

In a similar vein, Ferro (2005; 2006) proposes that lived emotional experience can be contained by a container who, through the use of *waking dream thoughts*, alters and makes it available to the individual being contained. Through the container's employment of reverie and alpha function, or waking dream thoughts, the analyst's alpha elements are able to do the unconscious psychological work of transforming a patient's raw emotional experience (Ferro, 2005; 2006). Such a process is not directly accessible to the conscious mind of the analyst or the patient but the analyst's and the patient's waking dream thoughts are in a constant state of flux throughout the analytic session due to their ongoing interaction (Ferro, 2002; 2005; 2006). In this context, reverie has been conceptualised as a state in which the analyst's waking dream state allows for acceptance, metabolization and transformation of that which the patient projects (Ferro, 2005). This transformed material can then be used in formulating an interpretation, which may generate pain, rage or irritation on the one hand, and relief, well-being or a sense of being fed on the other (Ferro, 2002).

It appears that Lafarge's (2000) reference to elaborated fantasies corresponds to Ogden's (2004) dream-thoughts and Ferro's (2005; 2006) waking dream thoughts – each identified as alpha elements which aid the analyst's somewhat unconscious ability to think about his/her

patient's raw experience. This kind of process allows the analyst to associate freely whilst engaging with his/her patient's unconscious material (Lafarge, 2000). It is apparent that in addition to tolerating powerful unconscious communications, the therapist container also needs to be able to cultivate a particular kind of open-ended consciousness allowing for the metabolization of such communication.

It has become evident that containment as described thus far has been situated within an object-relations framework; one in which part-object and whole-object transferences act as significant ingredients and markers within the containing process. Other theorists, however, have expanded upon containment in a somewhat different manner. As the exploration of containment is taken further, it is useful to keep the following in mind: the distinction between containment of part-object transferences associated with beta elements expressed as concrete entities in affect and action on the one hand; and the interpretation of whole-object transferences that is associated with waking dream thoughts, verbal communication and alpha elements on the other. Up to this point, keeping in mind the emphasis on the receipt, tolerance and transformation of projective identifications, containment has been depicted as a predominantly unconscious process of transformation through the container's unconscious engagement with the patient's unconscious communication and his/her waking dream thoughts.

2.4.2 Containment According to More Contemporary Writers

Caper (1999) acknowledges the unconscious process of transformation that may occur in psychotherapy but did not feel that this necessarily required the function of a container. In this respect, Caper (1999) distinguishes between two types of alpha function: one synthetic and the other analytic – labelling only the latter as containment. Bion seemingly applied the notion of 'alpha function' to what Caper (1999) feels are two distinct processes - one that renders unbearable states of mind bearable, and another that renders raw physiologic sensation into something that is psychologically meaningful. This is a conceptualization that according to Caper is confusing in that it appears to classify both unbearable states of mind and raw physiologic sensations, which are seemingly not states of mind (and therefore perhaps neither bearable nor unbearable), as beta elements (Caper, 1999).

Asserting the need for greater differentiation of aspects of containment, Caper (1999) defines synthetic alpha function as a process through which raw sensations or perceptions are rendered psychologically meaningful and analytic alpha function as a process through which

unbearable states of mind are made bearable. In some respects, Caper's (1999) synthetic alpha function corresponds to the abovementioned notions of the interpretation of whole-object transferences through waking dream thought (and both are likened to unconscious dream work), however, Caper's (1999) synthetic alpha function does not require the provision of containment in its proper sense. Caper (1999) explains that the mating of a sensory perception and an instinctual drive, both of which are psychologically meaningless, gives rise to an unconscious phantasy suitable for dream work. Contrary to previously mentioned theorists, Caper (1999) proposes that this synthetic alpha function requires 'little or no psychological work' (p. 146) but is instead likened to the function of dreaming. In this respect, Caper (1999) disputes the necessity of the presence of a container for synthetic alpha function to occur and sees analytic alpha function as the prototypic form of containment, involving the container thinking about and interpreting material to the patient being contained.

Caper (1999) continues to explain that a process of learning from experience is set in motion as unconscious phantasies are tested as hypotheses against the perception of external objects, a process which, when proven, creates a blurring between perception and hallucination and which, when disproven, allows for the crucial distinction between external and internal reality. Caper (1999) therefore views the ability to see the difference between phantasy and reality as equivalent to Bion's emphasis on frustration as necessary for the development of thoughts. In both theoretical explanations thought is derived out of some tension pursuant on taking account of reality.

In addition, Caper (1999) links Bion's notion of omnipotent projective identification, where there is a permanent lack of differentiation between external and internal reality, with an 'anti-alpha function'. This function destroys one's capacity to dream, imagine and perceive. The capacity to feel frustrated and satisfied as the means of learning from experience has been destroyed and replaced by concrete mental entities, which Caper (1999) called anti-alpha elements. These elements differ from beta elements in that they consist of delusions, hallucinations and bizarre objects; experiences which are distorted and which thwart further development of unconscious phantasy while also destroying true contact with objects (Caper, 1999). Thus, Caper (1999) proposed that while dreams, perceptions, knowledge and moral values can cause psychological pain, only anti-alpha elements truly fall within the realm of unbearable states of mind since these concrete experiences 'encompass, invade and deaden

the mind' (Caper, 1999, p. 148). Anti-alpha elements are therefore fundamentally unable to be borne in mind.

"Analytic alpha function" restores the capacity for thought by converting anti-alpha elements back into their intended form with the processing of a patient's anxieties (Caper, 1999). Beta elements for Caper (1999) are thus anti-alpha elements which require the function of a container; one that contains the tendency to confuse internal and external reality, and one that confronts that part of the personality engaging in the anti-alpha function. Through this process, Caper (1999) suggested that frustration is eased because states of mind are less concrete. In this regard, the container increases the contained individual's ability to distinguish between internal and external reality (Caper, 1999). The purpose of this is to allow the contained individual to think objectively whilst also experiencing actual satisfaction with its objects (Caper, 1999). In this manner, Caper (1999) identified analytic alpha function as a form of containment which later becomes introjected as self-containment.

Given this understanding, Caper (1999) argues the need for the container to be realistic when detoxifying anti-alpha elements that have been projected into it. This means that the analyst needs to have a realistic attitude about who is who in the analytic relationship. In effect, this discriminating capacity allows the analyst to withstand the pressures towards enactment stemming from the patient's use of projective identification, whilst still transforming his/her sense of the role into which he/she has been unconsciously drawn, into an interpretation (Caper, 1999). In this manner, the analyst becomes able to distinguish who he/she is from the patient's phantasy about who he/she is, thereby allowing opportunity for useful interpretations. Again, the emphasis is placed upon the therapist's state of mind and the capacity to identify when his/her patient blurs internal and external reality. This in turn allows the patient to realise that his/her projections and beliefs may not truly represent reality (Caper, 1999). This understanding of containment, that of containment as analytic alpha function focussed on helping the patient to distinguish between projection and reality, will form one of the key theoretical frames informing the case analysis.

Sorensen (1995) asserts the necessity for the container to emotionally resonate with what has been projected into it. This allows for openness to receive unconscious communication about the object's most primitive communications. This being said, Sorensen (1995) asserts that emotional resonance alone can lead to an idealisation of the countertransference which may *"obfuscate the essential mystery and reality of the other"* (p.15) as the therapist focuses on their feeling responses perhaps to the exclusion of the reality of the patient. Sorenson affirms

the need for the "containing process" to include more active interventions like observation and clarification. Sorensen's (1995) containing mind aims to gain a more precise understanding of the nature of that which is being observed by caring for the concrete suffering of real individuals; a view that Casement (1985) also holds. As such, a therapist must be devoted to observing the details of his/her patient's unknown pain, using clarification as the vehicle through which a more precise understanding of the nature of that which is being observed is gained (Sorensen, 1995). Mental activities such as clarifying, sorting out, differentiating, identifying and naming are therefore necessary (Sorensen, 1995). These active and integrative attempts at focusing, discriminating and feeling, accordingly produce a sense - however fleeting - of containing and of being contained (Sorensen, 1995). Sorensen (1995) thus situates observation, clarification and emotional resonance at the heart of therapeutic containment, further adding that observation alone can be overly clinical and clarification alone can be overly arid.

Casement (1985) maintains that the provision of containment in therapy should propel patients along a path of recovery as well as towards a capacity to manage life's difficulties without avoidance or suppression. He feels that containment provides a breathing space where life's difficulties can be attended to; a function that he feels should not be undervalued as it can be remarkably helpful to someone in acute distress (Casement, 1985). He adds that some individuals are persistently gripped by a phantasy that their most difficult feelings can only be dealt with by avoidance (Casement, 1985). In such cases, the endurance and recognition of intolerable feelings as manifested within the bounds of a containing therapeutic relationship may lead to some insight into underlying phantasies (Casement, 1985). The provision of containment therefore requires the therapist to survive the patient's attacks calmly, preventing the patient from receiving typically avoidant or attacking response (that he/she typically experiences in relationships). In a similar vein to other theorists, Casement (1985) outlines that therapists should have insight into what the patient is re/enacting with them, as the unconscious feelings are firmly believed by the patient to exist within the therapist. Thus, the reality centred capacity of the therapist is crucial as his/her presence, insights and/or interpretations, underpin what contains a patient in therapy (Casement, 1985). Casement's (1985) explanation of what containment entails is thus somewhat less 'mystical' than that of Bion and some other Kleinian influenced theorists and suggests a stance that might be accessible to cultivation in a beginner therapist.

In the course of the discussion, a number of processes of containment have been identified within the therapeutic setting – those in response to whole object transferences, which do not require containment or alpha functions in their proper sense, but rather the use of interpretations, and those in response to part object transferences, requiring the provision of containment. Within this kind of formulation falls Caper's (1999) notion that 'synthetic alpha function' is that function applied to the transformation of raw beta elements into alpha elements without the requirement of the function of a container, whereas 'analytic alpha function' is the function applied in the transformation of anti-alpha elements back into alpha elements through the employment of a container. Caper (1999) places his emphasis on elaborating an understanding of analytic alpha function (also identified as analytic containment) as he feels it relates more closely to Bion's intended notion of containment within the therapeutic setting. The therapist's strong base in reality is required for the detoxification of a patient's anti-alpha elements and the containment of his/her tendency to confuse external and internal reality. The elusiveness of the concept of containment appears to lie to some extent within the distinction raised in Caper and other's work as discussed here as many authors have attempted to engage with these two processes (synthetic and analytic) as if they were one and the same phenomenon.

Sorensen (1995) and Casement's (1985) engagement with Bion's theory seems to afford a more concrete, practical and measurable definition or description of containment. Their understandings of the phenomenon suggest that containment requires the therapist to survive, tolerate and think through the patient's communication of overwhelming distress through the use of projective identification – while simultaneously observing, clarifying and emotionally resonating with that which is primitively communicated. The process of containment can therefore be achieved in quite general and yet profound ways through the analyst's realistic and self-aware attitude and communication of reality oriented perspectives and material to the patient. The understanding of these aspects of containment is central to the endeavour to provide meaningful therapy. Bearing this in mind, the case study presented in this research report will employ an understanding of containment based primarily upon the more accessible work of Caper (1999), Sorensen (1995) and Casement (1985).

2.5 The Relation between Containment and 'Holding'

From the discussion thus far it seems evident that the notion of containment has been understood and applied in various ways. Some interpretations have led to considerable

confusion between the concepts of containment and 'holding' and a number of authors have emphasised the need to differentiate Bion's idea of *containment* from Winnicott's idea of *holding* (Caper, 1999; Moss, 1998; Ogden, 2004; Symington & Symington, 1996). Ogden (2004) argues that the two concepts, holding and containment, address quite different aspects of the same human experience and involve their own distinct forms of analytic thinking. Using these two concepts interchangeably therefore means running the risk of missing what Winnicott and Bion originally intended by these concepts (Ogden, 2004).

For Winnicott (1960), *holding* refers to a mother's expression of love primarily through the physical holding of her infant and through her thorough observation of and attention to her infant's every need. Winnicott's (1960) notion of holding promotes a healthy sense of omnipotence in the infant, by reducing his/her awareness of a reality separate from him/herself. In this manner, the provision of a holding environment contributes to the development of the infant's continuity of being whilst allowing the infant a space to express his/her creative gestures (Winnicott, 1960). Within the therapeutic space, this concept holds more of a metaphorical connotation; one which Winnicott (1963) described as the analyst "conveying in words at the appropriate moment something that shows that the analyst knows and understands the deepest anxiety that is being experienced, or that is waiting to be experienced" (p. 240). While this may sound similar to the provision of containment, in this context, holding refers to a therapist's care of and empathy in response to his/her patient's distress, which may be verbally or non-verbally expressed. In this manner, holding is different from containment as it does not focus on transforming the beta elements or anti-alpha elements into alpha elements. However, it is apparent that there is also room for potential overlap between the two therapeutic functions.

Modell (1993) notes that the provision of a *holding* environment affords the individual being held an illusion of safety and protection from both internal and external dangers. The absence of this holding environment on the other hand, forces the infant, or patient, into premature maturation or self-sufficiency by removing his/her sense of safety. Modell (1993) adds that the provision of a holding environment depends upon the therapist's consistency and reliability; upon the manner in which he/she responds to and accepts his/her patient; in his/her being primarily there to meet the patient's needs rather than his/her own; in not retaliating in relation to the patient's inner psychic reality but in clarifying what may appear bewildering/confusing through his/her 'better grasp' of the patient (p. 277). In this manner, the therapist's provision of a holding environment plays a supportive function in meeting and

attending to the patient's needs. Again however, it is evident that some aspects of holding sound very similar to aspects of containment. There is perhaps a difference in emphasis rather than a complete distinction between the two constructs. The distinction may be as much about the theoretical paradigm informing the intervention as it is about the way in which the intervention takes place in the room and is experienced by the patient.

Moss (2008) outlines that the mother's provision of a *holding* environment helps the infant to feel whole rather than fragmented, contributing to a feeling that basic needs are being met. Holding can be provided nonverbally, for example, primarily through a mother's gaze, and this function is gradually introjected as a source of strength aiding in the development of the infant's 'true self'. In contrast, Moss (2008) outlines that the provision of *containment* involves the mother's making sense of her infant's experience by thinking for her infant (Moss, 2008). In this manner, the mother contributes to the integration of conflicting experiences such as good and bad, love and envy, anger and compassion. For Moss (2008), the provision of containment occurs later developmentally than the provision of a holding environment. This is because containment is more complex and verbal, concerned more with the development of thoughts (Moss, 2008). In this light, it could be hypothesised that the provision of a holding environment precedes the provision of containment in the therapeutic setting.

Ogden (2004) argues that *holding* is a deceptively simple notion involving the mother's cradling or safeguarding of her infant - a process which contributes to the sustaining of the infant's 'continuity of being'. He adds that holding becomes more metaphorical at a later stage through the mother's provision of a 'place' or psychological state in which the infant is able to gather him/herself together (Ogden, 2004). Winnicott (1945, as cited in Ogden, 2004) notes that this is attained in therapy through a patient's finding contentment and relief in his/her "*rattling off of every single detail of his/her weekend*" (p. 150) for example, even though the analyst feels like no work has been done. Winnicott (1945, as cited in Ogden, 2004) understood this as a patient's need to be known in all of his/her bits and pieces, and thus to feel integrated by one person's (the analyst's) understanding of him/her. The provision of a psychological space in therapy depends on the analyst's ability to tolerate the feeling that 'no analytic work has been done' as this contributes to the safeguarding of the patient's continuity of being and becoming over time (Ogden, 2004). Consequently, this provision of holding within the therapeutic space may correspond to a more supportive form of therapy that does not challenge the patient's sense of being. In contrast, Ogden (2004)

refers to *containment* as the manner in which a container processes and thinks about lived emotional experience. In this regard, containment is a process in which the container engages in unconscious psychological dream work and the contained individual experiences a living process, consisting of the sharing (consciously and unconsciously) of thoughts and feelings that are continuously evolving and expanding (Ogden, 2004).

Caper (1999) outlines that the analyst's provision of a *holding* environment conveys that the analyst is able to identify with his/her patient's perspective by communicating a degree of reassurance that does not add to or challenge the patient with new perspectives. The analyst sustains the patient's continuity of being by minimizing the patient's awareness of inconsistencies between his/her beliefs and the analyst's. In this regard, Caper (1999) notes that holding produces no real change in the patient's relationship with the analyst but rather positions the analyst on the good side of the patient's splitting. *Containment*, on the other hand, elicits insecurity by moving the patient into unfamiliar territory. This means that in the analyst's employment of containment he/she challenges the patient's perspectives by exploring his/her unconscious as separate from external reality (Caper, 1999). Caper (1999) notes that the patient's realisation of an internal reality separate from and not in keeping with external reality, elicits a sense of insecurity and isolation. Through the process of containment, the patient may be shifted towards more depressive feelings of guilt and remorse in having to engage with conflicting feelings of persecution and relief – experiencing a 'peculiar insecurity' (p.155) that characterizes analytic alpha function or containment (Caper, 1999). Accordingly, Caper (1999) suggests that the hallmark of analytic alpha function or containment is the conversion of an unbearable state of mind (not yet able to be borne in mind) into a state of mind that is merely insecure. Furthermore, Caper (1999) adds that the absence of this insecurity indicates a failure of analytic containment with 'something like holding' (p.54) occurring instead.

Finally, Symington & Symington (1996) distinguish between *containment* and *holding* by suggesting that the container is internal and the holding environment is external or transitionally present between the internal and external; that the container is 'non-sensuous' (p. 58) and the holding environment sensuous; and that the container/contained relationship is actively integrating (or destructive), whilst the holding environment is positive and growth promoting. In keeping with these ideas, Casement (1985) notes that the provision of a holding environment with appropriately communicated interpretations provides an experience of containment that potentially allows the patient to experience real feeling contact with the

therapist with the realisation that the therapist is still able to continue functioning and is separate from the patient (Casement, 1985). The discussion thus points to the necessary differentiation between holding and containment, the former involving an alignment to and support for the patient's being which may in some instances become the precursor for the latter, more challenging function, to occur. It is evident, however, that in discussing therapeutic practice therapists do not always use the terms accurately. This kind of conceptual confusion is something to which a beginner therapist with a broad psychodynamic training may be particularly vulnerable.

2.6 Operationalizing Containment

As mentioned previously, the concept of *containment* needs to be described in a way that makes it possible to practise in psychotherapy. While this may involve some degree of simplification or reductionism, the operationalization of containment may be particularly useful for therapists in training. Such an attempt at operationalization is also perhaps necessary for this case study which aims to look at containment in action or at least whether it is possible to observe this.

Thus far, different versions of containment have been discussed in the context of psychotherapeutic work. One version emphasizes the container's capacity to "*dream"* the contained individual's beta elements in a rather unconscious manner. Caper (1999) felt that this function 'required little or no psychological work' (p. 146) as it was as easy as dreaming. He termed this process synthetic alpha function, noting that it did not require the presence of a container. For this reason, the second version, Caper's (1999) analytic containment will be drawn upon as the framework for understanding and attempting to operationalize the function of containment in the context of this case study. For Caper (1999), anti-alpha elements are distorted thoughts, delusions and hallucinations that inhibit emotional growth and destroy true contact with objects. This makes them unbearable as they prevent thoughts from being borne in the mind. The container is required to immobilize this anti-alpha function by containing its tendency to confuse external and internal reality and to aid in the processing of anxieties and in the symbolization of experience.

Thus, in a therapist's endeavour to contain a patient, the therapist will need to distinguish the patient's distortions or delusions from external reality. Caper (1999) noted that this is achieved when the therapist remains realistic, having a clear understanding of who he/she is in the transference and countertransference as well as who his/her patient is in the

transference. This knowledge or awareness allows the therapist to avert enactments and to challenge the patient's perspectives when appropriate, aiding in the patient's awareness that his/her perspectives may not truly represent external reality. This is supported by Casement (1985) who emphasised the necessity for therapists to have insight into what the patient is re-enacting with them. In this manner, Caper (1999) noted that anti-alpha elements or unbearable states of mind are converted back into alpha elements or states of mind that are merely insecure.

Caper (1999) added that analytic containment involves the processing of some anxieties, suggesting that the provision of this function is also somewhat supportive in the face of anxieties – as anxieties seem to allude to thoughts or feelings that are unbearable. This appears to affirm Casement's (1985) emphasis in writing about containment, that containment involves the provision of a breathing space where life's difficulties can be attended to and where the therapist endures and acknowledges the patient's intolerable feelings. Thus not only must the therapist have a reality centred capacity in the therapy room, but he/she must also have the capacity to survive the patient's attacks calmly – protecting the patient from receiving the typically avoidant or attacking responses (or enactments) that he/she would in other relationships (Casement, 1985; Caper, 1999). In this regard, therapists convey containment through their presence, insights and/or interpretations, and by their survival, tolerating and thinking through of their patient's overwhelming distress and unbearable states of mind. Sorensen's (1995) view of containment as a process of obtaining a more precise understanding of a patient's distress is important in this regard. The container/therapist is expected to observe closely and focus on the patient's concrete suffering by caring for him/her in a particularly sensitive manner. Sorensen (1995) feels that this is provided through mental activities such as clarifying, sorting out, differentiating, identifying and naming. The therapist is also expected to emotionally resonate with what he/she is engaging with rather than responding at a purely cognitive or thinking level. The integration of these functions is perceived by Sorensen (1995) to produce a sense of containing and of being contained.

The provision of containment appears demanding, requiring a dependable, resilient and robust container (Sorensen, 1995; Caper, 1999; Ogden, 2004; Ferro, 2005). A therapist in training is, however, affected by a number of different pressures which will be explored with regard to potential difficulties in attempting to become a good container/therapist.

2.7 Beginner Therapists' Difficulties in Attempting to Understand and Provide Containment

Bion regarded containing functions as being highly demanding on the container as he/she is expected to receive, acknowledge and absorb all of the contained individual's projective identifications with a degree of selflessness, self-knowledge, and receptivity to both conscious and unconscious communication (Elmhirst, 1980). This is, however, an ideal to aspire towards. The therapist should not be seen as a mere respondent to his/her patient's unconscious pressures but as an equal participant, actively shaping the process according to his/her own unconscious conflicts and fantasies, which may lead to a deviation from the analytic attitude as well as the expression of some countertransference feeling (Ivey, 2008). In this light, according to Steiner (2006, as cited in Ivey, 2008), a rupture in the containing process may occur when the therapist, who allows feelings and reactions to well up within him/herself, acts upon them. Countertransference is thus not necessarily viewed as negative to the therapeutic process unless it is enacted. Enactment may then represent a failure in containment as it may result in the unconscious gratification of the therapist's own anxieties which may negatively impact on the therapeutic process (Ivey, 2008). With this and other concerns in mind, there may be times when the container is unreceptive or out of tune to what he/she is trying to contain as a result of enactment, passivity, avoidance, or of feeling overwhelmed by the patient's material (Casement, 1990).

Waddell (1998) notes that even if a mother is physically present, she may not always be emotionally present (as she has her own difficulties) and the infant may, from very early on be required to 'struggle' with this reality. Equivalently, the therapist may at times only be physically present which induces within the patient an emotional emptiness. More undesirable may be when the therapist's anxieties are projected into the patient (Halewood & Tribe, 2003), in which case the patient may be pushed into the containing role. According to Waska (1995) this may occur if the therapist's anxiety is felt by the patient as more significant than his/her own overpowering affects. In an attempt to save the therapist from the unbearable difficulties which he/she has come to know, the patient may make a type of 'altruistic sacrifice' (Waska, 1995). These reactions can be regarded as transference and countertransference reactions that are inseparable from the transference analysis as the two continually influence each other (Ivey, 2008). According to Bion, through the process of projective identification, countertransference reactions are regarded as essential to the

therapeutic situation and to understanding the patient's psyche if the therapist is able to understand, tolerate and work with these reactions (Money-Kyrle, 1956; Waska, 1995).

Furthermore, containment is not about offering reassurance or extra support as that communicates that the therapist does not trust the patient's ability to contain him/herself (Casement, 1985). This may occur when the therapist struggles to tolerate his/her own anxiety as well as his/her patient's anxiety - the patient is then not given the opportunity to think for him/herself and is forced to depend fully on the therapist's capabilities (Casement, 1985). Casement (1985) concludes then that containment is the capacity to interpret what the patient is feeling at that particular moment in time rather than what the therapist would like the patient to feel. This interpretation of the patient's state should be accessed through trial identification, holding themes, holding patients' unbearable emotions, analysing what is consciously and unconsciously communicated (in terms of the patient's history), non-verbal signs, the transference and the countertransference (Casement, 1985).

An appreciation of therapist countertransference is important for the operationalization of containment as the therapist's own emotions may obstruct his/her implementation of alpha functions or containment as a whole, which in turn may result in the inadvertent proffering back of interpretations polluted by the container's own difficulties. Consequently, this may result in the patient's material being stripped of meaning as well as a possible reversal of roles within the container/contained dynamics (Waddell, 1998; Waska, 1995).

With this in mind, beginner therapists may experience their own countertransferential reactions as potentially problematic in their attempts (and failures) to contain their patients (Kottler, 1991). Stoltenberg & Delworth (1987, cited in Hawkins & Shohet, 1989) outline how training to be a psychologist is internationally recognised as a long, arduous and often difficult task, in which there is often a sense of uncertainty and fragmentation. Brightman (1984) described the range of concerns that trainee therapists have around their professional self-worth, which trainee therapists often confused with their own personal worth. More conscious concerns involve the realistic pursuit of intellectual, technical, and personal mastery of treatment skills together with the doubts and fears around attaining them (Brightman, 1984). Other concerns impacting on a trainee therapist's self-esteem are influenced by his/her direct self-observation as well as inferences drawn by supervisors of their students' aspirations (Brightman, 1984). All of these factors affect the trainee's '*grandiose professional self'* which Brightman (1984, p. 297) disaggregated into omniscience, benevolence, and omnipotence.

Omniscience refers to the trainee's need to *know enough.* This need is generally frustrated by the trainee's lack of clinical and technical knowledge and the patient's needs not to know and to be unknown. This incongruence often leads to feelings of not being good enough, particularly because trainees often imagine that "immediate understanding is required of them by patients and supervisors" (Casement, 1985, p.ix). This statement illustrates the type of pressure which beginner therapists seem to place on themselves in order to be viewed as 'competent'; an expectation which trainee therapists often inflate unrealistically (Brightman, 1984). In addition, Bruch (1974) viewed patients as well as beginner therapists as expecting therapy to solve patients' problems and make them happy, which may instead be the fortunate side effect of psychodynamic psychotherapy. Benevolence refers to trainee's idealised perception of therapists as 'all-loving', which Brightman (1984) noted as resulting in a denial of any feelings of self-interest or hostility. This means that there is a tendency in trainee therapists to deny any negative countertransference feelings to the extent they feel that this is inconsistent with a therapist's role. The trainees' tendency towards control and power, or need for omnipotence, may further interfere with their ability to master their own affects, and affect their clinical work as well as their capacity to be attentive to their patient's needs (Sharaf & Levinson, 1964, as cited in Brightman, 1984). The struggles of attaining professional goals and aspirations are difficult to manage for a trainee, and are only thought to surface when actual clinical work begins (Brightman, 1984).

Kottler (1991) perceives these pressures and expectations as augmenting unrealistic expectations and goals for therapy, including, it could be argued, the expectation to provide good containment. Brightman (1984) added that the presence of such idealised expectations and goals results in a subjective sense of inadequacy and failure in the beginner therapist. According to Kottler (1991) beginner therapists encounter unexpected 'first contact' difficulties, learning only through experience and supervision that therapists do not behave like other people as there is a subversion of certain conversational and interaction rules. Accordingly, they are required to learn to listen to and take in their patient's information both empathically and analytically with a heightened sense of awareness (Bott Spillius, 1992). They must also realise the importance of maintaining boundaries and discover the difference between empathy and sympathy. Kottler (1991) calls this learning process and particularly the first experience of actually working with a patient, the separation phase, in which beginner therapists feel vulnerable, naked and ill-formed with a sense of defensive grandiosity against feeling helpless and unsure. These emotions and expectations become dismantled and entangled within the learning process of psychotherapy and become

manifested as narcissistic injuries (to self-esteem and self-image) accompanied by doubts about being good enough (Gluckauf-Hughes & Mehlmon, 1995).

Such narcissistic injuries have been defined as the damage experienced by an individual's real self; focused on difficulties in self-development with regards to feelings about the self and past relationships (Halewood & Tribe, 2003). In this light, Ford (1963) and Menninger (1957, as cited in Halewood & Tribe, 2003) argue that one of the reasons that psychologists are attracted to the profession is a striving for self-realization and self-identity. Glickauf-Hughes & Mehlman (1995) believe that therapists with such needs are sensitive, empathic and aware of others needs, traits which were perhaps misused by parents with narcissistic needs. Therapists in this regard often struggle with unresolved narcissistic issues, which include audience sensitivity, perfectionism, imposter feelings and unstable self-esteem. These difficulties often elicit feelings of doubt and uncertainty, particularly within those who desire a concrete sense of achievement (Glickauf-Hughes & Mehlman, 1995).

In a study by Halewood and Tribe (2003), the presence of narcissistic injuries was concluded to be higher in trainee therapists than more experienced therapists, and was further accompanied by a higher degree of the following aspects: restriction of emotional affect; lack of understanding of the self; the presence of 'false self' traits (in a Winnicottian sense); the need for mirroring and understanding; problems with setting boundaries; grandiosity; depression; and perfectionism. These themes are believed to manifest within a trainee therapist's countertransference through the disowning of unwanted parts of themselves, which are consequently projected into patients (Halewood & Tribe, 2003). It is thus very important for trainee therapists to be self-aware; honest, able to be self-reflective and self-critical, with the assistance of personal psychotherapy which aids in the resolving of such conflicts and prevents such consequences as burnout (Halewood & Tribe, 2003).

Trainee therapists have thus been observed to experience forms of narcissistic distress which Kottler (1991) and Schumacher Finell (1985) suggest is typically sidestepped in supervisory processes as a result of the obvious focus on the patient's rather than the therapist's narcissism. This in turn may have deleterious effects on the therapeutic process. In addition, Bott Spillius (1992) noted that the therapist's process of understanding his/her responses and feelings to the patient requires constant psychic work, since, if confused with the patient's feelings, the therapist's vulnerabilities can be hazardous. In such cases, failures in containment can be noted when beta elements (or anti-alpha elements) remain as undigested facts waiting to attain thinkability; or evacuated as hallucinations, psychosomatic illnesses; or

enactments without any depth or thought (Bion, 1962, as cited in Ferro, 2005). It therefore seems important for therapists to be aware of their own anxieties, insecurities and underlying conflicts when listening to and analysing their patient's communications. Whether responses are induced by projective identification on the patient's part or evoked by the therapist's own unresolved issues, it is necessary that countertransference reactions are analysed in light of both the therapist's concerns and the patient's transference (Ivey, 2008).

In accordance with this, it is anticipated that themes regarding narcissistic injuries vis-à-vis feelings of incompetence, inadequacy, low self-worth or self-esteem will surface during the course of a therapist's first time therapy experience and may impact on the ability to develop the capacity for the provision of containment. Thus it is important to acknowledge that therapist dynamics may also play an important role in helping or hindering the provision of therapeutic containment.

2.8 Working with Individuals with Deprived and/or Abusive Childhoods

Since the primary focus of the case study is on the trainee therapist's difficulty in grasping the idea of and attempts to provide containment in the therapeutic encounter this last section of the literature review is somewhat brief and is not intended to provide exhaustive coverage of the dynamics of sexually abused and deprived patients. However, it was considered important to provide some theory that might assist in understanding aspects of the patient's presentation in this case. The extensive literature on childhood origins of pathology precludes thorough coverage of this material in this research report of limited scope.

According to Bruch (1974) individuals who seek therapy carry a sense of hopelessness, fear and inner conviction of being unable to cope with and change things. In this way, patients carry with them 'beta elements' or 'anti-alpha elements' which require some external intervention in line with aspects of Bion's theory of containment. In many instances, this distress may be related to early trauma, deprivation or abuse.

The experience of sexual abuse in childhood is traumatic and has devastating effects, highlighted by Briere & Elliot (1994). They suggest that sexually abused individuals more prevalently experience a wide range of psychological and interpersonal problems in the short and long run. They categorise such effects as including posttraumatic stress, cognitive distortions, emotional pain, avoidance, impaired self-esteem and interpersonal difficulties.

Mendel (1995) highlights that male children often do not disclose their abusive experiences through fear and shame and are more likely to encounter helping professionals as a result of repressive and aggressive behaviour than out of overt expressions of distress. Abused boys attempt to cope with these experiences by withdrawing from society due to their sense of helplessness, shame, self-blame, victimisation and failure to self-protect - in part owing to the society's perceived ideals of masculinity (Mendel, 1995). In addition, sexually abused children are found more likely to be diagnosed with posttraumatic stress disorder, and as adults display more intrusive, avoidant and arousal symptoms in the form of intrusive flashbacks, nightmares, memories and thoughts, than individuals not abused as children (Briere & Elliot, 1994). In a study on male survivors of childhood abuse, Lisak (1994) identified fifteen themes that arose in clinical work with such men including: anger, betrayal, fear, homosexuality issues, helplessness, isolation and alienation, legitimacy, loss, masculinity issues, negative childhood peer relations, negative schemas about people, problems with sexuality, self blame/guilt and shame/humiliation. Within this sample, the majority of them had a history of substance abuse and half of them came from disrupted or violent homes (Lisak, 1994).

Britton (1993) and Symington & Symington (1996) note that individuals being contained may have fears which potentially prevent them from being contained. These include fears that their distress (beta elements/'anti-alpha elements') may be rejected, devoured or stripped of meaning and/or individuality by the container. For example, adult survivors of abuse may fear the consequences of allowing their unbearable distress to surface within the therapeutic setting in fear that the therapist will not understand the perceived severity of this distress. Bion emphasized that an infant's reactions are of equal importance to the container's responses as the infant may have a low innate tolerance for anxiety (in this case towards what Klein referred to as 'depressive anxiety'), which affects the infant's capacity to progress in unstable environments (Elmhirst, 1980). The symptoms and effects associated with sexual abuse can be understood as illustrating an apparent lack of containment during these boys' developmental years. It is thus anticipated that a male adult survivor of childhood sexual abuse may fear rejection from a potential container in that they themselves feel overwhelmed by their anxiety, guilt or shame concerning their experience. In addition, those individuals who have lived through their abusive experiences in isolation may have been prevented from receiving the type of containment thought necessary and ideal for these situations and may thus mistrust any container. It is also hypothesised that emotions of envy, shame, low self-worth and guilt may arise in men who were sexually abused when another individual is able

to contain what he finds/found so difficult to bear (Britton, 1993; Mendel, 1995; Waddell, 1998). Thus it cannot be assumed that the provision of containment for such patients will necessarily be perceived as helpful or taken up when presented.

An infant deprived of sufficient containment will try to maintain some psychic integration by resorting to a range of defences which prevent feelings of panic and disintegration, but which may also elicit feelings of isolation within him/her (Waddell, 1998). In time, this defence may habitually solidify into a sense of pseudo-independence, which will become part of the individual's personality (Waddell, 1998). It is possible that adults who were sexually abused as children may exhibit this sort of pseudo-independence, which may prove difficult to work with within a therapeutic setting, again, hindering their access to what containment is available. Thus in applying notions of containment to the therapeutic setting, it is important to look at both the capabilities of the therapist to offer and the capacities of the patient to receive in this regard. In conclusion, and for the purposes of this research, the literature review has discussed the importance of containment within the therapeutic setting. In addition, it has discussed issues anticipated to arise within a therapy setting when the process is impeded by the anxieties of a beginner therapist or of a patient with a history of abuse and non-containment, which then affects the relational dynamics of the therapy and the possibility of the provision and receipt of containment.

Chapter 3: Method

3.1 Research Design

3.1.1 Case Study Method

The case study method involves an in-depth analysis of a single subject (or small group of subjects), and is usually non-experimental and longitudinal in nature (Travers, 2001). The case study method is employed when data is regarded as idiographic and holistic, rather than as fitting into a particular set of variables on a single occasion (Yin, 2002). As such, the case study method was advocated for this research as it requires detail and inclusivity of more subtle ideas and concepts that are often neglected in the statistical method (Kazdin, 2004).

The inclusive detail of the research findings does not imply a singular applicability, and is certainly not reproducible or generalizable. This is evident in Edwards (1990), who states that "*the assumption is not that the case in question is necessarily typical or modal, but that the key aspects of theory implicit or explicit in the presentation of the case material will be of value in conceptualising other cases*" (p. 372). Therefore, the intrinsic value of the case study is that it allows for the generation of subtle and individualised detail that can be applied where similar issues arise in other cases. However, Fishman (2005) argues that the accumulation of such case data, when similar results are fashioned, may allow for generalisability to be established with great credibility and temporal validity.

In addition, it should be noted that the case study method contains several variations within itself. Edwards (1990) notes that theory-testing and illustrative case-studies are often used in the discipline of psychology; however, for the purpose of this research, the approach being advocated is a descriptive, embedded single case study design. This method does not consist of data in the form of variables and manipulations, but rather an exploration of the case material and what the implications of that material are (Edwards, 1990). In this case, it was employed to assess the phenomenon, i.e., the attempted operationalization of Bion's theory of containment in the context of therapy with 'JD'. Casement (1985) argued that the research space created by scrutinizing the dynamics of intimate interactions within the therapeutic relationship allows the therapist to learn from his/her patient in the process of intervening. It is in this spirit that this research has been conducted. The method, as Fishman (2005) notes, should allow for a comprehensive understanding of a particular problem within a local and

time-specific context, relevant to psychotherapy practice, as opposed to attempting to generate abstract, general, timeless principles and laws.

3.1.2 Psychotherapy Case Study:

Psychotherapy generally consists of work with a single subject as the presenting patient, and is, by its very nature, case specific. The exploratory-descriptive case study method therefore lends itself well to the study of the psychotherapeutic process, as it is naturalistically and unobtrusively able to consider any and all facets of psychotherapy, without contaminating it through manipulation of important yet less prominent data (Strupp, 1981; Yin, 2002). Furthermore, as the process of psychotherapy is also a process of analysis and interpretation, it allows for the accepted gathering of and analysing of data of a single case, with an added and impending advantage of patient care and psychotherapeutic change (Strupp, 1981). The process of psychotherapy, therefore, allows for an inherent and natural inclination towards detailed, open-ended and case-specific data gathering (Edwards, 1990). The use of the case study method is thus, the likely method of choice in psychotherapeutic work.

Adding to this, psychodynamic theory stresses neutrality and impartiality of the therapist within the therapy setting (Jones & Windholz, 1990). As such, the descriptive case study allows the therapist/researcher to gather, interpret and analyse data and execute treatment without intruding or imposing upon the therapeutic process per se. The data being gathered in a descriptive psychotherapy case study is, therefore, elicited freely from the patient without manipulation and coercion, and conforms to the rich history of research into psychodynamic therapy (Jones & Windholz, 1990). Strupp (1981) argued that "*there can be no doubt that most of what the field has learned about psychotherapy since Breuer treated his famous patient, Anna O., a century ago, has come from astute and creative clinical observations*" (p. 216). In this manner, Strupp (1981) brought attention to the richness of the researcher's (as the psychotherapist) contributions to clinical work in a context where a naturalistic, non-directive and neutral stance is advocated, as the most appropriate method to understand the process of psychotherapy whilst still adhering to psychodynamic principles.

Although the validity of the case study method has been questioned, it has been recognized as the primary method of choice for empirical research within the psychoanalytic tradition for over a century (Attwood & Stolorow, 1984). Freud, himself, employed the case study method, generating much detail and insight into a substantial portion of his theory, which is now considered a 'watershed' in the study of human behaviour (Jones & Windholz, 1990). It

is therefore apparent that the method in question is able to add to both theoretical and practical knowledge in the field of psychodynamic psychotherapy. Furthermore, the psychotherapy case study approach is justifiable when exploring new and under-researched areas as it illustrates, with depth, concepts and ideas that have not been sufficiently explained through other methods of study without causing significant disruption to the therapeutic process (Edwards, 1990; 1998).

It should be noted that single-case studies require careful investigation to minimise chances of misrepresentation, as embedded single-case studies may at times fail to acknowledge the larger unit of analysis by focusing only on the sub-unit level (Yin, 2002). This caution was kept in mind in investigating the particular sub-unit of interest within the context of psychotherapy with 'JD' as a whole. However, the focus was necessary in terms of the research endeavour.

3.2 The Clinical Setting in Which the Psychotherapy Took Place

'JD' has been receiving weekly therapy at a university clinic (still ongoing) where student psychologists, speech and hearing pathologists, and social workers are trained. The service provided by trainee clinical psychologists in this clinic is medium to long-term psychodynamically oriented psychotherapy (usually of 6 to 18 months duration). Fees are based on a sliding scale and are negotiated with the client. Clients are aware that the therapists are in training and work under supervision.

3.3 Data Collection

Data for this research consisted of all records of patient-therapist interaction relevant to the relational dynamics observed in the psychotherapy with 'JD'. Data thus consisted of therapeutic communication that took place with the patient, including 'JD's reported experiences, observations of here and now processes, observations of the therapist's countertransference reactions, and various provisions of supervisory input over the course of the trainee therapist's first year of study. The course of therapy (see chapter 5) was also considered an important source of data, as the case narrative depicts the therapist's developing understanding of operationalizing and providing containment, the patient's needs for and receipt of containment, as well as the transferential and countertransferential aspects of the therapy process.

Data collection took the form of audio taped recordings, direct observation, case notes and transcribed session material. Supervisory observations are also included as data. Material pertaining to the role and provision of containment in the psychotherapy was the focus of the exploration and thus the case material was selectively extracted with a view towards highlighting this particular dimension. Weekly session notes, providing detail about 'JD's reported experience, behaviour and interaction as well as clinical impressions were utilised, as well as discussions that took place during weekly group and individual supervision. In addition, the therapist kept a journal noting personal experiences and feelings evoked in working with 'JD'. As countertransference reactions are, by definition, unconscious and bound up with the therapist's personal psychotherapy experience and difficulties in relation to a specific patient, it is important to note that self-analysis has limitations. The supervisory input as well as the group supervision observations served to provide some degree of triangulation or verification in interpreting the data, in this case all records kept of and observations made concerning the therapeutic process. Attention to reflexivity as part of the research process also proved helpful in interpreting the data.

3.4 Data Analysis

The data in the clinical case study was interpreted through a broadly defined psychodynamic framework with an emphasis on Bion's notion of containment. A hermeneutic approach was employed as it involves the study of contextual information that is historically and culturally constructed (Edwards, 1998). In this light, the hermeneutic approach attempts to make sense of human experience in context and is not necessarily concerned with objective, law-like patterns of human behaviour (Kelly, 2004; Fishman, 2005). Kelly (2004) argues the importance of understanding human experience within its social, linguistic and historical location. The hermeneutic approach is concerned with the contextual basis of functional reality and takes a relativistic perspective (Fishman, 2005). Kelly (2004) also highlights the empathic nature of understanding that is embodied in the hermeneutic approach, which appears to link well to the study of the psychotherapeutic process. The hermeneutic approach essentially allows for the interpretation of material through a lens of understanding that seeks to uncover hidden elements or that which is not necessarily evident at face value. In this case the lens for the interpretation was psychodynamic theory, allowing for the uncovering of layers of understanding. Psychodynamic formulation essentially aids in the development of appropriate interventions for the purposes of achieving certain therapeutic goals (McWilliams, 1999). In this instance, psychodynamic theorization not only aided therapeutic

progress but also added depth to the specific case study with its focus on the training therapist's attempt at operationalizing the function of containment.

It should be noted that this method of interpretation has certain limitations with regards validity as the framework that is used to make sense of the data is also comprised of the same data (Edwards, 1998). This problem is called the hermeneutic circle which was kept in mind during the research process through the acknowledgement of certain assumptions implicit in Bion's theory of containment, as well as through a critical assessment of the validity of the conceptual structure of the hermeneutic lenses being employed (Edwards, 1998). Edwards (1998) argues that in achieving this, the lens being employed in the hermeneutic case study method can be adequately validated.

Material was selected according to the way in which it related to and illustrated the process of exploring, comprehending and providing containment. Material relating to the interrelational dynamics between patient (subject) and therapist (researcher) as the container and contained is therefore concentrated upon in the case study, as well as individual dimensions that have relevance to this focus. Excerpts from the transcripts as well as from personal case notes are used to explore and illustrate this focus in the report. This material is explored in a rather descriptive manner with caution not to make overly speculative interpretations (Edwards, 1998). As Edwards (1998) argues: "The main aim of the case study was not to build case law or grounded theory in a rigourous manner but to use these existing theoretical frames as lenses through which the rather unusual phenomena of the therapy sessions could be viewed coherently" (p. 45). The data interpretation employed in this case study was therefore directed towards allowing for a unique understanding of a beginner therapist's experience in trying to operationalize the function of containment for a patient who has lacked this function while growing up.

3.5 Reflexive Considerations

As part of the focus of this research is on the researcher's experience as a trainee therapist in a first therapeutic encounter, it seems important to consider the notion of reflexivity. This process requires self-reflection upon one's involvement in a process/event, and exploration of the role that that participant understood in their engagement (Taylor & White, 2000). This reflection generates 'process knowledge' at face value and a further engagement in reflexivity is required to "*interrogate those previously taken-for-granted assumptions*" (Taylor & White, 2000, p. 198). The critical reflection upon actions and feelings that occur whilst engaging in a

process of discovery allows for the acknowledgement of one's impact, constructive or not, on the situation (Taylor & White, 2000). As such, it has some similarities to the psychoanalytic notion of countertransference. Studies involving reflexivity often include accounts of the emotional and other difficulties experienced while engaging in the research process (Travers, 2001).

The reflexive focus founds itself on intimate details of the people's lives that are being studied and particularly the manner in which their negative reactions and other aspects of engagement are responded to by the researcher/s (Travers, 2001). The researcher's (therapist's) views and assumptions were therefore subject to critical scrutiny in the light of this concern and supervisory and other forms of input aided in the reflection upon the role of the researcher in both the therapeutic and research processed. The inclusion of discussion on aspects of the personal experiences of the author was necessary and contributed depth to the study. As Travers (2001) states, "The researcher is expected not simply to produce emancipatory knowlege, but to demonstrate that she has come to view her own life differently through conducting empirical research" (p. 138). This research therefore allowed the researcher as the trainee therapist to engage critically in the therapy process, while still illustrating how a trainee grows and matures through a first therapeutic encounter. In describing the work with the case, the author will use the first person pronoun since this seems appropriate to the research design and emphasizes the role of researcher as also in some senses a subject in the research process.

3.6 Confidentiality and Ethical Aspects

'JD' committed to therapy at the beginning of psychotherapy, giving voluntary written consent for his case data to be used for the purposes of research, as well as separately to the audio-taping of each session, given undertakings of confidentiality and protection of identity (See Appendix A and B). All information pertaining to 'JD' has been kept in a secure place. Identifying material has been disguised as far as possible for the purposes of maintaining the client's anonymity - recognizing simultaneously the need to remain as true as possible to the process and dynamics of the case for clinical veracity. Furthermore, as work with this client is ongoing, care has been taken to maintain awareness of the possible influence of the research process on the therapeutic process. Although the writing of the case study made the therapist more self-conscious perhaps, overall it seemed that the careful attention to this containment element of the process probably enhanced the therapy.

Chapter 4: Case Context

4.1 Demographics and Motivation for Seeking Psychotherapy

'JD', a twenty five year old African, Christian man is currently in his third year of university study. 'JD' was self-referred for long-term therapy to deal, in his opinion, with the consequences of his sexual abuse as a child. He felt that this was impacting upon his current functioning when interacting with those he considers close to him as well as particularly with other men. He had been seen for 21 sessions at the time of writing up the research.

4.2 Reason for Referral and History of Previous Counselling

'JD' was referred for therapy as he had come to recall that he was sexually abused from the age of 8 for about an 8 year period and found that knowledge of this experience was impacting his current functioning. Specifically, the referral noted the impact manifesting in his anger and his interactions with other men. The referral also reported that this has been affecting his relationships with other people onto whom he felt he 'transfers' his feelings. He particularly worries about making his girlfriend 'suffer'.

In 2006, 'JD' saw a female intern psychologist at a university clinic but her term of employment ended in June and 'JD' was reallocated to a male social worker whom he saw for 6 more sessions. 'JD' found this transition difficult as he had to 'start again' but found it easier talking to the second therapist whom he felt 'completely understood' him. He felt the male therapist was '*not just [his] therapist but [his] friend too'* and said that he '*was the first male to be comfortable to talk about **that thing**'*. Post termination he found out (through a notice) that this therapist was shot and killed which he felt '*really, really deeply hurt*' about. This has led to consultation with the present therapist (after about a year and a half) and for the third time 'JD' noted starting again as difficult, intense and unravelling. Later 'JD' shared that he does not feel he is making the type of progress that he would like to have made with any of the therapists he has seen and frequently considers '*hypnotherapy'* as an alternative to psychotherapy in assisting in '*deleting his past'*.

4.3 Presenting Problem

4.3.1 Mental Status Exam

'JD' is in his mid-twenties and of medium build and medium height. His clothing is neat and clean though well worn. He usually dresses smartly in jeans and a shirt or jersey. His hair is short and he is usually clean shaven. He wears glasses and appears older than he is. He maintains appropriate eye contact, although his posture is usually slouched and his stance rather guarded.

'JD's attitude has ranged from reserved, to friendly, to hostile from session to session. 'JD' is quiet but when he starts to relax his manner is more animated. At times he appears to relate to me as a friend - describing situations in quite an entertaining manner, seemingly to make me laugh as this seems to ease his anxiety. He becomes easily engrossed in and overwhelmed by his thoughts, such 'deep' thoughts typically giving rise to feelings of helplessness and distress. What appear to be traits of passive-aggression are also evident in 'JD's employment of subtle interpersonal attacks when he does not feel understood or heard. He fairly often uses the expression "*anyway, I'll be okay",* in an apparent attempt not only to reassure himself, but also it seems to communicate a need not to pursue a particular issue any further.

'JD' speaks reasonably good English, at times in a quiet, reserved manner and at other times in quite an assertive, opinionated manner. His speech is usually slightly slow and emotionally charged with his voice expressing possible emotional fragility at times. His mood appears generally depressed and his affect is usually appropriate to context – ranging from being composed, to teary, to distressed, to aggressive - depending on the issues he is dealing with. There are times, however, when 'JD' displays inappropriate affect, for example when describing how "*rested*" he felt after a suicide attempt in adolescence.

'JD' does not appear to suffer from perceptual disturbances and his thought process appears logical and coherent. 'JD' is at times circumstantial, particularly when he struggles to make sense of confusing ideas or beliefs. In the early phase of therapy, his thought content centred on a theme of becoming a "*much better person*", illustrating how unbearable he finds his life at present. It is unclear whether 'JD' experiences clear suicidal ideation although he has mentioned that he "*sometimes feels like dying*".

'JD' appears well oriented to time, place and person and is able to retrieve childhood memories as well as current information without difficulty. 'JD' is also able to think abstractly and appears to have some degree of social judgement. Even though he is preoccupied with his own needs and feelings – 'JD' realises that his actions may hurt others. He appears to have the capacity for emotional insight, as he is able to admit to and identify his insecurities and inner struggles as well as to look at his role in interpersonal interactions. At times, however, 'JD' locates all his problems externally, i.e., as caused by the abuse or as attributable to the behaviour and attitudes of others. 'JD' can also be impulsive in acting on his emotional states and has described times of extreme emotional distress.

4.3.2 Initial Impressions

I initially imagined that 'JD' would be somewhat reserved, apprehensive and vulnerable – expectations which were met in initially encountering an anxious, acutely self-conscious and guarded individual who appeared to express much of his anger passive-aggressively. 'JD' seemed to struggle to make sense of his experiences, which magnifies his feelings of frustration. In this regard, 'JD' appeared to be largely intolerant of himself – always doubting his abilities. He appeared to be an ambivalent individual, caught in the crossfire of deep conflicts, eliciting emotions that he struggled to contain, regulate and tolerate. From the onset of our therapy, 'JD's stated expectations of therapy were considerable, as he expected me to understand and for therapy to "*heal*" him quickly – placing some pressure on me as the therapist to live up to his expectations.

4.3.3 Presenting Problem

'JD' was sexually abused for eight years from the age of eight - he feels this robbed him of his childhood and his ability to "*feel free"* when interacting with people. He expresses a desperate need to close this chapter of his life and is determined to become "*a better... a much better person"*; someone who can think independently whilst interacting with people in a "*very, very nice and polite way"*. He feels that he compromises a lot in relationships which he perceives as represented in the sacrificing of his own needs in many instances in order to prevent his past from being exposed. Furthermore, 'JD' shared that the abuse left him feeling *"scared of... of... of males"* and wondering "*what makes a person to be gay?*" In this regard, he has a strong need to prove his masculinity, protect himself and be "*in control"*. He displays strong emotions, communicating deep distress, anger, guilt and fear which he tries hard to avoid.

4.3.4 Signs and Symptoms

'JD' finds it very difficult to communicate and interact with other people - as he fears exposing his vulnerability. Accordingly, 'JD' prefers to isolate himself as he feels he "*does not owe anybody an explanation*". In this regard, 'JD' often feels lonely, neglected and insignificant – a pattern further exacerbated by his inability to make sense of his overwhelming past. He deals with his anxiety primarily through avoidance (sleeping) and distraction (taking long walks). During his "*off days",* 'JD' feels "*emotionally unstable"* and typically "*just sits and cries*". It is during these times that 'JD' has expressed marked distress and frustration at his inability to understand himself and his responses. He shares that he hates feeling out of control and needs to have clear explanations for the situations he finds himself in, as he finds the uncertainty deeply anxiety provoking and somewhat unhinging. On one occasion, 'JD' resorted to inflicting pain on himself (by cutting himself), and more recently, he has begun to use alcohol and other substances (sleeping tablets) to help him "*escape".* He has noted that "*sitting alone is something of a defence mechanism... of fearing what I don't know is going to happen",* and thus appears to be developing some insight into how his defensive style may be counterproductive at times.

'JD' finds it particularly difficult to talk about his experiences of abuse in therapy. Some time ago, 'JD' mentioned a dream in which he dreamed that the perpetrator tried to abuse him, and recollected feeling very angry on waking. 'JD' then wondered how people are "*labelled as gay"* and explained how he was nearly beaten up by a group of boys a few years ago as they thought he was gay. 'JD' noted feeling "*guilty"* and embarrassed about this and wondered "*if people are seeing a lot of what happened"* in his past. In addition, he questions whether people in general avoid him because of "*the mask that he puts on"* or because "*they find him intimidating"* and he constantly ruminates about how he is perceived. One of the ways in which 'JD' tries to connect to other people is by spending time in helping others with their problems. This also seems to counteract his common feeling of inadequacy.

'JD' specifically struggles with feelings of rage, which he goes to great efforts to suppress as he "*does not want to make you cross if you have made [him] cross"* – seemingly fearing retaliation and hostility from others. He also feels that he "*can't find it in [himself] to be mean to other people"* and avoids interpersonal confrontation out of fear that he may become like his perpetrator. Thus, at times when he feels taken advantage of or challenged by others he is aware of intense feelings of rage but withdraws in order to punish the other and discounts the relationship he had with that person, rather than tackling the difficulty more

directly. In such circumstances, 'JD' becomes highly punitive of himself, labelling himself "*stupid"* and "*cowardly"* – yearning for the courage to stand up for himself. His inhibition of his anger is linked to his expressed concern that his anger has been "*building up for so long"* and his fear of the implications if it were to be expressed. He feels that "*he* (the perpetrator) *taught [him] to be angry"* and these attributions are accompanied by strong desires for revenge. Thus 'JD' displays considerable ambivalence in relation to aspects of his identity, his interpersonal relationships and has particular difficulty in negotiating conflict and disagreements and in the management of his aggression.

4.3.5 Onset, Duration and Relevant History

'JD' accounts for most of his difficulties as stemming from the abuse that he suffered from the age of eight to sixteen years. However, his suspicions or fantasies about what caused him to be singled out for the abuse elicit fears relating to some doubt as to his self-worth. 'JD' also seems to have lacked sufficient containing experiences in growing up. His father left his mother when he was two years old. His mother has been described as rather unavailable and as not very in tune with 'JD'. As discussed further she appears to have been traumatized by the death of 'JD's younger brother and struggled to deal with this loss, suggesting that she became detached from 'JD' and his siblings and was possibly seriously depressed. 'JD' was then sent to boarding school for his entire school career with a sense that "*they should have protected him*" in relation to the abuse. 'JD' has never felt comfortable to disclose the abuse to anyone (including his mother and siblings) as he feared the consequences, questioning whether anyone would take him seriously. It thus seems likely that there are certain aspects of 'JD's psychic difficulties that are rooted in the abuse but there are other aspects that seem attributable to a lack of containment whilst growing up. This early deprivation or lack of containment is reflected in his sense of isolation in bearing the abuse and very likely intensified the damage he experienced.

'JD's biological father left his mother when he was two years of age and 'JD' remarks that he has no recollection of him. He has since tried to make contact with him; initially through a social worker who notified 'JD's father of his visit, and thereafter through a friend and sister-in-law of his father, who drove him to his father's current home. Both attempts to meet with his father were unsuccessful as he was absent at the time. 'JD' insists that he needs nothing from his father yet admits wondering if he would accept him if they did meet, as he feels that a part of his identity is missing.

In addition to his father leaving when he was two years of age, his grandmother – who had helped to take care of him – left too. Although the reasons for this are unknown, 'JD' noted that she had a disagreement with his mother which led to her abandoning both him and his mother. In this context, 'JD', the middle child of three siblings, grew up with a mother who he reports loved them very much. However, when he was four years of age, his little brother accidentally and traumatically drowned, during a time when he and 'JD' had been playing. 'JD' remembers this vividly and recalls his mother staying at the hospital for four days even after his brother had been declared dead, as she could not let go of him. When he was seven years of age 'JD' was sent to a boarding school.

'JD' initially remembers his mother being "*the most loving of all of the children's mothers*", taking him to school every week, bringing him "*nice clothes and food"* and never forgetting his birthday. As time passed however, he recalls being expected to be more independent – able enough to take himself to school. During this time, 'JD's mother stopped visiting him leaving him confounded by the change in her treatment of him. His sense of isolation from his home was then exacerbated by the sexual abuse which he became prey to at school. Adding to this, 'JD' reported that his mother was physically abused by a boyfriend with whom she later conceived three more children – a "*new"* family which seemed to consume much more of his mother's attention. With all of this in mind, 'JD' was unable to disclose his situation to his mother, and now resents what he perceived as her neglect and lack of protection of him. 'JD' misses his deceased brother deeply and feels he "*would have (had) a good friend and somebody [he] could talk to"*.

At boarding school 'JD' described being very close to the head of department who treated him as a mother would. She did, however, discipline him harshly. 'JD' outlined how she allowed him to sit and cry in her office without needing any explanations from him. 'JD's experience of being sexually abused was both confusing and distressing, leaving him with constant questions about his self-worth as well as his capacity to trust others. The sexual abuse was perpetrated by an older school boy over an eight year period and appears to have been more coercive than seductive in nature as 'JD' described feeling afraid of and dominated by this boy and immense relief when he left the school. However, 'JD' has not to date shared much detail about the nature of the abuse. 'JD' spent much of his time at school alone, crying and day-dreaming about "*all the nice things that [he'd] do when [he was] older"*. 'JD' has expressed intense feelings of guilt about his decision to conceal what happened when he was young but explained that he feared the consequences, doubting

whether people would "*take [him] seriously"*. With hindsight 'JD' described himself "*as a child, and everything that happened [he] just locked up somewhere in [his] mind"*; a stance that has endured into the present in his stringent attempts to suppress his memories of the abuse.

At present 'JD' suffers from stomach ulcers and high blood pressure, for which he takes medication. He has been in a long-term relationship with his girlfriend from school but has noted that he has stayed with her for so long because he "*fears rejection*" rather than for more positive reasons. 'JD' feels that he does "*not get along with many people*" unless he is willing to compromise his own needs. This is evident in 'JD's attempts to help his female friends with their emotional difficulties by listening to them, (never revealing his own struggles), and in his newly found attachment to alcohol as it helps him get along with his male friends.

4.4 Case Formulation

'JD' experiences chronic feelings of loneliness and isolation, particularly in his struggle to make sense of his past. 'JD' often feels anxious, doubting his sense of self-worth and continuously trying to bolster his self-esteem by attempting to live up to the expectations and needs of others. In this sense, it appears that 'JD' has an underlying narcissistic personality structure. In his perceived need to compromise in relationships and his need for adulation and to be seen as strong by and for others, he presents with what could be understood as sense of pseudo-independence. Nonetheless, 'JD' appears to have a level of insight into his behaviour, aspects of which he is able to explore in therapy. It is therefore thought that he has the capacity to utilise psychotherapy productively.

In addition, 'JD' displays some borderline personality features as will become further evident in the discussion. These include considerable ambivalence in his interpersonal relationships and interactions, and inability to regulate his affect well, feelings of rage and abandonment, a past history of several suicide attempts and a current tendency towards some self-destructive behaviours (including alcohol use verging on abuse and one instance of 'cutting'). This presentation would not be inconsistent with a history of sexual abuse that was not in anyway mediated or processed at the time.

In 'JD's description of his childhood, he felt abandoned by his father and somewhat neglected by his mother. The loss of 'JD's little brother seemed in part to be a consequence of 'JD's inability to save him and the later experience of sexual abuse persisted because of his

felt inability to stand up for himself. In this manner, 'JD's history was characterised by serious abandonment experiences and loss, together with a sense of inadequacy. Coupled with this is the absence of any parental figure who was able to contain and mediate his experience of the world. This seems to have translated into 'JD's inability to contain himself. He had to construct his own version of the world; one which is typified by extremes and rigidity.

'JD' carries strong feelings of anger, helplessness, guilt and confusion in a world in which his objects – both real and imagined – "*failed to protect [him]*". These feelings have been unbearable for 'JD' and have led to a number of externalizing patterns of behaviour. Amongst these is his use of substances linked to three attempted suicides in the past. It seems that 'JD' not only lacked a holding environment but also a containing one in that he had no supportive, available caregiver to empathise with and transform his unbearable experiences into more bearable ones. He was further physically abused by his hostel mothers and harshly loved by his head of department – experiences which created expectations of love and care as dependent upon his portrayal of himself as obedient and pleasing. Thus, it appeared that 'JD's image of a container, or caretaker, became one that was selfish, unable to meet his needs consistently, and quick to communicate disapproval of him through a level of punishment or neglect and abandonment. Not only has he introjected such a container, but 'bad objects' – that is, images of his neglectful parents and the abusive perpetrator – have further become a part of his inner world that he often retreats into; persecuting on the one hand and isolating on the other.

Stemming from this set of experiences, 'JD' is harrowed by feelings of loneliness and abandonment in a world which he currently perceives as insensitive and judgemental. As a primary means of coping he suppresses and compromises his own needs and feelings to attain a level of acceptance and intimacy with others, which often elicits feelings of resentment in relation to people's perceived unfair treatment of him. As such, 'JD' oscillates between appearing guarded and suspicious of my treatment of him, and open and entertaining in his efforts to be accepted and acknowledged by me. These efforts are typically accompanied by a need to reassure me that he is okay, to prevent my disapproval and rejection of him as weak and problematic and to avoid eliciting rejecting (and perhaps ultimately abandoning) responses from me. Although this behaviour has allowed him a sense of achievement through his promotion to president of a committee at the university, his still fragile sense of self-worth remains dependent upon others' treatment of him, which is either built up when he feels

appreciated and accepted by people or broken down when he feels challenged, disrespected and/or belittled. The latter experiences echo his childhood, experiences which he markedly struggles to understand and contain. In response 'JD' often retreats into his "*quiet world*". He is, however, plagued by unbearable feelings that appear unmanageable not only to himself but to others too. He worries that if these feelings are expressed, they may contaminate others and cast them into a similarly unbearable, confusing and distressing world. Such risks to express himself (particularly his anger) are also accompanied by a worry of abandonment and rejection as past figures in 'JD's life have been perceived as abandoning or rejecting. As such, 'JD' seems to have developed a sense of pseudo-independence allowing 'him to hide his feelings of vulnerability when he is treated carelessly or harshly. This defence, however, also makes 'JD' vulnerable to being taken advantage of.

4.5 Treatment Plan

The primary goals of therapy have been twofold. Firstly the aim has been to provide 'JD' with a consistently safe and containing environment in the form of a therapist who is able to empathise with, acknowledge and survive his emotions and experiences, thereby helping him feel understood and become better able to handle overwhelming emotions. Secondly, it was intended that the therapy should aid in making sense of 'JD's' past (and present) experiences and the emotions attached to them, emotions which he often finds unbearable and uncontainable. These goals have several dimensions including: (a) increasing his awareness of how past difficulties and experiences have shaped his current life functioning; (b) distinguishing between his perceptions of situations and the external reality of such situations; (c) aiding in the understanding and expression of feelings such as anger, guilt and shame that accompany many of his presently perceived deficits; (d) understanding his fears of rejection and abandonment and the ways in which he compromises to meet others expectations of him; and (e) making sense of his "*quiet world*" which he experiences as persecutory as well as calming.

Through the development of a trustworthy alliance and the provision of containment, it has been and is hoped that 'JD' becomes better able to introject and perform a containing function for himself, which will aid in his regulating and surviving his distress as well as support his ability gradually to make sense of that which he experiences.

Chapter 5: The Course of Therapy: with Emphasis on the Illustration and Discussion of the Operationalisation of Containment

5.1 Early Phase of Therapy: Finding our Feet (Sessions 1-3)

In my initial contact with 'JD' I became aware of the place from which I had begun my training as a psychotherapist – a place in which I had not expected to be referred what I perceived to be such a serious case (based on the referral information which noted a history of sexual abuse and relational difficulties) (see previous section) as my very first psychotherapy patient. From the outset I had to take ownership of these perceptions and to keep my expectations and judgements consciously in check in meeting 'JD' for the first time. Thus, from the start of our sessions, I tried hard to listen – *without memory or desire* (Bion, 1984) – and facilitated the first session by allowing him to speak as he wished.

'JD' began our first session in a rather open fashion, revealing much of his vulnerability in explaining the distress he felt from being sexually abused as a child. In what seemed like a desperate plea for help, he anxiously described how this experience had contaminated and damaged his life, stating that he needed to be "*a better... a **much** better person*". In this regard, therapy seemed to be the beacon that represented his last hope, an ideal which I felt quite inadequate to meet. In our second session, 'JD' shared that therapy was making him feel emotionally unstable in surfacing a past that he normally tries to avoid. Adding to this, he shared that his friend had also queried his reasons for attending therapy. During the next few sessions, 'JD' backed away from exploring his distress, often stating – somewhat ornately - the opinions he had about society's harsh treatment of different groups of people. For him, women and children need to be empowered as they have the right to be "*loved, educated, protected and fed – not abused*". He found human cruelty upsetting on the whole, using his mistrust of human interactions to explain why he had difficulty forming friendships with others, whilst adding that he much preferred to be on his own as he then felt "*free*". As the first three sessions unfolded, it became clear that 'JD's openness about his vulnerability turned to anger and self-consciousness. This anger was expressed in the content material he brought; whilst the emotion itself seemed discomforting to him and he seemed to need to show his aggression covertly without necessarily taking ownership of it. Instead, 'JD' described how he reacted when he was angry, noting that I would know that he was angry when I saw tears running down his face. It was thus becoming evident to me that 'JD's anger

possibly in part related to my inability to adequately hear and respond to his pain and distress, despite my best early efforts. This alarmed me and the anxiety of hearing that he might wish to discontinue therapy, further hampered me from exploring what he appeared to be communicating. Thus, the beginning stages of therapy were about recognizing my own anxiety and possible defensiveness and about survival of 'JD's aggressive attacks, whilst gradually and empathically attempting to enter into his isolated world. There were also times when 'JD' apparently tried to contain and repress his own distress in response to my unconsciously projected anxiety. I was struggling to deal with the gap between his idealized expectations and my own sense of inadequacy, as well as with the anxiety stemming from my fantasy that this was a difficult patient, beyond my level of capability. I think 'JD' was both alarmed and angry at my rather tentative and frozen early responses. At this stage, my supervisor brought to my attention to the fact that I needed to be careful of basing my worth as a therapist on 'JD's interactions with me and suggested that my self-consciousness was impeding my ability to make contact. This allowed for some space to explore vulnerable emotions that 'JD' typically hides.

5.2 Managing the Loneliness of his "Quiet" World (Sessions 4-5)

In our exploration of 'JD's inclination towards being on his own, he became aware of the extent of the loneliness of his world. This realisation was both frightening and distressing to him. He had distinguished between his "*quiet*" world which he saw as relieving, free from judgement, persecution and ridicule; and the social world, which for him was experienced as harsh, critical and intrusive, filling him with anxiety and fear about exposing his past. Still, his "*quiet world*" felt isolating at times, leaving 'JD' wondering whether people had avoided him because of the way "*society works*" or because he was "*different*" or "*intimidating*". He shared that even in the presence of others he often felt lonely and self-conscious, expressing a fervent desire to be "*free*". With this in mind, we came to the conclusion that his need to feel "*free*" not only at home, but in the presence of others, meant being without a fear of rejection. Although helpful to a degree, 'JD's realisations distressed him, deterring him from exploring the anger, guilt and shame that accompanied this loneliness. He had linked this sense of social isolation to the abuse, as he recollected "*playing a lot*" with his friends when he was young, before something "*clicked*". Even then, he became aware of his differences as children often mistook him for the oldest in his peer group because he was the tallest, even though he was sometimes the youngest. In addition, he recalled never being chosen for sports

at school. It thus became apparent that 'JD' contained very difficult feelings within himself, which he struggled to fit together on his own and that his feelings of difference and exclusion had a long history.

These early sessions were difficult, with 'JD' filling the space with detailed complaints of how others (including me) in the environment were making things hard for him. The defences most evident at this point in the therapy were denial, projection and displacement. 'JD' was quite ambivalent about therapy, viewing the work we had done as unhelpful yet still looking forward to sessions as his only uncensored human contact of the week, seemingly sharing more with me than with others. Even so, 'JD' would always leave with some comment like: "*Anyway, I'll be okay*" and "*If only someone understood – I feel so alone*" which created a strong push/pull dynamic between us. In the first two months of treatment, I had difficulty in finding a way to connect with 'JD'. I felt both locked out of meaningful contact and punished for not matching up to the ideals of his previous therapist and "*friend"*, as in some way he would always let me know how lonely and misunderstood he felt. In the countertransference, I experienced feeling quite incompetent and frustrated with my many attempts to respond or understand seemingly falling on deaf ears.

5.3 Sifting Through his Disappointment: The Beginning of a Containing Process (Sessions 6-10)

In the sixth session, after a two week break, 'JD' expressed feeling overwhelmed by what he called his "*bipolar*" moods – with his low moods often leading him to tears. 'JD' expressed feeling confused, distressed and frustrated, noting during one week that he had wanted to talk to me before the time of the scheduled session. In some way, 'JD' had found my presence comforting, which I somehow found comforting too, even though I felt that I had not aided very much in enhancing his understanding. Already in this early phase of therapy, my presence seemed to play a role in relieving some of the despair he felt when alone; a despair which he routinely avoided through engagement in external tasks or behaviours when not at therapy. This is illustrated in the following excerpt (excerpt 1A), which began at the start of our sixth session. (Excerpts 1A to 1C all form part of a single continuous exchange in the psychotherapy but have been broken up into 3 separate sub-sections in order to illustrate somewhat different points about what took place in this early period in the psychotherapy).

First Excerpt from Psychotherapy: 1A

JD*: I don't know what's going on with my emotions. I just sometimes… I feel fine, and then other moments I feel soooo down… and that part is not nice, the down part, it just, takes a lot from, from me, and uh, ja. It's just… that's what I hated about these two weeks and I wished sometimes that I can call you and just please make a sooner appointment so that I could come.*

T*: it was quite tough...*

JD*: Ja, ja… I don't know what is going on now, I don't know if it's the pressure that I'm feeling, um, from my books, or what, I don't know.*

T*: What does that down-ness feel like for you?*

JD*: It sucks, it sucks a lot. It just drains me and just go into… down. And when I'm down I want to sit alone in my room. And ja.*

T*: and what sort of things do you think about when you're down?*

JD*: Um, everything that is not going right in my life at the moment: my finances, my relationship, my relationship with my mother, whatever, those sorts of things… and ja, what am I still doing here, and I don't want to be here. It's just so stressful, very stressful… and, uh, I think I got some relief on Wednesday and Thursday because we had to go to Deloite…*

The next excerpt (excerpt 1B) illustrates the type of containment that I think 'JD' desired after expressing a number of confusing, distressing and unbearable emotions, which I had not been able to relieve. This conversation followed on from excerpt 1A during the sixth session.

First Excerpt from Psychotherapy: 1B

JD*: I found myself on Saturday I was very, very, very, very upset, I don't know why… and I packed the whole of my room, took everything in the wardrobe, put them down and repacked them. It's much better when I'm doing that, very much better, I just feel… okay. After that I take a walk, it's, it's fine then, I don't, it's a bit of relief. Still, it's still there. I just, I just want to shut down, I just want to… I wish I can, sometimes I don't know, I want to die or something. I just, I don't know… I hate that feeling.*

T*: Mmm, what is the biggest part of that feeling that upsets you?*

JD*: I can't communicate with anybody while I'm in that state. I can't… I avoid everybody; I just don't want to talk. If you try to talk to me, and I will answer, but I will not give you the satisfactory answer. Ja. Sometimes I think that's the reason that my girlfriend is always avoiding me, and ja, I don't like those. I really don't know what is going on with me.*

T*: mmm, it seems like you're experiencing a lot of very extreme emotions that you can't really understand and that really frustrates you…*

JD*: Ja. … anyway*

T*: What stops you from talking about it? From communicating?*

JD*: I can't, I just can't, I just, you just, you can see the tenseness, it's just… I can feel it here when I'm tense it's just, it becomes tense. I actually said to myself last night 'okay release' and when I said so, it, it felt better and I was actually angry yesterday fighting with my girlfriend so, ja…and I released it and I often still feel bad. I have to just relax my muscles here. When I relaxed them, it feels better but 10 minutes later, I'm tense, unconsciously it just gets bad again… I just wish, ja, it can go away.*

T*: It seems like there is a lot building up inside that might be causing that tension?*

JD*: mmm, maybe? (laughs) maybe because I cannot explain it. I don't know, I don't know what is it. That's the reason why I don't want to agree and say there is something building up, because if I say there is something building up, I have to say what is it, but I can't explain it, that's the real problem.*

T*: Do you feel you have to be able to explain it?*

JD*: I would love to; I would love to explain it. It just… it's so stupid, it's so stupid and the other day I found myself crying, I don't know why, oh I was watching a movie (laughs). I was watching this lady and I just, tears rolled down my cheeks, I don't know what the hell is going on.*

T*: What was the movie about?*

JD*: It was this woman; she was a teacher at a boarding school. I forgot the title; I think it's more than meets the eyes… it's got 'eyes' and 'meets' and she was teaching at this blind school and eventually she went slowly blind and then she became totally blind. Then she was talking to this kid that she was teaching and she said what's good or what's better about me*

is the fact that I do have some pictures in my mind of how is the world, how is everything and I can't imagine what you go through everyday - she was talking to this boy – and ja, she started explaining how are things, he was asking how is grass, how is the sky and so on, and she was explaining, and he was asking about the colours and um, he was asking if the colours have smells, and she was trying to explain, and she took the grass and said 'do you know what green smells like, it smells like this'. This is green. It was, it was ja, and later in life, oh the husband died, after she became blind, the husband just developed cancer in the sinuses and he died. It was very sad, I cried there (laughs). I don't like seeing people very, very sad. Ja, and she moved to another town, stayed and ja she started her life again, and she became a motivational speaker and I think she remarried again. I think the real story, her name is Joan Brock.

T*: Sounds like it really resonated with you*

JD*: Ja*

T*: Could you identify with a lot of things?*

JD*: ...Ja.*

T*: Mostly with the boy or the teacher?*

JD*: Both… they've got courage, ja, especially the woman. It's, it's, it's very, very hard to start your life after, after what happened and yet, she, she did it.*

T*: and that is something that inspires you?*

JD*: Ja, ja…*

T*: Do you think characters on TV help you express yourself more?*

JD*: some…*

T*: I mean, maybe characters on TV that you identify with help you understand your emotions?*

JD*: sometimes. Ja, sometimes… I actually told myself that I'm not going to watch it (laughs), and I saw myself watching it. Actually it was very interesting.*

Within this excerpt, 'JD' relayed a story of a process which could be seen as mirroring Bion's notion of alpha function in which the teacher, as the container, symbolised what her student,

as the contained, could not. 'JD' marvelled at the teacher's courage and perseverance ("*It's very hard to start your life after what happened*"), as even though she went blind and her husband died of cancer, she went on to become a motivational speaker. Nonetheless, her bad fortune in going blind could also perhaps be understood as a fear within 'JD' of contaminating his container, which is further evident in the next excerpt (excerpt 1C), which occurred later on in the sixth session.

First Excerpt from Psychotherapy: 1C

JD*: I found myself yesterday, uh, talking to my girlfriend and saying that it's better for us to separate if I'm like this. Part of me, doesn't want this to affect her. I am… sick and she mustn't suffer for that. I couldn't say it; actually, I couldn't get to saying it… I don't know.*

T*: was it too frightening to say?*

JD*: Ja.*

T: *Is that why you had a fight?*

JD*: I feel like sometimes I am giving so much to people and I feel like I'm getting nothing back… it's frustrating.*

T*: You don't feel like people acknowledge what you do…*

JD*: Ja*

T*: and that's very difficult for you…*

JD*: it's very difficult.*

T*: and do you feel that way with your girlfriend?*

JD*: Ja, I feel like that, it's just me, I always tell myself that its just you alone, you have to work it out, whatever it is, you just have to work it out because you are alone and nobody, does actually cares. It actually breaks my heart when I think that way because I'm not sure if there's somebody who really cares. I rarely get calls from my mom, I… nobody is here.*

T*: You really feel alone and that can be quite scary when you face difficult and confusing times…*

JD*: very, and I actually told my girlfriend that I feel lonely as if you're not there…*

T*: and how did she respond?*

JD*: she just kept quiet. … I feel, I felt, I felt* ***so*** *lonely this weekend. I just felt the emptiness and the space, I just, I feel that way.*

Further evidence of this sense of being possibly contaminating, is illustrated in excerpt 1C where 'JD' considers breaking up with his girlfriend to prevent her from suffering the effects of his "*sickness*". In this light, 'JD' noted that he had to "*work it out alone as nobody actually cared*". Evident in this is my struggle as a beginner therapist to fully contain 'JD' and bring meaning to his unbearable emotions. Perhaps my role during this somewhat early phase of therapy was felt to be more of a *holding* one than a *containing* one as I had not enhanced our understanding of some of 'JD's painful emotions. 'JD' often displayed a hesitance against sharing difficult memories, continually noting how important it was for him to be in control. Perhaps my difficulty in containing him, in responding with greater insight to his emotions and needs, contributed to some difficulties in the therapy process, and left more room for fear, shame and a sense of despair when facing his struggles. One could understand some of the communication here to be about transference feelings that I too might not care, including not caring to understand him and might leave him feeling lonelier in his attempts to communicate. Although I reflected aspects of his distress I did not bring any of the material into the here and now of the psychotherapeutic relationship which might have been helpful at this point.

During this session, 'JD' had also shared how a friend of his had called him a "*hypocrite"* as he always gives them "*good advice*" but is now "*falling apart"*. 'JD' felt upset by this, explaining that he is a hypocrite only because he cannot control what is going on around him. While exploring this, 'JD' often switched his focus from sharing his vulnerability to pushing it aside, noting that he would be "*better soon*". This seemed indicative of both my failures to fully contain him as well as his own fears of being contained. This leads us to the next excerpt from psychotherapy, illustrating my inability to contain some of 'JD's very overwhelming emotions. This discussion began by my drawing 'JD's attention to his struggle to balance out his need to understand his own confusing and distressing emotions on the one hand and to convince people around him that he is alright and in control on the other. Whilst exploring this, 'JD' became confused and evasive, expressing doubt about his ability to overcome his struggles, his past and his emotions.

Second Excerpt from Psychotherapy

JD: *Sometimes I have this feeling of suffocation, just feeling like I'm being suffocated and it makes me angry.*

T: *mmm, do you feel that way now?*

JD*: I felt like that on Saturday*

T*: and today?*

JD*: today uh, not really, today I'm between things, I just want to sit and get my work done. I'll be fine… I have to start gym as soon as possible as exercising releases some energy.*

T*: It's okay to feel down….*

JD*: I'm not sure, (laughs) I'm not sure… (long pause). It's like, if there was someone who could understand, if there was just someone who could just understand and actually understand what I'm going through, I'd feel much better.*

T*: Have there ever been times where you've felt understood?*

JD*: No, I don't feel understood. And the worst part of it, I don't feel accepted. That's the most stupid one (laughs).*

T*: Is there a part of you that wonders if I understand you?*

JD*: (sniffs) Ja. … (long pause)… I actually did this… this thing on my finger, I cut myself, it felt better.*

T*: when did you do that?*

JD*: A few weeks ago, seeing the blood, it just, you transfer the pain from something onto something else and you can see its bleeding. It's stupid, but it's…*

T*: it gave you some relief.*

JD*: It relieved me, it feels, it feels better. It's fine now.*

T*: I realize that you haven't felt as understood maybe as you expected from these therapy sessions and I wonder if maybe we could speak about that next week as it is something that is*

important for you to feel understood in these sessions… and to feel heard. …Would that be okay?

JD*: Ja. …I'm just, I'm just so scared, I'm just so scared… and I feel like I'm alone in what's going on. It scares me. It scares me.*

T*: it is a very difficult thing to go through by yourself…*

JD*: What if, what if… I just have thoughts, what if you don't understand me, what if you don't… its stupid but I feel that way.*

T*: Mmmm… and I think its okay to feel that way. Unfortunately our time is up, can we pick up on it next week?*

JD*: Okay.*

'JD's emotions had previously caused him to cut himself in a way that helped him "*transfer*" his distress onto something more bearable. During this session, whilst 'JD' was expressing feelings such as anger, fear and desperation, he began to feel as though he was being "*suffocated".* It is during these times in therapy that I struggle to contain 'JD' fully, who in turn has difficulty accessing my support as he fears that I might not be able to help him. Instead, 'JD's attempts to distract himself from these fears and perceptions as echoed in his use of phrases such as "*Anyway*" and "*I'll be better*".

'JD's distress seems to centre around his struggle to make sense of his experiences, which I tried to normalise by adding that it was also okay for him to feel down at times. 'JD's response communicated that of disappointment and fear of isolation. I think he experienced my responses as rather glib and as minimizing his distress. Still, this error allowed us the opportunity to explore and acknowledge how misunderstood and disappointed he had been feeling about the therapy process thus far, potentially opening doors for improvement. In my awareness that 'JD' had felt more misunderstood after my somewhat cliched, if well meant, intervention I queried whether there had ever been times that he had felt truly understood. 'JD' replied that he had not; further sharing his feelings of loneliness with me and in this instance I attempted to empathize rather than reassure.

Through my own therapy and supervision, I had been gaining insight into my struggle with my patient. What followed was a gradual realisation of my striving towards perfection as being rooted in my own narcissistic needs. I feared 'JD's criticism as it would – in my mind –

reflect my lack of worth as a therapist. My anxiety and fear prevented me from exploring his feelings of disappointment in life and in therapy, leaving me feeling overwhelmed by his pain and frustrated by his disregard of my efforts to help him. With this in mind, I had come to realise that my struggle to connect with my patient was being tainted by my own narcissism and insecurities, which further distracted me from being able to use insights about his transference and my countertransference constructively. I have since had to keep these expectations in mind when in the presence of my patient and this has allowed me to enter more genuinely into his world. Thus, I took the risk of acknowledging to 'JD' my realisation that he had not felt as understood in his time with me as he had hoped or expected, noting that it was something we should explore as it would be important for him to begin to feel understood in this setting. 'JD' agreed, explaining that he often felt scared and alone, constantly wondering if anyone would ever be able to understand him. In the transference, it seemed that my failure to demonstrate empathy and understanding adequately, due to my preoccupation with my own insecurities, echoed much of his experience of how his mother and father had been out of touch with his needs and preoccupied with their own. The acknowledgment of my failure and authentic communication seemed to relieve him and to lead to a deeper level of sharing of distress.

Following that session, what appeared to be a shift began, with 'JD' starting to take ownership of his feeling state and bringing material related to his attempts to distinguish between his perceptions of situations and the reality of those situations. This seemed to be his way of helping me to understand what he was feeling as well as to reflect upon it for himself. This appeared to demonstrate his readiness to engage with what Caper (1999) terms analytic containment, as he was willing to compare his perceptions of various incidents with 'reality'. In this manner, 'JD' displayed a willingness to engage in a process of trying to name and sort out his feelings, trusting me to assist with this process. This was still difficult, as although 'JD' displayed the willingness to examine his feeling states, he often reverted to quite literal and physical descriptions of such, almost somatising his pain. For example, 'JD' revealed that he felt insecure when his girlfriend appeared to ignore him. Whilst exploring this concern, he gradually reverted to describing it as a sense of panic that he related primarily to a physical pain (stomach ulcer) which he often relieved by placing pressure on his stomach. This parallels to Bion's (1962, as cited in Ferro, 2005) descriptions of the way in which beta elements manifest themselves.

‘JD’s shift towards allowing his distress to be explored and understood was slow, often pulling me in only to reject my attempts at understanding him. During this time, I continued to wonder how helpful ‘JD’ was finding my interventions as I found it difficult to respond to and make sense of his distress due to his evasive responses. He often expressed much frustration at his inability to understand himself as well as his situations, usually leading to a commonly expressed need for “*hypnotherapy*”, a “*delete button*” and even a personality test. He wanted answers immediately, but he also wanted some way of numbing the pain. In our ninth session, ‘JD’ arrived half an hour late. Although he apologised profusely, this was the first time that ‘JD’ had ‘forgotten’ a session. During this session, he expressed wanting to take a break from therapy as he had found it “*too painful*” and thought more progress would have been made by now. He admitted that he felt it was partly due to the pressure associated with the high expectations he placed on himself that he was experiencing therapy as dissatisfying, but noted that he wanted to start again after the mid-year break. This proposal was accompanied by accounts of how he had disclosed his experience of the abuse to a female friend with a similar background, as well as how he had been going to talk to one of his lecturers when the pain felt unbearable. These descriptions appeared to have a somewhat attacking quality and seemed to express some dissatisfaction at the lack of progress that therapy appeared to be making. The reported incident represented the first time that ‘JD’ had actually disclosed his abusive experience to a peer. Despite the circumstances, ‘JD’ appeared to have in some way introjected my presence as surviving his attacks (rather than as leading to abandonment) and was allowing himself to begin to trust. Still, at the same time as reporting on this progress, ‘JD’ was acting out, punishing me for not hearing him or helping him ‘heal’ sufficiently. It is also possible that the deepening attachment was fearful as well as gratifying, leading him to fantasize about severing the relationship before he became more vulnerable.

Remembering that I had not explored ‘JD’s lack of feeling understood since my early intervention, I queried whether his needing a break was related to the fact that I continued not to understand him as well as he would have hoped. ‘JD’ agreed, rather frustrated, noting how he had mentioned this issue three weeks previously, and explaining that he had not felt understood by anyone except the friend who he had recently told about the abuse. Looking back at my decision not to broach the topic earlier, I realized that this was due to my anxiety and fear that I would not be able to handle his response. I anticipated that this might involve surviving an intensly aggressive attack, based on feelings of being unheard or misunderstood

over many years. Instead, I justified my decision by passively waiting for 'JD' to bring it up as he felt comfortable.

In my attempt to contain and explore his frustrations with me, I began by exploring 'JD's previous experiences of therapy. He noted that his previous therapist was very interactive and asked many questions; they spoke "*like friends*". He felt comfortable with this style but later added that he has not felt as though he has made much progress in any of his experiences of therapy. When queried as to how he had experienced our sessions to date, he shared that he felt happy at times, but angry at other times, which had made him feel uncomfortable. In acknowledging the unpredictable flow of his therapy experiences with me, questions such as "*did [I] think he was stupid?*" and "*did [I] think he was boring?"* followed. He was concerned that I may think less of him from all that he had shared with me, and for the first time, I became fully aware of and experienced what I imagined others in his world also experienced, 'JD's self-consciousness and projection of negative judgements onto others.

Furthermore, 'JD' shared that he found me intimidating as I did not talk much. He added that in those times, his "*system*" usually shut down as he felt "*out of control*". I responded somewhat defensively, explaining my 'psychodynamically-driven' reasons for my behaviour. Nonetheless, we came to the understanding that 'JD' sometimes needed an invitation to explore issues as he would not push himself into exploring his overwhelming past. Added to this, I realised that I needed to find more ways to be myself in the room without having to introduce self-disclosure. I had been highly anxious of my ability to manage my patient, and as such I may well have appeared somewhat rigid, distant, tense and overwhelmed. I assured 'JD' that I was committed to trying to understand him, noting that this would take time and suggested that it might be useful for him to share with me when he did not feel understood if this was possible, as this might be helpful for both of us.

5.4 Finding a Place for his Anger (Sessions 10-16)

In our tenth session before the July two week holiday break, the therapy relationship, both in terms of the transference and countertransference, shifted markedly in response to the acknowledgement of his feelings as well as my own in the previous session. 'JD' expressed wanting to disclose his childhood experience of sexual abuse to his family and spoke of a movie in which a little boy magically transcends his difficult past. This story seemed to signify his newly found sense of hope, mixed in with older feelings of despair and desperation.

On his return from his vacation leave, however, a rather different dimension of 'JD's anger emerged. He explained how he had thoroughly enjoyed his time with his family and excitedly shared that he had passed his exams. In a rather new sense of belonging and achievement, 'JD' had developed greater self confidence, which was evident in the therapy room. In the midst of this excitement, however, 'JD's feelings of anger and resentment were brought to my attention. His trip home had left him feeling excluded, missing out on family life as he recalled being the only child sent to boarding school. In the next five sessions, this first disclosure of a sense of being let down in his past was followed by sharing recollections of other situations that angered him. 'JD' expressed sentiments such as wanting to "*take those people to pieces*" if they ever hurt his [future] children and his anger at how colleagues and peers failed to acknowledge him and appreciate his efforts by taking advantage of him, challenging and disrespecting him, or by not pulling their weight. Such situations made him feel "*stupid*", undermined, challenged and betrayed and we began to link these feelings of inadequacy to his fears of rejection and abandonment. Still, 'JD' continued to express his frustration with my inability to 'heal' him. It became clear that he felt incapable of controlling his deeply repressed anger and as such often withdrew from talking about it, whilst commenting that "*anyway*" he would be alright – probably as he did with others. In these times, 'JD' often spoke about the book *The Secret*, "*Mr Amstel*" (referring to the make of beer he drank) and his need for sleep, all of which seemed to be comforting mechanisms that allowed him to forget about his pain.

At this time through supervision, I became aware of a possible personal agenda manifested in pursuing certain facts I thought necessary for the writing up of my research, and leading to asking too many questions and looking to 'JD' for answers, which he may have found not only irksome but also anxiety provoking as he was being required to symbolize rather than a container being available to assist him to do this. I came to the realization that I needed to work on making more reflections and links whilst acknowledging the transference communication in his material. Thus, I began to link his present experiences back to his past. 'JD' found these links difficult and often prevented us from exploring them by noting that he would be "*okay*". I reflected that I noticed that he often told me he would be "*alright*" and asked him what he felt it was about. 'JD' shared that it was his way of consoling himself as he feels that many people do not understand him. He added that "*it was part of life*" and shared that he often tells people that "*[he] does not care*" even though it still hurts him on the inside. In many ways, 'JD's evasive behaviour during our therapy sessions communicated his fears of being misunderstood and invalidated. I reflected how frustrating and lonely it must

been for him to hide his pain from everyone over such a long period of time, particularly because he worried that people may not understand him. 'JD' added that he wished people would reject him earlier to avoid him from reaching out to them. I noted that perhaps he was telling me that not only was it difficult for him to feel understood by me but that it also took a lot for him to open up to me, an effort which could possibly elicit rejection. This seemingly created a space for us to explore some of the reasons for his patterns of avoidance, which he linked primarily to his self-consciousness. 'JD' appeared more willing to explore this and at one stage displayed a distinct eagerness to understand his behaviour through his expressed desire to continue the discussion even after our time was up.

5.5 Uncovering Aspects of a Harrowing Past (Sessions 17-19)

In the following sessions, the acknowledgment of my own struggles gave rise to a shift that allowed 'JD' to broach the long-standing and avoided topic of his reported sexually abusive experience. With the subsequent sessions in mind, I had highlighted his many references to his anger and his need to withdraw from thinking about the abuse and associated affects. During session 17, 'JD' became visibly overwhelmed, stating that his failure to explain and understand his sexually abusive experience angers him most and often sends him into an isolating depression. He further expressed concern over his use of substances to avoid the pain, noting that it was always "*back to reality*" when he woke up the next morning. He spent much of this session agonizing over the confusion, guilt and shame he felt as the child who was sexually abused. At some point he retreated from further exploring the topic, and, while he reassured me that he would be alright, he was visibly upset and struggled to contain himself right to the end of the session.

During our next session, 'JD's attempts to hide his feelings of embarrassment and shame from the previous session were apparent as he avoided the topic completely. Instead, 'JD' began the session noting that he had been coping. He related this to a nurse's unsettling concern at his high blood pressure when he had been for a medical check-up the previous week. He '*coped*' with this communication by "*telling*" himself to relax. 'JD' evidently found this exchange highly anxiety-provoking, querying whether he would need to be on medication for the rest of his life. This seemed to insinuate a possible fear of becoming dependent on me, his therapist, if he was to let some very difficult emotions arise. This next excerpt from psychotherapy demonstrates my attempt at putting into words what 'JD' struggled to – an attempt at containment, which allowed for the development of some

understanding and growth in both the container and the contained as I broached the avoided topic of the previous week's session.

Third Excerpt from Psychotherapy

T*: Last week was quite a hectic week for you?*

JD*: It was, ja, very, it was a bad day.*

T*: Bad day for you?*

JD*: It was a bad day, it was a bad... just felt so down and out, and stupid and guilty and all sorts for things*

T*: Tell me a bit more?*

JD*: it's like I feel suffocated, I feel like I'm in the dark and I don't know what to do*

T*: it's almost like you're drowning?*

JD*: It's almost like I'm drowning, it's the feeling that I feel when I'm in a pool because you know I just hate water. I just, it's, I can't, I don't know, these things that happen to me, how do I explain them to myself… it's another story. I have to convince that it's going to be better; it's going to be fine. I try and lock them away, as much as I know they are going to come back and... I can't, I just cannot seem to do the right thing which can help me to survive. I am surviving but I need to see my life better than this, and it's so stressful, it's so, so painful.*

T*: Perhaps it feels like that silent killer is something that really gets you down on the inside but you don't show it on the outside? Perhaps it is easier to try to move on as quickly as you can, but deep down it distresses you and that can be a difficult thing to hide, even here with me. Perhaps you're also wondering if I will ever be able to understand or if I will ever be able to help you?*

JD*: That's the reason why I've decided to stop doing those things as they just push me to the edge of wanting to cry all the time, I just feel so stupid. I just, why do I have to cry!*

T*: Perhaps from last week's session, you wonder if I think you're stupid because of how the session went.*

JD*: (nods)*

T*: I'm wondering why that is? Perhaps the first thing that you think of when you feel like something happens that doesn't quite agree with you?*

JD*: that's the easiest way to explain it… it comes first…*

T*: I guess I'm wondering why it comes first*

JD*: it's a deeper feeling than just feeling stupid. I just always call it stupid. There was this Indian teacher who used to shout at us and call us stupid and we used to imitate her because at that stage, we didn't know what it meant. It was grade 12, and the only coping mechanism that we had was to laugh at her, forget about it because she was always like that.*

T*: It seems like it hurt you to hear that*

JD*: Well at first, when it first happened, she was the only teacher that was pushing us to our limits as she wanted us to pass her own subjects, and she kept giving us more work for her subjects, forgetting about the other subjects that we were doing. It made me hate economics, it made me hate agriculture. I hated economics. I was studious in agriculture because I was curious to learn about that but in economics, there was never anything interesting and the teacher was always pushing us, shouting at us, calling us stupid. She was the first teacher to call us that. It was, it was okay then….*

T*: it sounds like it's something that you've started doing to yourself?*

JD*: Yes, that's what happened actually because I just feel like stupid whenever something happens that doesn't agree with what I want. It's stupid.*

T*: You said it was a deeper feeling than just stupid?*

JD*: It's deeper than that, it's just, I don't know how to explain it. Stupid. It hurts somewhere deeper…*

T: *I wonder if a part of you feels a bit embarrassed.*

JD*: I must admit, it's one of the feelings that I carry. Um, it's, I feel down, I feel embarrassed, I feel hurt, I feel stupid, I feel… ja, but the overall that partially describes the feeling is stupid.*

T*: And what sort of situations make you feel that way?*

JD*: when I can't do something right it means that I'm stupid because in my world, it's either done or not done, but done in a way that feels perfect. If … I mustn't attempt something that I won't be able to finish. Everything that I attempt to do should be 100% right, and 100% means that I should be satisfied. If I'm not satisfied, it means that I'm stupid. And uh, that is how I feel after I wrote a (Subject) test, which seems to be the only thing that I'm failing in this university. Compare this subject to my other one, yet I love this subject more than I love the other one. And I feel stupid. And I don't understand why, and today, why am I still doing it the second time, which makes me feel confused and stupid.*

T: *It makes you feel very frustrated. What other things do you need to be done properly?*

JD*: um, you know that example I gave you about my room when I didn't clean it? It stays clean, but when I clean it I should do it well, as afterwards I feel good. So, now you will find books on the shelves and notes, they are organized but I don't want them to be there, I want them to be packed nicely somewhere else on the shelf or thrown away or put away in a certain suitcase under my bed or in the kist close to my bed. It goes back to my wardrobe again, I tried to organize it last night but it's still a mess. Its better when I don't see them on my bed, when I don't see them on the table and they are somewhere else packed away. But the fact remains, its something that I have to do in that list. So when I clean it, I make sure that I take them away and throw them in the dustbin; clean my room, polish my room, and dust everywhere, and I'll sit on my bed and sleep, satisfied. It feels very, very nice when my room is that way. At the same time, it is very, very hard to do it, it just takes the step of packing it nicely, doing it*

T*: sounds like you're very systematic about cleaning your room, about how things should be done?*

JD*: (nods)*

T: *From what I'm hearing, it sounds like the things that you are talking about are very concrete, things that you can see, that are easy to tidy up, even though they are sometimes difficult to tidy up. And I almost get the sense that for something like this, I mean the sessions that we have, it almost seems a little more difficult to organize. It seems like we work more with abstract things, things that are in your mind, things that you can't see, that you can't sort of lay out and clean up, polish and put them aside in their place and I think that must be very frustrating, not to be able to tidy them the way that you would like them to be tidied?*

Make sense out of them, as they don't quite have a set place in your mind. Perhaps this makes you feel like a failure in therapy?

JD*: (Nods) The worst part is that I can't control them; I can't feel that sense of control. In my room, I control the things in such a way that I can, it never moves, my TV stays, it never moves. You put a TV there, it never moves, I even become angry some of the times, 'Why do you stay there, why didn't you go somewhere else?' It's the sad truth. I don't know, how could I describe it, I can't. All I know is that it feels better when I keep my room as clean as ever.*

T*: It makes it harder with what you want to do with your emotions.*

JD*: And if I polished them, I even wake up the next morning to do it again, just to keep that order and my mind like open and stuff.*

T*: Sounds like the loss of control that you experience over your emotions and things that you remember can feel very overwhelming for you, so to be able to order your room, helps you feel like you gain some control over something of your own?*

JD*: It's going to be okay sometime… I don't know when but… it's going to be.*

This excerpt from psychotherapy illustrates an instance in which 'JD' and I try to make sense of his tendency to call himself "stupid". This notion included feelings of embarrassment, shame, sadness and hurt, which surfaced when he failed to meet his expectations of himself, at which stage he usually placed himself in the "*not-done*" category. This was therefore one of 'JD's means of being evasive, and could only be explored when I acknowledged how difficult last week's session appeared to have been for him. His need to "*clean, order and polish*" everything in his room perfectly, gave him a sense of relief. My link between concrete and abstract entities seemed to make sense to 'JD' who outlined his feeling of being out of control in relation to his thoughts and feelings. It seems that 'JD' finds it difficult to engage with his overwhelming thoughts and feelings especially when he expresses feeling "*stupid*", which often makes him feel somewhat threatened by the therapy space. These links allowed us to understand 'JD's embarrassment more deeply as linked to his sense of being out of control, with a sense that he is unable to overcome and understand his own difficulties. By linking the effects of 'JD's avoidance of his inner emotional world to the "silent killer", it gave him a sense that I was engaging with and tracking what he was sharing with me.

Nonetheless, 'JD' found these links somewhat overwhelming and chose to withdraw from exploring them further. It was at this stage that I wondered if his use of "*anyway*" meant more than we had previously discussed, explaining that I had noticed his tendency to push away from exploring difficult topics, talking about topics that were less emotionally charged, and which may even make us laugh. I added that I wondered if his decision to talk about funnier topics was to prevent me from thinking of him in a certain way and to perhaps ensure that he did not overwhelm me. At the onset of this interpretation, 'JD' disagreed, explaining that he merely finds it easier to listen to his friends' problems, than to talk. He added that this (listening) comes with the responsibility of needing to help his friends and fix their problems, about which he often feels helpless and incompetent. He later admitted to some fear of burdening me, noting that "*it makes [him] feel bad*" if he shared too much with me. I reflected that to him sharing things with me would mean placing a huge amount of responsibility on me to fix his situation, something which he fears I may not be able to accomplish. At that stage, I noted that perhaps it was not so much about taking on all of this responsibility but more about us sharing the responsibility as a team to explore and make sense of his feelings, thoughts and experiences. This session therefore aided in the exploration of some of the more detrimental aspects of 'JD's defences, allowing him the openness to explore feelings and thoughts which he usually avoided.

Following this discussion, 'JD' spontaneously went on to explore the very vivid memory of the day that his little brother died. During this session, 'JD' became visibly upset at his perceived inability to deal with his past, which he generally hides away. He described a friend being very similar to him in the way in which she portrays herself as strong, only ever crying when she is alone. Her reported behaviour had made him feel "*more normal*". However, 'JD' displayed a sense of hopelessness at the fact that he lacked answers and explanations. He added, for the first time, that he did not even have any photographs of himself and has not been able to look at himself in the mirror. It seemed that 'JD' tried to maintain a view of himself as uncontaminated, pre the abuse, and fears what he may see in himself at present; a perception which shall be explored in the future. What was apparent was that 'JD' was becoming willing to talk about and disclose more difficult and exposing material.

5.6 Some Closure before the Break (Sessions 20- 21)

The last two sessions focussed on offering more supportive interventions as they coincided with 'JD's exams as well as his preparation to go home for the year-end break. This slight change in approach was discussed in supervision as there was some concern that a more expressive or exploratory focus at this particular point in time might cause 'JD' to unravel during his exam period. We explored ways in which 'JD' could manage his distress when feeling overwhelmed if therapy was not available. However 'JD' used much of the time to express some discontentment at the anticipation of going home. In the last session, we summarised the year's progress noting what we had started to work through, with an awareness that there was still much to be done. We summarised by exploring his change of therapists, with 'JD' noting that his previous therapist usually suggested practical ways of managing his distress which he found "*helpful but confusing*". Therapy with me on the other hand, involved him coming to "*talk, sit and cry*". He noted that from our sessions, he had learnt that he has his bad days and his good days, adding that when he has his bad days, there is no other place he wants to be than at therapy – something for which he expressed appreciation. The session ended with discussion and my giving 'JD' a journal, with the intention of keeping the therapy alive in 'JD's mind and offering him some means of recording significant experiences during the break. The idea of the journal had been suggested in supervision and while it was a somewhat unorthodox intervention and perhaps represented a frame deviation, it was intended to provide some sense of a link to the therapist over an eight week break. 'JD' seemed moved to receive the journal and to like the idea of keeping some record of his experiences over the December and January break.

It appears that the therapy process had played some positive function for 'JD' – possibly in providing what Winnicott refers to as a sense of "going-on-being" whilst in the process of attempting to bring meaning to unbearable and unthinkable situations.

5.7 Therapy Monitoring and the Use of Supervisory Feedback

As mentioned in chapter 3, there was ongoing supervision whilst this case was in process. This was especially important in the beginning of therapy in helping me to articulate and manage the negative, countertransferential feelings I was experiencing towards 'JD'. My struggle at the beginning of therapy elicited feelings of doubt in my ability to understand the patient, specifically in comparison to his previous therapist, who was somewhat idealised. In

addition, my stringent attempts at fitting myself into the psychoanalytic stance of neutrality elicited considerable anxiety, but also served as a justification for remaining distant from my patient, adding to my difficulties in relating in the room. Initially, my patient's anger and repressed aggression overwhelmed and frightened me. If I had allowed these feelings to persist, this would still be impinging on the quality of my presence as a therapist, which would have further confirmed the patient's initial expectations of me to be another judgemental and withholding caretaker. This would have undermined the core, effective process of the therapy, namely, the patient experiencing the therapist as accepting, supportive and containing.

Attention was also brought to my overly critical nature and need to perform perfectly, as it resulted in me being somewhat defended and rigid when attending to my patient. Furthermore, it was emphasised that this part of myself could potentially fall prey to my patient's capacity to judge and criticise others. It was therefore suggested that I build up a more realistic sense of myself in the room, in order not to take on my patient's projections of failure and weakness. It was also emphasised that I needed to use less questioning and aim instead to identify and name the underlying affect in the room as well as to work more in the here-and-now transference when this seemed appropriate.

Chapter 6: A Critical Commentary on the Process of Provision and Receipt of Containment

The purpose of this research was to illustrate and explore the challenges of operationalizing and providing the function of containment in psychotherapy by a trainee therapist in relation to a distressed patient with a history of sexual abuse. In doing so, the experience of providing the 'role' of the container for the contained from the perspective of a beginner therapist is further explored, as well as the receipt (or not) of the therapist's attempt at containment by a patient who seems to have lacked a consistently containing environment whilst growing up. Excerpts 1, 2 and 3 are the main focus of the discussion engaging with whether the therapist's interactions with the patient can be understood as containment or not and whether this might alternatively rather be understood as 'holding'. This is followed by a discussion of my dynamics and difficulties in providing the function of containment, some observations concerning the patient's capacity to access and utilise this function, as well as the interactive dynamics observed with regards to the attempted provisions of containment.

6.1 A Trainee Therapist's Operationalisation of the Concept of Containment

As Bion's notion of containment was found to be rather opaque in its application to therapeutic practice, even perhaps intentionally so, I enlisted a somewhat simplified view of containment, using Caper (1999), Casement (1985) and Sorensen's (1995) notions, to inform my understanding of the construct. In this regard, the notion of containment is understood with reference to: the therapist's capacity to observe, clarify and emotionally resonate with the patient's distress using mental activities such as sorting out, differentiating, identifying and naming (Sorensen, 1995); the therapist's capacity to transform this material by being realistic and empathic (Caper, 1999), as well as the therapist's ability to survive the patient's attacks calmly by tolerating and acknowledging the patient's intolerable feelings (Casement, 1985). Within this personally integrated framework, the provision of containment can be understood as requiring a particular kind of sensitive care and empathy from the therapist, as this allows the therapist to process some of the patient's anxieties and to convey an attunement to the patient's difficulties through comprehending communications in the psychotherapy including, particularly, communication via projective identification (Caper,

1999). Therapists providing the 'role' of the container should therefore aim to provide a kind of breathing space in which the patient's difficulties, that which is being contained, are endured, attended to and thought through (Casement, 1985). In addition to this, the therapist needs a reality centred capacity in the therapy room, enabling him/her to identify and resist what the patient is trying to enact with him/her (Casement, 1985).

6.1.1. An Illustration of the Unsuccessful Provision of Containment

Excerpt 2 (see chapter 5) illustrates how as a beginner therapist, feeling overwhelmed by 'JD's distress, I failed to contain him, through the provision of what I retrospectively understood to be reassurance rather than containment.

'JD's feeling of suffocation seemed to communicate his despondency, frustration and 'stuck'ness about his struggle to make sense of his experiences. I perceived this distress as stemming from my failure to provide more adequate psychotherapeutic input and containment, and his description of his mental state was thus perceived on my part to be an indication of a failure of the therapy. Feeling anxious, responding somewhat automatically I remarked that it was "okay" for him to feel that way. In contrast to my intention, this reflection left 'JD' feeling misunderstood and despondent (evident in his response), further confirming his belief that people can neither understand nor help the distress that ties to his experience of the abuse. Thus my rather superficial, even if well intended, response had the opposite effect to what was intended and at the time I was aware of a disjuncture in our communication without fully understanding what had taken place.

Again, with supervisory input and the benefit of reflection, I realized that instead of tolerating and attempting to transform and symbolize what was being communicated both consciously and unconsciously, I had conveyed my inability to tolerate my own as well as 'JD's anxiety (Casement, 1985). In this manner, my somewhat dismissive intervention left 'JD' struggling with his emotions on his own, creating a dynamic in which I seemingly colluded with 'JD's inability and perhaps reinforced old patterns in the transference in suggesting that I was a rather out of touch, albeit caring mother, who did not want to have to engage with the intensity and depth of his difficulties (Casement, 1985). At this moment in time, I failed to respond in a containing manner in the sense that containment is understood in psychoanalytic therapy.

Steiner (2006, as cited in Ivey, 2008) notes that ruptures in the containing process occur when the therapist, who allows feelings and reactions to well up within him/herself, acts upon them. This type of 'enactment' is evident in this excerpt, unconsciously gratifying the therapist's own anxieties and negatively impacting upon the therapeutic process (Ivey, 2008). I thus imposed what I wanted 'JD' to feel by providing a response that was polluted by an uncontained countertransference reaction, instead of reflecting or interpreting what 'JD' was feeling at that particular moment in time (Casement, 1985). My need to 'make nice' and perhaps to reassure myself that I was a good and kind therapist meant that I intervened in a rather superficial or automatic way. I wanted the client to see me as helpful and perhaps also wanted to reduce the intensity of affect in the room. I therefore possibly enacted the role of an apparently concerned, but in essence rather unavailable mother. Failing to receive and tolerate both his conscious and unconscious communication, I was unable to provide 'containment'. Excerpt 2 is therefore an example of the container being unreceptive to or out of tune with what he/she is trying to contain as a result of feeling overwhelmed by the patient's material and lacking insight into this dynamic (Casement, 1990).

6.1.2. An Attempt at Containment

Excerpt 3 (see chapter 5) illustrates the provision of aspects of containment. As mentioned in chapter 5, this interchange followed on from a previous and somewhat painful session in which we acknowledged for the first time 'JD's anger in relation to the sexual abuse he had experienced. This had left 'JD' feeling quite emotional and the subsequent session consisted of a number of attempts on 'JD's part to highlight that he had been coping, despite expressing immense worry about his high blood pressure which a nurse he had consulted had referred to as a "*silent killer*". Excerpt 3 demonstrates two related attempts to put words to that which 'JD' appeared to be struggling with, which was a concern about feeling and sounding "*stupid*".

Casement (1985) argues that the provision of containment in therapy should propel patients along a path of recovery as well as towards a capacity to manage life's difficulties without avoidance or suppression. It could be argued that my relating his feeling of sounding "*stupid*" to last week's session served to promote a space in which the struggles that he typically tries to avoid and suppress could be thoughtfully explored. In some respect my willingness to bring this perception into the open and to begin to discuss it allowed 'JD' to separate projection from reality. The implication was that in reality I did not necessarily perceive him to be 'stupid' and had not become captive to his projective identification. Casement (1985)

also emphasizes that the provision of containment requires the therapist to survive the patient's attacks calmly, preventing the patient from receiving typically avoidant or retaliatory responses. In some way, 'JD's expressed attempts to distract himself from crying could be viewed as his attempts at pushing me away and keeping me at a distance in response to his sense that I had not provided adequate enough containment in the previous session when deep aspects of his vulnerability were revealed. 'JD's urge was to withhold his pain from me and convince us both that he was alright. Rather than my reacting to his reproach of me, I acknowledged it and explored that it could encompass much more than *my* failure.

Sorensen (1995) argues that the provision of a containing space involves observation, clarification and emotional resonance when caring for the concrete suffering of real individuals. Observation and clarification are evident in this extract, as I tried to clarify, differentiate and identify his feeling of sounding "*stupid*" in the context of his distress, embarrassment and frustration, for example, through the elaboration of feelings that he initially struggled to explain. Sorensen (1995) maintains the importance of these two processes (observation and clarification) when emphasizing the *active* component in containment. However, he still argues that emotional resonance is a necessary element of containment, as together, observation, clarification and emotional resonance produce a sense – however fleeting - of containing and of being contained. Emotional resonance implies an awareness and receipt of projective identifications in a classical or Bion theorized manner, and since there is no reference to an awareness and use of this in the excerpt, I cannot claim to have contained 'JD' in the fullest sense of the definition.

Nonetheless, according to Casement (1985), a more contemporary theorist, I was able to provide a breathing space for 'JD', allowing his distress to be endured, attended to and thought about by allowing his experience of shame, attending to it and linking it to his feelings of inadequacy and loss of control. Adding to this, I was further able to maintain and demonstrate a somewhat realistic stance by not colluding with 'JD's acute sense of embarrassment and shame (Caper, 1999). Caper (1999) asserts that the reality centred capacity of the therapist is vital in the provision of analytic alpha function as it contains the patient's tendency to confuse external and internal reality and aids in the processing of anxieties and symbolization of experience. 'JD's perception was challenged and expanded upon, allowing for a distinction to be made between his perceptions and external reality (Caper, 1999). Thus, in this particular exchange and according to more contemporary views, I

was able to convey and integrate my observations, my felt empathy and my sense of reality, into interventions that communicated the provision of some containment.

This allowed for further exploration of that which makes him feel "*stupid*", in the context of 'JD's need to "*clean, order and polish*" his room, which, through his expressed sense of failure in a subject which he thoroughly enjoys, was linked to his sense of failure in finding some control over his emotions and thoughts. I was able to convey this understanding by acknowledging and naming his sense of frustration, embarrassment and helplessness in his struggle to "*clean, order and polish*" his thoughts and feelings in therapy and in his interaction in general (Sorensen, 1995). This allowed 'JD' to acknowledge his need for control and provided a space in which he felt understood and accepted at a much deeper level than had previously been the case, even though he found these links somewhat overwhelming and chose to withdraw from exploring them further. This withdrawal could be understood in the context of Caper (1999) who asserts that analytic alpha function converts anti-alpha elements or unbearable states of mind into alpha elements or states of mind that are merely insecure. Thus, 'JD's perceptions (anti-alpha elements) previously blocking thought and true contact with objects were in some way received, transformed and proffered back as alpha elements, which were possibly experienced and transformed into insecure states of mind (Caper, 1999).

The interventions referred to in this section allowed for a shift in the therapeutic space, with 'JD' soon thereafter spontaneously sharing difficult emotions that linked more directly to childhood memories that were experienced as traumatic and anxiety-provoking. This intervention also allowed us to engage with the meaning of 'JD's tendency to withdraw from exploring such difficulties within the therapy setting, which was in this context, related to a fear of burdening me as his therapist with an overwhelming sense of responsibility. This intervention thus allowed us to restore the capacity for thought by converting anti-alpha elements back into their intended form with the processing of the patient's anxieties (Caper, 1999).

Caper (1999) emphasizes that the transformation of anti-alpha elements requires a reality centred capacity which infers the need for the therapist to withstand the pressures of enactment stemming from the patient's use of projective identification. Although these excerpts provided an elaboration of what took place in therapy, they did not fully illustrate the provision of containment due to the lack of explicit reference to and awareness of projective identification. There were, however, instances where aspects of containment were

provided. This was specifically in relation to operationalizing aspects of analytic alpha function in producing states of mind that appeared to be insecure rather than annihilatory, attempts at processing 'JD's anxieties through observation, clarification and empathy, as well as efforts to withstand my need to defend against possible attacks by being thoughtful about 'JD's fears.

6.2 Containment and Countertransference Dynamics

As evident in the excerpts presented and discussed in Chapter 5 and this chapter, the therapist is an equal participant in the therapy process in the manner in which he/she shapes the process according to his/her own unconscious conflicts and fantasies (Ivey, 2008). In this regard, my countertransference feelings and reactions (as mentioned in chapter 5) as a trainee therapist are further explored in relation to the operationalization of containment, with the understanding that the therapist's own emotions may obstruct his/her implementation of alpha functions or containment as a whole.

In introducing the psychotherapy with 'JD' I mentioned that I had not expected to attend to what I perceived to be "*such a serious case*". This statement reflected my expectations and judgements which I acknowledged by outlining my need to separate my perceptions from the person of the patient. I also noted that after the first session I had a perception that my patient had placed a weight of expectation on therapy, as it represented his only beacon of hope. This left me feeling anxious, inadequate and afraid of failure at the outset, a stance which my supervisor cautioned me to reflect upon as it was likely that my anxiety would interfere with my ability to be present to my patient, potentially confirming exactly that which I was afraid of, i.e. therapeutic failure.

Brightman (1984) outlines the fact that trainee therapists often confuse their worth as a therapist with their personal worth, adding that this is often accompanied by doubts and fears about mastering treatment skills. This kind of scenario has been evident in my work with 'JD', and I have felt anxious, fearful and incompetent on a number of occasions. I linked these feelings primarily to a sense of inadequacy as a therapist, which was apparent in many aspects: in my perceived inability to contain and relieve 'JD's distress on many occasions; in anticipated fears of being criticised as a therapist; in feeling "*punished*" and "*locked out of meaningful contact*" with my patient; and in my feeling overlooked and disregarded through 'JD's frequently expressed need for alternative interventions such as "*hypnotherapy*", "*a delete button"* and "*a personality test*", his evasion and minimizing comments ('*Anyway I'll*

be okay") and his expressed disappointment in all interpersonal contacts ("*if only someone understood me*"). While these examples convey the dynamics of 'JD's somewhat mistrustful and defensive style of relating, as well as interactive patterns relating specifically to our therapy (which shall be explored further in a subsequent session), the focus of this section will be on my countertransference reactions to these dynamics.

Trainee therapists' emotions (anxiety, fear and frustration) and expectations generally become entangled within the learning process of psychotherapy and manifest themselves as narcissistic injuries and doubts about being good enough (Glickhauf-Hughes & Mehlmon, 1995). This was certainly the case in my work with 'JD'. My insecurities were evident in this regard in the form of audience sensitivity, perfectionism, imposter feelings and unstable self-esteem (Glickhauf-Hughes & Mehlmon, 1995). 'JD's comments about not feeling understood and contained affected my sense of self-esteem as his therapist which resulted in a need to strive harder to attain his approval and to feel competent. My unresolved difficulties hooked onto 'JD's unconscious conflicts. This was evident in my need to reassure 'JD' that things were not as bad as he thought, in my need to ask questions that at times related more to my feelings and fears about being inadequate or making progress in the therapy, and in my resistance to exploring projective identifications which I engaged with rather as uncomfortable countertransference reactions to my heightened sensitivity to 'JD's manner of relating to me. The projective identifications that I did receive became firmly intertwined with my narcissistic anxieties, which prevented me from making sense of 'JD's own anxieties. With the help of supervision and my personal psychotherapy, I became aware of how certain unresolved issues were affecting my ability to connect with 'JD'. For example, I became aware of how my need for perfection and my tendency to be overly self and other critical had hooked onto 'JD's needs and expectations, resulting in some remoteness and distancing on my part.

Glickhauf-Hughes & Mehlmon (1995) explain that therapists who desire a concrete sense of achievement experience feelings of doubt and uncertainty to a greater degree than those who allow for more ambiguity. These insecurities often manifest themselves in a trainee therapist's countertransference through the disowning, and projection of unwanted parts of the self into the patient (Halewood & Tribe, 2003). It appeared that my idealized expectations and goals for therapy and need for affirmatory feedback from my patient (Kottler, 1991) impeded my capacity to be more fully containing. This was especially evident in the beginning stages of the therapy as I lacked a level of self-awareness, which was, however,

gradually attainable through my more open engagement in the process (Halewood & Tribe, 2003). The process of containment was particularly lacking when my lack of self-awareness created room to act out or upon my own feelings and fantasies (Steiner, 2006, cited in Ivey, 2008), rather than remaining mindful of my patient's needs and communications. This was evident, for example, in the exchange mentioned in excerpt 1B (see chapter 5) in which 'JD' expresses admiration for a teacher from a movie who displayed insight and resilience. As mentioned in chapter 5, this interchange left me feeling somewhat anxious as from my perspective this relayed that I had failed to contain 'JD'. My sensitivity to this left me feeling alarmed and my urge was to work harder to provide and possibly impose some meaning onto 'JD's sense of confusion. This is evident in my somewhat vigorous attempts to encourage 'JD' to use television characters to make sense of his confusing emotions, which, given his response, did not seem to add to his understanding.

Adding to this, the previously referred to section focussing on my failure to contain 'JD' through reassurance (excerpt 2, chapter 5) demonstrates how my anxiety resulted in attempts to convince 'JD' that his feelings were not as unmanageable as he (or I) experienced them to be. This was possibly a projective identification, which hooked onto my own narcissistic anxieties about not being able to manage or contain him adequately. It is evident that the provision of containment is largely dependent upon the therapist's state of mind, and requires the processing of both the therapist's and the patient's anxieties, even if they are shared. The extracts discussed in chapters 5 and 6 show that as a beginner therapist, my receipt of 'JD's projective identifications tended to be confused with my own narcissistic anxieties, which were at times unconsciously gratified as described by Ivey (2008). Ivey (2008) notes that such enactments impact negatively on the therapeutic process and represent failures in the provision of containment. What is important to note here is that countertransference is not necessarily negative to the therapeutic process unless it is enacted (Ivey, 2008). My failures in providing containment were often a consequence of my acting in response to my overwhelming affect and to a lack of awareness of aspects of my countertransference, some of which have been discussed already.

Therapists therefore need to display a willingness to be honest and able to acknowledge and resolve both conscious and unconscious conflicts (Casement, 1985). It is of great importance that beginner therapists show a capacity for self-reflection as it allows them to attend more genuinely to their patient's material (Halewood & Tribe, 2003). Trainee therapists will make mistakes, but their willingness to explore and understand their enactments, possible areas of

passivity and/or needs for avoidance, as well as possible feelings of being overwhelmed by the patient's material, may help them to avoid being out of tune to what they are trying to contain (Casement, 1985). Moreover, such disciplined awareness prevents the patient from being pushed into the containing 'role' (Halewood & Tribe, 2003; Waska, 1995). I hope I have demonstrated the development of some of this kind of awareness in the material presented in the report.

The narratives used from Excerpt 2 illustrate the importance of the therapist's state of mind in the provision of containment, more so perhaps for trainee therapists whose narcissistic anxieties may predominate and become intertwined with a patient's projections. Beginner therapists need to monitor their countertransference reactions closely if they are to provide containment even in circumstances where they feel overwhelmed and inadequate. Waddell (1998) and Waska (1995) view the kind of *contamination* that takes place when the therapist is unaware of his/her countertransference contributions as stripping material of meaning, potentially causing the 'roles' to be reversed in the container/contained dynamic. This appears to have happened at points in my therapy with 'JD' although his predominant responses to feeling uncontained appeared to be to withdraw, to attempt to reassure himself, to seek alternative forms of self-soothing, and, at times, to communicate his distress more intensely. Despite my errors, 'JD', gave me and the therapy process the benefit of the doubt in continuing to attend, perhaps precisely because at times I was able to acknowledge my inadequacies and in this respect allowed for 'real' exchanges in the room. This kind of communication was possible when I was more conscious of the role played by aspects of my countertransference.

6.3 The Patient's Dynamics and Receipt of Containment

As described previously, 'JD's history was characterised by abandonment experiences and loss, coupled with the absence of any parental or caregiving figure who was properly able to contain and mediate his experience of the world. This translated into an inability to contain himself and hampered his capacity to access later or future provisions of containment, although this appears to be something that he desperately seeks.

Excerpt 1B (see chapter 5) illustrates 'JD's overwhelming frustration and struggle to make sense of his emotions and experiences, which resulted in a number of concrete attempts to manage, direct and express his overwhelming affect. Bion (1993) refers to such confusion as raw emotions or beta elements that are concrete, chaotic, confusing and distressing, protested

to and evacuated because of their unbearable nature (Bion, 1993). This kind of uncontained material appears to be evident in 'JD's reference to unpacking and repacking his room, suggestive of a rather concrete attempt to both organise and possibly evacuate the chaos, confusion and distress he is feeling. His need to take a long walk can also be understood in this manner, and his desire to "shut down" or "die" further communicates the experienced intensity of his affect as well as his need to protest to and evacuate the distress. These concrete and rather futile attempts suggest primitive attempts at self-containment. The degree to which he struggles to regulate and tolerate his emotions is indicative of 'JD's desperate desire for a container to add form and shape to intolerable emotions and experiences.

Caper (1999) argues that beta elements are anti-alpha elements or concrete mental entities that destroy one's capacity to learn from experience. He asserts that such entities consist of delusions, hallucinations and bizarre objects, which distort and thwart further development of unconscious phantasy and destroy true contact with objects (Caper, 1999). This kind of pattern seems to be evident in 'JD' sharing that the most distressing part of his overwhelming affect is his inability to communicate with others constructively and sincerely. Thus, even when I was able to reflect to 'JD' that it is difficult for him to make sense of extreme and overwhelming affect, he was unable to receive this reflection and chose to withdraw from engaging with me. The material reflected was possibly highly anxiety-provoking for 'JD' to acknowledge, however Caper (1999) notes that the projector's response to the form of containment offered is dependent upon his/her motive for the projection. 'JD' often responded in a non-committal and sometimes somewhat attacking manner to my interventions and attempts to clarify and reflect the frustration that he feels. This is possibly suggestive of his disappointment, envy and rage at me, his therapist, for not providing adequate containment, perhaps echoing childhood memories of neglect.

'JD's frequent references to 'being okay' are a rather weak attempt at self-containment and are perhaps used when he feels he might overwhelm me with affect and when he senses that I am not quite 'with' him. The receipt of the provision of containment in therapy is as much dependent upon the patient's state of mind and motives for projection as it is upon the therapist's state of mind to receive and transform these projections and anti-alpha elements (beta elements) and it appeared at times that 'JD' was not necessarily receptive to containment.

What is also evident in Excerpt 1B (see chapter 5) is the type of containment 'JD' seems to desire in his expressed admiration for the teacher who displayed insight and skill that allowed her the capacity to attribute meaning to experiences that her blind student struggled to comprehend. This seems to be indicative of the type of containment he may desire from me, a therapist who should have the insight and skill to attribute meaning to his experiences by being creative in conveying experience.

Individuals being contained may also fear that their beta elements will be rejected, devoured or stripped of meaning and/or individuality by the container (Britton, 1993; Symington & Symington; 1996). This kind of fear may lie behind 'JD's apprehension and his refusal to allow his unbearable distress to surface in many instances. He seemed to fear that I (as his container) might not understand or might negate the perceived severity of his distress; or that I might be contaminated or destroyed by his distress. 'JD' fears expressing the distress that is linked to his repressed feelings of anger, shame and guilt, particularly with regards his experience of being sexually abused. Coupled with this are possible feelings of mistrust in any container due to his experience of not being adequately contained as a child.

'JD' expresses a desperate desire for containment but may feel envious of others' abilities: including my perceived capacity to make sense of experiences. He may also give up or retreat very quickly when my responses appear neglectful and withholding due to my difficulties as a beginner therapist. It is as if he anticipates being let down by his objects and finds it easier to mistrust others efforts to understand him than to render himself vulnerable and potentially disappointed. Further, as suggested previously, 'JD' fears that he may overwhelm the source of the little containment that he does receive.

> JD: *I found myself yesterday, uh, talking to my girlfriend and saying that it's better for us to separate if I'm like this. Part of me, doesn't want this to affect her. I am… sick and she mustn't suffer for that.*

This illustrates 'JD's expectation of affecting or overwhelming those around him. Perhaps in comparable ways to the teacher in the film who slowly went blind and who later lost her husband to cancer. 'JD fears contaminating and/or destroying his container. 'JD' appears to fear "*burdening*" and losing me as his therapist as he had previously 'lost' two other therapists. His need to push aside his distress "*even when it hurts on the inside*" thus may signify a fear that not only will people struggle to understand him but also that they will be contaminated by his levels of distress. 'JD' thus brings to the therapy some awkwardness in

the receipt of containment, experiencing his own affect states as so unbearable that they are likely to be intolerable for others and yet desperately seeking containment, trying to protect himself from potential disappointment by misplacing trust in a container and yet conveying some sense of invitation or need in this regard.

'JD' has resorted to a range of defences to maintain some psychic integration but this appears to have resulted in feelings of isolation from others. 'JD's patterns of defensive behaviour are typically followed by severe complaints of loneliness, isolation and neglect. 'JD' attempts to portray robustness in his interpersonal world by repressing his vulnerable self. This style of engagement has proven difficult to work with within a therapeutic setting. 'JD's transference dynamics have therefore played some role in hindering his ability to make use of what containment was made available. Nonetheless, 'JD' has displayed a capacity to access aspects of containment in response to the part of the therapist that has managed to survive his attacks (Casement, 1985). This has been apparent, even early on in the therapy process, in his expressed need to be at therapy on his "*bad days*", suggesting that the therapist is seen as an ally in attempting to manage his intense distress. There is also some sense of increasing trust in me as therapist/container with the passage of time, since the enduring relationship is unlike his previous experiences of (short term) therapy.

6.4 Interactive Dynamics in the Provision of Containment

Bion (1978) was aware of the improbability of a perfect fit between the container and the contained and developed the notion of different types of containing relationships. Excerpt 2 (see chapter 5) shall be explored in this regard with a focus on the interaction between 'JD' as the contained and me as the container. While this excerpt has already been explored in some depth, it is revisited with a focus on the type of containing relationship that develops out of the interaction between 'JD's despondency, frustration and 'stuck'ness and my own difficulties in providing containment in response to my own narcissistic anxieties.

The interchange demonstrating 'JD's reference to a feeling of suffocation illustrates how his struggle and sense of frustration, which I perceived as a failure to contain on my part, elicited a level of anxiety that I attempted to relieve by attempting to determine whether or not 'JD's anger was directed at me. This generated a sense of tension in the room that 'JD' seemingly reacted to by noting that he was "*fine*" and merely needed to "*release some energy*". Thus, my reaction to 'JD's distress created some distancing that further confirmed his beliefs that people are easily overwhelmed by his experiences and can neither understand nor help him

with the distress tied to his experience of abuse and other difficulties. Our mutual anxiety and awkwardness led to a kind of stalemate.

What is also evident in this excerpt is how my narcissistic anxieties thwarted the therapeutic work as they hampered me from exploring the full extent of 'JD's distress, one aspect of which significantly was a feeling of being overwhelmed by his emotions and experiences of a world that is generally out of touch with him. In this regard, the example previously used to illustrate a lack of containment could be understood as illustrating a parasitic type of containment that produced objects threatening to both container and contained as they confirmed both 'JD's anxieties as well as my own (Symington & Symington, 1996). On a few occasions this kind of dynamic resulted in some stringent attempts to fit myself into the psychoanalytic stance of neutrality as this manner of relating served as a justification for remaining distant from my patient, even though it added to my difficulties in relating to him.

Several excerpts demonstrate how 'JD's mistrust could at times evoke my defensiveness and anxiety, which in turn created a distancing or a kind of panic that appeared to leave 'JD' feeling misunderstood. Such a dynamic can confirm the narcissistic anxieties of the therapist who becomes a fragile and rigid container and the anxieties of the patient as the overwhelming and uncontainable entity who cannot be contained. This may be understood as a parasitic link which can be experienced as threatening to both parties. My enacted defensiveness and anxiety as a beginner therapist therefore resulted in some failures to respond in a containing manner when intertwined with 'JD's dynamics and difficulties in accessing containment.

6.5 The Role of 'Holding' in the Therapy

As there has been considerable confusion and overlap between the notion of containment and 'holding', it seems important to consider whether or not in reflecting upon this therapy process I made use of 'holding' rather than containment. Ogden (2004) argues that these two concepts address different aspects of the same human experience and involve their own distinctive forms of analytic thinking. As such, the next section will briefly engage with my use of 'holding' in my therapy with 'JD'.

Excerpt 1A (see chapter 5) illustrates how 'JD's desire to see me earlier for an appointment was understood as communicating that he found comfort and relief in my presence, even though I had not felt that I had aided much in enhancing his understanding. Winnicott (1945, as cited in Ogden, 2004) recognized this kind of way of being together as a patient's need to

"*rattle off every single detail of his/her weekend*" (p. 150) even though the analyst feels like no psychoanalytic work has been done. The initial stages of therapy with 'JD' thus appeared to assume more of a 'holding' character that allowed for 'JD' to be 'known in all of his/her bits and pieces' (Winnicott, 1945 as cited in Ogden, 2004) and therefore to feel integrated by my understanding of him.

My 'holding' presence as his therapist played an important role throughout our therapy sessions, which, coupled with 'JD's awareness of the longer potential duration of our therapy, allowed 'JD' to begin to trust the supportive function of the therapy space. This was perhaps evident when 'JD' took the risk outside of therapy of sharing his experience of the abuse with a peer for the first time. From his experience of our therapy, it seems that he was able to introject a somewhat reliable and consistent 'holding' figure such that he was able to start to trust other figures in his life. Such provision of a *holding* environment seemingly affords the individual being held an illusion of safety and protection from both internal and external dangers (Modell, 1993). The role of 'holding' was clear when 'JD' explained in our last session that therapy involved him coming to "*talk, sit and cry*", which was a space that he longed to be in on his "*bad days*". The 'holding' environment thus assisted 'JD' to begin exploring more difficult experiences as our time together progressed.

Thus, even though I found it very difficult to contain 'JD's confusion fully, I was able to provide a strong sense of 'holding' support both verbally and non-verbally (Winnicott, 1963). In the therapy setting, the provision of 'holding' possibly precedes the provision of containment and allows the setting up of a foundation in preparation for the provision of containment (Moss, 2008).

It appears that as a beginner therapist the provision of containment requires a level of sophistication in both skill and self-awareness, particularly in relation to the receipt and interpretation of a patient's projective identifications. The provision of a 'holding' environment may be simpler in this regard and more readily evident purely in the provision of therapist care and empathy. Winnicott (1963) described this as the analyst "conveying in words at the appropriate moment something that shows that the analyst knows and understands the deepest anxiety that is being experienced, or that is waiting to be experienced" (p. 240). The provision of a 'holding' environment is therefore important when caring for a patient's distress, but is different from containment which requires beta elements or anti-alpha elements to be transformed into alpha elements. In my efforts to contain 'JD', I intended to provide a breathing space in which his unbearable feelings could be tolerated,

acknowledged and explored through sensitive care and empathy. As containment as it was first elaborated by Bion requires an acknowledgement of and working with projective identifications, there is a failure to evidence deeper aspects of containment in the work with this case even though there were instances where more contemporary aspects of containment appear to have been illustrated.

Chapter 7: Conclusion

This clinical case study aimed to explore the challenges of operationalizing and providing the function of containment in psychotherapy as a trainee therapist working with a distressed patient with a history of sexual abuse. The study has drawn attention to the necessity of the therapist's self-awareness, his/her capacity for self-reflection and his/her acknowledgement of countertransference reactions, all of which play a vital role in the (trainee) therapist's capacity to provide containment according to Casement (1985), Sorensen (1995) and Caper (1999). My initial struggle to contain my own anxiety and distress clearly hampered the provision of containment at the outset of the therapy. In this regard, supervisory and therapeutic input was essential in allowing me to develop an understanding of and develop the capacity to be able to begin to provide a platform for the operation of containment. What also proved to be challenging in the provision of containment was 'JD's lack of experience of containment whilst growing up. Given this history, 'JD' struggled to trust and openly share his distressing experiences as he feared the implications of this despite his desperate need for containment. 'JD' both feared the receipt of rejecting or invalidating responses as well as his potential destruction and contamination of his container. As his therapist, I needed to strike a balance between validating his emotions and experiences on the one hand, and surviving his attacks without reinforcing his perceptions of his potential destructiveness, on the other. Transference and countertransference dynamics consequently played a central role in shaping the manner in which containment was absent, attempted, offered, provided and received. The study has illustrated that the provision of containment by a trainee therapist is difficult given the common struggle to overcome narcissistic anxieties. What is evident in assessing the difficulties involved in attempting to provide containment is that interventions in line with more contemporary aspects of containment may well be more possible in a first therapeutic experience, whereas a more classic or Bion informed view of containment (which places emphasis on the receipt and transformation of projective identifications) may prove more difficult for a beginner therapist to comprehend fully and engage with. Supervisory input plays a large role in the beginner therapist's capacity to provide aspects of containment as well as the therapist's capacity and willingness to be self-aware and to learn to contain his/her own distress and anxieties. However, it seems that such provision requires skill that develops with time and experience and suggests that a beginner therapist is more readily able to provide a 'holding' environment in preparation for the provision of containment. Adding to

this, a realistic appraisal of the limitations of what can be offered and received in any particular therapeutic interaction is necessary.

7.1 Limitations of the Study

There are some limitations to this study that are important to review. The fact that the research data was based on the therapist's/researcher's own understanding and perceptions of the therapy process is a potential limitation, given the manner in which unconscious processes can affect such understanding as well as vested interest in reading material in particular ways. The therapist's sessions were audio-taped and transcribed, and the research and therapy process were closely monitored through a number of supervisory and therapeutic inputs as provided over the course of the learning year. There was also considerable supervisory input in writing up the case material as well as some feedback from two fellow trainees who were in the same supervision group. These inputs provided some confirmation of my observations as well as offering a critical lens to counterpose some of my 'blind spots'. I have attempted to take a sufficiently self-critical and open stance to writing up the data to allow for some clarity regarding my subjective contributions to the research 'findings'.

Another limitation may relate to the nature of the data collection, the choice of material being predominantly decided upon by myself as the therapist/researcher, which may have led to the exclusion of negative and contradictory evidence (Messer, 2007). The amount of therapy material covered in this case study was, however, reasonably comprehensive and in this respect, hopefully protected the research from presenting too narrow a selection of data that merely corresponded with the therapist's hypotheses. Care was also taken, through supervisory input, to prevent a sense of 'narrative smoothing' as the inclusion of clinical case material was monitored to ensure as far as possible an accurate reflection of both positive and negative content.

A further criticism that might be levelled at this piece of research is some tendency to interpret the case material through a reigning theoretical orthodoxy (Messer, 2007). The aim of this clinical case study was not to illustrate the veracity of Wilfred Bion's notion of containment, but to explore the case in a way that potentially allowed for other possible theoretical understandings to inform the discussion as the notion of containment proved to be difficult to define or concretize and apply therapeutically.

The lack of generalisability of the single case study method could also be regarded as a limitation, however, generalisability is not an aim of qualitative research and this study aimed to offer insights and understanding into the challenges that a trainee therapist may be confronted with in operationalizing and providing containment to a patient, more particularly the kind of patient who appears to have lacked this type of containment in his or her early environment, rather than aiming to provide broad conclusions.

Overall it could thus be argued that the subjective nature of this case study, focussing solely on my experiences as well as on the patient's difficulties as perceived by me, the therapist, is a limitation of the research. It is these accounts, however, that provide the real-life descriptive material used in the analysis. Although the researcher was the therapist working with the patient explored in this case study, this relational connection allowed the researcher greater access to understanding of the therapeutic process further elaborated by both personal therapeutic and supervisory input. It was kept in mind, throughout the write up, that as the therapist I should maintain a reflexive awareness, as this played an important role in the research process. This sort of reflexivity is expected in any case from work conducted by a trainee therapist and the process of engaging with this research therefore allowed for increased growth and insight as both therapist and researcher within the field of psychotherapy. It is hoped that the record of the case reflects this attempt at conveying the unfolding learning process with sufficient coherence and veracity.

7.2 Implications for Practice and Future Research

There are important and ongoing debates about the difficulty of learning how to conduct clinical practice as trainee therapists due to the layers of complexity that are involved in this type of learning (Brightman, 1984; Bruch, 1974; Cushway, 1992; Eckstein & Wallerstein, 1958; Ford, 1963; Goretti, 2006; Halewood & Tribe, 2003; Hawkins & Shohet, 1989; Hermann, 2001; Kottler, 1991; Kottler & Swartz, 2004; Kovitz, 1998; Mollon, 1989). Through the use of material related to a first therapy experience, this research has offered a viewpoint on this process. This clinical case study has drawn attention to the specific nature of challenges faced by a trainee therapist, firstly, in her attempts to grasp the concept of containment, and, secondly, in her attempts not only to contain and transform her patient's anxieties, but also to contain her own anxieties, both conscious and unconscious, in order to allow for meaningful work. The provision of containment to patients by trainee therapists thus underlines the importance of both supervisory and therapeutic input, particularly when

the role of the container is required for a patient who has lacked an adequate sense of containment in his/her early life. Such cases are likely to be common in psychotherapy. Not only is the provision of containment important for patients in therapeutic work, but the containment of trainee therapists is equally important. This clinical case study may hopefully serve as a source of reassurance for other trainee therapists and may provide further insight into instances where a patient's transference dynamics hook onto a therapist's countertransference dynamics within the therapy space.

This study touches on a number of other important research areas, including the role of supervision and the importance of utilizing the insights from personal psychotherapy during a trainee therapist's training year, the importance of self-awareness and the emphasis on enactments as failures of containment, as well as the many ways in which the notion of containment can be elaborated upon and utilised. This study has begun to explore the 'mystical' nature of the notion of containment and the compulsion to employ a rather reductionist definition of containment for the employment of the construct in therapeutic work. Further research on clarifying and debating this notion seems important, particularly as the concept is widely spoken of and reported within the field of psychodynamic psychotherapy. Overall, the study illustrates that the provision of more contemporary aspects of containment by a trainee therapist is possible with appropriate self-insight and supervisory input, while the provision of a more classic Bion theorized view of containment with an emphasis on projective identification is difficult, given the trainee therapist's inexperience and self-consciousness stemming largely from narcissistic anxieties and *uncontained* countertransference reactions.

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Appendix A: Research Consent Form

CONSENT FORM TO RECEIVING SERVICES FROM STUDENTS:

I, _____, hereby consent to receiving services rendered by final year students at the Emthonjeni Centre in the School of Human and Community Development, University of Witwatersrand.

- I understand that the services are rendered under the supervision of qualified and registered members of staff.
- I understand that the services are available by appointment during university terms times.
- I consent that my information may be used for research purposes and that my confidentiality will be protected in all such research, including any research publications that may result.

Therapy days and Times: _____

Signature: _____

Relationship to the patient: _____

Date: _____

Please tick here if you would *not* like your information to be used for research purposes: ☐

Appendix B: Recording Consent Form

PSYCHOTHERAPY SESSION RECORDING CONSENT FORM

The Wits University of Psychology trains clinical psychologists as well as providing a professional service to members of the community at greatly reduced cost. Psychological assistance will thus be provided to you by one of our training psychologists. In order to monitor the psychotherapeutic work of all training psychologists we require that either a video or audio tape recording be made of all sessions. This is a training requirement of the clinical Psychology Masters Program and a condition for you being accepted as a psychotherapy patient here.

The purpose of the tape is to evaluate the training psychologist's work. It will thus only be played in the presence of a senior supervising psychologist and other training clinical psychologists. The confidentiality of the material respected and falls under the code of ethics of the Professional Board for Clinical Psychology. The tape is shown to no other persons. At the end of the year the taped sessions are erased.

Statement of consent:

I consent to my sessions being audio and/or video taped.

Name: _____

Signed: _____

Date: _____