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Psychotherapists' perceptions of countertransference in working with psychotic patients.

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Supervised by Patrick Connolly

A research report submitted to the Faculty of Humanities,
University of the Witwatersrand, Johannesburg,
In partial fulfillment of the requirements for the degree of
Master of Arts in Clinical Psychology.

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Declaration

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

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Abstract

In literature as well as published case material, psychotherapists are often reported to experience a range of strong countertransferential reactions in working with psychotic patients. In this study, psychotherapists' experiences of countertransference in their work with psychotic patients were examined, and how these responses are perceived to impact on therapy was also investigated. Non-probability, convenience sampling was used. The sample consisted of seven participants, one male and six female psychotherapists working in the Johannesburg vicinity. Semi-structured interviews were used, and the data was analysed using thematic content analysis. The results of this analysis have shown that the participants in their work with psychotic patients experienced various, multi-levelled countertransference responses. Firstly, the results indicate that participants report experiencing feelings such as fear; horror; anxiety; frustration; anger; sadness and disintegration. Secondly, the participants described the quality or characteristics of the feelings themselves (termed 'meta-affective' themes), these relating to either the reported intensity of feelings, or views on who is 'causing' the feelings in therapy. The final level to these countertransferential experiences described aspects of the relationship between patient and therapist and how the countertransferential feelings are involved in this, these included themes of power, responsibility, avoidance and boundaries. Discussion drew on psychoanalytic theory in understanding the intersection of these countertransferential feelings with the particular presentation evidenced in psychosis. To the author's knowledge, there is no research previously conducted in South Africa addressing this aspect of therapeutic contact with psychotic patients, as such some recommendations suggested for future research were made. These include: further exploration of therapeutic contact with psychotic patients in South Africa – including the exploration of other professionals' countertransference experiences such as those experienced by psychiatric nursing staff, furthermore it is recommended that research be done in regards to exploring countertransferential reactions in brief-term work with this patient population.

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Chapter 1: Introduction

Working with patients who are psychotic poses a number of challenges, many of which dissuade therapists from engaging in this type of work. One of the challenges that psychosis typically presents, is that it elicits intense feelings in the therapist. The feelings which develop in the therapist in response to the patient, and what he or she brings to the therapeutic encounter, are known as countertransference. It is proposed in various sources that because of the intense nature of working with psychosis, a particularly intense kind of countertransference occurs (Horowitz, 2002; Baranger & Baranger, 2008). This research study explored the specific kinds of countertransferential reactions which are experienced by therapists working with psychosis. Psychoanalytic (or psychodynamic) theorists and clinicians present countertransference as a concept and feeling state which is important to investigate, with much having been written about the phenomenon (for example Grinberg, 1962; Heimann, 1950; Langs, 1978; Little, 1951, Kernberg, 1965; Racker, 1972; Reich, 1951; Tower, 1956). It is with this emphasis in mind that this study is grounded in psychoanalytic thinking and writing.

It would seem that in working with psychotic patients, therapists encounter intense, sometimes bewildering, feelings within themselves (Gibbs, 2007; Spillius, 1992). Such feelings evident in the literature are described as discomfort, sadness, gloom, despair, hopelessness, anger, frustration and anguish (Horowitz, 2002; Liegner, 2003). These countertransference reactions are thought to be of a particular flavour when working with psychotic patients (Baranger & Baranger, 2008). The implication of this is that there may be a qualitative difference in experiencing psychotic patients which differentiates these experiences from working with other patient populations. It was the purpose of this study to explore the types of reactions and feelings that have come about within therapists who have had experience working with psychotic patients and how these feelings had or potentially could affect the therapeutic process. Furthermore, this study explored if there are commonalities across participants in terms of the types of feelings which are often elicited which are linked specifically to working with psychosis.

Furthermore, it would seem that working with psychosis requires an adjustment of the typical therapeutic model (Sadock & Sadock, 2003), especially regarding psychoanalytically oriented therapy. It is reasoned that the ambiguity inherent in the therapeutic situation is

intolerable to the psychotic individual and thus becomes unproductive therapeutically (Baranger & Baranger, 2008; McWilliams, 1994). As such, the therapy attempts to be more supportive, at times more directive, and less ambiguous (Gibbs, 2007; Kates & Rockland, 1994; McWilliams, 1994). This seeks to assist the patient in general by adjusting the therapeutic encounter so that it may be used productively by the patient (as opposed to being experienced as highly persecuting for example), and more specifically, encourages reality testing by supporting the ego (these aspects shall be further elaborated in the literature review). As such, it would seem that patients who are psychotic do not experience the typical therapeutic situation as other patients would. The psychotic patient cannot deal with the abstraction and 'as if-ness' (Baranger & Baranger, 2008) of the therapeutic situation, rather it is experienced through a mental reality that is often frightening and persecuting. As such, psychotic patients bring with them the very realness and intensity of their internal worlds into the therapeutic space. Furthermore, because of the slow pace of work in which change is often imperceptibly small, the therapist may encounter great frustration (Horowitz, 2002). This intensity and frustration inherent in this remodelled type of work, it is proposed, affects the therapeutic situation and also the therapist's own way of being in the therapeutic situation.

The implications of such countertransferential reactions are important to consider. These experiences could influence the therapeutic encounter in a number of ways. It is proposed that these intense feelings are potentially damaging if left unchecked as they may lead to countertransference enactments (Reich, 1951), but it is also proposed that these feelings may be utilised in the therapeutic encounter (Little, 1951; Tower, 1956). As Searles describes, work with a psychotic patient leaves neither party untouched, he writes:

> [t]he mutual individuation which follows, again by dint of many ambivalent weaning struggles by both patient and therapist, leaves each deeply changed. The patient will never again, presumably, be so vulnerable to psychosis. But neither will the therapist ever again need to repress so fully his own more primitive processes, processes which include the kind of nonintegration and nondifferentiation of experience that have compromised the defenses of the formerly psychotic patient (Searles, 1967a).

Therefore, it is crucial to foster an investment in exploring these reactions as they can both harm and offer something to the therapeutic relationship. As such, this research further aimed to explore therapists' perceptions of the usefulness of countertransferential reactions in their therapeutic encounters.

Novice psychologists who may experience such countertransferential reactions but not understand nor recognise them, may benefit from the findings of this research: “Armed with knowledge from books and journal articles about induced countertransference, psychotherapists can prepare themselves for the sometimes confusing and distressing reactions that may develop while working with certain client populations” (Schwartz, Smith & Chopko, 2007, p. 389). It may be helpful to the training novice psychologist in his or her developing clinical practice to read of other therapists’ reactions and understandings of their own countertransference in order to inform and recognise the process within themselves as “[c]ountertransference becomes window or wall, either widening the therapist’s own experience of self and in turn deepening the connection to the client’s reality or erecting a barrier that prevents access to the internal experience of both client and clinician” (Horowitz, 2002, p. 240).

While there is dearth of writing on countertransference and psychosis as separate topics, there is certainly room for, and a need for, further study regarding the intersection of the two - an exploration of how the therapist’s experience of therapy intersects with the symptomology of psychosis. While there are expositions of countertransferential reactions which occur with psychotic patients (often written up as case studies in journals or in technical books authored by well-renowned analysts like Harold Searles and Herbert Rosenfeld), this body of knowledge is still considered to be relatively small (Horowitz, 2002) and cannot be considered complete or definitive. As such, there is room to explore further in order to deepen and enrich the existing information. Furthermore there has been little research of the intersection of these two aspects within South African research. It is hoped that this research will be considered as an addition to a body of knowledge concerning countertransference in working with psychosis.

Chapter 2: Literature Review

In order to understand psychotherapists' responses to the psychopathology of psychosis, this literature review shall begin by orienting the reader to the nature of psychosis. As such, this paper begins with an overview of the categorisation of psychosis as it is viewed in psychiatric diagnostic nosology. The literature review then moves to a psychoanalytic presentation of the development and maintenance of psychosis and a brief orientation to the therapeutic treatment of the psychotic patient. Following on from this the literature review then diverges to an overview of the concept of countertransference and lastly brings together how countertransference and psychosis coalesce in the therapeutic encounter.

Psychosis as a Diagnosis

Contemporary psychology literature holds that psychotic disorders are marked by impairment in reality testing - this pertains to incorrect inferences made about reality, "improper evaluations of the accuracy of…thoughts and perceptions, and continues to make these errors in the face of contrary evidence. Classic symptoms include delusions, hallucinations, severe regressive behaviours, dramatically inappropriate mood and markedly incoherent speech" (Reber, 1985, p. 598). Characteristic symptoms of psychosis are hallucinations, delusions, disorganised speech (for example, derailment or incoherence), and grossly disorganised or catatonic behaviour (APA, 2000). Schizophrenia may present with the aforementioned features and also with negative symptoms such as affective flattening or alogia (APA, 2000). Disturbances in perception such as hallucinations are known as positive symptoms (Sadock & Sadock, 2003). Hallucinatory experiences may be experienced in any of the five sense modalities, although auditory hallucinations are the most common. The psychotic individual may experience voices which are often threatening, obscene, accusing, or insulting. Visual hallucinations are also common, while olfactory, tactile, and gustatory hallucinations are rare. Illusions, on the other hand, are distortions of *real* images or sensations (Sadock & Sadock, 2003). Delusions present as disorder in thought content. Thought content reflects the patient's ideas, beliefs and interpretations of experiences. Delusional content often involves persecutory, grandiose, religious or somatic ideas (Sadock & Sadock, 2003).

The DSM-IV-TR (DSM) specifies the following disorders under the umbrella category of psychotic disorders: schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, psychotic disorder

due to a general medical condition, substance-induced psychotic disorder, and psychotic disorder not otherwise specified (APA, 2000). Other forms of psychopathology may present with psychosis as an atypical or additional feature of the disorder, for example in the mood disorders such as bipolar mood disorder or major depressive disorder (Ohayon & Schatzberg, 2002). As the *Psychodynamic Diagnostic Manual* (PDM) points out, while these disorders may share symptoms, the symptom constellations differ and separate each one from the next (PDM Task Force, 2006).

The psychoanalytic paradigm offers more than a diagnostic description of psychosis, it also seeks to understand and explore the particular presentations and experiences of psychosis. It is to these theoretical formulations which we now turn.

Psychoanalytic Descriptions of Psychosis

Some psychoanalytic views consider the difficulties of those with psychosis to be a result of fighting off existential terror, and being left with little psychical energy left for use in reality testing (Gibbs, 2007; McWilliams, 1994). Another preposition is that the terror of death (or the death instinct) leads to a psychic retreat into psychosis (Gibbs, 2007). The ego psychology models stress a lack of internal differentiation between the id, ego, and superego (McWilliams, 1994). Those influenced by the interpersonal, object relations, and self psychology branches of psychology would posit a confusion between internal and external experiences and a deficit in basic trust which makes it impossible for the individual to enter into an engagement with the 'normal', assumptive world that the non-psychotic person exists in (McWilliams, 1994). McWilliams succinctly identifies the core aspect of an individual suffering through (overt or potential) psychosis: "one can always find both mortal fear and dire confusion" (McWilliams, 1994, p. 59). This review will centre discussion around those conceptualizations of psychosis as offered by Freud, Klein and Bion.

Freud was sceptical about the possibility of effectively treating psychosis but nevertheless his formulation of the condition paved the way for later theorists to posit ways in which it could be engaged with and treated. He wrote: "[s]uch patients, whom I shall call paraphrenics, display two fundamental characteristics: they suffer from megalomania and they have withdrawn their interest form the external world (people and things). In consequence of this latter change in them, they are inaccessible to the influence of psycho-analysis and cannot be cured by our endeavours" (Freud, 1914/1925, p. 31).

Perhaps one of the most commonly cited, and sometimes the most obvious feature of psychosis, is the individual's difficulty in perceiving and managing interaction with reality. Freud (1916/1925) describes reality testing as "one of the great institutions of the ego" (p. 149) and in psychosis this capacity is severely impoverished. Freud understood the fundamental difference between neurosis and psychosis as regarding the way in which the ego relates to reality. Freud believed that with psychosis, instead of the ego repressing the id (as it is with healthier functioning), the ego withdraws from reality into a psychic retreat. In psychosis libidinal cathexis is withdrawn and directed back to the self, and so object-representations of the external world are not cathected (Freud, 1917/1962). This lack of cathexis, of the therapist and the therapy encounter itself, is what makes relating to psychotic individuals in therapy difficult.

As a result of an upbringing in which the psychotic individual has to deal with a barrage of threatening emotions, schizophrenia or psychosis develops as a defense - in other words, the individual 'escapes' into a psychotic fantasy world where external mixes with internal and ego fragmentation in a paradoxical way protects the individual from having to engage with a seemingly overwhelming reality (Searles, 1967). Reality is turned away from as it is unbearable, and so the psychotic is able to deny reality existing (Freud, 1911/1925) by a flight into psychosis (1894/1924). In this 'escape' "…the ego breaks off its relation to reality…With this turning away from reality the testing of reality is done away with, the (unrepressed, completely conscious) wish-phantasies can penetrate into consciousness and thence be regarded as a more desirable reality" (Freud, 1916/1925, p. 149) and herein the individual attempts to create a new substitute for reality (Freud, 1924/1979). This substitution can be understood in terms of the production of hallucinations which can be understood as an attempt to restore libidinal cathexis to the ideas of objects (Freud, 1916/1925). This means that the psychotic 'injects' psychic energy into his or her ideas (phantasies) and so they are given more life, but this life is internal within the person's mind. Furthermore, hallucinations are seen to be an attempt to achieve gratification through hallucinatory wish-fulfilment (Freud, 1916/1925).

It is the ego which is the mediator between the superego, the id and reality; and so in psychosis, the weak ego (for which Klein provides a helpful explanation as shall be discussed below) is unable to cope with these demands, relinquishes its attempts at doing so and the id

and superego take centre stage in psychic functioning. Freud (1923/1979) explains that in psychosis the ego is in conflict with reality; "the essential difference between neurosis and psychosis consists in this: that in neurosis the ego suppresses part of the id out of allegiance to reality, whereas in psychosis it lets itself be carried away by the id and detached from a part of reality" (Freud, 1927/1950, p.202). For the psychotic individual this means a state of existence which is predominated with instinctual drives and wishes pushing for expression and gratification becoming mixed in with the pressures from a critical and harsh superego – this combination, with little help from the ego, is a recipe for psychical turmoil. The ego makes some feeble attempts at protecting its fragile self and the individual by use of a particular array of defenses, such as Klein's notion of splitting off and projecting bad feelings into the external environment (1946/1986).

Klein posits that the infant is born with a rudimentary ego, and so implicitly, also with anxieties (Klein, 1935/1986, 1946/1986). The infant initially has a sense of persecutory anxiety – a fear that one may be annihilated or destroyed, this is the essence of psychotic anxieties and paranoia (Klein, 1946/1986). In this early state the rudimentary ego makes use of splitting and projection to reduce this anxiety (Klein, 1946/1986, 1952/1975). These defense mechanisms, over time, develop into more sophisticated defenses as found in depressive position functioning (Klein, 1935/1986, 1940/1986). The situation goes awry when the child, for either internal or external reasons (or both), feels completely overwhelmed by persecutory anxiety and makes excessive use of splitting and projective identification. Pathology sets in when these defenses are used in over-abundance in an attempt to avoid persecutory anxiety and so the individual becomes in a way pathologically fixed in the paranoid-schizoid position (O'Shaughnessy, 1981).

In 'normal' development, the ego becomes stronger with a build up of introjections of good experiences (Klein, 1946/1986). These good experiences come to be with time, integrated with the bad experiences and so, in healthy development, the splits in the ego (which were necessary in early existence) come to grow closer together and so eventually are able to integrate (Klein, 1946/1986). In the psychotic individual these splits in the ego persist, and so splitting continues to be a predominant manner of existence for the psychotic individual. In order to protect the self, the ego splits off 'bad' parts/experiences/instinctual wishes and projects them outwards (Klein, 1946/1986). It is not always bad parts that are projected outwards, but good parts may also be projected outwards for 'safekeeping'. Whichever it may

be for the individual (and it may often be both of these facets occurring for an individual), what results is a sense of the self being split, cut off and extreme in its position (either being all-good or all-bad) as a part of the ego is also then lost to the self (Klein, 1946/1986). For the psychotic, the ego comes to be made up of incomplete part-objects (which are introjections of 'parts' of early experiences and relationships, particularly with the mother) which rarely find integration with one another. This means that the apparatus for negotiating and existing in the world, the ego, is constituted of 'broken' parts, and so exists in a dysfunctional manner – as Klein (1946/1986) writes: "the effect of this phantasy [splitting of the object] is a very real one, because it leads to feelings and relations (and later on, thought processes) being in fact cut off from one another" (p. 181). This means that the psychotic individual is unable to assimilate objects into a coherent whole, and so objects, remain in a disjointed state – as either good or bad. The psychotic individual's mental life is marked by this split between the idealized, perfect good and the persecuting, annihilating bad. This is perhaps best evidenced with those patients who experience paranoid delusions (Steiner, 1992). The paranoid delusions are held to have come about by the individual projecting their badness outside of him- or herself, this protects the self (and the internalised good object) in a manner but at the same time leaves the individual's threatening content externally and thus the individual feels he or she may be attacked. This split is also evident in the psychotic individual's ego, this is apparent, for example, in those patients who have grandiose delusions (where only good is left within the individual).

Bion elaborated on both Freud and Klein's work and he saw the psychotic mind involved in "a minute splitting of all that part of the personality that is concerned with awareness of internal or external reality, and the expulsion of these fragments so that they enter into or engulf their objects" (Bion 1957, p. 43). Bion saw this pathological fragmentation and expulsion as being an expulsion of the "*means* by which the ego knows reality" (O'Shaughnessy 1992, p. 90) – i.e. the senses, consciousness, and thinking. In other words, Bion not only saw a projection occurring but also a part of the ego being lost or expelled by the projection which then leaves the psychotic individual's ego and ability to function fragmented.

Further, Bion offered something new in his conception of thinking in regards to the psychotic individual (O' Shaughnessy, 1981). He proposed that when the individual makes excessive use of the defenses of splitting and projection, something happens to the developing capacity

to think. The excessive use of these defenses in fact results in an impoverishment in the ability to make meaning and sense of the world and experience (Bion, 1993). Searles describes the panic that is often present within psychotic individuals as being "at a loss for reliable organising principles to render meaningful and manageable the chaotic perceptions which assail him" (Searles, 1967a, p. 6).

Searles sees the development of psychosis as being reflective of a number of aspects: the first being that the person has retreated from a reality or environment which is plagued by confusion and threatening emotions (1967a); secondly, the individual has had difficulty in separating out from the parental figures. In this regard, either pressure from the parent or the patient's own desire to remain unified, has led to a manner of existence in which the psychotic individual has introjected incomplete parents within him- of herself and so the patient holds onto this symbiotic relationship and manner of relating, in an attempt to restore the person to fullness (as the object can only be full when complemented by the other) (Searles, 1967a). Furthermore Searles argues that often despite the best efforts by therapists, the system the patient exists in is entrenched in the maintenance of the patient's psychosis (Searles, 1976) and so progress with a patient is often thwarted by his or her family (for example by withdrawing the patient from treatment). It is to a discussion of the treatment of psychotic patients which we now turn to.

Treatment of Psychosis

Treatment for the psychotic patient is often dependent on how psychosis has presented for the individual (patients may have deficits in different areas of functioning and different symptomology). It is acknowledged that schizophrenia and other psychotic disorders have biological and psychosocial components (Sadock & Sadock, 2003). Often, treatment modalities such as biological therapies and psychotherapy are combined – in an attempt to address the many facets of psychotic disorders. Pharmacotherapy seeks to treat the symptoms of schizophrenia, but does not alleviate all the difficulties suffered by psychotic patients. As Horowitz (2002) describes: "improvements that often stem from medication may leave people looking far more functional than they feel…sometimes more stability means a greater awareness of all that is missing" (p. 239). Often psychosocial therapies are introduced which aim to increase the patient's social functioning, self-sufficiency, practical skills, and interpersonal communication (Sadock & Sadock, 2003). Some examples of psychosocial

treatments are social skills training, family-oriented therapies, case management, Assertive Community Treatment, group therapy, cognitive behavioural therapy and individual psychotherapy (Sadock & Sadock, 2003).

Therapeutic activities are jeopardised by intense feelings that are generated in the course of therapeutic interaction with psychotic patients. In order to explore this particular aspect of working with psychosis, it is necessary to provide a description of the manner in which psychotherapy is approached in working with this particular patient population, and so it is to individual psychotherapy which we now turn. For the purposes of this study, supportive and psychoanalytic (psychodynamic) treatment activities will be discussed below.

Individual psychotherapy

Analysts and therapists have long recognised the need to adapt and modify the usual practice of psychotherapy when working with psychotic patients (Gibbs, 2007). Supportive therapy is often 'prescribed' in working with psychotic patients. Supportive therapy aims to nourish the therapeutic alliance; some of the qualities of such an interaction are delineated by Kates and Rockland (1994). These recommendations are listed below:

- Defining early in the treatment, the responsibilities of each party and stressing the collaborative nature of the encounter.
- Striving to increase and affirm the patient's feelings of trust and safety in the relationship, being reasonable and being open to negotiate with the patient while not being complicit in self-destructive behaviours.
- Facilitating open communication, proving a space and respect to listen and make meaning with the patient regarding his or her views.
- Intervening with negative transferences and primitive defenses that have the potential to destroy treatment.

In her book *Psychoanalytic Diagnosis: Understanding Personality Structure in the Clinical Process*, McWilliams (1994) offers a comprehensive account of the presentation and treatment of psychotic patients. In it she describes the psychoanalytic conception of the psychotic character. Much of this text has been used in this section as it provides a helpful manner in which to understand and treat psychotic patients. She posits that "[t]herapy with a psychotic person should aim at strengthening defenses, covering over primitive preoccupations, influencing realistically stressful circumstances so that that they are less

upsetting, encouraging reality testing, and pushing the bubbling id back into unconsciousness" (McWilliams, 1994, p. 44). Essentially, prior literature says one should support the defenses of a psychotic patient (McWilliams, 1994). An approach filled with ambiguity (such as traditional analytic approaches) is contraindicated for working with psychotic patients as the ambiguity has the potential to further increase the already present and extreme annihilation anxiety. For Bion, the horrifying projections of the psychotic individual must be contained by the therapist, by this he means that they must be received and understood – when this occurs the possibility is opened up to the patient that he or she is less isolated than previously assumed and that this may encourage a decrease in splitting (O'Shaughnessy, 1992). This, in turn, could lead the patient towards attempting to think (a capacity which Bion posits is impoverished as the psychotic individual loses parts of his ego when he employs projection) – which is vital if the fragmented ego is to be repaired. This can apparently be a very uncomfortable experience for the patient, and felt to be something akin to a physical attack. Bion saw this as progressing the patient to a point where he or she is "sustaining a more human contact with whole objects and an increased ability to think and use verbal thought in place of action and projective identification" (O'Shaughnessy, 1992, p. 98).

McWilliams (1994) offers a sensitive way of being in working with psychotic patients. She posits that one must demonstrate trustworthiness. This requires a more active effort on the part of the therapist in exhibiting a complete acceptance of the patient. Another aspect of trustworthiness is behaving in a manner that is emotionally honest. Psychotic patients are attuned to affective nuance (McWilliams, 1994), and so therapy with a psychotic patient requires more emotional disclosure than working with a different patient population. A certain level of disclosure and affective honesty is important as the psychotic patient – and his or her often very accurate emotional thermometer – will be 'lied' to if the therapist is unwilling to admit to an affect and so confirms the patient's distrust. McWilliams (1994) argues that such a disclosure still offers the patient an opportunity to explore what the particular instance and therapeutic response means to the patient, as apposed to shutting down exploration by refusing to address an inhibiting apprehension with a specific response or information. Furthermore, working with a psychotic patient often requires a more specific, problem-solving manner than is customary in working with 'healthier' patients.

The educative role of the therapist working with psychotic patients is also important (McWilliams, 1994; Sadock & Sadock, 2003). Psychotic patients experience cognitive confusion, and this confusion extends to making sense of emotions and fantasies. Therapists need to assist such patients in learning about these aspects. This is linked to normalization: "[p]sychotically inclined people become traumatically overstimulated by primary process material and can only reduce that upset from that material by having it normalized" (McWilliams, 1994, p.77). In working with psychotic patients one would interpret up (as apposed to work with neurotic level patients which begins work with addressing whatever defense is close to conscious understanding). Interpreting up involves going right to the heart of the concern, naming the content, and providing an explanation of why the material would have been activated by the patient's life experiences (McWilliams, 1994).

In working with psychotic patients, rather than interpreting defenses (as in therapy with other patient populations), feelings and life stresses are interpreted. One must help the patient find what set off the distress, often the content of what the patient is saying is peripherally related to what is really bothering him or her. It is the therapist's task to uncover what is in fact driving the patient's upset (McWilliams, 1994).

Sometimes known as 'joining the resistance' or 'paradigmatic psychoanalysis' (Coleman & Nelson, 1957, as cited in McWilliams, 1994), the therapist must join with the patient in order to facilitate further exploration (an opportunity which is often foreclosed upon if the therapist attempts to rectify the psychotic patient's understanding of reality). On such occasions, the therapist does not explicitly agree with the patient's interpretation of events but does not dismiss the patient's experience by dismissing the experience. With such an approach, the therapist invites further exploration and discussion, "usually, once the client lets off enough steam, a more realistic understanding of what is going on will gradually replace the paranoid distortions" (McWilliams, 1994, p. 80).

Defining Countertransference

Traditionally, transference and countertransference are located distinctly in the psychoanalytic tradition. While Freud wrote extensively about transference and the analytic setting, he wrote very little on the phenomenon of countertransference. In *Analysis Terminable and Interminable* (Freud, 1937/1950), he identified it as an experience existing within the analyst and as a limiting factor in analytic work. The phenomenon of

countertransference is central to understanding therapist reactions to patients and to recognise the usefulness to therapeutic work that it offers and also the impediment which it can sometimes pose. What follows is a presentation of various understandings of countertransference which are all located in the analytic tradition.

Many descriptions in analytic work describe the 'good' analyst as not feeling, as detached, as one whose analytic attitude does not waver from mild benevolence and where any emotional disequilibrium should be overcome (Heimann, 1950). It seems that Freud mostly disavowed holding any strong feelings towards a patient, but some like Ferenczi and Balint posit that the analyst does have a wide variety of feelings towards patients and at times should express them openly (Heimann, 1950).

Heimann (1950) describes countertransference as covering all the feelings which the analyst experiences towards his or her patient. She argues that the emotional responses towards the patient provides the therapist with a valuable tool for therapeutic work (Heimann, 1950). Heimann puts forward that the analyst must not only employ freely working attention, but also needs to be emotionally tapped into the patient's emotional movements and unconscious phantasies (Heimann, 1950). The underlying assumption is that the analyst experiences feelings which surface, and the analyst notices, in response to the patient. These emotional responses guide can potentially guide and furnish the therapist's understanding of the patient's unconscious processes (Heimann, 1950). This helps the analyst identify what is most urgent in the patient's unconscious and helps to guide interpretation. While this is a useful tool, Heimann concedes that it can also fall prey to misuse. It is only through the analyst or therapist having 'met' his own unconscious that it shall be useful as the analyst will not be imparting his own conflicts into the situation, but acting as a medium for the patient's unconscious (Heimann, 1950).

Little (1951, as cited in Langs, 1981, p. 144) defines counter-transference as the following:

(a) the analyst's unconscious attitude to the patient

(b) repressed elements, hitherto a\unanalysed, in the analyst himself which attach to the patient in the same way as the patient 'transfers' to the analyst affects, etc. belonging

to his parents or to the objects of his childhood: i.e. the analyst regards the patient…as he regarded his own parents.

(c) Some specific attitude or mechanism with which the analyst meets the patient's transference.

(d) The whole of the analyst's attitudes and behaviour towards his patient.

Reich (1951) describes the process of countertransference as being achieved via the analyst's unconscious, a partial identification with the patient. Countertransference, in the traditional sense, is that transference which is evoked in the therapist as a result of something in the patient which elicits in the therapist emotions and reactions which are joined to his or her past (Reich, 1951). Countertransference can, in some instances, be thought of as a defense against something the patient is exhibiting as intolerable – a defense against that which the analyst sees within him- or herself (Reich, 1951).

Tower (1956) moves towards the notion that countertransferences can be specific, making a distinction that some transferences and countertransferences are inevitable because they are based in the repetition compulsion (as she posits these are unspecific and will manifest in all sorts of situations and contexts). Tower offers the notion that transference and countertransference co-exist in a way and can be mutually useful in the therapy. Essentially, Tower (1956) acknowledges a dynamic relationship between people, and the notion of countertransference helps our understanding of this dynamic interaction. Racker (1972) too appreciates the interactive nature of therapy and the interplay of transference and countertransference. He further posits that countertransference reactions can be specific and this may further inform our understandings of patients' psychological realities.

Over a century has passed since Freud first noted that feelings may occur in the analyst or therapist. Views of countertransference have moved from a narrow or classical view (Rosenberger & Hayes, 2002) – those early views of Freud and his peers where countertransference was seen as a result of unresolved personal conflicts – to a view which now incorporates a two-person picture (Gabbard, 2004) and which is more expansive in the conception of the origin of countertransference (Schwartz et al., 2007). In the contemporary psychoanalytic view, countertransference is seen as an occurrence that happens because of

both the therapist's and patient's contributions – the therapist brings his or her own history into the relationship but the patient can also induce feelings within the therapist (Gabbard, 2004). The concept of projective identification is a familiar one to contemporary psychotherapists. This notion implies several things, firstly the process of projective identification sees a self or object representation being unconsciously spilt off and projected out of the patient, the patient unconsciously places pressure onto the therapist to identify with the projection which then becomes a feeling within the therapist (Gabbard, 2004). In this way, projective identification is both a defense mechanism but also a means of communication (Gabbard, 2004; Ogden, 1992). Gabbard (2004) proposes that this dynamic process can have therapeutic implications – if the therapist can contain and 'digest' the feeling which for the patient is intolerable, the patient will in turn be able to internalise this function within him- or herself in time (as it is presumed that the patient's own containing function is impaired or inadequate) (Gabbard, 2004). The unconscious pressure the patient exerts on the therapist to identify with a projection belies that there must be something within the therapist that the projection 'hooks' onto: "the countertransference response arising in the therapist must be viewed as having a latent structure that was somehow triggered by the patient's nudging" (Gabbard, 2004, p. 134). This sort of countertransference sees the therapist being at odds with how he or she typically experiences him- or herself, in such instances where the therapist's equilibrium is upset (Shulman, 2005), indicates something occurring in the therapeutic dyad (Gabbard, 2004).

For the purposes of this study, countertransference was viewed in the 'totalistic' definition of countertransference as espoused by Heimann (1950) and Little (1951) which encompasses all of the therapist's reactions towards the patient (Rosenberger & Hayes, 2002). Included within this position it is considered that the therapist's countertransferential feelings are likely to be a combination of the therapist's own reactivated history with the patient's projections (Gabbard, 2004).

Experiences of Countertransference in Working with Psychosis

While there is an increase in literature exploring the role of psychotherapy in the treatment of schizophrenia, the exposition of countertransference in this endeavour has received much less attention (Horowitz, 2002; Schwartz, et al., 2007) but that these responses can often become "mirrors of the complex internal world of the long-term mentally ill" (Horowitz, 2002, p. 237) and so can be crucially important to those who have often been rendered voiceless and

senseless in the face of such a debilitating illness. The PDM offers a useful description of the internal experience of psychosis. An understanding such as this is useful in that it provides the clinician with a deeper understanding of a psychotic's internal world. This may offer us further insight when we attempt to look at and understand transferential and countertransferential reactions in working with psychotic patients. Affective states commonly experienced may include:

> feelings of emptiness or numbness, detachment from emotions and other people, often accompanied by a difficulty expressing or identifying feelings. Intense feelings of anxiety, nervousness, and desire to draw into isolation or sleep. Intense anger in response to perceived threats. Urgent neediness and fears of being left alone, often accompanied by anxiety and intense urges to cling to anyone available (PDM Task Force, 2006, p. 145).

A description of people who are close to a psychotic person explains that the individual "may feel frightened, helpless, or exasperated, as their efforts to calm the patient fail, and their attempts to persuade the patient of their own version of reality are rejected" (PDM Task Force, 2006, p. 146). Similar reactions may present in therapists and so work with psychotic patients is often difficult work. Countertransferential feelings in the therapist identified by another source suggest common feelings of despair, hopelessness, anger and frustration (Horowitz, 2002). Furthermore, that the therapist who requires validation will "suffer feelings of inadequacy and grow bored, dissatisfied, or impatient with the lagging indicators of growth" (Horowitz, 2002, p. 241) as the pace of change in such work can be imperceptibly slow.

Such work exposes the therapist to intense distress or seemingly very peculiar behaviour, which is often extremely disconcerting. Working with psychotic patients may provoke some intense and extreme feelings within the therapist.

> Madness is frightening, and cannot be observed from a so-called "objective" professional stance. The madness of our patients will inevitably affect us deeply in terms of countertransference responses because the madness of the external Other resonates with our own internal madness. The terror and chaos that is involved in these treatments is difficult to bear (Gibbs, 2007, p. 306).

Rosenfeld describes, learnt through his own journey of working with psychotic patients, that an unskilled therapist working with psychosis is a dangerous undertaking as, he proposes,

working with psychosis often takes the therapist to his or her own feelings of omnipotence or helplessness – if the therapist is unaware of the complexity of this type of work, his or her personality may come under threat (Rosenfeld, 1987).

The psychotic patient invariably communicates verbally and non-verbally through primitive means, often by projection (Rosenfeld, 1987). Much of this line of thought was developed by Bion, who argued that projective identification is the earliest mode of communicating (1993). He argued that the psychotic is a person who is unable to move beyond this type of communication and whose general way of being involves massive evacuations from him- or herself parts of the self and so instead of being able to think and learn the person develops a way of being that involves rather omnipotence and omniscience as expressions of his or her fragile ego (O'Shaughnessy, 1981). This splitting of the individual sees masses of projected elements being pushed into others in the environment and thus sees the psychotic individual living within a world in which expelled, disowned projections are felt to be surrounding him or her and are felt to have developed into something foreign and bizarre (O'Shaughnessy, 1981). Thus working with a psychotic patient, often involves the invocation of powerful and emotionally charged feelings in the room. Klein (1946/1986) thought that the excessive use of projective identification occurred with severer pathology. Bion (1993) extended on this notion formulating that it is not only the quantity of projective identification which is a marker of pathology but also the intensity saying that if the projections cannot be tolerated "the infant is reduced to continued projective identification carried out with increasing force and frequency" (p. 115). This manner of communicating extends into adulthood and in analysis or therapy this mode becomes evident. Rosenfeld (1987) explains that this may very easily interfere with the therapist's function if not understood and worked through, this interference may involve collusion and acting out or feelings of being overwhelmed or intruded upon. Baranger and Baranger (2008) describe a potential to feel overwhelmed or inundated because the psychotic patient will "try to inject their madness into the analyst" (p. 809). It is imperative that the therapist be able to distinguish what is his or her own feeling and what are the patient's projected feelings – this also requires that the therapist be open to receiving the patient's communications via projective identification and not defend against them (Rosenfeld, 1987), through this the therapist offers a containing function where difficult feeling can be held and understood (Symington, 1996), where the therapist can think about what is unthinkable to the patient (Rosenfeld, 1987). Rosenfeld argues that even the most disturbed behaviour from a psychotic patient, if looked at carefully, can communicate

something meaningful. Being sensitively aware of countertransference helps the therapist to become aware and really understand the feeling state of the patient (Rosenfeld, 1987).

Rosenfeld (1987) explains that psychotic patients often think concretely, use overwhelming projections, can become easily confused, and fear falling to pieces. Thus it is imperative for the therapist to be able to quickly understand and follow what the patient is communicating as this may be easily lost or misunderstood and so result in what Rosenfeld terms, a therapeutic impasse.

Bion saw the therapist as struggling under the barrage of extremely hostile and anxiety provoking projections from the patient, the intensity and persecutory nature of the patient's projections can arouse highly disturbing countertransference reactions in the therapist. Working with a psychotic individual has the potential to stir up the analyst's own encounters with disintegration: "the powerful stimulus of the extensively disintegrated personality touches on the most deeply repressed and carefully defended danger spots in the analyst and, correspondingly, the most primitive…of his defence mechanisms are called into play" (Little, 1951, as cited in Langs, 1981, p. 147). At the same time, through this dual identification, the patient may identify with a fragment of the therapist's ego and be helped to make contact with reality through his ego (the patient can introject part of the therapist's ego – which has been acting as a filter). As psychotic patients do not respond in a typical way to the traditional analytic situation (by developing transference which is resolved following interpretation) "the counter-transference has to do with the whole of the work, and in order to find something in the patient with which to make contact the therapist has to allow his ideas and the libidinal gratifications derived from his work to regress to quite an extraordinary degree…it has been said that greater therapeutic results are found when a patient is so disturbed that the therapist experiences intense feelings and profound disturbance" (Little, 1951, as cited in Langs, 1981, p. 148). Little proposes that this occurs because the therapist allows him- or herself to identify with the patient's id.

McWilliams explains that patients who are structurally in the psychotic range often elicit positive countertransference in their therapists: "[o]ne ordinarily has more subjective omnipotence, parental protectiveness, and deep soul-level empathy toward psychotic people" (McWilliams, 1994, p. 60). The countertransference specific to working with psychotic patient has been likened to normal maternal feelings towards children below the age of a year

and a half (McWilliams, 1994). Similar countertransferential feelings were found in an empirically oriented study which reported positive and protective feelings – "feelings such as sympathy and compassion…In addition they felt a personal responsibility to actively help the patient" (Schwartz, et al., 2007). Kates and Rockland (1994) identify "[d]esires to rescue, to control, or to teach the patient how to live" (p. 552) as common feelings in the face of schizophrenic patients' helplessness. McWilliams describes the psychotic patient, in terms of his or her relations with the therapist, as being "wonderful in their attachment and terrifying in their needs" (1994, p. 60). The exhaustive needs of psychotic patients have been experienced by therapist as all-consuming, a feeling of being eaten alive (McWilliams, 1994). Another common facet which occurs when engaging in working with psychosis is that psychotic level individuals seem disconcertingly in touch with disturbing realities which many would rather prefer to ignore (McWilliams, 1994). Accounts of specific countertransferential feelings while working with psychotic patients are hard to find and are often presented in case studies. For example, Horowitz (2002) describes feelings of hopelessness, and sadness recounting "[n]o clinician can be unaffected by the ceaseless waves of sadness, the unrelieved gloom" (p.240) but that these feelings are "shadowy representation" (p.240) of his patient's feelings. In another single case study feelings of irritation, annoyance and anger were described, which during the course of treatment escalated to wrath, hostility and vengeance (Liegner, 2003). Fear, frustration, anxiety and hopelessness have also been commonly cited (Schwartz, et al., 2007).

It is for these reasons – the difficulties and arousal of strong emotions in the therapist – that there is a need to visit the notions of countertransference, specifically in working with psychotic individuals. Countertransferential reactions have the propensity to impact negatively on the therapeutic encounter: it would seem that the uncomfortable emotions which the therapist encounters often results in a failure to examine these aspects (Tower, 1956) and may lead to enactments that are unhelpful (Little, 1951). It is posited that, by being open to examining countertransferential reactions, the therapist procures yet another tool in trying to understand his or her patient and also minimises the potentiality of unexamined countertransference impacting on the therapeutic process (Racker, 1972). Further,

> there is serious risk that the reawakening of painful recollections may lead to emotional distancing, a protective retreat from intolerable feelings where the therapist and client engage in silent collusion. But there is also the alternative possibility that such moments, properly explored, may open the way to a

> deepening of empathic understanding and an enriching of the therapeutic relationship (Horowitz, 2002, p. 236).

While there is a dearth of psychoanalytic opinion regarding countertransference, there is comparatively little which explores countertransferential reactions in working with psychotic patients – often, such matters are touched on within a broader discussion regarding the manifestations and treatment of psychosis, barring of course the works of Harold Searles in which he courageously elucidates his various, and often unpleasant or abhorrent, countertransferential reactions in nearly two decades of work with psychotic patients. Given the intense nature of such work, it can be daunting to therapists. It is with this in mind that this research endeavoured to explore countertransferential reactions in working with psychosis.

Research Questions:

1.) What countertransference reactions have therapists perceived themselves to have had when working with psychotic patients?
2.) How has countertransference been perceived by therapists to affect their work with psychotic patients?

Chapter 3: Methodology

The nature of this type of exploration was best pursued in the qualitative research domain, and specifically located in the phenomenological/interprevitist paradigm. This approach seeks to understand the person, phenomenon or experience (Babbie & Mouton, 2005) and espouses qualities such as reflexivity, subjectivity, meaning, and self-definition (Babbie & Mouton, 2005). These aspects are aligned with the qualities essential to the exploration of therapists' experiences of countertransference in their work with psychotic patients. Furthermore, the analysis was conducted deductively as it is theoretically driven and specific (Braun & Clarke, 2006).

Participants

The sample for this research was a non-probability, purposive, convenience sample. The sample population utilised in this research consisted of seven psychotherapists (one male and six female participants) working in Johannesburg who have had opportunity to work with psychotic patients. The relatively small sample is justified as this research sought to find rich and in-depth data, detailing therapist's individual responses to psychotic patients. Information gleaned in the interviews was based on participants' experiences of working with psychotic patients in establishments ranging from a non-governmental organization to government hospitals to a private halfway house. Non-probability purposive sampling was used (Babbie & Mouton, 2005). Given that this is a very specific enquiry into a particular aspect of therapeutic practice, it is appropriate to select a particular sample – those who have worked with psychotic patients in therapy. The participants had varying ranges of working experience with psychotic patients, one participant had only had opportunity to work with this clinical population in group settings and in interactions in a ward setting, while most said that they had had opportunity for conducting individual therapy ranging from a few to many sessions with patients, and one participant had had much experience in working with psychotic patient in varying capacities over the past two decades. Six of the participants hold positions in which they supervise and oversee Masters Students' and qualified clinicians' therapeutic work - two of these participants work primarily in a university psychology department as supervisors, lecturers and also as practitioners. Three participants currently work primarily in the public hospital settings and hold senior positions therein – although all seven participants have had experience in hospital settings. One participant had worked in a non-governmental organization, in prisons and now works in private practice. One participant owns and runs a

halfway house for mentally ill individuals and has had much experience in working with psychotic patients.

Data Collection Instrument

In-depth, semi-structured interviews were used as this offered the researcher and the participant an opportunity to collaborate in the exploration of this subject (Babbie & Mouton, 2005). Each participant was interviewed at a time and place of their convenience. Interviews were between twenty and eighty minutes, and were audio-recorded. Semi-structured interviews were utilized as they allow for flexibility in exploring participants' responses, and provided the researcher opportunity to pursue and seek elaboration of participants' opinions and experiences of topics and related information which has been raised by the participants (Babbie & Mouton, 2005). Please refer to Appendix D to view the semi-structured interviewing schedule. This manner of data collection allowed for in-depth and rich accounts of countertransferential reactions to be explored. This instrument as used by the researcher, resembled a conversation (Babbie & Mouton, 2005), a conversation which was suitably located in the language or lexicon of psychology. Interviewing therapists resulted in the acquisition of very rich data which exhibits the complexity, but also the value, of turning therapeutic work into researchable experiences.

Procedure

Psychotherapists in psychiatric facilities and one in private practice were approached via email or telephonically determining their interest in participating in the research project. Non-probability purposive sampling was used. This involved approaching particular psychotherapists identified through the researcher's professional network as well as through some of her participants' professional networks. Following agreement to participate in the project, an interview was scheduled with the participant at a time and place of his or her convenience. Upon meeting participants were provided with an information sheet inviting them to participate in the research study and explaining in greater detail what the research entails (refer to Appendix A to view information sheet) and were provided with a copy of the Medical Ethics Clearance Certificate (refer to Appendix E). The participant was then given a Participant Consent Form (refer to Appendix B) and an Audio-recording Consent Form (refer to Appendix C) which was explained and discussed, and if the participant was satisfied the form was then signed so as to document his or her willingness to participate in this research study and his or her permission to be audio-recorded. The researcher also enquired if the

participant would like to receive a summary of the research findings, and as many of the participants did, the participant then provided an email address at the place indicated on the consent form (refer to Appendix B) to which a summary will be sent once this report has been assessed and finalized.

Data Analysis

The interviews were transcribed verbatim, and the data was analysed using thematic content analysis. This method was utilized as it allows for the identification, analysing and reporting of patterns within the data (Braun & Clarke, 2006). Furthermore, this method acknowledges the role of the researcher as not only reporting the data, but also interpreting it (Braun & Clarke, 2006) - an important aspect given the very subjective and reflexive nature of the topic itself. The first step of analysis was for the researcher to become familiar and immersed within the data (Terre Blanche & Durrheim, 1999). This involved reading, and rereading the transcriptions in order to identify common, and differing, themes and patterns. Beginning the analysis, the researcher considered the aims of the project to be rough outliners of themes. As analysis proceeded, more themes and sub-themes became apparent. The material was organised through themes (Terre Blanche & Durrheim, 1999), which involved eliciting a theme and then combing through all of the transcriptions for that particular theme, noting each instance of that theme. Following this, the themes were then reanalysed to find connected and interrelated themes and patterns. In other words, the analysis moved from finding themes within each interview, to finding themes within the entire data set which is constituted of all of the interviews (Braun & Clarke, 2006). While much rich and interesting data was found, for the purposes of this research project, only data alluding to countertransferential feelings and their impact upon therapy, the patient and the therapeutic relationship were included in the results sections as these two aspects are aligned with the research questions. The results of the analysis can be found in the Chapter 5.

Ethical Considerations

An application to the Medical Ethics Committee was submitted and medical ethics was granted (please refer to Appendix E to view Medical Ethics Clearance Certificate) – this was required as a number of the potential participants are employees of government hospitals. Confidentiality was assured to participants and was upheld. Informed consent was acquired in writing, as was consent for recording (please refer to the Appendixes to view the Information Sheet (A), the Consent Form (B) and the Audio-recording Consent Form (C)).

Protection of participants' identities was ensured by a coding system used in the transcripts and when writing up the research report; identifying information was not included in the transcripts or research report. The participants are coded as Participant 1, Participant 2 and so on. While confidentiality was upheld, anonymity was not possible as the researcher met in person with the participants. Audio-recordings were only listened to by the researcher, and during processing only the researcher and supervisor had access to the transcripts. Furthermore, all research material (audio-recordings and transcripts) shall continue to be kept in a secure and private place (as it was during throughout the research process) until the degree has been awarded and all publications finalized, whereupon the research material shall be destroyed.

Participants were informed that participation is voluntary, and that no person would be advantaged or disadvantaged in any way for choosing to participate or not participate in the study. Participants were informed that they may withdraw from the study at any point, and may refuse to answer any question if it would be preferred not to. Participants were informed that there are no direct benefits for participating in this research and there are no known risks associated with participating in this study. Contact details and the names of participants were protected and not disclosed to any one.

An important ethical aspect to consider was that of confidentiality of session content in terms of therapists' experiences of countertransference. In the pursuit of this research, essentially, therapists were asked about their experiences during therapy. It was foreseen that some session content may seep into the explanations. In such instances, the researcher endeavored to protect the information and not divulge identifying or revealing content in the research report.

Chapter 5: Results

The results section is ordered around three main sections. The first includes the presence of basic feelings. The second category holds the themes which tell us something of the quality or characteristics of the feelings themselves, these are known as the 'meta-affective' themes. In this category, we find descriptions of who produces a feeling in whom and also descriptions of the quality of feeling. The last category involves themes which described aspects of the relationship between patient and therapist and how feelings are involved in this.

Section I: Basic Feelings

1. Fear, Horror and Anxiety
2. Frustration and Anger
3. Sadness
4. Disintegration

Section II: Meta-Affective Descriptions

1. Agency
2. Intensity

Section III: Therapist-Patient Relationship

1. Power
2. Responsibility
3. Avoidance
4. Boundaries

Section I: Basic Feelings

1. **Fear, horror and anxiety**

Fear

There were many instances in the data of participants describing how in working with psychosis, therapists often encounter fearful or frightening feelings.

P2: "uh a sense of foreboding and evil"

P2: "uh fear of loss of control"

Here, the participant likens the disorganisation she experienced with an inconsolable infant to the kind of disorganisation one might feel with a psychotic patient.

P6: "Ja Mmm I mean if you've ever been, because I I I. I think the closest I ever came to was holding a screaming baby who **wouldn't** [participant's emphases in bold throughout] calm down and I I was completely disorganised by the whole experience because this child was **screaming**, she was obviously unravelling **completely**, she needed her mother, her mother wasn't there I was there and I just couldn't calm this child down. And then *I felt completely disorganised* [researcher's emphases in italics throughout] by that and I and ja and I think that was *very very frightening*, and I think something that I can potentially experience, and your psychotic can in a way as well."

Below, fear is described as a result of the patient being dangerously out of control:

P4: "And ja seeing people in their most undignified state, stripping, uninhibited sexuality, uh smearing faeces on walls and that kind of stuff, when you're see it and it's there and there's that amount of rage that somebody is trying to convey it can become **extremely** frightening"

P4: "I think suicide as well in psychotic patients is ja it feels more dangerous, I don't know why exactly, but it feels like there is something more destructive that can come out of that person. There's *no limits* on it."

P3: "Um when a child can just get distressed, or the adult can just get distressed and you become the figure of paranoia or part of the hallucination and they can attack you."

P3: "I've always felt the physical danger, ja, the physical danger."

P4: "he was talking very much feeling intensely angry, but like aggressively murderously angry with his mother and I just had the feeling that I needed to end the interview and I needed to get out. And a couple of days later he assaulted one of the registrars on the ward, I

mean it's that sense of you're no longer omnipotent and you can't survive everything and you do need to leave"

Fear of being devoured

Two participants described feeling as if they would be swallowed or consumed in their work with psychotic patients.

P3: "You know babies when they want to open you up and they run to swallow you, that's what these guys do concretely, they internalise you."

P4: "I mean psychosis just I think can be all-consuming"

Fear of being overwhelmed

P4: "sometimes that's where it can become unbearable."

P4: "Too much of it I think would be intolerable, there's too much."

Fear of failure

P7: "feelings of me of my own fear of failure of my own fear to not be able to rescue"

Fear of damaging the patient

P7: "So obviously the outbursts and the kind of narcissistic rage outburst that you get with psychotic clients, delusional clients also, can do definite damage to the relationship especially if the therapist is not supported in the supervisory relationship because then you *act on your own countertransference in a way that actually damages the patient*, not only the relationship, but it damages the patient."

P7: "Um there's *definite risk of damage of a psychotic client*, and in my opinion more so with a psychotic client than any other client because of *that fragile ego*. With a client who is less robust and less resilient in nature compared with a client another client with similar difficulties, I just wouldn't want to go there, especially if there are a whole lot of signs pointing to prognostic difficulties."

P6: "The problem is they can just get more and more stuck in there because what's going to, where's the ego capacity that's actually going to actually make use of what you're saying in a way that can help to bring them out of the psychosis and work with that psychotic part of them, something has to be able to work with it…but you're not going to make interpretations that are going to take them deeper because *they'll just fragment*."

P5: "So it very painful to have to say to her, you are sick, it's not that your boyfriend is trying to abuse you and destroy you, you are actually vulnerable and are struggling. And when I would say that to her it was like this terribly painful wound that I was *inflicting on her*, so it was that like that sort sense of betrayal."

Horror

In the quote below, the participant describes a sense of horror at what a patient did. This feeling involves a sense of shock at the atrocity.

P1: "was just a very gruesome story and you sort of you sort of, obviously it evokes quite a sense of horror at what he did and what he was able to do…. So I mean I think in that instance, it will obviously have evoked a deep sense of horror, um uh."

Anxiety

Many participants described the emergence of anxiety in the therapist. This anxiety took a number of forms:

P2: "uh anxiety that is extreme"

P4: "I mean ja, I suppose that, the whole fear of annihilation – those psychotic fears that I've spoken about you know from infancy that babies feel, I think it's that stuff coming through."

P7: "so I can imagine how anxious as a therapist you'd feel working on that level to effect change."

In the following instances, the participants describe the quality of anxiety, as feeling primitive or primal. Note again that almost all the descriptions of 'primitive' feelings were related to psychodynamic theory, almost all participants relating 'primitive' feelings to intellectual ideas such as 'repression', 'defenses' and 'infancy'.

P6: "So if you're going to link it to your question of psychosis and why is there such strong countertransference, ja I think it's that part of that psychotics live in that is terribly frightening, um. You know I almost get the image, it is it is almost like a building that is being imploded, that is constantly imploding, that's how it feels constantly imploding that it's something inside of us *that we can all have access to*, that um, especially at a very *primitive, unconscious level* as an infant. Something that is bloody scary."

P6: "Um ja in that it's our *own primitive infantile anxieties* that they manage to hook, because that's where they're living, they're them they're it. We've repressed it, you need to, you need to be in touch with reality to survive and function, to um ja, for survival. So ja they

hook what resides inside of us, and use very primitive defenses, like projective identification as well."

P4: "Um but ja they elicit primitive stuff, they elicit *all your own fear, terror*, and um ja I think they elicit a lot of stuff you would say you would *find unacceptable* in yourself."

P4: "So it's a lot of the *repressed stuff you don't want to think about,* so that's what makes them hard to work with"

2. Frustration and Anger

Participants described feelings of frustration. These feelings stem from various things: the work itself, the patient's resistance, and the recidivism often experienced with psychotic patients.

P7: "Um ja but definite frustration at the resistance, every client can be resistant but none more resistant than a psychotic client."

P1: "they just no matter how hard you tried, or tried to lure them to, you know, draw them towards some kind of different way of looking a things, ah I think that that is very um, unsatisfying."

P3: "but it can get frustrating, especially with adolescents when they're thirteen/fourteen, because they're becoming the revolving door type thing, especially the substance-induced psychosis."

P7: "it does become frustrating, lethargic, and almost your countertransferential picture takes on a picture of where therapy is at which is slow, gradual process, monotone and sort of going around in circles."

Some instances described experiences or feelings of anger and/or rage.

P2: "as well as anger, rage."

P4: "it was something that enraged me"

P4: "And that day I didn't touch him, I just sat in the chair and I said do you know if you jump down there you'll probably just break your leg and we'll have to take you to Pretoria Academic and you're not going to die. And and then I said unless we tie your hands behind your back and aim you head first, then you might die. And I knew that it was **complete** acting out as I was doing it, but I think sometimes that's where it can become unbearable."

Below, anger is described with regard to incidents of unwanted physical contact with psychotic patients

P4: "I could feel my own rage…The one day, I mean I had a realisation that a lot of it was about him wanting to be touched by me. And it enraged me, it just made me feel so angry."

P3: "'cause you know when that child came and grabbed me and stuff I was **very** angry"

3. Sadness

Some participants described feelings of sadness, disappointment and pity that they have experienced when working with psychotic patients. The first two instances describe a depth of sadness – tragedy.

P1: "and a *deep sense of tragedy* in regard to him because he, he um he uh wasn't a bad person he was just a very very sick person"

P6: "And so many you'll see all these burnt out schizophrenics, at Helen Joseph…You know they just come in again and again, because they relapse and they burn out and it's *tragic*."

P5: "And for a moment while sitting in the session while he spoke of that I felt this intense sadness of him, getting in touch with the separation which is unusual because in psychosis there is rarely any feeling other than anger or anxiety, so it's unusual to come across that. And I felt this intense sadness"

P3: "Perhaps uh you'd feel sorry for them"

P3: "Um so, that's what I think the downs are of working with psychotic patients, especially in children it's even worse. It's heart-breaking I think"

Here the participant describes how a patient's state of sadness affected the therapist's perceptual experience – where the visual information available in the room became personified appearing forlorn.

P5: "as I was sitting in the room *the whole light of the room even changed to me*. It became this very cold, sort of grey, very *forlorn kind of place*, it was like perceptually the countertransference had like affected my perceptions and then I I wondered about him getting in touch with the sadness which was maybe the most real way he presented in all of the sessions in the time we had been together."

4. Disintegration

This theme deals with instances where therapists felt that in their work with psychotic patients, a capacity to think and act in ways congruent with a predominant sense of self were eroded away, or 'disintegrated' in some manner. This disintegration was experienced in several ways.

The following participants spoke of the disintegration either using the word 'disintegrate' itself or, 'disorganised':

P4: "I mean some authors, distinguish between the **dis**integration as apposed to the **un**integration which I suppose is just a fear of not being, not being together, existence, all those existential things. But I think they do resonate because it's *those fears that cause the **dis**integration*."

P5: "[laughs] and I sort of feel like as I'm talking to you now, *I can kind of feel the disorganisation of the psychotic mind* see which of comes out in the way I'm talking, it's *hard to sort of organise my thinking* about it sometimes."

P6: "And disorganisation, like an *internal experience* of being *disorganised, fragmenting, coming undone*, and that's very very frightening."

Below, the participant describes the capacity within herself to identify with what it must feel like to be psychotic and how this identification would make her feel: the therapist is described as damaged, or even 'desecrated' (as if something sacred about the self is destroyed in some way).

P7: "Um so um I would imagine I would be able to connect with an internalised kind of way their feelings of intense desperation, to get away from what is essentially a reality that's fraught with damage and destruction, and possible *desecration, to the sense of self*."

<u>*Confusion*</u>

Some participants described coming to feel as if the world becomes confusing:

P6: "Because they evoke too much stuff, they make me feel, uh the world is mad, it's *not understandable*"

P4: "I think when you work with psychotic people very often you have to be able to tolerate confusion, I mean in terms of a thinking sense, let alone what's going on emotionally. Often

you'll feel *confused*, you won't know what the hell is going on, and it takes a while to process because you're there in the room with this person with all this powerful stuff, so ja difficult."

Below, the participant describes being unable to speak 'coherently' about their experience with psychotic patients

P5: "Even now, I'm just reflecting on talking about it it's feels hard to get it into a sort of coherent narrative. Which is a little bit how it is for the patient, when they're in a psychotic state. To talk coherently about it is very hard."

Losing your mind

An expression of the disintegration theme is that of losing one's mind. Some participants explained that working with psychotic patients can potentially open you up to loosing your capacities to think and your own hold on reality.

P3: "that's the thing where you don't have the capacity to have your brain your mind you know, where the patient, that's where I say you feel like you're colluding with the patient um *where you don't have your mind* as a clinician, you keep working with the psychosis and it just grows and grows and grows."

In this instance, the participant describes how one can feel crazy.

P4: "and I used to really love the drive home from that place, so I used to live in Jo'burg so it would be like a forty-five minute drive home with really loud music – it's something to try and *get rid of this craziness* that you could feel"

This participant describes imagining that one would lose one's mind with a psychotic patient, while stating that it has never actually happened to her:

P3: "It must be very frightening, I would imagine it to be very frightening to loose your mind. Because it can happen, that's why I say especially with these higher functioning psychotics, it's easy to intellectualise a lot. *It's easy to lose your mind in the working alliance*. But I've never experienced that to be honest."

Here, the participant describes that her predecessor had in fact become psychotic herself

P4: "the woman whose job I took had become psychotic from working in the ward…She had gone completely grandiose, and that talk about a defense from all the stuff um because it is, all the more dark places of humanity."

Section II: Meta-Affective Descriptions

1. **Agency**

This theme involved descriptions where feelings in therapy are viewed as the result of the actions of one of the parties – the active 'agent' in the transaction. In short, these are statements about who is causing the feelings in whom (and how they are doing so). Two main sub-themes within this theme are the therapist as the agent and the psychotic patient as the agent. As seen below this sense of agency can take a number of forms, some of which recur a number of times in the data.

Patient as Agent

This theme evidences instances where participants felt that the patient was the agent in making the therapist feel a particular way.

P6: "That's why *they can* also *make* you feel this, that's your countertransference."

Here, the participant describes her feeling of distress as having been induced by the patient invading one's sanity and exposing the therapist.

P7: "*And I think that continual violation of boundaries of your more psychotic patients will* induce that feeling of distress*, of having your own feelings, your own sanity invaded and exposed*"

In this instance the therapist is describing the feeling he is given as a source of information, and the agency of the patient lies in an attempt to communicate, trying to (unconsciously) provide the therapist with this 'information'.

P2: "information that the patient is *actively* verbally and non-verbally *giving me*, to form a picture of what the patient is going through or trying to communicate, what their state is."

In the Instance below, we see confusion not only as to who is the agent of the feeling inside the therapist, but also who the feeling in fact belongs to:

P4: "I mean thinking "what is this, is this how he is feeling, is it mine?" but I think making that distinction you know is difficult because it can also be his intense fear that you're feeling, which is common with psychotic patients."

Therapist as agent

In this theme, the therapist is seen as being the agent causing a feeling, either within him- or herself or within the patient. In the quote below, the participant seems to describe negative feelings as a weakness. By viewing negative feelings towards the patient as being a result of the therapist's 'weakness', the participant in the quote below is describing the therapist as the agent causing the (negative) feeling.

P1: "I was thinking about it because I don't think I have specifically negative countertransference to psychotic people, I don't think that would be *my weakness*"

This participant describes how the therapist's state of being can 'exacerbate' feelings in the patient.

P3: "But then you see when you become just as irrational and uncontained it exacerbates him, his like primitive defense"

The participant below describes the therapist as exercising agency with respect to controlling their own feelings, although this agency is limited – the therapist has agency to defend or distance him- or herself from psychosis (which in this quote is afforded a hidden agency itself, an agency which must be defended against as it has the capacity to expose the therapist to his or her own or the patient's vulnerability).

P6: "I think the way we understand psychosis helps us in a large part to defend against it quite easily. Often, well not easily, but we can defend against it more easily. Because there is something, where you can clearly you can clearly say this person is psychotic which *allows you* to distance yourself, and to see them as a condition and not to *engage* into a relationship where you're not as vulnerable."

In this quote we see ambiguity in who is causing the feelings in whom. Firstly, the therapist describes herself as feeling pulled and pressured by the patient's demands. However, at the same time, suggesting that the therapist, by pointing out reality to the psychotic patient, may cause feelings of extreme anxiety for the patient, and in this sense being the 'provocateur' of the feeling in the patient.

P5: "Yes absolutely, ja, and that is possibly the most difficult part of the work for me is to sort of try to work with that stuff around, either being *pulled in* to you know the *pressure* being put on me to uh affirm their version of the world or their idea of what's going on for

them because when when trying to point out reality it *provokes a lot of anxiety for the patient* ja."

2. **Intensity of feelings**

Participants often described feelings they encountered with psychotic patients as being qualitatively different due to the intensity of the feeling and also the frequency of feelings.
P4: "Um, well I think they can elicit stuff similar to other patients, but it's much *stronger*."
P4: "you'll have a *strong reaction* to a psychotic patient I find, one way or the other."
P4: "But I would say the primary difference, I think personality disordered patients can evoke primitive stuff as well, working with babies can evoke that primitive stuff as well. So I think it's just *much much stronger*. What they project is ja much bigger, let's say, than other people, other patients."
P7: "more *intense* and the *frequency* of those kinds of countertransferential feelings would obviously increase with a psychotic client for me at least."

Therapist-Patient Relationship

1. **Power**

This theme explores the existence of power in interaction with psychotic patients. Here, power is understood to involve having power over another person rather than, as above, agency in causing a feeling.

Therapist as powerful
In this quote we see how the participant views herself as powerful relative to the patient in terms of seeing her feelings as being able to contain and calm a patient.
P3: "that's where I saw the countertransference becomes a safety net for you because you talk him down because you're much more calmer in a safe place."

In this instance, we see the participant experiencing her role as involving the capacity to inflict unavoidable pain onto her patient, further feeling this to be a betrayal of her fundamentally beneficent role towards the patient.
P5: "So it very painful to have to say to her, you are sick, it's not that your boyfriend is trying to abuse you and destroy you, you are actually vulnerable and are struggling. And when I

would say that to her it was like this terribly painful wound that I was *inflicting on her*, so it was that like that sort sense of betrayal."

In this quote, the participant describes how the therapist has the capacity to shatter the patient's picture of the world.

P7: "that that started off with a clearly definable framework, from the basis of trust, um openness, and unconditional regard and all those good things *you profess* and then in contrast kind *desecrate* when you do present them with a picture that isn't their own."

This instance suggests the therapist as a potentially destructive agent.

P7: "so *you* can naturally do damage to the developing relationship."

In these descriptions, participants describe their power relative to the patient in terms of a feeling of being a rescuer or nurturer. By virtue of the therapist feeling as if he or she could rescue the patient, it implies that the therapist has a sense of being more powerful, more 'able' than the enfeebled patient who needs protection. Note that these are ambiguous instances as the therapists described being pulled towards rescuing or nurturing which implies a lack of power.

P4: "very much a pull to nurture and rescue"

P3: "it evokes these emotions of wanting to protect and rescue the patient"

This participant describes a sense of holding the power and responsibility for what transpires in the therapeutic relationship, and being fearful that she may fail in her endeavour to rescue the patient.

P7: "feelings of me of my own fear of failure of my own fear to not be able to rescue"

In this instance, the participant implies that the therapist is imbued with power but that at times this power is limited.

P4: "you are not seen as a whole person, you are not a whole therapist, so so much is projected off you, or into you that it's very difficult for the patient to have a sense of you as whole and *you can't control that all the time*"

Fragility/powerlessness of the patient

In this sub-theme, we see the perceived relative power of the therapist in descriptions of psychotic patient as being somehow incapable, immature or fragile relative to the therapist.

P3: "the parents, the caretakers – 'cause even when they're adults they still have *people looking after them*"

P7: clients…brought to me largely because their parents insisted on…who were also in their thirties and forties but who *were still also children*"

P7: "because of their *unfitness* to manage their own lives

The participant below describes awareness of this countertransference:

P2: "well I think because of the *incapacities* of psychotic patients they very often become *infantilised* and *disempowered*, through their own behaviours as well as the perceptions of others."

In this instance, the therapist is seen as being more 'conscious' than the patient who may easily fragment.

P7: "I mean how do you prevent them from not fragmenting once they leave the room? Because you're essentially presented reality to them in ways that are less conscious of their process than your own."

As an expression of the fragility of a psychotic person's selfhood, some participants described the psychotic patient as living in a more primitive existence and thereby implying a less sophisticated way of being. Note that the presence of the word 'primitive' in the data is always in proximity with theoretically loaded terms, particularly psychodynamic terminology.

P4: "With psychosis they feel very clear, *primitive defenses* and you can see what's going on. Ja very primitive stuff is clear as day"

P4: "You become respectful of more basic *primitive* human *wants* and *needs*."

P3: "you see when they get transported, the social workers or the paramedics they fear, like a small kid, you know they will punch you, they will hurt you when distressed – it's more like a fight or flight response. That that it's more in its *primitive* sense, so the primitive *defenses* come to play. And the primitive way of doing things come into play when you're dealing with these psychotic patients."

P6: "very very *primitive ego* if at all."

P4: "*primitive* stuff is clear as day, um ja but I I think it's hard stuff and we all *defend* against it and it's hard to see people that are people that are very psychotic because we all have that potential in us and I think it's frightening to see that state of *disintegration*"

Here a participant explains that psychotic patients may be less robust or resilient.
P7: "Um there's definite risk of damage of a psychotic client, and in my opinion more so with a psychotic client than any other client because of that *fragile ego*. With a client who is less robust and less resilient in nature compared with a client another client with similar difficulties, I just wouldn't want to go there, especially if there are a whole lot of signs pointing to prognostic difficulties."

This participant explains the temptation to interpret the unconscious material of psychotic patients, for which the patient is too fragile. The fragility here is specifically with reference to interpretation.
P6: "so what it means in terms of therapy, is that you have to be *so careful*. But I I I think sometimes people can be like cowboys, because they you go into it, you want… look you can understand the psychotics' experience, what they're talking about, is for us symbolic for them it's concrete – it's really happening to them."
P6: "The problem is they can just get more and more stuck in there because what's going to, where's the ego capacity that's actually going to actually make use of what you're saying in a way that can help to bring them out of the psychosis and work with that psychotic part of them, something has to be able to work with it…but you're not going to make interpretations that are going to take them deeper because *they'll just fragment*."

<u>The therapist as disempowered</u>

Helplessness

In this sub-theme, psychosis seems to hold agency and the therapist is left with feelings of helplessness.
P1: "but the part of me that would like to feel like a useful clinician feels helpless with them being psychotic. Whilst they're psychotic."
P7: "I would say off the cuff extreme helplessness."
P1: "they just no matter how hard you tried, or tried to lure them to, you know, draw them towards some kind of different way of looking a things, ah I think that that is very um, unsatisfying."

P3: "And when it's younger, and when I say young I mean someone in their early twenties um late adolescence, those are disheartening because you can see that the future is bleak."

Magnetism and repulsion

In this sub-theme, the therapist experiences themselves and their feelings as being subject to forces much like a 'magnetic' pull, these participants' experiences seem to articulate a feeling of either being drawn into psychotic patients or alternately a repulsion away from the patients. Firstly, a participant feels 'pulled towards' the patient:

P4: "but ja I suppose it was, what would the word be, *attractive*, there was a *pull towards it*."

P4: "I think it was also his deep need to be rescued, and be saved and all of that stuff to be *pulled* on your own strivings to rescue."

P5: "So sometimes the pull to say, ja he's been treating you very badly and he's he's bamboozled doctors who made who who and they they they've seen you in a certain way and treated you very badly and because of the dysfunction of the health system in the hospital, there are times when the patient aren't treated as they should be in the ward. And sometimes it's *easy to be pulled to*, *the pull of the patient*, to get you to say with them ja this is terrible what has happened to me."

Here, a participant feels 'pushed away':

P4: "Um because something about him, *reviled* me in that moment"

Enchantment/fascination

In this sub-theme, we see participants feeling enchanted, seduced or fascinated by psychotic patients.

P4: "I think it's *fascinating* to work with but I don't think you can do it for extended periods of time, if that makes sense."

P1: "I was *enchanted* by it in a way – it sort of had a *magical realism* to it, I don't know it was just lovely"

Below, the participant describes a fondness of psychotic people, seeming to present psychotic individuals as being innocuously endearing.

P4: "But he constantly, he found different hats everyday, he'd be wearing this different hat, and he was quite an overweight man so he was quite comical, but there was something lovely when you spoke to him, and he was so gentle"

P4: "I personally love psychotic people."

2. Responsibility

A few participants expressed that psychotic patients are not responsible for their symptoms, actions or themselves - in a sense articulating that illness 'excuses' behaviour somehow.
P3: "Something with psychotic patients, the one that attacks you but has remorse and so on is highly likely to be forgiven. You know that it's *not the patient's fault*."
P1: "he uh wasn't a bad person he was just a very very sick person"
P3: "I think there is because, with psychotic patients you will find, if that thing was done by a borderline person, that thing will be labelled as manipulation. But with a psychotic patient there will always be that level of leniency, *he is psychotic he doesn't know what he is doing* – that's what I get."

In contrast, these two responses indicate the therapist's sense that the patient is responsible for the maintenance of their psychosis.
P3: "Because you feel they did, they *brought it on themselves*, this is the *consequence*."
P3: "Because you can see *they're throwing away* their future, and you can see some of these young men – its predominantly males – that are psychotic. The young males how they just throw away their lives."

In this instance the participant describes how the psychotic patient will tenaciously cling to his reality and will contest therapy if it threatens his view of reality, as it inevitably does. The participant describes the patient as contesting and defending against the work that can occur in the therapy and herein lies an implication that the patient is choosing, is responsible for, the maintenance of psychosis as he or she is opting for his or her own psychotic reality over what the therapist offers.
P7: "Just purely *their contestation* of therapy, and what it means to them, and their denial of it in terms of a *defense against* the therapy and anything that might violate that reality would produce that same feeling of frustration in me."

3. Avoidance

In this theme participants explained why they or other might avoid working with psychotic patients, in most instances avoidance involved the presence of countertransference.

P6: "you can use to explain why people use it to avoid therapy with psychotics."
P6: "I can't do the work so I'm just not going to engage in therapy."
P6: "Um because of what it evokes in me with them, and and and that could be potentially for why we don't do in-depth psychotherapy with psychotics."
P6: "but but also I think, countertransferentially it's not a place people want to go."
P7: "I have no doubt that something that could prove fruitful, working against a system that has largely been successful with psychotic patients that cannot be implemented here it just seems difficult, almost impossible, but then again maybe that's the countertransferential reaction."
P7: "I think that in general has put me off, I think if we were able to work luxuriously as they did overseas in a pure psychoanalytic sense where you're having three to four a week therapy and clients are paying, then it's a different story."

4. Boundaries

Some participants described how in their work with psychotic patients, boundaries become a subject of attention. A boundary can be understood as the 'thing' that separates one person from another, one's mind from another's, and what is inside from what is outside.

Physical touch

Here a participant describes feelings of being invaded when she was physically touched by a patient.

P7: "My first psychotic patient in training sat in my lap and wouldn't get off. He hugged me, and he was all sweaty and vile, and it felt *invasive and exploitative*"

Invasion

In this example we see an invasion of a physical boundary.

P4: "They will *impinge* on your boundaries, you will have to talk to them in a language they understand and physically move them away and say no, I'm *not comfortable* with you here, that that kind of stuff."

In this instance, the participant describes how the patient's psychosis transcending boundaries to 'touch' something within the therapist.

P4: "ja in that sense, because of his psychosis, it caused that stuff to be touched *in me*."

In this example we see a slight variation on the above example, here the participant describes the intrusion as 'hooking' something within the therapist.

P6: "But there's something that they manage to *hook inside of you*, something that also *belongs to you.*"

Merging

In the instances below, participants describe how in therapy with a psychotic patient one can sometimes collude with the patient in an inaccurate reality - where the boundaries separating realities have become indistinct or dissolved away, even if only momentarily. In some descriptions the participants are dismayed to discover being merged symbiotically unified with the patient.

P5: "There were times when I played into the splitting so it was quite difficult to say to her what he has done to you is terrible and also say you are also struggling and you need help."

P7: "obviously having said that you would gradually confront delusional behaviour or the lack of reality testing, or the reality that looks socially inappropriate or sanctioned for this person, would have to be gradual now while that process is gradual, what it means by default is that you're colluding with their delusional picture essentially."

P1: "And um, then the one afternoon I came in to see him, and he was at the centre of a whole crowd of nurses who were challenging him on the reality of this and just as I was passing by he said 'you can't see him but let me tell you something, she can!'"

P5: "And I think sometimes my countertransference has pulled me into agreeing with the patient in a way that isn't helpful. And agreeing with the patient about her persecution."

Below, the participant describes how the therapist can come to embody a part of the patient's psychosis and unconsciously play out the role assigned to him or her. The merging or symbiosis is especially clear here.

P7: "and you become symbolically like the really punitive harsh superego voices they hear in abundance."

Chapter 6: Discussion

The aim of this research project has been to explore psychotherapists' countertransferential experiences in their work with psychotic patients and how these feelings impact upon the therapeutic encounter. The results were analysed using thematic content analysis (Braun & Clarke, 2006) and the analysis was couched in the philosophy of the phenomenological interpretive paradigm which espouses the position of subjectivity in the process of analysis (Babbie & Mouton, 2005). The themes were found to exist in three major categories. The first was the presence of basic feelings, those of fear, horror, anxiety, sadness, frustration and anger and a feeling of disintegration. The second category holds the themes which tell us something of the quality or characteristics of the feelings themselves, these were termed the 'meta-affective' themes. In this category, we find descriptions of who produces a feeling in whom - the agency theme, and also descriptions of the quality of feeling - this is the intensity theme. The last category involves themes which described aspects of the relationship between patient and therapist and how the feelings are involved in this; the themes herein include power, avoidance and boundaries.

In order to understand the nature and quality of these responses it will be useful to begin with an overview of how the psychoanalytic paradigm views and conceptualises psychosis. Following on from this, a discussion of how the reported countertransferential reactions may be linked specifically with these phenomena of psychosis.

In many prominent psychoanalytic developmental theories, for example to name a few prominent theorists: Freud, Klein, Bion, Winnicott and Kernberg, one will find an explanation for the development of psychosis. As it is with much of development in psychological knowledge, we develop our opinions of health through a study of psychopathology and so psychosis features as being a severe psychopathology which often sheds light on the earliest stages of psychological development, particularly insight into the development (Klein, 1946/1986) and workings of the ego (Freud, 1914/1925). What this points to is that something has occurred very early in the psychotic person's life which has affected his psychological development and ability to function in the world in an adaptive and integrated manner (Searles, 1951).

A review of the literature has led to a breakdown into three inter-related areas of functioning which will form the structure of this discussion. These three areas help to order and understand the reactions participants described in the data. The data reflect responses to the psychotic individual's: 1.) 'weak' or poorly formed ego and so the presence of psychologically 'primitive' object-relations; 2.) a dysfunction in perception and linked to this a dysfunction in making sense of the world (dysfunction in thought); and lastly 3.) difficulties, delays or fixations of psychological development.

In psychosis, the ego is viewed as being 'weak'. This notion alludes to the impoverishment of the ego in numerous functions: as a mechanism it lacks adequate means to make sense of existence (Bion, 1993), it directs energy towards the self and phantasy life as apposed to external reality and others, and it concedes to rather than being the master of, the id (Freud, 1914/1925). The psychotic individual has primitive object relations which mean that his or her internal world is constituted of part-objects. This implies that the person relies on primitive defense mechanisms like splitting and projection (Klein, 1935/1986) - some theorists (Bion, 1993; Ogden, 1994; Rosenfeld, 1987) describe the psychotic person as using projective identification as mechanism of communication (projective identification is used in infancy to communicate a feeling at a pre-verbal level; with a person who is psychotic, this method of communication persists).

Because of the over-use of these defenses, the psychotic individual's 'thinking capacity' is impaired and as such, the individual will struggle to make sense of and find meaning in experiences and the surrounding world (Bion, 1993; O'Shaughnessy, 1981). Linked to this is the psychotic individual's psychological and emotional developmental delay. The psychotic individual exists primarily in the paranoid schizoid position which denotes: the type of anxieties present (persecutory and annihilatory anxieties); the use of the above mentioned defenses; as well as the constitution of the internal object world (Klein, 1935/1986). This helps to explain the sorts of difficulties psychotic people encounter in their existence in the world, such as difficulties relating to others.

Returning now to the idea of the psychotic's poorly formed ego, we understand the individual as being dominated by instinctual id demands and harsh superego ideals (Klein, 1935/1986). Perhaps this knowledge of an impoverished ego - which has little ability to repress and control these aspects of the mind which are more conscious (Freud, 1916/1925) and have

more agency in the personality than they should have, leave the clinician with a fearful sense that the psychotic individual has less control over his impulses. As one participant described, even suicide with psychotic patients seems inexplicably more dangerous. Others described feeling in danger's way themselves, feeling as if the patient may unpredictably attack the therapist. This sense might also be explained as was above by the therapist's knowledge of, and one would posit almost intuitive sensing, the psychotic patient's volatility. Other instances of fear expressed almost an opposite fear that the therapist may harm the patient, and this fear was again grounded in the therapist's perception of the patient's weakly formed ego structure. For example, the quote provided evidences the participant's own opinion that the reason she may more easily damage a psychotic patient is because of his presumed fragile ego:

- P7: "Um there's *definite risk of damage of a psychotic client*, and in my opinion more so with a psychotic client than any other client because of *that fragile ego*. With a client who is less robust and less resilient in nature compared with a client another client with similar difficulties, I just wouldn't want to go there, especially if there are a whole lot of signs pointing to prognostic difficulties."

Searles, an analyst renowned for his extensive analytic work with psychotic patients over a period of more than fifteen years, has something further to offer in regards to understanding the above statement where the psychotic patient is felt to be extremely fragile. He explains that it is not that the patient who is fragile but it is the relatedness between therapist and patient (the therapeutic relationship) which is the fragile aspect (Searles, 1976). Indeed one participant confirms this sentiment when she described therapy with psychotic patients as being a 'precarious' therapy.

Another fear articulated was that of being consumed. In the literature surrounding psychosis, often what is discussed is the manner in which psychotic patients relate. Because of a pressure in infancy to remain symbiotically joined with a parent this becomes the patient's primary manner of relating to others (Searles, 1951). Because of symbiosis in the therapeutic relationship, the therapist can sometimes come to feel threatened (Searles, 1971); we might also add that psychotic patients can be felt to be all-consuming in their attachment as McWilliams writes (1994). In describing the initial stages of love, Freud (1915) describes a love which seeks to devour the other in an attempt to deny separateness. Perhaps this is what occurs regarding the feeling described in this theme, the therapist feeling devoured indicates

the psychotic patient's desire to join with the therapist in a union that sees no separateness. Searles aptly describes that in response to this merged or symbiotic state in the patient, the therapist experiences a fear of losing oneself as a part-person in the relationship (Searles, 1971). In such a symbiosis, each participant may feel as if they are vulnerable to being lost in this union. Furthermore, the fear of being consumed could also be a fear of the patient's primarily oral-aggressive urges so present in Klein's formulation of the paranoid-schizoid position (Klein, 1935/1986; 1946/1986). In the example below we see a participant's perception of the voracity of the patient's consumption:

- P3: "You know babies when they want to open you up and they run to swallow you, that's what these guys do concretely, they internalise you."

Related to fear is the theme of anxiety. Anxiety was often discussed by participants in terms of infantile anxiety. Participants seemed to describe the type of anxiety that occurs in working with psychotic patients as being something primal and very basic to humans. They described the type of anxiety which Klein (1946/1986) first formalised in theory, the anxieties which are rife in the paranoid-schizoid position. In this developmental position on the paranoid-schizoid depressive continuum, the person fears being annihilated or persecuted. What the participants articulated in their responses was that in their work with psychotic patients, their own buried (repressed) paranoid-schizoid anxieties are given life and revived (Horowitz, 2002). As Rosenfeld (1987); Searles (1967); and Winnicott (1947) state, working with psychotic patients exposes the therapist to their own earliest conflicts and anxieties. It would seem that therapeutic work with those patients who are residing predominantly in the paranoid-schizoid position exposes the therapist to his or her own 'buried' (repressed) infantile anxieties – those of being destroyed or persecuted. The example below demonstrates this well:

- P6: "Um ja in that it's our *own primitive infantile anxieties* that they manage to hook, because that's where they're living, they're them they're it. We've repressed it, you need to, you need to be in touch with reality to survive and function, to um ja, for survival. So ja they hook what resides inside of us, and use very primitive defenses, like projective identification as well."

Interestingly we see the participants turning to theory to understand their responses. In such responses, one will find in close proximity to the use of the word 'primitive' other

theoretically laden terminology. The quoted example below demonstrates this proximity of theoretical language:

- P6: "Um ja in that it's our *own primitive infantile anxieties* that they manage to hook, because that's where they're living, they're them they're it. We've *repressed* it, you need to, you need to be in touch with reality to survive and function, to um ja, for survival. So ja they hook what resides inside of us, and use very *primitive defenses*, like *projective identification* as well."

This perhaps helps therapists understand, to digest, and contain their own frightening feelings and responses to the patient. We see therapists using the lexicon of psychoanalytic theory to help put words to and make sense of something which is felt in a way that is threatening to the therapist's equilibrium (Shulman, 2005). Searles describes having theory as part of one's armament against the patient's seemingly infectious psychotic thought processes, as a way to keep one's mind amidst the lunacy and chaos (Searles, 1971). Shulman (2005) proposes that therapists use psychodynamic theorizing in order to manage countertransference: "the theory holds the analyst, so that the analyst can hold the patient" (Shulman, 2005, p. 476). Perhaps this can offer us an explanation of the predominance of the participants reversion to theory within the interviews, but specifically around the topic of anxiety – as if it is hard to discuss the topic more experientially, perhaps particularly with psychotic patients. Many participants offered theoretical explanations of their countertransferential feelings, and perhaps this occurred as it is the process by which the participants are able to digest through theory and contain for themselves the difficult and uncomfortable feelings (Symington, 1996).

As the psychotic patient is considered as having a weak or ill-formed ego, a corollary of this is the assumption that the therapist's ego is better formed, more able of depressive position functioning (Klein, 1935/1986) and so in a way is 'stronger' than the patient's ego. This expresses a relationship between the two, and so the theme of power could be understood in terms of this. In the data the participants sometimes experienced themselves as doing something to the patient, as seen in the quote below:

- P5: "So it very painful to have to say to her, you are sick, it's not that your boyfriend is trying to abuse you and destroy you, you are actually vulnerable and are struggling. And when I would say that to her it was like this terribly painful wound that I was *inflicting on her*, so it was that like that sort sense of betrayal."

Searles (1966) describes an early state in the analytic treatment of psychotic patients as being a symbiosis between patient and analyst. In this state the therapist is exposed to his omnipotent strivings and feels responsible for all that transpires in the relationship, he explains that because of this state of being with the patient, all one's seemingly unacceptable feelings such as those of eroticism and anger towards the patient are felt to be crazy and foreign to the analyst where in fact these very feelings are the analyst's own feelings. These feelings are felt to be dangerous to the patient, as if the instance of their welling up may damage of annihilate the patient and so the analyst feels a great sense of guilt (Searles, 1966). Searles (1966) explains this as being guilt at the therapist's own sadistic feelings towards the patient. In the quote above, we get a sense of the participant's guilt as she describes having betrayed her patient. He also proposes that this feeling comes about because of the perception that the therapist has of the patient as being fragile and weak and so, easily damaged (Searles, 1966). This leads to such individuals being viewed as incapacitated and incapable of caring for themselves. We see in the quote below a participant expresses awareness of such a process:

- P2: "well I think because of the *incapacities* of psychotic patients they very often become *infantilised* and *disempowered*, through their own behaviours as well as the perceptions of others."

Strongly linked to the infantilism described above is another illuminating aspect of participants' responses which indicate their perception of the patient's ego as being frail: a perception of the patient's impaired capacity for responsibility. Some felt that psychotic patients do not possess the capacity to care for themselves, or to control behaviour and impulses which describes the perception of the patient's lack of accountability - that psychotic patients cannot be held responsible for inappropriate or socially unsanctioned behaviour. There is a sense that the patient is under the sway of the disorder and has little ability to control his or her impulses:

- P3 I think there is because, with psychotic patients you will find, if that thing was done by a borderline person, that thing will be labelled as manipulation. But with a psychotic patient there will always be that level of leniency, *he is psychotic he doesn't know what he is doing* – that's what I get.

Another explanation for this perception might be that the participants are splitting off their own angry or disapproving feelings towards the patient so that the therapist may maintain his

or her self-image as the caring 'dedicated physician' (Searles, 1967b). If the therapists were to acknowledge their anger or disgust at what a patient had done it may affect the therapist's ability to 'care' for the patient. In contrast to this, there were also examples where participants felt that the psychotic patient has some responsibility in the existence of his or her illness, this was linked to substance-induced psychosis and choosing a psychotic reality over what the therapist offers in a healthier relating in an objective and shared reality.

- P3: "Because you feel they did, they *brought it on themselves*, this is the *consequence*."

- P7: "Just purely *their contestation* of therapy, and what it means to them, and their denial of it in terms of a *defense against* the therapy and anything that might violate that reality would produce that same feeling of frustration in me."

Searles contentiously proposes that the patient needs to decide to become well, that there is a choice to remain within the gratifying confines of illness or to join the therapist in healthy relatedness (Searles, 1967b).

Because of this fragile quality, participants described a desire to nurture, protect and rescue such patients. Searles proposes that the therapist's wish or phantasy to rescue the patient is in actual fact located in the therapist's envy of the patient's freedom in psychosis (Searles, 1976b). In his paper *The "Dedicated Physician"* Searles explains the mechanism of how therapists are drawn to infantilizing patients and how the patients "tend to coerce these therapists into the ever-alluring role of the dedicated physician treating the supposedly weaker patient" (Searles, 1967b, p. 73). In this statement, the essence of various elements found in the analysis of participants' responses is found – we see how the patient can become infantilized by therapists and people in general, and how this can occur by the patient's coercion and alluring suggesting the patient has power in causing others to act in particular way. The use of words also is aligned with the magnetism theme found in the data, which demonstrated the therapist's pull to engage in some action such as rescuing the patient, a pull which is beyond their own control or which occurs despite their own resistance to it.

The pull to embracing an omnipotent and powerful role occurs because the patient transfers this role to the therapist, but underlying it is an introjected inadequate and weak parent figure (Searles, 1968). In other words, in the transference the patient requires of the therapist a powerful and omnipotent character, but what feeds this is in fact a sense of how weak and

powerless the object being transferred is - it is almost a compensatory mask for the inadequate role the therapist is being assigned. Another perspective regarding the therapist's pull to embrace omnipotence and power might be found in what Klein (1935/1986, 1940/1986) theorises about manic defenses. She would understand this to be a manic defense against the therapist's awareness of his or her own vulnerable and primitive parts - the adoption of a powerful role would be an omnipotent denial of the therapist's vulnerability and most base parts of the self. In the example below, the participant offers an explanation of what therapists can see in psychotic patients (primitive aspects) and offers a reason why this would be defended against. Seeing the patient as fragile and incapacitated defends the therapist from encountering their own most primitive aspects.

- P4: "primitive stuff is clear as day, um ja but I I think it's hard stuff and we all defend against it and it's hard to see people that are people that are very psychotic because we all have that potential in us and I think it's frightening to see that state of disintegration"

Furthermore there is a need within the therapist which seeks to see the patient as still incapacitated, infantilized and fragile as it preserves his own narcissistic infantile needs and lets him retain his image of the dedicated healer (Searles, 1967b).

In contrast to a feeling of omnipotence and power, participants also described feeling disempowered by the patient or the illness. If we understand the feelings of power and omnipotence as in fact being a phantasy on the part of the clinician as Searles (1967b) proposes, we see that in these instances the therapist meets with his or her own fallibility and the phantasy of being the 'dedicated physician' falls short. A different explanation of this disempowered feeling may lie in the illness being afforded power. The psychosis is experienced as embodying power over both the patient and the therapist, and so both are left disempowered in the face of a personified powerful psychosis:

- P1: "but the part of me that would like to feel like a useful clinician feels helpless with them being psychotic. Whilst they're psychotic."

Related to feelings of disempowerment, is a feeling that one is under the influence of something. This sense of being under the influence of a force or a person was expressed by participants as being pulled towards something - for instance an action, or the opposite: being

repulsed away. Here, the participant's description denotes a force out of her control, coercing her to something:

- P4: "but ja I suppose it was, what would the word be, *attractive*, there was a *pull towards it*."

These sorts of descriptions - of feeling magnetically pulled towards an action or repelled away in therapy with a psychotic patient - is experienced as something which is irresistible. This can perhaps be explained by projective identification which "fosters strong feelings of attraction and repulsion within the analytic relationship. Sometimes the analyst and patient may feel magnetically drawn to each other" (Geltner, 2005, p. 75).

Similarly some participants expressed a fascination in doing the work, a sentiment shared by Searles (1967b) who feels that he finds the schizophrenic aspects of a patient far more interesting than the healthier aspects. Some described enjoying the work, finding psychotic patients' antics and the patients themselves enjoyable and colourful. The image of the 'hobo' patient is a treasured one, as is the "colourfully acting out patient whose dramatic escapades gives vicarious excitement to our humdrum workday lives…beautifully personifies just how inspired and effective we…often privately feel ourselves to be" (Searles, 1968, p. 108). This enjoyment of psychotic patients may also be understood as the therapist taking some pleasure in occupying a regressed position themselves. In the example below, we see the therapist's enjoyment of the story-teller quality of a patient's account:

- P1: "I was *enchanted* by it in a way – it sort of had a *magical realism* to it, I don't know it was just lovely."

As psychotic patients exist predominantly in the paranoid-schizoid position this denotes a particular type of object-relations within the person (Klein, 1935/1986). The psychotic person's internal object world is constituted of introjected part objects (Klein, 1946/1986). Because the mechanisms of splitting and projection cannot be relinquished by the individual (as the persecutory anxiety is too overwhelming, which of course by clinging to these defenses paradoxically intensifies the anxiety) and so the individual is unable to integrate part objects into whole ones. This means that the psychotic individual's internal world is constituted of fragmented parts (Klein, 1946/1986). Searles offers us something in understanding the early experience of the psychotic individual, he hypothesises that early in the child's life, the child was pressured to remain joined in a symbiotic union with the parent

and so the psychotic individual has not 'known' individuation (Searles, 1951). In terms of the results, what this helps us understand is the phenomenon that participants experienced in terms of merging with the patient and the theme of agency which saw the participants articulating a sense that the patient can cause a feeling within the therapist. Searles (1967) proposes that the psychotic person aims to heal his objects within himself. Searles thinks that the psychotic individual is in a state of psychosis because he or she is trying to complement, to complete an un-whole parent of their childhood.

In other words the psychotic condition comes about because the child initially was trying to complete an incomplete (ill) parent and so in adulthood is stuck in this state where he or she continues to attempt to heal the introjected parent within him- or herself (the internal part objects). This can occur in the therapy context with the psychotic individual as well, where the person's primary manner of relating is through joining with the other in a symbiotic relationship. What occurs in therapy is reflective of that symbiotic union which develops and within it the patient attempts to 'do' something to the therapist:

- P6: "That's why *they can* also *make* you feel this, that's your countertransference."

Some participants experienced this merging as unpleasant and distressing, as is seen in the quote below:

- P7: "And I think that continual violation of boundaries of your more psychotic patients will *induce* that feeling of distress, of having your own feelings, your own sanity invaded and exposed"

Searles describes having had experiences of feeling like certain psychotic patients were literally inside of him (Searles, 1971). These patients have introjected vengeful identifications of others and so a 'weak ego' develops, as such these introjects or identifications are indigestible and so the weak ego attempts to expel them (Searles, 1971) and they 'land' in the therapist.

The therapist as the agent or cause of feelings in the therapy room, was a far less recurrent finding. In the instances where it was found, the therapist's capability to be the agent of a feeling in the patient seemed to be about the patient being fragile, there was a perception that the therapist's behaviour could induce a feeling in the patient, and this process would be out of the patient's control:

- P3: “But then you see when you become just as irrational and uncontained it exacerbates him, his like primitive defense”

Perhaps this could be understood as an omnipotent striving on the part of the therapist: that in the face of the patient’s fragile ego and psychosis the therapist has the power to affect something within the patient. In this state the therapist is exposed to his omnipotent strivings and feels responsible for all that transpires in the relationship, Searles (1966) explains that because of this state of being with the patient, all one’s seemingly unacceptable feelings such as those of eroticism and anger towards the patient are felt to be crazy and foreign to the analysts where in fact these very feelings are the analyst’s own feelings. These feelings are felt to be dangerous to the patient, as if the instance of their welling up may damage of annihilate the patient and so the analyst feels a great sense of guilt (Searles, 1966). This anxiety and disowning of the therapists own feelings may go some way to explaining the relative lack of descriptions in the data of the therapists’ agency in causing feeling in the room. This disowning was at one point experienced as confusion as to whom the feelings belong and where they have come from, as seen in the following quote:

- P4: “I mean thinking ‘what is this, is this how he is feeling, is it mine?’ but I think making that distinction you know is difficult because it can also be his intense fear that you’re feeling, which is common with psychotic patients.”

An important thrust of Searle’s work is that he contends that when the patient projects material, it is not projected into nothingness but that it will hook something within the therapist as there is always a reality basis to a distorted transference or projection (Searles, 1972). In other words, the situation is like that of a lock and key – the patient’s projections are based in some part of the therapist’s, often unconscious, reality and so will ‘hook’ the therapist because there is a degree of reality in the situation (Searles, Bisco, Coutu, & Scibetta, 1973). Searle’s describes the power of the patient’s intense negative transference to enlist our most painful and fundamental parts of our past, and so our superego (Searles, 1976).

As described above, in therapy with a psychotic patient a symbiotic merged relationship can develop. This is a result of the patient having little ego boundaries. In psychoanalytic literature the concept of a boundary has been central to many facets of various psychic structures. Particularly in regards to the development and presentation of psychosis,

formulations around boundaries have been useful. Winnicott (1949) writes that as an infant's ego develops so does it's sense of what is inside and outside, what is 'me' and 'not-me'. For the psychotic individual, this aspect of ego development is particularly weak. The psychotic person struggles with what is internal and what is external, often these parts of existence blur into one another creating and internal world which is not distinctly separate from anything. Being able to distinguish between reality and phantasy lies in the "capacity to distinguish perceptions from mental images, however intensely recalled" (Freud, 1916/1925, p.147). In another way, Freud (1916/1925) explains reality testing to encompass an ability to distinguish what is outside of oneself from what is within oneself. Given this lack of ego differentiation and difficulties in knowing what is separate from oneself, it seems likely that similar difficulties would manifest in the therapeutic dyad. As participants described, work with psychotic patients leads one to encounter 'boundary issues' on numerous levels. At a concrete level, participants described having physical boundaries intruded upon:

- P7: "My first psychotic patient in training sat in my lap and wouldn't get off. He hugged me, and he was all sweaty and vile, and it felt invasive and exploitative"

Another participant described a psychical intrusion:

- P6: "But there's something that they manage to *hook inside of you*, something that also *belongs to you.*"

This participant implies that the patient touches something which is already within you. Again, this is reminiscent of what Searles (1972) argues, that the patient's projection will affect the therapist only if there is an echo of the projection already located in the therapist's history. In other words, the patient's projection only 'lands' within the therapist because there is some reality to it (Searles et al., 1973). As such, these interactions can potentially reawaken in us our own pain from our own earliest histories (Searles, 1976). This may assist us in understanding the emergence of the theme which describes avoiding therapeutic work with psychotic patients. Because relating is difficult with psychotic patients (because they have poor object relations which are the model for relationships), it makes the work incredibly difficult. As one participant succinctly said in explanation for why therapists avoid the work:

- P6: "I think, countertransferentially it's not a place people want to go."

Therapists may avoid working with psychotic patients as an expression of defensiveness, that the craziness inherent in psychosis enlists the therapist's defenses and so such pathology makes it easier to distance oneself from the relationship. Searles might understand this as

being a result of the therapist having projected his diabolical self image of "hatred, his rejectingness [*sic*], his subjectively nonhuman unfeelingness" (Searles, 1967b, p. 80) onto the patient and thus unconsciously pushing the patient back into a state of autistic incomprehensibility and so making it 'easier' to consider the patient as being unreachable and therefore defensively kept at arm's length. In this instance, the therapist essentially is trying to reach but concurrently keeping at a distance those projected parts of him- or herself (Searles, 1967b). What may also provide a credible explanation of the quoted example is a simple explanation of fear being incited within the therapist and so a resultant action of distancing from the patient.

The concept of boundaries has a further impact upon the therapeutic relationship. Because the patient's need to merge is so strong, and it is their primary manner of existence, so the pull in therapy to collude is present. At the core of schizophrenia or psychosis, there is an attempt to join and complement an incomplete self, this explains the therapist's strong pull to join or collude with the patient (Searles, 1971). This can occur as a result of counteridentification with the patient, where the therapist avoids making the necessary reality-based intervention and instead joins with the patient in a particular stance (Feinsilver, 1997). In the examples below, we see how participants were pulled into colluding or merging with the patient:

- P5: "And I think sometimes my countertransference has pulled me into agreeing with the patient in a way that isn't helpful. And agreeing with the patient about her persecution."

- P7: "and you become symbolically like the really punitive harsh superego voices they hear in abundance."

Searles speaks of the therapist having to be open to seeing the world through the patient's eyes but still maintaining one's own reality so that one can slowly help the patient to "bridge the experiential gulf" (Searles, 1972, p. 204). He sees as indispensable the therapist capacity to be available to his own primitive experiencing so as to understand and work genuinely with the patient (Searles, 1975). This he also links to a feeling of great responsibility on the therapist's part which may cause the therapist to encounter feelings of omnipotent guilt. He also describes how such patients can help us to learn things about ourselves (Searles, 1972), a sentiment shared by one participant:

- P4: “useful because you get to look at your own primitive stuff, so yes useful for the patient, and the therapeutic relationship and what’s going on with them and also useful in your own development as a therapist.”

In order to help the psychotic patient integrate within him- or herself, the therapist must be able to recognise within him- or herself the capacity to fragment (Feinsilver, 1997). Further, this tendency comes about within the therapist often is in parallel with the same emergence in the patient (Feinsilver, 1997) and so this supports one participant’s view that often the therapist’s countertransference is a mirror or reflection of what is occurring in the therapeutic contact.

We turn now to discussing psychotic patients’ dysfunctional thought processes and how these are linked to countertransferential feelings. Psychotic patients have difficulty ordering experience and being able to make meaning of experiences; this often comes across in their thought disordered presentation (O’Shaughnessy, 1981). This facet of psychosis can be one of the elements which makes the therapeutic process (which is essentially one of making meaning) extremely challenging. In the data, some participants articulated a sense of becoming frustrated in the therapeutic process. It is hypothesised that perhaps this frustration is a response to the kind of dysfunctional, often incoherent way that psychotic patients present.

Frustration and anger were two feelings which were grouped together. Anger was sometimes a result of being frustrated but this was not always so. Frustration on the other hand comes about by a goal or a drive towards something being thwarted or frustrated. Often in the treatment of psychotic patients, therapists will experience frustration as the dividends of such work are meagre and often arduously won (Sutherland, as cited in Searles, 1965). One could hypothesise that because of the patient’s often incoherence and inability to make meaning (Bion, 1993) the task for the therapist is a mammoth one and one that must be hugely frustrating as it is difficult to make headway in the face of such incomprehensibility. One participant described working with psychotic patients as feeling as if you are banging your head against a wall.

- P7: “Um ja but definite frustration at the resistance, every client can be resistant but none more resistant than a psychotic client.”

The patient's resistance frustrates the therapist's efforts at trying to effect change. Feinsilver (1997) hypothesises that it is the transference-resistance and the therapist's subsequent identification with part of the patient which sees the therapist as frustrated. In other words, the therapist identifies with the hurt victim side of the patient, and so this externalises the responsibility and anger within the therapist. Searles further adds that the patient often sadistically enjoys seeing the therapist's vain attempts at rescuing the patient from his or her psychosis: "we tend to lose sight of the extent to which our patient is sadistically thwarting our efforts to help him, and sadistically enjoying watching us beat our dedicated heads and hearts against the cliff of his resistance" (1966, p. 31).

Looking at the patient's difficulties in organising experience can assist one to make sense of a feeling often encountered in the data, a feeling of disintegration: a feeling of one's sense of self being eroded away or disintegrating. As has often been stated in this chapter, being faced with the psychotic patient's developmental level, it can remind the clinician of his or her own previous developmental challenges and also can expose the clinician to their own vulnerability to be in a similar state (Horowitz, 2002). Feinsilver writes that the therapist has the capacity to fragment – "a tendency to get caught up in a particular kind of confusing, emotionally fragmenting dichotomising process within themselves" (Feinsilver, 1997, p. 248). This Searles likens to the state a psychotic person is in, he describes the panic that is often present within psychotic individuals as being "at a loss for reliable organising principles to render meaningful and manageable the chaotic perceptions which assail him" (Searles, 1967a, p. 6) and similarly the therapist can become assailed with confusion and a loss of an organising mechanism. The example below illustrate how the therapist's capacity to think becomes severely challenged, as if the psychotic processes in the patient also begins to confuse and muddle the therapist:

- P5: "Even now, I'm just reflecting on talking about it it's feels hard to get it into a sort of coherent narrative. Which is a little bit how it is for the patient, when they're in a psychotic state. To talk coherently about it is very hard."

Bion would understand the above as being an effect of the patient's barrage of unsettling and dismantling projections which interfere with the therapist's ability to think (O'Shaughnessy, 1981).

Most participants said that a feeling one has in work with psychotic patients is an anxiety that the therapist may lose his or her own mind. One participant actually described how a predecessor of hers had become psychotic. Searles as also shared this sentiment, he writes " [m]ore than once I have felt close to psychosis in trying to cope with intense and simultaneous feelings of rage, hurt, sexual desire, grief, and so on, which a deeply psychotic patient was arousing in me" (1968, p. 97). For Winnicott, "[d]isintegration means abandonment to impulses, uncontrolled because acting on their own; and, further, this conjures up the idea of similarly uncontrolled (because disassociated) impulses directed to himself" (1945, p. 155). This may help us to understand clinicians' fear of disintegration, a fear that the therapist may unravel into a state which is uncontrolled and unrestrained which may be damaging to the self (as well as the patient) – so much so that the therapist fears being lost to him- or herself. The therapist may encounter what is known as unthinkable anxiety or psychotic anxieties which involves feeling as if one may be going to pieces, falling forever, as having no relationship to the body or having no orientation (Winnicott, 1962). Winnicott proposes that in infancy, disintegration is in fact a defense against unthinkable anxieties. He explains that the individual will disintegrate into a chaotic state as a defense against psychotic anxieties because in disintegration there is a sense of omnipotent control – of choosing a way of being, whereas unthinkable anxieties are that which are feared as something which happens to the individual beyond any measure of control. Perhaps we can understand the participants' responses from this regard, that while the participants fear disintegration, underlying this fear is a fear which is fact unthinkable and unspeakable – the decent into psychosis proper where there is no knowledge of me, not-me, a state of unintegration (Winnicott, 1962).

As has been described earlier in this chapter, the psychotic individual can be understood to be delayed, halted or fixated in an early state of psychological development. Psychologically, the adult psychotic is the infant who struggled to grow into depressive position functioning and so has become pathologically positioned in an existence which is predominated by part-object relating, and the defenses of splitting and projection (Klein, 1946/1986). Because of splitting, emotions are experienced for example as being all-good or all-bad. Winnicott (1947) explains that the level of relational capacity that the psychotic individual is at is one where hate and love are simplistic concepts, but ones which are present in alternating abundance. He explains that it is only reasonable to expect that the therapist would encounter such polarities and feelings of force as one does in such work describes and that hate in the

countertransference in working with psychotic patients is inevitable. He warns that "however much he loves his patients he cannot avoid hating them and fearing them, and the better he knows this the less will hate and fear be the motives determining what he does to his patients" (Winnicott, 1947, p. 16). In the instance below the participant regrettably describes how her anger was enacted with words:

- P4: "And that day I didn't touch him, I just sat in the chair and I said do you know if you jump down there you'll probably just break your leg and we'll have to take you to Pretoria Academic and you're not going to die. And and then I said unless we tie your hands behind your back and aim you head first, then you might die. And I knew that it was **complete** acting out as I was doing it, but I think sometimes that's where it can become unbearable."

Winnicott writes further that when working particularly with psychotic patients, "the analyst is under the greater strain to keep his hate latent, and he can only do this by being thoroughly aware of it" (1947, p. 20). In the above quote we see the difficulty with keeping our own aggressive feelings latent and how sometimes it can "become unbearable" and we enact something.

The perception of the patient as having a stunted psychological development was saddening to some participants. In these instances, the participants' sadness may be an expression of guilt, of having been unable to help. Klein (1935/1986) would explain this sense of guilt as the therapist's depressive anxiety. Instead of being able to help the patient, the therapist feels as if they may have harmed the patient and so feels a sense of depressive guilt. Searles offers a different explanation for feelings of guilt within the therapist: he explains this as being guilt at the therapist's own sadistic feelings towards the patient. He also proposes that this feeling comes about because of the perception that the therapist has of the patient as being fragile and weak and so, easily damaged (Searles, 1966).

In the following example, we see how the patient's sadness affected the therapist's perceptual experience:

- P5: "as I was sitting in the room *the whole light of the room even changed to me*. It became this very cold, sort of grey, very *forlorn kind of place*, it was like perceptually the countertransference had like affected my perceptions and then I I wondered about

> him getting in touch with the sadness which was maybe the most real way he presented in all of the sessions in the time we had been together."

This participant described a perceivable change in her perceptual experiencing during a session, literally seeing the room darken. This in psychiatric nosology is known as an illusion which is a misperception or "distortion of real images or sensations" (Sadock & Sadock, 1994, p. 492). Searles describes a somatic expression of a countertransference feeling as if the air was being pulled from his lungs (1970). He writes "[t]ypically with the more deeply schizophrenic patients, one finds oneself experiencing bizarre fantasies and physical sensations unique to one's experience, peculiar to one's relationship with this particular patient" (Searles, 1970, p. 154).

Winnicott (1949) writes about the link between the psyche and the soma and given the psychotic patient's developmental level in terms of this duality, the experiencing of somatic countertransference by the therapist working with psychotic patients seems to be a probable experience – that a psychotic patient is in a way preoccupied with somatic sensation and so it would be likely that in interaction with a therapist that this mode of communication or shared relating would take a developmentally 'basic' form located in the body or perceptual experiencing. It is hypothesised that in the fascinating example presented above, the patient's developmental level sees him or her experiencing the world primarily through sensation and perception - through the soma, and so in the room with the therapist this would come to be a mode of understanding for the therapist too. Here, she understood his sadness by the changes she experienced in the changes in her perceptual phenomena.

As mentioned at the beginning of this section, emotions for psychotic patients, as a result of splitting, are often simpler, all or nothing emotions, emotions which are usually unambiguous in their presentation. Participants identified what distinguishes the emotional tone in therapy with psychotic patients as opposed to other populations was a marker of countertransference when working with psychotic individuals – the intensity of the feeling. These feelings were described as being stronger, more intense and also as being more frequent.

If we look to the mechanism of how these feelings are brought about in a therapist, projective identification may hold the key. As Klein (1946/1986) first noted, more disturbed patients make use of an excess of projective identification. A contemporary definition available in

current literature is: "[p]rojective identification arises when the patient is unable to tolerate a specific feeling (or fantasy or impulse), expunges it from his emotional experience, and induces it in the analyst" (Geltner, 2005, p. 73). The patient is now left feeling the direct opposite of the expelled feeling, while still remaining connected to the feeling within the relationship to the therapist and the projective identification is an attempt to deal with a particular intolerable feeling (Geltner, 2005). Projective identifications are experienced as being more primitive, simpler feelings – this being a result of the action of splitting (Geltner, 2005). While they lack complexity, they come with intensity and can often be felt as overwhelming (Geltner, 2005). With projective identification, the therapist can feel as if they have been invaded, as if something has been forced into the therapist but at the same time the "countertransference feels connected to something deep in the analyst's being, something very real" (2005, p. 75) and, as Geltner further explains, it is very easy for the therapist in this state to act on these feelings impulsively. Winnicott (1947) proposes that such 'blind' enactment is inevitable if the feelings remain unexamined, particularly hateful ones. Searles is a proponent for using one's countertransference in the therapeutic contact saying that his countertransference can be so distinct as to be a diagnostic indicator for him: "when I am left with such a feelings in *particular intensity* [italics added by present researcher], feelings that I am unworthy to be called a human being, I find this a reliable diagnostic criterion of schizophrenia in the patient" (1966, p. 34).

Conclusion

This research sough to explore and understand psychotherapists' countertransferential feeling in working with psychosis and how these feelings may impact on the patient and the therapeutic relationship. The results of this endeavour have shown that the participants in their work with psychotic patients experienced various, multi-levelled countertransference responses. Firstly, the results indicate basic feelings of fear; horror; anxiety; sadness; frustration and anger and a feeling of disintegration. Secondly, the participants described the quality or characteristics of the feelings themselves and were termed the 'meta-affective' themes by the researcher. In this category, descriptions of who produces a feeling in whom - the agency theme, and also descriptions of the quality of feeling - the intensity theme were found. The final level to these countertransferential experiences described aspects of the relationship between patient and therapist and how the feelings are involved in this; the themes herein include power, avoidance and boundaries. Within these levels of

countertransference experiencing, participants described instances where the feelings had affected the therapy, the patient and the therapeutic encounter.

These results are in accordance with the types of experiences and implications thereof as presented in the available literature but as authors on the subject explain (for example, Lysaker & Daroyanni, 2006; Schwartz, et al., 2007), these results are not generalizable as they represent a tiny sample of experience which is reflexively located in a particularly subjective subject matter (countertransference) and so is often reported in idiosyncratic case study reports (Liegner, 2003).

The results, being an indication of highly personal and idiosyncratic dynamics between therapist and psychotic patient, were viewed through the lens of psychoanalytic theorising. Participants' responses were understood through the theory which helps us to understand the advent and dynamics of psychosis. In essence, the discussion offers psychodynamic formulations of participants' experiences in an attempt to understand the mechanisms of the development of such responses. While there has been research exploring these phenomena written in other countries, to the author's knowledge, similar research has not taken place on South African shores. It is hope that this research might garner further interest in exploring countertransference reactions in the context of working in our South African context. For those already engaged in this work, this research may illuminate some aspect of their own practice they had not considered before or may alert them to future countertransference possibilities in the gambit of therapeutic contact. This research may also lead to a deepening reflexivity and acknowledgement and of therapists' own feelings and how these come into play in therapeutic contact. Furthermore, it is hoped that this research will assist those already working with psychotic patients in psychotherapy and may perhaps encourage others to take on such an endeavour.

Limitations

Interviewing psychotherapists offered a vast amount of rich and varied data. The interviews represent conversations about psychotherapy and the intricacies involved in this practice. As such, much data was found which was not aligned with the aims of this particular research project, and so due to the scope of this project had to be omitted.

A significant limitation of this project regards the type of practice available to clinicians working with this clinical population in South Africa. In the literature surrounding countertransferential reactions in working with psychotic patients (all originating in other countries), therapists have the opportunity to work in a significantly long-term manner with psychotic patients – many of the accounts are by psychoanalysts. In South Africa there seems to be very few psychotherapists engaging in long-term work with this clinical population, due to the socioeconomic and structural limitations of practice clinicians are faced with (for example, clinicians working in the hospital settings see patients for a limited amount of sessions and in terms of private practice, there are not many structures in place which could support the clinician wanting to do this sort of work). This population seems to be a severely underrepresented population in psychotherapy, with medication being the mainstay of treatment in South Africa. This aspect was a limiting factor for this research project as most of the therapists interviewed, had encountered their psychotic patients in hospital settings which are limited by the acute interventions offered therein. And as such, there was only one participant with the privilege and experience of treating the same psychotic patients over the course of many years. A further implication of this is the disjunction of looking to theorising and articles (which are based in long-term work with psychotic patients) to help us understand our unique South African experiences which occur in relatively brief-term settings.

Given the researcher's, and her supervisor's, own experience of working with psychotic patients, this research has had a particularly personal investment. The course of interviews and the aspects highlighted in the discussion section are likely to have been influenced by this personal interest. Furthermore, the topic of this research study finds its very location in the field of subjectivity. As such, the notion of subjectivity is pertinent in considering both the participants' perceptions as well as the researcher's analysis of these perceptions. It must also be noted that this research was biased in terms of its theoretical position; the research is

located firmly in a psychoanalytically oriented framework. Given the subject matter of this topic, and its highly idiosyncratic and personal investigation, it is likely that the researcher's own (unconscious) biases would have impacted on the literature drawn from and the aspects in the data focussed on.

Given that this research project was in essence asking therapists about their own personal feelings and experiences (something deeply personal to each person) the research may have benefited from having more than one interview with each participant – this would have given the participants time to consider and reflect on their feelings and responses between interviews. It is also likely, and understandable, that the participants may not have been entirely frank about their feelings and as such this would impact on the data collected. This seems to be a relative limitation as, with most qualitative and explorative research, the element of subjectivity and relative disclosure always come into play. Perhaps what is important to focus on is the rich information which the participants did choose to share. If nothing else, these interviews may have led to a deepening of acknowledgement of particular feeling states within the participants themselves.

Lastly, the small sample size in this study limits the generalisabilty of the findings but given the nature and aims of this research project this is not seen as a significant limitation but one that is often present in qualitative research which seeks to explore the rich and varied experiences of people.

Recommendations

Firstly, further study exploring therapeutic contact with psychotic patients in South Africa is greatly encouraged. It is hoped that this research may excite and encourage clinicians to embark in the work of seeing this clinical population in therapy, and furthermore to write up these experiences for publication. For those already engaged in working with psychotic patients in psychotherapy, this research may bring to awareness aspects of the clinical picture which may have been occluded from consciousness and may encourage therapists to unshroud their own 'unacceptable' feelings, opening up the platform to acknowledge and to think about what these feelings mean in the particular context of a particular therapy.

Secondly, it is recommended that a study of wider scope be conducted so that a fuller representation and report is possible in describing not only countertransferential experiences in working with these patients but a fuller account of therapeutic interaction generally with these patients may be afforded. Furthermore, more focussed research on countertransference in brief therapy with psychotic patients– focussing on the effects that the brief term work has on the therapist's feelings as well as the therapeutic relationship – would be beneficial to those who are working in time-limited contexts. Further research into countertransferential responses in other types of contexts would be beneficial to both patients and therapists, for example exploring countertransferential responses in nursing staff in psychiatric wards or countertransferential responses in group work with psychotic patients.

Lastly, given the seeming rarity of clinicians entering into therapeutic work with this population, it is hoped that clinicians and organisations may be encouraged in thinking about ways to therapeutically serve this patient population in our unique South African socioeconomic climate and healthcare system.

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Appendix A: Participant Information Sheet

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa
Tel: (011) 717-4500 Fax: (011) 717-4559

To Whom It May Concern,

My name is Wendy Cain, and I am conducting research for the partial fulfilment of my Clinical Masters Degree at the University of the Witwatersrand. This study will be exploring the nature of feelings which arise in therapist when working with psychotic patients. This study shall be exploring countertransference in relation to working with psychosis. I would like to explore therapists' countertransferential experiences in working with psychotic patients, and how this impacts on the therapeutic situation, in other words, what role countertransference plays in therapy and how it impacts upon therapy with psychotic patients.. In this regard, I would like to invite you to participate in this research study.

Participation in this research will entail being interviewed by myself, at a time and place that is convenient for you. The interview will last between thirty and ninety minutes. Participation is voluntary, and no person will be advantaged or disadvantaged in any way for choosing to participate or not participate in the study. With your permission this interview will be audio-recorded in order to ensure accuracy in recording and reporting responses, and so that direct quotes may be used in the research report to evidence findings. Your responses will be kept confidential, and no information that could identify you or identify you with your particular responses would be included in the research report. You will not be asked about confidential client information and are requested to protect such information, if any confidential client information does arise in the interviews it shall be protected in the research report. The audiotapes shall only be listened to by myself. Only myself and my research supervisor, Patrick Connolly, will have access to the transcriptions, and thus these will remain confidential. The interview material (audio-recordings and transcriptions) shall be kept in a secure and private place by myself, and shall be destroyed once the degree has been awarded and all publications finalised. You may refuse to answer any questions you would prefer not to, and you may choose to withdraw from the study at any point.

If you choose to participate in the study, I can be contacted telephonically at 082 335 4726 or via e-mail at wendy_cn@yahoo.com. If you chose to participate in this study, please fill in the details on the attached forms acknowledging your consent to be interviewed and your consent to be audio-recorded. If you would like to receive feedback (a summary of the research findings), please fill in your email address on the consent form.

Your participation in this study would be greatly appreciated. There are no direct benefits or risks predicted as a result of participating in this study.

Kind Regards
Wendy Cain.

_____

Appendix B: Consent Form (Interview)

I _____ consent to being interviewed by Wendy Cain for her study on exploring countertransference in working with psychosis. I understand that:

- Participation in this interview is voluntary.
- That I may refuse to answer any questions I would prefer not to.
- I may withdraw from the study at any time.
- No information that may identify me or identify me to my responses will be included in the research report, and my responses will remain confidential.
- Direct quotes may be used in the research report to evidence findings.
- I will not be asked about confidential client information and I shall protect such information, if any confidential client information does arise in the interviews it shall be protected in the research report.
- The results of this study may be published.
- There are no direct benefits or risks predicted as a result of participating in this study.

Signed _____

Date _____

If you would like to receive a summary of the research findings, please supply your email address below. Your email address will not be disclosed to anyone.

Email _____

Appendix C: Consent Form (Recording)

I _____ consent to my interview with Wendy Cain - for her study on the exploration of countertransference in working with psychosis - be audio-recorded. I understand that:

- The tapes shall not be heard by any person other than the researcher.
- Transcripts will not contain any identifying information.
- During processing, the transcripts shall only be seen by the researcher and her supervisor, Patrick Connolly.
- All audio-recordings will be destroyed after the degree is awarded and all publications are finalised.
- No identifying information will be used in the transcripts or the research report.
- At any point during the research process, I may refuse for recorded material (and direct quotes) to be included in the research report.

Signed _____

Date _____

Appendix D: Interview Schedule

This interview follows the format of a semi-structured interview. As such there are eight tentative questions, this will allow for greater exploration and probing during the interview.

1.) In terms of psychotic patients, could you describe the working experience have you had?
2.) How would you describe and understand psychosis?
3.) How do you treat psychotic patients therapeutically – what is your overall approach? Could you elaborate on what this therapeutic manner is composed of.
4.) What do you understand by the idea of countertransference?
5.) In your opinion, what feelings do psychotic patients induce in you that are distinct from feelings that are induced by patients who are not psychotic?
6.) How do you believe psychotic individuals produce these feelings in you?
7.) How do these feelings affect your behaviour in therapy?
8.) How do you see these feelings affecting the patient, the treatment relationship and the therapeutic process?

Appendix E: Medical Ethics Clearance Certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Miss Wendy Lee Cain

CLEARANCE CERTIFICATE	**M090433**
PROJECT	Psychotherapitsts' Perceptions of Counter-transference in Working with Psychotic Patients
INVESTIGATORS	Miss Wendy Lee Cain.
DEPARTMENT	Department of Psychology
DATE CONSIDERED	09.04.29
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 09.04.29 **CHAIRPERSON** .....
(Professor P E Cleaton Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : P Connolly

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

.....