

**AN EXPLORATION OF A PATIENT'S USE OF HERBODY
WITHIN THE TRANSFERENCE RELATIONSHIP IN
INTENSIVE PSYCHOTHERAPY TOWARDS ALLOWING
THOUGHTS TO BECOME THINKABLE**

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Paper ID: OO21405

**A thesis submitted in partial fulfilment of the requirements of the
University of East London in collaboration with the Tavistock and
Portman NHS Foundation Trust for the Professional Doctorate in
Psychoanalytic Child Psychotherapy**

July 2014

Abstract

The thesis is an exploration of a patient's use of her body in intensive psychoanalytic psychotherapy. The therapeutic encounter studied is between myself, a child and adolescent psychotherapist working in an NHS Child and Adolescent Mental Health Team, and a fifteen-year-old female diagnosed with depression. Pivotal sessions were examined: where significant shifts in the therapy were identified. These consisted of sessions where there was a transformation in anxiety; and the patient was able to verbalise what was otherwise being communicated in a bodily way.

The analysis of the data using grounded theory highlighted the importance of visual communication in the therapeutic encounter. The analysis indicated that vision is the receptive point for the beginning of the containment process. The analysis of the data also highlighted that when the patient is communicating intense primitive anxieties, the therapist needs to receive and process the anxieties at a bodily level, when the patient is, perhaps for the first time, coming into contact with the feelings from which they have dissociated.

The analysis of the data indicated that mirroring back emotional states that are congruent with those projected by the patient, makes the patient aware of themselves in terms of the effect they have on others. This suggests the importance of the therapist's non-verbal responses, which can be observed and introjected by the patient.

The study contributes to the understanding of bodily communication in the therapeutic exchange. It raises interesting technical issues about when the therapist should receive and hold the patient's projective identification at a bodily level and reflect back non-verbally that their communication has been received, and when to make a verbal interpretation. It also highlights the use of observation to gauge if the patient has been able to receive the therapist's communication at a bodily level.

Keywords: alpha-function, container-contained, thoughts becoming thinkable, bodily countertransference, persecutory evil eye, benign internal eye, mirror-mother, adhesive identification.

This thesis represents my research and original work. It cannot be attributed to any other persons.

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Glossary

Thoughts becoming thinkable

The title of the thesis is an exploration of a patient's use of her body within the transference relationship in intensive psychotherapy towards allowing thoughts to become thinkable. The concept of 'Thoughts becoming thinkable' as used in this study is a concept that Bion (1967) developed. He suggests that a thought is required for thinking about the self and one's own thinking processes: that the apparatus for thinking has to adapt itself for this purpose (Symington 1996 pp. 81-82).

Bion (1967) argues that:

'It is convenient to regard thinking as dependent on the successful outcome of two main mental developments. The first is the development of thoughts. They require an apparatus to cope with them. The second development therefore, is of the apparatus that I shall provisionally call thinking. I repeat-thinking has to be called into existence to cope with thoughts. It will be noted that this differs from any theory of thought as a product of thinking, in that thinking is a development forced on the psyche by the pressure of thoughts and not the other way round' (Bion 1967 pp. 110-111).

CHAPTER 1: INTRODUCTION

In this study I describe and explore how paying attention to the patient's use of the body in psychoanalytic psychotherapy might help the patient to transform anxiety in the transference and work towards thoughts becoming thinkable. I begin by introducing the aims of the research, and then describe the experiences that sparked my interest in this area and why I found this subject so fascinating. I go on to introduce the case and explain why this case had interested and perplexed the colleagues who had made the referral to me for an assessment for psychoanalytic psychotherapy. I present the literature review and indicate that not only is this an area of interest that is relevant to current therapeutic work with children, but also is an area that has not previously been studied in depth. I then give an overview of how I went about this study and what I found through the investigation. Finally, I consider the application of the new knowledge acquired through undertaking this study and its relevance to clinical practice in similar cases.

1.1 AIMS OF THE STUDY

The title identified in the proposal was: an exploration of a patient's use of her body within the transference relationship in intensive psychotherapy towards allowing thoughts to become thinkable.

The aim of the investigation was to explore how a fifteen-year-old female used her body in the transference relationship, the focus being upon primitive states of mind, where thoughts have not yet become thinkable. The investigation used clinical material from a single case study and attempted to look in detail at how the patient's anxiety was expressed through the body. A sample of sessions from the single case study was selected using the criterion that, at that particular junction in the therapy, the patient was in a primitive state of mind where their primary form of communication was bodily. The focus was upon the psychotherapist's technique and how the therapeutic process facilitates the emergence of thoughts becoming thinkable. Interactions between patient and therapist that hinder the emergence of thoughts were also examined. The patient's use of: eye contact, physical gestures, physical proximity, tone of voice and the therapist's countertransference were tracked in the analysis. The

therapist's verbal and non-verbal responses, along with those of the patient, particularly if the interaction facilitated the transformation of anxiety in the transference, were also examined.

1.2 INTRODUCTION TO THE CASE

In many ways the case considered in this study, a fifteen year old female, named Jane¹, was typical of cases referred by a General Practitioner to the Child and Adolescent Mental Health Team (CAMHS); a high achieving adolescent female with symptoms of depression. As would be standard practice, and in adherence to National Institute for Clinical Excellence (NICE) guidance for depression, she was prescribed medication and a course of Cognitive Behavioural Therapy (CBT). Whilst progress was noted, it was not sustained. My colleagues were perplexed by Jane. Why was a young woman with a relatively uncomplicated history suffering with severe depression that was resistant to treatment?

Jane was referred to me by a professor in child and adolescent psychiatry, who was both a clinician and a researcher, and whose research interest was adolescent depression with a focus upon CBT and medication. This was the first time that this professor had referred a case for psychoanalytic psychotherapy. Following her referral, Jane attended three assessment sessions to assess her suitability for this form of treatment. In the assessment sessions Jane quickly formed an intense relationship with me, such that I had to keep in mind that we were still at the assessment stage and were yet to begin a long term piece of work. It is worth noting that the clinical material from two of these assessment sessions is considered in the data analysis chapter. Jane was able to make use of interpretations in the sessions, and the assessment concluded that she might be able to make use of psychoanalytic psychotherapy.

1.3 RESEARCH INTEREST

I shall now describe how the seeds for my interest in this research were sown in my early career experiences of working with young children, and how this

¹ For the purposes of this study all names of the patient, her family and professionals are pseudonyms.

interest grew whilst I completed the training to be a child and adolescent psychotherapist.

When I worked with children under five in a social services setting I began to develop my interest in non-verbal communication. I noted how children, who had experienced abuse and or neglect, communicated to the staff, via their play or through non-verbal communication, that which could not be thought about. I shared some of my observations about the children I cared for in case discussions, initially my ideas about what was observed and not communicated in words were met with some resistance and scepticism from senior social work managers and they could not take such ideas seriously. However, as illustrated by the following example of my work with a four-year-old boy, my ideas were eventually shown to have value. This boy would freeze and make a high pitched whining noise when he fell over rather than seeking comfort from an adult. The boy's same response could be observed when returning him to the care of his mother, and following assessment by the social worker, it transpired that he was being physically abused. His mother was a frightening figure to him and this would explain his response: when needing comfort, the source of comfort was also a source of fear. He had powerfully communicated his feelings non-verbally, his terror and inability to move physically when in a frightened state. I felt the need for action on his behalf, to communicate to the professionals verbally something that he could not put into words. This case, amongst others, aroused my curiosity regarding non-verbal communication.

My interest in bodily communication was developed further by my experience on the psychoanalytic observational studies course, where I observed an infant for the first two years of her life on a weekly basis. I was struck by the way in which the infant communicates with the mother via movements of the body, eye contact and vocalisation. This experience enabled me to hone my observational skills, particularly my ability to be more aware of the subtle non-verbal dialogue that goes on between mothers and infants. This had a significant impact upon my thinking and my work with children and young people.

The clinical training in child and adolescent psychotherapy allowed me to develop further my thinking about bodily communication. Of particular note is a

meeting in 2006 of the trainee child and adolescent psychotherapists from the Northern School of Child and Adolescent Psychotherapy (NSCAP) and trainees from the Scottish Institute. Robin Anderson (2006) presented a paper entitled 'Adolescence and the Body Ego: The Reencountering of Primitive Mental Functioning in Adolescent Development'. His ideas about how the patient he described was not in contact with her feelings, but her feelings were communicated via her body, which became a metaphor for that which could not be expressed in any other way, resonated with my interest in this type of communication. I also discovered a paper written by the Italian analyst Lombardi (2008), which I found fascinating and made me want to explore bodily communication in the therapeutic encounter further. I was shocked that many psychoanalytic psychotherapists view non-verbal communication as peripheral. Needless to say, this is not a view that I hold, but I did note that British psychoanalytic psychotherapists had shown little interest, particularly in the use of the body in psychotherapy sessions. When considering the lack of interest on this topic, I began to reflect upon the reliance on verbal communication in therapy sessions at the exclusion of the body. My intensive case supervisor of this case was someone who was interested in bodily communication in the sessions and encouraged my growing interest in this area.

1.4 LITERATURE REVIEW

To ascertain what was already known about the use of the body in psychotherapy, I completed a search of the literature, which I found to be significantly less densely populated with conversations relating to the use of the body in the therapeutic encounter, in comparison to those discussing verbal communication. The themes considered in these discussions also appear, on initial examination, to be inhomogeneous and heterogeneous in terms of the diverse range of discussion threads contained in the literature.

Bringing together the literature on the mind-body debate, the use of the body in the therapeutic situation, and Bion's theory on thoughts becoming thinkable was a daunting task. It became apparent to me that the literature was disparate and hard to fit together. Much of the current literature is written by Italian, French and North American psychoanalytic psychotherapists and relates to adult

patients. Lemma (2010) suggests that these psychotherapists:

have all tackled the mind-body question more vigorously and they appear more attuned to the body in the therapeutic situation (Lemma 2010 p. 11).

I started by exploring the debate, which stems back to the philosopher Descartes, about the relationship between the mind and body. My interest is in the therapeutic encounter and the use of the body in the transference, particularly the gazing relationship and bodily movement. Relevant psychoanalytic literature is sparse. I found that ideas relating to the body were in the primary Kleinian psychoanalytic texts, but these ideas had to be extrapolated and made more explicit. Klein's (1931) and Isaac's (1948) view of the role of the body, with its roots in unconscious phantasy, and Segal's (1957) ideas about symbolisation in relation to thoughts becoming thinkable were considered. The concept of thoughts becoming thinkable, developed by Bion (1962), was also explored. His ideas on the subject are comprehensive and extensive.

1.5 METHODOLOGY

The methodology questions considered when conducting this study are reviewed in this section, along with the grounded theory method used to examine the process notes that provide the clinical material for this study. The potential to use methods other than grounded theory was considered, and the rationale for choosing grounded theory discussed. I describe how I started with grounded theory which proved useful up to and including the coding process but how the focused coding and the overall conceptual framework analysing the data was beyond the scope of grounded theory and into the realm of thematic analysis.

The factors leading to the decision to conduct a single case study are examined, these factors include the availability of clinical data and ethical approval to use that data. The clinical material that made up the data was gathered in routine clinical practice, and the methodology chosen needed to allow me to access, in the clinical material, the patient's use of the body within the transference. Issues of reliability, validity and generalisation in relation to

the single case study were considered to ensure the robustness of this study and its findings. Ethical considerations are also presented in this section.

1.6 PRESENTATION OF DATA

The presentation of data section gives examples of how the initial coding emerged from the data. In accordance with recommended grounded theory practice, the data is presented chronologically.

The clinical material is presented, some of which is in the form of substantial accounts of what was happening in a session, so as to allow the reader to form their own conclusions. I wanted to give the reader an experience of the essence of the therapy. What are considered pivotal sessions, drawn from the 18 coded sessions, are presented to illustrate the transformation of anxiety in the transference and how interactions through bodily communication were linked to thoughts becoming thinkable. In this section, I also illustrate how, using constant comparison across the clinical material, I was able to develop my ideas.

1.7 DATA ANALYSIS

In this section, the conceptual framework developed in the data presentation section is explored, bringing together what was already known in the literature with what emerged from the clinical data using grounded theory. I began to draw out from the clinical data where Jane was using non-verbal adhesive mirroring to avoid separation. Instances were identified where the clinical material suggested there was: incongruence between Jane's presentation and my expectation; incongruence in the transference; and incongruence in visual and verbal communication. The data analysis section provides a consideration of: communication through eye and bodily movement, the bodily countertransference and the development of a three dimensional internal space in the patient to think thoughts.

1.8 CONCLUSION

A summary of the findings that emerged from the analysis is presented. My findings illuminate aspects of the therapeutic exchange that facilitated thoughts

to become thinkable, including the need to pay attention to visual communication in the clinical encounter. I also consider the importance of receiving, holding and naming the patient's negative feelings, at a bodily level in the first instance, moving towards naming them and thinking about them in the therapeutic encounter.

Technical and clinical issues arising from my research findings for child psychotherapy practice are examined. Areas are identified that would benefit from further exploration with similar cases and discussion with psychoanalytic psychotherapy colleagues. My interest is in developing psychoanalytic technique, by thinking with my colleagues about the technical issues of working at different levels, bodily and non-verbally as well as verbally, with the patient.

The application of the new knowledge acquired through undertaking this study, and its relevance to clinical practice in similar cases, is highlighted, including the need to pay attention to visual communication in the clinical encounter. Noting the need to pay attention to visual communication, one of my conclusions on critiquing the methodology is that consideration should be given to using video recording for research in child and adolescent psychotherapy so as to capture the data on non-verbal communication occurring in the therapeutic encounter.

In the conclusion, I note my interest in further research into the bodily countertransference and its links to primitive states of mind, and also about the links between psychoanalytic theory and neuroscience.

In the next chapter, I will review the psychoanalytic literature related to the different aspects of my study, including: the mind-body debate, the patient's bodily experience, unconscious phantasy and symbolisation, and Bion's theory on thinking.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This thesis considers the patient's use of her body within the transference relationship in intensive psychotherapy towards allowing thoughts to become thinkable. The literature review will be presented in four sections: the mind-body debate; the patient's bodily experience; unconscious phantasy and symbolisation; and finally, thoughts becoming thinkable.

For the purpose of this study the literature on adolescence was not included. The focus of the study was on primitive states of mind, where thoughts had not yet become thinkable and the main form of communication was bodily. The focus was not on adolescence as a particular developmental stage, this was beyond the scope of the study. Whilst adolescence is a period of development that is characterised by changes of the body and mind, in the therapeutic encounter the adolescent sexual body came into focus towards the end of the therapy when the patient was able to engage in a verbal dialogue. The aim of this study was to explore the non-verbal communication where thoughts had yet to become thinkable.

2.1.1. Mind-body debate

In the section on the mind-body debate, the philosophical discussion on the mind-body is briefly outlined, contrasting the Cartesian dualist and the monist views on the mind-body. The psychoanalytic views on the mind-body, commencing with Freud's (1923) ideas that the body ego is the first ego, are explored. Winnicott's (1948) ideas about the psyche-soma, and how these are inseparable, are then examined.

Bick's (1968) view that there is a period of primary unintegration, where the skin acts as primary container, is considered, alongside the counterargument presented by O'Shaughnessy (2006) and Alvarez (2006) that the infant is object-related from birth and that unintegrated states are a defence against disintegration. Anzieu's (1990) theories about the skin ego as the first ego are examined along with Bick's (1968) ideas on adhesive identification.

2.1.2. The patient's bodily experience

In the section entitled the patient's bodily experience, Stern's (1985) definition of interpersonal non-verbal relationships, which is seen as of primary importance for this research, is discussed. Stern emphasises the communication that is carried in the tone of voice, gaze and manner of movement. In relation to the patient's bodily experience, the current literature on the early gazing relationship and the postural model of the body are reviewed. Literature on the voice is outside the scope of this study and has not been included.

The gazing relationship is explored, drawing upon literature from psychoanalytic psychotherapy and relevant literature from child development research and neuroscience. Literature relating to gaze and attunement; gaze and the mirroring relationship between mother and infant; gaze in relation to an ego-destructive superego; and gaze related to being seen and being watched is explored. The limited literature on the gaze in the transference is also explored.

I consider the literature on the postural models of the body: how a sense of self is built up through movement. I discuss body movements as a pre-verbal language (Anzieu 1990). I also look at the literature on the use of body movement in the transference. Bloom's (2006) ideas about how movement can be used to access primitive states of mind are discussed.

I briefly outline the development of the transference and countertransference in psychoanalytic psychotherapy, noting the current definition of the transference and countertransference. The literature on the patient's use of his/her body in the transference relationship and the bodily countertransference is considered. The literature relating to how bodily sensations in the therapist can be used to help to translate psychophysical experiences into words is discussed. Relevant neuroscience literature that suggests that the transference and countertransference are bodily based is also reviewed.

2.1.3. Unconscious phantasy and symbolisation

In this section Klein's (1931) view on the role of the body with its roots in unconscious phantasy is considered along with Isaacs's (1948) ideas that unconscious phantasies are in the first instance bodily sensations.

Segal's (1957) ideas about symbolisation, in relation to thoughts becoming thinkable, are also explored.

2.1.4. Bion: thoughts becoming thinkable

In this section, relevant aspects of Bion's theory on thinking are presented, starting with his ideas about proto-mental systems and then moving on to explore his concepts: container-contained, projective identification, alpha-functioning and his ideas about the contact-barrier.

2.2 THE MIND-BODY DEBATE

The relationship between the mind and body has been widely debated in philosophy. Descartes (1644) was one of the first philosophers in the modern western world to address this question. A dualist view, as defended by Descartes, is that the mind is different from the body in which it resides. Descartes uses the term 'Cartesian dualism' to describe a view that consciousness resides within the realm of thoughts, in contrast to the realm of material thinking (the realm of extension). He suggests that the mind exerts control over the brain via the pineal gland. The neuroscientist Damasio (1994; 1999), however, discounts the dualist view. Damasio identifies an interconnection between brain and body. He suggests that:

the comprehensive understanding of the human mind requires an organismic perspective; that not only must the mind move from a nonphysical cogitum to the realm of biological tissue, but it must also be related to a whole organism possessed of integrated body proper and brain and fully interactive with the physical and social environment (Damasio 1994 p. 252).

The monist view is that, in reality, the mind and body are just one subject. Monist materialists believe that they are both matter and mind, at one and the same time. Many modern philosophers maintain that the mind is not separate from the body (Kim 1995).

Noting the philosophical debate on the mind-body, the different views on the mind-body in psychoanalytic literature are explored, namely Freud's (1923) view that the body ego is the first ego, Winnicott's (1948) view of the psyche-soma, and Bick's (1964) view of the skin as a primary container.

2.2.1. Freud

Freud developed his theories from working with adults. He devised the free association method, where the patient uses a couch and no visual contact is made during the analytic session; the body is not seen as a primary mode of communication with the analyst. It is suggested that Freud comments that he sat behind the patient where he would not meet their gaze, because he would find the gaze of the patient difficult to tolerate (Ross 1999). However, Freud does note how the body can communicate to the analyst something that may not be expressed verbally by the patient:

He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his fingertips; betrayal oozes out of him at every pore (Freud 1905e pp. 77-78).

Freud also explores the relationship between the mind and body. He suggests that the ego is 'first and foremost a bodily ego' (Freud 1923 p. 26). Freud derived meaning from a range of physical symptoms in his treatment of patients with physical symptoms of conversion hysteria. This led him to suggest that a change in thinking could bring about a change in the physical symptoms (Freud 1923).

Lemma (2010) states that Freud believed that the 'most primitive form of self-representation is first and foremost a bodily representation, deriving from proprioception and the experiences of pain and pleasure' (Lemma 2010 p. 10). Proprioception is the sense that informs the current position, speed and movement of the body derived from muscular and articular sources and tendons. Freud seems to be drawing our attention to how our bodily representation is linked to sensations and movement of the body.

Freud cites in a footnote in the "Id and the ego" that the ego is 'ultimately derived from bodily sensations, chiefly from those springing from the surface of the body' (Freud 1923 p. 26). He suggests that the ego's 'structure and identity' are based upon bodily sensations and awareness of the body, but little is known about 'these bodily sensations and feelings, those belonging to pleasure-unpleasure'. Freud suggests that they are 'more primordial than perceptions arising externally and they can come about even when more elementary consciousness is clouded' (Freud 1923 p. 22).

Sletvold (2013) links Freud's idea with Damasio's term 'primordial feelings', which he describes as 'the feeling state that I regard as simultaneous foundation of mind and self' (Damasio 2010 p. 256). The 'primordial feelings' describe 'the current state of the body along varied dimensions, for example, along the scale that ranges from pleasure to pain' (Damasio 2010 p. 21).

Lemma (2010) argues that the mother helps the infant to bring together the 'otherwise disorganised sensory experiences', suggesting that 'these early physical and sensory experiences with others are inscribed somatically and lay the foundation for the development of the body self, and hence sense of self' (Lemma 2010 p. 6).

Freud saw the drives as being located in the body. He argues that the drives are 'the psychical representative of the stimuli originating from within the organism and reaching the mind'. He also states that the 'the drive is a measure of the demands made upon the mind for work in consequence of its connection to the body' (Freud 1915c p. 122).

Green (1998) highlights that Freud informs us of a double process: firstly, the transformation of the stimuli born in the body and reaching the mind, changing themselves from somatic excitation to psychic representation, and secondly, the work imposed on the mind in aiming to change the situation of frustration in the communicating of his representations to others (Green 1998).

Freud views the body as the container and foundation of the sense of self; this view was developed by others (Winnicott 1962; Haag 1985; Kruger 1989 and Bloom 2006). Lemma (2010) argues that understanding the patient's experience of the body self is imperative to understanding the psychic structures (Lemma 2010 p. 10).

Whilst it could be argued that the body is central to Freud's theories, he did not choose to develop his ideas further. In a letter to Ferenczi, he comments:

I would like to decline your second question as to how you should interpret the sentence that the conscious ego is above all a body ego. The generic meaning is certainly clear, and I would not like to touch the indefiniteness further (Freud 1923 p. 116).

Freud believed that the body ego is the first ego. Others suggest that the body and the mind are inseparable, and the body is not just the non-mental aspects of the self (Grotstein 1997; Winnicott 1949; Sansone 2002 and Bloom 2006).

Grotstein states:

I believe that the mindbody constitutes a single, holistic entity, one that we can think about and believe that we can imaginatively experience as being separate but that is mockingly nonseparate all the while...I believe that psychoanalytic investigation demonstrates that the "body" is not merely non-"mental" or nonpsychical aspect of the self; rather it is the "mind's" "alter-ego" or second self, one that speaks in its own private language, but is always part of the "Siamese twinship" (dual track) with its alter. That is, the mindbody is always one but seems to be two! (Grotstein 1997 p. 204).

2.2.2. Winnicott

Winnicott differs from Freud on the place of, and emphasis on the role of, the mother in the infant's ego development. Winnicott worked as a paediatrician and then as a psychoanalyst from the 1930s. His ideas are based on his clinical experience. He observed mother and infant interactions in the consulting room which led him to emphasise the importance of the interactions between mothers and their infants in the development of a healthy ego.

In his paper "Mind and its relation to the psyche-soma", Winnicott suggests that healthy early development of the psyche-soma requires a 'continuity of being' where initially there is a need for a 'perfect environment' (Winnicott 1949 p. 245). Winnicott (1960) refers to a 'holding' stage of maternal care, where physical holding, including handling, bathing and rocking, is an instinctual experience, which helps the infant to pull together the personality from within. The mother-infant relationship provides the first context for experiences of touch or 'handling'. This stage is 'associated with the attainment of the infant's psychosomatic existence'. Winnicott refers to this as the 'psyche indwelling in the soma' (Winnicott 1960 p. 45).

Winnicott (1962) is drawing upon Heidegger's (1927) idea of a psychic 'indwelling'. He defines the indwelling as 'the achievement of a close and easy relationship between the psyche and the body, and body functioning' (Winnicott 1962 p. 68).

Winnicott suggests that:

The basis for this indwelling is a linkage of motor and sensory, and functional experiences with the infant's new state of being a person. As a further development there comes into existence what might be called a limiting membrane, which to some extent (in health) is equated with the surface of the skin, and has a position between the infant's "me" and his "not me". So the infant comes to have an inside and out, and a body scheme (Winnicott 1960 p. 45).

Winnicott suggests that any separation in the psyche and the soma is a choice of perspective rather than inherently within the individual:

Here is a body, and the psyche and the soma are not to be distinguished except according to the direction from which one is looking. One can look at the developing body or at the developing psyche. I suppose the word psyche here means the imaginative elaboration of somatic parts, feelings, and functions, that is, of physical aliveness. We know that this imaginative elaboration is dependent on the existence and the healthy functioning of the brain, especially certain parts of it. The psyche is not, however, felt by the individual to be localized in the brain, or indeed to be localized anywhere (Winnicott 1949 p. 244).

Winnicott (1967) suggests that the psyche-soma in health are an inseparable unity; a split between them is the basis of disturbance:

psycho-somatic disease is sometimes little more than a stressing of the psycho-somatic link in face of a danger of a breaking of the link; this breaking of the link results in various clinical states which receive the name "depersonalisation (Winnicott 1963 p. 224).

Winnicott emphasises the unintegration of the early ego whereas Klein suggests the early ego lacks cohesion and moves between a tendency towards integration and a tendency towards disintegration. She draws upon Freud's ideas about projection, as an outward deflection of the death instinct. Klein suggests that it is the individual's defence against anxiety 'by ridding it of danger and badness' (Klein 1946 p. 6). She uses the term projective identification to describe the splitting off of destructive parts of the ego and the projecting of them into the mother. The destructive parts of the self intend to injure and control the object; consequently, the mother contains the intolerable aspects of the infant. Excessive splitting off of parts of the self and expelling them weakens the ego.

Bloom (2006) highlights the psychophysical effects of splitting and projective identification; she notes that projective identification could be an attempt to rid

oneself of contact with both body and mind. Bloom (2006) draws a parallel to splitting of the mind and body, where the patient cuts off painful feelings and thoughts. This is a defensive type of splitting: 'the infant exists in a disembodied mental space, quite dissociated from uncomfortable, perhaps unbearable, physical sensations' (Bloom 2006 p. 50). Bloom suggests that the infant may disengage from experiences in order to keep unbearable feelings at bay. Schore (2001) suggests that underneath dissociation is hyper arousal, but it is 'anaesthetized' or 'numbed' (Schore 2001).

In the next section, I will present Bick's (1964;1968) argument that at birth infants have a period of passive un-integration. I will go on to examine the suggestion of others that a phase of passive un-integration is not the infant's first stage; rather, passive states of mind are the patient's defence against disintegration (Alvarez 2006; O'Shaughnessy 2006; Waddell 2006).

2.2.3. The skin as a primary body container

Esther Bick's seminal 1968 paper on the containing function of the skin in the early relationship between mother and infant identifies a stage in development when parts of the self have no cohesion:

in its most primitive form the parts of the personality are felt to have no binding forces amongst themselves and must therefore be held together in a way that is experienced by them passively, by the skin functioning as a boundary. But this internal function of containing the parts of the self is dependent initially on the introjection of an external object, experienced as capable of fulfilling this function. Later, identification with this function of the object supersedes the unintegrated state and gives rise to the fantasy of internal and external space (Bick 1968 p. 484).

Bick (1968) suggests that, until 'the containing functions have been introjected, the concept of a space within the self cannot arise. Introjection, i.e. construction of an object in an internal space, is therefore impaired. In its absence, the function of projective identification will necessarily continue unabated, and all the confusion of identity attending to it will be manifest' (Bick 1968 p. 187). She suggests that we are 'dealing with the situations conducive to catastrophic anxieties in the un-integrated states, as compared with the more limited and specific persecutory and depressive ones' (Bick 1968 p. 187). The need for a

containing object in the infantile un-integrated state brings about a:

frantic search for an object-a light, a voice, a smell, or other sensual object- which can hold the attention and thereby be experienced, momentarily at least, as holding the parts of the personality together. The optimal object is the nipple in the mouth, together with the holding and talking and familiar smelling mother (Bick 1968 p. 199).

Mitrani (2001) suggests that 'the external object' that Bick refers to, might be thought of as a complex undifferentiated object, composed of experiences of continuous interactions between a physically and emotionally holding and mentally containing mother, and the surface of the infant's body as a sensory organ. Lemma (2010) argues that Bick identifies that the 'central organising function of skin sensations – that is, that the actual sensations act as a primary bodily container' (Lemma 2010 p. 161).

Klein (1946) suggests that infants from birth are object-related where introjection and projection are in operation. Klein suggests that introjection of good objects is also a defence against anxiety:

Introjection of good experiences, firstly the mother's breast, safely located inside is a precondition for the development of an internal sense of goodness and mental stability (Klein 1946 p. 9).

Alvarez (2006) agrees with Klein that infants are object-related from birth. She questions Bick's view of a phase of primary unintegration. She also challenges Bick's view that 'in its most primitive form the parts of the personality are felt to have no binding forces amongst themselves' (Bick 1968 p. 484). Alvarez also disagrees that the containing function comes from an external object. She suggests that:

Some babies, probably most babies, are born with a great deal of inner cohesiveness and solidarity. But all babies have their limits, and surely levels of integration fluctuate through the course of even the most solid baby's day (Alvarez 2006 p. 167).

Alvarez (2006) puts forward the idea of a hierarchy of preconditions which she links with Bick's idea of necessary preconditions, without agreeing to a total developmental phase of primary unintegration. She agrees with Bick's idea that 'only then (when the external object's containing function has been identified with) the stage is set, without accepting unintegration as a primary phase' (Alvarez 2006 p. 167).

O'Shaughnessy (2006) argues that Bick's phase of passive unintegration is not a normal phase, but a response to early trauma. She suggests that the infant uses the skin as a means to survive and not disintegrate.

The French analyst Anzieu (1990) develops Bick's ideas. He focuses upon the role of touch and the skin, suggesting that the ego is primarily a 'skin ego'. He argues that the baby develops a perception of bodily surface through the skin-to-skin contact with the mother as she is caring for him/her. Anzieu (1990) suggests the 'skin ego' is:

a mental image of which the ego of the child makes use during the early phase of its development to represent itself as an ego containing psychical contents, on the basis of its experience of the surface of the body (Anzieu 1989 p. 40).

He suggests that through being fed and cared for the infant begins to develop a perception of bodily surface. Anzieu highlights the importance of being physically held in the mother's arms and physical care including washing, dressing and caressing that is alongside the experience of being fed. He describes how the mother and infant have a 'common skin' which necessarily has an adhesive quality, not as a substitute for a containing object, as Bick (1968) suggests, but an important part of internalisation and identification with an aspect of the mother that supports the baby's physical and psychical development (Anzieu 1989).

Anzieu suggests the 'skin ego' acts as a screen that gives protection from excessive excitation and filters the first communication (Anzieu 1990 p. 65). If all is going well, the 'skin ego' provides the infant with a sense of security.

Bick (1968) suggests that, if the containing object has not been established, the infant will develop a method of holding himself/herself together that avoids the need for the passive experience of the object:

Disturbance of the primal skin function can lead to development of a 'second skin' formation through which dependence on the object is replaced by a pseudo-independence, by the inappropriate use of certain mental functions, or perhaps innate talents, for the purpose of creating a substitute for this skin container (Bick 1968 p. 484).

Using the term adhesive identification, Bick (1968) describes a phantasy of sticking to an object rather than projecting into an object. If the infant has not

developed a sense of an internal or external space, the consequence is that the relationship to the object is two-dimensional, and there is a lack of internal space.

If infants have failed to introject a psychic skin or an object capable of mentally containing emotional experiences, Tustin (1990) argues that the infant can become over-reliant upon bodily continuity with the mother. Tustin (1986; 1990) believes that babies who have experienced absence of mind, and who have to make do with the mother's physical presence, rely on the sensations of the mother's skin, touch, milk, smell, taste and sight to hold themselves intact when mental containment and emotional contact are critically deficient or absent. Consequently, the baby then becomes overtly reliant upon the bodily contact.

When the object is unable or unwilling to receive, to make sense of and to reflect the baby's own internal state, or when the object projects her own internal state onto the infant, Mitrani (1994) suggests that intentional states will not be symbolically bound and the developmental basis of the self-structure will be absent. The weakening of the self-image leaves the child with affective and perceptual happenings that remain nameless, confusing and frightening. Bion (1962) calls this unmetabolised or uncontained. Others call this unmentalised (Mitrani 1994).

Mitrani (1998) makes reference to children who have sensation-dominated delusions. She suggests this serves as a distraction away from unbearable terrors, providing an illusion of safety, strength and impermeability, or there may be a numbing or tranquillising effect on the individual that blocks out unthinkable agonies. Sensation-dominated delusions serve as protectors against unmanageable states of unintegration and disintegration, of non-being and madness, equated with the fear of breakdown (Mitrani 1998).

Winnicott (1974) considers that the breakdown, a failure of a defensive organisation, suggests that 'primitive agony', the agony of 'unintegration, of falling endlessly, of loss or failure of psychosomatic integrity, of the loss of the sense of being, and the capacity to connect with the object. He argues that, if this occurs too near the beginning of the patient's life and at the moment when the necessary environmental supports were either deficient or altogether

missing, the experience of the 'primitive agony' is impossible for the infant to process (Winnicott 1974).

McDougall (1989) makes a similar point; she suggests that an experience of intense, unprocessed raw feelings towards the primary object can lead to an eruption of psychosomatic illness. She suggests that this experience is often charged with a sense of danger, as the hated object is also felt to be needed for the subject's own physical and emotional survival. This anxiety of disintegration is experienced as belonging to both the emotional and physical realms. The object is then experienced not only as somebody who lacks the capacity to contain the patient's anxiety but as the one who is triggering it (McDougal 1989 p. 189).

In this section I have explored the debate about the mind and body relationship from a number of different perspectives. In the next section I will consider the literature relating to the patient's use of the body, including visual communication, the postural model of the body and the use of the body in the transference and countertransference.

2.3 THE PATIENT'S BODILY EXPERIENCES

In this section I use Stern's (1985) definition of non-verbal communication, which emphasises what is carried in the tone of voice, gaze and manner of movement. I review the psychoanalytic literature on the early gazing relationship along with the literature on bodily movement; this literature is sparse.

Ogden et al. (2006) argue that the patient's embodied self is viewed as peripheral to traditional therapeutic formulations, treatment plans and interventions. Bloom (2006) defines the embodied self as the integration of mind, body, feelings, internal and external world. Ogden et al (2006) suggests that:

The majority of human communication is not through verbal language but through body language; facial expression, eye contact, movement, behaviour, posture, autonomic arousal, gestures, muscular tension, and so forth. In other words, the meaning and interpretation of each conversation that we have with another human being is built on observing, inferring, compiling, and making meaning of the other person's body movement, posture, and expression and much of how we

communicate in response is through our body reactions to the other (Ogden, Minton and Pain 2006 p. xxxiii).

Psychoanalytic literature has paid little attention to the visual communication between patient and therapist. This is not surprising; in psychoanalysis many patients lie on a couch where eye contact is not maintained, and the emphasis is upon words and free association.

2.3.1. Mother-infant gazing relationship

Lemma (2010) highlights the importance of the early gazing relationship and the skin-to-skin contact. She suggests that ideas about the body should be firmly located in the external world. Looking and touching carries the mother's loving feelings towards her baby. However:

when they are absent, or in short supply, or if looking and touching are laced with hatred, possessiveness or envy, then the body self may feel neglected, shamed or intruded upon. These early physical and sensory experiences with others are inscribed somatically and lay the foundations for the development of the body self and hence of the self (Lemma 2010 p. 6).

When there are difficulties in the early gaze-touch relationship, it can be impossible to feel at home in one's own body, or indeed feel that the body is one's own (Lemma 2010; Krueger 2004).

Sansone (2007) highlights the importance of eye contact in the attunement between mother and infant. He suggests that the pupil of the eye operates as a tool of non-verbal communication:

When the baby looks at his or her caregiver and sees dilated pupils, the baby receives information that the caregiver's sympathetic nervous system is aroused, and is experiencing pleasure. In response, the baby's own nervous system becomes pleasurable aroused and the heart rate increases. This is biochemical attunement between caregiver and baby (Sansone 2007p. 115).

Schore (1994) suggests that, in infancy, eye contact and smiles help to grow the brain. He states that gazing is vital for the development of the 'social, emotional and intelligent brain'; here he is referring to the right hemisphere. Le Grand et al. (2003) suggest that the right hemisphere is essential for the processing of information from faces. Schore (2001) refers to unconscious transmission of psychobiological states from one person to another, between

their right brains. He describes a 'pre-verbal bodily based dialogue' (Schoore 2001a p. 67).

Kohut (1971) makes the link between the gazing relationship between infant and mother and the bodily display that is the response to the positive twinkle in the mother's eye. He refers to a sense of pleasure experienced in the visual exchange and believes that early mental representations are explicitly visually orientated (Kohut 1971). Alvarez (1999) suggests that a mother 'claims' her baby through her gaze and draws him/her to engage.

In his paper the "mirror role of mother and family in child development", Winnicott (1967) suggests that the baby derives its fundamental sense of existence and goodness from what it sees reflected in its mother's face. He draws on Gough's (1962) observations that, when infants are feeding, they do not look at the mother's breast, they look at her face. Winnicott asks: what do they see?

I am suggesting that, ordinarily, what the baby sees is himself or herself. In other words the mother is looking at the baby and what she looks like is related to what she sees there. All this is too easily taken for granted. I am asking that this which is naturally done well by the mothers who are caring for their babies shall not be taken for granted. I can make my point by going straight over to the case of the baby whose mother reflects her own mood or, worse still, the rigidity of her own defences. In such a case what does the baby see? (Winnicott 1971 p. 151).

Winnicott (1971) suggests that there will be times when the mother does not respond. Some babies have to experience not receiving back what they are giving: 'They look and do not see themselves' (Winnicott 1971 p. 151). He argues that the failure of this function leads to a desperate search for alternative ways of containing experience, including the intense feelings and anxiety engendered. The child introjects the mind of the other, with its distorted, absent or maligned picture of the child, as part of his or her own sense of identity. A germ of a potentially persecutory object gets lodged in the self but is alien and inassimilable (Winnicott 1971).

Building upon Winnicott's ideas, Lemma (2010) highlights the importance of the

mother's admiring gaze. She suggests that:

the desire to be looked at and admired requires the presence of an other willing not only to look, but above all to also take pleasure in the self's desirability (Lemma 2010 p. 56).

She argues that the early desirability is 'rooted in the body and mediated interpersonally through the gazing relationship' (Lemma 2010 p. 56).

Lemma (2010) believes that, if all goes well between the mother and infant, the baby internalises a mother that is able to enjoy the baby's body and is willing to accept the infant 'warts 'n' all'.

Lemma (2010) explores the mother's role as a mirror to her infant, focusing upon the early physical interactions between mother and infant in the establishment of a 'stable representation of the body' (Lemma 2010 p. 57). She identifies different types of mirror-mothers: the one-way mirror-mother and the distorting mirror-mother. Infants with a one-way mirror-mother experience repeated exchanges with an actual mother who is felt to be inaccessible, for whatever reason. Lemma (2010) believes that this experience may contribute to the establishment of an internal tormenting experience of uncertainty about feelings towards the self. These infants need absolute certainty in what the other 'sees' when looking at the self, which can lead to a desperate attempt to create the ideal body that will guarantee the other's loving 'gaze'.

Such infants have failed to make any real impression on the mother as being in some way special and attractive. Instead of welcoming eyes, Lemma (2010) thinks that these infants are met by emptiness or absence, a blank mirror, nothing on which to impress and so build an image of themselves as appealing and special. Kilborne (2002) suggests that there are infants who cannot find themselves in their mother's eyes.

Lemma (2010) describes the 'distorting mirror-mother'. Here the baby's body is not only viewed as undesirable, but also becomes the receptacle for the mother's projections. The hostility might be overt; as she looks at the baby, the mother might see something 'ugly' and unacceptable in herself, but she locates the 'ugliness' in the baby, relating to the baby's body as something 'bad' and 'ugly'. The mother uses her gaze to project 'ugly' unwanted parts of herself into the baby, only to condemn the baby for not matching up to her expectations.

The hostility may, however, be more implicit in the mother's failure to receive the baby's projections of her 'ugly' feelings. This may result in a marked deficit in the development of symbolic thinking, making it more likely that undigested projections become concretely located in the body (Lemma 2010).

In the presence of a distorting mirror-mother and the absence of other receptive eyes/minds, the baby may be forced to include the mother's distorted image of her into its own emerging sense of who she is.

Lemma (2010) argues that, if all is going well, the mother 'glosses over the true state of affairs' in order to help her infant to feel 'whole, robust and desirable' (Lemma 2010 p. 60). Lambrou (2006) suggests that if the mother has not helped the infant to introject a 'rose coloured pair of glasses', then a persecutory gaze may be installed in the infant's internal world. An example would be the mother's ability to gloss over her distaste during nappy changing.

Wright (1991) develops Searle's (1963) ideas about the face as a 'non-verbal qualifier of verbal messages'. It is through the face of the other that we check if there are discrepancies in the verbal and non-verbal. Wright suggests that it is easier to suppress verbal messages than non-verbal facial communication:

The larynx is more under voluntary control than the small muscles of the face, and almost certainly an emotion, together with its characteristic facial gestalt, is organised in an older and more primitive part of the brain than speech (Wright 1991 p. 7).

2.3.2. The ego-destructive superego: being seen or being watched

In this section the development of the Kleinian and Freudian perspectives on the super-ego are compared and contrasted. I include developments on Klein's theories of the depressive position and projective identification, and her ideas on envy as the basis of the 'ego-destructive superego'.

Klein (1926) developed her idea of a harsh superego from her work with young children. She notes how, as young as two and a half years of age, children have intense feelings of guilt. Freud (1923) suggests that guilt is a result of the conflict between the instincts (the id) and the superego. He argues that the superego is the heir to the Oedipus complex and is formed by the introjection of the internalised parents (imagos) who are taken inside the ego and set up as an internal watchful self-critical agency (Hinshelwood 1991).

Klein challenges Freud's beliefs about the Oedipus complex and superego formation on three counts. She places the origins of the superego much earlier than Freud. Klein argues that the super-ego's constituents are multiple and varied, and not a 'monolithic amalgam of introjected oedipal parents' (Hinshelwood 1991 p. 98), and she identifies a specific developmental history of the superego from harsh to soft.

She argues that the oedipal introjects, which form the superego, are distorted into terrifying figures by which the child projects her aggressive sadistic impulses into the object, a process that she later calls projective identification (Klein 1946).

The importance of the concept of the superego in Klein's theory diminishes as she develops the concept of the 'depressive position', which notes the ego's changing relations to the internalised and external objects. The infant realises the object that has been attacked in phantasy is also the object that is loved. This is a change from part-objects to whole objects. The infant becomes afraid of losing the loved good object, and she feels remorse, guilt and sadness associated with her aggressive attacks on the object. Klein describes how the infant pines for the object lost or damaged by hate and the wish to repair surfaces, which encapsulates her theory of guilt. There is a strengthening of the feelings of love towards the object. Klein states:

excessive envy, an expression of destructive impulses, interferes with the primal split between the good and bad breast, and building of a good object cannot sufficiently be achieved (Klein 1957 p. 192).

Klein, in the footnotes to her 1957 paper, draws upon the ideas of Dr Elliott Jacques, who links envy with the idea 'to cast an evil eye upon', to envy or grudge anything (Klein 1957 p. 181). Klein emphasises the projective character of envy, the feeling that someone possesses and enjoys something that is desirable, and the envious impulse is to take it away and destroy it. She suggests that envy implies the relationship to one person only, which she links back to the early relationship to the mother. The unconscious wish is to put the bad parts of the self into the mother in order to spoil and destroy her.

Klein describes how some patients feel that they are at the mercy of the harsh watchful gaze, an 'evil eye' (Klein 1957), which is mostly a symbol of envy that

threatens to humiliate the subject and constitutes an important part of what Bion calls the 'ego-destructive superego' (Bion 1959).

Bion (1959) introduced the term 'ego-destructive superego' to describe where there has been a failure in the communication between infant and mother. He suggests that:

It is a superego that has hardly any of the characteristics of the super-ego as understood in psycho-analysis: it is "super" ego. It is an envious assertion of moral superiority without any morals. In short it is the resultant of an envious stripping or denudation of all good and is itself destined to continue the process of stripping...till container contained represent hardly more than an empty superiority-inferiority that in turn degenerates to nullity (Bion 1962 p. 97).

Bion (1959) suggests that the ego-destructive superego is the outcome of the infant's introjection of an object that fails to introject her distress, or is felt to introject the infant only to destroy her. He argues that the failure is due to the constitution of the infant, and the mother's incapacity to introject. Bion (1959) states that, in the ego-destructive superego, the internal objects refuse to receive projections, and the capacity for thinking is impaired.

With Klein's development of the concept projective identification (1946), she emphasises that projective identification is a way of dealing with persecutory anxiety. Klein (1946) defines projective identification as an attack on an object by the means of 'forcing parts of the ego into it in order to take over its contents or to control it, and occurring in the paranoid-schizoid position from birth' (Hinshelwood 1991 p. 179).

Klein (1946) identifies two ways in which projective identification can be used: firstly, towards the ideal object to avoid separation, and secondly, it may be directed towards the bad object to gain control of the source of danger. Both good and bad parts of the self can be projected in order to get rid of them.

Segal (1983) suggests that in 'Envy and Gratitude', Klein (1957) describes

fully the deployment of projective identification as an implement of envious aims and also as a defence against envy – for instance getting into an object and taking over the object's qualities. She does not in that connection refer to narcissism, yet in this work it is implicit that there must be an intimate relation between narcissism and envy. Freud's description of primary narcissism is that the infant feels himself to be the

source of all satisfaction. The discovery of the object gives rise to hate (Segal 1983 p. 271).

On the other hand, primary envy as described by Klein is:

a spoiling hostility at the realization that the source of life and goodness lies outside. To me envy and narcissism are like two sides of a coin. Narcissism defends us against envy. The difference would lie in this. If one believes in a prolonged narcissistic stage, envy would be secondary to disillusionment. If, with Melanie Klein one contends that awareness of an object-relation, and therefore, envy, exists from the beginning, narcissism would be seen as a defence against envy and therefore to be more related to the operation of the death instinct (Segal 1983 p. 271).

Steiner (2006) identifies seeing and being seen as important parts of narcissism:

When a patient loses the protection of a narcissistic relationship and is obliged to tolerate a degree of separateness, having felt hidden and protected, he now feels conspicuous and exposed to a gaze which makes him vulnerable to humiliation. This has a devastating and unbearable quality to it, particularly when it is felt to rise in retaliation to the patient's own gaze to establish superiority which allows the patient to look down on others (Steiner 2006 p. 1).

Steiner (2006) suggests that the patient struggles to deal with guilt and other emotions connected to loss. He suggests that the patient needs to get support from the analyst to make humiliation better understood and tolerable. He argues that vision plays a central role in seeing, as the object comes to be observed from a distance, and also in being seen, where the expectation of a hostile gaze, which threatens humiliation, can become prominent. Anxieties arise from looking and from being looked at, and both lead to an intensification of narcissistic defences. The situation is complicated by the way gaze can be used to re-establish the narcissistic relationship, in particular by using eyes to enter objects and to take refuge there, and to once again control and acquire the properties of the object. Humiliation is particularly feared in these cases (Steiner 2006).

Fonagy (1991) argues that some patients can experience the body self as a refuge, in which they have some sense of safety and understanding. If objects cannot be properly represented as thinking and feeling, they may to some extent be controlled, distanced or brought into proximity through bodily

experiences. Self-cohesion is limited by inhibition of the capacity to reflect on and integrate mental experience.

Steiner (2006) makes reference to an unpublished paper by Segal (2002) where she looks at the role of vision in psychosis. Segal describes a patient whose 'healthy curiosity' became transformed into an omnipotent and omniscient voyeurism. The voyeurism turned to exhibitionism because the whole point of using his eyes was to enter his object, to reverse the feeling of smallness.

If humiliation is too painful and separateness becomes unbearable, the patient may be able to recreate a sense of proximity by using the eyes to obliterate the awareness of separateness. The mechanism relies on the ability of the eye to take over some of the functions which previously relied on proximity senses, and which are associated with part object relationships. In particular, projection and introjection now come to be mediated by the eyes, and gaze becomes capable of penetrating and can be used not only to observe the object as a whole, but also to enter the object and identify with it. The excitement associated with entry transforms the child's position from that of an observer into that of a voyeur, and the identification can lead to further transformation phantasy from a watcher at a distance to that of a participator in bodily contact. It is as if vision is then used as a proximity sense enabling a part object relationship to be re-established (Steiner 2006 p. 8).

Schafer (1960) outlines the importance of a benign loving superego, which is the product of the mother who looks lovingly at her baby. Lambrou (2006) describes how mothers have 'rose tinted glasses', which he argues is the product of the mother's early care, love and concern with her baby (Lemma 2010 p. 84).

2.3.3. Gaze in the transference

Lemma argues that the patient's relationship to her body reflects the early gazing experience. She states that:

for some, words offer a containing function, but for others the visual relationship is more important at least until some understanding of how they are using their body and their experience of the gazing relationship has been understood. (Lemma 2010 p. 8).

For some patients, the primary task is understanding the visual relationship before words can be used to contain the patient (Lemma 2010).

In the next section I consider literature on the postural model of the body and how a sense of self is built up through movement.

2.3.4. Postural model of the body

The way in which a sense of self is built up through the movement of our bodies receives little attention in psychoanalytic literature. However, movement psychotherapists are interested in how we build up our sense of ourselves through movement and suggest that movement can help to access primitive states of mind.

The Austrian psychiatrist and psychoanalyst Schilder (1950), who was a pupil of Sigmund Freud, draws from physiology, neuropathology and psychology to inform his thinking. He developed his concepts from his experience of treating psychotic patients.

Schilder (1950) draws upon Sir Henry Head's postural model of the body and Freud's view that the first ego is the body ego to develop his own thoughts on the fundamental role of the body image in the individual's relationship to herself, to fellow human beings and to the world around her. Schilder (1950) suggests that:

it would be erroneous to suppose that phenomenology and psycho-analysis should or could be separated from brain pathology. It seems to me that the theory of organism could and should be incorporated in a psychological doctrine which sees life and personality as a unit. I therefore used the insight psycho-analysis has given to us with its psychic mechanisms for the elucidation of problems of brain pathology (Schilder 1950 p. 7).

Whilst Schilder (1950) draws upon Freud's theories, he differs in some respects. He refutes the idea of regression as a central plank to his theory. Schilder (1950) believes that Freud neglects the 'principles of emergent evolution', which leads to the creation of new configurations.

Schilder (1950) suggests that we build up a picture of our own body which we form in our mind. He makes reference to sensations and points out that we are

part of the 'body surface' having 'tactile, thermal and pain impressions'. He suggests that sensations come from the muscles, noting:

We call it a schema of our body or bodily schema, or, following Head, who emphasises the importance of the knowledge of the position of the body, postural model of the body (Schilder 1950 p. 11).

Schilder (1950) also notes that Head writes:

But, in addition to its function as an organ of local attention, the sensory cortex is also the storeroom of past impressions. These may rise into consciousness as images, but more often, as in the case of special impressions, remain outside of central consciousness. ...the final sensation of position, or of locality, rises into consciousness charged with a relation to something that has happened before (Schilder 1950 p. 11).

He suggests that we are always building up a postural model of ourselves, which constantly changes. Every new posture or movement is recorded on this plastic schema, and the activity of the cortex brings every fresh group of sensations evoked by altered posture into relation with it (Schilder 1950).

Schilder (1950) considers the relationship between anatomy and the postural model and knowledge of the body. He argues that there is in our body image more that we consciously know about our body (Schilder 1950 p. 13). He also suggests that, in studying body-image, we must focus upon the problem of the relation between the impressions of our senses and our movements and motility in general. He argues that our knowledge of our bodies 'will be dependent on the erotic currents flowing through our body and will also influence them. The erotic zones will play a particularly part in the 'postural model of the body' (Schilder 1950 p. 15).

Schilder (1950) states that, through at least partial contact with the outside, world we discover our bodies. He identifies touch and the interest others take in the different parts of the body as major factors in the development of a 'postural model of the body'. We take in the body of others into our own. We also project it into others.

Schilder (1950) suggests that:

every action of the ego in the analytic sense, every grasping, groping, and sucking, will again have an enormous influence on the structure of the body-image. The senses will influence the motility, the motility will influence the senses, but the motility is also directed by strivings, tendencies, and desires (Schilder 1950 p. 123).

Sansone (2002) argues that the mother-infant relationship is the first context for early movements and the sense of 'proprioceptions'. One of the baby's earliest interests is the exploration of his or her mother's body, the breast being the baby's primary object which stands for the mother. Through breast feeding the infant has an experience of themselves as well as their mother.

Sansone (2002) suggests that:

these early experiences impinge on the development of a grounded bodyself, and on the way a mother uses her body and its expressions in interacting with her baby...Through movement and gesture, often combined with vocalization and eye contact, the infant signals a desire for interaction. So does the mother, and in doing so, she reinforces the infant's initiations and responses (Sansone 2002 p. 7).

If an infant has missed these earliest experiences of maternal touch, this becomes evident in her lack of vital movements and inert body.

2.3.5. Bodily movement and the transference

Anzieu (1990) argues that, if a patient has serious flaws in the ego, they need to find in their analyst, 'in addition to verbal dialogue, the visual exchange and communication through mime and posture that they have not made sufficient use of previously' (Anzieu 1990 p. 71). The analyst has to find words that are symbolic equivalents to what was missed in the tactile exchanges between the baby and his/her mother. Anzieu (1990) notes that 'the psychoanalyst's body is also speaking on a pre-linguistic and infra-verbal level - that active communication is going to be established about the patient's anxieties and phantasies' (Anzieu 1990 p. 74).

Damasio (1999) refers to background emotions and he suggests:

when we sense that a person is "tense" or "edgy," "discouraged" or "enthusiastic," "down" or "cheerful," without a single word having been spoken to translate any of those possible states, we are detecting background emotions (Damasio 1999 p. 52).

Background emotions are internal states brought about by 'ongoing physiological processes or by organism's interaction with the environment' (Damasio 1999 p. 52). He suggests that background emotions are expressed in 'musculoskeletal changes, for instance, in subtle body posture and overall shaping of body movement' (Damasio 1999 p. 53).

Bloom (2006) suggests that the therapist attending to the body and its movement can provide a medium closely related to the infant's pre-verbal language, through which the primitive phantasies and what Bick(1968) refers to as the 'second skin formation' can be touched upon and brought into consciousness, where they can then be thought about and tolerated. She believes that attention to the body and its movement can offer a route by which primitive feelings, and parts of the self that may have been split off and dissociated from, can be retrieved. Bloom suggests that psychoanalysis and movement analysis can provide a helpful route towards working through the impediments to restoring what Winnicott (1960) refers to as the 'psychic indwelling in the soma'. Bloom (2006) argues that movement takes place in a medium that gives form to, and can monitor changes in, what is occurring (often unconsciously) from moment to moment.

The French linguist Boileau draws upon the research of Stern (1985) which looks at mother-infant relationship and suggests that emotional effects and thought are firstly linked to the rhythmic body motion of the dyad. Boileau suggests that 'thought', which he defines as sensori-motor in its 'nature', is the 'invisible correlate of the dyad's body motion' (Boileau 2008 p. 3). He argues that the child's later thinking processes that constitute symbolic thinking are the outcome of the invisible dyadic co-thinking.

The movement psychotherapist Bloom (2006) suggests that the therapist, by attending to physical sensation and movement, can help the patient to recognise psychic states and can provide a way of interacting with them. She highlights that the body exists in a concrete form in the here and now, whilst reflecting unconscious introjections and projections. Bloom cites the psychoanalyst Quinodoz (2003), who suggests that when the patient is:

deeply affected by early experiences, it is the re-experiencing of the bodily experience that will enable him to recover his unrecognised affects and his bodily fantasies (Quinodoz 2003 p. 104).

Bloom (2006) suggests that this helps the patient to make links 'between body, mind, and feelings, that help support awareness of what parts of the self have been abandoned' (Bloom 2006 p. 21). Bucci (2002) believes that 'we recognise changes in emotional states of others based on perceptions of subtle shifts in

their facial expression or posture, and recognising changes in our own states based on somatic or kinaesthetic experiences' (Bucci 2002 p. 194).

Neuroscientists argue that the right hemisphere functions in a 'free-associative primary process manner' which is usually seen in states such as reverie (Grabner 2007 p. 228). Schore (1994) describes a pre-verbal bodily based dialogue that takes place between the therapist's and patient's right brains. He describes a process of unconscious transmission of psychobiological states from one person's right brain to another's right brain. The right hemisphere which is dominant for body and feelings, and is in ascendant for the first years of life. The right brain decodes emotional stimuli by actual felt somatic emotional reactions to the stimuli in a 'pre-verbal bodily based dialogue' (Schore 2001a p. 67).

Lemma (2010) argues that the body can communicate an internal state:

The body, in other words, is the most pliable medium at our disposal for displaying or communicating our internal state of mind. Our relationship to our body is probably the most concrete marker we have of how we feel about ourselves and about others (Lemma 2010 p. 7).

Rhode (1997) states that the mother's ability to attribute meaning to the infant's interactions brings together 'words, mental and physical experiences and in the first instance this happens in the mother's mind' (Rhode 1997 p. 142). She suggests that it is necessary for the mother to see the infant as a separate person and for the infant to be able to take up what the mother offers.

2.3.6. The use of the body in the transference

Little has been written about non-verbal bodily communication in the transference. The transference is a pivotal concept in psychoanalytic psychotherapy. In current Kleinian thinking, the transference is considered to encompass all aspects of the patient's relationship to the analyst (Bott Spillius et al. 2011).

Breuer (1895) first noted the transference in his work with Anna O, a female patient who began to develop loving feelings towards him; he was perturbed by this and left the profession. Freud began to study the phenomena of the transference. He recognised that past relationships were being re-enacted in the present relationship with the analyst. Klein's work with children brought

about further development; she suggested that the transference was an enactment of unconscious phantasy. She emphasises the 'total situation' where attention would be paid to the patient's anxieties, his relationship with his internal objects both past and present. She maintained that the different aspects of the patient's phantasies and experiences should be considered. Klein developed the idea of the negative transference when she began to develop her thoughts on splitting (Klein 1946).

The countertransference is considered to be an important aspect of the transference. Hinshelwood (1991) defines the countertransference as thoughts, feelings and phantasies that arise in the analyst as an emotional response to the patient. Countertransference is a fusion of past and present. It is a means of communicating which originates from the patient's early infantile primitive experiences.

Freud (1910a) became aware of the countertransference, which occurs within the analyst as a result of the patient's influence on her unconscious. Freud advocates the 'blank screen approach' where the analyst shows the patient as little of their personal life as possible. He felt there was a danger of 'projecting outwards some of the peculiarities of his own personality' (Freud 1912b). Freud saw the countertransference as an obstacle which impedes the understanding of the patient. The trainee's own analysis would be where the trainee could gain insight into his or her own unresolved unconscious conflicts (Sandler 1992).

Heimann's paper "On countertransference" (1950) challenges the 'blank screen' approach, moving away from Freud and Klein's idea that it is an aspect of the therapist's psychopathology (Freud 1912e; Klein 1957). She identifies positive aspects of the countertransference that could provide the therapist with information that would be helpful in understanding the patient's unconscious life. Heimann (1950) argues that the analyst's emotional response to the patient is the 'most important tool of work and instrument for research into the patient's unconscious' and suggests that the relationship with the analyst and patient is not the presence of feelings in one partner and their absence in the other, the analyst. She suggests that the analyst's unconscious understands that of the patient. This deeper relationship comes to the surface as feelings in the

analyst, which the analyst takes note of in her countertransference. The analyst may become aware of feelings emerging that do not immediately relate to the material being presented by the patient, but which indicate that something is unconsciously being communicated to the analyst. Thus the countertransference provides information about the patient's unconscious mental processes (Heimann 1950).

The 'blank screen' approach seems to reduce analytic work to a purely intellectual procedure, a defensive prescriptive approach that hampers the progress of the work (Heimann 1950). Bott Spillius and O'Shaughnessy (2012) note that Heimann does not suggest that the stimulus for the therapist's countertransference is projective identification. They suggest that projective identification is a term that Klein devised in 1946 but was not one that Heimann used.

Money-Kyrle (1956) uses the term 'normal countertransference' to describe the cycles of projection and introjection between analyst and patient. The patient brings something to the analytic session and 'conveys the experience'. The patient's experience is projected into the analyst, who has an experience of him or her 'intra-psychically'. The analyst returns the modified projected experiences that have been through his or her mind and are now expressed verbally to the patient. This is a process of 'reintrojection' where something is given back to the patient that had been previously projected into the analyst, thus demonstrating to the patient that the experience projected can be thought about. The analyst attempts to put into words what the patient is feeling, particularly relating to 'unconscious experiences and phantasies'. This process is repeated throughout the session (Money-Kyrle 1956).

Heimann (1950) suggests that an important factor within the analysis is the degree of feeling the analyst experiences and use he/she makes of his feelings. Pick (1988) argues that it is necessary for the analyst to be sensitive emotionally to the patient's projections, as well as thinking about his/her own responses to what is projected. Like the patient, the analyst may wish to avoid uncomfortable feelings, as well as trying to link with the patient.

Pick (1988) suggests that:

If we keep emotions out, are we in danger of keeping out the love which mitigated the hatred, thus allowing the so-called pursuit of truth to be governed by hatred? What appears as dispassionate, may contain the murder of love and concern (Pick 1988 p. 39).

2.3.7. Bodily countertransference

The idea of bodily countertransference extends our view on the countertransference. It is a new concept to which a scattering of psychoanalytic psychotherapists make reference (Lemma 2010; Sansone 2002; Bloom 2006; and Mitrani 2001).

Bloom (2006) suggests that the psychic internal world will have a 'real effect' on the 'real body' and this can be observed in the patient's 'posture, facial expression, and pattern of movement' (Bloom 2006 p. 48). She wonders if it is possible in psychotherapy to develop an area of technique which would incorporate the bodily and sensori-affective experience into the practice of psychotherapy. She suggests that bodily sensations are often viewed as those which cannot be brought into the level of thought. Bodily sensations can take the form of a retreat or an escape into physical action.

Bloom (2006) argues that the task is how to translate primitively based psychophysical experiences into words. She believes that the therapist's own bodily sensations can help the therapist to develop their empathic connection with the patient. Bloom (2006) draws upon the ideas of Schore (2001), and suggests that 'the body is the tool for psychic attunement' (Bloom 2006 p 7).

Bloom (2006) believes that the therapist's own bodily sensations can provide a deepening awareness of empathic connections with the patient through a more consciously 'embodied' awareness of the manifestations of the transference and the countertransference. She describes a state of 'multi-dimensionality receptivity' where the therapist is exploring the moment-to-moment experience of what is happening, without being pulled into the past or future of 'memory or desire' (Bion 1967). Bloom suggests that 'this capacity might depend upon the therapist's (conscious or unconscious) sense of three-dimensional embodied presence' (Bloom 2006 p. 7).

The direct experience by therapists of their own bodies, Bloom (2006) argues, may strengthen the therapist's recognition of the countertransference. This use of the body could be especially helpful in strengthening therapists' ability to differentiate between their own feelings and those that belong to the patient.

Wilkinson (2010) highlights that transference and countertransference experiences are bodily based. She argues that:

The right hemisphere, the seat of the bodily based self-system with its store of early relational patterning, is the source of originality, creativity, and emotional growth and development; it is also the source of all transference and countertransference experience. Unconscious emotional processing of current experience is undertaken by the right hemisphere and measured against earlier experience in order to determine the degree of threat. This processing inevitably leads to an unconscious emotional response that is based on earlier patterning (Wilkinson 2010 p. 9).

Schore (2007b) suggests that when 'emotions have not become feelings' (Damasio 2003), the therapist needs to work at:

the primitive levels at which relational development needs to occur in therapy for patients with early relational trauma to experience change in the underlying fundamental patterns of feeling, being and behaving that persist and cause distress (Schore 2007b p. 6).

Schore (2007b) stresses that:

attachment communications of trauma patients are implicit, affective, and non-verbal, and that unconscious affect regulation "expressed in rapid nonverbal, emotional communication at levels beneath conscious awareness within the dynamic intersubjective field" plays a crucial psychobiological role within patient-therapist dyads. It is these unconscious processes in therapy that lead to changes in the way a patient becomes able to relate not only to others but also to his or her own inner world (Schore 2007b cited in Wilkinson 2010 p. 6).

Wright (2009) argues that the capacity to feel in touch with another's experience, and equally the capacity to share one's own, requires a different ability from a straight forward expression. This is the ability to represent an emotion, to hold in mind and convey it in 'quasi-symbolic ways'. The optimal relation to emotion would not simply involve the 'right' amount of emotional expression, but rather the ability to convey its 'sense' or 'feel'. This requires a different stance in relation to oneself and one's experience, an ability to stand

back from it in order to apprehend it. It implies a different 'psychological 'space' (a space for reflection); in short, a space in which emotion can be felt:

First, a sense of the patient's varying relation to his own feelings; and second, a sense of the therapist's shifting emotional contact with the patient. Experienced location and distance in relation to feelings emerge as important: inside or outside, in touch (i.e. very close) or watching from further away (i.e. from outside) (Wright 2009 p. 18).

Mitrani (2001), drawing upon the work of Tustin (1986), suggests that traumatic experiences are walled off from the conscious and unconscious awareness. The analyst needs to work 'in the moment', paying close attention to transference and countertransference. Stern (1985) describes 'moments of meeting', which he suggests should be explored in an unhurried way, allowing different paths to open up, which can then be pursued. Freud (1912e) refers to 'evenly suspended attention' whilst Bion (1962) uses the term 'capacity for reverie' to describe a state of multi-dimensional receptivity to the moment-to-moment experience of what is happening.

Lemma (2010) suggests that it is necessary to attune to the body self and to the bodily countertransference, so that a language can emerge. The use of words, she warns, can shame the patient, leading to a feeling of exposure to what the body is communicating. It is necessary for the analyst to hold the patient's projections in her body and her mind until meaning can emerge (Lemma 2010).

Lombardi (2008) argues that focusing upon the transference and object relations deflects from personal and intimate experience of bodily sensations, which the patient may for the first time be allowing herself to experience. Allowing the body into the analysis helps to demonstrate the possibility of thinking and discriminating within the experience of the body (body-mind relationship) as the patient begins to approach her own sensations (Bion 1962, Lombardi 2008).

The importance of the 'transference to the body' is also noted by Lombardi (2005a); Bion called this 'introducing the patient to himself'. Lombardi argues that transference interpretations are of limited use where somatic

experiences are centre stage. He believes that

the process of approaching the body calls for an unfolding of symmetrical thinking in the analytic session before one can move on to a specifically relational working through the transference (Lombardi 2008 p. 95).

Lombardi (2008) suggests that the experience of sensory contact and the associated mental perception can heal the body-mind dissociation. When the body makes an appearance, there can be a tendency to panic which results in mental paralysis. By activating the mind, the emotional heat could be lowered. Bion(1967) in his theory refers to 'maternal reverie' as the mother's ability to think about her baby's needs and experiences, and return them to the baby in a manageable form, thus transforming the infant's overwhelming bodily experiences into an experience that can be dealt with in a mental way.

The most pressing need according to Lombardi (2010) is to pay attention to the patient's body via the process of containment (Bion 1962; Ferrari 2004). When the therapist is then faced with the 'somatic countertransference', Lombardi (2010), drawing upon Bion's (1979) ideas, states that in this situation:

it is the totality of the analyst's person that is involved, in the sense that the analyst is called upon to contain first and foremost in his body the pre symbolic and concrete manifestations that "anticipate" the birth of emotional and mental phenomena (Lombardi 2010 p. 1425).

This creates the conditions for activating of the alpha-function and hence the possibility of generating both conscious and unconscious phenomena (Bion 1962). Lombardi (2010) suggests that, in cases of mind-body dissociation, it is necessary to 'activate the patient's transference to the body and the transference to the therapist's body' (p. 1423). Lombardi (2010) suggests that this is an essential component of what Bion (1962) refers to as the therapist's 'reverie':

This is generally manifested in a range of diverse phenomena, such as an increased perception of one's own body weight, particular sensitivity to internal sensory movements, such as certain sensory experiences coming to be noticed by the mind as if the relevant sense data were being observed through a magnifying glass, as well as various subjective somatic phenomena (heat, vegetative sensations of different kinds, nausea, vertigo, changes to respiratory rate and the like) and transitory sensations of physical-ill-being (pains, muscular contractions, cardiac arrhythmias, and so on) (Lombardi 2010 p. 1423).

I will discuss Bion's concepts, alpha-function and maternal reverie, in the section on Bion. The following quote from Meares (2005) encapsulates how paying attention to bodily communication can bring about changes in the patient's emotional state:

Not only is the therapist being unconsciously influenced by a series of slight and, in some cases, subliminal signals, so also is the patient. Details of the therapist's posture, gaze, tone of voice, even respiration, are recorded and processed. A sophisticated therapist may use the processing in a beneficial way, potentiating a change in the patient's state without, or additional to, the use of words (Meares 2005 p. 124).

In this section I have explored the literature on the patient's use of the body in psychoanalytic psychotherapy. I will now consider the literature on unconscious phantasy and symbol formation in the process of thoughts becoming thinkable.

2.4 UNCONSCIOUS PHANTASY AND SYMBOL FORMATION

Klein's ideas on unconscious phantasy, which are central to her theory, are explored. Isaacs's seminal 1948 paper, which explores the nature and function of phantasy and how unconscious phantasy is experienced in the first instance in bodily sensations, is discussed. Segal's development of her ideas of symbolisation is examined in relation to Klein's concept of projective identification and Bion's concept 'container-contained'.

2.4.1. Klein

Klein suggests that infants are object-related from birth. This view is supported by infant and child development research in which filmed interactions between mothers and neonates have identified 'proto-conversations', with turn-taking and matching of rhythm and expression in neonates. These studies illustrate attunement between emotional and body movement. The baby and caregiver attune to each other through matching internal and external rhythms, and it has been seen that sounds also match the bodily rhythms. In this way baby and caregiver mutually regulate arousal level, and there is a positive enhancement of the baby's development (Beebe and Lachmann 1988; 2002; Stern 1985; Tronick 1987). This provides evidence that the body and mind are linked up.

Klein, from 1918 onwards, developed her theories from her clinical work with children. She developed the play technique, where children had freedom of

movement and could make visual contact with the therapist; she does not directly refer to this, but it is implied in her writing. Klein places unconscious phantasy at the centre of her theory. She extends and places a greater emphasis on unconscious phantasy than Freud. Klein discovered a rich phantasy world of children, concerning 'birth, death, primal scene and bodily processes in self and parents' (Bott Spillius et al. p. 14). She builds upon the work of Abrahams (1924) who suggests that phantasies are rooted in bodily experiences; fundamentally, the roots of unconscious meanings, experiences and activities in phantasies are connected with bodily sensations.

Klein argues that the first introjects are sensations, concretely experienced in the body and accompanied by unconscious phantasy (Bott Spillius et al. 2011). Whilst the concept of unconscious phantasy is central to Klein's theory, she did not provide us with a definition. It was Isaacs's seminal paper in 1948 on the nature and function of phantasy that defines and categorises Klein's ideas about unconscious phantasies; she notes how phantasies are experienced in the first instance as bodily sensations. Isaacs suggests:

Instincts, arising from somatic stimulation, are psychologically represented as unconscious phantasies of relationships with objects...Different objects and relationships are discerned according to the bodily sensations which are aroused: e.g. hunger and feeding, warmth and cold, a full bladder or an emptied one, etc....Unconscious phantasies are experienced in the first instance as bodily sensations, later as plastic images and dramatic representation, and eventually in words (Hinshelwood 1994 p. 33).

Isaacs (1948) uses as an example an infant that is taken over by the bodily sensation of hunger, arising perhaps from the stomach walls rubbing together, producing an unpleasant sensation. She suggests this will be represented in a most primitive way as the something inside the tummy which is malevolently intent on causing painful sensations. The supposed malevolent intent on the part of the object is innately terrifying for the infant. The terror is the experience of being attacked with malevolent intent (especially from inside, by something malevolent there). The infant is not capable of expressing those experiences clearly, yet through empathy adults can sense a baby's fears of malevolence, and these can be formed into words. With pleasure by contrast, the object is supposed to be lovingly intent upon making the infant feel safe, alive and

blissful. Despite the term 'unconscious phantasy', the infant experiences objects as completely real, not as imagined phantasy at all.

Segal (1973) suggests that 'the operation of an instinct in this view is expressed and represented in mental life by the phantasy of the satisfaction of that instinct by an appropriate object'. The example cited above is hunger. Segal suggests that:

As phantasies derive directly from instincts on the borderline between somatic and psychical activity, these original phantasies are experienced as somatic as well as mental phenomena (Segal 1973 p. 13).

Segal (1973) suggests that phantasy-forming is a function of the ego. This view of phantasy as a mental expression of instincts through the medium of the ego assumes a higher degree of ego-organisation than Freud would suggest. It assumes that the ego from birth is capable of forming primitive object relationships in phantasy and reality and indeed is driven by instincts and anxiety to do so. At birth the infant faces frustration and gratification. Reality experiences immediately influence and are influenced by unconscious phantasy.

Klein suggests that the first relationship is between the infant and the mother's breast. She suggests that 'The mother's body is the first object of knowing' (Klein 1931 p. 429). Klein believes that the infant develops primitive phantasies about the breast through its relationship with it. These phantasies are formed from the infant's relationship with the 'part object', most notably the breast (Bloom 2006 p. 47). She argues that the mother's body 'in phantasy is explored and investigated, as well as attacked with all the sadistic armoury' (Klein 1931 p. 240). Klein suggests that it is important that the mother's body should be felt to be unharmed:

It represents in the unconscious the treasure-house of everything desirable which can only be got from there; therefore if it is not destroyed, not so much in danger and therefore not so dangerous itself, the wish to take food for the mind from it can more easily be carried out (Klein 1931 p. 241).

Totton (1998) suggests that Klein is talking about the body in phantasy rather than the 'fleshy body'. Bloom points out that this view does not acknowledge that 'physical sensations are at the root of phantasy' (Bloom 2006 p. 49).

Bronstein (2011) suggests that, from Kleinian theory,

The body is not only a source of unconscious phantasies, but can also become an important part of the content of unconscious phantasies...the body can function as the arena onto which unconscious phantasies can be projected and unconsciously enacted (Bronstein p. 184).

Klein's ideas about unconscious phantasy are linked to her theories of the movement from the paranoid-schizoid position to the depressive position. In Kleinian theory unconscious phantasies 'are mental representations of those somatic events in the body that comprise the instincts, and are physical sensations interpreted as relationships with objects that cause those sensations' (Bott Spillius et al. 2011 p. 3).

2.4.2. Symbolisation

Freud (1895) makes a brief reference to symbolism in 'Project for a scientific psychology', when he comments about the way in which a soldier may be willing to die for a flag. He suggests that the soldier is aware that the symbolic object represents the true object of love. Bott Spillius et al. (2011) describe how Freud compares this 'normal' symbol formation to 'hysterical symbol formation', where the idea that 'causes distress in the neurotic patient is linked to and symbolically represents the patient's hidden and truly upsetting unconscious idea' (Bott Spillius et al. 2011 p. 185).

In the 1916 paper 'The theory of symbolism', Jones views symbolisation as a primitive process of expression, which is defensive rather than creative. Jones distinguishes symbolisation from sublimation.

Klein developed Freud and Jones's ideas about symbols. She challenged the distinction that Jones made between symbolisation and sublimation, suggesting that symbol formation is the basis for sublimation (Klein 1923b). Thus,

because in Klein's work bodily sensations are represented in phantasy as relationships with objects, we can in fact see the beginnings of symbolisation as part of the very nature of mental life (Bott Spillius et al. 2011 p. 187).

Through her work with children, Klein began to realise the symbolic value of children's play. In "The psychological principles of early analysis", she

comments, 'In their play children represent symbolically phantasies, wishes and their experiences' (Klein 1926 p. 134).

Segal (1957) developed Klein's ideas further, making use of Klein's 1946 concept of 'projective identification' in her paper 'Notes on symbol formation' (1957). Segal distinguishes between 'symbol proper' and 'symbolic equation'. She suggests that 'symbol proper' is in the depressive position and the more primitive 'symbolic equation' in the paranoid-schizoid position. In the 'symbolic equation', the symbol is equivalent to the thing in itself.

The patient's experience of frustration and gratification in the transference and his or her capacity or not for unconscious phantasy that leads to the thoughts becoming thinkable or not.

2.5 BION'S THEORY OF THINKING

Bion (1967) suggests that thinking is dependent on the successful outcome of two main developments. The first he cites as the development of thoughts, which require an apparatus to cope with them. Bion suggests that the second development is this apparatus that he calls thinking.

Bion (1967) identifies thoughts according to their 'developmental history', as pre-conceptions, conceptions and concepts. He suggests that the coming together of a pre-conception with a realisation produces a concept, with an expectation that it will be constantly conjoined with an emotional experience of satisfaction. He describes how the baby waits for a breast, but it does not come, causing frustration. With a realisation of no breast available for satisfaction, the baby's experience is of an 'absent breast' inside, a bad, cruel, denying breast. The next step depends on the infant's ability to tolerate frustration or to evade it. If the capacity for tolerating frustration is sufficient, the 'no-breast' inside becomes a thought and an apparatus for thinking develops. This initiates the state, described by Freud (1911) in his paper 'Formulations on the two principles of mental functioning', as the dominance of the reality principle. This state is synchronous with the development of the ability to think, and to bridge the gulf of frustration between the moment when a want is felt, and the moment when action appropriate to satisfying the want cumulates in its satisfaction.

The extensive literature on Bion's theory on thinking has been reviewed. For the purpose of this literature review, the focus is upon Bion's ideas about proto-mental systems, his concepts of container-contained, his use of Klein's concept of projective identification, and alpha-function and the contact barrier.

In his book *Experiences in Groups*, Bion (1961) describes the proto-mental system which contains primitive data of the mind where the physical and psychological or mental are undifferentiated. Bion (1959) suggests that these processes can remain active in some adults.

Bronstein (2011) highlights how, in his later work, Bion returned to his interest in 'proto-mental' functioning and its relationship to the bodily processes. She suggests that some symptoms could not be understood without linking them back to archaic states of mind. Bronstein (2011) cites Bion in suggesting that the idea of caesura of birth prevents thinking about the continuity between the pre-mental experience of gestation and post-natal thought. Bion focused upon the importance of continuity between intrauterine into post-natal life at a physical and mental level. Bronstein suggests that:

He thought that embryonic stages have a distinct representation in the structure of the self and that there are primitive parts of the self that do their thinking with the body and follow laws closer to neurophysiology than to psychology. He thought that some intense inchoate feelings might be then experienced to be physiological. It would be a world very much influenced by a degree of quantities of excitation rather than by emotional nuances (Bronstein 2011 p. 187).

In his later work Bion describes what he called beta-elements as the raw elements, the content of the proto-mental system. I will discuss beta-elements later when thinking about the contact-barrier.

My interest is in the role that non-verbal instincts, as a pre-conception of an object-relation, might play in thoughts becoming thinkable. Bion (1962) suggests that the body might play a role in creating the 'groundwork phenomena of thought'. Bion (1962) suggests that the patient's use of the physical body in the session draws attention to events which have not yet been thought about, but which are at the point of becoming so. Lombardi (2008) suggests that Bion sees the body as 'the repository of a germinal element that can give rise to a new thought which has never been thought before' (Lombardi 2008 p. 92).

Bion highlights how the infant is reliant upon the mother. He developed the concept container-contained, building upon Klein's original description of projective identification where one person can contain projected parts of the other. Bion (1990), in the Brazilian lectures, describes the process of container-contained:

Suppose the mother picks up the baby and comforts it, is not at all disorganised or distressed, but makes some soothing response. The distressed infant can feel that, by its screams or yells, it has expelled those feelings of impending disaster into the mother. The mother's response can be felt to detoxicate the evacuation of the infant; the sense of impending disaster is modified by the mother's reaction and can then be taken back into itself by the baby. Having got rid of a sense of impending disaster, the infant gets back something which is far more tolerable (Bion 1990 pp. 53-54).

Bion (1974) argues that the infant over time begins to introject the containing function; this enables her to develop the apparatus for tolerating frustration and for thinking. He contrasts the situation where the mother contains and metabolises the infant's projections with a situation where the mother is unable to receive the infant's projections and metabolise them:

let us imagine the baby is very upset and feels afraid of an impending disaster like dying, which is expressed by crying. That kind of language may be both comprehensible and disturbing to the mother who reacts by expressing anxiety –'I don't know what's the matter with the child!' The infant feels that mother's anxiety and impatience and is compelled to take its own anxiety back again...The infant takes back into itself the sense of impending disaster which has grown more terrifying through the rejection by the mother and through its own rejection of the feeling of dread. This baby will not be able to feel that it gets back something good, but the evacuation with its badness worse than before. It may continue to cry and rouse powerful anxiety in the mother. In this way a vicious circle is created in which matters get worse and worse until the infant cannot stand its own screams any longer. In fact, left to deal with them by itself, it becomes silent and closes inside itself a frightening bad thing, something which it fears may burst out again. In the meantime it turns into a 'good baby', a 'good child' (Bion 1990 pp. 53–54).

Bion describes how the infant is evacuating in the first instance and attempting to communicate the evacuated feelings through projective identification. The consequences to his projections not being received are the intensification of projective identification and the internalisation of an impervious internal object.

Bion (1959) and Rosenfield (1971) note a differentiation between normal and pathological projective identification, unlike Klein who focuses upon the

defensive use of projective identification rather than its communicative use. In normal projective identification, where the function is an adaptive one, there is a wish to communicate something that the subject does not understand about himself/herself to the object.

In normal projective identification, the infant communicates something to the object. The mother uses a receptive state of mind, which Bion calls 'reverie', to receive and contain the infant's projections. Bion (1967) in defining reverie states that 'the mother's capacity for reverie is the receptor organ for the infant's harvest of self-sensation gained by its conscious (Bion 1967 p. 116).

If there is a breakdown in reverie, the rudimentary consciousness cannot tolerate this burden, and there is an establishment of a 'projective identification-rejecting object. The infant has a wilfully misunderstanding object with which it is identified'. Consequently, the development of an apparatus for thinking is disturbed and instead the apparatus of projective identification is enhanced. When projective identification dominates, the distinction between self and the external object is blurred, leading to an absence of two-ness.

In order for an individual to mentally digest experiences, they need to be subject to the process of alpha-functioning. Bion (1962) uses the term alpha-function, drawing upon Freud's description of 'sense organ for the perception of psychic qualities', to describe the capacity to change sense impressions into alpha-elements. He suggests that alpha-function:

transforms sense impressions into alpha-elements which resemble, and may in fact be identical with, the visual images with which we are familiar in dreams, namely, the elements that Freud regards as yielding their latent content when the analyst has interpreted them..... Failure of alpha-function means the patient cannot dream and therefore cannot sleep. As alpha-function makes the sense impressions of the emotional experience available for conscious and dream-thought the patient who cannot dream cannot go to sleep and cannot wake up (Bion 1962 pp. 6-7).

Bion (1962) suggests that alpha-function makes emotional experience comprehensible and meaningful, by producing alpha-elements consisting of 'visual, auditory and olfactory impressions', which can be stored in memory and are usable in dreaming and in unconscious waking thinking.

In normal conversation a visual image might arise in the mind of the listener in response to both the content of the conversation but also to the 'total experience' in that moment:

This visual image is a result of a mental assimilation of the experience which is being perceived sensorially and it can be stored in memory or used in dreams. It is also in a suitable form to become a symbol. The experience has been subjected to alpha-function and has thus been rendered assimilable to the mind (Symington 1996 p. 61).

Alpha-function is a product of an adequate relationship between infant and mother, and is the function of the mother as a container for the infant's thoughts and not-yet-thoughts. When the emotional experience is not processed into symbolic representations that can lead to dream-thoughts, it will be 'evacuated'. One of the roots for evacuation is via psychosomatic disorder (Bion 1962; Meltzer 1986; Ogden 2006).

Lombardi (2008) suggests that, when working at Bion's intervening stage between beta and alpha, the therapist needs to respond in a way that helps the patient to come into contact with her sensations, with which she is fearful of coming into contact.

If alpha-function becomes immobilised, sense impressions and emotional experiences remain unaltered, creating what Bion calls 'beta-elements'. These represent the thing in itself whereas alpha-function represents the phenomena. Beta-elements are on the boundary of somatic and psychic and are sense impressions devoid of meaning, or nameless sensations which cause frustration. They may be depressive or persecutory in nature. They are undigested and feel like things-in-themselves, as foreign bodies in the mind. They are suitable only for evacuation because they cannot be thought about. If persecutory, they feel like debris of which the mind wants to rid itself; they cause discomfort and are expelled. The expulsion takes place through projective identification into the body, or into the external world. Although this is a mental event, it is described as if it were a physical process and indeed may be experienced as such (Bion 1962).

Bion (1962) suggests that beta-elements are not in a condition to be thought about. They cannot be verbalised, but they can be transformed so they become suitable for use in thinking. Bion (1962) describes how beta-elements are acted

upon by alpha-function leading to the development of alpha elements and undergoing a process of symbol formation.

Bion (1962) makes reference to the 'contact-barrier,' a place that is in-between consciousness and the unconscious. Freud (1895) originally used the term 'contact-barrier' to describe a 'neuro-physiological entity subsequently known as synapse' (Bion 1962 p. 17). Bion uses the term contact-barrier to describe a place where transformations take place:

alpha-function whether in sleeping or waking transforms the sense-impressions related to an emotional experience, into alpha-elements, which cohere as they proliferate to form the contact-barrier. This contact-barrier, thus continuously in process of formation, marks the point of contact and separation between conscious and unconscious elements and originates the distinction between them (Bion 1962 p. 17).

Bion (1962) suggests that the nature of the contact-barrier will be influenced by the nature of the alpha-elements and their relationship to each other. He identifies various possibilities: they may cohere, they may agglomerate or they may:

be ordered sequentially to give the appearance of a narrative (at least in the form of which the contact-barrier may reveal itself in a dream). They may be ordered logically. They may be ordered geometrically (Bion 1962 p. 17).

Bion differentiates between the contact-barrier composed of alpha-elements and one that is composed of beta-elements where the patient intends to destroy the analyst's thinking and to withhold rather than to share information.

Bion (1962) suggests that beta-elements are stored differently, not so much as memories but as undigested facts (Bion 1962 p. 7). Attacks on alpha-function, stimulated by hate or envy, destroy the possibility of the patient's conscious contact either with himself or another (Bion 1962 p. 9).

Bion (1962) suggests that these patients do not use articulate speech. He argues that they have an inability to understand their own state of mind even when it is pointed out to them. Bion states that the contact-barrier is replaced by the beta screen, by which he means the:

replacement of alpha-function by what may be described as a reversal of direction of the function. Instead of sense impressions being changed into alpha-elements for use in dream thoughts and unconscious waking thinking, the development of the contact-barrier is replaced by

destruction. This is effected by the reversal of alpha-function so that the contact-barrier and the dream-thoughts and unconscious waking thinking which are the texture of the contact-barrier are turned into alpha-elements, divested (Bion 1962 p. 24).

Bion links transformation via alpha-functioning with the mother's capacity as a container for the infant's thoughts and emerging thoughts.

Summary

This chapter provides a review of the literature on the mind-body debate and the patient's bodily experience in the therapeutic encounter. The current literature on the early gazing relationship and the postural model of the body are explored. The literature on the patient's use of the body in the transference relationship is reviewed, including how the bodily sensations in the therapist can be used to help to translate psychophysical experiences into words. Bion's theory on thoughts becoming thinkable is explored. The research method discussed in the following chapter, would need to allow access to data on bodily communication in the therapy.

CHAPTER 3: METHODODOLOGY

This chapter presents a discussion of the research methods adopted for this research study. The rationale for choosing a qualitative research method is examined, along with a discussion of the strengths and weaknesses of using such an approach. Reasons for choosing a single case design are examined, and the process by which the single case was chosen is described.

A description of how the data was analysed using grounded theory is presented, along with a discussion of coding, both initial and focused/theoretical, and the use of memos. Ethical issues are also considered.

3.1 THE RESEARCH QUESTION

My ideas underlying this research study have been developing over the course of my career working with children and young people. As noted in the introduction whilst working with children under five in a social care setting, there were instances where sudden changes in the way in which children communicated non-verbally alerted me to significant changes in the child's world. I would share my thoughts with my social worker colleagues; initially some would not take seriously that which was observed and not spoken about. However, as my observations of children were corroborated when it subsequently transpired that significant events had taken place in the child's life, such observations became an important part of case discussions.

My interest in this area was further developed on the psychoanalytic observational studies course, where I undertook a two-year observation of an infant from birth to two years of age. I observed the significance in the way in which infants communicate with their mothers using both their bodies and vocalisation. My interest was developed further by my observation of how a bodily based dialogue seemed to be taking place between mothers and infants.

Whilst attending the psychoanalytic observation studies course and working on a CAMHS team, I began to think about some of my patients with whom I worked individually, using a psychoanalytically informed approach, under the supervision of a consultant child and adolescent psychotherapist. I used my

observation skills, which I developed further on the course, to begin to note non-verbal as well as verbal communication.

The clinical data used in this research study was obtained whilst I was working on a CAMHS team as a child and adolescent psychotherapist in clinical training. I attended a year of weekly research seminars at the Northern School of Child and Adolescent Psychotherapy (NSCAP). In these seminars I had the opportunity to begin to think about this research study, whilst presenting individual process notes to a group of child psychotherapists in clinical training and two experienced consultant child psychotherapists. The process notes are a written record based upon my recollection of what happened in the therapy session, including the non-verbal communication, particularly movement of the body and eye contact, and the countertransference and observations. The process notes presented at these seminars described psychotherapy with an adolescent girl. The aim was to begin to formulate an area of interest to explore within the research.

During this period, I began to develop a curiosity as to how patients use their bodies within therapy to communicate something that cannot be verbalised. I also had weekly supervision sessions on my intensive cases, and it was here that the process notes were presented and the details of the therapeutic encounter considered. I also began to read literature that related to my growing area of interest, including mind–body relationship (Lombardi 2005; Mitrani 2007); adolescence and conflicts over the sexually mature body (Laufer 1978); psychosomatic illness (McDougall 1989; Sommer-Anderson, 2007); early mother–child interaction (Trevarthen 2005; Stern 1985); and processes within psychotherapy (Bion 1963).

In addition to the above, I had regular meetings with my tutor, where the research study was discussed, and I began to think about how thoughts become thinkable and the role that the body might play in this process.

3.2 RESEARCH DESIGN

It might seem somewhat obvious to state that the research design needed to investigate the area of interest to be studied: the patient's use of the body within the transference relationship in intensive psychotherapy, towards allowing

thoughts to be thinkable. This area of interest was developed prior to the analysis of the data. An objective of this study was to look in detail at intensive three-times-a-week psychoanalytic psychotherapy sessions with a single patient. The method adopted needed to allow a focus upon the relationship between the therapist and the patient; that is the transference. This research tracked the patient's use of their body within the sessions: their eye contact, physical proximity, tone of voice and the therapist's countertransference. The method chosen had to enable me to access this data. The research design also needed to be able to track when thoughts became thinkable.

3.2.1. Why qualitative research?

The first stage in designing the research was to decide whether a qualitative or quantitative research methodology was most appropriate. Quantitative research is built upon positivism, the dominant paradigm of inquiry in the natural sciences. In quantitative research, objectivity, generality, replication of the research and falsification of competing hypotheses are stressed. The aim is to discover causal explanations and to make predictions about an external knowledge of the world (Strauss and Cobin 2008), based on the belief that there is a stable, unchanged reality that can be studied using empirical methods. The claim is that this is done in a value-free framework where, as far as possible, bias and opinion have been eliminated (Denzin and Lincoln 2005).

In contrast, qualitative research is based upon pragmatism. I will refer to a particular strand of qualitative research that is based upon pragmatism: informed symbolic interactionism, as advocated by Charmaz (2006). This is a theoretical perspective that assumes society, reality and self are constructed through interactions, and thus rely on language and communication. This perspective assumes that interaction is

inherently dynamic and interpretive, and addresses how people create, enact, and change meanings and actions (Charmaz 2006 p. 7).

It is argued that each person experiences and gives meaning to events in light of his or her own life experiences, according to their gender, cultural, political, religious and professional backgrounds (Schwandt 1998).

The area examined within this research study is psychoanalytic psychotherapy: the encounter between the therapist and the patient. In psychoanalytic sessions, the therapist uses observation and interpretation of the use the child/young person makes of their relationship with the therapist to help the child/young person understand some of their inner conflicts and to be less dominated unconsciously by them. The internal world of the child/young person is the main focus, the area of interest being the meaning the patient gives to their own experiences and how they construct their own reality, alongside studying the unconscious phenomena that are outside the conscious awareness of the patient. The patient's 'subjective meaning' and 'self-definition' are important (Rustin 2003), and qualitative research methods are considered appropriate to study these.

A qualitative research method allowed a single case to be studied in detail, including verbal and non-verbal communication, noting that the aim of the study was to look at the patient's use of their body within the psychotherapy sessions. Qualitative research methods also allowed an examination of 'psychoanalytical change processes' within the therapy (Hilliard 1993). A particular interest was in tracking when thoughts became thinkable.

The qualitative research method enabled the psychotherapy to be studied in its natural environment, the actual consulting room. The interaction between the patient and therapist, which is routine clinical practice, was studied in an environment that had not been changed or modified to fit in with the requirements of the research study.

A strength of qualitative research is that, in addition to being carried out in a natural setting, there is a stress on interpretation and meaning, and a deeper understanding of the respondent's world is achieved, which preserves a more realistic view of the world. However, many of the weaknesses of qualitative research reflect the positivist views of the world. Objectivity is sought with the aim of minimising prejudice and bias, ensuring that social reality will be 'represented as it is' rather than as it is 'interpreted or imagined by the investigator' (Sarantakos 1993 p. 18). From the positivist perspective, research should be value free, and there is no room for subjective views.

For qualitative research, objectivity does not exist but is created through interaction and through the meaning given to events. Reid (2003) quotes Van Langenhove (1996) who argues that:

human beings cannot be treated as if they are natural objects within an experimental situation where causation is the main criteria without including the exploration of reason and meaning. As psycho-analysis explores the meaning of the emotional experience for the patient it seemed important that the design of the research project reflected this way of thinking (Reid 2003 p. 211).

In the context of such exploration, Bion (1962) refers to 'learning from experience'. Rustin (2003) succinctly describes Bion's (1963) view:

Bion (1963) described this process as the bringing of coherence to hitherto disordered and apparently unrelated phenomena. What brings coherence, he argues is what he calls 'selected facts'. The apprehension of a 'selective fact' is, he said, an 'emotional experience'. The assimilation of the selected fact and the coherence that this brings to psychic phenomena, to a logical deductive system of theories and concepts, necessarily comes afterwards – after the fact, so to speak. That is the essence, so far as Bion sees it, of the process of psychoanalytic discovery, which he also thinks mirrors in many respects the processes of learning from experience during normal human development (Rustin 2003 p. 141).

O'Shaughnessy (1994), building upon Bion's ideas about 'selective facts', notes Kant's view that:

objective reality is known only through the structure of thinking mind and uses this to argue that we should not discount "clinical facts" that are developed "through categories of the mind in the belief that they cannot be known" (O'Shaughnessy 1994 p. 941).

It could be argued that the way to improve objectivity is through the mental preparation of the therapist. Rustin (2003) suggests that psychotherapists need

to be prepared mentally, as Bion (1967) states, 'without memory or desire' or in line with Freud's idea of 'evenly suspended attention' (Freud 1912e).

Having reviewed the decision to adopt a qualitative approach for this research study, I will now examine the advantages and disadvantages of using a single case design.

3.3 SINGLE CASE STUDY

As noted above, a single case study was chosen as it allowed a detailed focus on the area of interest: the patient's use of the body in the transference relationship in allowing thoughts to become thinkable. A defining feature of a case study is 'the desire to derive an up-close or otherwise in-depth understanding of a single or small number of cases set in their real-world contexts' (Bromley 1986 p. 1 in Yin 2012).

The single case study is a method of studying the unconscious that goes back to Freud. His study of Little Hans was written as a case study, where an in-depth narrative account of the patient's inner world was presented. Freud developed, through clinical case studies, key concepts that are still used in psychoanalysis today. Rustin (2003) suggests that the single case study is still the most widely used method of studying the unconscious amongst psychoanalytic psychotherapists.

However, the single case in the hierarchy of reliable evidence for medical research is deemed to be at the bottom whilst the Randomised Controlled Trial, a quantitative method, is deemed to be at the top and the 'gold standard' (National Service Framework for Mental Health DoH 1999) for being scientific, verifiable and neutral. Randomised Controlled Trials also have institutional, academic and political status (Richardson 2003). However, Randomised Controlled Trials do not reflect the clinical population, co-morbidity and case complexity where young people require support from multiple agencies (Richardson 2003). Noting these concerns, I shall now consider reliability, validity and generalisability in relation to the single case study.

3.3.1. Reliability

A key component of this research study is the reliability of the data collected; did this data accurately reflect the phenomena being studied?

The data collected for this research study is in the form of process notes, produced as part of my training as a psychoanalytic psychotherapist, and were not gathered with the intent that they would be used for this study. On that basis, it is considered that the potential for the objectives of the research study to bias the production of the clinical material is limited.

The use of process notes has a long-standing tradition in child psychotherapy, but their reliability has been the subject of debate. Melanie Klein (1961), in "Narrative of a Child Psycho-Analysis", details how she gathered her 'data' on which she built her theories and highlights the limitations and advantages of the use of process notes:

I took fairly extensive notes, but I could of course not always be sure of the sequence, nor quote literally the patient's associations and my interpretations. This difficulty is one of a general nature in reporting on case material. To give verbatim accounts could only be done if the analyst were to take notes during the session; this would disturb the patient considerably and break the unhindered flow of associations, as well as divert the analyst's attention from the course of the analysis. . . For all these reasons I am sure that notes taken as soon as possible after each session provide the best picture of the day-to-day happenings in the analysis, and therefore of the course of the analysis. Hence I believe that – allowing for all the limitations I have enumerated – I am giving in this book a true account of my technique and of the material (Klein 1961 p. 11).

Whilst Klein is noting the limitations of process notes, she does seem to be suggesting that her account of her analysis with Richard is an accurate reflection of the sessions. Some, however, have questioned the value of the facts as reported by Klein. Midgley (2006) questions if a 'clinical fact' (O'Shaughnessy 1994) actually exists in reality or is merely a 'construct within the therapist's mind' (Midgley 2006 p. 127). The accuracy of process notes has

also being challenged by research carried out in adult psychotherapy which notes the variation in what is recorded by different therapists. This study also suggests that sufficient clinical data is rarely provided to back the conclusions that are being drawn (Klumpner and Galatzer-Levy 1991).

In terms of this research study, the accuracy of the recording of process notes has been improved by providing what Lewis and Richie (2013) describe as 'thick description', providing sufficient detail of the original observations or commentaries, and the environments in which they occurred, to allow the reader to gauge and assess the meanings attached to them (Lewis and Richie 2013 p. 268). In the context of this research study, 'thick description' refers to the presentation of the data in the form of process notes of whole sessions, enabling the reader to follow the argument presented and draw their own conclusions from the data.

Another issue that needs to be considered is the subjectivity and the potential for bias, noting that the person who produced the process notes, that is, the therapist, is also the researcher. This problem has been addressed by separating the narrative of the account of the session from my interpretation of the narrative. Writing process notes is a skill that is learnt during the pre-clinical training and clinical training of psychoanalytic psychotherapists. The notes are presented without any reference to the therapist's thoughts or understanding of the material. It is in supervision that meaning is given to the interactions between patient and therapist. This is based upon the Tavistock model developed by the child analyst Esther Bick (1948), for the training of child psychotherapists.

It has been suggested that a way of providing a more literal account of what happens in a therapy session is through audio recording. Klein, in her preface to 'Narrative of a Child Psycho-Analysis', suggests that

Another possibility of obtaining literal accounts is the use of a recording machine, either visible or hidden – a measure which, in my view, is absolutely against the fundamental principles on which psycho-analysis rests, namely the exclusion of any audience during an analytic session. Not only do I believe that the patient, if he had any reason to suspect that

a machine was being used (and the unconscious is very perspicacious), would not speak and behave in the way he does when he is alone with the analyst; but I am also convinced that the analyst, speaking to an audience which the machine implies, would not interpret in the same natural and intuitive way as he does when alone with his patient (Klein 1961 p. 11).

Whilst Klein had reservations about audio recording, it could be used as a way of separating the therapist from the researcher, providing a more *complete* account of the therapy that would be free from subjective distortions (Midgley 2006). This view suggests that psychoanalytic psychotherapy is a 'talking therapy' where the interactions between therapist and patient are solely a verbal dialogue. My research is about the patient's use of the body in the transference, and audio recording would not capture the non-verbal communication between patient and therapist.

Video recording would capture some of the non-verbal communication. Alvarez and Lee (2004) used video recording, as well as clinical observations, in their research on autistic children. This allowed them to study moment-to-moment interactions. Rustin (2003) suggests that use of audio and video recording makes psychoanalytic concepts more visible and replicable, and could be used to assess the reliability of the process notes.

Using video recording for this research study could have made it easier to follow some of the processes, where thoughts become verbalisable in the therapist and the patient. Video recording could have also captured:

- changes in facial expressions
- visual communication between the patient and therapist
- the bodily movements of both the patient and therapist
- the use of the physical space in the room; linking proximity to the verbal and non-verbal communication

However, audio recording and video recording are not able to register the transference and countertransference, let alone the bodily countertransference. It should also be noted that, as stated earlier, the primary function of the clinical

material was for my training as a child psychoanalytic psychotherapist, where video recording and audio recording are not currently considered to be an appropriate method for gathering clinical material.

3.3.2. Validity

Case studies have been criticised for their lack of rigour in inquiry (Yin 2012). To address this concern, researchers have adopted methodologies to provide a framework for analysing the clinical data. Reid (2003) and Anderson (2003) conducted psychoanalytic psychotherapy research using the grounded theory approach. This methodology, developed by Glaser and Strauss (1967), enables data collected by traditional methods, that is process notes, to be analysed in a more systematic and explicit way. I used grounded theory to analyse my data, and I will explore this research method further in the data analysis section.

In terms of validity, Lewis and Richie (2013) refer to robustness. They identify that one of the ways in which it is possible to ensure that research is as robust as it can be is to carry out internal checks on the quality of the data and its interpretation. For this research study, I used triangulation to gain multiple perspectives on the same data. This was in the form of presenting data for clinical supervision as a child psychotherapist in clinical training and presenting data and the grounded theory coding to my research supervisor. These aspects of triangulation will also be discussed further in the data presentation section.

Another way in which I will ensure robustness is by looking for counterarguments, counteracting the criticism that case studies are written in a way that convinces the reader of the research conclusions and makes it difficult for the reader to develop their own view:

There is the possibility that a good, well told coherent story creates the risk of seduction, which is the context of communication to others can be summed up thus: the more a narrative is intellectually, emotionally and aesthetically satisfying, the better it is incorporates clinical events into rich and sophisticated patterns, the less space is left to the audience to

notice alternative patterns to elaborate alternative narratives’
(Tuckett 1993 p. 1183).

In my research study, I examined instances where potential for a counterargument to the prevailing dominant interpretative framework was present: for example, where paying attention to bodily communication did not bring about transformation of anxiety. This led to an understanding of the importance of the therapist putting her thoughts into words, particularly the patient’s negative feelings towards the therapist.

3.3.3. Generalisation

A question to consider in relation to the single case study is whether the research is ultimately interested in a particular individual or whether the intent is to be able to generalise to a wider population (Lewis and Richie 2013). Single case studies generate detailed insight into one particular patient, but this has been cited as a limitation as questions are raised as to whether generalisations beyond the study can be made legitimately:

An obvious weakness of a single case study is that it can provide no indication as to whether the relationship applies to all other, many other, a few other, or no other human beings’ (Wallerstein and Sampson 1971 p. 41).

However, it has been argued that the research findings of single case studies may have relevance to other studies within the particular area of interest, where comparisons may be made to see if there are any similarities within the findings (Morse 2006). Rustin (2003) suggests that psychoanalytic theory has been built up through a process of generalising from one case history to another similar case history. In the use of the single case study for this research, the aim was not to generalise the findings but to provide a hypothesis for further exploration and consideration by other child psychotherapists.

3.4 SAMPLE

Access to a single case, and the availability of data for analysis, were factors that formed part of my decision to undertake a qualitative research study of a single case design.

Intensive psychotherapy had been undertaken with three cases, which provided me with a pool of data which could potentially be used for my study. As part of my training as a child and adolescent psychotherapist, I had to see three patients for intensive, three-times-a-week psychotherapy: under five, latency and adolescent. The clinical supervision requirements were for weekly supervision of each of the three intensive cases. I was required to write up detailed process notes of each session, and these were discussed with my intensive case supervisor. The function of the supervision was to 'help the student to understand the patient's communications and to discuss the management and setting of psychotherapy' (Clinical Training in Child and Adolescent Psychotherapy Handbook 2013–2014 p. 8).

I considered all three of these intensive cases for their suitability for this research study. I considered the case of an eight-year-old boy who had received intensive three-times-a-week psychotherapy. However, his adoptive parents did not give written consent. A five-year-old girl who had received intensive psychotherapy was also considered, but she was not chosen as the family were involved in a complex court case, and it was felt to be unethical to contact the family with regards to possible involvement in the research study.

The sample chosen was one that fitted my area of interest and one where the patient had given written consent for her psychotherapy to be used in the research study. The case was that of Jane, who was aged thirteen years and seven months when she was referred to CAMHS. She was diagnosed with severe depression for which she was prescribed medication and received CBT. An improvement was noted in her mood, and CBT treatment was no longer considered necessary. However, she was not able to maintain the progress, and she began to present as low in mood with suicidal ideation. An in-patient admission was considered, but her family opted for psychotherapy. Jane was fifteen years and two months old when she commenced psychotherapy

3.5 DATA COLLECTION

As noted earlier, the data used for this research study was the clinical process notes produced primarily as part of my training as a psychoanalytic psychotherapist. These process notes were written as soon as possible after the therapy sessions and in as much detail as possible. This detail includes verbal exchanges and non-verbal communication, including eye contact, bodily movement and appearance. The transference and countertransference are also noted. The process notes do not include any of the therapist's understanding of the material. Process notes were written from the psychotherapists's perspective. Inevitably there is a degree of subjective bias in any attempt to write an objective account, but I have attempted to write a descriptive account without interpretation and I have not included any theoretical formulation.

The patient attended 260 sessions over a period of two years and ten months: three assessment sessions, which were then followed by nine months of weekly psychotherapy, and then a further two years of intensive three-times-a-week psychotherapy. Detailed process notes were written for all of the assessment sessions and used for supervision. In addition, within the first nine months of weekly psychotherapy, process notes were written for sessions, and these were discussed on a regular basis with my service supervisor in the clinical service. After nine months of weekly sessions, Jane's sessions moved from once a week to three times a week (intensive work). An intensive case supervisor was allocated. In the second year, detailed process notes were written up for one session per week, whilst brief notes drawing out the main themes of the sessions were written for the other two sessions per week. Discussions with the intensive case supervisor were in the context of a psychoanalytic framework for thinking about communication and development.

At the start of the data analysis, I read through all the 260 sessions and began to identify sessions where the main form of communication was bodily. Certain sessions appeared to stand out as pivotal; significant shifts in the therapy were noted where there was a transformation of anxiety, and the patient was able to verbalise what had otherwise been communicated in a bodily way. 'Purposeful sampling' (Bryman 2008) was used to select the 18 information-rich sessions as

data for the study. The logic that supports 'purposeful sampling' is that insight can be gained by selecting information-rich cases for study (Bryman 2008).

3.6 TRIANGULATION

I met on a regular basis with the two research supervisors; on one occasion all three of us met to set up the arrangements. Within these sessions the emerging categories were discussed, enabling different interpretations of the data to be thought about, which validated the representation of the categories emerging from the coding. Hence triangulation, by obtaining multiple perspectives on the data, has been used to increase the objectivity of the coding as different perspectives on the same material were considered. Anderson (2006) suggests the triangulation in child and adolescent psychotherapy can be found in information from other professionals, reflections on clinical material in supervision and multi-disciplinary case discussions. The case manager was a psychiatrist with whom I discussed the case.

3.7 ETHICS OF TREATMENT AND ETHICS OF RESEARCH

The data was gathered from psychoanalytic sessions carried out in the process of normal clinical practice. Jane and her mother gave consent to treatment. Jane also gave both verbal and written permission for the clinical material to be used as part of a research study. I was a trainee member of the Association of Child and Adolescent Psychotherapists (ACP), who have a code of professional conduct and ethics (2013), to which all therapists are expected to adhere. The issues of consent, confidentiality and avoidance of harm when psychoanalytic treatment is offered are addressed. Alongside, but separate from the issue of clinical consent, is the issue of research ethics. Research that is carried out in the National Health Service (NHS) in the United Kingdom is governed by the Department of Health Research Governance Framework, requiring permission from the local ethics committee. A standardised framework is provided. As is the case for clinical ethics, the issues of consent, confidentiality and avoidance of harm are the central planks of research ethics.

The standardisation of research ethics has come under some criticism for adopting 'paternalistic' and 'constraining' procedures. (Haggerty 2004 p. 391). Some suggest that, in adopting a set of procedures that have to be followed,

there is a danger that researchers will not engage in ethics in a live and ongoing way (Small 2001).

3.7.1. Informed consent: consent to treatment

Jane had received several episodes of treatment of another modality. The case manager discussed two treatment options with both Jane and her mother. One option was an in-patient admission whilst the other was psychoanalytic psychotherapy. Jane and her mother visited the in-patient unit and also spoke to me about psychotherapy. As advised in the code of professional conduct and ethics, I explained the nature of psychotherapy offered to ensure that Jane and her mother were making an informed choice. Without the young person's consent to engage in treatment, the therapy would not have taken place. Daws (1986) suggests that consent is something that develops throughout the treatment to enable work to take place between the therapist and patient, and she argues that this is a central plank of the therapy and treatment.

3.7.2. Informed consent: consent to research

I did not seek informed consent for research at the beginning of the treatment, because this was a routine clinical treatment, and at that time was not linked to this research study. I might speculate that consciously and unconsciously the dynamic between a patient and therapist would have changed if the patient felt they were part of a research study.

It is interesting to note and speculate about the issue of consent. Jane broached the subject herself after session number 55, following a particular turning point in the therapy, by asking if the therapist was considering using her as part of a research study. It is interesting that at this point I was attending seminars to help me to generate ideas about potential research topics. Jane seemed pleased about the idea of being studied and written about. I wondered if she was feeling a sense of gratitude.

I sought guidance from the trust in which I worked and was advised that full ethics approval was not necessary for retrospective single case studies, but permission from the patient was necessary. I applied for and was granted, approval from the university ethics committee, subject to minor alterations.

I wrote to Jane seeking consent to use her psychotherapy in my research study. She was informed that she was not obliged to give consent and could withdraw it without having to give a reason why. She completed that attached form which gave consent. The case was anonymised by changing identifiable factors, such as her name and the name of the therapist. The geographical area of the research was also changed.

3.8 DATA ANALYSIS

Grounded theory, one of the first formally identified methods of qualitative research, was the methodology initially chosen for the study. Grounded theory was devised by Glaser and Strauss (1967) for the purpose of building theory from data rather than deducting testable hypotheses from constructivist grounded theory (Charmaz 2006).

An alternative method considered for this research was that of Interpretative Phenomenological Analysis (IPA). The original author of the IPA methodology (Jonathan Smith, 1999) describes the application of IPA as building an analysis in a step-wise fashion, comparing one case with others in a group. The aim of IPA is to explore how participants make sense of their experiences, engaging with the meaning that experiences, events and actions hold for participants (Chapman and Smith, 2002).

There are similarities between IPA and grounded theory in terms of what they can do and in that they both have a broadly inductive approach to inquiry. However, whilst an IPA study is likely to offer a more detailed analysis of the lived experience of the case material, the application of grounded theory is likely to push towards a more conceptual explanatory level where the case material is used to illustrate a theoretical claim. Smith, Flowers and Larkin (2009) contrast the aim of grounded theory, which is to produce mid-level theoretical accounts of psychological phenomena, with that of IPA, which is to provide micro-analysis of individual experience, with the 'texture and nuance arising from the detailed exploration and presentation of actual slices of human life'. Whilst grounded theory and IPA have similarities in how they analyse the data, grounded theory uses constant comparison across the data to build codes.

Given that the aim of this research study was to build a conceptual understanding of a patient's use of her body in the transference relationship, with an expectation that this knowledge will be useful practically to other child psychotherapists, the grounded theory methodology was considered more appropriate. It is also worth noting that, early in the design of this research study, grounded theory was recommended by my supervisors, and there were other researchers around in the profession with experience of using this methodology available to provide support.

There are criticisms of grounded theory that needed to be considered in the design of this research study. Glaser and Strauss (1967) included in the defining components for grounded theory practice that analytic codes and categories are constructed from data, not from preconceived logically deduced hypotheses. However, some have questioned if it is possible to enter into research without any preconception. The objective of this research study was to examine the patient's use of the body within the transference relationship in intensive psychotherapy and how this contributes towards allowing thoughts to be thinkable. I approached coding with an open mind, but inevitably I would bring my understanding from my psychoanalytic training to bear on the focused coding. I used triangulation of perspectives in supervision to militate against the subjective use of my existing conceptual categories.

A criticism aimed at grounded theory is that the researcher is personally involved in the acquisition of data, raising concerns about subjectivity and validity of findings. These concerns were considered earlier in relation to the single case study and the use of process notes. Another criticism of grounded theory is that some researchers find it hard to theorise beyond the basic data, resulting in a form of re-description. A constructionist view as advocated by Charmaz (2006) would suggest that 'data should guide and not limit', allowing greater flexibility of process (Charmaz 2006).

Whilst I made every attempt to apply the grounded theory to my study, in practice it was found to be not a good fit. I came to the conclusion that thematic analysis better describes the method I used as it gave the flexibility to incorporate a psychoanalytic perspective into the analysis of the data. Thematic analysis is a methodology for analysing qualitative data that is

theoretically flexible. A number of theoretical frameworks can be used within thematic analysis, it can be:

‘an essentialist or realist method, which reports experiences, meanings and the reality of participants, or it can be a constructionist method, which examines the ways in which events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society. It can also be a ‘contextualist’ method, sitting between the two poles of essentialism and constructionism, and characterized by theories, such as critical realism (e.g Willig 1999), which acknowledge the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of ‘reality’ (Braun and Clarke 2006 p. 81).

It is important in thematic analysis that the theoretical framework of the analysis is clearly identified and that the decisions about the methodology of choice are made explicit. The theoretical framework should be congruent with the researcher’s aims, which should be identified and discussed.

Thematic analysis is a method for identifying, analysing and reporting patterns (themes) in the data, whilst the data is minimally organized it is rich detail. However, frequently it goes further than this, and interprets various aspects of the research topic’ (Braun and Clarke 2006).

Braun and Clarke (2006) argue that a lot of analysis is essentially thematic, whereas it is often not cited as the method of analysis. They suggest that thematic analysis is widely used, but there is a lack of clarity about what constitutes thematic analysis, consequently it does not appear to exist as a ‘named’ analysis in the same way as grounded theory or IPA.

Holloway and Todres (2003) suggest that thematic analysis should be viewed as the ‘Foundational Method’ for qualitative research, providing the development of core skills necessary to undertake qualitative research. They identified ‘theomatized meanings’ as a generic skill that is shared across qualitative research (Holloway and Todres 2003 p.347). Ryan and Bernard (2000) suggest that thematic coding should be viewed as a process which is undertaken within methodologies such as grounded theory, rather than a methodology in its own right. Others, however argue that thematic analysis is a method within its own right (Braun and Clarke 2006).

Patton (1990) highlights the similarities between thematic analysis and grounded theory; both are inductive approaches where the themes/codes identified are strongly linked to the data (Patton 1990). Thematic analysis acknowledges the active role of the researcher. The identification of the assumptions and values informing the analysis are essential components of the methodology (Braun and Clarke 2006).

‘Any theoretical framework carries with it a number of assumptions about the nature of the data, what they represent in terms of ‘the world’, ‘reality’, and so forth. A good thematic analysis will make these transparent’ (Braun and Clarke 2006 p. 81).

Thematic analysis allowed the data to be analysed using a conceptual framework according to psychoanalytic theories, which on reflection makes it the method of choice for the study.

In the next section ‘coding’ I will describe the initial coding using the grounded theory methodology. I discuss focused/theoretical coding and how I began by using grounded theory to analyse the data, but found that the overall conceptual framework for analysing the data took me beyond the scope of grounded theory and into the realms of thematic analysis.

3.9 CODING

Noting that the initial stages of coding for grounded theory and thematic analysis are similar, the initial coding allowed me to begin to study what was happening in the data and to think about what it meant. Qualitative coding allowed me to separate and sort the data. Initial codes were attached to segments of data in the process of categorisation. I could then make comparisons with other segments of data (Charmaz 2006).

I followed the strategy developed by Glaser and Strauss (1967) for coding data:

- Construct analytic codes and categories from data, not from preconceived logically deducted hypotheses.
- Use the constant comparative method, which involves making comparisons during each stage of the analysis.
- Advance theory development during each step of the data collection and analysis.

- Use memo-writing to elaborate categories, specify their properties, define relationships between categories and identify gaps.
- Conduct the literature review after developing an independent analysis.

In thematic analysis, like grounded theory, the researcher moves back and forth between the data and coded extracts of data. Both use a method of noting ideas and codes as they emerge and expand the ideas as the codes develop. Grounded theory refers to this process as using memos.

I briefly looked at the literature prior to analysing the data in order to complete my application to register for the Professional Doctorate in Child Psychotherapy. Whilst Glaser (1992) suggests that reading literature prior to the analysis might 'contaminate, stifle or otherwise impede the researcher's efforts to generate categories' (Glaser 1992 p. 31), other researchers, such as Urquhart and Fernandez (2006), suggest that it is possible to view existing literature without seeing it as the only way of viewing the area of study. They suggest looking at substantive theories before the analysis and then again, post-analysis, in more detail. The differing views in grounded theory on when to read the literature is also reflected in thematic analysis which suggests that the reading of the literature can be approached in a number of ways. A more inductive approach might engage with the literature in an earlier stage of analysis, in contrast to a theoretical approach where the literature would be engaged in following the analysis of the data (Braun and Clarke 2012).

I would argue that it is not possible to approach data without a tendency to order it according to pre-existing knowledge, and there is a need to adapt the method to accommodate this. Thematic analysis suggests that it is important the researcher acknowledges that pre-existing knowledge will influence the analysis of the data.

It was important for me to acknowledge my own theoretical stance and values, as a psychotherapist I draw upon the ideas of Bion, particularly his theories about learning from experience. Bion (1963) suggests that it is through emotional experience that appears to be disconnected that apparently unrelated phenomena can be brought together. This is a process that takes place

between two minds and I would suggest through two bodies. It could be argued that this approach is more in keeping with inductive thematic analysis which is a

'a process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher's analytic preconceptions. In this sense, this form of thematic analysis is data-driven'
(Braun and Clarke 2006 p.84).

However for this study it was important that I acknowledged that I could not free myself from the theories that underpin my psychoanalytic practice.

Clarke and Braun (2006) argue that grounded theory increasingly uses a set of procedures for coding data that is closer to thematic analysis. Both using coding to:

'seek patterns of meaning and interest, moving back and forth between the data and coding' (Clarke and Braun 2006 p.81).

A challenge I faced when analysing data, using grounded theory, was to remain open to the data and to what emerged from within the data. Glaser (1998) warns that the researcher's view of the world, and professional interests or focuses upon particular theories, could affect the researcher's ability to suspend preconceptions. Glaser and Strauss argue that 'grounded theory meets the following criteria: a close fit with the data, usefulness, conceptual density, durability over time, modifiability, and has explanatory power' (Glaser and Strauss 1967 cited in Charmaz 2006 p. 4). Thus they challenge the belief that qualitative methods are impressionistic and unsystematic.

In analysing the data, using grounded theory, I used two phases of coding: initial coding and focused/theoretical coding (Charmaz 2006).

3.9.1. Initial coding

Initial coding allowed a close reading of the data and helped me to remain open, whilst exploring all possibilities (Charmaz 2006). Line-by-line coding was chosen to ensure that I was not imposing my own story on the data whilst a systematic and detailed examination of the data was pursued. It also helped to avoid what Glaser (2005) terms as 'pet theoretical codes' being introduced into the study from the outset. Whilst the area of interest was defined at the start of

the research, the initial line-by-line coding guarded against me imposing my own views:

By studying the data, you may make fundamental processes explicit, render hidden assumptions visible, and give participants new insight (Charmaz 2006 p. 55).

I followed Charmaz's (2006) initial coding practices as follows:

- remain open
- stay close to the data
- keep codes simple and precise
- construct short codes
- preserve actions
- compare data with data
- move quickly through the data

Charmaz (2006) suggests that, by conducting careful line-by-line coding, the researcher is fulfilling two criteria for grounded theory: fit and relevance.

Charmaz (2006) also suggests that the study will fit the empirical world 'when you have constructed codes and developed them into categories that crystallize particular participant's experiences.' The study also has relevance when a careful analytic framework has been used that 'interprets what is happening and makes relationships between implicit processes and structure visible' (Charmaz 2006 p. 54).

The aim of this research was to study psychoanalytic processes. By using initial coding, fundamental processes within the interaction between patient and therapist are made explicit. Holton (2007) suggests that the coding practice increases 'content validity'; that is, what has been measured is what the researcher thought was being measured. Line-by-line coding allowed me to separate the data into categories and to begin to see processes.

Charmaz (2006) advocates looking critically at the data and suggests asking the following questions:

- What process(es) is/are at issue here? How do I define it?
- How does the research participant act when involved in this process?

- How does this process develop?
- How does the research participant(s) profess to think and feel while involved in this process? What might his or her observational behaviour indicate?
- What might her observed behaviour indicate?
- When, why and how does the process change?
- What are the consequences of the process?

(Charmaz 2007 p. 51).

The following table provides an example of initial codes identified in the clinical material for assessment session number 3.

Assessment Session Number 3

INITIAL CODING	CLINICAL MATERIAL
Communication of anger via movements of the body Being drawn into looking at her bodily communication	Jane began to shake her legs in an agitated way. She was looking at her legs and clearly wanted me to notice them and remark about them. It felt like I was being drawn into some kind of game. I was unsure what the game was and what part she had given me.
Therapist wondering about meaning of bodily communication	Jane began to move her legs again. I began to wonder if she wanted to kick me or if she felt like I had kicked her.
Patient challenging the therapist via eye contact	Jane looked at me with a look that seemed to be testing me; what was I made of? We held the look briefly.

The example above shows how the patient's use of bodily communication, including movements of her body and eye contact, was coded.

I used the constant comparison technique, which involved three different stages. Incidents were firstly compared to other incidents in the data to look at the similarities and differences. The emerging concepts were then compared to other incidents to develop new theoretical properties of the concept. Finally, emergent concepts were compared to each other with the purpose of

establishing the best fit between potential concepts and a set of indicators enabling their integration (theoretical coding) into hypothesis to become theory (Glaser and Holton 2004). Theoretical saturation was achieved when the comparison of incidents in the data were repeated until no new dimensions were emerging from the coding and comparison.

3.9.2. Memoing

Whilst carrying out the coding and analysis, I began to write memos. These memos noted my initial responses to the data, including the codes and comparisons, which included countertransference responses (Charmaz 2006). At the start, these responses were often single lines and involved descriptions. As the research continued, memos became more complex as they began to integrate ideas from previous memos.

Memos are narrative records of the therapist's analytic conversations with herself about the research data. It is through writing memos that I began to formulate my ideas, and explore and expand them. Memos help the researcher to 'elaborate processes, assumptions, and actions covered in the codes or categories' (Charmaz 2006 p. 82). In writing memos, the relationships between categories were 'successively reconsidered' (Strauss 1987).

Memos helped me to decide what direction to take in both the coding and analysis. The memos were also used in the later stages of analysis to help to pull together the overall theory. I also re-read memos to recall my instant reactions during and after discussions with the supervisors and other researchers, as advocated by Hamberg and Johansson (1999).

Both initial coding using grounded theory and initial coding using thematic analysis seek to capture important aspects of the data. A significant difference is that in thematic analysis the judgement of the researcher is considered to be an important aspect of the research. Gilgun(2012) suggests that the researchers ability to reflect upon their role is important. Archer (2007) argues that human reflexivity works through internal conversations using language, but also emotions, sensations and images. These ideas are in keeping with my study which looked at the patient's use of her body in the therapeutic

relationships and also the therapist’s emotional responses, including bodily responses.

3.9.3. Focused coding/theoretical Coding

The second phase of coding using grounded theory was focused coding. Within the initial coding stage, the most significant codes were identified. These codes were then used to allow me to move between sessions comparing ‘experiences, actions and interpretations’ (Charmaz 2006 p. 59). The aim was to look at the adequacy of the codes and to compare codes and data with each other, which then helped to refine the codes.

An example of focused coding is shown in the table below for assessment session number 3:

Assessment Session Number 3

CLINICAL MATERIAL	FOCUSED CODE
I tried to comment about how difficult it seemed, thinking about me seeing other people.	Therapist’s thoughts not yet thinkable
Jane began to shake her legs in an agitated way. She was looking at her legs and clearly wanted me to notice them and remark about them. It felt like I was being drawn into some kind of game. I was unsure what the game was and what part she had given me.	Patient uses eye contact to draw therapist’s attention to the bodily communication Transference to an object that taunts her
Jane began to move her legs again. I began to wonder if she wanted to kick me or if she felt like I had kicked her.	Physical movement: communicating non-verbally her aggression

The above example of focused coding illustrates how the patient verbalises her thoughts whilst her anger is felt in the therapist’s countertransference. The patient communicates, via her bodily movement and eyes, her emotional state, which cannot yet be verbalised.

I went back to the clinical material and began focused coding, noting the different ways in which the patient was communicating at a bodily level and

identified where there was reference in the data to:

- eye contact
- physical proximity
- tone of voice
- therapist's countertransference

I continued with the focused coding and identified several other codes in the data:

- movements of the body
- physical appearance
- bodily countertransference

As I continued with the focused coding, I began to use memos to note the different aspects of the codes and also how these developed as the therapy progressed. I also began to locate within the therapy where the different codes began to emerge and where they occurred in conjunction to each other.

This was the second stage of analysis within the research study. The focused codes were 'more directed, selective, and conceptual' than the line-by-line coding (Charmaz 2006 p. 59). Theoretical coding was used to look at the relationship between categories that had emerged within the initial coding stage. Glaser (1992) argues that theoretical coding allows the researcher to bring together the different parts of the story.

The codes that emerged within the initial stage were scrutinised to discover meanings within the codes. I began to ask different questions, thus exploring unforeseen and new areas of interest. An example was the importance of words, which might seem strange when my study is about non-verbal communication. Words were found to be important in describing what I felt in the bodily countertransference, particularly relating to negative emotions.

When inevitable questions arose and gaps in the categories appeared, I went back to the data to seek answers to such questions, thus filling the gaps. The categories that began to develop became more theoretical because I was engaging in the successive levels of analysis. I constantly went back and forth to the data to check and refine the emerging categories.

Within theoretical coding, I hoped I would be able to begin to identify 'specific conditions under which a particular phenomenon is evident, for example, when I noted the bodily countertransference. I wanted to know if the patient began to be in touch with her feelings. I asked this question: does putting into words the patient's projections, via the bodily countertransference, help or hinder thoughts to become thinkable?

Memos were sorted at this stage and integrated into the emerging theoretical outline. Theoretical sorting of the memos was based upon conceptual sorting rather than data sorting. Similarities, links and 'underlying uniformities' were focused upon so as to help to begin to place the particular memo. The ideas memos were closely examined:

facilitating the emergence of relevant theoretical codes requires close attention to the ideas memoed, submersion at the conceptual level, a balance of logic and creativity, openness to the unexpected, and confidence in following what emerges regardless of how counter-rational it may seem (Holton 2007 p. 284).

Sorting allowed data and ideas to begin to be ordered, and at this stage more memos were produced. Relevant literature was also integrated into the theory. In the literature review I had looked at the literature on the use of the body in psychoanalytic psychotherapy; I felt that it was important to go back to the literature, particularly the work of Bion and Klein, to focus on thoughts becoming thinkable. The different concepts were pulled together, and I began to think about their relevance within the whole theory, and where each memoed idea fitted within the emerging theory.

As noted earlier, I met on a regular basis with the research supervisor/s; on one occasion all three of us met to set up the arrangements. Within these sessions, I discussed the emerging categories with my supervisor/s, which enabled different interpretations of the data to be thought about. These discussions provided validation for the representation of the categories emerging from the coding and, by taking into consideration different perspectives on the material, increased the objectivity of the coding.

The focused coding brought in a psychoanalytic perspective that had not arisen entirely from the data in the way that is required by grounded theory. Rather, it

reflected psychoanalytic theories that underpinned the therapeutic encounter described in the data. Thematic analysis is the method that best described how I framed my conceptual framework according to psychoanalytic theories.

The title of the study; the patient's use of her body within the transference relationship in intensive psychotherapy towards allowing thoughts to become thinkable. The concept of 'thoughts becoming thinkable' is one that Bion developed. The transference relationship is a psychoanalytic concept that underpins my clinical practice. Thematic analysis recognises the theoretical stance adopted by the researcher as an important part of the analysis of the data and argues it needs to be made transparent. Whereas grounded theory generates codes the expectation is that these emerge from within the data.

The focused coding and overall conceptual framework for analysing the research took me beyond the scope of grounded theory and into the realms of thematic analysis.

Summary

This chapter provides a discussion of how my research question was developed and describes how I approached my study. The process I used to explore the clinical case material is also illustrated. I also describe how the data was initially analysed using the grounded theory method but I came to the conclusion that thematic analysis better describes the method I used, as it gave the flexibility to incorporate a psychoanalytic perspective into the analysis of the data. In the next chapter I will present some of the data used in this research study.

CHAPTER 4: DATA PRESENTATION

4.1 INTRODUCTION

In chapter 4, I will present clinical material to illustrate how the initial codes emerged from the data:

- use of eyes
- movements of the body to communicate an emotional state
- bodily countertransference
- use of physical proximity in the sessions

Data which illustrated the developments in the bodily countertransference will be presented. Three further sections are presented which demonstrate the development of a persecutory internal eye which allows no space for thinking, the development of an apparatus for thinking and the development of a space for thoughts to emerge.

4.2 INTRODUCTION TO THE CASE

Jane was thirteen years and seven months old when she was referred to the Child and Adolescent Mental Health Service by her General Practitioner for an assessment for depression. Dr Baxter, Specialist Registrar, assessed Jane and confirmed the diagnosis of depression. She was then prescribed medication along with CBT. Improvements were noted in her mood and she began to attend school again. Six months after the original referral, Dr Baxter, who undertook the CBT, went on maternity leave. The case was transferred to Professor George, Consultant Child and Adolescent Psychiatrist, who reviewed Jane's progress whilst Ms Armitage, Child Psychologist, continued with the CBT.

Four months later, Jane was making good progress and no longer required the CBT. However, after a further four months, Jane began to present as low in mood and was having suicidal thoughts; she had said that she wanted to walk in front of a car, and her school attendance had deteriorated. Professor George reviewed her mental state and concluded that she was suffering from severe depression. He then saw Jane on a regular basis, but Jane's mood did not lift.

Professor George requested a psychoanalytic psychotherapy assessment; Jane was then 15 years and 2 months old. He also referred Jane to the in-patient unit with regards to the possibility of an in-patient admission.

Dr Jones took over the management of the case. The family had been offered an assessment appointment at the in-patient unit. They attended the appointment, but Jane's mother concluded that she did not want Jane to be admitted as a cousin had been in the unit and the outcome had not been positive. Feedback from the unit suggested that, whilst Jane and her mother had wanted to go and look around the unit, they had already decided before their visit that they did not support an admission.

4.2.1. Family composition and early history

Jane has a sister, Louise, who is five years older than her. Jane lived with her mother and father, who were in their early forties. Louise was at university, but still lived at home. Other significant family members were her maternal grandparents and maternal aunt.

Jane was breast-fed for the first six months and was described as 'loving food'. She was also described as a 'sleeper'. She was described as a baby who suffered from numerous allergies and had experienced bouts of croup and whooping cough within her first year.

Jane's maternal aunt provided day care for Jane when she was six months old, following her mother's return to work. Jane also had a period of day care with her maternal grandmother and then returned to the care of her aunt. The maternal aunt suffered from an eating disorder and also had bouts of depression.

Jane described her relationship with her aunt as very close and that they both had in common a feeling that they were the less favoured within their family. Her aunt felt that her mother (Jane's grandmother) favoured her other sisters over her. Jane's aunt had died of cancer just over two years prior to her commencing psychotherapy. Jane's maternal grandfather died in the same year as her aunt. Jane stated that she was closer to him than her maternal grandmother.

4.2.2. Psychoanalytic frame

Jane attended three psychoanalytic psychotherapy assessment sessions. She attended three sessions on the same day of the week, in the same room and at the same time. These sessions were fifty minutes in duration. Following the completion of the assessment, a review meeting was held and once-weekly psychoanalytic psychotherapy was commenced. Jane attended nine months of once-weekly therapy sessions, followed by two years of three-times-a-week psychotherapy.

4.3 INTRODUCTION TO THE DATA

Data for the first eighteen months is presented in chronological order to demonstrate examples of the different ways in which Jane used her body within the therapy, and how these developed over the course of the therapy. I will present data from selected clinical sessions divided into three sections to illustrate the clinical material and the emergence of the initial and focused codes.

The developments in the therapy which occurred in between the sessions will be briefly outlined. I will highlight new themes as they develop, and any external events which impacted upon the course of psychotherapy.

4.3.1. How the initial codes emerged from the data

I will use five clinical sessions to illustrate how the initial codes began to emerge from the data: assessment session numbers 2 and 3; session numbers 2 and 3; and session number 10.

Assessment session number 2

INITIAL CODING	CLINICAL MATERIAL
Engaged in activity by herself away from her mother Clinic feels like home for Jane and her mother	When I went to collect her, she was reading a magazine, as was her mother. They both looked very much at home in the clinic.
Positive greeting of therapist by mother and daughter	I said "hello" to Jane, who smiled at me and both Jane and her mother said "hello" back to me.

INITIAL CODING	CLINICAL MATERIAL
Appears well dressed and ready to engage	Jane is fifteen, tall with shoulder-length shiny dark brown hair and engaging dark brown eyes. She was smartly dressed in fashionable jeans and a hooded top.
Therapist is surprised by Jane's physical appearance	This was the second time I had met with Jane, and I was again taken by how she did not look as I had expected from reading her file. I had expected a more dishevelled, sad-looking young person.

When coding the second assessment session, Jane's physical appearance began to be noted, and I started to think about how her appearance was communicating aspects of her internal world that were not communicated verbally, but which could be observed by me: that is, Jane's physical appearance did not match the description of the severity of her diagnosed depression described in her file. Physical appearance was identified as a code to be tracked throughout the therapy.

When coding the third assessment session, I began to note the different ways in which Jane used her eyes.

Assessment session number 3

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODE
Feeling like one of many patients.	Jane commented that I had lots of people to see; this was slipped in quite quickly, and she then moved onto another subject.	Verbalising her thoughts
Therapist comments about the patient's struggle with idea of the therapist seeing others whilst she had restricted number of sessions	I said that Jane seemed to be thinking about all the other people that I see. I sensed that she was fuming and angry with me, seeing all these other people, whilst she had only three assessment sessions and then a review.	Patient's anger felt in the therapist's Countertransference
Therapist struggling to verbalise the patient's struggle with her relationship with others	I tried to comment about how difficult it seemed, thinking about me seeing other people.	Therapist's thoughts not yet thinkable

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODE
<p>Communication of anger via movements of the body</p> <p>Being drawn into looking at her bodily communication</p>	<p>Jane began to shake her legs in an agitated way. She was looking at her legs and clearly wanted me to notice them and remark about them. It felt like I was being drawn into some kind of game. I was unsure what the game was and what part she had given me.</p>	<p>Patient uses eye contact to draw therapist's attention to the bodily communication</p> <p>Transference to an object that taunts her</p>
<p>Therapist wondering about meaning of bodily communication</p>	<p>Jane began to move her legs again. I began to wonder if she wanted to kick me or if she felt like I had kicked her.</p>	<p>Physical movement: communicating non-verbally her aggression</p>
<p>Patient challenging the therapist via eye contact</p>	<p>Jane looked at me with a look that seemed to be testing me; what was I made of? We held the look briefly.</p>	<p>Holding the communication non-verbally via eye contact</p>
<p>Able to put into words her thoughts</p>	<p>I commented that Jane's legs seemed to be moving. She said they did that when she was anxious and sad.</p>	<p>Patient links bodily movements with emotional state</p>
<p>Therapist speculates about link between physical movement and end of assessment sessions</p>	<p>I said perhaps your legs are letting me know that it is difficult thinking about the end of our three sessions.</p>	<p>Therapist interprets</p>
<p>Patient responds to interpretation with bodily movement and eye contact</p>	<p>Jane's legs moved again and she looked at me again, with what felt like a more confrontational look.</p>	<p>Physical movements: holding her feelings along with the countertransference picking up the intensity of the projection</p>
<p>Patient verbalises fear of abandonment</p>	<p>Jane commented about her need to cling to people because she did not want to be alone.</p>	<p>Able to express her thoughts verbally</p>

In the session above, Jane used her eyes to link with me and to draw attention to emotional states that have not yet been thought about, but which are at the point of becoming so.

In this session, Jane's eyes were used to draw attention to the movements of the body which communicated her aggression, and which could not yet be verbalised. Another code was identified, Jane's body movements, which continued to be tracked throughout the data analysis. I also began to note when, in the therapy session, I was struggling to articulate my own thoughts in the transference. It was therefore decided to track instances where I was struggling to verbalise my thoughts.

Following the three assessment sessions, Jane commenced once-weekly psychotherapy. The next session presented below is after a month of once-weekly psychotherapy. In the following session, another code began to emerge: that of the therapist's bodily countertransference.

Session number 2

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Ill-treatment at the hands of others	Jane went on to tell me again about being shouted at when she went to work.	Patient's anger is located in others
Encouraging patient to express her own feelings	I said that perhaps she wondered if she could bring her angry feelings in here with her.	Therapist interprets
Communication via eye contact something serious	Jane looked at me: a serious look.	Following an interpretation by the therapist, the patient links visually with the therapist
Twisting with a tight grip something that feeds you	Jane picked up her drink and began to turn it around in her hand, slowly turning with one hand whilst she held it tightly with the other hand.	Attack on the maternal function is communicated via physical movements
Uncertainty about what is being communicated Link in the therapist's mind to attack on the mother	I was not sure what to make of this, but it felt like she was slowly twisting the carton. I thought about breast-feeding and found myself wincing.	Attack on the maternal functioning of the therapist felt in the therapist's bodily countertransference

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Therapist's comments are dismissed as unimportant	I began to think that I had not referred to the break the following week. I commented about the fact she would miss a session next week. Jane said she was not bothered.	Thoughts about imminent break become thinkable in the therapist's mind

The bodily countertransference is where I experience the patient's communications at a bodily level. I wanted to track this bodily countertransference in the therapy; in this session, following the bodily countertransference experiences in the therapy, it is noted that my thoughts became thinkable with regards to the imminent break, which I verbalised to Jane. However, I noted that, when I verbalised my thoughts in the transference, this did not bring about a transformation of anxiety.

From this, I began to examine the data for instances that the notes referred to when I did not verbalise my thoughts in the session. I noted two different aspects: was it a struggle for me to verbalise my thoughts, or was I hesitating to verbalise my thoughts?

Within the next session, I began to note the different ways that Jane used her eyes to link, watch and hold my eye contact and project into me.

Session number 3

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODE
Warm greeting	I said "hello": Jane looked up and smiled. I asked Jane to come through to the therapy room.	Making a link with the therapist via eye contact
Arrival of previous therapist engaged with other family	Just as we got up, Dr Baxter, Jane's previous CBT therapist, came into the waiting room and began to talk to another young person and her mother.	

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODE
Observation of patient's shock and anticipation on seeing previous therapist	I found myself looking at the expression on Jane's face; it was one of shock and also one of anticipation: was Dr Baxter going to speak to her? Dr Baxter was talking to the family.	Therapist observing the patient's non-verbal responses
Lack of proximity	Jane and I walked through the door to the therapy room. I was walking quite slowly, but Jane seemed some way behind me.	Patient is physically disconnected
Patient is hesitant on entering the room	When we finally reached the therapy room, Jane hesitated and then sat down on the patient's chair. I put the engaged sign on the door.	
Linking visually with therapist	I could feel Jane's eyes watching me with some intensity.	Attempting to connect with the therapist via eye contact
Patient seeking and holding onto therapist with her eyes	I sat down and Jane looked at me with her big brown eyes; I sensed she was trying to hold my gaze.	Patient holding herself together via eye contact with the therapist when disintegrating
Confusion in patient about last contact with therapist	Jane, in a disorientated, puzzled and enquiring way, commented that we had missed a session the previous week because she had been on holiday.	Patient and therapist trying to orientate the patient in space and time
Therapist comments about seeing previous therapist in the reception	I also commented that I had been surprised to see Dr Baxter in the waiting room today.	Therapist verbalises what she has observed and felt in the countertransference
Mismatch in verbal and bodily communication	Jane said that it was okay in a dismissive tone of voice, but her eyes seemed to say something quite different.	Patient not able to verbalise emotional state

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODE
Communication of emotions via her eyes	She looked shocked and distressed. I looked at her and she looked at me. I felt a wave of sadness come over me.	Projection of emotional state which cannot be named is communicated via eye contact Sadness is experienced in the therapist's bodily countertransference

In session number 3, I used my eye contact to observe Jane's emotional state and to hold Jane via her gaze when she was in a disintegrating state, thereby holding parts of her personality together.

The researcher noted that verbal interpretations did not always bring about a transformation of anxiety. In this session, I noted to Jane the presence of her previous therapist in the reception. However, Jane was unable to verbalise her sadness, but her sadness was experienced at a bodily level in me.

When coding the session above, I also began to code physical proximity, how Jane and I managed the transition through the physical space between the reception and the therapy room.

It was at this point in the therapy that Jane requested a change in the time of her session to an after-school appointment to ensure her attendance of core GCSE lessons. A change was agreed, and she was informed that she would be allocated the next after-school slot when it became available. Over the following weeks her mother, school mentor, class teacher and tutor either contacted me by telephone or accompanied Jane to the clinic to 'put her case' for an after-school appointment. In the transference, the object was someone who was cruel, rigid and denied her what she needed.

Session number 10

In the session presented below, Jane's mother had asked to speak to me before the session to request a change in the time of Jane's session. I had suggested that we spoke about this after Jane's session. Within the session below, the intensity of Jane's rage is communicated via her bodily movements.

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODE
Jane turned away from the therapist's greeting	I said "hello" to Jane; she looked away, biting her lip. Jane carried on looking down.	Attack on the link with the therapist is communication via an oral attack
Noting withholding something from the therapist	I said that she seemed to be holding something in.	
Names sadness but still withholding feelings	Jane said that she was feeling sad. Tears seemed to be just about to overflow; she was still biting her lip.	Sadness is expressed verbally Oral attack on the self which silences the patient
Therapist enquiring about emotional state Debating if to pick up sadness or biting Patient dismisses therapist's attempts to understand her emotional state	I asked if she could say anything else about her sadness (I wondered if I should be talking to her about her struggle to talk about sadness or her biting her lip). Jane said she did not know in a dismissive, don't-care tone of voice.	Transference to an object that cannot hold both sad and angry feelings and who does not care
Turning away and denying sadness	Jane seemed to be trying to swallow her sadness. She looked away from me.	Visual link with the therapist is disconnected Therapist observes repression of feelings
Therapist attempting to link with patient	I leaned forward; Jane continued to look away.	Therapist moves physically closer to the patient
Trying to hide anger	Jane began to pull the sleeves of her jumper over her clenched fists. She began to shake her legs.	Rage is expressed through the patient's physical movements Transference to an object that is non-receptive
Therapist receives projection. Decides not to comment	I felt like she might hit me, rage seemed to be in the room. I decided to wait to see what would emerge.	
Noting patient's ambivalence	After some time, I commented that Jane seemed to be turning away from the session that day; perhaps she felt that there was nothing therapist Julie could offer her that day.	Therapist drawing patient into the transference
Continues to turn away from the therapist	Jane continued to look away.	Patient continues to cut the visual link with the therapist

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODE
Therapist feels frustration	I began to feel frustrated.	The patient's rage is felt in the therapist's countertransference Projecting what could not be thought about verbally
Patient harming herself Anger turned on self	Jane began to bite her already very bitten nails; she crunched them with her teeth.	Communication of her anger via an oral attack on the self
	I tried to formulate some words about Jane's nail-biting but struggled to do so.	Therapist struggles to verbalise her thoughts
Therapist notes patient's self-harm rather than verbalising her anger Anger with self rather than unreceptive object Therapist comments about patient's angry feelings.	Jane bit the side of her nails. I commented that she seemed to be biting her already sore nails: rather than talking to me about her anger, she was biting at herself. She carried on and her left leg began to move in an agitated way. I commented that things seemed to be stirring her up that day. Jane's leg continued to move and she clenched her fist. I said that perhaps she would like to hit me as she was so angry with me.	Patient's anger is expressed in body movement Transference to an object that can't think about her rage. Communication is non-verbal and expressed through the body via physical movements Drawing the patient into the transference

In the session above, the physical proximity to me is worth noting; I get physically closer to Jane's rage and this draws her into the transference. My thoughts become thinkable, and subsequently Jane projects into me via her eye contact. Thoughts about her angry feelings cannot yet be verbalised by Jane, but they can be communicated non-verbally.

Within the next seven sessions, Jane's physical appearance continued to be incongruent with her emotional state. Within the sessions, her feelings, particularly angry feelings, were expressed non-verbally, turning her anger inwards and attacking the surface of her skin. Her rage was expressed through her bodily movements. There was a theme of Jane drifting off in the sessions, with a transference to a disconnected object.

Emerging framework from coding the three assessment sessions and session number 1 through to session number 11

<p align="center">Physical proximity</p> <p align="center">Merged</p> <p align="center">Disconnected</p> <p align="center">Connecting</p>	<p align="center">Transference</p> <p align="center">Disconnected object</p> <p align="center">Cruel and denying object</p>	<p align="center">Eyes</p> <p align="center">Linking</p> <p align="center">Watching</p> <p align="center">Holding</p> <p align="center">Projecting</p>
<p align="center">Physical appearance</p> <p align="center">Incongruent</p>	<p align="center">Physical movements</p> <p align="center">Oral attack on the skin</p> <p align="center">Movement of her legs communicating her aggression</p>	<p align="center">Bodily countertransference</p> <p align="center">Wincing</p> <p align="center">Sadness</p>

A change in Jane's physical appearance is noted in session number 12. In the second session in the therapy, a mismatch had been noted between her immaculate physical appearance and the severity of her depression.

Session number 12

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Surprised to see Jane on her own	Jane arrived on her own, I was quite surprised to see that her mother was not with her.	Therapist taking patient in visually and surprised by absence of her mother
Feeling lost on her own	As we walked to the therapy room it felt like she was a little girl who was lost walking down the corridor.	Disconnected from object
Dishevelled and dirty appearance	Jane sat on her usual chair she looked less glamorous than usual wearing a t-shirt and shorts. Jane looked at her hands; her nails were bitten and looked like they had some dirt under the finger nails.	Appearance is congruent to emotional state of a young person with severe depression

In session number 12, I observed how her physical appearance was now more congruent with the severity of her condition. In this session, she appeared dishevelled with bitten dirty nails. The theme of a mother that was 'out of sight', an absent mother, which was reflected in the transition from the reception to the therapy room. As we walked down the corridor, I could not see Jane as she was walking directly behind me. In the countertransference, I felt I had lost sight of her.

I will briefly outline the themes in relation to the transference and developments in the therapy in sessions 12–32. The transference continued to be to a non-receptive object: someone who could not manage her intense feelings of both anger and sadness, an object that physically needed to keep a distance from Jane.

Jane's use of eye contact was particularly striking, in that she would often communicate the intensity of her feelings via eye contact. Within this period, her non-verbal communication was predominantly through eye contact. She continued to draw me to her via her eyes. She would also continue to project into me via her eyes.

At this stage in the coding, I begin to think about what could and could not be thought about, and what could only be communicated through non-verbal communication. Observation of non-verbal communication was used in the therapy to inform my interpretation, thus helping different aspects of the transference to develop, facilitating the emergence of an internal object capable of reflection on feelings.

I began to think with Jane about a move to three-times-a-week intensive psychoanalytic psychotherapy. After nine months of once-weekly psychoanalytic psychotherapy, Jane's sessions were increased to intensive psychotherapy at three times a week. The next session is the first session of the week following the increase to three times a week.

4.4 DEVELOPMENTS IN THE BODILY COUNTERTRANSFERENCE

Session number 32 demonstrated the development in the therapy of the bodily countertransference.

Session number 32

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Direct expression of feelings is articulated rather than expressed non-verbally	Jane came into the room, sat down and told me she was really angry.	Thoughts thinkable
Therapist noting start of the session	I noted the late start of the session and apologised for this.	
Patient commenting on therapist's appearance	Jane said I looked pale and tired. I felt like I had been slapped around the face. Jane said I looked like I had been rushing.	Transference to a fragile object not capable of meeting the demands of a needy patient
Patient linking angry feelings to her grandmother	Jane said she was angry with her grandmother who was the cause of her problems.	Patient's anger is projected in the grandmother

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Patient noting inability to listen and remember	People had told her grandmother but she still did not listen. Jane said that perhaps she could not remember.	Transference to an object that is mentally incapable of attending to the patient
Therapist acknowledging patient's difficulties with being left out linked to the late start of the session	I said that perhaps she thought I had not heard her tell me that she found it very difficult when people favoured other people, and perhaps she thought I had been favouring someone else when I had turned up late.	Therapist brings transference back to self
Patient denies angry feelings towards the therapist	"I'm not angry with you," she said. I was not convinced.	Patient unable to express anger in the transference
Patient acknowledges angry feelings verbally and non-verbally.	Jane clenched her fist and said she could hit her; I wondered to myself if she felt like hitting me. Jane continued to tell me about her anger.	
Therapist speculates that patient is actually angry with her	I said perhaps she was very angry with me as she may think I have not remembered the time of the appointment; perhaps I was the old woman who had not kept her in my head.	Therapist intensifies transference
Patient verbalises feelings	Jane said that she was angry with her grandmother, perhaps me and people.	Thoughts become thinkable
Linking with the therapist verbally	Jane began to move her leg and commented that, when she was angry, she would move her leg.	Patients verbalises her awareness that her anger is often located in her physical movements
Therapist acknowledges patient's angry feelings	I commented about how angry she was that day.	

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Patient turns anger on herself and makes herself both victim and aggressor	Jane began to bite her nails; I could hear the crunching. Jane began to bite around her nails; this always makes me wince as they are very sore.	The pain associated with a ferocious oral attack on the self is felt in the bodily countertransference of the therapist
Therapist comments about patient hurting herself	I commented that her nails were quite low, and perhaps biting them stopped her from using her nails. Jane sat back in her chair; she seemed to be switching off. Jane then looked around the room.	Identified with a mother that is disconnected and does not understand
Patient scratching hard surface	Jane began to rub her fingers and then the little bit of nail she had along the radiator.	Wish to attack the object is translated into the scratching of an inanimate object
Therapist experiences urge to scratch	My right breast began to itch and I felt the urge to scratch; it was very hard not to scratch.	The wish to attack the object is felt in the therapist at a bodily level
Therapist comments about patient's wish to hurt others	I commented about her nails scratching along the radiator and making a scratching noise; perhaps she was letting me know that she felt like she could scratch someone.	Therapist encouraging aggression to be expressed in transference
Patient's repeated attack on self	Jane bit her nails again, and she then leant forward.	Aggression is again turned on the self Physical movement closes physical proximity to therapist
Therapist comments about harm inflicted	I looked at her nails and commented in a quiet voice that her nails were really quite low and looked very sore.	Therapist looking and reflecting on the pain inflicted by the patient's aggressive attack on herself
Patient displaying effects of attack on self	She looked at them and held them up; I thought about a child saying "Look what you have made me do."	Patient physically displaying the outcome of the aggressive attack on herself

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Continued attack on self. Therapist wishes to intervene	One nail was red and bleeding; she then bit it and I wanted to stop her.	Physical attack on the self is relentless
Therapist speculates that patient feels therapist is responsible for her actions	I said "Perhaps you really want to show me your nails, as if to say 'Look at what you have driven me to do.'"	Therapist interprets
Patient acknowledges her own part	Jane said sternly, "I bite them."	Able to think about her own aggression
Patient is in touch with sadness and pain	I said "Perhaps you are letting me know that the biting side of you is with you a lot, and it causes you a lot of pain a lot of the time." She agreed and looked in pain and sad.	Able to recognise the pain and sadness linked to aggressive attacks
Patient in touch with her own sadness	Jane became quite quiet and looked like she was trying not to cry. I commented about her distress.	Able to express non-verbally her distress
Therapist reminds patient of next session	It was time to finish. I reminded her that I would see her on Tuesday; she had cancelled Monday due to an interview at college.	Anger at neglect due to missing session

At the start of session number 32, Jane was able to express anger at me, but not in the transference. As the session progressed, and following work in the transference, she briefly expressed her angry feelings toward me. Jane then reflected upon how emotional states are communicated via her bodily movements. An oral attack followed, which I interpreted in the transference. I experienced in the bodily countertransference, Jane's urge to scratch me, and I used this to inform my interpretation and to draw Jane into the transference. Jane moved physically closer to me; I noted a change in her tone of voice, and thoughts become thinkable in me about the pain inflicted by the oral attack. We shared a moment looking together at the damage inflicted, and Jane was then able to own her own aggression and be in touch with the pain inflicted subsequently. I began to explore the idea of the bodily countertransference as

an important factor in the emergence of new thoughts: how Jane's projections are received at a bodily level in the first instance.

I will outline the developments in the therapy that occurred between session number 32 and session number 53. During this period, Jane had her 16th birthday. Within the transference, the object continued to be viewed as someone who would favour others and was unable to alleviate her pain and suffering. However, she began to be able to view her object as someone with whom she could share her sadness, in anticipation that her projections would be received.

Attempts to draw her into the transference brought about a withdrawal to a bodily form of communication. However, she could communicate her rage, via eye contact, which I held visually rather than verbally. A change in her physical appearance was noted during this period. Her appearance was for most of the time congruent to her developmental stage and to her emotional state.

The emerging framework for coding presented below identifies the codes that have arisen at this stage in the therapy, including those that I have highlighted. These themes will be discussed in more detail in the following chapter, the analysis of data.

Emerging framework from coding session number 11 through to session number 53

Eyes	Physical appearance	Physical proximity space
Communicate her rage	Congruent	Physical movement communicating need for closeness
Transference	Bodily countertransference	Thoughts become verbalisable
Object that favours others	Fear	Rage about being left out but not in the transference
Object that patient could share her sadness with	Panic	Struggle to re-connect Own her own aggression
Object that can receive patient's projections	Wincing	Ability to recognise sadness is linked to aggressive attacks

Within session numbers 53 and 54 presented below, there is an illustration of how the different forms of bodily communication began to be observed in a session, and the need for the following to be viewed in conjunction with each other: the use of eyes, physical proximity, countertransference, bodily countertransference and physical appearance. The development of a

persecutory internal eye begins to develop, where linking with me (the therapist) is not allowed.

Using sessions 53 and 54, I will demonstrate how the work in session number 53 facilitated thoughts to become thinkable in session number 54.

4.5 A PERSECUTORY INTERNAL EYE WHICH ALLOWS NO SPACE FOR THINKING

The session presented below was on a Friday, the end of the therapeutic week. Jane's mother had cancelled the session on Monday as Jane could not get out of bed. Within the therapy session on Tuesday, Jane had turned away both verbally and physically from me; I had to experience being abandoned.

What is interesting is that, in my process notes for the session, no record was made of the walk to the therapy room. The first thing that is noted is my response to Jane's arrival. This is quite unusual and worth noting.

Session number 53

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODE
Juxtaposition between patient expressing tiredness and observed physical movements	She said that she was tired and just wanted to sleep. Jane closed her eyes, but her right leg was still moving.	Closing her eyes as a way of severing contact with the therapist, thus allowing no space for thinking Physical movements representing some sense of life inside
Therapist observes damage to body and physical movements	I noticed her finger nails, which were bitten and quite low; she drummed her finger on the table. I watched the movement.	Attack on the self is observed by the therapist and displayed via her physical appearance Drawing the therapist's attention to her physical movement
Therapist notes contradiction between appearance and emotional state	I commented that, whilst her eyes seemed closed, there still appeared to be a lot going on.	Therapist observes liveliness of patient represented in the bodily movements

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODE
Patient's verbal and bodily movements are contradictory	Jane said that she had lots of things to think about, but closing her eyes helped her to focus.	
Frustration is felt by the therapist	I asked what she would like to focus upon that day. "Nothing," she said. I felt frustrated. I said that "perhaps nothing seems preferable today".	Deadly internal object Therapist is wilfully excluded
Therapist experiences unease	I asked what the place was like. She said "quiet". I felt uneasy.	Therapist experiences via the countertransference feelings not yet able to verbalise
Patient shutting down physically	Jane sat on her chair, put her head back, stretched out her legs and closed her eyes. I felt a distance away.	Killing off link with the therapist
Therapist links patient's anger to imminent therapeutic break	As we sat there, I began to feel angry and wanted to shake her. I looked at her and said that I wondered if she might be quite cross; last time I had seen her, I had told her about the Bank Holiday break the following Monday.	Therapist wanting to bring patient back to life physically in the countertransference Thoughts about the break become thinkable in the therapist's mind Patient is identified with wilfully unavailable object
Patient physically moves towards the therapist	Jane leaned over towards the table so she was closer to me.	Patient's physical movements communicate to the therapist the need for close observation
Therapist notes patient watching her through closed eyes	I looked at her and noticed her eyelids looked transparent. I could see her eyes moving underneath; eerily it felt as if she was watching me. I saw Jane's eyes open slightly and could just about see her eyes. I felt like I was being watched.	Patient physically moves closer, allowing the therapist to gain some access to her non-verbal communication Therapist has to experience being watched
Therapist is neglected and abandoned	I felt myself becoming quite distressed and struggled to hold back the tears.	Distress is felt by the therapist in the countertransference

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODE
Patient's eyes looking and watching the therapist	I could see Jane looking at me. I said that, whilst she had her eyes closed, I felt that part of her was watching me very carefully.	Patient watching to see the impact of projection
Something uncomfortable is communicated visually	Jane continued with her eyes shut, her eye again looking out. I thought about Lucinda's rabbit, a colleague's rabbit which had a penetrating look that she referred to as its 'evil eye'. I felt very uncomfortable; the eye was looking intently at me.	Patient is identified with cruel, persecutory object
Patient does not respond to therapist	I noted the time; it was time to finish. I told Jane, but she did not move.	
Alarm is felt by the therapist	I again informed her it was time to finish that day, but got no response; she was lying very still. I became very worried. I called her name; she was very still, although a couple of minutes previously she had been looking at me.	Worry that the patient is dead
Therapist unable to get a response from the patient	I got out of my seat and stood next to her. I said her name quietly; she did not move. I felt alarmed and gently touched her arm, saying her name; still no response.	Alarm is experienced by the therapist in the countertransference
Panic is felt by the therapist	I began to feel a growing sense of panic; was she dead?	A growing sense of panic is experienced in the therapist's countertransference
Therapist wakes patient	I touched her arm; she woke. I saw her red eyes.	Physical movement of therapist wakes patient
Patient enquires about her absence	Jane said that she had been asleep. I felt like my head was spinning; I was disorientated.	Disorientation is lodged in the therapist's body

I began to develop my thoughts on Jane's use of her eyes to take in what is communicated. As in the previous session, there was a sense of looking and taking in Jane's communication, which required very close and careful

observation. In this session, Jane also used her eyes to sever contact with me. Also the theme of watching emerged; in this session, it was both watching and penetrating. My associations were to the idea of an ‘evil internal eye’ that was deadly, which needed to be projected into the therapist. I will refer to this as a persecutory internal eye.

Bodily movements were again used to draw my attention to the non-verbal communication; in this session, it was to the eye movements under the eyelid: signs of life. This observation could then be used to inform my explorations with Jane about the internal space or lack of it in this session.

Within session number 53, the transference was to an absent object. I had to experience, at a bodily level, disorientation, confusion and a sense of panic, linked in the transference to an abandoning, neglectful, dead object (one that was taken in via the eyes).

Jane was unable to verbalise her thoughts; I had to experience Jane’s projections in the countertransference and the bodily countertransference, which I linked in my mind to the imminent Bank Holiday break.

The session that followed session 53 is presented below and illustrates how Jane was able to think with me about the previous session.

Session number 54

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Enforced separation from maternal figures based on age alone	Jane said that her mum walks away now that she is sixteen.	Transference to an abandoning inflexible object
Therapist makes links to breaks, separation and Jane’s internal objects	I commented firstly about the Bank Holiday, then about how she worries what will happen when she is an adult. I also commented about someone keeping an eye on her. I linked this with the holiday and the need for a therapist who keeps an eye on her.	Therapist presents the idea of a benign internal eye

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Able to verbalise suicidal thoughts through sharing dream	Jane told me about a dream, after which she said that she did not feel like killing herself. She told me that she dreamt she was crying and crying, and taking the top off some tablets.	Transference to object that is interested in her distress
Patient is able to share worries about herself	I commented that she was letting me know that at times she does dream about taking tablets, when she is very distressed. Jane said that she worried she might do something when she is asleep.	Worries about destructive/aggressive aspects of her personality
Patient pleased by therapist's close observation of internal state	I commented about the eye that I saw, when she was in the deadly state. Jane seemed pleased and said that someone was keeping an eye on her.	Transference to an observant object
Therapist notes close observation of her ability to be alert/alive presence	I said that I thought she was watching what I did when she was sleeping, very carefully: was I taking a nap or was I still with her?	Transference to an alert present object internally
Patient is pleased that the therapist is able to observe lively aspects of her personality	I said that whilst she was asleep I felt that part of her (smaller part) was still awake. She asked if her eyes were moving. I said I could see them moving. She seemed pleasantly surprised by this. I said that the feeling at the time seemed to be about real sadness.	Transference to an object that recognises her varying emotional states

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Expression of feeling linked to abandonment	Jane began to tell me how the receptionist had ignored her when she had come into the reception (she had been five minutes late). She said that she was very angry about being ignored/forgotten. She became very angry, saying that the receptionist was not doing her job.	Able to express her angry feeling
Therapist speculates that the patient is angry with her	I said that perhaps she was very angry with me about Monday, when I would be not doing my job properly.	Therapist makes transference interpretation Transference to a neglectful object
Thinking together about ways Jane manages separation	Jane commented about keeping herself busy with school work. I said that she seemed to be trying to find a way of managing the Monday break/missed session.	Therapist drawing patient into the transference
Patient expresses her feelings, both positive and negative, linked to breaks	Jane got very cross and said something about holidays and the sun coming in through the window; she said that it was nice to be in the sun, but it also reminded her of the holiday.	Transference to object that is warm but frustrating Patient is able to verbalise how positive feelings can intensify feelings of loss linked to separation
Therapist names feelings about separation	I said that perhaps she would miss the session on Monday but would also be very angry with me for not being there.	Transference to an object that can manage sad and angry feelings
Patient is able to share increased optimism	It was time to finish. Jane told me that she went swimming that morning and that she was tired but wanted a routine. I commented about changes in routine.	Verbalising her ability to be flexible and manage change

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Therapist shares increased sense of hope	Jane seemed brighter; she seemed more hopeful about managing.	

In the session presented above, Jane was able to reflect verbally on her emotional states. At the start, the transference, as in previous sessions, is to an object that cannot manage the intensity of her feelings; an object that is rigid and inflexible in her thinking and is unable to observe distress, a relationship where there is no space for thinking to develop.

The idea of a protective internal eye developed in the middle of the session, which facilitated the transference to an object that is observant, alert and manages a variety of feelings both positive and negative: an internal object that is capable of reflecting upon feelings. Jane was correspondingly beginning to develop an interest in her own internal states.

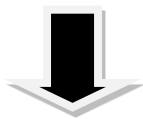
I had informed Jane that she would be moving to another room in six weeks time, a new portakabin that could be seen from the therapy room window. The sequence of sessions described below is of interest for the way in which Jane manages the physical separation at the end of the session, particularly the physical space between us.

The framework presented below illustrates the change in codes from one session to another, demonstrating the movement towards thoughts becoming thinkable.

Framework which illustrates the movement in thoughts becoming thinkable

Session number 53

<p>Transference</p> <p>Object that cannot observe emotional states</p> <p>Inflexible object</p> <p>Object that follows rules rigidly</p> <p>Object that is irritated by sadness</p> <p>Object that misinterprets emotions</p> <p>Object that is neglectful</p>	<p>Physical space/proximity</p> <p>Patient that has no internal space in objects/dead object</p> <p>No internal space for thinking in object's mind</p>
<p>Eyes</p> <p>Object who cannot visually take in the object's distress</p>	<p>Thoughts become verbalised</p>



Session number 54

<p>Transference</p> <p>Object that thinks about emotional states</p> <p>Object that is alert</p> <p>Object that is warm but frustrating</p> <p>Object that can manage sad and angry feelings</p> <p>Object that is interested in distress</p>	<p>Space/physical proximity</p> <p>Space for thinking/verbalising thoughts</p>
<p>Eyes</p> <p>Communicate a readiness to link</p> <p>Benign internal eye</p>	<p>Thoughts become verbalisable</p> <p>Thoughts about therapist's observation of the patient's deadly state</p> <p>Distress and how she manages anger</p> <p>Positive feelings linked to loss and separation</p>

I will now go on to think about how space between therapist and patient develops: a space for thoughts to emerge.

4.6 DEVELOPMENT OF AN APPARATUS FOR THINKING

I will now present some clinical material from session number 55; the focus will be on the separation from the therapist at the end of the session.

Session number 55

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODE
Transition back to the reception	It was time to finish; we walked back to the reception.	
Exiting to the other side Therapist has to observe the patient disappearing out of sight No space in between Therapist seeking patient with her eyes	Jane opened the door just a little and squeezed her body through the door, a bit like she had disappeared down a hole. I felt disorientated and wanted to look through the window in the door to see if I could see her.	Therapist feels in the bodily countertransference sense of falling (timeless, no boundaries) Thoughts about the end of the session (move to the portakabin) are communicated in the way Jane uses her body, in that she squeezes through a small space to the other side. Disorientation about moves/separation is felt in the bodily countertransference of the therapist.
Therapist left out and looking for patient Therapist watching departure No marking of separation	The door shut and the therapist was left on the other side of the door looking through the small glass window in the door. I watched Jane in the distance; she was walking through the door leading out of the clinic. Jane had not said "goodbye" and I found this really hard.	Therapist has to experience feeling left and seeking the object in the countertransference Transference to an abandoning object

In session number 55, Jane communicated through the use of physical space a sense of being dropped by me at the end of the session. This was felt in the therapist's countertransference and bodily countertransference: a feeling of disorientation following separation. The transference was to an object that would abandon her.

The next session coded is session number 63. Developments in the bodily communication and also the transference will be briefly described in the intervening sessions, along with any general developments.

During the period between sessions 55 and 64, Jane was taking her GCSE exams; consequently, some sessions had to be changed or cancelled. She began to think with me about the move to the portakabin. The transference was to an object that does not have any space of her own, someone who is being ejected from her previous therapeutic space due to her failings and inadequacies. Another aspect of the category, physical appearance, began to emerge, the idea of lack of space in the object's mind due to her inability to attract her positive gaze.

Jane was able to think about how any progress in the therapy was often followed by a ferocious oral attack on her body, which she called 'being made to pay'. The transference was to a voyeuristic object who did not intervene when a ferocious attack was taking place.

She began to reflect upon the link between what was presented as a physical pain and its link to emotional states of mind. The transference was to an object that would dismiss her physical pain and was not able to think that it was linked to her emotional state.

In session number 63, the transformation of anxiety in the transference is illustrated. When Jane had arrived at the clinic the receptionist had been away from her desk.

Session number 63

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Patient noting blockage	Jane rubbed her face and then across her forehead. I asked what she was thinking about. She said she had sinus problems; her nose was blocked.	
Therapist linking patient's comments to transference	I said "A little like the start of the session when your access to me was blocked." Jane had let people know where she was, but it had not been communicated to me. There seemed to have been a blockage.	Transference to an unavailable object
Acknowledging misery	Jane leant on her arm; she said she was tired. Jane looked at the window and said "It's still miserable". I said "It's miserable".	Patient able to name her feelings
Highlighting struggle	Jane looked deflated; she said she was tired but did not need any more sleep.	Therapist observes the patient's body physically collapsing
Patient verbalises her feelings	I said "Perhaps it is a different type of tiredness." I said that perhaps she thought I would not be interested in a tired and miserable Jane. Jane said "Cranky." I said "Miserable, tired and cranky." Jane looked down.	Transference interpretation Patient is able to identify and share her feelings with the therapist
Therapist unable to maintain visual contact with the patient	Jane shut her eyes for what seemed like a long time.	Disconnecting visually with the therapist
Ignoring therapist's comments	I made several comments about being left out, etc, but to no avail.	Therapist's verbal comments do not assist the patient's thinking
Looking at therapist	I saw Jane's 'evil eye' and it looked like it was really looking at me.	Patient's eyes communicating to therapist idea of a persecutory, cruel object

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Therapist noting contradiction	I said "Whilst you have your eyes shut, I feel that part of you is really keeping a close eye on me."	Therapist uses observations to inform her transference interpretation Transference to an object that needs to be watched at all times
Awakening and acknowledging struggle	Jane's eyes opened widely; she sat up, rubbed her eyes and said that they were heavy. I commented that things seemed really heavy, and I wondered if there was a struggle going on inside.	Patient resumes the visual link with the therapist, and the therapist is able to verbalise her internal struggle
Noting distress and inability to settle	Jane said that her mother said that she used to scream as a baby. She did not sleep.	Verbalising thoughts about a distressed infant who could not settle
Reporting shocking treatment	Jane said that her mother said it was her sinuses as they were blocked; she used to put her head under the steaming water with Vic. I think that would be quite shocking for a baby.	Transference to object that would be out of touch with infant's needs
Therapist's comments dismissed	I said that perhaps there was a baby part of her that was screaming and wanted to be looked after. Jane dismissed this coldly.	Drawing patient to the transference
	She lay across the nearby table. I began to feel quite useless.	Feelings expressed through physical movement
Turning away from the therapist	Jane looked away.	Transference to an unavailable object
Therapist notes dissatisfaction with care given	I said that I wondered if the beginning of the session had seemed quite unsatisfactory: people who were not looking after her or taking care of her, and perhaps she felt like a screaming, distressed baby who was left.	Interpretation linked to transference
Patient responds to therapist's comments	Tears began to fill her eyes.	Patient in touch with her distress and can be observed non-verbally

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Therapist comments about patient's distress	Jane looked at my watch; I commented that I wondered if there was also an angry Jane and a baby Jane that was screaming inside. Jane looked overwhelmed.	Therapist interprets

Following a transference interpretation about blocked access to me, she was able to be in touch with and express her sadness, misery and anger in relation to feeling forgotten in the transference.

The next session to be presented is session number 66. A brief outline of developments in between session numbers 63 and 66 will be given. Within this period, separation and loss appeared to be a central feature. Jane was able to express her wish to be an independent adult versus her wish to be looked after and cared for. There was a new development in the transference; concerns were expressed about an object that clings and is unable to allow the patient to become independent. At the end of the sessions, Jane was able to initiate leaving me, and it was me in the countertransference who had to experience being left behind. This seemed like an appropriate adolescent development.

There was a sense of a growing reality that people do care for her. The transference was to an object that was thoughtful and interested. Within the transference, there arose the idea of an internal eye that needs to be alert at all times and 'on watch'; consequently, Jane never felt that she could be at ease. The transference was to an object that watches or would watch.

Emerging framework from coding session number 55 through to session number 65

<p align="center">Transference</p> <p>Object that has no space of her own</p> <p>Object that clings</p> <p>Object that is unable to manage separation</p> <p>Thoughtful and interested</p> <p>Object that has flexibility in thinking</p>	<p align="center">Physical proximity</p> <p>Patient is able to initiate separation at the end of the session</p>
<p align="center">Eyes</p> <p>'on watch'</p> <p>Inability to attract the gaze of the object</p>	<p align="center">Thoughts are verbalisable</p> <p>How progress can be sabotaged</p> <p>'being made to pay'</p>

The next session to be presented followed Jane's one-week break. The therapy room had moved from a shared room in the main building to my own room in a portakabin. This involved leaving the main building and walking approximately one hundred yards along a path leading from the main building to the portakabin.

Session number 66

The Monday session is usually at 10.15. Jane had exams in the morning and afternoon, so I had offered a 4 o'clock session, which she attended.

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Presence of the therapist seems to lift her mood	Jane lifted up her head; she looked quite small and tired. She smiled, and her face seemed to brighten.	Appearance reflects her infantile and vulnerable emotional state

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Needing therapist to support her to the door	She seemed to take some time to get to the door, although the distance was quite short. I moved towards her, as if to help her to the door.	Therapist moving physically closer to the patient
Anxiety about the space for two	I held the door for her; she asked if we were going to the other room? I said that we were. We walked down the corridor; Jane was slightly behind me, as there was not enough room for two people.	Worries about space are reflected in the physical proximity to the therapist.
Someone has taken possession of the old room	As we approached the previous therapy room, I noticed the door was wide open and Peter was standing by his filing cabinet. I began to feel uneasy walking past. I opened the outside door, and wondered whether to walk by Jane's side or in front or behind. I decided to walk by her side.	Concern about space available is located in the therapist
	"Is that it?" she said, looking towards the portakabin. I was surprised by this remark; we had looked out the window of the previous therapy room at the portakabin. I said that the room was in there. I opened the door and Jane walked in; she seemed to hesitate. I said that the room was at the end, pointing to it, and walking slightly in front of her.	Therapist helping the patient to locate and gain access to the new therapeutic space
Pleasure at the contents in the therapeutic space	I opened the therapy room door and she walked in. Her eyes seemed to fix onto the couch. "A bed!" she said excitedly.	Patient is able to verbalise her pleasure Patient using her eyes to explore the new environment
Taking in the new environment visually	Jane looked around the room, as if she was getting her bearings, and I stood whilst she decided where to sit. Jane sat by the window on one of the chairs. Jane commented that this room was better than the other room.	Patient verbalises her pleasure with the superior new therapeutic space

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Pleasure in getting something right for the patient	I felt pleased with myself for providing a nice new room.	Transference to an object who provides for her well
Provided with something expensive but worried about letting her defenses down	Jane commented again about the bed, saying it was like in the American movies where people with lots of money went to be hypnotised. I asked what she thought about hypnosis. She said she would worry that when she woke up, she might not know what she had said.	Verbalising her ambivalence about the new therapeutic space
Physical movements: trying to establish a comfortable position	Jane shuffled in her chair, as if she was trying to get comfy. She stretched her legs, and then moved down slightly.	Physically adapting to the new space
Keeping her awake purposely	She commented that you would not go to sleep in these chairs. I said that perhaps she thought I had given her hard chairs on which she could not sleep.	Transference to an object who provides her with an uncomfortable physical environment to suit its own purpose
	Jane squeezed the cushioning on the chair and said that it was comfy, but the back was not so comfy.	Thoughts about the object in the new space expressed via the furniture
Ambivalence about the physical environment provided	I said that there seemed to be two different thoughts about the room: one seemed to be about a Julie who provided a bed to sleep in, and the other was about a Julie who wanted to keep you awake by giving you hard chairs.	Drawing the patient further into the transference
Therapist's comments evokes feelings in the patient	Jane leant on her hand and looked quite sad.	Sadness is observed visually
Linking to infantile feelings	Jane said something about a baby; I said perhaps there was a baby Jane, who would like to make herself comfy. I could see tears fill Jane's eyes.	

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Expressing feeling of revenge	Jane said smugly that the receptionist had rung Peter and he had been off with her, telling her that he was in the room and not you. She had then heard her ring me.	Feelings of displacement are located in others
Expressing pleasure seeking revenge	She said that it felt like getting her own back for making her wait. She said she knew it was not right to laugh, but she had found it funny. I said that there seemed to be some thoughts about someone getting their own back when they have been made to wait.	Verbalising her wish for revenge
Things can easily be dismissed	Jane said "Oh, the exams", as though she has just remembered. She said that she had had geography and English that day. She said that she did not think she had done well in the geography, but she was not bothered as she did not need geography.	Transference to an object who is uncaring and easily transfers its allegiances elsewhere
Verbalising her dissatisfaction with what is offered	Jane said it was not fair having two exams in one day. I said perhaps it felt like she has had two sessions that day: the one that was cancelled (the 10.15 session) and the 4 o'clock. Jane said she could not have come at 10.15 as she had an exam.	
	I said that perhaps she would have liked to have come earlier in the day, when she would not have had such a long wait.	Therapist drawing the patient into the transference
Therapist is unable to think about the patient's dissatisfaction with having to move to another room	Jane said that she had a lot on, exams and work. She said that she had asked to do one day at work, but nobody at work had been listening, and they kept giving her two days at the weekend. Jane said that she had rung in sick, but she could have gone in as she was not that ill.	Transference to an object that does not listen Recognition of the part of her personality that tricks people

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Drawing Jane into the transference	I commented that we have just had a break, and before the break there had been some times when she had been collected late, when the receptionist had not contacted me. I said that today's session was different to our usual Monday session, in that it was at 4 o'clock, and perhaps she would have liked to have cancelled it but felt I had not been listening to her and had made her come into work.	Transference to selfish, unreliable therapist who does not take in her words
Acceptance of therapist's interpretation	Jane said sheepishly that she hadn't wanted to come in today.	Mismatch verbal and non-verbal communication
Unable to believe that people will respond to her needs	I said that there does not seem to be any thoughts that you could ask for something and people would listen. Jane agreed; I felt despondent.	Transference to therapist who does not hear and respond to her requests
In touch with infantile feelings	Jane touched the wall with her hand; she asked if it was paint or wallpaper. She then speculated that it could be painted wallpaper. Jane said it was still like a hospital; I asked in what way.	Sensual exploration of the physical environment
Patient is able to think she might be able to have some space for herself	She said that the walls were white. I felt like the bubble had been burst. Jane said that she had had her own room when she had been in hospital. I said that reminded me of the fact that, before I had a room, I used to share Peter's office.	Loss of the other room becomes thinkable in the therapist's mind
Feelings communicated via physical movements	Jane began to tap her foot rhythmically on the floor. I was unsure of the meaning of this, as it was not the irritating sort of tap that she had done before. She was looking at her foot.	Therapist notices a difference in the way she is communicating via her bodily movements

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Curiosity is located in the therapist	I noticed a little tear where the sole meets the shoe and began to think about a little mouse peeking out of the hole. I asked in a quiet voice what she was thinking.	Space for a different thought to emerge Therapist adjusting the tone and level of her voice
Anticipates that adults will find her irritating	She said that it irritates her mum when she taps her hands on her knee or taps her foot. I said that she seems to worry that her foot-tapping will irritate me. She said abruptly that it irritates her mum.	Transference to an object that is easily irritated by physical movements
Therapist suggests that physical movements could have multiple meanings	I said that there does not seem to be any thoughts that we could think about the foot-tapping as it could mean lots of different things.	Transference to rigid inflexible object
Expression of a different view from one anticipated	Jane said, in a very quiet voice, "Doing a jig." I asked what sort of jig and began to imagine a little girl dancing around the room. Jane said "A dance around the room."	Patient is able to express her own thoughts linked to joy
Therapist speechless but filled with emotions	I didn't know what to say and felt quite emotional.	Intense emotions felt in the countertransference Therapist is overwhelmed with emotion and struggling to verbalise feelings

In session number 66, Jane reverted back to an infantile state where the non-verbal communication was the main form of communication, particularly the use of the eyes and the physical proximity to me. Jane's need was for me to be physically closer to her in the transition to the therapy room at the start of the session.

The idea of space to think has emerged. Jane explored her new environment through touch. The way in which the physical space in the session was used is worth noting. The idea of internal space where something can be taken in and

processed and then given back was explored through the sequence about ventilation; space to breathe.

What is also of interest is how thoughts become thinkable in me. I am unable to think about Jane's communication about the loss of the other therapy room until I felt in the countertransference feelings of loss. Jane then began to explore the new room in a tactile way.

At the start of the session, the transference was to an object that did not listen, did not take in her words and was inflexible and unable to let her settle. Near to the end of the session, she was more able to access a maternal object.

In session number 67, a different view of separation emerges.

4.7 DEVELOPMENT OF A SPACE FOR THOUGHTS TO EMERGE

Session number 67

The beginning of this session is interesting in that Jane arrived 45 minutes early.

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Wanting an end to the hard work	Jane said that she wished that the exams were over; she had only done five exams and had six more to go.	Verbalising her thoughts
Therapist verbalising her worry that there is much work to be done	I said that she seemed to be thinking that she was not yet halfway there, and perhaps this reminded her that there was a long way still to go.	
Therapist's words are received physically as an attack	Jane leant back in her chair and looked like I had just hit her. I felt like an insensitive, heartless, cruel therapist, reminding her that we had lots more work to do.	Transference to an object that is cruel and thoughtless

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Patient turning away from the therapist	Jane looked out of the window. I wondered what she was looking at; was she looking to see who was walking down the road or was she quite bored? I felt like I was of no use.	Use of eyes to distance herself from the therapist
Therapist giving her something she does not like	I commented that I wondered if she thought my comments about a long way to go seemed like I was reminding her of something that was quite hard for her. Jane continued to look out of the window. I said that perhaps she thought I was being quite cruel to her.	Transference interpretation
Insensitive therapist who is out of touch	Jane looked around and gave me a serious look. She started to tell me how, in the exams, people had got up whilst she was still working, and it had really annoyed her. She commented that people did not realise how stressed she was.	Angry feelings are expressed through eye contact and named in relation to others
Drawing Jane into the therapeutic relationship	I commented that perhaps she was really annoyed with me, as she felt I have not been sensitive to her stress by not seeing her straight away.	Transference interpretation
Patient able to tolerate thoughts about the therapist's other patients as well as acknowledging her wish to be first	Jane commented about arriving early; she said that she thought I might not be able to see her as I might be in with someone else. I said perhaps this was particularly difficult the day before, when if she had had the 10.15 session, she would have	Patient verbalises her thoughts

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
	<p>been the first person to see me in the new room. I commented that she had told me before how she would have liked to be first.</p> <p>Jane smiled and said that she would have liked to be first.</p>	
<p>Something painful and new is emerging in the therapy</p> <p>Inflicts pain on herself that arises in relation to having to wait whilst others are seen</p>	<p>Jane began to pull the mascara off her eyelashes. I began to wince; she continued and I asked her what she was thinking about.</p>	<p>Painfulness of allowing therapist to observe all aspects of her personality is communicated via a physical action</p> <p>Pain is felt in the therapist's bodily countertransference</p>
<p>Physical pain of being seen</p>	<p>Jane said that she often does it; she pulls the mascara off her lashes, but sometimes her eyelashes come out and this hurts. I thought about something that is being ripped out from the root.</p>	<p>Demonstrating her aggression/destructive tendencies</p> <p>Bodily expression of something being torn from the roots</p>
<p>Difficulties in verbalising thoughts</p>	<p>I found myself struggling to articulate this;</p> <p>I commented that she was letting me know about things that are being pulled out in a way that hurts her.</p>	<p>Therapist struggling to think about patient's aggression</p>
	<p>Jane said that she worries they will all fall out and that would be really weird.</p>	<p>Verbalises her worry that everything will be destroyed</p>
<p>Debating if damage inflicted upon the self can be repaired</p>	<p>Jane asked me if eyelashes are like hair, will they grow back? I found myself feeling quite puzzled and thinking about the texture of hair and eyelashes.</p>	<p>Exploring verbally if a sense of hope is alive in the therapist</p>

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
<p>Concludes that certain parts of her personality are not desirable</p> <p>Worries about exposure</p>	<p>I asked what she thought; she said emphatically that people would not like her without her eyelashes.</p>	<p>Transference to object that accepts her as she is</p>
<p>True self is not acceptable to others</p>	<p>I commented that we often think about how she puts make-up on, and sometimes she has said that this is like putting a mask on. Jane said that people would not like her without her make-up on.</p>	
<p>Drawing patient into the transference</p> <p>Expresses a view that the therapist would not accept the different sides of her personality</p>	<p>I said that perhaps she worries that I would not like her as she is, without her mask. Jane said that her mum is the only one that would like her without make-up/mask; nobody else would.</p>	<p>Transference to an object that would not manage her aggression</p>
<p>Is able to share her struggle</p>	<p>Jane said that when she takes her mask off at night it stings.</p>	<p>Verbalising how painful it is underneath her mask</p>
	<p>I commented that she was letting me know that taking her make-up off hurts, and perhaps she worries about letting people see her sadness and distress.</p>	<p>Transference interpretation</p>
<p>Therapist encourages the patient to share all aspects of her self</p>	<p>Jane looked across at the couch. I was aware that we had five minutes to go; should I say anything about the couch? I commented that perhaps she thinks she could find a place on the couch where she could take her mask off.</p>	
<p>Patient is in touch with her sadness</p>	<p>Jane put her head back as though she was trying to keep her tears in. I said that she seemed to be holding on to her sadness, as perhaps she</p>	<p>Therapist observes patient's distress which she is suppressing</p>

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
	thought that she needed to do this whilst her exams were on.	
	Jane pulled her fingers through her hair, looking at the ends. I said "It is time to go."	
Patient is able to initiate the separation from the therapist	Jane said that I did not have to take her back to the reception as she was going down the side of the building.	Verbalising to the therapist her ability to manage the separation
Growing independence and internalisation of the frame of the sessions	I walked with her to the door; she walked through the door, stopped, turned around and said she would see me tomorrow.	Able to mark the separation and expectation of continuity of the relationship.

In session 67, the transference is to an object that is viewed as cruel and lacking in a capacity to protect. Separation is viewed as a tearing apart. I have to experience in the bodily countertransference the pain of something being torn off: the mascara from the eyelashes. Jane is then able to verbalise her aggressive destructive thoughts and her worry that the object would not be able to observe and think about her aggression.

Interestingly, session number 67 ends with Jane formally saying goodbye to me. She leaves me and this is a very different experience in my countertransference. It is I who have to manage the separation: Jane establishing eye contact, verbally marking the separation and then leaving me.

In session number 68, there is a development in the transference, to an object that can tolerate separation whilst still remaining close; also an object that can tolerate being on the outside of a couple.

Session number 68

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Therapist searching for patient	I opened the outside door and we walked down the steps. I began to feel quite awkward as Jane seemed to be several steps behind me. "Where is she?" I thought as I looked over my shoulder.	Therapist feelings disconnected from the patient
Patient is communicating via movement her wish to attract the attention of young doctor	I noted a young doctor walking down the side of the building that we had just come out of. Jane seemed to be swinging her hips. I began to think about Bridget Bardot.	Object that can take pleasure in patient 'normal' adolescent development
Therapist and patient re-connect	We reached the door of the new building, and I opened it. We walk in together	Object that manages on the outside of a couple

A development in the non-verbal communication is also noted. A theme that is beginning to emerge, which was communicated via her appearance and bodily movements, is that of a physically attractive sexual body.

I will briefly outline the themes which emerged in the intervening sessions, 68 to 81. In these sessions, Jane was able to verbalise her thoughts and feelings. She was finishing her GCSE exams, finishing school and was planning to go to college. Jane had her GCSE results during this period and was preparing to attend college, leaving the hospital school, which was a pupil referral unit for young people aged 11-16 who had struggled to access mainstream education. She was able to verbalise feelings of loss linked to the move from high school to college. It was necessary to move the time and day of some of her sessions to accommodate the change in her timetable.

Sessions 79 to 86 followed my summer break and also Jane's break, a holiday with her boyfriend. Within these sessions, bodily communication took centre stage. The theme of abandonment was explored, linked to the breaks. The

feelings associated with the separation were located in the body as physical pain.

In sessions 86 to 93, most of the communication was verbal, but not necessarily in the transference. The theme of an abandoning and cruel therapist not caring about an ill patient emerged in the transference. There was also a continuation of the theme of a parental couple enjoying themselves whilst leaving Jane on the outside. Jane continued to struggle to express aggressive and murderous thoughts in the transference. However, in session number 89, which followed a cancelled session by Jane, there was a 'moment of meeting' where something was understood at a non-verbal level. Following this communication, Jane was able to challenge me via eye contact to find out if I had the internal strength to manage her intense rages, this is further discussed in the analysis of data chapter.

It was at this point in the therapy that I began to think with Jane about using the couch. In the transference, I was seen as someone who could not bear to observe Jane and would use the couch to trick Jane and leave her to indulge herself.

Session number 93 has been included as it demonstrates a process of moving from not linking with me and avoiding eye contact, but projecting her internal state via the countertransference, to being able to release her distress physically through crying and by verbalising her distress

Session number 93

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Therapist to feel concerned about the patient	When we reached the therapy room, Jane sat on her usual chair; her body was facing forwards but her head was down. "What is the matter?" I thought and found myself leaning forwards. Jane looked pale and I felt worried about her. She was dressed in black, except for her	Bodily communication of the patient draws the therapist into closer contact with the patient. Internal state communicated via the patient's physical appearance, dress and also via the use of her body

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
	jacket, which was white with a fur trim.	Alarm is felt in the countertransference
Patient able to verbalise sadness	I asked how things were that day. A single tear rolled down her face. Jane said she was feeling really sad; she started to cry again.	Appearance congruent with emotional state
Feeling forgotten/abandoned/ignored	Jane said that she had arrived at 4.10 and had told the receptionist not to ring straight away, but later. However, the receptionist did not ring.	Able to share verbally with the therapist the reason for her distress Transference to an object that can manage her sadness
Therapist drawing patient into therapeutic relationship	I said that she forgot about you and perhaps you were very worried and angry that I would also forget about you. Jane began to cry and sob in what looked like waves of distress.	Patient able to share her distress with the therapist
Therapist empathising with patient but holding additional thoughts in her mind	I said that twenty minutes might have seemed like a very long time. I thought about being left to die, linked to her earlier comment.	Sharing intense distress with regards to her feelings of abandonment
Patient's fear of dying can be experienced by Jane and her therapist	I said that we have had a lot of disruptions to our sessions recently, and this is the first week of three sessions that we have had for some time. I said "I wonder if when I have left you it has felt like I have left you to die."	Therapist intensifying the transference Transference to an object that would let her die

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
Is able to share her distress with therapist	Jane was sobbing uncontrollably with her head in her hands. She looked like a teenager that day with red spots on her forehead. After a couple of minutes, she took a tissue out of her pocket and wiped her face.	Thoughts about distress are thinkable Appearance is congruent with emotional state and developmental stage
Change noted in the patient's emotional state from expression of sadness to bodily expression of anger	Jane began to tap the side of the chair with her fingers and her leg began to move in an agitated way. There seemed to be a marked change in the session. Her body was facing away from me, and she was looking away from me out of the window, at the filing cabinet, anywhere but at me. I felt like I had done something wrong, something to upset her.	Anger communicated via her physical movements Patient physically turning away from the therapist Transference to an object that is neglectful
Patient attacks the therapist's attempts to link verbally with the patient	After some time, I said that something else seemed to be stirring inside her. Jane continued to look away from me and said in a dismissive tone of voice that she was not thinking about anything.	Patient turning away from the therapist, avoiding eye contact No space for thoughts
Therapist's words are followed by bodily communication	I felt like she now had her back to me. I said that, as well as feeling very upset, she had also mentioned feeling angry. Jane started to	Physical movements; communicating her rage

INITIAL CODING	CLINICAL MATERIAL	FOCUSED CODING
	tap her other leg with some force on the floor in a sharp rhythm. I thought that I had better watch out as her physical movements seemed like a warning to me.	
Patient begins to express her feelings	Jane continued to look away from me; she said with some meaning that she hated her mother. I said "Perhaps it is quite hard for you to let me see your hatred."	Verbalising hatred but does not allow therapist to observe it in her eyes?
Non-verbal communication of murderous feelings	Jane continued to look away; she then turned around and glanced at me with a cold, hard, penetrating stare. I thought 'if looks could kill'.	Able to communicate her feelings via eye contact
Therapist naming her murderousness	I said that, as well as feeling she has been left to die, I wonder if there are times when she might like to leave people for dead. Jane had a hard look on her face.	Therapist verbalising the patient's murderousness
Verbalising her wish to punish	Jane commented that she is not speaking to her mum and dad as they don't deserve it.	Punishing the object by cutting the verbal link
Concern about damage	I said that perhaps she felt that I did not deserve to have her thoughts, and she felt like keeping them to herself. Jane began to scan the room with her eyes. She seemed to be staring at the dents in the wall.	Eyes: looking for damage

Session 93 above demonstrated how Jane's and my use of eye contact developed. There is an idea of an absence of a watchful mother who was in touch with the baby's emotional state. As the session developed, Jane was able to project, via her eye contact, her hatred, which was felt in my countertransference and bodily countertransference.

Following a silence, she communicated via her body, by turning away from me. I allowed Jane some space, and she was then able to verbalise her hatred and murderousness.

I will outline the developments in the bodily communication and transference, and note any external factors in the remaining twelve months of the therapy.

4.7.1. External factors

During the remaining twelve months of the therapy, the following external factors emerged:

- Jane moved to the couch, with the therapist's chair positioned slightly to the side of the couch so that Jane could see me. This was partly because of the design of the room but also because I felt that sitting out of her sight would neither be beneficial to Jane nor something she could tolerate.
- Twenty months after the start of the therapy, Jane's boyfriend ended their relationship; Jane was shocked and distraught.
- The idea of abuse from the past was explored in the therapy. Jane linked this to events on a holiday abroad when she was twelve. She alleged that someone had attempted to sexually assault her. During this holiday, Jane had been pretending to be older than her years, and her parents had colluded with her pretence that she was sixteen rather than twelve.
- Jane applied to undertake professional training; she was accepted on the course, and at the point the therapy ended, she was waiting to hear her exam results.

4.7.2. Developments in the transference and the use of non-verbal communication

Jane began to think about the ending of the therapy. Worries about her need to cling emerged, as in assessment session number three. She was able to express her concern that she would not be able to manage the separation. Thoughts about losing someone became more thinkable.

She was increasingly able to occupy her own space as an individual, separate from the therapist. Whilst Jane could think about the endings, she sometimes communicated this via the body. The ferocity of her anger about the end of the therapy was sometimes felt in my bodily countertransference. Jane continued to express her envy of the others who would be continuing sessions with me, who in her mind were younger children, this was expressed verbally and was thought about in the sessions.

The final holiday break was also thought about in detail, and was seen as a practice for the ending of the therapy. Jane began to think about trying to find ways of managing without the therapist. Jane began to reflect upon how the therapy helped her when she was feeling low. She was able to use the sessions to think about her distress and was able to show some gratitude.

Alongside this was the idea of growth:

‘She continues looking out of the window. I ask what she is thinking about. Jane says the spring, when the buds grow on the trees, in a sad voice’.

Summary

In this chapter I have demonstrated using the clinical material the emergence of the codes and how these developed in the course of the therapy. I illustrated the developments in the transference and the inter-relationship between the codes, in the process of thoughts becoming thinkable. The conceptual framework developed will be presented at the beginning of the next chapter, analysis of data.

CHAPTER 5: ANALYSIS OF DATA

5.1 INTRODUCTION

In the data presentation chapter, the different ways in which Jane used her body within the therapy and how these developed over the course of the therapy were presented. In this chapter, the data describing Jane's use of the body in the transference is analysed and presented in terms of the following conceptual framework:

- non-verbal adhesive mirroring
- incongruence: in presentation and my expectation; in the transference; in visual and verbal communication
- eyes and bodily movement
- bodily countertransference
- development of a three-dimensional internal space to think thoughts:
 - developments in the bodily countertransference;
 - developments in the use of the gaze; and
 - developments in bodily integration
- vision and separation

I will explore my observations of how Jane uses non-verbal adhesive mirroring as a defence against separation, which militates against communication of any kind. In the next section, false self-mirroring will be explored, where there are parts of the personality left behind, which contributes to an impression of incongruence. Two different aspects of incongruence are considered: how Jane does not present according to my expectation of a severely depressed adolescent and incongruence in the transference between Jane's expectations of me and what she actually finds.

The development in Jane's use of her eyes to communicate her emotional state, rather than using her adhesive mirroring that dominates at the start of the therapy, is explored. I will argue that vision appears to be central to the development of thoughts becoming thinkable. I will also use the data to examine how vision is the receptive point for the beginning of the containment process.

Difference in the quality in the non-verbal (visual) communication is explored, noting that there is a difference in the quality of the non-verbal (visual) communication of Jane's aggression compared with that of the visual contact she was using as a receptor for containment. The idea that communication is dyadic and involves introjection and projection at a bodily level, through bodily movement and eye contact, is discussed. The importance of receiving Jane's primitive unconscious communication, particularly her hostile feelings in the bodily countertransference, is considered. I will also discuss the significance of the need to name some of Jane's more hostile feelings.

I will consider the development of a three-dimensional internal space for Jane to think her thoughts, following the containment of her projections at a bodily level. Developments in the bodily countertransference and the gazing relationship, and the shift from the paranoid-schizoid to the depressive position will be demonstrated. I will illustrate how Jane moves away from the harsh internal observing object following the introjection of a benign internal object. Jane is identified with the object and it enables her to perceive internally her emotional experience. I demonstrate how Jane is aware of her emotional state and can verbalise it; a transformation has taken place where her thoughts have become thinkable.

I examine how my reverie is linked to my ability to integrate my countertransference feelings with my concern for Jane. The importance of the therapist holding the depressive position will be discussed. Integration of earlier anxieties into the later stages of development of symbolisation will be considered as an important aspect of the move to the depressive position. I will explain how the ability to symbolise reduces anxiety and is the basis for verbal thinking. Jane is able to begin to experiment at a non-verbal level in the first instance with separation.

5.2 NON-VERBAL ADHESIVE MIRRORING TO AVOID SEPARATION

In this section, I will draw upon my observations of verbal and non-verbal mirroring as a defence against separation. I will explore these observations and link Jane's anxiety with an infant's need for a container to hold his or her primitive anxieties. I will make reference to assessment session number 2 from

the data presentation chapter (page number: 79-80). Further observations of Jane and her mother from session number 1 are presented to illustrate a sense of a lack of maternal containment and an inability on the mother's part to observe and take in Jane's distress.

I will explore the idea of the therapist's eyes observing her patient as someone who is separate from herself, introjecting her visually and communicating through eye contact and change in facial expression that Jane's communication is being received and processed.

In assessment session number 2, I observe Jane and her mother together and note that they seem to mirror each other in their interactions. I begin to think about my observations of the mother and daughter. I am struck by the symmetry, how the mother and daughter are both engaged in identical activities, their body posture mirroring each other, and they both respond together when I say "hello". It is hard to see them as a mother and daughter. I begin to wonder if they are two separate individuals (psychologically).

I am curious about how I observe Jane and her mother and begin to develop my own thoughts about their interactions. I use my internal capacities, my alpha-function, to process my observations of Jane as a separate person from myself. This enables me to have different thoughts about what I observe: to note the lack of differentiation between mother and daughter. I note how Jane and her mother seem comfortable in the clinic; there are no visible signs of anxiety, even though Jane has severe depression and has already seen two cognitive behavioural therapists in our service, before commencing psychotherapy.

I also wonder what function the eyes and facial expression play in this process. What does Jane see as she looks at me when I greet her? Does she see me, via eye contact, as a person who is already visually taking her in and is processing what I observe? To do this, she would need to experience me as separate from herself. Does Jane experience me as a 'container' (Bion 1962) providing a space for her communication to be received and thought about? I begin to think about the idea of my eyes as the third in a couple where separation is incomplete.

Bion (1967) suggests that the mother needs to be able to receive the baby's projections, which arouse feelings in the mother that it cannot tolerate. Central to the task is the need to communicate feelings to another via projective identification. States of feelings become thoughts if subjected to the mother's alpha function. The therapist needs to begin to experience visually a desire to communicate with the patient through her eyes and facial expression, before the patient can begin to use projective identification. I have to be able to use my alpha-functioning (Bion 1962) to be able to receive, observe and note the lack of separation between mother and daughter.

Mitrani states that the 'baby must first have an experience of being introjected by the mother as an object with the capacity for alpha-function' (Mitrani 1995 p. 9). She suggests that this is particularly important following the birth, which has the potential for evoking terrifying anxieties. The infant's experience of the 'container' (Bion 1970) precedes the infant's development of alpha-functioning (Mitrani 1995).

Jane's mother has experienced long-standing depression. I wonder if she has been able to hold Jane's terrifying anxieties as an infant and has returned the projections with the addition of her own anxiety, resulting in what Bion (1967) refers to as 'nameless dread'. In session number 1, I meet with both Jane and her mother at the beginning of the session to outline the assessment. In this meeting, I am able to observe a mother who is struggling with her own anxieties about Jane's low mood; when, in the session, Jane becomes distressed, she does not seem able to observe her distress.

Session number 1

Jane arrived with her mother ten minutes early for her appointment. I walked to the waiting room and was met by an attractive, smart and alert teenager. Jane smiled at me as I introduced myself, an engaging sort of smile. I asked Jane and her mother to come to the therapy room. Jane and her mother took the comfy chairs whilst I sat on the smaller chair from another room. I introduced myself and said that Professor George had asked me to see Jane and explained that we would have three assessment sessions following which we would have a review to think about the possibility of Jane commencing psychoanalytic psychotherapy. Jane's mother explained that Jane had seen lots of people from our service, and Professor George had suggested that she needed to see someone who could see her for some time, unlike the interventions that other people had offered, which had been short term and ended abruptly. Jane's mother talked about how low Jane gets. Jane's eyes

filled with tears; her mother continued to talk about her and did not seem to notice her distress. I found it very hard to suggest to Jane's mother that she could go to the reception whilst Jane had her session. When I eventually suggested this, Jane's mother commented that she was very talkative and how it was difficult for Jane to get a word in.

In session number 1, Jane's mother wants me to hold her anxiety about her daughter's low mood. She does not observe Jane's response to her comment about her distress, but wants her own distress containing. Bion (1967) highlights how the infant is reliant upon the mother. If the mother is unable to receive the infant's projections, and projective identification dominates, the distinction between the self and the external object is blurred, leading to an absence of any perception of two-ness.

McDougall (1989) suggests that some mothers may, due to their own inner problems, impose their own ideas and thoughts on what the baby feels or needs, rather than responding to the baby's needs and communications:

experiences of separation and the recognition of existential differences are the poles around which the sense of self and of individual identity is constructed. Whenever separation and difference are not experienced as psychic acquisitions that enrich and give meaning to instinctual life, they become feared as realities that threaten to diminish the self-image or to empty the individual of what is believed to be vital for psychic survival, namely the maintenance of the illusion of fusional oneness with the archaic mother-image of babyhood (McDougall 1989 p. 41).

McDougall (1989) uses the term 'one-body for two' to describe the infant who is unable to distinguish between 'the self-representation and the representation of the other' (McDougall 1989 p. 2). In the assessment sessions, it was hard to distinguish between Jane and her mother.

As the assessment comes to an end, and I note the need to think about the imminent review meeting, Jane's anxieties about separation are apparent at a bodily level: her hunched position, her shock and the collapse in her ability to engage in the session.

Assessment session number 3

Jane walked down the corridor; her shoulders were hunched and I could hear her dragging her feet on the carpet. I felt like I was rushing in front of her. Jane sat on her usual chair. She looked at me with her big brown eyes: it felt quite false, as though her presentation was hiding some very different feelings (rage). Jane said "third one"; I was slightly taken back by the abruptness of this remark.

I commented that it was the third session before the review meeting the following Tuesday. I also commented that it might be useful to spend some time that day thinking about how Jane had found the sessions and planning for the review. Jane looked surprised by this; did she think our sessions would just carry on and on without question? Jane asked what we were supposed to be thinking about. She looked dazed and had her head leaning on her hands.

Jane seems to have an idea of a third assessment session but appears disorientated when I differentiate between the assessment and the psychotherapy. My words communicate the need for a space, to think about the review meeting. I am separating the assessment and the psychotherapy, which brings about a state of confusion in Jane. I suggest that we have a two-way conversation about the assessment sessions; this would imply that she is separate from me.

Bick (1968) describes infants whose mothers have not been able to contain the infant's anxiety (catastrophic anxiety), leading to a disintegrated state where the infant feels muddled, paralysed and unable to do anything. Bick suggests that these patients do not feel held together by a skin. Meltzer (1974) reports that, when Bick was trying to describe these patients, she would state that they stick to you. Bick describes a 'second skin formation' as a defence against disintegration. She suggests that these patients have difficulties with introjection and do not use projective identification very much. Meltzer describes how their relationships are not developed:

through internal relationships, not based on observations of themselves but as it were looking in a mirror of other people's eyes all the time, imitating, fashion conscious, pre-occupied with manners and social forms...children who had experiences by imitating other people (Meltzer 1974 p. 344).

Meltzer refers to the patient who never intends to finish his or her therapy. Jane appears shocked when I differentiate between the assessment and the psychotherapy. My thought is that she has become adhesively identified with the therapist; in her mind, the sessions would continue for ever, without any gaps which would put her in contact with painful feelings linked to separation.

I consider adhesive mirroring to be a defence against separation which militates against communication of any kind. This amounts to non-verbal adhesive mirroring, rather than communication of an internal state. In the next section, I

will explore false self-mirroring, where parts of the personality are left behind, which contributes to an impression of incongruence.

5.3 INCONGRUENCE

In this section, I will think about two different aspects of incongruence. The first aspect is how Jane does not present according to my expectations of a severely depressed adolescent. The second aspect is incongruence in the transference, between Jane's expectations of me and what she actually finds.

5.3.1. Incongruence in presentation and my expectation

In this sub-section, I will illustrate, using a clinical example, how I begin to observe incongruence between Jane's appearance and my expectation of a severely depressed adolescent. The clinical material for assessment session number 2 is presented in the data presentation chapter (page number: 79 - 80).

I note in assessment session number 2 Jane's immaculate appearance. I begin to think about Jane's diagnosis of severe depression with suicidal ideation, which is long-standing in its nature. Two weeks before the start of the assessment, the consultant child and adolescent psychiatrist had described Jane as low in mood, having had thoughts about walking in front of a car and feeling hopeless, that life was not worth living. She reported sleeping for 12 to 17 hours a day but still woke feeling tired.

Physical symptoms of depression include slowness of movement, lack of energy and unexplained aches and pains. It is difficult to reconcile these symptoms with Jane's physical presentation. Noting the incongruence in Jane's external presentation and that implied by the diagnosis, and the description from her meeting with the child and adolescent psychiatrist, alerts me to aspects of her personality with which she does not seem to be in touch. Noticing difference is important; I am beginning to process my observations with what I already know about the patient, and there is a mismatch.

Neuroscience research suggests that the brain predicts non-consciously what is most likely to happen, setting 'in motion certain perceptions, emotions, behaviours and interpersonal responses best adapted to what is expected – before the event occurs' (Pally 2007 p. 861). My observations of Jane do not

match what I might predict in an assessment with a severely depressed adolescent. It is worth noting that, in assessment session number 2, I am observing Jane's appearance, and I describe her 'dark brown engaging eyes', which seems to bring to my mind the incongruence in her presentation.

What I observe suggests that she seems to be in an adhesive identification with her mother. Taking this in and matching it against my own schema of what someone diagnosed with severe depression would look like challenges my view. I need to be aware of aspects of Jane with which she does not seem to be in touch and hold them in my mind before she can access these aspects of herself. My observations of Jane start a process where alpha-function (Bion 1962) allows me to begin to process what I see, and begin to think about what I know about the patient and what is being communicated via her appearance.

Wolf (1963) suggests that at birth the mother scans the baby's body. I wonder if, in the initial assessment sessions when I am meeting Jane for the first time, I am scanning her appearance, facial expression, body posture and looking at her in a way that a mother scans her infant.

I will now examine how I began to think about incongruence in the transference relationship.

5.3.2. Incongruence in the transference

The following session provides a clinical example of how Jane perceives me in the transference and how this is challenged as the therapy progresses.

Session number 3

Jane began to talk about her holiday and how it had been okay, but she had been dragged around old houses by her mother and father. She said that it was the sort of thing that old people do.

In the transference, I am an internal object who is older than she is, not interested in her and disconnected from her. Her expectations of relationships will be challenged during the course of the therapy, when I am presenting myself as a different object to Jane, one that does not fit with her predicted responses.

As the therapy progresses, the psychoanalytic frame, that is, the sessions being in the same room at the same time, for fifty minutes on a weekly basis, then moving to three times a week, challenges her view of me as someone who is not interested in her. I try and approach sessions using Bion's idea of 'without memory or desire' (Bion 1967 p. 143). This involves not imposing my pre-conceived ideas onto the session, to allow Jane to communicate what is on her mind.

Pally (2007) suggests that it is the conscious self-reflection that brings about therapeutic change. I am suggesting that noting incongruence is an initial factor in the process of change in the therapeutic encounter.

The two examples illustrate how incongruence, of Jane's presentation and my expectations of Jane, and incongruence in the transference, alert me to aspects of Jane which she is unable to verbalise. As the therapy progresses, Jane begins to use her eyes to communicate her emotional state, rather than using her adhesive mirroring that dominated at the start of the therapy. However, incongruence between her visual and verbal communication continues.

5.3.3. Incongruence in visual and verbal communication

Incongruence in visual and verbal communication was noted. However, Jane was able to communicate visually what was yet to be verbalised. The clinical material from session number 3 is presented in the data presentation chapter (page number: 80-82). It is in this session that Jane observed her previous therapist, Dr Baxter, in the reception interacting with another family when I collected her for her session.

In session number 3 Jane experiences being with someone who responds to her non-verbal responses to seeing the previous therapist. She experiences non-verbally my response as I observe her shock, anticipation and a feeling of disconnection. I process my observations, and this brings about a change in the tempo of the session and the use of space. I slow my movements in an attempt to gain closer proximity to Jane, to manage the transition to the therapy room.

The space between Jane and me is important in the transition to the room; I feel that I need to be in close proximity to Jane. On reflection, I wonder if I wanted

Jane to be able to have the experience of an adult who is physically close to her, to be able to see her in the way that a young infant might need its mother to hold it close to her when it feels like it has lost contact with the mother, as Jane had lost contact with me on the way to the therapy room. I am presenting myself as a different object for Jane to introject, one that is aware that Jane has become dis-connected from me and attempts to re-connect. The incongruence in her expectation of me in the transference is challenged; the reality is that I am in touch with her distress and my response is congruent with Jane's emotional state.

Boileau (2008) suggests slowing physical movement down, as a way of following the patient, when attempting to link with patients who are disconnected. I also think about Jane's need for live company. Alvarez (1992) suggests that, when working with severely withdrawn patients, the therapist has to reach the patient 'long enough, loud enough, or alerting enough, or human enough to get his attention' (Alvarez 1992 p. 84). She believes that the therapist's 'vitality and activity' are important. She suggests that the therapist needs to help the patient to reach out and grasp, as the infant would in relation to people and toys. Jane needs a therapist who actively links with her when she is disconnected.

As stated above, I move to be in closer proximity to Jane when she feels disconnected. Bick describes infants who are in an un-integrated state as 'in the position of an astronaut who has been shot out into outer space without a space suit' (Bick 1986 p. 66). Bick is referring to a stage that is prior to the existence of the ego, with the necessary boundary. I am referring to Jane being in a disintegrated state (Klein 1946) of mind, a psychic disintegration that comes and goes according to her identifications with her external and internal objects.

When Jane is in the therapy room, she does seem to have a pre-conception of a containing object. Bion describes a pre-conception as a state of expectation, the idea that the baby has a prior disposition towards the breast (Bion 1962 p. 91). Jane seems to be seeking out eye contact. I believe that Jane is accessing, visually, my alpha-functioning and my ability to take and hold her communication via eye contact.

Jane's shock on seeing the previous therapist is registered in the change of her facial expression, which suggests that she has taken in and begun to process her experience. Jane then uses her eyes to try and link with me, looking for me to hold her visually when in a disintegrating state. The eye-to-eye gazing holds her together and then allows her to communicate her sadness.

Jane is using the visual link with me to hold herself together when she feels she is falling apart, as demonstrated in the sequence of watching, looking and gazing. The French analyst Haag (1992) views the 'jump into the mother's eyes' as benign projective identification, which is prerequisite for overcoming the infant's terror of falling through space.

Wright (1991) quotes Searles (1963), who notes that, when working with recovering chronically schizophrenic patients, they have to go through a 'symbiotic stage' which is characterised by:

his or her sitting and staring at my face, in the session after session, with all the absorbing wonderment and responsive play of facial expressions of a child immersed in watching a fascinating motion picture (Wright 1991 p. 5).

Jane watches me and holds my gaze in the way that Searles describes, staring at me with some intensity. Jane is not emerging from schizophrenia, but she is recovering from a shocking experience that she is struggling to process. Jane's eye contact moves to looking, which is different, in that this recognises a degree of separation; she is looking at me, accessing me via eye contact. Jane then holds my gaze, using my capacity to process her feelings through alpha-functioning to try and hold herself together when she feels like she is falling apart.

Jane's words suggest that she is not affected by seeing her previous therapist in the reception. However, when I put into words my thoughts about what her visual communication conveys, what cannot be verbalised, Jane projects her sadness, which I receive via my bodily countertransference. Putting my thinking into words seems important, even though Jane responds through projective identification, rather than direct verbal acknowledgement. Wilkinson (2010) suggests that:

Well-timed interpretations that involve putting implicitly experienced feelings into words encourage the integrated functioning of both

hemispheres of the brain. This process also helps play a crucial role in helping the patient gradually to build a personal narrative that is not so unbearable that it has to be split off again. When what is remembered implicitly becomes explicit, it loses the “here and know” quality and frees the patient to live in the present. Psychotherapy needs to take on board the importance of both the interpersonal and the relational; both the explicit and the implicit; both the cognitive and the affective; both the interpretational experienced; both the left and right hemispheres of the brain; both the mind and the body (Wilkinson 2010 p. 347).

Jane communicates via non-verbal communication her intense sadness which is received in the bodily countertransference. Symmington (1996) suggests that Bion wonders:

if there is communication of thought or pre-thought in the body before it registers at conscious levels, say along the sympathetic or parasympathetic nervous system or the glandular system, particularly as the adrenaline produced by the adrenal medulla has the effect of activating the organism, rendering it ready, at least for flight or fight (Symmington p. 172).

In session number 3, it is Jane’s sadness that is felt in the bodily countertransference. Bion (1962) suggests that an infant cannot acquire the capacity to transform its primitive experiences from beta to alpha elements, except via the identification with an object capable of performing this fundamental function. He suggests that sensations which emanate from sense impressions are transformed by alpha-function to produce alpha elements suitable for being thought about. Jane’s sadness linked to the loss of the previous therapist are projected and received at a bodily level. I feel a wave of sadness that flows through my body; this produces an emotional response with the associated sensations in my body. Jane has not yet thought her own thoughts about her sadness linked to the loss of the therapist, but has communicated her sadness to me.

Grotstein (1981) describes alpha-function as:

a gating mechanism which receives data from the sensory and emotional experience, sensory in terms of the data of external experience, and emotional in terms of the data of internal experience. Alpha-function represents in par, therefore, a porous repressive barrier between our conscious and unconscious and/or internal and external worlds. Yet, as I have stated, Bion believes that the capacity to think, that is, to have an organ for thinking known as the mind, depends upon the infant’s

acquiring his/her mother's alpha-function to project into or onto (Grotstein 1981 p. 16).

I am also interested in what Jane takes in via my alpha-functioning. When I make eye contact with her, she sees a concerned, shocked face, reflecting back what has been communicated and received visually in the countertransference. I think about the infant's need to have reflected back its emotions via the mother's facial expression. Winnicott (1971) and Lemma (2010) use the term mirror-mother and suggest that an infant's sense of self is reflected back to the infant via the mother's face. It is following her gazing at me that Jane comments about absence. Jane is beginning to think about loss linked to my non-verbal processing of her emotional state. Maybe she is able to identify with my capacity to process her loss of her previous therapist, communicated through facial expression. I note my surprise at the presence of the previous therapist in the waiting room and, whilst she dismisses my comments verbally, she does communicate her sadness, via the bodily countertransference.

I began to think about the interplay between Jane's non-verbal communications and my ability to receive and process this and to put it into words, in a verbal and non-verbal 'dance' (Stern 1977). What seems to be important is that the patient's response can be received at a variety of levels: visually through the eyes; via movement and bodily countertransference; through an awareness of the transference; and verbally. The different levels of communication need to be responded to at a variety of levels through non-verbal communication: by change of proximity to Jane; through visual communication; with physical movement; change of tempo; and also, at times, by the therapist putting her emotional communication into words.

In session number 3, Jane's communication needs to be received via the bodily countertransference. Alpha-function (Bion 1962) working on bodily communication enables me to begin to process what is being communicated through the body. Rhode (2005) suggests that it is the quality of the emotion that movements can convey. Jane is in contact with me visually as I feel the sense of sadness which would have been reflected upon my face. I am mirroring back to Jane the communication that has been received at a bodily level, in a way that makes Jane aware of herself in terms of the effect that she has produced (Pines 1987).

I would suggest that, in session number 3, eye contact allows Jane, via mirroring, to be in touch with her emotions. This challenges her view of me, in the transference, as a disconnected object, and presents me as an object who is able to emotionally connect with her.

Jane needs me to hold onto, and communicate back to her, via the eye contact and facial expression, feelings of sadness with which she is beginning to be in touch. Bion (1962) calls this introducing the patient to her sensations. I am suggesting that eye contact is a receptive point for the beginning of the containment process, where the patient's projections can be received and thought about and reflected back.

Some psychoanalysts, including Winnicott (1965; 1971), Wright (1991), Eigen (1980) and Lemma (2010), have highlighted the importance of the face in psychoanalysis. Eigen (1980) suggests that the way in which a therapist uses her face may play a central role in evoking and broadening the patient's ability to be in touch with her experiences. My findings would tend to be in agreement. In session number 3, Jane is beginning to communicate her feelings via her facial expression and eye contact.

To conclude, vision appears to be central to the development of thoughts becoming thinkable. I would suggest that vision is the receptive point for the beginning of the containment process. Visual contact, through the use of benign projective identification, helps Jane to overcome her infantile terror of falling apart. To introduce the patient to herself, I introject and process her communications, and communicate them back to her via my facial expression and eye contact.

Whilst the focus of this study is the use of the body in the transference towards thoughts becoming thinkable, I am beginning to note the importance of words in this process. At this point of the therapy, it seems to me that the therapist needs to put into words what cannot be verbalised by the patient, but which can be communicated via projective identification and received in the bodily countertransference. The mind of the therapist, linking with the bodily communication of the patient, enables Jane to begin to be in touch with aspects of herself of which she is not consciously aware.

If, as I suggest, vision is the receptive point for the beginning of the containment process, it would not be appropriate to use the couch at this point in the therapy, as it would deny Jane visual access to a container. The danger is that the analyst would be splitting the mind and body and working purely at a verbal level. Rey (1994) suggests that:

‘In every analysis one has to arrive at the body-self if one wants to achieve deep and enduring change’ (Rey 1994 p. 267).

5.4 EYE AND BODILY MOVEMENT

In this section, I will explore using assessment session number 3 presented in the data presentation chapter (pages number: 80-82), how Jane moves in and out of a state where she uses eye contact and physical movement to communicate an emotional state.

Jane is able to verbalise her jealousy in relation to other children, although she does move on quickly from it. Her aggression is communicated via bodily movement. She does not, however, appear to be able to verbalise her envy of what I possess, that is, my independence. Her aggression is communicated via bodily movement.

A sequence is noted where I make an interpretation, and Jane takes this in and processes it at a bodily level. She then uses eye contact to draw my attention to the incongruence in verbal and non-verbal communication: Jane verbalises her sadness, but her leg movements communicate her aggression, her wish to kick me, which I receive in the countertransference. Jane has an idea of a ‘container’ (Bion 1962) that will receive her communication. It is interesting to note that it is when she moves her legs on the second occasion that Jane’s aggression comes to my mind. I would suggest that a process of projection and introjection is taking place where what cannot yet be verbalised is beginning to be thought about. This happens firstly in my mind, which then allows a space in my mind for Jane to project her aggression via eye contact, enabling her to move on from communicating via physical movement. I note an intensification of the projection, a testing of my ability to hold Jane’s confrontational look. Her aggression is beginning to be thought about, as it is subjected to alpha-function in my mind, opening up the possibility for introjection by Jane.

This session illustrates a direct communication about an emotional state that is communicated via the body. At the end of the exchange, Jane is able to note her struggle with separation and her sadness, but not her aggression. I feel that she is still in the paranoid-schizoid position (Klein 1946), where there is a need to keep hostility very separate from the loved object. She is not yet able to own her wish to attack and destroy the object. She is, however, communicating her aggression non-verbally.

In assessment session number 3, Jane is developing, via her non-verbal communication, a shared understanding with her therapist of how she manages absence. Fonagy and Target (2007) highlight the importance of the maternal gaze as a process where meaning is developed from experience. They suggest that eye contact is an 'evolutionarily prepared mechanism' to enable shared meaning.

I would suggest that the shared meaning is developed via different forms of communication, including visual communication and through movement of the body. Drawing upon the ideas of Spitz, Wright (1991) suggests that:

The therapist (and in particular the face) comes to serve as a mirror image to the patient, as, that is, an alter-ego, preliminary to the patient's identifying with the increasingly emotional responsive therapist, who confirms, by his increasingly rich responses, the patient's own differentiating emotional capacities (Wright 1991 p. 5).

Wright emphasises Spitz's suggestion that it is the face of the therapist which reflects back the emotional experience, giving the patient a sense of satisfaction that his or her communication has been received, and that they are engaged in dyadic communication; a sense of to and fro between the pair. This is evident in assessment session number 3, by the way in which Jane's visual communication intensifies; she feels understood and is then able to note her worries about absence.

In the way that the visual communication allows an exchange of emotions between Jane and me, bodily movements communicate an emotion linked to the absence of my gaze: the idea that I see other people. At the beginning of the session, Jane responds to my comments by moving her legs; she is experiencing this particular movement with its associated sensation in her body.

Schilder (1950) builds upon Freud's ideas; he suggests that 'we discover our bodies through at least partial contact with the outside world'. He identifies touch, and the interest others take in the different parts of the body, as major factors in the development of a 'postural model of the body' (Schilder 1950 p. 125). We take in the body of others, into our own. We also project a sense of our bodies into others. In this session, Jane is communicating via her bodily movement, and wants me to take an interest in this movement. My verbal response notes her bodily communication, which then brings about an exchange between Jane and me at a number of levels – bodily, visually and verbally – resulting in her noting her struggle with separation. Jane is able to recognise and think about separation issues before she can acknowledge her aggression. Jane is introjecting my alpha-function and is developing some capacity for thinking about emotional states.

Sansone (2002) suggests that because of the way in which the mother uses her body and its expressions in interacting with her baby, through movement and gestures often combined with vocalisation and eye contact, the infant signals a desire for interaction. So does the mother, and in doing so, she reinforces the infant's initiations and responses.

Schilder (1950) suggests that bodily movements influence the way in which we see our world. Jane's movements are thought about in this session and bring together bodily movement followed by visual and verbal communication, allowing Jane to experience myself as someone who can receive and process her non-verbal communication and help her to put her communication into words. Schilder posits that we are always building up a postural model of ourselves, which constantly changes. Schilder (1950) suggested that:

Every new posture or movement is recorded on this plastic schema, and the activity of the cortex brings every fresh group of sensations evoked by altered posture into relation with it (Schilder 1950 p. 123).

This is illustrated in the repetition of the bodily movements, although each movement is different. The first movement is in response to Jane's own comments about absence, and then the second is in response to my interpretation about absence. This second movement communicates her aggression. Finally there is an intensification of her visual communication about her anger. Jane's aggression can be held and thought about and eventually

integrated. What she experiences in sensations at the start of the session can be put into words at the end of the session.

Jane is beginning to move to a more integrated state. She brings together eye contact and bodily movement, to communicate an emotional state to the therapist. Her non-verbal communication is congruent with her emotional state. Jane and I are involved in dyadic communication where projection and introjection are taking place. Jane communicates her aggression via the movement of her legs; she introjects my comments and then projects through bodily movement and eye contact. She is introjecting my ability to withstand her visual challenge. I am not destroyed by her confrontational gaze. Jane is then able to verbalise her struggle with separation.

Schore (1994) suggests that infants require a social engagement system to build attachment: face-to-face interaction alongside body-to-body interaction with an attachment figure. He suggests an attuned interaction with a primary caregiver who responds to sensory and motor contact of the infant's communication long before verbal communication is possible.

In assessment session number 3, I am responding to Jane's bodily movements and what is being communicated visually. Words are used at the beginning and end of the interaction. Jane's aggression is communicated non-verbally, but this has a different quality to when she was using visual contact as a receptor for containment. Communication is dyadic and involves introjection and projection at a bodily level, through bodily movement and eye contact. Are feelings the body's thoughts? There is a potential for a thought, but not a thought at this stage. The movement of her body facilitates a to and fro of communication between Jane and me. Whilst Jane does not verbalise her aggression, it is communicated non-verbally, and she does respond to comments about feeling excluded through non-verbal communication of her aggression. This continues to be received and held visually. It seems important that I am beginning to name some of Jane's more hostile feelings.

I will now begin to think about the importance of receiving Jane's communication about her more hostile feelings in the bodily countertransference in the process of allowing thoughts to become thinkable.

5.5 BODILY COUNTERTRANSFERENCE

I will illustrate, using clinical material from session number 2 and session number 32, how the bodily countertransference is important in receiving primitive unconscious communications. In session number 2, the bodily countertransference facilitates the therapist's thinking about an attack on the object. In session number 32, the wish to attack the breast is felt in the bodily countertransference. Following this communication, Jane is able to work in the transference and eventually own her own aggression and sadness linked to her attack on the object.

Session number 2

Jane went on to tell me again about being shouted at when she went to work. I said that perhaps she wondered if she could bring her angry feelings in here with her. Jane looked at me with a serious look. Jane picked up her drink and began to turn it around in her hand, slowly turning with one hand whilst she held it tightly with the other hand. I was not sure of what to make of this, but it felt like she was slowly twisting the carton. I thought about breast-feeding and found myself wincing. I began to think about how I had not referred directly to the break the following week. I commented about the fact that she would miss a session next week. Jane said she was not bothered.

I want to note the processes in this session. Jane draws my attention to her anger, which is located in others. When I comment about this, she seems to be testing me visually, and her aggression is communicated via the bodily countertransference. I have to feel the pain of a physical attack, and it is at this point that absence due to a therapy break comes to my mind. Jane needs me to experience at a bodily level her aggression linked to absence. Whilst Jane can project her anger into other people, the work colleague, she is not able to be in touch with her own feelings linked to her aggression. I feel that if she is dissociated from her aggression, then it would not be helpful to attempt to draw her into a discussion in the transference. From his own clinical practice Lombardi (2008) suggests that:

focusing upon the transference and object relations deflected from personal and intimate experiences of bodily sensations which the patient may for the first time allow themselves to experience. Allowing the body

into the analysis helped to demonstrate the possibility of thinking and discriminating within the experience of body (body-mind relationship) as the patient began to approach his/her own sensations (Lombardi 2008 p. 90).

I think this is an important point: that I need to hold in the countertransference her wish to scratch and attack the object, and allow space for Jane to observe, through my non-verbal and verbal communication, that I have received her projection with which she is yet to be in touch with.

I believe that, when I experience Jane's projections in the bodily countertransference, we are working at Bion's intervening stage between beta-elements and alpha-elements. Lombardi (2008) suggests that, when the therapist is working at this intervening state, it is important that the therapist responds in a way that helps the patient to come into contact with her sensations of which she is fearful of coming into contact. Lombardi (2005a) suggests the importance of 'transference to the body'. Bion called this 'introducing the patient to himself' (Bion 1990 p. 90). Lombardi argues that transference interpretations are of limited use where somatic experiences are centre stage. Lombardi (2008) states that:

the process of approaching the body calls for an unfolding of symmetrical thinking in the analytic session before one can move on to a specifically relational working through the transference. (p. 95)

For the therapy to progress a mental space has to develop in the patient's mind.

Jane is able to express her angry feelings in the session, but she is not able to work in the transference. My comments about her anger linked to the imminent break are dismissed. I need to experience, in the bodily countertransference, the infantile wish to attack and destroy the denying breast (Klein 1931) linked to the imminent break. Alvarez, referring to Bion, suggests that:

some projective identifications expressed a need to communicate something to someone on a very profound level; he began to see this as related to a fundamental process in normal development, and compared the analyst's "containment" and "transformation" of the patient's feelings and thoughts to the primitive but powerful pre-verbal communications that take place between mothers and tiny infants (Alvarez 1992 p. 4).

I will use session number 32, to illustrate my work with Jane, using both verbal and non-verbal communication, particularly the bodily countertransference. The

clinical data for session number 32 is presented in the data presentation chapter (page number 94-98). I will also demonstrate how I use the bodily countertransference to inform my interpretations.

Session number 32 is a pivotal session. In this session, we are working in the transference whilst using both verbal and non-verbal communication. This session illustrates a move from the paranoid-schizoid position to the depressive position (Klein 1946). Jane is able to own her aggression. Klein (1946) describes how, in the depressive position, the infant realises the object that has been attacked in phantasy is also the object that is loved. The infant becomes afraid of losing the loved good object, and she feels remorse, guilt and sadness associated with her aggressive attacks on the object. Klein describes how the infant pines for the object lost or damaged by hate, and the wish to repair surfaces.

Session number 32 is an example of transformation; Jane is able to verbalise her aggression in the transference. One of the significant factors in the transformation is when I am able to hold both her aggression and the sadness linked to the attack on the object. I am holding the depressive position at this point. I comment twice about the damage caused by the aggressive attack: “they are very sore” and “nails were low”. Earlier in the session, Jane notes her anger in the transference, but the full force of her anger is received in the bodily countertransference, the wish to attack the breast.

I comment about this, which brings about a change in the temperature of the session. She moves her body, and I wonder if something has been processed at this point; her projections have been received. I am able to observe the ferocity of her aggression whilst holding onto her sadness linked to the attack. I note a change in my tone of voice (Trevarthen et al 2011). I would suggest that this is what Stern et al. (1989) call a ‘moment of meeting’, Bion (1965) calls a ‘transformation’ and Schore (1994) calls an ‘interpretation with empathy’.

Carlberg (2009) cites the Erica process and outcome study, which identified several factors that underlie change in psychotherapy: adopting a waiting, wordless attitude and relinquishing the ambition to attain a flow during the sessions or to put words to feelings. A direct interpretation, as a factor underlying change, is only mentioned on one occasion. One of the factors

identified is 'moments of meeting' (Stern et al. 1998), which Stern et al. describe as 'powerful inter-subjective encounters'. Session number 32 has a 'moment of meeting' at the end of the session. I would argue that, whilst such 'moments of meeting' are important, they should be seen in the context of the work that has preceded them.

The neuroscientist Pally (2007) suggests that the therapeutic change takes place through self-reflection. She suggests that, when what is predicted does not happen, consciousness can be engaged. Jane predicts that I will not understand how angry she feels when the session starts late. However, in the transference, she is able to name her anger. Following the naming of her anger, the ferocity of her anger is projected in the bodily countertransference, which she is also able to reflect upon at the end of the session. Pally states that unconscious repetition is fundamental to brain function. The brain non-consciously predicts what is most likely to happen. The change in Jane's body posture is worth noting: does this represent a processing and change of the body schema, in that the therapist has experienced, at a bodily level, the sensation in her body of a wish to scratch? She feels that her communications have been received and understood, and moves closer to me. The temperature of the session seems to change, and I note a mirroring between me and Jane, in that when I receive both of the aggressive attacks in the bodily countertransference, wincing and then the wish to scratch, I am able to comment about sadness and feeling low. At the end of the session, Jane is in touch with both her aggression and also the pain linked to the aggressive attacks on the object.

A space seems to be developing in Jane, where new thoughts and ways of relating can develop. In session number 32, Jane experiences me as a different object to the one expected. At the beginning of the therapy, her transference was to a cruel and denying object whereas here she is experiencing me as someone who can provide a space for her projections, and someone who can hold the depressive position. Jane is able to introject my alpha-function, enabling her to think about her aggression and not just experience it as sensations. However, Jane's main form of communication is still projective identification, as evidenced by my countertransference. Thoughts that are not yet thinkable are still present in her communication.

In the next section, I will demonstrate, using three consecutive sessions, a significant shift in Jane's internal world. In session 53, she communicates non-verbally a primitive state of mind, which is contained by her therapist. This leads to a shift in her ability to verbalise her thoughts in the subsequent session number 54. In session number 55, Jane begins to explore different ways of separating from me at the end of the therapy session. Clinical material for session numbers 53 and 54 is presented in the data presentation chapter (page numbers 99-102 and page numbers 103-106 respectively).

5.6 DEVELOPMENT OF A THREE-DIMENSIONAL INTERNAL SPACE TO THINK THOUGHTS

I will use sessions 53, 54 and 55 to illustrate how space is developing in Jane's mind following the containment of her projections at a bodily level. I will demonstrate the developments in the bodily countertransference and developments in the gazing relationship, and the shift once more from the paranoid-schizoid position to the depressive position.

Sessions 53 and 54 are pivotal sessions; they are, in my opinion, the turning point in the therapy. At the start of session number 53, Jane seems to feel guilt when I greet her in the reception, and also later in the session, when she asks if I have received a message when she cancelled the previous session. In the transference, she views me as an unreceptive and unavailable object and does not believe that I might be pleased to see her regardless of her emotional state. Jane anticipates a hostile gaze as she arrives and I am waiting for her in the reception. She seems to be shocked at being met by my gaze, and she anticipates humiliation rather than concern.

Jane seems to feel watched rather than seen when I greet her at the start of the session. She needs me to experience feeling watched and the overwhelming distress linked to the harsh watchful gaze that feels like it is killing off any liveliness or links with me. It is the intensity of the penetrating gaze that seems important.

The idea of a persecutory evil internal eye is beginning to emerge. Klein (1957) in footnotes draws upon the work of Dr Elliot Jacques and describes envy as 'to

cast an evil eye upon or grudge anything' (Klein 1957 p. 180). She points to her emphasis upon the projective character of envy.

It is also important to use my observations and countertransference to enable me to be in touch with aspects of her that might be more in the service of life. Following my comment about the Bank Holiday, Jane changes her body posture, leaning over the table that is close to me, and she opens her eyes slightly, which enables me to see the eye that is eerily watching me. This allows me access to a small part of Jane that might be more in the service of life, a smaller part that I need to link with visually and begin to verbalise to help Jane introject the nourishing and good aspects of the therapeutic relationship. O'Shaughnessy (1999) suggests that a pathological internal object can exist alongside a normal, not harsh internal object, and the patient then oscillates between the two. She suggests that it is important to recognise and differentiate between them.

I think that the eye contact is important in this session; it is through eye contact and the proximity to Jane, in that I am sitting very close to her, that I am able to really observe the minutiae of her communications and begin to feel the envious attack which could engulf the personality. Feeling the intensity of emotions that Jane is projecting is important.

In session number 53, what is predicted does not happen; Jane does not expect to see me waiting for her. I present myself as a different object, and this challenges her views of me. She seems to predict a hostile response, not a thoughtful one. When I verbalise my thoughts about absence, she seems able to take in my comments and begins to relate to me in a different way in the transference, oscillating between the two internal objects. She is able to hold her anxiety in mind, and use alpha-function to think about it.

Jane's body movements, in the finger tapping, communicate something very lively, even though at the same time she seems to be cutting the link with me. Observing this communication, and holding in my mind the more lively aspects of her internal world, allows Jane to access something lively in my mind. My ability to keep thinking whilst under attack from the 'evil persecutory eye' is also important in keeping alive the transference to the more benign internal object.

Noting communication of different ways of relating to me in the transference is important, that is, her appealing eyes in contrast to her leg movements, which communicate her anger. Also, there is the oral attack on the self, in the biting of her nails, in comparison to her more lively movement of her body, the drumming. I comment about the two different views that are presented. I am holding the depressive position in my mind, the two views of the object representing the good, nurturing object and the object that is hostile and frustrates (Klein 1946).

In the countertransference, I feel like I am losing contact, whilst also receiving her anger and experiencing a wish to enliven her by physically shaking her. This brings to my mind the imminent absence. My verbal interpretation effects a change in her posture; Jane moves physically closer to me. I view this as evidence of a transformation: Jane has projected into me and I have received her projections, processed them and verbalised my thoughts, which seem to resonate with Jane. The change in body posture communicates to me that she is beginning to introject me as a thoughtful and interested object who can withstand her envious attack.

Jane's emotions are communicated to the therapist and felt as feelings in the therapist's body, which enables them to be processed and thought about. Wilkinson (2010) notes that Damasio's (1999) differentiates between emotions and feelings; he views emotions as adaptive changes that take place in the body as a result of some particular stimulus, whereas he sees feelings as the conscious mental representations of these emotional responses.

5.6.1. Developments in the bodily countertransference

In session number 53, Jane is communicating her feelings. She projects quite powerfully her primitive anxieties (Bion 1967) that in the absence of the object she might die. This needs to be felt by me and held at a bodily level: panic, confusion, and disorientation. Session number 53 is an example of how it is important when the body takes centre stage that I hold the feelings in my body until a space can develop in the patient's mind (Lombardi 2008). Lombardi advises against working in the transference until a space has developed in the patient's mind. In addition, processing of the bodily experiences alerts me to the issue of risk.

I am able to observe the 'persecutory evil eye' and experience a feeling of being watched. At the same time, I am also able to observe some movement of the eye; this seems important. The eye is slightly open, which allows some access to Jane's distress that can be observed and held. It is important that I hold the eye contact, which allows her to link, hold and communicate her emotional state via eye contact. The intensity of the look is important, so that I can hold and think about Jane's wish to destroy the link with me. The intensity of the harsh internal object is observed in the redness of her eyes; she eventually opens them, evoking a worry in her therapist that Jane's persecutory evil eye has engulfed her.

I would suggest that this is a restorative session, where I am able to hold Jane's primitive anxieties, her fear that she might die without the presence of an object. This enables the restoration of 'the psyche in the soma' (Winnicott 1960 p. 45).

5.6.2. Developments in the use of the gaze

The gaze is important in session number 53, and it is worth noting how the different aspects of Jane's personality come into the therapy. Steiner (2006) argues that vision plays a central role in seeing, as the object comes to be observed from a distance, and also in being seen, where the expectation of a hostile gaze, which threatens humiliation, can become prominent.

Initially, Jane anticipates criticism rather than understanding. Lemma (2010) reminds us that we are all subject to the gaze of others. Lemma (2010) differentiates between being seen and being watched. Jane needs me to be in touch with a feeling of being watched. Lemma describes how some patients feel that they are at the mercy of the harsh, watchful gaze: an ego-destructive superego (Bion 1962).

It seems important that I am able to hold visually the intensity of her penetrating look alongside the sadness linked to her intense gaze. I need to hold the communication visually and keep thinking so that a space can develop as a result of this session in the subsequent session. Such a space should enable her to think about the communication in this session (number 53). When I am holding Jane visually, I wonder: what is she taking in from this experience? Does she need to observe my response to her envious attack? Lemma (2010)

refers to a mirror-mother, explaining how the mother's experience of the infant is mirrored back to the infant and how this can be distorted if the mother is projecting her own experiences into her infant. I would suggest that, in session number 53, Jane experiences me as someone who can take in and feel her projections, and experience her at an emotional level. My experience of Jane is received back by her in the first instance (before words) through my non-verbal communication, that is, my facial expression, which changes following the visual exchange.

Steiner (2006) uses Britton's (1989) ideas, building on his work on the 'triangular space'; he describes how the child's relationship with the primary object, or object of desire, is complicated by an awareness of a secondary object which becomes an observing object, in particular making judgements on the relationship with the primary object. Unsatisfactory experiences with the primary object predominantly lead to guilt, while those in relation to the observing object give rise to shame.

Steiner (2006) suggests that the observing object is often represented by the observing part of the primary object, often in fact the mother's eyes, while the observing object also frequently shifts to become the primary object so that the shame it creates is mixed with guilt. In session number 53, there is a split in the transference: there is an observing object watching me in the transference whilst a primary object wishes to have a good link with me.

It is at this point in the therapy that I begin to be in touch with the different aspects of Jane's personality. Jane is able to tolerate a level of separation, unlike at the start of the therapy where she was in a state of adhesive mirroring with the object. However, the gaze of others leaves her feeling exposed.

Steiner (2006) suggests that:

When a patient loses the protection of a narcissistic relationship and is obliged to tolerate a degree of separateness. Having felt hidden and protected, he now feels conspicuous and exposed to a gaze which makes him vulnerable to humiliation (Steiner 2006 p. 939).

Jane uses session number 54 to think about the previous session. She is able to work in the transference, verbalising her thoughts and, in the transference, Jane has moved away from the observing object; she has interjected a benign internal object.

In session number 53, Jane's primitive anxieties have been contained; this enables her to reflect upon her thoughts in the subsequent session. She expresses herself freely and engages in a verbal dialogue with me. Jane is able to think her thoughts in this session; a transformation has taken place where her thoughts have become thinkable. Jane is aware of her emotional state and can verbalise it. It is no longer necessary to pick up fragments of feelings and carefully link them with her emotional state.

Jane wants to think about how she gets into a deadly cut-off state. She seems to recognise how she is drawn to a deathly state. We explore the idea of a benign internal eye that keeps her safe, reminding her of a more lively part of herself that is in the service of life. Jane is able to think with me. Bion (1962) defines thinking as the process where emotional experiences are retained and metabolised. Alpha-functioning is central to this process. He suggests that 'in so far as alpha-function is successful alpha-elements are produced and these elements are suited to storage and the requirements of dream thoughts' (Bion 1962 p. 6). Bion argues that the contact barrier is formed when sense impressions are transformed into alpha-elements that are liable to be used in dream thoughts or in waking unconscious thoughts.

Bleandonu (2000) puts forward Bion's view that dreams can give direct access to the contact barrier:

If the contact barrier is evident in clinical work, it takes a form something like that of dreams, protecting reality perception from being overwhelmed by emotions and phantasies emulating from within (Bleandonu 2000 p. 153).

Bion (1962) suggests that:

The sleeping man has an emotional experience, converts it into alpha elements and so becomes capable of dream thoughts. Thus he is free to become conscious (that is wake up) and describe the emotional experience by a narrative usually known as a dream (Bion 1962 p. 15).

Jane brings a dream; alpha elements have formed internally in relation to her anxieties about the deathly lifeless state, but unconsciously she is worried that her symbol formation will collapse and she will act out concretely in reality whilst she is asleep. Segal (1957) suggests that the capacity to communicate with oneself by using symbols is the basis of verbal thinking, which is demonstrated

through Jane's capacity to verbalise her deathly state in the session.

Segal (1957) suggests:

An important aspect of internal communication is the integration of earlier desires, anxieties, and phantasies into the later stages of the development by symbolisation....I think that one of the important tasks performed by the ego in the depressive position (Segal 1957 pp. 169-170).

Bion (1962) suggests that alpha-function is needed for conscious thinking and reasoning. Symbolism is an activity of the ego attempting to deal with the anxieties stirred by its relations to the object. In the depressive position, the anxiety is in relation to the hostility towards a good object.

Bion (1967) suggests that the establishment of a relationship between infant and mother, in which normal projective identification is possible, precludes the development of an alpha-function. I am suggesting that projective identification needs to lodge in my bodily countertransference and be communicated through the eyes and bodily posture, before it can be the beginning of thoughts. Projective identification provides the potential for forming thoughts.

Reverie is an important factor in both session number 53 and session number 54. In session number 53, there is incongruence between Jane's expectations in the transference, that her object would be inflexible, rigid and neglectful, and her actual experience in the session. What she experiences is an object that is congruent with her. This is a state of reverie. This brings about a change in her internal object, which is illustrated in session number 54. Jane is able to engage in a verbal dialogue about session number 53. She anticipates that the object will be able to receive her communication and think with her.

Bion (1967) suggests that 'The mother's capacity for reverie is the receptor organ for the infant's harvest of self-sensation gained by its conscious' (Bion 1967 p. 116).

He also suggests that:

If the feeding mother cannot allow reverie or if the reverie is allowed but is not associated with love for the child or its father this fact will be communicated to the infant even though incomprehensible to the infant. Psychical quality will be impaired to the channels of communication, the

links with the child. What happens will depend on the nature of these maternal psychical qualities and their impact on the psychical qualities of the infant, for the impact of one upon the other is an emotional experience subject, from the point of view of the development of the couple and the individuals comprising it, to transformation by alpha-function (Bion 1962 p. 36).

My reverie is linked to my ability to integrate my countertransference feelings with concern for Jane. The therapist herself must be located in the depressive position. As demonstrated in session number 53, when Jane closes her eyes and I notice her eyelids, which look transparent whilst I can see her eyes moving underneath the lid, it is at this point that I begin to feel sadness and concern for Jane in the countertransference.

In session number 53 and session number 54, a development is noted in the way in which Jane uses her body in the sessions, from a closed posture, where she is cutting the link with the therapist, to an open posture, where she communicates a readiness to engage. The following section describes Jane's move towards bodily integration.

5.6.3. Developments in bodily integration

At the start of session number 54, I note how Jane is sitting upright in her chair. She is alert and ready to relate, looking out and ready to communicate. This is in contrast to the previous session, when she had her eyes shut and was cutting the link with me. Her posture was communicating being in a cut-off state.

In session number 54, her posture communicates to me a sense of integration, where all different aspects of her body and mind are working together.

Ogden (2006) suggests that:

All early relational dynamics with primary caregivers, traumatic or non-traumatic, serve as blueprints for the child's developing cognition and belief systems, and those belief systems influence the posture, structure, and movement of the body, and vice versa....Chronic postural and movement tendencies serve to sustain certain beliefs and cognitive distortions, and physical patterns, in turn, contribute to these same beliefs (Ogden 2006 p. 10).

Jane's posture reflects a change in her beliefs, and this is reflected in the transference. She does not feel watched or humiliated by my gaze. In the transference, Jane has introjected an internal object that watches over her in a

protective way. This internal object is available, potentially, whether or not the actual object is present.

There is an identification with a benign internal eye, introjected visually, that is linked to liveliness. This internal eye is in the service of life, and it militates against the harsh persecutory eye. Jane asks in session 54 if her eyes were moving in the previous session; she wants to know if I am able to be in touch with her benign internal eye. She seems pleasantly surprised when I confirm that they were. Following this exchange, Jane is able to verbalise her anger about feeling forgotten and ignored. At the end of the session, she is able to verbalise her sad and angry feelings about the imminent break. Jane is identified with a protective and alert internal eye, which enables her to perceive internally her emotional experience.

It is interesting that, following session number 53 and session number 54, Jane begins at the end of session number 55 to experiment with the experience of separation. I will explore in the next section the importance of vision and separation.

5.7 VISION AND SEPARATION

In this section, I will examine how Jane is beginning to explore the idea of separation.

Session number 55

Jane opened the door, just a little, and squeezed her body through the door, a bit like she had disappeared down a hole. I wanted to look through the window in the door to see if I could see her. The door shut and I was left on the other side of the door looking through the small glass window in the door. I watched Jane in the distance; she was walking through the door leading out of the clinic. Jane had not said “goodbye”, and I found this really difficult.

Separation evokes terrifying feelings in Jane. Bick describes the feeling of falling in space, linked with the experience of separation (Bick 1989). In this session, these feelings are projected into me. I have to experience a feeling of sudden dislocation and not being able to gain any access to Jane. I watch Jane walking away without an acknowledgement of a separation. Watching in this session has a different quality. In previous sessions, watching is linked to the persecutory evil eye. In session number 54, a new development is noted; Jane

has introjected a benign internal eye that is in the service of life, and watching is linked to keeping her safe. In session number 55, watching is linked to separation and the anxieties linked to this.

My association to session number 55 is the television series 'Doctor Who'. I have to experience Jane very suddenly disappearing out of my sight into a new, exciting but scary world.

Jane seems to be experimenting with a different way of being. She leaves me, rather than allowing me to accompany her to the outer door, where Jane and I would usually mark the separation verbally. I have to feel the terror that she might not return. Jane is projecting into me, ridding herself of worries about abandonment. Jane needs me to experience feeling abandoned and the terror this instils. She needs me to hold these feelings and to begin to process them. Separation does not have to be catastrophic. A space between the patient and therapist has developed which enables Jane to explore different ways of experiencing endings.

Previously, in session number 53, I could hold the projection of Jane's anxiety that she might die without the presence of an object. However, she was cut off from her feelings. Segal (1957) cites the integration of earlier anxieties into the later stages of development of symbolisation as an important aspect of the move to the depressive position. She suggests that the ability to symbolise reduces anxiety and is the basis for verbal thinking. In the subsequent session (number 54), a development in Jane's internal object is noted. Jane is then able to verbalise and explore her feelings about the previous session, linked to deadly aspects of herself, where she cuts the link with the object. In session number 55, Jane is able to experiment with separation as she no longer views this as catastrophic. In session number 55, the therapist has to experience the patient leaving her.

In the next session that I will analyse, session number 63, the clinical data is presented in the data presentation chapter (page number: 111-114).

At the start of session number 63, when Jane arrived, the receptionist was not at her desk. In this session, Jane is able to be in touch with her feelings of

abandonment as a result of this incident, and linked to separation from her object.

It is a verbal interpretation in the transference about her internal struggle that draws Jane back from a cut-off state into a verbal dialogue with me. Jane is working in the transference and a space is opened up in the therapeutic relationship, in which she can begin to think her thoughts in relation to her anxieties stirred up by the relationship. The idea of access that is blocked emerges. The symbol of a screaming baby is a direct communication of Jane's feelings of abandonment. She is able to think this through in identification with an internal object capable of alpha-function. The link between her baby-self, crying and not being heard, and her state of distress understood and held by her therapist, is palpable. The transference here is to an object who is not abandoning her.

Abandonment seems to be a recurrent issue for Jane throughout session number 63. It is interesting that it is in this session where she is able to communicate powerfully her primitive anxieties, linked to being abandoned and left to die, and she begins to move to the depressive position.

Jane uses non-verbal communication at the start of the session, which I use to inform my interpretations. She is then able to reflect upon her internal struggles and verbalise her infantile anxieties linked to abandonment. She is also in touch with her feelings linked to separation. Her thoughts have become thinkable in the transference relationship linked to separation; this is a significant progress in the therapy. The mind and body are working together.

I will consider session number 67, which is presented in the data presentation chapter (page number: 125-130) and session number 68 presented below, to illustrate how Jane manages a transition to another therapy room, a portakabin located a short distance away from the building.

The move to the new therapy room, and the change in the time of the session to accommodate the timetable for Jane's examinations, evokes feelings linked to separation. In this session, Jane views separation as something violent, where everything will be destroyed. In the session, I struggle to pick up the idea of growth. I wonder if there is something about what Jane is communicating that

is difficult for me to verbalise, perhaps the intensity of the projection about the violence brings about a paralysis in my ability to process her communication. I struggle to hold the different aspects of Jane's personality in my mind.

However, whilst I could not verbalise thoughts about growth, it is interesting that, in the subsequent session, we are able to explore the positive aspects of the new therapeutic space. I wonder if it is important in session number 67 to hold the more negative aspects linked to separation. The move to another room allows Jane and me to work through primitive anxieties linked to separation at a deeper level.

In session number 67, the bodily countertransference contains wincing, through which Jane is describing pain linked to having the different aspects of her personality recognised. Wincing is also a bodily countertransference in sessions 2 and 32. It is interesting to note the similarities and differences between the manifestations of wincing in these sessions. In session number 2, Jane's projections are received and held at a bodily level by me. This induces an action in me, a wish to scratch. In session number 32, Jane is in touch with the feelings projected, and this is felt in the bodily countertransference. In session number 67, wincing in the bodily countertransference is linked to an intensity of pain that makes it impossible to know and hold together in the therapist's mind different aspects of Jane's personality.

In the next session presented, session number 68, a transformation takes place from the previous session. Jane is now able to explore the new environment sensorially, in a way that a newborn might begin to explore its environment.

Session number 68

Jane walked towards the door. I said "hello" as she approached, making eye contact with her. We walked down the corridor. Jane was walking behind me as usual, but this felt comfortable. We passed the room which was the old therapy room. There was an engaged sign on the door, but it was turned towards the door, rather than facing outwards. I thought "how odd", and wondered if the young person in the room had done that. I opened the outside door and we walked down the steps. I began to feel quite awkward as Jane seemed to be several steps behind me. "Where is she?" I thought as I looked over my shoulder. I noted a young doctor walking down the side of the building that we had just come out of. Jane seemed to be swinging her hips. I began to think about Bridget Bardot. We reached the door of the new building, and I opened it. We both walked together. I opened the therapy-room door, and Jane walked over to the chair and sat down.

I looked at Jane and noticed she had no mascara on. This was very unusual. I commented about the fact that she seemed to have come without her make-up, which she often describes as her mask. Jane said she had not put any on today. I said that perhaps she wants to come into the room today without her mask on. Jane began to look at the couch. I said perhaps she is thinking about whether she would like to use the couch.

Jane got out of her chair and quickly walked across to the couch. She moved the throw that was on it and said "Oh, it's blue." She sat on the couch, bounced up and down like a small child and said "It's soft." She moved the throw from the back of the couch and looked underneath. I said she seemed to be really exploring the couch. Jane lifted the throw at the bottom and said "Oh, cushions." She ran her hand along the piece at the back of the couch. I said perhaps that feels quite different, one big and soft and the other hard. Jane lay back on the couch, looking quite pleased with herself. She commented that it was really comfortable.

Jane looked at the back of the couch and said that the bit at the back reminded her of a hospital. I asked in what way. She said "The sides, like on a hospital bed." I asked her what she thought about the sides. She said that she did not like them as she liked her independence. Then she hesitated and said that the sides stop you from falling out of bed. I commented that she seemed to wonder whether this couch and room could hold her if she fell, or would it limit her independence?

Jane communicates by the way in which she holds her body, the rhythm of the walk and the feelings she evokes in the countertransference. The way in which Jane feels comfortable in her own skin, as a separate individual, is worth noting. She moves her body in a way that indicates to me that bodily integration has taken place.

When she sees the young doctor, her body seems to be communicating that she is desirable and wishes to attract the young doctor. Lemma (2010) highlights the importance of the mother's gaze alongside touch. She uses the term 'object of desire' to describe the:

sensory, sensual, bodily components of the earliest relationship and how critical it is to the establishment of a desiring and desirable body-self. This provides the foundation for the expectations that the self will be desirable and loved, and that it can desire and love (Lemma 2010 p. 26).

I am able to take pleasure in Jane's adolescent development. In ordinary adolescent development, there is a conflict, which Jane experiences at the end of the session when she refers to the sides of the hospital bed; Jane wants to be held but also wants to be independent. Jane feels I am able to manage my own Oedipal feelings about being on the outside of a young couple.

Jane explores the room in a sensual way, touching the walls and bouncing on the couch. Jane is able to experience sensations via touch and then verbalises her thoughts and feelings. She shares her thoughts for us to think about together, developing a shared meaning. Bick (1968) refers to the importance of the sensual experience of the mother's skin. We are working together in the transference at a number of levels, through touch, vision and verbal communication.

It is interesting that she approaches the couch at the time that she begins to verbalise her emotional experience. As stated earlier, vision is important up to this stage and the couch is contra-indicated.

Summary

The analysis of the data highlights the importance of vision in the development of thoughts becoming thinkable. Non-verbal adhesive mirroring was used at the start of the therapy to avoid separation. I suggest the importance of mirroring back emotional states that are congruent to those projected by Jane made her aware of herself, in terms of the effect she had on me. This seems to be an important aspect of the process whereby thoughts are becoming thinkable.

CHAPTER 6: CONCLUSION

This study provides an exploration of the patient's use of her body in the transference relationship in intensive psychotherapy towards allowing thoughts becoming thinkable. This concluding chapter outlines the findings of the study. The methodology used for this study is reflected upon, drawing out its strengths and weaknesses. Consideration is also given to the development of professional practice and implications arising from this study's finding for further research.

6.1 FINDINGS

At the start of the therapy, Jane appeared to use adhesive mirroring as a defence against separation, militating against communication of any kind. When I first met Jane, I noted the importance of scanning Jane's appearance, facial expression and body posture, in a way similar to how a mother may scan her baby. A process begins whereby this information is received as communication. It also became evident that Jane needed me to make a non-verbal link with her, through my receptive mind, using my facial expression and eye contact. Jane could then begin to use projective identification.

I was presenting myself in the transference as an object that is different to Jane, one that is aware that Jane has disconnected and wishes to reconnect; thereby challenging Jane's expectation of me in the transference. This alternative object presented to Jane is in touch with her distress and congruent with her emotional state. Jane's preconception of a receptive object is realized in this encounter.

When Jane accesses my alpha function visually, she was able to access my capacity to take in her communication via eye contact, and hold her communication in mind so as to process through my alpha function. Jane also used the visual link with me to hold herself together, when she was in danger of psychic disintegration.

Jane was able to communicate her intense sadness via non-verbal communication, which I was able to receive in my countertransference. She was not able to think her own thoughts about sadness, but her non-verbal

communication enabled me to begin to process her feelings in my own mind through my alpha function. As a result of my processing of her emotional state via my alpha functioning, Jane was able to begin to think about her feelings in relation to loss. In order to be able to do this, she needed to be able to introject and identify with my capacity for alpha function.

I received Jane's responses at a variety of levels: visually through eye contact, through movement, through the bodily countertransference, through awareness of the transference, and verbally. I suggest that vision appears to be a receptive point for the beginning of the containment process. It is worth noting at this point in the therapy, given that the use of the couch excludes eye to eye contact between analyst and patient, I suggest that such a use of the couch is inappropriate for the patient at the beginning of the containment process, before verbal communication of feelings is possible. .

I noted how mirroring back emotional states that are congruent to those projected by Jane made her aware of herself, in terms of the effect she had on me. This seems an important aspect of the process whereby thoughts are becoming thinkable. However, I began to think about the importance of putting into words what cannot be verbalised by Jane, but which can be communicated through projective identification and received in the bodily communication.

A process of introjection and projection takes place between Jane and myself, where that which cannot be verbalised is in the process of being thought about. A space in the therapist's mind enables the intensification of projections, and allows projection through eye contact. By subjecting patient's projections to alpha function, the therapist enables the patient to introject a capacity for rudimentary thought. Thoughts become thinkable as a result of the projection/introjection cycle.

When I do not collapse under Jane's intense non-verbal communication, and I am able to withstand her projections, Jane moves to a more integrated state. She introjects my responses and she is then able to verbalise her difficulties. Jane needs me to experience in my countertransference, her aggression at a bodily level. It is important to hold this communication in mind, to receive the projections that she is yet to experience herself. This is work at the intervening stages between beta and alpha elements.

When I am able to hold on to Jane's aggression and sadness linked to her attack on the object, that is to hold the depressive position, a transformation has taken place and she began able to verbalise her aggression. New thoughts, and new ways of relating, develop in Jane. There is a corresponding transformation in the transference. Thoughts have become thinkable. There is an internal object that keeps her safe, which is in the service of life,

I note that alpha elements form in relation to Jane's anxieties and develop into a capacity to dream. Jane can communicate her feelings of distress directly, through the use of symbols (the screaming baby). Jane is then able to verbalise and explore her feelings about the deadly aspects of herself, where she cuts the link with the object. She is able to engage in a verbal dialogue about her feelings in anticipation that the object will be able to receive her communication and think with her.

The way Jane uses her body in the sessions changes, from a closed posture where she is cutting the link with the therapist, to an open posture where she is communicating a readiness to engage. This constitutes a move towards bodily integration.

Jane becomes identified with a protective and alert internal eye, which enables her to perceive internally her emotional experience, and which militates against a harsh, persecutory eye. Jane can work in the transference. A space has opened up in the therapeutic relationship, in which she can begin to think her thoughts in relation to her anxieties stirred up by the relationship.

Jane's thoughts, linked to separation, become thinkable in the transference relationship. A significant progress in the therapy is that she is then able to experiment with separation, as she no longer views this as catastrophic.

The intensity of projective identification can bring about a paralysis in the therapist's ability to process Jane's communication. The therapist needs to occupy the depressive position otherwise it isn't possible for her to integrate different parts of the patient's personality in her own mind.

Jane develops an adolescent image of herself as desirable. She suffers the ordinary adolescent conflicts between needing, holding, and desiring independence.

Although this is a small scale piece of research, it offers a contribution to professional practice and knowledge in the field of child and adolescent psychotherapy.

6.2 CRITIQUE OF THE METHODOLOGY

Grounded theory was the methodology initially adopted for the data analysis, on the basis that it provided a structured means of examining data from a single case. However, whilst it allowed theories to emerge from the data, which is one of its strengths, it is a complex and time consuming method.

In the grounded theory method a constant comparative technique is used for analysing data in order to develop the codes. Clearly, the use of a constant comparison strategy is limited when analysing data from a single case. Multiple cases would have enabled a more extensive comparison of emerging codes. However, it was possible to use constant comparison of the initial codes to begin to build upon and develop aspects of the code further. I was able to look at the ways in which the different codes interrelated in the process of thoughts becoming thinkable.

The initial coding did allow me to stand back from data that I had already thought about in supervision and as a result alternative ways of viewing that data began to emerge. It was, however, easy to get swamped by the vast amounts of data. The development of initial codes allowed me to use constant comparison to work through the data in a systematic way without getting overwhelmed by the minutia.

Whilst grounded theory was the methodology initially adopted for the data analysis, focused coding brought in a psychoanalytic perspective, which hadn't arisen entirely from the data in a way that is required by grounded theory. On reflection, whilst I started using grounded theory the focused coding and overall conceptual framework for analysing the research went beyond the scope of grounded theory and into the realms of thematic analysis.

The point at which I carried out the literature review in this study is of importance. It was undertaken following the coding of data, as recommended by Glasser and Strauss (2008), to avoid imposing my preconceived ideas upon the data. Inevitably, the completion of five years of clinical training to be a child

and adolescent psychotherapist would have influenced my thinking about the clinical material. Similarly intensive case supervision, whilst helping me to think about the patient's communication, would also introduce a degree of influence. A constructionist approach, as advocated by Charmaz (2006), would argue that knowledge and reality are created through social relationships and interactions. From this perspective it is impossible to approach the clinical material without any prior thinking. I would argue that this is both a strength and a weakness of the methodology.

The ability of process notes to provide an accurate and full description of the clinical encounter has been questioned. However, I suggest that by presenting in full the sessions that I consider as pivotal and turning points in the therapy, allows the reader to gauge and assess the meaning attached to them.

Alvarez and Lee (2004) used video tapes in their research on autistic children, which allowed them to study moment-to-moment interactions. I would recommend that consideration should be given to using video recording for research in child and adolescent psychotherapy. I understand that such a view is controversial in the profession, as many would suggest the use of video recording would be intrusive and would impact upon the therapeutic relationship. I feel, however, that the use of video recording has the potential to provide a rich source of data on the processes, both verbal and non-verbal, in the therapeutic encounter. Whilst such recording would not allow access to the transference and countertransference, it would allow access to patient's non-verbal responses, via bodily movements and facial expression, to the therapist's verbal and non-verbal communication.

The issue of how far my findings can be generalised has been considered throughout this study. Whilst this is a small scale study, and the intent was to provide a detailed insight into a single case and not to generalise findings, the single case study can offer a contribution to professional practice and knowledge in this field.

6.3 ETHICS

The patient received appropriate and timely therapeutic input. Consent for a retrospective study was sought following the completion of the therapy. In order

not to shift the focus with the patient away from free floating attention, I would advocate retrospective studies for single case study research.

6.4 PROFESSIONAL DEVELOPMENT

The close examination of clinical material using grounded theory methodology has been useful for my professional development. Reading the literature and thinking in research supervision has helped to expand my knowledge, understanding and application of this to clinical work

The case studied was one that had perplexed my colleagues and I would hope that the in-depth knowledge I have acquired through this study could be shared and facilitate discussions about similar cases, and the use of long term treatments. Whilst this is a single case study I would hope that my learning would benefit both the team and the young people with whom I work on a daily basis.

I will draw out some of the technical issues that might be worth further consideration.

6.5 VISUAL COMMUNICATION

I would like to draw attention to the importance of visual communication in the therapeutic encounter. I suggest that vision is the receptive point for the beginning of the containment process. This highlights the importance of making visual contact with the patient and might challenge the use of the couch at certain stages of the therapy.

I suggest that mirroring back emotional states that are congruent to those projected by the patient make them aware of themselves in terms of the effect they are having on others. This view suggests the importance of the therapist's emotional responses, which can be observed and introjected by the patient. A more neutral response to the patient's communication when they are not in touch with their feelings could be unhelpful. This is a technical issue worthy of further discussion with child psychotherapy colleagues.

6.6 NEGATIVE TRANSFERENCE

I note in this study that the patient's aggression did not begin to surface until the issue of separation had been contained. Following the containment of the patient's sadness linked to separation her aggression was communicated and received in the therapist's bodily countertransference. It seems important that the therapist could hold the intensity of these projections. Ferrari draws our attention to the importance of therapist's ability to hold intense primitive communication. Ferrari(2004) refers to Bion's ideas of the receiving of the 'violence of the primitive function' Bion (1965). When the intensity of the projective identification could not be received and processed by myself, this brought about a paralysis in my ability to process the patient's sadism.

When the patient is communicating intense primitive anxieties the therapist needs to receive and process these anxieties at a bodily level, when the patient is perhaps, for the first time is coming into contact with feelings from which they have dissociated. Following some processing by the therapist's alpha function, it is important to put into words some of the patient's negative feelings even if the patient responds via projective identification. I am suggesting that the therapist should pay attention to the patient's non-verbal communication to determine whether the interpretation has been received at a bodily level. I think these are technical issues that would be useful to consider when working with similar patients:

- when to receive the patient's projective identification at a bodily level and reflect back to the patient non-verbally that their communication has been received
- the use of observation to gauge if the patient has been able to receive the therapist's communication at a bodily level.
- When to make a verbal interpretation
- Being open to noticing the bodily countertransference, which is often uncomfortable and intimate.
- Being able to record the bodily countertransference honestly as part of a clinical interaction.

6.7 THERAPIST'S ABILITY TO HOLD THE DEPRESSIVE POSITION

This study highlighted to me the importance of the therapist holding the depressive position and how this is linked to thoughts becoming thinkable. When I struggled to receive and process the intensity of projective identification, the patient's sadism, this brings about a breakdown in my ability to process the patient's communication via my alpha functioning. This is a technical point that might be worth considering in supervision if the patient is struggling to make any progress.

6.8 FURTHER RESEARCH

It would be interesting to develop the above technical considerations and explore them further with other patients and other child and adolescent psychotherapists. In addition the following areas of interest have been identified whilst undertaking this study:

- Exploring further the bodily countertransference and its links to primitive states of mind, particularly Bion's (1965) idea about violence and the primitive anxieties.
- I am interested in further exploration of the links between psychoanalytic theory and neuroscience. To consider how the two disciplines can inform clinical practice.

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Appendix A - Ethical Approval Letter

Ms Julie Klingert-Hall

Hazelhurst Cottage
20 Sandbach Street
Sandbach
Cheshire
CW11 1FX

21 March 2014

Dear Ms Klingert-Hall

**University of East London/The Tavistock and Portman NHS Foundation Trust:
research ethics**

Study Title: An exploration of a patient's use of her body, within the transference relationship, in intensive psychotherapy towards allowing thoughts to be thinkable.

I am writing to inform you that the University Research Ethics Committee (UREC) has received your NHS application form and Consent Form, which you submitted to the Chair of UREC, Professor Neville Punchard; but no evidence of ethical approval has been provided. Please take this letter as written confirmation that had you applied for ethical clearance from our UREC at the appropriate time; it is likely it would have been granted, although no ethical approval has been obtained. Please note this does not place you in exactly the same position you would have been in had clearance been obtained in advance. Therefore, when responding to any questioning regarding the ethical aspects of your research, you must of course make reference to and explain these developments in an open and transparent way.

You will be aware from David Woodhouse's letter dated 11th December 2013 that there were other procedural matters relevant to your programme in addition to matters relating to ethical clearance. For the avoidance of any doubt, or misunderstanding, please note that the content of this letter extends only to those matters relating to the granting of ethical clearance. Any other outstanding matters, if not yet resolved, will be dealt with entirely separately as they fall entirely outside the remit of our University Research Ethics Committee.

If you are in any doubt about whether, or not, there are any other outstanding matters you should contact Mr William Bannister at the Tavistock and Portman NHS Foundation Trust (e-mail WBannister@tevi-port.nhs.uk).

Yours sincerely



pp: Catherine Fieulleteau
Ethics Integrity Manager
For and on behalf of
Professor Neville Punchard