An adaptation of Luborsky's Core Conflictual Relationship Theme (CCRT) method: a phenomenological case study

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Submitted in partial fulfilment
of the requirements for the degree of

MAGISTER ARTIUM
in
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Dedication

To a mysterious God, whom I long to know and understand, but whose ways and being has eluded me thus far and will probably continue doing so in future

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I would like to thank:

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For his consistency in always being available for excellent and respectful guidance

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My patient

For challenging me as a therapist and through whom I have come to know myself better

My parents and friends

Without whose support this task would have been considerably more arduous

Bernard Nel

Whose friendship made a very difficult internship more bearable

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Abstract

Adaptation of Luborsky's Core Conflictual Relationship Theme (CCRT) method: A phenomenological case study

by

JC Kruger

Department of Psychology

Supervisor: Prof JB Schoeman

Submitted in partial fulfilment of the requirements for the degree of

MAGISTER ARTIUM (CLINICAL PSYCHOLOGY)

In this research a novel adaptation of Luborsky's Core Conflictual Relationship Theme (CCRT) method was implemented within a phenomenological methodology. The Duquesne phenomenological research method (DPRM) provided the framework for the new methodology. This new method was applied to a case study consisting of transcripts of therapy sessions conducted by the researcher with a Burning Mouth Syndrome (BMS) client.

The CCRT method provides a useful structure for analysing relational experiences in transcripts. Application of the CCRT to a transcript however proved insufficient to provide the depth and richness of information that was of interest to the researcher. For this reason application of the CCRT as a technique within a broader phenomenological method was considered. This integration combines benefits of both methods, in terms of providing a more structured way of identifying meaning units in transcripts, as well as through retaining the depth and richness of recorded relational experiences.

In the original CCRT method client accounts of relational interactions are analyzed in terms of the wishe/s, need/s and intention/s (WIN/s) of the client directed towards some person/s,

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the response of the other person/s and the client's response to him/herself. In the proposed modification of the CCRT method the emphasis was changed to analysis of all accounts of interactions, even if occurring outside of therapy, as pertaining to interpersonal occurrences within the client-therapist relationship. Analysing transcripts in this way, i.e. emphasising the importance of current context, required a structured means of identifying relational experiences, not only in terms of the client's WIN/s, but also in terms of the therapist's WIN/s.

The results of this study suggest that the above method resulted in increased insight and understanding of the interpersonal experiences examined, and that it transformed the therapist's insight regarding his own role in interpersonal interactions with this specific client. The increased understanding resulting from this study should benefit future clients in therapy with the therapist.

The modified method's main contributions are that it provides a more structured approach to the identification of meaning units as well as a more formal way of including context through evaluation of the flow of experiences between relational experiences (REs). The main drawbacks of the method were the difficulties associated with demarcating REs and ordering of information in the developed Unit Interaction Record Sheet (UIRS). These difficulties initially caused application of the method to be very time consuming. This improved as the researcher's expertise at using the new technique increased.

Although the method has the potential to be a general tool for analysing transcripts, which are not limited to a specific theoretical orientation, further research is necessary to determine the usefulness of the modified methodology as a general research instrument.

KEY WORDS: phenomenology, Core Conflictual Relationship Theme (CCRT) method, case study, relational experiences, psychotherapy, Burning Mouth Syndrome (BMS),

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transcriptions, meaning units, Duquesne phenomenological research method (DPRM), Unit Interaction Record Sheet (UIRS)

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CHAPTER 1: INTRODUCTION

1.1 General introduction

In this study a novel adaptation of Luborsky's Core Conflictual Relationship Theme (CCRT) method[1] is implemented within the general framework of a phenomenological methodology. The new methodological approach is applied to a case study consisting of a series of therapeutic sessions with a single client conducted by the researcher. The primary research question is whether an adaptation of Luborsky's CCRT technique for analysing relational experiences in transcripts, and applied within a phenomenological approach, can transform a therapist's understanding of interactional experiences in individual therapy.

In the remainder of chapter 1, the motivation, main objectives, and a brief overview of the research design and methodology for this study used are discussed, followed by an outline for the remainder of the dissertation.

1.2 Motivation for the current research

The above research question was shaped through the researcher's own commitment to improve his therapeutic understanding during the first year of his MA Clinical Psychology training. The CCRT technique[2] provided a useful structure for analysing relational experiences in therapeutic transcripts, but application of it to a transcript proved insufficient to provide the depth and richness of information that was of interest to the researcher. For this reason, application of the CCRT as a technique within a broader phenomenological method was considered. This study is therefore primarily phenomenological in nature.

[1] The CCRT method was developed by Luborsky and is an extensively researched method used to measure and understand transference in therapeutic interactions. This is achieved through identification of three components namely, client wishes, needs and intentions, response of objects, and finally the client's response to self. These triadic units are then analysed individually as revealing information regarding the client's general responses to other people in interpersonal interactions.

[2] Although the CCRT is generally described as a method, it will be referred to as consisting of a CCRT technique under an overarching CCRT method in this research. This is done to avoid confusion with the more general case study method which will be applied. The CCRT will be used primarily for its contribution as a technique for identifying relational units rather than as a more extensive method for analysing transcripts as originally intended by Luborsky. When referring to it as a technique the term *technique* will be used, while the term *method* will be used when referring to the CCRT as a broader method of analysis.

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The client selected for this research was primarily chosen, because the therapist experienced his therapy with her as one of his least successful interventions during his MA Clinical psychology training. The client was seen at an academic institution dealing with Burning Mouth Syndrome[3] (BMS) clients. Initially the client's chief complaint was somatic in nature, focussing on a burning pain she experienced in her mouth. Secondary to this, she also mentioned other somatic complaints and interpersonal difficulties. Over time her interpersonal difficulties became the focus of attention in therapy.

From the research question mentioned above, it should be clear that, if successful, the current study should make a contribution to the therapist's understanding of his interpersonal interactions with the client in this case study. This in turn should inform his thinking about relational experiences in future individual therapy sessions with other clients. In order to do this, a technique applied within the CCRT methodology was integrated into another methodology based on a different ontology, namely the phenomenological methodology. Such an integration has the potential of combining the contributions of both approaches within one unified method. The viability of conducting further research on this novel integrated methodology is also considered in the current study. This research can thus be motivated as potentially improving the researcher's understanding of his interpersonal interactions in therapy as well as exploring the viability of conducting further research on the newly proposed methodology.

1.3 Justification, aim and objectives of the study

The main aim of this research is to develop an adaptation of the CCRT technique within an existing phenomenological methodology and to apply it to a case study. This method should provide the researcher with a tool to improve his understanding of interpersonal experiences in therapy as recorded in transcripts. It was hoped that this analysis will result in a better understanding of interpersonal phenomena, which may guide future therapeutic interventions. Should this exploratory research significantly improve the therapist's insight into the therapy sessions, the proposed method may suggest additional future research. A secondary aim of this research is thus to suggest the viability of further research with regard to the usefulness of the method in the two domains mentioned below.

[3] Burning Mouth Syndrome (BMS) is a condition where clients typically experience a burning sensation or taste disturbances in their mouths, for which no organic origin can be found. The literature differs in the origin of this syndrome, but in general a large psychological component is hypothesised.

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The new method may potentially serve as a training instrument. The usefulness for novice therapists of having a structured and relatively straightforward tool to improve understanding of relational experiences recorded in transcripts has already been discussed. Although Husserl has mentioned that the phenomenological approach is laborious and difficult in that it requires extensive training (Misiak & Sexton, 1973), providing a more structured approach to ordering data, may make it easier to apply. Another advantage of the proposed method is that it is not associated with a specific school of psychological thought, but rather focuses on understanding phenomena, or relational experiences in therapy.

The new method may potentially make a methodological contribution. The CCRT method focuses on understanding the client's relationship to people in general, including the therapist and people outside of therapy. In the current research an attempt will however be made to consider all relational accounts in therapy as also being representative of phenomena occurring interpersonally between the therapist and client. Further research building on the preliminary outcomes of this exploration, thus has the potential to make a methodological contribution, by illustrating the viability of combining a variation of the CCRT technique in a phenomenological method of analysis.

1.4 Brief overview of the research design and methodology

As mentioned before, in the current study, existing methodological approaches are combined and modified to see whether they may provide increased understanding of interpersonal experiences in the therapies under investigation. As such the methodology itself and not only the case material under consideration is being scrutinised. Since the nature of the methodology forms such an important component of this research it will be elaborately discussed in the methodological section. A brief overview is however provided here, in order to contextualise the research.

In short the current study is an interpretative, qualitative design conducted within a phenomenological theoretical orientation. Qualitative research and interpretative research designs are concerned with describing and understanding (Babbie & Mouton, 2001). Qualitative research can be conducted in different ways, with the current research making use of an exploratory-descriptive case study method. Broadly the case study was analysed using a

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modification of the Duquesne phenomenological case study method. A pure Duquesne method was not used, since the step used for ordering meaning units was replaced by a more structured variation of the CCRT technique. The final interpretation was however based on a phenomenological orientation.

1.5 Outline of the remainder of the dissertation

In chapter 1 a brief overview of the current research has been provided. In the remainder of this dissertation these themes are further developed. A brief outline of the content of the remainder of the chapters is as follows:

In chapter 2 a literature overview of two methods used for analyzing relational units in transcripts of therapeutic interviews is provided. The methods considered are the CCRT method as developed by Luborsky and the general phenomenological research method. The advantages and disadvantages of both these approaches and the motivation for considering an integration of the two methodologies are explored. This is followed by a discussion of the phenomenological research method, which constitutes the encompassing methodological approach. The tension existing between qualitative interpretative methodological approaches and the approaches of the natural sciences is also examined. Finally the selection of the phenomenological method above other naturalistic scientific approaches for a study of complex human experiences is motivated.

In chapter 3 the arguments in chapter 2 culminate in a discussion of the exact nature of the research design followed, including: selection of participants, collection of data and analysis of data. In chapter 4 the analysis is conducted. This is followed by a discussion of the relevance and trustworthiness of results in chapter 5. Finally, also in chapter 5, the study is evaluated in terms of its strengths and limitations and recommendations are made for future application of the method.

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CHAPTER 2: LITERATURE REVIEW-THE CCRT METHOD AND PHENOMENOLOGY

2.1 Introduction

This chapter begins with a motivation for developing a method to analyse transcripts of therapy sessions that is not associated with a particular school of psychological thought. This is followed by a discussion of two possible methods for analysing transcripts, namely the CCRT method and the phenomenological method. Finally the compatibility and usefulness of combining the two methods are explored.

2.2 Motivation for an atheoretical method of analysing transcripts of therapies

Young therapists are often overwhelmed by exposure to a myriad of therapies built on diverging theoretical principles (Kottler & Swartz, 2004). These differences do not only occur between different types of therapies. Examination, for example, of differences within the broader psychoanalytic approach, reveals that considerable variation of therapeutic techniques and principles occurs, even within these bodies of thought (Wallerstein, 1990). Although research has indicated that there are more similarities between successful therapists of different orientations, than poor and successful therapists within the same orientation (Truax & Carkhuff, 1967), and research has failed to demonstrate clear advantages differentially attributable to different psychotherapy systems (Clarkson & Pokorny, 1994), therapeutic training often occurs and is also evaluated within the framework of specific therapeutic modules. Many therapeutic approaches may thus be equally valid forms of therapy, despite the fact that they are often built on mutually exclusive theories (Decker, 1988; Eaton, 1989). Even if some attention is given in training to the qualities and characteristics of successful therapists and therapies, there is less emphasis on generic ways of examining and analysing transcripts from an unbiased therapeutic perspective, making it difficult for novice therapists to develop an integrated framework of thinking.

Although a pure unbiased position is impossible, an attempt to set aside assumptions and emphasizing the data under consideration, rather than a specific theoretical model, can lead to new insight, which may in a later stage be augmented by adding a theoretical perspective. Focussing on theoretical concepts, instead of returning to the client's structure of existence

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and experience, has the inherent danger of breaking away from an in depth understanding or interpretation of the phenomena observed, resulting in a break in the hermeneutic circle (Brooke, 1991), where hermeneutics can briefly be described as the art or science of interpretation (Kruger, 1991). According to Brooke (1991) this can lead to a particular interpretation or set of interpretations resulting in reification of lived realities, rather than increased understanding of the phenomena under consideration.

Given the above information it seems reasonable that a relatively straightforward method to analyse transcripts of therapies, that are not associated with a specific school of thought, should be beneficial to therapists in that it could facilitate focussing on the content and process of experiences in therapy, rather than trying to fit it to existing theoretical models. This could reduce distortions in their understanding of the experiential information. Such an analysis, initially focussing on the content of therapeutic interactions and events, does not however preclude further analysis of the results in terms of a specific theoretical orientation. Although a completely assumptionless position in research is unattainable, the phenomenological approach strives to be atheoretical and to bracket assumptions, while focussing on observable interpersonal phenomena, making it a viable choice for the current study. More detail regarding the advantages of a phenomenological approach is provided in a subsequent section.

As mentioned before, a novel adaptation of Luborsky's Core Conflictual Relationship Theme (CCRT) technique is implemented within the general framework of a phenomenological methodology in the current study. Both the CCRT method as well as the phenomenological method can be used to analyse relational experiences in therapy. These two methods and their potential advantages and limitations as well as there compatibility are discussed in detail in the following sections. The CCRT method is discussed as a method consisting of a useful technique which is utilised in the current study. The phenomenological method in turn is discussed in terms of its potential contributions for analysing relational experiences, but additional information is provided regarding phenomenology's point of departure, since it also provides the epistemological position for the current study.

2.3 Relevance of the CCRT method

Before highlighting the motivation for using the CCRT technique and a phenomenological method in combination, a brief overview of the development and motivation for Luborsky's

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CCRT (Luborsky, 1990) method is provided. According to Luborsky his original aim was to find a way to *measure therapeutic alliance* and to better understand the bases for his own judgements in therapy through the examination of transcripts. Over time this aim broadened into an attempt to understand how the therapeutic alliance fits the client's central pattern of relationships. Through these endeavours Luborsky became concerned with *patterns in therapeutic relationships* and found that three categories were particularly pertinent for inferring the relationship pattern, namely: what the client wanted from other people, how the people reacted, and how the client reacted to this. This led to the conception of the CCRT method in which transcripts are divided into units of relational experiences, each consisting of:

- The wishe/s, need/s and intention/s (WIN/s) of the person or client
- The response of the other person/s
- The client's response to the self

Following identification of the above categories, the units are cross analysed for central and repetitive components, which are used to better understand the nature of the interpersonal patterns.

Luborsky describes his method as a vehicle for *measuring personality*, through the analysis of the central pattern, script, or schema that a person exhibits in relationships. The CCRT measures relationship patterns and have high correlation with other measures of personality (Luborsky, 2000). Examination of relationship patterns is therefore seen as a pathway to measuring personality. Luborsky's method is thus clearly geared towards achieving the goal of quantification of certain constructs in psychotherapy such as personality and transference. Initially Luborsky and his team of researchers attempted to better understand the central relationship pattern and it was only later that clinical and research experience suggested that what they were measuring with the CCRT had much in common with what is *measured or gauged* by the transference concept.

The CCRT method has been deemed useful for the following reasons. Wallerstein (1990) has suggested that the CCRT method of analysis provides a bridge between different psychoanalytic orientations, since it does not adhere to a specific school, but rather focuses on understanding the relationship between a client and his/her objects within and outside of

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therapy. Within general psychoanalytic theory the CCRT method should therefore be able to provide a tool for beginning therapists to better understand their therapeutic interaction. The researcher hopes to show that a modification of Luborsky's method of analysis, implemented as a building block in a phenomenological approach, can make it even more widely applicable, to for example analysing transcripts of psychological orientations outside the psychoanalytic framework. Another advantage of the CCRT method is that it provides a structured and relatively easy way of analysing transcripts.

Despite its advantages the CCRT method has some limitations. Whereas Luborsky's method focuses on the client's interaction with objects[4] brought into therapy, and with the therapist, and uses methods to compare these interactions with each other, and its changes over time, this researcher was more interested in all relational experiences in the therapy as phenomena occurring primarily between the therapist and the client. I.e. all accounts of relationships with objects are seen as potentially being influenced by the therapist-client context[5]. Analysing transcripts in this way, i.e. emphasising the importance of current context, requires a method which also allows relational experiences to be evaluated, not only in terms of the client's wishes, needs and intentions, but also in terms of the therapist's wishes, needs and intentions.

Another difficulty that the researcher encountered when evaluating Luborsky's method is that it proved to be too linear for an in depth understanding of the relational experiences, always starting with a wish, need or intention of the client, followed by a response of the object and ending with a response to the self. Although this more linear approach, of breaking the transcript into relational units, that can be analysed relatively independently, is conducive to operationalisation of the method, the connection between different relational units and the therapist's needs, wishes and intentions is lost. In order to improve the understanding of relational experiences in therapy the researcher deemed it necessary to include the therapist's own wishes, needs and intentions and responses to self, wherever this information is available through reflections included in the transcripts. To make the process less linear the researcher attempted to link subsequent relational units, rather than treating them as isolated units. I.e.

[4] Due to the CCRT's association with psychoanalytic theory, Luborsky makes use of the concept of *objects.* In the current research *objects* will rather be referred to as *people* in order to remain true to the phenomenological tradition.
[5] The relevance of *context* in a phenomenological study is addressed in the section dealing with the theoretical or paradigmatic point of departure.

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preceding units were considered as potentially influencing, or providing additional contextual information about, successive units.

2.4 Relevance of the phenomenological approach

Considerable emphasis has so far been placed on the reasons for the use of the CCRT method, but less for its application within a phenomenological approach. Although the current research is primarily phenomenological in nature and references to phenomenology have been made, it has as yet not been properly defined. An attempt to do this is made in the following section. Briefly, however, it can be said that phenomenology was chosen because it provides a method whose results can be used as the building blocks in different types of theoretical orientations. In addition it provides a method for focussing on an in depth and rich understanding of interpersonal phenomena in therapy.

2.4.1 Psychology as a human science

Prior to discussing phenomenology as the epistemological position of the current study a short discussion regarding psychology as a human science is necessary. Examination of the literature (Fischer, 1994; Giorgi, 1970; Giorgi, 1985; Willig, 2001) highlights the tension and self-consciousness (Van Vuuren, 1991) experienced by many psychological researchers in terms of a need to validate psychology as a recognizable science. Without providing details of this debate, a short discussion reflecting what seems to be generally acceptable by most phenomenological researchers regarding psychology's status as a science is now given. In brief, most of these authors, and in particular Giorgi (1970), believe that due to the major impact of the natural sciences and positivism, naturalistic scientific method has erroneously become equated with all scientific methods. As a result many psychologists have tried to impose natural science methodologies on human studies, in some cases inappropriately.

Although natural science methods and techniques are acknowledged as having the potential for making contributions in studies concerning certain aspects of human behaviour, it is deemed inappropriate to studies concerned with in depth understanding of human experiences. In studies such as these, a return to description and explanation is deemed to be more useful. Giorgi (1970) believes that psychology should develop its own techniques and methods as guided by the phenomena under observation. In general phenomenologists seem to argue that even when phenomenology does not conform to natural science techniques and

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methods, it can still be scientific. Human science and natural science are both seen as subsiding underneath the more global scientific umbrella. In order to position the current research epistemologically, a brief discussion of two epistemological positions namely, that of the positivist social sciences and interpretative social sciences, is provided in the following two paragraphs.

2.4.2 The positivist epistemological approach

In a positivist epistemological approach it is assumed that a straightforward relationship exists between objects, events and phenomena in the world and that these relationships can be determined from an outside perspective (Willig, 2001). This approach aims at achieving objective knowledge, which is assumed to be attainable independently of the observer's assumptions and perspective. Positivism is closely related to and mostly the epistemology of choice in the natural sciences (Neuman, 2000). Also closely related to positivism is empiricism, which attempts to uncover these objective relationships through the use of direct observations, such as for example by constructing experiments where data is gathered through the senses and thereafter analysed (Willig, 2001). From the above description it should be clear that the CCRT method can play an important role towards achieving the aims of the positivist social sciences as illustrated by Robert Wallerstein's (1990) concerns. He believes that there has been a progressive erosion of the commitment to natural science as a determining component of the psychoanalytic discipline. He suggests that despite their theoretical frameworks, the majority of psychoanalytic approaches are still primarily metaphoric and are "merely large scale explanatory metaphors, or symbolisms, which we employ to give a needed sense of coherence and closure to our psychoanalytic understandings and therefore to our interventions" (Wallerstein, 1990, p. ix). As a result Wallerstein criticises psychoanalytic approaches for not being amenable to scientific study. He sees the CCRT method as a positive development, making it possible to substantiate theoretical assumptions of, for example, transference.

2.4.3 The interpretative social science approach

The second epistemological position considered, is the interpretive social science approach. According to Neuman (2000) this approach is concerned with observation of people in natural settings in order to better understand and interpret how these people create and make sense of their social world. Phenomenology as defined by Husserl (Misiak & Sexton, 1973), namely as

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a science of phenomena as they are experienced or present in our consciousness or *Lebenswelt* (world of everyday experience), clearly falls within the interpretative approach. Hermeneutics can be defined as the science or art of interpretation and is therefore also closely related to the interpretative social sciences (Kruger, 1991). According to Kruger, hermeneutics as defined by Heidegger goes even further in that understanding is not only seen as something a human being can have in terms of knowledge or insight, but is also something that s/he actually is. Kruger believes interpretation is a necessary component of all meaningful psychological research. He mentions that interpretation is always imbedded in what is "already there" (p. 110).

Interpretation clearly implies a subjective component, but this need not however be a problem as addressed in a paper by Martin Drapeau (2002) where he reviews techniques and emphasises the importance of peer debriefing in understanding subjectivity and its effect on research. Martin Seligman (1990) mentions that the CCRT method can increase our insight and self-understanding of interpersonal therapeutic relations. Although *understanding* as used by Seligman, may not fully embrace what is referred to by the term *understanding* in interpretative approaches, it is clearly closer to the goals of the interpretative social sciences. The CCRT method's commitment to better understanding of interpersonal phenomena in therapy can therefore also make a contribution to phenomenological studies and the interpretative social sciences.

2.4.4 Phenomenology

A brief introduction to phenomenology is provided in this section. Further relevant details are provided in the subsequent section dealing with integration of the modified CCRT technique within a phenomenological method.

Phenomenology, as first developed by Edmund Husserl, advocates that the scientific study of immediate experience should be the basis for psychological research, i.e. that the focus should be on the experience of events, rather than objective reality (Reber, 1995). A phenomenological approach belongs to the tradition of Descriptive Psychology and is one of many ways of treating descriptions (Giorgi, 1985). From this perspective objective reality's existence is not denied, but the individual's perception and experience is seen as central to understanding the individual's relationship to real-world events.

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Even though phenomenology and existentialism have different founding fathers, namely Husserl (Giorgi, 1970) and Kierkegaard (Preller, 1991) and originally developed as two new and original philosophical movements in the first half of the twentieth century they are both historically and conceptually closely related to each other (Misiak & Sexton, 1973). Strictly speaking existentialism can be defined as a philosophical movement emphasising subjectivity, free will and individuality in a world without reason or purpose (Reber, 1995). This definition does not however clearly highlight its association with phenomenology. Existentialism is for example also linked to experience of existence and as Schneider and May (1995) mention, existential-integrative psychology mostly employs phenomenological methods to arrive at better understandings of human existence. In addition Giorgi (1970) defines existential-phenomenology as the study of phenomena as they are experienced by a person; as a person living in the world. Clearly some overlap between the definitions of phenomenology and existential-phenomenology exists. Although it seems that the terms existential-phenomenology and phenomenology are often used interchangeably, the current research will not emphasise the philosophical concepts of free will and individuality in a world without reason or purpose. Since phenomenology sufficiently encompasses what is aimed at in this research, it, rather than a slightly narrowed and more specifically defined existential-phenomenological methodology, will be embraced as the methodology of choice.

Some of the advantages of phenomenology for the current study are discussed in the remainder of this section. A big advantage of phenomenology is that it is flexible to new techniques, values and insights that emerge both from inside and outside of its current domain (Van Vuuren, 1991). According to Van Vuuren phenomenology is new and still constantly forming and therefore cannot be fitted into any encompassing frame. These contentions are important in the current study where emphasis is placed on the newly developed method not being closely associated with a specific theoretical orientation.

Another advantage of phenomenology is its association with how people come to know themselves in the world. In the context of psychotherapy, this highlights its concern with not only the content of, but also the process of experiences (Todres, 1991), making it very relevant to the current study. Analogously to process, is phenomenology's concern with streams of consciousness. By including, in the current research, how meaning units link to each other, this aspect of phenomenology is also addressed.

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Phenomenology is also concerned with the influence of context (Todres, 1991). In the current research considerable emphasis is placed on the importance of context, including first and foremost the therapeutic context, but also the context in terms of the client's experiences with people outside of therapy.

Another important characteristic of a phenomenological methodology is its concern with conscious experience. According to Missiak and Sexton (1973) phenomenology is a systematic and full exploration of how objects are experienced or present themselves in consciousness and since they are the only information accessible to us conscious experience of phenomena must be the mainstay of revealing what objects essentially are. According to Husserl all acts of consciousness are naturally related or point to something. The ambiguity of clearly demarcating the conscious and unconscious has been mentioned by Brooke (1991). He reminds how Carl Jung for example did not make such a rigid distinction and goes further by highlighting Merleau-Ponty's contention that both conscious and unconscious are modes of presence and both are intentional. Through analysis the unconscious can become conscious and thus move into the defined domain of phenomenological studies. In this research the focus will be on what is consciously available to the researcher. The main reason for this will not be to maintain congruence with the phenomenological approach as such, but rather because of the difficulty of making unconscious experience conscious without the help of a skilled therapist. Another reason why the focus will not be on the unconscious is because the proposed method will attempt not to associate closely to particular theoretical orientations. Including the unconscious has the inherent danger of recourse to preexisting analytical assumptions about the unconscious, which may be one of the reasons why phenomenologists shy away form including the unconscious.

2.5 Combining the CCRT technique with a phenomenological methodology

The inherent tension as well as the advantages of applying a component of the CCRT method, which is associated with psychodynamic schools of thinking, within a phenomenological methodology is discussed in this section.

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In the preceding paragraphs it has been shown that the CCRT method contains elements of both positivist approaches, in terms of its focus on measurement, and interpretative research, in terms of its aim of increasing understanding of interpersonal phenomena in therapy. Examination of the CCRT method reveals that Luborsky shifted from a focus on measuring (therapeutic alliance) to a more phenomenological congruent goal of understanding (pattern of interpersonal relationships) and then back to measuring again (personality and transference), which is again further removed from a purely phenomenological goal. The CCRT thus has goals that are compatible with a phenomenological approach and goals that are clearly not congruent.

These two aims are also exemplified by Martin Seligman (1990) who commends the CCRT for making a contribution to measuring transference (more positivistic), but also for increasing our insight and self-understanding of interpersonal therapeutic relations and being a useful guide to beneficial interpretations (more phenomenological). It seems thus that the CCRT method has one foot in a more positivistic natural science approach and another in a more phenomenological interpretive approach. In general it seems however that the CCRT method's main contribution is seen by its developer, as well as by other authors, as lying in the quantitative domain as a measuring tool in the natural scientific tradition. The CCRT method is most essentially seen as an instrument to provide support for existing theories making use of transference phenomena. Wallerstein (1990) for example espouses the need for psychoanalysis in general to be defined in ways that can be operationalised and empirically studied in a systematic manner and believes that the CCRT's major contribution has been towards this goal. Application of the CCRT method within a phenomenological approach therefore clearly raises methodological challenges, which need to be addressed in the current study.

An important link between phenomenology and the CCRT method becomes apparent through examination of one of Husserl's contentions. He proposed that all experience is intentional (Gergen, 1999). It is this intentionality or mental orientation (e.g. desires, wishes, judgements, aims and purposes) that allows objects to appear as phenomena (Willig, 2001). Any experience is intended on something or someone, i.e. an object. According to Husserl any experience is directed towards or absorbed by some object or person in the external environment and therefore experience can be said to be fundamentally relational. Objects can thus be said to exist intentionally in the mind and are always related to real objects (Misiak &

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Sexton, 1973). I.e. a strong link between phenomenological relational experiences and intentionality is proposed. The concept of intentionality is however strikingly similar to Luborsky's use of wishes, needs and intentions in the CCRT method. The CCRT method seems ideal to highlight the link between relational experiences and intentionality, which becomes a phenomenological endeavor.

Another link between a phenomenological approach and the CCRT method is associated with both these methods' emphasis on units of interactional experiences. In the CCRT's original formulation the focus is more on meaning units as providing information related to previous or current experiences of objects outside of therapy. In the revised form proposed, all these meaning units are examined as potentially providing information regarding the interaction between the therapist and the client. The phenomenological method is however also concerned with conscious experiences or moments in the presence. Increased understanding of these moments can also provide access to and facilitate movements in the therapeutic space (Brooke, 1991). By examining experiential meaning units as delineated in the adapted CCRT method, access to these therapeutic moments can be facilitated, which again links well with the goals of the phenomenological approach.

Some of the complications in applying Luborsky's method of analysing transcripts within the phenomenological theoretical orientation are now discussed:

- <u>CCRT as a measuring tool to promote psychoanalysis as a natural science</u>

  The CCRT method's focus on measurement of transference and personality has already been mentioned as being problematic within a phenomenological approach. By only using the CCRT as a convenient structure through which transcripts can be analysed thematically this problem is overcome. Methods to make sense of data that were developed within the phenomenological theoretical approach, also utilize schemas to order information gained from the transcripts. Since one of the CCRT's original aims was to increase understanding of interpersonal interactions in therapy it also has the scope to be used in the context of understanding rather than measuring.

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- Relationship of the CCRT method to psychoanalytic theory

  Even though the phenomenological approach is also built on an ontological orientation, it attempts to suspend prior theoretical assumptions when studying the phenomena of human experience. Since the CCRT method has links with psychoanalytic theories, making use of theoretical constructs such as transference, a critical examination of this link is required. Wallerstein (Luborsky, 1990) suggests that the CCRT method has a unifying effect between the different approaches in psychoanalysis that have over time increasingly diverged within the overall psychoanalytic umbrella. According to him, the CCRT method is not associated with a specific psychoanalytic school of thought, but rather focuses on measuring a unifying principle of transference in therapy. It is important to notice however that although the structure of the CCRT makes use of objects (people) and their relationships with each other, Luborsky does not lean on a specific psychoanalytic theory. His method is thus not directly influenced by any specific school of psychoanalytic thought, such as object relations, although it may be used to operationalise theory in any of these schools of thought. Overall Luborsky seems more interested in understanding interpersonal interactions as universal phenomena. According to Wallerstein (Luborsky, 1990) the CCRT is applicable to most of the psychoanalytic schools through its focus on the unifying concepts of “low level, experience near, and common, clinical theory, the theory of transference and countertransference, of resistance and defence, of anxiety and conflict and compromise, of self and object representation” (Luborsky, 1990, p. ix). Psychoanalytic research and phenomenological research thus seems to share a common interest in the rich description of experience near phenomena.

  Since the CCRT is not theoretically associated with a specific psychoanalytic theory it becomes more amenable to a phenomenological orientation. The CCRT does however retain the existence of the concept of transference as an explanatory principle, which remains problematic. This may bias the researcher’s study and deter from extracting a pure description of phenomena. This complication is addressed in the following section.

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- CCRT's association with transference

  The definition of transference varies somewhat depending on the theoretical school in which it is applied. Most generally it refers to the displacing or transferring of an emotion or affective attitude from one person onto another person and more specifically in the psychoanalytic context it refers to displacement of emotions or attitudes, typically figures from a person's early life, onto the analyst (Reber, 1995). Transference thus refers to the interpersonal expectations recreated in therapy in the presence of the therapist. The methodological problem associated with using a method acknowledging and influenced by the theoretical assumption of the existence of transference within a phenomenological approach, which attempts to suspend prior biases, has already been mentioned. It is however important to remember that Luborsky did not originally attempt to develop a measure of transference, but rather of personality and it was only later that he realised that what he was measuring could also be reconciled with a measurement of transference.

  Although the CCRT's association with transference may be problematic, the phenomenological approach does not exclude the use of context. From a personology perspective Luborsky (1990) quotes Murray as saying:

  > **Experience was to teach us that…it was possible to find in most individuals an underlying reaction system, termed by us as unity-thema, which was the key to his unique nature…A unity-thema is a compound of interrelated-collaborating or conflicting-dominant needs that are linked to [the] press[es] to which the individual was exposed to on one or more particular occasions, gratifying or traumatic, in early childhood. The thema may stand for a primary infantile experience or a subsequent reaction formation to that experience. But whatever its nature and genesis, it repeats itself in many forms during later life. As soon as we realised the importance of the unity-thema its importance in the interpretation of each session became to dawn on us. For if every response is the objectification of an aspect of a particular personality and the most fundamental and characteristic determinant of a personality is its unity-thema, then many responses cannot be fully understood except in terms of their relationship to the unity thema. (p. 4)**

  Using context to understand interpersonal interactions, rather than the more theoretically based concept of transference, this study effectively transfers the use of the CCRT back into the realm of studies that may be analysed using a phenomenological approach.

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Although transference has specific associations within psychoanalytic theoretical orientations, especially in regard to past significant figures within current interpersonal relationships, the use of a broader defined transference, focussing on the influence individuals have on each as part of the other individual's context of interpersonal experience becomes less problematic. The term *transference* will not be used in this research in order to avoid association with its analytical theoretical associations. In addition unconscious intrapsychic processes which may be projected onto the object or person in experience will not be a focus of this study.

Although measuring as such, as well as the use of constructs such as *personality,* will not be the focus of this study, some authors such as Sullivan (1997) have argued that personality is an interpersonal phenomenon rather than a fixed intrapsychic structure. Viewing *personality* as a context bound construct that is interpersonally constructed also makes its use in the CCRT less problematic in the current phenomenological study.

2.6 Conclusion

In this chapter motivation for developing a structured method for analysing transcripts of therapies that are not associated to a specific school of psychological thought has been provided. Combination of the CCRT technique within a phenomenological methodology was considered as potentially providing such a method. It was argued that combination of the CCRT technique with a phenomenological approach provides a well structured means of identifying meaning units in transcripts, but also has the potential of providing an in depth understanding of phenomena. Critical examination of these methods revealed that the CCRT technique is compatible for integration within an overall phenomenological method. In particular it was shown that CCRT's association with transference and psychodynamic schools of thought do not pose serious methodological difficulties.

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CHAPTER 3: RESEARCH DESIGN

3.1 General introduction

Generally research design refers to a strategy for collecting observations in research (Vadum & Rankin, 1998). A more useful definition in the current research is that research design can be seen as an approach through which phenomena can be evaluated and which provides a framework for establishing valid inferences (Kazden, 1992). Research designs can generally be grouped into two main categories, namely qualitative and quantitative research designs. In a preceding section, dealing with the theoretical or paradigmatic point of departure, it was shown that the current study is an interpretative, qualitative design conducted within a phenomenological theoretical orientation. A brief overview of the interpretative social science approach and the phenomenological orientation has already been provided. A more detailed discussion of the characteristics of the broader category of qualitative research designs is now provided.

3.2 The qualitative research design

Whereas quantitative research is focussed on discovering universal truths (Neuman, 2000), qualitative research is related to the interpretative approaches in that its primary goal can be defined as describing and understanding (Babbie & Mouton, 2001). Babbie and Mouton (2001) mention the following key features of qualitative research:

- Qualitative research is conducted in the natural setting. In this study the therapeutic setting constitutes the natural setting, since this is precisely what the researcher was interested in studying.
- A primary aim of qualitative research is in depth and thick descriptions and understanding of actions and events. This is clearly congruent with the phenomenological approach.
- In qualitative research the focus is on process rather than outcome. As mentioned previously an attempt was made in the current research to evaluate both the content and process of experiences or stream of consciousness. In this research the term context is used to refer to the relational context in which the interpersonal experiences between the therapist and client take place. It refers to both the therapist's and client's current state in therapy, as well as the client's relationships outside of therapy.

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- Qualitative research emphasises the insider or emic view. In the current research the focus is on describing and understanding experiences as they present themselves within the therapist's and client's consciousness.
- Qualitative research is concerned with understanding social action within a specific context (idiographic motive) rather than on generalization to a theoretical population. The importance of context in this study has been emphasised. Nomothetic studies are mostly associated with quantitative research with the aim of finding regularities or laws of human behaviour. In contrast idiographic or contextualising studies are concerned with understanding particular and specific events within their own context. This study follows an idiographic approach in that it deals with the concrete, the individual and the unique, rather that the abstract, the universal or the general as in nomothetic approaches (Reber, 1995). In ideographic research the uniqueness of phenomena, in this case relational experiences, is highlighted.
- Qualitative research is often inductive, resulting in the generation of new hypotheses and theories. Although the current research does not aim at generating hypotheses and theories it should also lend itself to this.
- In qualitative studies the researcher, rather than the use of specific techniques, is seen as playing the most important role in the research process. As such reflection plays an important role in this study. Emphasis has already been placed on the aim of the current research of improving the researcher's understanding and thinking as a therapist. By focussing on the researcher as the main channel through which increased understanding is achieved, growth in the therapist should be facilitated. Increased understanding should result in structures of thinking that could guide future therapeutic interventions.

Different ways of conducting qualitative research exist, but three typical designs include ethnographic studies, case studies and life histories (Babbie & Mouton, 2001). The current research makes use of the case study method. Case studies may make an important contribution when planning future therapeutic interventions. In the current study where an important goal is for therapists to better understand relational interactions to inform future therapy interventions, the case study method is relevant. A variety of case study methods exist, each applicable to different levels of abstraction and theory building (Kazden, 1992), namely: explorative-descriptive case studies, descriptive-dialogical case studies, theoretical-heuristic case studies and crucial or test case studies.

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Although Luborsky's CCRT method can be applied to the first three levels of case study methods, where the focus gradually shifts to theory building and testing of theories, the present study focuses on the exploratory-descriptive case study method, where the aim is not on generalisation or creation of theory, but rather on achieving in depth understanding of relational phenomena in therapy. Higher levels of case study methods, where existing theoretical assumptions are made or tested, become problematic in a phenomenological theoretical orientation, where prior theoretical presumptions are limited to a minimum.

In this research the Duquesne phenomenological research method (DPRM) is used. Edwards (1991) has convincingly argued that the DPRM is simply a special case of a more general case study research method (CSRM). He believes that many authors confuse phenomenology with the DPRM and as a result adhere rigidly to its rules, resulting in some cases in methodological limitations. According to Edwards, recognition of the DPRM as a special case of the CSRM allows more flexibility in application of phenomenological case studies and that not rigidly adhering to the DPRM guidelines does not necessarily violate the criteria for a phenomenological study. Edwards shows how the DPRM in its purest form is most suitable for studies where the reported experiences are not too complex. He believes a more flexible approach within the general structure of case study is often more appropriate. This seems particularly important given phenomenology's focus on being true to the data under consideration and not enforcing prior techniques and assumptions. Given Edwards' contentions it may even be considered that some degree of flexibility should be a characteristic of phenomenological methodologies. Edwards' remarks are especially important in the current study where the DPRM's general procedure was followed, but some modifications were made to incorporate the modified CCRT technique. Careful consideration of how these modifications were done, need then not necessarily violate the framework of a more general phenomenological case study.

In summary thus it can be said that, in this study, Luborsky's CCRT technique for analysing transcripts is used in an explorative descriptive case study method (more specifically a variation of the DPRM) as informed by a phenomenological theoretical orientation. I.e. the adaptation of Luborsky's CCRT technique is used to identify relational units in the case study transcripts, while the phenomenological orientation is used to interpret the results.

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3.3 Reliability and validity in qualitative research

Two limitations of a single case study method, namely trustworthiness and generalisability are now discussed. Trustworthiness can be defined as the neutrality of its findings or decisions (Babbie & Mouton, 2001). Since alternative explanations or interpretations are possible, methods for increasing trustworthiness are imperative. Babbie and Mouton outline Lincoln and Guba's work on trustworthiness. According to this model trustworthiness is related to credibility, transferability, dependability and confirmability. Credibility refers to the compatibility of the constructed realities existing in the minds of the participants and the realities that are attributed to them. Some of the major contributors to credibility are prolonged engagement, persistent observation and triangulation. Since several in depth sessions had previously been conducted and were available for this study, comparison of results of the analysis obtained from different sessions with each other improved credibility. Credibility can also be enhanced through peer debriefing. Observational bias can thus be reduced by using different researchers to evaluate the same transcripts. Due to the limited scope of this research, this was not done. The dissertation was however monitored by a supervisor and finally evaluated by examiners, which also to some extent reduces observational bias. Finally credibility can be enhanced by verifying the interpretations with the participants. Due to time constraints this was not done with the client. Since the therapist-researcher also constitutes a participant, some degree of verification with one participant was however possible. This raises concerns regarding whether such a subjective endeavour is possible in an academically disciplined manner. Regular interaction with a supervisor exposed these reflections to more rigorous scrutiny, thereby increasing its trustworthiness. The trustworthiness of interpretations could potentially also be improved through comparison of the results with available biographical information and psychometric evaluations of both the therapist and client. Due to the limited scope of this research, these comparisons were however not done.

Transferability refers to the extent to which the findings can be applied in other contexts. Only one series of therapeutic notes obtained from one client's therapy was used in this case study, reducing the generalisability of the research. One way of increasing this would be to conduct more case studies applying similar methods, and possibly using different researchers to avoid observational bias (Kazdin, 1992). Comparison of the success of the adaptation of the

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CCRT technique to improve understanding between different case studies should also increase its generalisability. Due to the limited nature of this study, only one case study was conducted. In this context the research may be seen as a preliminary explorative study, with the potential of being expanded to a broader multi-case study, should the results of this study show potential.

Dependability refers to the capacity of the inquiry to provide similar findings should it be repeated with the same respondents in a similar context. According to Guba and Lincoln (Babbie & Mouton, 2001) credibility is sufficient to guarantee dependability. They have however been criticised for this contention. In order to counter these criticisms they proposed additional methods to improve dependability. Examination of these methods however reveals considerable overlap with the methods used to improve credibility as described above.

Finally confirmability refers to the degree to which the findings are the product of the focus of the inquiry and not a result of the biases of the researcher. To some extent a supervisor performs this function as well and increases both dependability and confirmability.

Although analysis of transcripts are diluted representations of relational experiences, in that the focus is on the content of verbal communications, and considerable non-verbal communication is therefore lost, it still provides a point of reference to experienced phenomena. The richness of information was also enhanced via reflections and observations also included in the transcriptions. The trustworthiness of data was increased by completing the transcriptions as soon as possible after completion of the sessions (in most cases immediately afterwards). Reflections and observations were made by the researcher and are therefore subjective. From a phenomenological approach, this is not necessarily problematic and in particular in the current research, where the focus is on the therapist's perspective of relational experiences, a subjective component is automatically implied.

3.4 Selection of participant

Phenomenological analysis relies on the representational validity of language (Willig, 2001). Since it may be argued that language limits what can be expressed (Willig, 2001), participants' ability to express their experiences through language, should play an important role in participant selection in a phenomenological study. In phenomenological research thick

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descriptions of experiences are sought, since they facilitate interpretation of an individual's experiential world. Selection in the current study was mainly based on this criterion. Transcriptions[6] of therapies conducted with different people were available. Two of these therapies were selected as containing sufficiently rich information for a phenomenological study. Finally only one of these sets of transcriptions was used as motivated in a subsequent section. It is also important to remember that although the therapist is also the researcher in this study, he is also a participant, i.e. a participant researcher. The research was thus conducted on interpersonal interactions as experienced by two participants namely the therapist and the client. Clearly the transcriptions should be subjective as it was reported from the researcher's perspective. It is this perspective of the therapist, as represented in transcripts, which is the focus of this study. This raises issues of subjectivity, which was addressed in the section dealing with the paradigmatic point of departure.

Since the client in this study, suffers from a condition known as Burning Mouth Syndrome (BMS) a brief summary of the clinical presentation of BMS is provided in the following section, followed by summaries of the client and therapist's demographic information and backgrounds.

3.4.1 Summary of Burning Mouth Syndrome (BMS)

BMS is most often diagnosed in postmenopausal women and its symptoms typically consist of a burning sensation in the mouth, most commonly on the tongue (although other areas of the mouth may also be affected) without other clinical signs and or related laboratory findings (Al Quran, 2004; Grushka, Epstein & Gorsky, 2002). Clients with this condition typically present with multiple oral complaints as well as variation in taste symptoms such as for example dryness or a metallic salty taste instead of a burning sensation (Grushka, Epstein & Gorsky, 2002). Although BMS is not the focus of this research, a brief overview is provided in this section as it constitutes part of the context of the current study.

Different etiological factors for BMS have been proposed. Some researchers believe BMS to have a large organic component and may for example be related to organic, e.g. hormonal changes, or damage to cranial nerve tissue (Grushka, Epstein & Gorsky, 2002; Grushka,

[6] A detailed description of what is referred to by *transcriptions* is provided in the following section where the method of data collection is discussed.

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2002; Grushka & Sessle, 1991), while others focus on psychological causes and/or personality factors (Al Quran, 2004). Several studies have for example indicated that psychological causes could explain burning mouth symptoms in more than 50 percent of the client population, with depression being the most common factor (Browning, Hislop & Scully as cited by Al Quran, 2004). Al Quran (2004) found that the personality factor of neuroticism and all its facets, including anxiety, angry hostility, depression, self consciousness, impulsiveness, and vulnerability are the most differentiating factors for BMS clients from controls. Al Quran describes the personality of a typical BMS client as follows:

> **The personality of BMS patients according to the NEO PI-R scales tends to be anxious, fearful, prone to worry, nervous, and tense. BMS patients have a tendency to experience anger and related states such as frustration and bitterness. They have scored high on the depression scale, which makes them prone to feelings of guilt and sadness. The BMS patients are more self-conscious, which makes them uncomfortable around others and sensitive to ridicule; they are more impulsive and vulnerable to stress (p. 343).**

Although the exact etiology of this syndrome is unclear, it has been illustrated that medical treatment failed to guarantee symptom relief, especially in cases where a psychological component was suspected (Botha, 1996; Grushka, 1987). In some of these cases psychotherapy has resulted in a reduction of the pain or burning symptoms experienced by the clients. In an in depth study of four BMS clients Daws (1999) has shown how these clients struggle to deal with aggression and had interpersonal styles demanding continual closeness, while they persistently struggled with abandonment anxiety. He suggested that most of these difficulties could be associated with insufficient parenting, in particular to an impaired individuation process as described by Mahler. Daws also showed how these clients often used internalised aggression through constrictive control and that this could account for the development of masked depression and later BMS. The current author's experience was that these clients often exhibited passive aggressive traits and although they asked for help, they would often simultaneously reject it. From a psychological perspective it should be clear that the psychological make up of these clients make them particularly difficult to treat in psychotherapy.

The BMS clinic at which the client was seen was established to support clients suffering from BMS symptoms and was the only clinic of its nature in South-Africa at the time of this writing. It is important to note that the focus of this study was not to make a contribution specifically to the understanding of BMS, but rather to improve understanding of

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interpersonal interactions between the therapist and a particular client, who coincidently in this case was seen for her BMS symptoms.

3.4.2 Summary of client's demographic and background information

A pseudonym, namely Mrs Smith, was used for the client in this case study. At the time the therapy was conducted, she was 70 years old. Mrs Smith is Caucasian and grew up in a medium sized town with both her parents and one older sister. She described her childhood as very happy, with hardly any conflict. After finishing matric, Mrs Smith attended a university where she obtained a teaching degree as well as a performance licentiate in singing. Mrs Smith married for the first time when she was 38 years old and became a widow when her husband died a few years later. Mrs Smith remarried a year or two after his death to her current husband. Currently she is a pensioner and resides in an old age home with separate living units in the vicinity of Pretoria. When Mrs Smith came for therapy, she was suffering from several medical ailments, some of which seemed to be psychosomatic in nature. The worst of these symptoms included a burning sensation on her tongue as well as severe back pain. Mrs Smith's husband had been diagnosed with cancer and suffered from poor health.

3.4.3 Summary of therapist's demographic and background information

The therapist is a Caucasian male and was 32 years old when the client was seen for therapy. The therapist has never been married and was not in a relationship when this research was conducted. Prior to studying psychology the therapist worked as an electronic engineer at the University of Stellenbosch. The therapist grew up in the Cape Province, but completed his Master's in Clinical Psychology at the University of Pretoria. The therapist views himself as a sensitive person and enjoys working with people. In general he perceives himself as conscientious and hard working. At the time of the therapy, the therapist was himself engaged in personal therapy and was aware of his tendency to take too much responsibility for the clients seen by him. The therapist saw Mrs Smith at a BMS clinic in an Academic Hospital, where he conducted therapy for one afternoon per week as part of his MA1 clinical training. Each session was stringently supervised by a psychologist specializing in clients with BMS symptoms.

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3.5 Ethical considerations

Two potential participants were considered for this research. One of the clients was however still in therapy with the researcher when the research was considered. The possibility that using her transcripts may have had detrimental effects on the therapeutic relationship resulted in her eventually being excluded from consideration. Although the other client was previously seen for therapy by the researcher, her therapy was terminated approximately 5 months prior to the start of this study and no negative consequences on the therapeutic relationship were anticipated. The client gave written permission for the use of transcripts of her therapy sessions. The intended purpose of the research was discussed with her prior to asking her permission. The extent to which her confidentiality could be protected, and the steps taken to accomplish this, were discussed with her and are also specified in a written agreement. Due to the sensitive nature of the research the anonymity of the participant was preserved. This was achieved by using a pseudonym and changing identifying characteristics in the transcripts. The consent form is attached in Appendix A.

Initially the participant did not indicate particular interest in the outcome of the research, but should she change her mind an opportunity will be scheduled to discuss the results with her. During such a feedback session she will be explained that the research was not specifically focused on her, but rather on application of a new method to better understand the therapeutic interaction between a therapist and a client. Feedback regarding the outcomes of the research will then be discussed with her.

3.6 Method of data collection

Although it was initially planned to use some or one of the therapeutic notes of therapies conducted during the first year of the MA Clinical Psychology Degree, the exact nature of the research was not yet known at the time. Several therapies with clients, each consisting of several therapy sessions, were recorded in detail, but only two were finally considered due to the richness of experiential information contained in them. For succinctness the term *transcripts* or *transcriptions* was used to refer to these therapeutic notes up to this point in the dissertation. The term is however not strictly speaking accurate, since transcriptions refer to an "exact copy of something" or a "complete record of what was said" (Reber, 1995 p. 801). In the current study notes of what was said in therapy sessions were made during the session. As soon as possible, after completion of therapy, these notes, which served as memory aids,

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were used to reconstruct as closely as possible what was said in therapy. This was done in the same format as transcriptions, i.e. indicating what was said by whom. The notes also included some therapist reflections, which were used in the analysis. This way of collecting data was deliberately used, rather than implementation of more accurate recording devices, since these devices may potentially interfere with the therapeutic process (Balint, Omstein & Balint, 1972). Although such an approach can be criticised, since the therapist may selectively remember, it has also been promoted as a valid method for case studies by some researchers (Balint, Omstein & Balint, 1972). They argue that inclusion of electronic devices can negatively impact on the disclosure of clients in therapy. Examination of the therapeutic notes used in this research revealed how the amount of detail increased as the therapist's capacity to memorise improved. This resulted in longer and more accurate therapeutic notes as the sessions progressed. In the remainder of this dissertation the term *therapeutic notes* rather than *transcriptions* is used to refer to the data used for analysis. It should however be remembered that these notes closely resemble transcriptions and that great care was taken to represent the content and process of therapy sessions as closely as possible. The method proposed to analyse these therapeutic notes should therefore also be applicable to transcriptions made with more accurate equipment, such as recording devices.

3.7 Data analysis and interpretation

Since a considerable part of the current research is directly related to the method of data collection and analysis, attention has already been provided to this issue in preceding sections. In short the process of data analysis was approached as follows. The first phase of the research consisted of developing an adaptation of Luborsky's technique and applying it to therapeutic notes of a case study. During this phase the modification of the CCRT technique was evaluated in terms of its capacity to sufficiently fit and incorporate the majority of the content of the therapeutic notes. Secondly, the resulting data or interactional meaning units, were analysed with a method based on a phenomenological theoretical orientation. In the third phase of the research an attempt was made to gauge whether the information gained from the method was useful to improve the therapist's understanding of interpersonal experiences.

As mentioned before the general guidelines of the phenomenological method was followed using the DPRM's general guidelines as set out for example in Giorgi (1985). The method

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essentially consists of four steps and is very similar to other interpretative phenomenological methods (Willig, 2001):

1. Read the entire description in order to get a general sense of the whole statement.
2. Once a sense of the whole has been grasped, read through the text again to discriminate meaning units. It is in this phase that that the modified version of the CCRT technique was used to order data.
3. The meaning units under consideration are then examined in terms of providing insight into the phenomenon under consideration.
4. Finally all the synthesised meaning units are integrated into a consistent statement about the individuals' experiences.

3.7.1 Developing the modification of the CCRT technique

In this section the development of the modified version of the CCRT's Unit Interaction Record Sheet (UIRS) is discussed. A basic description of the CCRT technique has already been provided in a previous section. In the CCRT method each session is viewed as consisting of several relational experiences (REs). Clearly this delineation of REs is artificial, since the whole session could also be considered as a RE. Breaking the session into smaller REs could be regarded as reductionistic; however, by first examining REs individually the data become more cognitively manageable. Afterwards an attempt can be made to reintegrate the understanding gained from the individual REs.

A preliminary prototype of the proposed modified technique was applied to the therapeutic notes of the first session and seemed to result in the identification of useful units of interpersonal interaction. Using an iterative process the proposed modified technique was modified to fit the data under consideration. In each of the REs the following sequence of events was typically observed and therefore recorded in the original CCRT Unit Interaction Record Sheet (UIRS). Typically a client would express some wishes, needs or intentions (WIN/s) towards a person/s outside of therapy or towards the therapist. The person/s or therapist would then respond to these WIN/s in some way, activating some response of the client towards the self. As mentioned before the above structure of ordering data proved insufficient to provide the depth of information that was required for this study leading to the consideration of its integration into a phenomenological methodology. In addition the

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researcher was also interested in all client accounts of REs as occurring in the first place within the context of the client-therapist relationship. For this reason the basic structure of identifying meaning units within relational experiences was modified to also include the therapist's WIN/s as well as the client's response to these WIN/s and the therapist's response to self. In this section the thought processes leading to the final modified UIRS are discussed.

The first session of the case study was used to develop the modified technique. Initially Luborsky's UIRS was applied in its original form as described above. In other words REs were identified and the information in these REs was then ordered as consisting of the following meaning units: client WIN/s, the response of the person or persons towards whom these WIN/s are directed and finally the client's response to self. After applying this to the session an attempt was made to also examine relational experiences in the context of the therapist's WIN/s. Clearly this task becomes more complicated since less data are available for objectively determining these WIN/s, since the client generally being the focus of attention in a therapy session and the therapist seldom directly expresses his or her own WIN/s or responses to person/s or self. In some relational experiences it was however possible to identify therapist WIN/s from the content of the therapists interpretations, comments or questions. Reflections included in the therapeutic notes further proved valuable to identify therapist WIN/s. Since therapist and client WIN/s were not in all cases directly expressed, but could often be inferred it was decided to include the qualifiers expressed or inferred to all the WIN/s.

An initial record sheet was adapted using the considerations expressed in the previous paragraph and again applied to the first therapy session. The record sheet was then continuously altered to include information deemed valuable to the researcher. For succinctness and to avoid confusion, only the final product is included in Table 1 and should facilitate understanding of the current discussion. Alphabet letters are also included in each block to suggest a generally effective order in which to complete blocks. Further comments on how to actually complete these spaces and difficulties encountered are discussed in the section dealing with completion of the UIRS. In this section the focus is on understanding the UIRS.

A discussion of the layout of the UIRS now follows. The left hand side of the record sheet is devoted to the client, while the right hand side is used for the therapist. On the left hand side

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the person/s towards which the client's WIN/s are directed are noted. This is followed by a space in which the WIN/s are recorded. In this block it should also be noted whether the WIN/s were directly expressed or whether it was inferred from the information contained in the therapeutic notes. Directly on the right hand side of this block a space is provided in which any WIN/s towards the therapist may be inferred from the client's account of outside interactions. This was not included in the original CCRT method. Following the WIN/s the person/s response to the client's WIN/s are recorded as recounted by the client. This is similar to the original CCRT record sheet where the terminology *response of object* (RO) was used. The next meaning unit consists of the client's response to self, which is again similar to the original CCRT formulation.

The right side of the UIRS is similar to the left side, but focuses on the therapist's WIN/s, response of the client to the therapist's WIN/s and the therapist's response to self. Information may not often be available to complete this space and will often be inferred from reflections included in the therapeutic notes. Finally another addition was made to the original CCRT record sheet. Examination of therapeutic notes revealed that most of the relational units concluded with some expressed or inferred response from the therapist, from which therapist WIN/s could often be inferred. In general the client then responded to the therapist's verbal response again either directly or indirectly.

At the beginning of this section a brief description of the sequence of events within a particular RE was described. These sequences can now be re-described given the modified UIRS. At the beginning of each RE WIN/s of either the client or therapist or both will either be expressed or may be inferable from the therapeutic notes. All relational experiences are seen as occurring within the context of both these WIN/s although both may not always be accessible from the available information in the therapeutic notes. In most cases the client's WIN/s will be directed at person/s outside of therapy, but in the current research will be examined for the presence of inferable WIN/s towards the therapist as well. Similarly the therapist's WIN/s may also indirectly be inferred to indicate a WIN/s towards another person in the client's life. In general the person/s towards whom the WIN/s are directed will respond to the client. Similarly the client may respond to the therapist's WIN/s in a particular way. These responses are always subjective as reported by the therapist or client. Following this, both the therapist and the client react to the response of a person/s to their WIN/s with a response to self. Finally it was found that most of the REs concluded with some response

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from the therapist to which the client responded and therefore a space for recording this was also created on the recording sheet.

<table>
<tr><th colspan="4">Table 1: Blank Modified Unit Interaction Sheet</th></tr>
<tr><td colspan="2">Session:</td><td colspan="2">Response:</td></tr>
<tr><td colspan="2">Client</td><td colspan="2">Therapist</td></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed</td><td colspan="2">A) Person/s at which WIN/s Directed</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s</td><td>Towards Therapist</td><td>Towards Client/s</td><td>Towards Other Person/s</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s</td><td colspan="2">C) Response of Client to WIN/s</td></tr>
<tr><td colspan="2">D) Client's Response to Self</td><td colspan="2">E) Therapist's Response to Self</td></tr>
<tr><td colspan="2">G) Client's Response to Therapist's Response</td><td>F) Therapist's Response to whole RE</td><td>Therapist's WIN</td></tr>
</table>

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3.7.2 Completion of the UIRS

In this section practical guidelines are provided on how to complete the UIRS. These guidelines were compiled concurrently with the researcher identifying RE's and meaning units in the therapeutic notes. Consulting the UIRS provided in Table 2, while reading this section, should improve comprehension of the current discussion. Firstly the whole session is scanned, while concurrently text which seems to consist of REs is roughly selected. During this phase all text may not necessarily be selected. Certain sections of the text will more clearly represent relatively independent REs. After selecting the more prominent REs it becomes easier to decide how the remaining text could be logically organised into REs. The researcher found that although it was initially difficult to identify REs, they could often be chosen in a useful way when selected around a specific topic or person/s under discussion. A transition to a new RE is often initiated with a new topic or person being mentioned and typically ends with the therapist interpreting or commenting on the whole RE and the client accepting or rejecting the therapists' input.

Once all the REs have been selected, a more thorough reading of the data is necessary. During this phase an attempt is made to complete the spaces provided on the modified UIRS. The alphabet letters A to G provides a guideline on the order of events in a typical RE. From the information provided in the previous section it should be clear that not al spaces will be applicable to every RE. In most cases any relational experience will focus either on the WIN/s of the client or that of the therapist. In all cases as much as possible information will be included whether it is directly expressed or logically inferable. Logically inferable in this context requires that an outside person would be expected to make roughly the same inference. During this phase small changes in what exactly constituted an RE should be made in order to better fit the structure of the UIRS.

Finally all the RE's as recorded in the UIRS are examined critically to see whether they make sense. Often it may be necessary to return to the raw data to verify that something critical had not been missed. As mentioned before, more than one way of choosing REs are possible, but overall most of the information in the therapeutic notes should be recorded in the UIRS.

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<table>
<tr><th colspan="4">Figure 2: Guidelines for Completing the Modified Unit Interaction Sheet</th></tr>
<tr><th colspan="2">Session:</th><th colspan="2">Response:</th></tr>
<tr><th colspan="2">Client</th><th colspan="2">Therapist</th></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Record person/s to which client WIN/s is directed here. Mostly this will be either outside person/s or the therapist.</td><td colspan="2">A) Person/s at which WIN/s Directed
Record person/s at which therapist’s WIN/s is directed here. Mostly this will constitute the client, but can also be directed towards outside person/s mentioned by the client in therapy.</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
Record WIN/s towards a person/s outside therapy here.
Indicate whether WIN/s is expressed or inferred.</td><td>Towards Therapist
In some cases a client WIN/s will be expressed towards the therapist directly. In other cases a WIN/s may be inferred from the client’s WIN/s towards a person outside of therapy.
Indicate whether WIN/s is expressed or inferred.</td><td>Towards Client/s
Record therapist’s WIN/s towards the client here. This will mostly not be expressed directly, but may sometimes be inferred from the therapist’s comments, questions or interpretations.
Indicate whether WIN/s is expressed or inferred.</td><td>Towards Other Person/s
In some cases WIN/s towards person/s mentioned by the client outside of therapy may be expressed by the therapist.
Indicate whether WIN/s is expressed or inferred.</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Record the response of the person/s to the client’s WIN/s in this space.
Indicate whether this response is expressed or inferred.</td><td colspan="2">C) Response of Client to WIN/s
Record the client’s response to the therapist’s WIN/s in this space.
Indicate whether this response is observed, expressed or inferred.</td></tr>
<tr><td colspan="2">D) Client’s Response to Self
Record the client’s response to self in this space.
Indicate whether this was expressed or inferred.</td><td colspan="2">E) Therapist’s Response to Self
Record therapist’s response to self in this space.
This will typically only be inferable from therapist reflections included in the therapeutic notes.</td></tr>
<tr><td colspan="2">G) Client’s Response to Therapist’s Response
In most cases the client responds to the therapist’s final comment, interpretation or question and this should be recorded in this space.
Indicate whether this response was expressed or inferred.</td><td>F) Therapist’s Response to whole RE
Record the therapist’s final response to the whole RE in this space. This will typically be in the form of a comment, interpretation or question.
Indicate whether this response is expressed or inferred.</td><td>Therapist’s WIN/s
Often a therapist’s WIN/s can be inferred from the therapist’s final response recorded in the left block and should be recorded in this space.
Mostly this WIN/s will be inferred and this should be indicated.</td></tr>
</table>

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3.8 Conclusion

In this section the basic strategy for collecting observations in the current research, i.e. the research design, was discussed. The main reasons for considering a qualitative design were provided and issues related to reliability and validity in qualitative research were explored. This was followed by a discussion of how the participant was selected and relevant ethical issues that needed to be addressed prior to conducting this research. Finally the method of data analysis and interpretation was discussed. An important part of this final section dealing with data analysis was a description of how the modified CCRT technique was developed followed by guidelines for completing the modified UIRS.

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CHAPTER 4: RESULTS

4.1 Introduction

In this chapter the results of the qualitative analysis are presented. Since one of the aims of this study is to evaluate the new methodology, sections of the analysis are reproduced within the body of this text in order to give the reader an opportunity to track and evaluate the usefulness of the process followed.

4.2 Qualitative analysis

As mentioned before, the general DPRM guidelines were followed throughout the analysis. During step one of the analysis, in which a general sense of the whole should be accomplished, the therapeutic notes of all eight sessions were read. Summaries of these eight sessions are provided in the following section to give the reader an overall sense of the whole and to provide the context within which the anlysis was conducted. During this preliminary reading three sessions, were selected for analysis. Specific sessions were selected with two criteria in mind. Firstly they had to contain rich and in-depth information. Some of the therapy sessions were less useful, as far as the current study is concerned, because they for example contained assessments or were more informative in nature. Secondly, an attempt was made to select therapeutic sessions to include one at the beginning, one in the middle, and one at the end of therapy. This was done in order to see how therapy changed over time.

In step two of the DPRM the sessions were subdivided into meaning units or REs. Each RE was then individually examined and the data ordered using the modified UIRS. During this process an attempt was made to keep the context of the whole therapeutic session in mind. Immediately after ordering the data in a specific RE, step three of the DPRM was conducted, namely examination of the meaning unit or RE in order to achieve a better understanding of the phenomena under consideration. Practically this was done through writing a small summary of the researcher's understanding of the RE after completion of each RE. Often the increased insight resulting from trying to understand the RE resulted in additions and modifications to the initial ordering of the data in the UIRS. This feedback process continued until the researcher felt that the UIRS and the subsequent summary complimented each other.

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The above process consisting of step two and three of the DPRM was repeated for every RE. In summary thus, each identified RE in the text, is followed by a UIRS, in which the data is ordered, as well as a summary of the researcher's understanding of the information as represented in the RE. Since the REs within each therapeutic session were analysed in chronological order it was possible to consider potential effects of previous REs on any particular RE under investigation. This was done because, as was mentioned in a previous section, the phenomenological method takes context into account. Complete isolation of REs would therefore violate the importance of context. As mentioned earlier, subdivision of a therapeutic session facilitates analysis, but it is also artificial, since the whole session could also be argued to represent a single RE.

Step four of the DPRM in this research consisted of a meta-analysis of the understanding gained from individual RE's in each therapeutic session. Each session was first evaluated in isolation. All the summaries of understanding of REs were reread to identify common themes and the results were integrated. The understanding of individual sessions was then integrated into one overall understanding of the interpersonal experiences in therapy over the three chosen sessions. By first integrating the therapeutic sessions individually it was possible to say something regarding the process of therapy over time. The modified DPRM steps, as summarised above, are demonstrated with examples and summaries in the following sections.

4.2.1 Step 1 of the DPRM

Brief summaries of the demographic information of the therapist and researcher as well as the context in which the therapy sessions took place were provided in a previous section. In this section a summary of the eight sessions conducted is provided in order to give the reader a sense of the whole therapeutic interaction.

4.2.1.1 Summary of session 1 (11/2/2005)

This was the first contact with Mrs Smith. She arrived at the clinic with her husband. She was very neatly groomed, while he was dressed very casually in shorts. Her husband seemed disinterested in her attending therapy and preferred to wait outside. Mrs Smith did most of the talking, while her husband seemed to deliberately stay uninvolved in the conversation. Prior to the session she provided some demographic information. The session roughly progressed as follows. She immediately started sharing the details of her medical symptoms. This

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focussed mostly on what she referred to as a geographical tongue. She shared how this started after an operation was done to insert implants which would have helped her to fasten her dentals. She accepted the doctor's explanation that her pain was mostly psychological in nature and agreed to see a psychologist at the BMS Clinic.

During the session the therapist explained the BMS hypothesis to her and what realistic expectations of therapy would be. Mrs Smith shared how desperate she was to talk to someone. She said that she was concerned about becoming a burden to people around her. Mrs Smith was willing to commit to a minimum of four sessions. During this session she shared some of her medical history. She said that she had had a hysterectomy shortly after marrying, when she was aged 39 years. In 2002 she had a colon operation, resulting in her having to carry a bag on the outside of her body. She shared how difficult this was for her and how heavily she had to rely on others' support. According to her she also experienced a heart attack shortly after the operation and took several months to recover. Her last medical problem was related to her dentures, which started in August 2004. Mrs Smith shared that she has also suffered form migraines for most of her life. According to Mrs Smith her husband suffered from a type of stomach cancer. She described this as a slow cancer, for which he occasionally received chemo treatment.

Mrs Smith elaborated on the symptoms she experienced in her mouth. She said that she could not enjoy food as she used to and that she often felt desperate and helpless. She shared that she struggled to sleep and used medication for this and for her migraines. She also used pain pills for her mouth. Mrs Smith said that she was not using anti-depressants. She shared that during holidays and when she was more relaxed her BMS symptoms reduced. Mrs Smith also shared that she used to have a very good relationship with her sister, but that she could not see her very much, because her sister had to look after her own grandchildren after the children's mother died in a car accident. She expressed sadness at not being able to see her sister more often.

During this session she cried often, but towards the end composed herself. She invited the therapist to call her on her name in future, but he did not feel comfortable doing this. The therapist's impressions of her after this first session was that she was a very frail and vulnerable person, who was desperate to have someone to listen to her. At the same time the therapist experienced her as proud and ashamed of being weak and needy. At other times she

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was experienced as becoming mildly irritated at being interrupted. She evoked feelings of empathy, but the therapist wondered whether she repressed considerable anger and frustration. The therapist felt that she could benefit from therapy, but was concerned that she may eventually reject any help offered.

4.2.1.2 Summary of session 2 (1/4/2005)

Since session 2 was analysed, the full therapeutic notes with clearly demarcated REs are included in Appendix B. These notes should be read at this stage of the analysis.

4.2.1.3 Summary of session 3 (15/4/2005)

At the beginning of this session Mrs Smith appeared disoriented and anxious. She shared that she was not feeling well and suffered with pain in her legs and back. Her mouth was also very painful. She shared how difficult it was for her to stay on her feet and for example prepare meals for guests etc. She indicated that she wished to continue entertaining guests, but that the pain was making it very difficult for her.

Mrs Smith shared many activities that she still enjoyed, such as singing in the choir and going to operas with her husband. She appreciated his willingness to attend operas with her and agreed that these activities were a valuable outlet for her emotions.

Mrs Smith felt that the biggest problem in her life was the constant pain she experienced in both her mouth and back. She shared that she had to use relaxation and pain pills on a daily basis, but that they only provided temporary and partial relief.

Mrs Smith shared how much she appreciated that her husband managed to ask her for help during his most recent chemotherapy. She acknowledged that her husband's chemo and the accompanying anxiety may have played a role in the increased symptoms she started experiencing directly after they returned from hospital. Despite this acknowledgement she still seemed hesitant to make an association between depression, anxiety and BMS. The therapist tried to reinforce this connection with some success. She for example shared how she had felt better after spending a few peaceful days at the beach. A connection between her available resources and ability to deal with the pain was made and Mrs Smith seemed willing to consider this hypothesis. Mrs Smith shared how she could mostly deal with her symptoms,

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but how at times it was simply too much for her to bear and that she then felt like discontinuing her life. At the same time she emphasised how important it was for her to stay positive. It became clear that although she desperately needed to share her difficulties and feelings of hopelessness with the therapist, she felt ashamed of doing this. She acknowledged the importance of exploring her preconceptions with the therapist.

In a note to the supervisor the therapist indicated that he had not experienced this session as very successful, because the client talked continuously and it was very difficult for him to interrupt her. His impression after this session was again that the client was a very vulnerable and sensitive person who was easily overwhelmed by external events.

4.2.1.4 Summary of session 4 (22/4/2005)

Mrs Smith appeared healthier than during the previous session. She shared that she had less pain in her back and indicated that she would attempt to give the therapist more opportunity to speak. This was probably in response to the therapist's request to interrupt her more often during a previous session. The therapist shared his intention to do a visual relaxation exercise with her during the following session and explained how this could be viewed as a psychological equivalent of a pain pill. The therapist again made an attempt to link her pain symptoms with growing anxiety and tried to sensitise her to early signs of anxiety in her body. Although she acknowledged the possibility of such a connection, she struggled to find examples of them in her own life. She did share that she often had migraines in her life, but related them more to food intolerance or allergies.

Initially Mrs Smith seemed determined to talk less and to allow the therapist more time to speak, but as the session progressed, she reverted to continuous talking. It seemed that it was a way for her to deal with anxiety and to keep the therapist at a distance. The therapist interpreted this for her and also her tendency to start sessions in a very polite, but emotionally distant way, and then how she often at some stage during the session became very emotional. She acknowledged this interpretation, but did not seem to listen very well. The therapist often had the impression that she was waiting for him to finish talking so that she could continue talking. At times she seemed surprised and possibly amused at the attention that was given to her experiences. The therapist also interpreted her talking as a way to keep him from gaining access to her vulnerability and she again acknowledged this. This initiated talk about her

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shame at showing her vulnerability in front of people and how she felt that she was being ungrateful towards God by complaining. She was encouraged to share her emotions and their importance was validated.

The therapist and client talked about how hard she tried to control her emotions, but how at times she was overwhelmed by her sadness. She shared that there were very few people that she could talk to. She said that she used to be able to talk to he sister, but unfortunately her sister was not available enough anymore. It was discussed how difficult it was for her to show her vulnerability in front of the therapist. She shared that she used to be more spontaneous when she had been younger, but was becoming less so with age. She also talked about her husband's aging and that it was something she had to accept. She mentioned how there were less people to talk with in her life and how the activities she could engage in were becoming less. She talked about the increasing number of deaths of friends and people in her age group. She again emphasised that she should be more grateful for what she had. The therapist encouraged her to share her sadness more readily in therapy.

At the end of the session she indicated that she would probably not be able to attend therapy for much longer, because it was expensive to drive to the hospital and because her husband was against her attending therapy. The therapist suggested that she based her decision on whether it was meaningful for her to attend therapy. She indicated that if it was left to her, she would prefer to continue coming to therapy.

After the session the therapist wondered whether she really wanted to be helped, because it often felt as if she did not really listen to what he said. The therapist also contemplated whether she should not be referred for use of antidepressants. The therapist's impression was still that her difficulties were to a large extent psychological in nature, but felt that antidepressants could alleviate some of her suffering. It also became more apparent in this session that many of her depressive thoughts were related to loss of vitality, illness, death and disease and the therapist planned to spend more time addressing these issues in subsequent sessions. The therapist's overall impression was still that the client was very fragile. He experienced her as exhibiting very little aggression when she felt well, but that when she did not feel well it felt as if he was merely tolerated. The therapist often wondered whether there were considerable anger and frustration that she suppressed.

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4.2.1.5 Summary of session 5 (29/4/2005)

Since session 5 was analysed, the full therapeutic notes with clearly demarcated REs are included in Appendix B. These notes should be read at this stage of the analysis.

4.2.1.6 Summary of session 6 (13/5/2005)

Mrs Smith did not appear to be feeling well, but was polite and friendly and did not seem disoriented. She shared that she was still in considerable pain as a result of her back and mouth. She shared what interventions the dentists were considering to alleviate the pain in her mouth. She sounded desperate and willing to do nearly anything to stop the pain. She also shared that she had undergone an MRI for her back pain, but was still waiting for the results. Mrs Smith talked about her ambivalence regarding entertainment of guests. On the one hand she enjoyed having them and also felt that they distracted her from the pain she was experiencing, but they also taxed her limited energy resources. She shared a need to have a little time in the day to rest, but that it was often difficult with all the guests they entertained.

Mrs Smith mentioned that she tried the relaxation exercise once, but complained that there was nobody to read it to her. She indicated that she did not think she would be able to do it on her own and that her husband would not be able to do it in the same way that the therapist did. The therapist gave her a tape recording of the relaxation exercise, which she offered to pay for, but the therapist refused to accept. The therapist suggested that she listened to the tape about two times per day. He also asked her permission to do a Rorschach the coming week, and explained how it could also benefit her future therapy.

Mrs Smith again indicated that she was trying to give the therapist more time to speak. The therapist read her a letter that he had written to her. The letter was a way in which the therapist hoped to make her therapy more personal and also to facilitate her listening. In the letter the therapist addressed the issue of termination and whether it was her or her husband that wanted her to terminate. In the letter the therapist suggested that it was difficult for her to say that she did not find the therapy useful. Afterwards she indicated that she did want to continue and that it was only her husband that wanted her to stop coming to therapy.

In the letter the therapist addressed the therapeutic relationship and how it could potentially be a place where she could openly share her difficulties, should she feel safe enough. He also

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asked how safe she felt and what it was that was preventing or making it more difficult for her to share her feelings.

In the letter the therapist addressed her concerns regarding losses in terms of death and youthfulness. He suggested that perhaps she was uncertain about the future and was also losing hope. He asked whether perhaps the past seemed more pleasant and recourse from her daily hassles and difficulties. He asked rhetorically how she could be helped to return to the present and how the present could be made more bearable for her.

Mrs Smith reacted positively to the letter and said that the therapist understood her concerns well. After the letter she indicated that she enjoyed talking to him, because she couldn't talk to her husband in the same way. She mentioned that she appreciated the therapist not judging her. She felt that her husband was more understanding towards other people than he was towards her. She shared her fear of differing with her husband. She acknowledged that her husband may perceive her as weak and vulnerable and that he did not perceive her as a threat to him. She suggested that it was perhaps partially her fault in that she complained too much about her pain and was often forgetful.

Mrs Smith talked about her love for her husband and how she longed for recognition from him. She talked about how impossible she perceived this to be and how she had to go out of her way not to agitate him in the house. She cried when the therapist mentioned how sad she felt that her husband did not recognise and attend to her needs for love and attention. She talked about her need for someone to hold on to and how her husband was unable to provide this emotional support for her. She shared how he was still very willing to share their costs etc, but that she needed emotional support more than financial support. In spite of this, she recognised that she was financially dependent on him. She expressed her sadness about the certainty that her husband would not change. Mrs Smith also compared her previous marriage with the current one and mentioned how much more affection her previous husband had shown. She talked about how everybody viewed her current relationship as being perfect, but that they were unaware of what she was experiencing in marriage.

Towards the end of the session she indicated that she still had many things to share. She did however also mention that she felt bad about talking about her husband in a negative way.

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She acknowledged indirectly that at times she deliberately tried to avoid talking about important issues in her life.

The therapist's experience was that this was one of his more successful sessions, despite the fact that it still felt as if she distanced herself from him through talking, when sensitive issues were discussed. She seemed to respond well to the therapist interrupting her and bringing her back to the issues under discussion during this session. The therapist also felt that he had heard her better and was more accurate in his interpretations. The therapist believed that the letter had helped to open areas of discussion, which she normally managed to avoid.

4.2.1.7 Summary of session 7 (20/5/2005)

This session was exclusively used to administer a Rorschach Test.

4.2.1.8 Summary of session 8 (24/7/2005)

Since session 8 was analysed, the full therapeutic notes with clearly demarcated REs are included in Appendix B. These notes should be read at this stage of the analysis.

4.2.1.9 Summary of final telephone conversation (16/8/2006)

On this day the therapist returned a message from Mrs Smith. She sounded quite ill over the telephone. She shared that she had decided to stop coming to therapy. She said that she had had a very difficult time in her relationship with her husband. Apparently he had said that her problem was "in her head" and that she should see a psychologist. She said that according to him her current therapist was not yet qualified and therefore wouldn't be able to help her. The therapist suspected that something else happened in the mean time, because her son had managed to convince her husband to attend couple therapy sessions with another psychologist. She shared that they would start seeing a psychologist the following week. The therapist could hear that she was very upset and talked with her for approximately 20 minutes. He encouraged her to go for couple therapy with her husband. The therapist suggested that she shared with the new psychologist that she had been in therapy, since if it had been meaningful to her, the new psychologist could perhaps help convince her husband to allow her to continue with individual therapy. Mrs Smith agreed to do this and that she would try to share more openly with the new psychologist than she did with me.

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The psychologist asked her about her last session and whether there had been anything in particular that upset her. She denied this. The therapist also asked her whether she thought the therapy may have had a negative impact on her relationship with her husband. Again she denied this, although the therapist suspected that therapy may have created additional conflict between her and her husband. The therapist said that she was still welcome to come and see him in future. She said that she would and that she would phone him in future when she was alone again. She thanked the therapist for what he had meant to her. The therapist was very upset at her anguish, but was relieved that at least they were planning to see another psychologist. Unfortunately it eventually turned out that they only went to see the psychologist once.

4.2.2 Step 2 and Step 3 of the DPRM

The full analyses of individual REs in the three chosen therapeutic sessions are provided in Appendix C. It is imperative that the reader review at least some of these RE analyses at this stage in order to fully appreciate the nature of the analysis that was conducted. The REs that are referred to in these analyses can be traced in Appendix B.

4.2.3 Step 4 of the DPRM

The main goal in step 4 of the DPRM was to re-examine the analysis of individual REs conducted in step 3 and to integrate these findings. This was first done for the individual sessions 2, 5 and 8, followed by an integration of the findings of all three sessions. The integration of individual sessions was done by reading all the RE analyses in a particular session and highlighting content that subjectively appeared to be relevant to a better understanding of the client-therapist relationship. In order to better understand the client's relationship with the therapist, it was sometimes necessary to also include information pertaining to the client's relationships with people outside of therapy. An important consideration during the re-evaluation of the RE analyses was: the context of WIN/s within which the RE took place, whether these WIN/s were satisfied or not, and correspondingly how the client and therapist reacted. Three particular aspects that were kept in mind during the re-evaluation of the RE analyses were:

A Their general contribution to an overall understanding of the therapist-client relationship.

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B Their contribution to understanding the interconnectedness or flow of experiences between REs in a particular session.

C Their contribution to suggesting alternative responses that may have been considered had the new understanding of the RE been available to the therapist at the time of the interview.

The final results of both the integration of individual session analyses as well as the summary of combined results are presented in the format of the above three mentioned aspects: A, B and C. It is important to note that during the first 2 parts (A and B) of the integrations of RE analyses no attempt was made to validate more effective or less effective strategies. An attempt was made to focus on describing and understanding of REs without judging the usefulness of interventions. In the final part (C) of the integration as well as the overall integration of the results of all three sessions some comments on more and less effective strategies and interventions are made. Although the therapist at times during the analyses, became aware how some of the interpersonal occurrences could be explained with specific theoretical models, no attempt to do this was made in order to maintain as close as possible to an assumptionless position. In the final integration some references to generally effective and ineffective psychotherapeutic interactions are however made, to show how some of the results are in line with what would be expected in general psychotherapeutic practice. In the following paragraphs references to specific REs can be traced in Appendix B.

4.2.3.1 Integration of Session 2

4.2.3.1.1 Contribution to general understanding of therapist-client interaction

In this session the client expressed a need for people and her husband and the therapist in particular to acknowledge her suffering and to place fewer demands on her. Many of her needs were expressed in the context of her husband, such as a need for her husband to be more acknowledging of her efforts and sensitivity, to be more tolerant towards her, less critical, more forgiving, less serious, more spontaneous and less easily angered. Many of the needs expressed towards her husband seemed to also apply to other people and to the therapist. Other needs that emerged in this session were a need to be comforted by an external source such as the therapist as well as a need for more hope. The client's experience was that most people did not acknowledge her and that they continued to place excessive demands on her, resulting in her feeling helpless, overburdened and out of control. Mostly, when the

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therapist managed to acknowledge her needs, the client continued to disclose information regarding her emotions and was also more accepting of the therapist's interpretations, even at times reviewing her view of herself as for example: being more capable than she thought, being a sensitive person, etc.

The therapist in turn experienced a strong need to help the client and to reduce her suffering. The therapist often experienced frustration, discomfort and anxiety at perceiving himself as not being able to help her or facilitate her movement towards less suffering. This seemed to have resulted in the therapist often trying to find solutions to her difficulties and to attempt to make her take more responsibility for her own role in her relationships. Another consequence of the therapist's discomfort was attempts at times to boost the client's sense of efficacy or self image. Analysis revealed sufficient grounding to indicate that most of these interventions were unsuccessful and that they rather resulted in the client becoming more guarded and resistant to interpretations. Despite this, the therapist mostly did not respond to these cues, but continued pushing towards finding solutions to decrease her suffering. It seemed that these interventions were often driven by the therapist's own feelings of insecurity rather than what was at that point in time the most beneficial to the client. Mostly attempts at suggesting solutions or strengthening her sense of being capable failed when the driving force was the therapist's own anxiety at not being able to deal with the discomfort of her suffering. The client also responded to such solutions, by reporting increased number and intensity of events that could illustrate how taking responsibility was impossible and outside of her control. By doing this she effectively stalled any attempts by the therapist to offer additional solutions and at the same time increased the therapist's feelings of helplessness and frustration.

The only occasions where the therapist managed to get the client to critically examine her perceptions and role was when the therapist's underlying goal directedness was not so obviously present or when he engaged in more neutral attempts to gain a better understanding of the client. During such occasions the client was more open to interpretations and she was more willing to consider reviewing her view of herself. When the therapist did manage to accurately reflect the client's state it seemed to provide him with some relief and a feeling of satisfaction. Towards the end of this session another dimension of the therapist's insecurity emerged. It seemed that he started to doubt his own ability to deal with negative criticism or anger expressed by the client. This resulted in intensified efforts to convince the client that he

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was mature enough to do this. Instead of reassuring the client it resulted in a need of the client to reassure and comfort the therapist.

Some paradoxes emerged in this session. One of them was that although the client wished to be acknowledged by the therapist for her efforts to deal with her relationship difficulties with her husband in the past, and experienced some consolement at this being acknowledged, she seemed to be reluctant to fully own these efforts as it may have resulted in her being viewed as being capable to help herself and therefore needing less external support from the therapist. When she asked for external acknowledgement for her efforts, she seemed very apprehensive of any form of criticism. From the analyses it was inferred that the therapist's attempts to help her own her successes seemed to have a secondary effect in that it strengthened her perception of being inadequate and needy of external support and acknowledgement. It seemed that the therapist's attempts to strengthen her self image and to take more responsibility were opposing her own need for simply being acknowledged and understood. When the therapist failed to acknowledge these needs, she seemed to perceive that she was not truly being heard and understood and probably felt that the therapist had become similar to people outside of therapy. When this happened she seemed to lose hope and became even needier and felt more depressed and helpless. It seemed that she could not express this feeling that she was not being properly understood directly, and her main way of dealing with this seemed to be through passively rejecting the therapist's interpretations and suggestions. The client also seemed to reject any interpretations which could potentially be seen as criticism against her as well as any focussed attention on her own role in her interpersonal relationships. She for example more easily accepted an interpretation of herself as a peacemaker than an interpretation of her dependence on other people.

Another paradox emerged in terms of the client's need for her sensitivity and vulnerability to be acknowledged, but at the same time having a sense of proudness and fear of being seen in a vulnerable emotional state. From the analysis it seemed that even though she felt very vulnerable inside she put effort into appearing more in control of her emotional turmoil than she felt. It seemed that by doing this she was trying to hold on to a sense of self respect. Where the therapist was able to show empathy and respectfully enquiry, the client was able to stay in a more vulnerable state and to verbally acknowledge some of her self perceptions.

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Some loose themes emerged in this session. One of these was related to the client's capacity for self nurturing. Some degree of self nurturing was present in this client as was inferred from her attempts to rationalise some of her behaviours, such as using medication and not being able to help herself, as acceptable given her circumstances. Although this may be seen as a possible positive sign, it was of concern that it seemed to be more related to self pity and rumination, than a healthy capacity to be gentle and nurturing towards herself, thus reinforcing her perception of herself as helpless and needing external validation and support.

Another loose theme that emerged was related to the therapist. Within the context of the client sharing all her intentions to satisfy her husband, and him failing to acknowledge this, it seemed that the therapist started taking the side of the client against her husband, creating a sense of having an ally and facilitating the client's experience of being close to the therapist. Although this facilitated further disclosure of her suffering it may also have strengthened her perception of herself as being a martyr.

Another important theme that started to emerge in this session, but continued to play an important role in therapist-client interactions in session 5 and 8 was related to termination. In this session the client indicated how difficult it was for her to attend therapy and it was considered that she may have had doubts about the potential usefulness of therapy. How much of these doubts were actually only perceived as a result of the therapist's insecurity is unclear, but regardless it became an important issue in future REs. In this RE it seemed that the client was more ambivalent about therapy than necessarily critical about therapy. In addition she may also have acted on the therapist's insecurity and was trying to prepare him for possible disappointment, should she eventually decide to discontinue. One way she did this seemed similar to her other coping mechanisms in that she shifted the responsibility for such a decision to her husband. The therapist's fears of her terminating may have planted the seeds of a self fulfilling prophecy, since his fears may have placed an additional burden on a client who already felt overburdened.

4.2.3.1.2 Connection or relationship between respective REs (Flow of REs)

In this section an attempt is made to represent the flow and connectedness of REs throughout session 2. Some of this information has already been indirectly represented in the previous session and the focus here will be more on the flow than an in depth examination of the content of the interactions.

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Initially in the first RE the therapist was merely listening and did not directly act on his feelings of frustration at not being able to help the client. This resulted in the client feeling acknowledged and she continued to disclose her experiences. Gradually the therapist made more attempts to boost the client's sense of being capable. Although the client managed to acknowledge this feedback and it created some sense of consolement, she also seemed reluctant to fully accept it, since this would indicate that she needed less external support and comforting and she still had a strong need for this. As this pattern continued the client's hopes for the therapist to be different from other people outside of therapy seemed to have diminished. The therapist was perceived as not fully understanding, but rather as trying to provide solutions to her problems. This caused the client to become more depressed, helpless and needier.

When the therapist did manage to be more congruent with the client's perception of her needs for acknowledgement not being met and temporarily abandoned his need for providing a solution, the client was more capable of incorporating therapist interpretations of being for example a sensitive person. Continued empathic reflection of what the client said as understood by the therapist, resulted in continued disclosure by the client. Even when the therapist may have internally experienced a need to move closer to a solution this did not seem to hamper disclosure when not expressed overtly in therapy. When the therapist subtly started to take the client's side against her husband, it also resulted in the client feeling heard and continued disclosure, but it may also have colluded with her sense of being a martyr.

The therapist's need to provide a solution remained in the background. When this culminated in interpretations of the client's response to conflict, the client was able to respond only to the interpretations, which did not reflect negatively towards her, such as being a peacemaker. At this stage the therapist still experienced a need for the client's husband to be fairer towards her. This may have made it easier for the client to accept interpretations of her husband's shortcomings, but at the same time to refuse any allusions to her own shortcomings. Eventually the therapist's need to provide a solution returned again in full force through an attempt to explore her own role in conflict situations, but this opposed the client's needs for acknowledgement and to be seen as a victim of her situation. She responded by providing more extreme examples of what she was exposed to, resulting in the therapist again relinquishing his need for providing a solution. Thereafter the therapist's need may however

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have emerged in a disguised way as indicated by interpretation of the client's overt appearance of weakness, but inner strength. This seems related to his initial attempts to boost her sense of efficacy, but this time, within the atmosphere acknowledgement of her effort under very difficult circumstances, she seemed more accepting of the interpretation. This may also have been because she experienced the therapist as understanding her better than in previous cases. It is also an interpretation that does not judge or criticise and also does not directly or immediately expect a counter behaviour from her.

Towards the end of the session, the therapist's sense of insecurity remained, resulting in increased efforts to convince the client of his maturity to deal with any spontaneous expression of emotions. Rather than comforting the client, it seemed to have resulted in the client assuming the role of comforter and reassuring the therapist that he was not failing in his role. This insecurity continued into the final RE where the therapist responded to the client's ambivalence towards therapy, by trying to facilitate the client's continued attendance. The client may still have been aware of the therapist's insecurity and responded by trying to relieve her own sense of responsibility towards the therapist, by preparing him for potential termination. She also managed to provide rationalising of such a decision, by denying her own responsibility.

4.2.3.1.3 Possible alternative interventions that could be considered given the new insight

In this section alternative options for therapeutic interventions that emerged during the analysis are summarised. These interventions may have led to their own complications, but they grew out of the insight gained from the analysis, and having access to them should increase the therapist's range of potential responses to interpersonal occurrences and in some cases probably result in more useful therapeutic responses than was the case in these sessions.

The therapist often did not seem to be aware of his own sense of insecurity and more specifically how it resulted in frustration and discomfort at not being able to help the client. This discomfort seems to have been the source of many less therapeutic interventions, and being more conscious of it, could have resulted in more useful therapeutic responses in general. Even if the therapist did not always recognise it in a particular RE, recognition of the same recurring themes in subsequent REs could have prevented repetition of the same patterns in therapy. The therapist for example often did not fully attend to the client's

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emerging feelings of helplessness and her intense need for being acknowledged. The most extreme case of missing such cues is observable in response 9 where it reached the extreme of the client comforting the therapist.

Other examples of potentially less therapeutic interventions driven by the therapist's insecurity include his attempts at providing potential solutions to the client's difficulties and pointing out what her own role in her difficulties was. While this may have been appropriate interventions further on in therapy, it was difficult for the client to acknowledge these interpretations at this stage. It is also highly probable that the client would have been able to generate these anxiety provoking interpretations herself when she felt safer in the therapeutic environment. In some cases, instead of trying to boost the client's sense of efficacy, it may for example have been more useful to interpret her feelings of helplessness and fragility. The therapist could also have interpreted the client's need for approval from him. Rather than trying to convince the client of the safety of the therapeutic environment it may have been more useful to interpret how difficult it was for her to be vulnerable in the therapist's presence and to rather create this sense of safety by continuously attending to the client and acknowledging her without directing her towards solutions. Many opportunities for acknowledging the client were missed, such as for example validating her pride at her efforts at sexual accomplishment in her marriage.

Often the therapist's sense of insecurity resulted in him being more comforting towards the client, where it may have been more useful to allow her to express her distress and discomfort and not to feel that it would immediately be cottonwooled by the therapist's comforts. Another way to create a safe environment would have been for the therapist to deal with his own anxiety and insecurity in a more appropriate manner. One way would have been to be more aware and not to act on his insecurities. Another possibly would have been for the therapist to be more empathic towards his own insecurity, which should have resulted in less urgency to solve the client's problems.

In two of the REs in session 2 there are indications that the therapist sided with the client against her husband. Even though it was not explicitly expressed, it would probably have been picked up by the client. In most types of therapies it is advisable not to side with client against external people, since it can have many repercussions in therapy. In this particular session it

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was considered that it may have colluded with the client's perception of being a martyr and a victim of her circumstances.

It has been mentioned already that the therapist attempted to boost the client's sense of efficacy, without much success, because it may have been perceived by her as an attempt by the therapist to indicate that she did not need continued support and should take more responsibility for her own actions. Rather than directly commenting on her successes in the past, it may have been more useful to ask her how she felt for example at having been able to do this in the past. If she still did not acknowledge her successes, this could be interpreted, e.g. in terms of it being difficult for her to acknowledge any successes in the past and that she would rather minimise her own contribution. Her fear of accepting positive feedback for her successes resulting in her being seen as capable of continuing to do so in future may also have been interpreted as well as her fear of not being able to do so again in future.

The client did respond to interpretations that could not be perceived as criticism towards her and did not directly suggest her taking responsibility for future interactions. The usefulness of any of these interactions is uncertain. Perhaps in general it would have been better to simply reflect as accurately as possible the client's experiences and perceptions of herself. Interpretation of her difficulty to hear interpretations of her efficacy and strengths, because she did not feel capable of implementing them, could possibly also have been considered. In general perhaps the therapist could have followed through with her responses to his interpretations in more depth, rather than moving to following topics of discussion.

4.2.3.2 Integration of Session 5

4.2.3.2.1 Contribution to general understanding of therapist client interaction

The reflection at the end of this session is worth noting. In this reflection the therapist mentioned his ongoing concern about the client considering terminating therapy. There is however very little evidence for this in the therapeutic notes. This may have influenced him to try harder to keep the client in therapy and also may have increased his levels of insecurity, which seems prevalent in most of the REs in this session. Some of this insecurity may for example be inferred from his response to her querying his capacity to help her with her symptoms. The therapist responded with a need to convince the client of his experience of working with clients suffering with similar symptoms. At the same time it seemed as if the

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therapist was trying to sooth and comfort himself by providing cognitive solutions to the client's difficulties and explaining his motivation for certain actions. Another example of the therapist's insecurity was his inferred need for confirmation of his usefulness. An interesting interplay between the therapist's uncertainty about his own ability to be of help and the client's perception that nobody could help her took place, probably resulting in both parties feeling less hopeful about the outcome of therapy. In general the therapist also seemed uncomfortable to stay with the client's distress and often moved to a next topic or RE before what was happening in a specific RE was fully explored. During the analysis the therapist realised that by trying to direct the client he was probably reacting very similar to people outside of therapy.

In this session the therapist often did not seem to be fully with the client in the moment. In RE5 for example the therapist seemed to become preoccupied with his failure to previously acknowledge his concern for her husband. This was not brought into therapy by the client, but seemed to be something the therapist suddenly realised. This instigated a whole discussion regarding her husband. The client suddenly started talking about his good characteristics and seemed to experience guilt about being critical towards him.

In this session the client initially appeared to have improved. From the analysis, the possibility was considered that it may have been an attempt by her to appear strong and to maintain her self respect in therapy rather than real signs of improvement. The overall pattern in this session seems to be of the therapist trying to get the client to acknowledge improvements made by her and to give her hope. The client's needs however seemed to have been more focussed on being heard and acknowledged by the therapist. In one RE it was inferred that she needed the therapist to stop focussing on small improvements, but to rather acknowledge her.

Trying to convince the client of his ability to help her did not seem to reduce her concerns about the therapist's capacity to help her. Instead she countered this by saying that she was different from other people and that even if the therapist could help them it did therefore not necessarily imply that he could help her. The client seemed doubtful of the therapist's ability to help her. In the client's mind the therapist may have become similar to other people outside of therapy whom she perceived as being unable to help her. Some secondary gain was inferred: through creating this impression of herself as not being helpable, the client could

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maintain her sick role without directly challenging the therapist's skills as a therapist. It seemed that she felt alone in her suffering and overwhelmed by her symptoms and needed someone to hear and understand her. In general she resisted interpretations of improvement, possibly because they induced her to take more responsibility and also because it may have indicated that she needed less external caring and nurturance. The client was more capable to accept interpretations such as how she was trying to maintain hope for the future and how hard she tried to not be a burden to others. It seemed that these interpretations were less threatening than interpretations of her improvement. These interpretations did not judge or direct her towards doing anything in particular and was probably experienced by her as the therapist hearing and acknowledging her. It was inferred that she felt ashamed at her neediness. Her shame at not being as independent as her husband was also inferred. Overall it seemed that this client was in extreme distress and needy of external support and nurturing, but was unable to ask for this directly. It was inferred that she did not feel worthwhile and did not feel that she was of value to other people in her life. The client's symptoms seemed to have been her only way of accessing the nurturance and attention she needed from others and this may explain why interpretations of improvement in her symptoms could have been perceived as a threat to her. In fact it seemed that focussing on the client's symptoms, except for acknowledging them had little therapeutic value.

The client also seemed to try in this RE to keep up appearances of being in control of her emotional distress. The therapist observed this outward appearance and reflected on it, but failed to interpret how this may in fact have been an attempt to maintain her self respect, rather than a reflection of how she was feeling. In order to create this initial façade of improvement the client, must have had slightly more resources available than for example in the first session, when she often cried. Overall it seemed that the client was feeling self pity and felt that she was losing hope for the future.

The very tentative manner in which the therapist promoted the relaxation exercise seemed to be related to a more general need of the therapist to not cause damage or pain to the client. This may also be related to the inferred need of the client to be protected from pain and for others to take responsibility for her. Although the therapist actively tried to motivate the client to take more responsibility for her own improvement, these attempts were resisted by the client and she managed to get the therapist to take more responsibility for her. As mentioned

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above, by appearing helpless and needy, the client seemed to experience secondary gain in terms of other people, in this case the therapist, taking responsibility for her.

4.2.3.2.2 Connection or relationship between respective REs (Flow of REs)

The session started with the therapist trying to focus the client's attention on her improvement as perceived by him. This did not seem congruent with the client's need to be comforted and acknowledged and she resisted the therapist's comments and appeared even more helpless and hopeless. The therapist continued to not respond to the client's needs and instead continued with his own agenda of consolidating improvement made and sketching his understanding of her difficulties. The client did not respond to this in a verbal manner, probably indicating that she did not feel heard and acknowledged. When the therapist managed to temporarily relinquish his needs and empathically reflected how desperate the client felt, she continued disclosing information regarding her feelings of hopelessness, difficulty maintaining hope, etc.

The therapist's need to provide solutions to the client's difficulties returned in subsequent REs and continued to oppose the client's need to be acknowledged rather than advised. This resulted in the client not feeling heard. It seemed that being acknowledged was what she needed most from other people, such as her husband, sister and here the therapist. At the same time she in general seemed unable to acknowledge her own vulnerability. When the therapist reflected her pride and how important it was for her to not to be a burden, the client reengaged and continued disclosing. This was followed by a few relatively loose standing REs related to her husband's illness. In the following RE the therapist motivated the use of a relaxation exercise in a very tentative manner, and thereafter seemed to need confirmation that it had been useful to the client. The therapist also tried to motivate the client to take more responsibility, but instead her own need to be cared for and nurtured dominated, resulting in the therapist being the one to take more responsibility. Again this seemed to be similar to what occurred with other people outside of therapy.

In general thus the pattern seemed to be similar to that of session 2, with the WIN/s of the client and therapist often opposing. Where the therapist managed to relinquish his own WIN/s and effectively reflected what the client was experiencing, the client continued to disclose information, while when he failed to do this, the client became less responsive and more resistant to interpretations. It is again interesting how the therapist managed to relinquish his

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WIN/s temporarily by for example reverting to empathic reflection or questioning aimed at improving his understanding, but also how his WIN/s to find a solution and to reduce her suffering continued to return in subsequent REs.

4.2.3.2.3 Possible alternative interventions that could be considered given the new insight

Many opportunities for reflecting or acknowledging the client were missed. The therapist seemed to struggle to learn from his failed attempts at providing direction to the client and often returned to his own agenda and WINs. RE2 provides an extreme example where the therapist seemed to engage in a monologue and no response of the client was observed. More attention to such occurrences could reduce repetition of the same type of ineffective interactions.

Rather than reacting to the client's doubts about his ability to help her, the therapist may have reflected on how uncertain she felt about his ability to help him. The client in general asked her questions in a very indirect manner. Possibly she could have been encouraged to share her concerns in a more overt manner. Doing this would have facilitated therapy in the moment. In general the therapist seemed to have missed many opportunities such as this and seemed to have preferred to stay with more distant and safe comments about improvements made etc. It may for example have been more useful to interpret her:

- feeling of being alone in her suffering
- her sense of hopelessness
- perception that nobody could understand or help her
- difficulty in staying strong and maintaining hope for the future
- inferred self blame for her current difficulties
- shame at the neediness she felt
- need to be needed by someone else and to have meaning in someone else's life

Interpretations such as those mentioned above could have led to more in depth explorations of REs rather than the more superficial level that was currently observed such as attempting to comfort, convince and direct.

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Rather than convincing the client of the usefulness of the relaxation exercise a more neutral explanation of the relaxation exercise would have sufficed. The therapist could also have been more neutral regarding his need for her to use the relaxation exercise at home. The therapist could for example have interpreted how valuable it was for her to have a space where someone else cared for her and nurtured her and how she did not feel capable of performing these functions of nurturing for herself.

Rather than taking more responsibility and providing the protection for the client that she seemed to need so much, it would probably have been more useful to reflect or interpret these needs to her, i.e. how much she wanted to feel protected and cared for by another person.

4.2.3.3 Integration of Session 8

4.2.3.3.1 Contribution to general understanding of therapist client interaction

While analysing this session it became evident that the client and therapist were both using very similar, tentative and indirect methods of requesting for their individual needs to be met. This specific client seemed to have had high expectations of herself to satisfy other people's needs and to not disappoint them. At times the therapist's own needs became too apparent and therefore placed an additional burden on her. Since these needs were in some cases opposing her own, it also became more difficult for her own needs to be satisfied. One example of this was the therapist's need to keep the client in therapy and his disappointment at her not being able to make such a commitment. It seemed that the therapeutic context which could potentially have been a place where she did not have to take responsibility for other's needs was being redefined as a place where the therapist's needs were becoming a burden. In general it seemed that the client found it very difficult to directly ask for her own needs to be met. Despite this the client's desperation for her own needs to be met became so great in this session that she managed in an indirect way to assert her own need for more time and less responsibility. Unfortunately she could not experience the full benefit of her accomplishment, since she probably felt that she disappointed the therapist, as indicated by her need to rationalise her decisions.

Similar to the previous session a client wish was inferred for the therapist to acknowledge the improvement in her symptoms, but to not overemphasise this as she still needed support and nurturance. When the therapist placed too much emphasis on her improvement she seemed to

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experience the therapist as not seeing her remaining symptoms in a serious enough light. In response to this she started reporting other pain symptoms. This did not seem like a deliberate attempt, but more an outflow of her neediness for external support. In RE4 the therapist tried a different approach, by focussing on her underreporting of her symptoms. This interpretation was more easily accepted, but on the downside could have been incorporated into a perception of being a martyr. Whether this was a useful response is doubtful, but it did seem to result in the client feeling heard and acknowledged.

In this session any attempts from the therapist to make the client take responsibility for her own role in the relationship with her husband was resisted and she responded rather by providing information indicating the impossibility of her situation and examples of how she had already tried. It seemed that the client perceived the therapist's attempts to direct her towards a solution or towards taking more responsibility, as being unreasonable and not truly reflecting an understanding of her situation. Her main need continued to be validation of her suffering and the impossibility of her situation. She wanted the therapist to simply acknowledge her situation, without expectations of her taking responsibility. Possibly she perceived the therapist's responses as judgemental. Although the client was capable of acknowledging and taking credit for her past efforts and successes she resisted any attempts to use this information to motivate her to take more responsibility in the future. She also found any interpretation that may be perceived as criticism very difficult to acknowledge and found ways to rationalise her behaviour.

It seemed that the therapist was slightly more attuned to interpersonal occurrences in this session and tried less to reinforce his own agenda, but to follow what the client was experiencing. In RE7 the client for example felt safe enough to express her feelings of neediness, inability to be alone, and frustration at her husband. These issues which the therapist had previously tried to interpret were thus spontaneously expressed by her, indicating that given conducive circumstances she could look at herself critically, and for example acknowledge her dependence. Within the same context she also became very emotional and was more open to input from the therapist and could acknowledge further interpretations such as her own difficulty in openly sharing her emotions, how needy she was for appreciation and how hard it was for her to suppress her frustration and anger. All issues which, if interpreted, when she did not feel acknowledged and understood, would typical have been resisted. It seemed that the client accepted input from the therapist and was able to

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critically reflect on herself most readily, when the therapist put effort into improving his understanding and perception of her without trying to move her towards a specific goal. It seemed that interpretations that were not threatening, but more enquiring and empathic in terms of how difficult it was for her, were more successful.

Another interesting issue that emerged from the data was how difficult it was for the client to overtly criticise other people. When she for example criticised her husband she reacted to her own response by reprimanding herself and emphasising her husband's good qualities. It may also be that she grew up with a perception that it was not appropriate to criticise other people and specifically your own husband.

Although the therapist in general managed to refrain from directing the client towards specific goals in this session, he failed at this in the final RE, where he started to take responsibility for the client through his need to protect her form her husband and through describing her as precious but fragile. Although the client accepted these interpretations it probably colluded with her sense of fragility and neediness for protection and nurturance. It may also be that even though she was unaware of this, it was the perception that the client wanted people to have of her, since it resulted in her being accepted as special, but also as fragile.

4.2.3.3.2 Connection or relationship between respective REs (Flow of REs)

The session started with subtle attempts by both the client and therapist for their needs to be met. These needs were however opposing. The therapist asked for more time and commitment to therapy, while the client needed more time and freedom from commitment. Although the therapist eventually relinquished his attempts to gain more commitment from the client he expressed his disappointment, resulting in the client experiencing the emotional burden of having disappointed him. In the following RE the client continued with her theme of need for having more free time and for less demands being placed on her by people. The therapist successfully managed to relinquish his own personal needs for more commitment from the client and seemed more focussed on a professional need to interpret and improve the client's insight into her own behaviour. This seemed to reduce the emotional burden on the client, but valuable opportunities for exploring what was occurring in the RE were missed, such as her difficulty in expressing her needs more directly.

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In the following RE the client reported some improvement in her symptoms, but when the therapist was experienced as placing too much emphasis on the relevance of these improvements and not sufficiently acknowledging the seriousness of her symptoms, the client reacted by focussing on other pain symptoms she was experiencing. In this RE an attempt was made by the therapist to lighten the atmosphere, but the client did not seem to respond to it. The client's need to reinforce the seriousness of her symptoms flowed into a subsequent session. Although the therapist initially still tried to re-establish the pain-stress hypothesis, he managed to relinquish this need and focused more on the client's need for the seriousness of her symptoms to be acknowledged. The therapist did the opposite of what he attempted prior to this, i.e. in the place of trying to consolidating her improvement he focused on how her anxiety was actually underreported, in other words that her situation was even worse than she indicated. This seemed to have resulted in the client feeling acknowledged and in this atmosphere the client seemed to feel heard and could again accept the therapist's interpretations.

When the therapist returned to an attempt to get the client to acknowledge her previous successes in her relationship with her husband, she resisted these interpretations and re-emphasised the impossibility of her situation. The therapist responded by trying to show that he was listening. In this atmosphere the client was able to partially acknowledge her dependence, but qualified this by also taking pride in sharing her own attempts at becoming more independent. Any attempts by the therapist for her to continue taking responsibility were resisted.

In this session the therapist gave feedback on the Rorschach protocol that was administered during a previous session. The client did not directly respond to the Rorschach results, but continued focussing on sharing her unmet intimacy needs and a need for her husband and probably people in general to not be too critical of her. Again she seemed to be asking for acknowledgement. When the therapist managed to show empathy and reflected her unmet needs without criticising or blaming, the client seemed to feel safe enough to continue disclosing her feelings of neediness and frustration and anger towards her husband. Within a safe environment, where the therapist put effort into acknowledging the client's need for appreciation, her growing negativity towards herself and how difficult it was for her to suppress her frustration, the client was able to continue sharing and could even reflect critically on herself.

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Although the latter part of the session was in general more conducive to the client accepting interpretations and critically reflecting on herself, it ended with the therapist seemingly trying to end the session on a more positive note by again attempting to boost the client's self-esteem through commending her efforts and sharing his positive experience of her through a metaphor. Although she acknowledged the metaphor, it may also have strengthened her perception of herself as fragile and needing protection from an outside source. In the final RE it seems that the therapist took more responsibility for the client and experienced a need to protect her from her husband. This is in strong contrast to the previous REs where the client was taking more responsibility.

4.2.3.3.3 Possible alternative interventions that could be considered given the new insight

Although the first RE seems to have been "messy" in that the therapist's and client's needs were opposing each other and neither the therapist nor the client was very keen on relinquishing their needs, it provided a useful, but unused, opportunity to reflect on what was happening between the client and therapist. The strong underlying emotional content of these interactions could also have been explored more. I.e. she could have been asked how she felt when she perceived herself as not meeting the therapist's needs. It may be that a more direct approach on the therapist's side may have made it easier for the client to express her own needs, and could have created a space that was different from the type of relational experiences she was used to. Failing to do this, a more accurate reflection of the client's feelings and thoughts may also have been helpful. Her need for more time and difficulty to claim more time could for example have been reflected, as well as how difficult it was for her to tell the therapist that she would have preferred not to have more regular sessions. Attempts to do this in other sessions however failed in that she simply denied that she didn't want to come for more sessions. The client could also have been made aware of how subtly she expressed her needs and what her fears were of expressing them more openly.

In RE3 it seemed that the therapist overemphasised the improvements reported by the client and may have moved at a faster pace than the client was prepared to. The therapist may have reflected that his focus on her improvement may have felt to her like an attempt to discount the seriousness of her other symptoms and that she still needed considerable support and help. Alternatively the therapist could have acknowledged her improvement without creating higher

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expectations than she was prepared to accept. Another possibility would have been for the therapist to interpret her fear that acknowledging her successes would result in expectations for her to take more responsibility.

Possibly interventions such as the Rorschach were not directly useful in terms of sharing the results with the client. The Rorschach could however still have been used to improve the therapist's understanding of the client.

In this session the therapist could have been more aware of his own superficial attempts to boost the client's self esteem through for example providing the metaphor of her being a jewel in a clay pot. It would have been more useful to reflect her own perceptions of herself or, if the therapist included interpretations, to share them in a more neutral manner.

The final reflection is again mentioned here as it constituted part of the context in which this session occurred. In the reflection the therapist commented on the slow progress made in therapy and his perception of himself as failing in therapy. In strong contradiction, after analysing this session, it seemed that session 8 was one of the more successful sessions conducted. In it the client expressed her emotions and was able to accept interpretations. She could also critically reflect on herself, which she typically found too threatening. Although the therapist experienced the session and therapy in general to be progressing too slow, this session may have been the one in which the most progress was made. The therapist was more able to sit with the discomfort and in general managed to refrain from directing the client towards specific outcomes.

4.2.3.4 Integration of the three sessions

Summarising all the findings of the three analysed sessions dilutes the richness of information contained in them. Rather than attempting an exhaustive summary, some points that seemed particularly pertinent are highlighted in this section. This is again done roughly under the three headings used in the integration of the individual sessions, except that the second category also deals with the connection or flow between the three sessions analysed and not only with the connection or relationship between individual REs. Some references from literature dealing with general therapeutic principles, that are not specifically associated with

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particular theoretical orientations, and that were observed in the results of this study, are also provided in this section.

4.2.3.5.1 Contribution to general understanding of therapist client interaction

The first category was subdivided into three subcategories to show specific contributions to understanding the client and therapist individually, followed by improved understanding of their interaction. This was done in order to organise the wealth of information in a logical manner. Clearly some overlap between these categories will however occur.

Improved understanding of the client

Within the context of the therapeutic relationship, the client presented in a particular manner. It is important to note that this presentation does not necessarily represent intrapsychic characteristics, but could also be viewed as context dependent or relational phenomena (Sullivan, 1979). Overall the client presented as very vulnerable, sensitive, fragile, dependent and lonely.

Reich and Neenan (1986) emphasise the importance of identifying individual needs of a client in order to select effective interventions in shorter term supportive therapies. The following needs could be identified for this client:

- need for being heard and understood
- need for acknowledgement of her efforts and suffering
- need for comfort, nurturance and protection
- need for people to place fewer demands on her
- need for more tolerance and less criticism
- need for people to not get angry with her
- need for acknowledgement of her sensitive nature
- need for less seriousness and more spontaneity in her life
- need for more hope

Some of the needs mentioned above, such as being heard and understood, and feeling acknowledged are common needs experienced by most clients in therapy (Kleinke, 1994; Reich & Reenan, 1986; Teyber, 1992; Truant & Lohrenz, 1993), while others seems more specifically related to this client, such as her need for people to place fewer demands on her,

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need for people to not get angry with her, need for acknowledgement of her sensitive nature, etc. Unfortunately it seemed that the therapist did not at all times sufficiently validate the client's needs. According to Teyber (1992) validation of client experiences is one of the most effective ways therapists can help their clients change. In this therapy the client did not seem to perceive most of her needs as being met and further did not seem to feel worthwhile of having her needs met. She seemed to feel ashamed of her own neediness and dependence and rather seemed to have expectations of herself meeting other people's needs. The client did not seem to perceive herself as having value in other people's lives. Despite her vulnerability she also presented as proud. She seemed to find it extremely difficult to ask for her needs to be met directly and seemed to feel ashamed at being perceived as a burden to others. Related to this seemed to be a fear of loosing her self respect. During periods when she did have more resources, she seemed to use this to control her emotional expression, creating a false impression of improvement. The client's symptoms seemed to have been a way to satisfy her needs. Although some degree of self nurturance could be inferred, this seemed to be more in the form of self pity. She for example rationalised her use of medication in the context of the suffering she was enduring.

The client also seemed to have an extreme fear of criticism and of disappointing others. She was for example very sensitive to any perceived criticism from the therapist and tried to avoid disappointing him. Similarly she did not feel it was appropriate to criticise other people such as her husband. The client found it difficult to confront the therapist and to show her frustration directly, but rather used indirect methods, such as rejection of interpretations and offered help, to indicate that her needs were being obstructed. Research has shown that patients who are unable to express disagreements with their therapist's directly report less improvement in therapy, while those that can express a small amount of hostility do better (Clemence, Hilsenroth, Ackerman, Strassle & Handler, 2005).

Another important aspect of this client's presentation was that throughout all the sessions she managed to avoid taking responsibility for her behaviour. Patterson (1986) suggests that all therapies, including more directive approaches, expect active participation by the client. Taking responsibility for their role in therapy thus seems to be an important predictor of successful therapeutic outcomes across different therapeutic modalities. Related to taking responsibility is motivation to change. Garfiel (1980) however warns that more defensive clients and clients who suffer from somatic symptoms, such as the client in this study, are

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often mistakenly perceived as not being motivated for therapy. The importance of clients taking responsibility for their role in therapy is further addressed in the section dealing with therapist-client interaction.

Improved understanding of the therapist

Similar to the above section, an attempt is made here to integrate the results of how the therapist presented in therapy. In the analysed sessions one of the most prominent presentations seemed to be one of insecurity. The therapist seemed to have often doubted his own ability to be of help to the client. One specific instance of this was his perception of being unable to deal with criticism or anger from the client. According to Teyber (1992) therapists often struggle most to deal with client's angry and critical feelings towards them, but that failure to attend to them can often result in therapy failing. The therapist also showed a tendency to try to find solutions. Although it may have been related to his insecurity, it may also present a general tendency in the therapist. Another important aspect of the therapist's presentation was his tendency to take too much responsibility. Some needs that were identified in therapy were as follows:

- need to help the client and to reduce her suffering
- need to provide solutions
- need to protect the client
- need for confirmation of usefulness from the client

Teyber (1992) described typical reactions of therapists taking too much responsibility. Some of these reactions, such as he following, are clearly similar to what was observed above:

- Becoming anxious and changing the topic
- Becoming more directive
- Reassuring the client
- Diminishing the client by trying to rescue him or her

The presenting tendencies and needs identified above at times occupied the therapist to such an extent that he became less attuned to the client's needs in the moment. The here-and-now has been emphasised as being essential in monitoring the interpersonal process occurring between therapist and client (Sullivan, 1997; Kleinke, 1994). The most extreme instances of

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the therapist not sufficiently attending to the here-and-now were where he engaged in short monologues, nearly completely excluding the client.

Improved understanding of the client-therapist relationship

The importance of a good therapeutic alliance or working relationship between client and therapist seems to be common across different therapies (Clarkson & Pokorny, 1994; Decker, 1988; Kleinke, 1994; Patterson, 1986). Although many therapists are threatened by evidence that the relationship involving personal factors of the therapist, such as empathic understanding, respect, warmth, and therapeutic genuineness, is a necessary and sufficient condition for therapeutic change, there are according to Patterson "little or no evidence for the effectiveness of any other variables or techniques or for the effectiveness of other methods or approaches in the absence of these conditions" (p. 562). Understanding the therapist-client relationship is thus crucial and an attempt is made to integrate the insight gained from the analysis regarding the client-therapist interaction in this section. The previous two sections, summarising insights regarding the client and therapist's presentations and needs in therapy, were provided to set the scene for this discussion. If the most prominent needs had to be selected it would probably be a need from the client's side to be acknowledged, heard and understood, while the therapist's main needs seemed to have been centred around stopping the client's suffering and providing solutions. This last need was probably related to feelings of insecurity in the therapist and this also resulted in a need for confirmation by the client of his usefulness. The above needs were however often opposing each other, resulting in a type of power struggle that often ended in a deadlock, with the therapist temporarily relinquishing his needs, only to attempt satisfying them again at a later stage. It also became apparent that both the therapist and client employed indirect ways to satisfy their needs. The dynamics of this push and pull process between the client and therapist are the main focus of the following paragraphs.

The therapist's attempts to meet his own needs were mainly through the following interventions:

- Actively focussing on finding solutions to the client's difficulties
- Actively directing the client towards a solution, through interpretations, suggestions etc.
- Encouraging the client to examine her own role in her interpersonal difficulties
- Encouraging the client to take more responsibility

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- Boosting the client's self esteem and sense of efficacy
- Convincing the client of his ability to be of help to her

Mostly the above interventions seemed ineffective and resulted in the client becoming more guarded and less responsive. This occurred especially when the therapist's inputs were perceived as criticism directed at her. It seemed that these interventions interfered with the client's own needs, i.e. she did not feel acknowledged, understood and heard and this resulted in her feeling more helpless, depressed, overburdened and out of control. According to Neuhaus and Astwood (1980), one of clients' most pervasive fears during therapy is of the therapist not understanding and accepting their thoughts feelings and experiences. Reich and Neenan (1986) also mention that if clients do not perceive the therapist as understanding their problem or as being interested in them, the chances of successful therapy are significantly reduced, even if the therapist objectively understands the client well and is interested in the client.

In this therapy the client's hope of the therapist being different from other people seemed to gradually diminish. According to Reich and Neenan (1986) a primary requisite of therapy is the restoration of hope. In this therapy the client seemed to loose hope that the therapist would be able to help her. The client's first reaction to not feeling acknowledged, heard and understood was often to become less responsive. Typically the therapist's needs were then even more frustrated resulting in him trying even harder and feeling even more uncomfortable, insecure and helpless. This preoccupation of the therapist often resulted in him not being sufficiently attuned to the client's needs in the moment. When this situation became unbearable the client typically became more resistant. Although her difficulty to express her needs openly hindered direct expression of her needs or her frustration with the therapist, she managed to employ indirect methods to convey that her needs were not being met, such as the following:

- Reported more intense, varied and frequent symptoms
- Reported more extreme events to illustrate the impossibility of her situation and support her reasons for not being able to take more responsibility
- Indirectly rejected interpretations and suggestions offered by the therapist

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Although the client mostly managed to indirectly convey the message that her needs were not being met, she did not experience the full benefit of her accomplishments, because she experienced herself as disappointing the therapist. This was exacerbated by the therapist's insecurity, which in one or two instances became too apparent and resulted in the client feeling burdened by a need to comfort and reassure the therapist. Some authors have suggested that therapist self-confidence may be an important facet of the relationship in successful therapy (Eaton, 1989; Patterson, 1986). Lack of confidence clearly impacted negatively on the effectiveness of the therapeutic relationship in this study.

The client in general seemed more open to input from the therapist in the following scenarios:

- When the therapist's goal directedness was less obvious
- When the therapist made more neutral inquisitive inquiries to better understand the client
- When the therapist empathically reflected and acknowledged the client

Under the above circumstances the client was more open to interpretations of herself for example being capable, sensitive and a peacemaker. She could also spontaneously critically evaluate herself in terms of being a dependent and needy person. Typically when this occurred the therapist experienced some relief in anxiety as well as a degree of satisfaction. From the above list it should be clear that empathic listening was an important component of more successful client-therapist interactions. Truant and Lohrenz (1993) observed that many therapists, in particular novel therapists, underestimate the process of effective listening, in particular when they feel pressured to do something in therapy. The importance of therapist empathy in the current therapy was mentioned above and has been mentioned on a few occasions in this research. This is not surprising, since empathy is probably the most commonly identified relational element in successful therapies (Patterson, 1986).

Although some therapist actions resulted in the client sharing more openly, it was considered to collude with less adaptive views of herself. Some of these, such as the following, for example colluded with her perception of being a victim and a martyr:

- The therapist at one stage allied with the client against her husband
- The therapist interpreted her underreporting of her symptoms

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Two other therapist interactions that colluded with her perception of being helpless and needy of external nurturance and protection were:

- The therapist at times treated the client in a very tentative way
- The therapist at times tried to comfort and reassure the client

According to Kleinke (1994), although it is mostly appropriate to show empathy, attempts at rescuing the client through reassurance and gratification of dependency needs should always be carefully considered, since it may often be that in the long run the client will benefit from finding their own solutions to their difficulties.

An important interplay occurred between therapist and client in terms of taking responsibility. It has already been mentioned that the client tended to avoid taking responsibility, while the therapist typically took on too much responsibility. In their interactions, although the therapist tried to encourage the client to take more responsibility, she effectively managed to avoid this, resulting in the therapist generally taking more responsibility. One important example of this was regarding termination, where the therapist tried to encourage a larger commitment to therapy from the client, the client in turn tried to avoid taking responsibility for the possibility of her eventually deciding to terminate therapy. According to Garfield (1980) young therapists often have unrealistic expectations regarding the length of therapy. They often expect psychotherapy to be longstanding and expect that the client shares this expectation. Teyber (1992) also mentions that novice therapists often have a strong need for their clients to like them, find their therapy useful and to keep coming to therapy. It was previously mentioned that the therapist in this study was often preoccupied with the client terminating prematurely. Regardless of the fact that the client, who was initially asked to commit to a minimum of four sessions, stayed in therapy for eight sessions, the therapist still seemed to have had an expectation or hope of the client staying in therapy for a longer period. More realistic expectations would have resulted in the therapist experiencing less anxiety.

Termination was further complicated by a related issue. The therapist's insecurity seemed to place a burden on the client, resulting in therapy becoming less appealing to her. According to Kleinke (1994) therapists often experience self doubt, self-depreciation and depression and may question their own competence during termination. The therapist may then become dependent on the client for reassurance regarding their clinical skills and personal value.

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Clearly this therapist struggled with many of these issues, and the client at times reacted to his insecurities by for example experiencing a need to comfort and reassure him.

Reflecting on this therapy it may have been worthwhile to have spent more time on establishing the client's expectations of therapy. Expectant readiness is considered a common principle of therapeutic change (Mahrer, 1989) and many therapies use methods aimed at placing the client in such a state of expectancy. Reich and Neenan (1986) also acknowledge the importance of realistic expectations for success in shorter term therapies. According to Garfield (1980) many therapists overlook the fact that many clients are not knowledgeable and do not necessarily have realistic expectations of therapy. Truant and Lohrenz (1993) suggest that initially after full assessment of the client's situation, goals should be set jointly between the therapist and the client. Helping the client to have expectancies that are realistic may therefore benefit therapeutic change. Disconfirmation of client expectations has been related to adverse effects on therapeutic outcome as well as premature termination (Horenstein & Kent, 1976; Patterson, 1986). Clarifying and addressing client expectations more specifically at the start of therapy may have reduced client disillusionment regarding therapy.

Some paradoxes emerged from the analyses. The first was that although the client wished her efforts to be acknowledged and experienced some consolement when this need was met, she was reluctant to fully own responsibility, due to fears of creating expectations of her taking more responsibility and creating the perception that she was less needy of external support. The second related paradox was that although the client wanted therapy to be a place where she could show her vulnerability, her perception of being vulnerable was threatening her self respect. As a result, when she had more resources available, she often used this to be more in control of her emotions than she actually felt, resulting in the appearance of improvement.

The results of this section indicate that the therapist and client often deemed very different aspects important in therapy. The client's focus was generally on being acknowledged, heard and understood in the moment, while the therapist was often more centred on a cognitive endeavour of guiding the client towards a solution through interpretations etc. A phenomenological study in which participants who were involved as both therapists and clients in therapy, were asked to indicate what they viewed as being most therapeutic in therapy, revealed that the same participants emphasised different aspects in therapy,

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depending on the role they were filling (Straker & Becker, 1997). In their client role participants emphasised the importance of the therapist's attentional-being-with them and the emotional tone of the relationship and downplayed cognitive factors, while in their therapist role, although they acknowledged strong emotional content, they focussed on form and content and containment through cognitive insights. These findings seem congruent with the results of the current study. Being more aware of what is experienced by the client as facilitating change should generally increase the overall efficiency of therapy and may have benefited the current client.

Reflection on the results of this section, made the therapist more aware of the difficulty in working with the current client. The extent of the client's resistance against taking responsibility and how this severely limited the therapist's options became clearer. According to Reich and Neenan (1986) motivation is one of the most important prognostic indicators. In order for the client to move closer to a resolution of her difficulties she first needed to take more responsibility. Prior to this occurring the therapist's main function would have been to listen and reflect on what the client was saying without colluding with her perceptions of not being capable of helping herself. This would probably have been a lengthy process, for which the therapist did not seem to have the necessary patience or security. Truant and Lohrenz (1993) emphasize the importance of the therapist having the tolerance of "not knowing" (p. 15) as an important aspect of the therapeutic stance. Rather, in this study, the therapist often probed whether the client was readier to take responsibility, creating a type of power struggle between the client and the therapist. Truant and Lohrenz (1993) mentions that when clients do not take responsibility for their role in therapy, it becomes a crucial aspect of therapy, since it probably constitutes part of the relational difficulties that led to them coming for therapy in the first place. They emphasise the importance of addressing issues related to not taking responsibility, since it often constitute the client's best way of dealing with difficult situations. If unaddressed due to the therapist's anxiety it may result in premature termination (Teyber, 1992).

Although the therapist was probably less directive than people outside of therapy, it is highly likely that his actions resembled the response of people towards the client outside of therapy. Related to this theme was an interesting interplay between the client's perception that nobody could help her and the therapist's perception and anxieties about not being able to help the client. This resulted in both feeling less hopeful about the usefulness of therapy. According to

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Clemence, Hilsenroth, Ackerman, Strassle and Handler (2005) forward moving therapies have been related to the hopefulness of both the therapist and the client. They also identified clients' confidence and commitment to therapy as significant factors in the alliance as well as the process and outcome of therapy. Losing hope may also result in clients discontinuing therapy (Patterson, 1986).

4.2.3.5.2 Connection or relationship between respective REs (Flow of REs)

A meta-analysis of the flow of experiences within sessions 2, 5 and 8 revealed interesting patterns in the movement within therapy sessions. In all the sessions there was an ebb and flow between attempts of either the therapist or the client trying to satisfy their needs. Mostly it seemed as if the movements between these states were modulated by the therapist and not the client. In one state the therapist for example displayed a strong need for providing a solution in order to decrease his own sense of insecurity and discomfort. The therapist would then typically continue with this theme until the client sufficiently resisted such a definition of the relationship, resulting in the therapist temporarily relinquishing his need, and returning to a more empathic reflective position. The client then typically shared more and felt less pressured and more heard and acknowledged. Often however the therapist's unmet needs would return at a later point in the therapy session and the pattern would again repeat.

When transcribing the sessions, the therapist did not reflect awareness of the above movements in therapy sessions, probably indicating that even then the therapist was not fully aware of these changes. Higher awareness of these movements could have helped the therapist to understand what was occurring interpersonally. These movements between states seemed to be slow and often occurred over two or three relational experiences. Full awareness of them will always be difficult in that considerable energy is typically required to be in the moment with the client. Some level of awareness of these movements in therapy may however be beneficial in that these patterns constitute part of the context and are therefore also necessary to understand the moments.

A review of the sessions also revealed a distinction between the beginning, middle and end of sessions. In the beginning of sessions it seemed to be more mechanical for the therapist to simply reflect or gain more information from the client. Usually this instigated the middle of the session, with the therapist trying to use the new information to provide a solution and some direction to the client's difficulties. Often this resulted in a type of power struggle

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between the client's needs for being acknowledged and the therapist's need to provide help and a solution. Often still during the middle phase of the session, the therapist would manage to relinquish his needs temporarily, resulting in a higher intensity of disclosure on the part of the client. The latter typically constituted the end of the middle phase of a session. During the final phase of a session, different issues typically emerged. There also seemed to often be an attempt by the therapist to end the sessions on a more positive note. Themes broadly related to termination of therapy also often occurred.

Looking back over the three sessions, it seems from the analysis that the therapist managed to be most attuned to the client in the final session. Although the reasons for this are not clear, the therapist seemed more successful at containing his own discomfort and was less directive in the session. Given that this session was conducted several weeks after initiation of therapy and that this client was the therapist's first client during his MA1, it seems reasonable to conclude that it may have reflected some reduction in the therapist's own insecurity regarding his ability to be of help to clients. At the time of the final session the therapist had conducted many therapy sessions with different clients.

4.2.3.5.3 Possible alternative interventions that could be considered given the new insight

In this section possible alternatives that the therapist could have considered in the three analysed sessions are provided. These alternatives are divided into three categories, firstly general alternative interventions that the therapist could have considered or tried, followed by interventions that seemed less useful and could possibly have been avoided, and finally specific interpretations that may have been beneficial for this client. It is important to emphasise that these suggestions may have resulted in their own difficulties and that the client's response to them would have determined their usefulness. Although categorisation of useful and less useful categories may be criticised, since even less successful interventions or actions by the therapist can be useful in providing guidance in terms of further interventions, the categorization was attempted in order to provide a structure for presenting the data in a logical way. More important than the usefulness of a specific intervention by the therapist is probably what the therapist learned from the intervention and how the client responded to the therapist's intervention.

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Some general interventions or actions flowing from the analysis that the therapist may consider in future are presented in this paragraph. In general the analysis suggested that the client could have benefited from the therapist being more attuned to her in the moment. One practical cue the therapist may use in future to improve this will be to be more aware of the amount of talking done by him. The therapist could also have spent more time focussing on the client's responses to his interventions. Valuable opportunities for interpretation and reflection were missed, with the therapist tending to move to different topics too quickly. Teyber (1992) mentions how performance anxiety can cause therapists to be less empathetic and to push clients towards premature change. Truant and Lohrenz (1993) emphasise the importance of staying with specific significant events or topics, avoiding abstraction and generalization, until the particular pattern is clear. In general it seemed that the most useful interactions between the client and therapist were when the therapist reflected as accurately as possible the client's perception of herself and her responses to the therapist interventions. The therapist could also have considered asking the client what she needed from therapy and what her fears were in therapy. Finally it seemed that the therapist could in future consider dealing with his own sense of insecurity differently. Some suggestions include:

- Being more aware of his insecurities and avoiding acting on them, such as for example trying to convince the client of his ability to help her, or motivating specific actions taken in therapy.
- Being more empathic towards himself

Truant and Lohrenz (1993) stress the importance of therapists being aware of the significance of their own emotional responses in therapy. Trying to convince the client and to reassure the client of his ability to be of value seems in this case to have been a defence against the therapist's underlying insecurity. Neuhaus and Astwood (1980) mention the importance of a therapist being non-defensive and that the best way to deal with such reactions is through acknowledgement and acceptance of their inevitability. Acknowledging and accepting these reactions can also be seen as an act of empathy by the therapist towards himself. Patterson (1986) also mentions that one of the characteristics the most effective therapists ascribe to themselves is being optimistic (Patterson, 1986). Being more accepting and empathic towards his/her own insecurity and maintaining an optimistic attitude therefore seems to be important characteristics of successful therapists.

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Some interventions and actions seemed to have been less useful. With this client the therapist could have in general tried less hard:

- To provide solutions and direct the client
- To encourage the client to take more responsibility
- To boost the client's sense of self-efficacy and self-esteem
- To convince her that she was safe in therapy
- To provide hope

Further the therapist:

- Could have been more aware of his own tendency to take responsibility and the client's need for other people to take responsibility for her
- Could have been more careful to side with the client against her husband
- Could have spent less time comforting and assuring the client
- Could have been less tentative in making interpretations or suggestions and in explaining reasons for actions taken in therapy

Some of the possible interpretations that could have been considered are listed below:

- Client's need for approval
- Client's pride at sexual accomplishment
- Client's fear of acknowledging her past accomplishments in her relational difficulties, due to fears of having to take more responsibility in future
- Client's fear of creating expectations of being able to take more responsibility in future
- How the client's appearance of being improved was an attempt to maintain her self respect
- Her uncertainty about the therapist's ability to help her
- How difficult it was for her to express her needs
- Her sense of hopelessness
- How hard she was trying to stay hopeful about the future and how difficult it was for her
- How important it was for her to not disappoint the therapist
- Her feeling of being alone in her suffering
- Her perception that nobody could understand or help her
- Her inferred self blame for her current difficulties
- Her shame at the neediness she felt

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- Her need to be needed and to be of value to other people
- How difficult it was for her to show her vulnerability
- How helpless and fragile she felt

One overall reflection on the analysis is that the therapist seemed to have found it easier to reflect on his shortcomings in therapy than on his successes. This is important in more than one way. On the one hand it illustrates the subjectivity of the current research and that it is seen through the therapist's eyes and coloured by his own psychological make-up. Although an attempt at neutrality was made, the results indicated the therapist's limited capacity to see his own successful interventions. Ironically this more critical attitude is probably related to the therapist's sense of insecurity and discomfort in the sessions, which was his main obstacle in the current therapy. An important outcome is therefore that a less critical attitude towards self would have created less discomfort for both the therapist and the client and therefore may have created a more conducive atmosphere for therapy. An attempt to view data as an external observer, when the researcher was in fact also a participant, was thus clearly impossible. Perhaps the closest to managing this is a final reflection on this paragraph: During re-examination of the data, the researcher was capable of feeling more empathy towards himself as he became aware of how he had struggled through his own insecurities as a novice therapist. The therapist could also acknowledge that although the successful parts of therapy were less conspicuous to him, due to his own biases, therapy may have been more useful to the client than he initially thought. Evidence of this includes for example the client's comments during the final telephone conversation on how much she valued her interaction with the therapist on a human level. The ability of the researcher to have more empathy with himself thus indicates that the current research also had therapeutic utility for the therapist.

4.3 Conclusion

In this chapter the results of the case study conducted with the newly developed method was presented. The analysis not only resulted in improved understanding of the client and therapist on an individual level, but also resulted in considerable new insight into the nature of the therapist-client relationship, which was one of the aims of this study. One indicator of this improved understanding is the multiple alternative strategies that could be suggested from the analysis. This included specific interventions that the therapist could have considered with this client as well as interventions that could have been avoided. Some of the results seemed

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to be potentially applicable to other clients as well and may therefore guide the therapist in future therapy sessions with new clients.

It was shown that, despite the researcher's efforts, it was impossible to do the analysis as if conducted by an external observer. Despite this shortcoming, considerable new information was gained from the analysis. Paradoxically the subjective component inherent in the analysis due to the researcher's role as a participant, proved useful in that the therapist could also not distance himself from the results pertaining to himself. The therapist for example became more aware of his tendency to not be empathic towards himself and how this negatively impacted on therapy. This will probably prove to be of value to the therapist as well as to his clients in future therapy sessions.

In this chapter the usefulness of the results of the analysis, using the new method was presented. Overall the results as presented in this chapter should be sufficient to indicate that the new method of analysis resulted in considerable new insight into the nature of the client-therapist relationship. Evaluation of the new method as a general tool for analysing therapeutic notes have however not been addressed and this is attempted in the final chapter.

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CHAPTER 5: EVALUATION OF THE USEFULNESS OF THE STUDY

He is quick, thinking in clear images;
I am slow, thinking in broken images.

He becomes dull, trusting to his clear images;
I become sharp, mistrusting my broken images.

Trusting his images, he assumes their relevance;
Mistrusting my images, I question their relevance.

Assuming their relevance, he assumes the fact;
Questioning their relevance, I question the fact.

When the fact fails him, he questions his senses;
When the fact fails me, I approve my senses.

He continues quick and dull in his clear images;
I continue slow and sharp in my broken images.

He is in new confusion of his understanding;
I am in a new understanding of my confusion.

In broken images Robert Graves

5.1 Introduction

The current study was an interpretative, qualitative design conducted within a phenomenological theoretical orientation. Since the aim of interpretative research is not to uncover facts or to realise accurate models, but rather to describe and to increase

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understanding of the phenomena under consideration (Babbie & Mouton, 2001), its results are always partially subjective and open to different interpretations. Analogously to Robert Grave's poem, interpretive research mostly does not result in clear images, but rather in broken images - more questions arise and there is always room for improved understanding. This does not imply that the new confusion flowing from our understanding is not useful. In fact, as mentioned before, Kruger (1991) believes interpretation is a necessary component of all meaningful psychological research. More important is whether the research resulted in improved understanding of the interpersonal interactions under investigation.

In the context of the current research three important questions needed to be addressed in order to evaluate its usefulness. The first of these concerns the trustworthiness of the results. The second, whether the research was conducive to a better understanding of the phenomena under consideration, has already been addressed in chapter 4. The third related question was whether the improved understanding resulting from application of the *new* methodology justified the effort put into the analysis. The above questions are explored in the following sessions under the following headings: trustworthiness of results followed by discussions related to the advantages and limitations of the current study. Finally possible changes to the new methodology that may be considered prior to future application are discussed.

5.2 Trustworthiness of results

Trustworthiness was defined as the neutrality of research findings or decisions (Babbie & Mouton, 2001). As mentioned before, interpretation clearly implies a subjective component and in the current study it is of particular importance since one of the participants, namely the therapist also constituted the researcher. Since alternative explanations or interpretations are possible, methods for increasing trustworthiness were imperative. Most of the ways to increase trustworthiness were thoroughly discussed in a previous section. Only two components of trustworthiness are revisited here, because it makes more sense after having viewed the results.

The first of these is in terms of prolonged engagement and observation. It was mentioned before that this was achieved through the use of several sessions. Analysis of three sessions revealed that although analysis of more than one session resulted in more detailed content information pertaining to both the therapist and client, the general trends in terms of the type

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and process of interaction between the therapist and client were very similar in all three sessions. I.e. many of the themes were already observable after analysis of only one session, and thereafter re-occurred in subsequent sessions. This re-occurrence of themes indicates saturation in terms of information related to the client therapist interaction, which increases the trustworthiness of results.

The second aspect of trustworthiness revisited here, is in terms of peer review. In this case the results were only reviewed and monitored by a supervisor. In general the supervisor agreed with the results of the analysis, but challenged a few of the conclusions. The supervisor's input was used to reflect on the results, resulting in a few modifications to the conclusions made.

5.3 Subjective evaluation of usefulness of the new methodology

The advantages and limitations of the new methodology are discussed in the following two sections.

5.3.1 Advantages of using the modified methodology

The strengths and advantages of using the new proposed methodology are provided in this section:

- It has already been shown in chapter 4 how the method resulted in considerable new insight into the nature of the relationship between the therapist and client. Although the modified approach was only applied to one case study in this research it should be possible to apply it to any transcript of therapy sessions, consisting of sufficiently rich information.
- One of the aims of this research was to provide a tool to investigate transcriptions that are not strongly linked to a particular school of thought. Although generally based on a phenomenological approach, it should be possible to apply the results of the method within other schools of thought. The analysis was exploratory and descriptive in nature and the resulting data can be used as a basis to formulate hypotheses or theories or verify existing theories in different schools of thought.
- Compared to the DPRM the modified methodology provided more structure to evaluate the data under consideration. Although the assumptions inherent in suggesting such a structure for ordering data may obscure emergence of some meaning, it was found that

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the meticulous intense scrutiny of the data that was required to think in terms of the structure resulted in increased insight. Further, meaning emerging from the data that could not specifically fit into the structure of the UIRS was not excluded from consideration, but was included in the notes following each UIRS. Although the UIRS was thus used to order data, it was not seen as the only access to meaning in the data under consideration.

- In the current study an attempt was made to take context into account, through examining of a particular RE in the context of the other REs in a particular session. Thinking in terms of context was encouraged through a formal attempt within the analysis to monitor the flow of experience between different REs. This was shown to provide valuable information in terms of changes occurring within sessions.
- Although three full therapeutic sessions were analysed in this research, it was found that many themes in terms of the client therapist relationship re-occurred in subsequent sessions. Analysis of only one session was thus already sufficient to provide valuable insight in terms of the client-therapist relationship and could already provide valuable suggestions in terms of future therapy sessions. The possibility of only examining one session at the start of a new therapy with a client could therefore be considered. Thereafter analysis of only specific critical or confusing sections of therapy sessions may be conducted. These follow up analyses will not necessarily have to be conducted as formally as was the case in this study. With practice it should be possible to quickly evaluate a particular RE in terms of the UIRS. Should a more detailed examination in terms of process as well as content be required, full analysis of sessions will however be advisable.
- Although this was a case study and interaction with only one specific client was considered, it is highly likely that the improved understanding in terms of the therapist's interaction with this client should also apply to similar situations with other clients. Further research will however be needed to verify this hypothesis.

5.3.2 Limitations of the current study

Some of the limitations of the current research have already been mentioned in the previous section, but will be summarised here together with other limitations.

- It has been mentioned that the assumption that REs can be structured in terms of WIN/s are not purely phenomenological. It has been argued that the modified methodology does

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not necessarily violate the criteria for a phenomenological study, but rather adds another means of evaluating the data under consideration.

- As discussed before, the therapeutic notes used in this research are not true copies of the verbal communication in therapy, but could rather be considered elaborate process notes presented in the format of transcripts. Since these notes were reconstructed from notes taken in therapy and are limited in accuracy by the researcher's memory it can be criticised as being subjective and inaccurate and therefore being inappropriate for a scientific study. Although the relevance of such an objection cannot be denied some qualifying remarks may also be made. The therapeutic notes used were compiled several months prior to the decision being made to include them in this research and could therefore not deliberately or inadvertently have been constructed to steer the outcome of this study in a particular direction. Further, no form of recording device can fully capture relational experiences in therapy and although electronic devices such as video recorders may be more accurate to capture what occurred during therapy they have the disadvantage of also influencing the therapeutic interaction. Both participants, namely the therapist and client may react differently with the pre-knowledge that they are being recorded (Balint, Omstein & Balint, 1972). The client in particular may be less likely to disclose sensitive information. Finally and perhaps most importantly, the current research was defined as being concerned with the therapist's perspective of relational experiences in therapy. This does not imply that the client's perspective of relational experiences was discounted, but simply that the former was more accessible from the available data and was therefore the focus of the study. From such a perspective the therapist actually becomes the main participant in this study.
- The UIRS was developed through an iterative process of fitting its structure to therapy sessions conducted by one therapist with a specific client. Although the final UIRS intuitively makes sense as a logical sequence of steps in any relational experience in therapy and is still to a large extent based on the well researched CCRT method, it may be that transcripts of sessions with a different client and therapist will not fit the current UIRS equally well. Further research will be required to verify this.
- Initially it was difficult to demarcate REs. With practice this became easier. It also seemed that different demarcations would not have resulted in drastically different understandings. Further research will however also be required to verify this fully.

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- Completion of the UIRS was also initially difficult, but became easier with practice. Application of the UIRS by new users will therefore be time consuming.
- Since this research is also concerned with the therapist's influence on and response to relational experiences, the therapist's reflections and observations included in the therapeutic notes provide valuable additional information in terms of analysis. The current study could have benefited form more such reflections and observations. It is therefore suggested that detailed reflections and observations should be included in future transcriptions, targeted for analysis with the new method. Further, in order to improve the trustworthiness of transcriptions, it will be advisable to complete them as soon as possible after conclusion of a session.

In the above two sections the advantages and limitations of the new methodology were discussed. The advantages seem to outweigh the disadvantages, indicating that the new method may be considered for use as a general tool for analysing transcripts of therapy sessions. In the following section possible modifications that may be considered prior to future application of the method are discussed.

5.4 Possible changes that may be considered prior to future application

During analysis some modifications of the current UIRS were considered, as summarised below:

- The WIN/s section should be expanded to also consider wishes not only related to other people, but also to the person him/herself and life in general. In this study this was done, although it did not strictly fit the description in the UIRS.
- In some REs it seemed that the final spaces provided for the therapist's response to the RE and the client's response to this were unnecessary. Omission of these spaces may therefore be considered, since most of the information contained in them, can often also be subsumed in different areas of the UIRS. In some of the REs the spaces did however make sense and at present the researcher is not sure whether omission will necessary be an improvement.
- The space provided for the therapist's WIN/s related to people outside of therapy was very seldom used, and in the cases it was used, the analysis generally suggested that it may have been less useful in a therapeutic context. Although omission of this space may

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therefore be considered, it may also be retained in terms of providing a flag for investigation of a potentially less useful therapeutic response by the therapist.

Except for the first minor modification suggested above, the UIRS in its present form thus seems to be sufficient for application within the modified methodology. As mentioned previously, it seems likely that the UIRS will also fit transcriptions of therapy sessions with different clients and therapists, but further research is required to verify this.

5.5 Conclusion

In this study integration of a novel adaptation of Luborsky's Core Conflictual Relationship Theme (CCRT) method within a phenomenological methodology was proposed. In chapter 2 it was shown such an integration is possible without violating the criteria for a phenomenological study and that the integration could potentially combine benefits of both methods. In chapter 4 this new method was applied to a case study consisting of therapeutic notes of therapy sessions conducted by the researcher. It was shown that the modified methodology resulted in improved understanding of therapist-client relationships, thus achieving one of the main aims of the current study. Analysis of the flow of experiences also proved valuable in terms of understanding individual REs in the context of overall therapy sessions. Finally the results could be used to suggest possible alternative interventions, including for example interpretations that would have been beneficial or should rather have been avoided. The results of the study also had therapeutic value for the therapist in that he came to a new understanding of himself, in particular in terms of his insecurity and tendency to not have empathy towards himself.

In chapter 5 the usefulness of the new methodology was evaluated. The advantages of using the new methodology were shown to outweigh the limitations of the method. Some of the main advantages can also be seen as the main contributions of the current study. The modified method's main contribution was a more structured approach for the identification of meaning units as well as a more formal way to include context, through evaluation of the flow of experiences between REs. The integration seemed to effectively combine benefits of both methods, in terms of providing a more structured way of evaluating meaning units in transcripts, as well as through retaining the depth and richness of recorded relational experiences. Another important asset of the new methodology is that it is not strongly linked

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to a particular school of psychological thought, making it more widely applicable. The main drawbacks of the method were the difficulty in demarcating REs as well as ordering information in the UIRS, making it time consuming to apply. Although this improved as the researcher's expertise at using the new technique improved, and analysis of only specific critical sections of transcripts of therapy sessions circumvents this difficulty to some extent, considerable practice or training will still be required by new researchers applying the modified methodology.

Although further research is required to verify some of the conclusions and suggestions made in terms of the usefulness of the new methodology, it seems that the new method can make a methodological contribution. It also has the potential for becoming a general instrument for analysing transcripts of therapy sessions.

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APPENDICES

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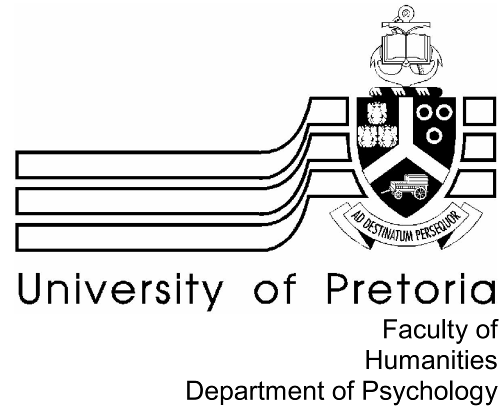
Appendix A: Consent Form



Faculty of
Humanities
Department of Psychology

Dear madam,

You were previously approached by myself, JC Kruger, to obtain your preliminary consent to partake in a research study that will be conducted by me through the University of Pretoria. The current letter provides information as to the nature of the research that will be conducted. Also attached is an informed consent letter, which should be signed should you still wish to give your consent to partake in the current research study after reading the current letter.

Should you require additional information or have any queries regarding the current information or the research in future, you are welcome to contact either myself or my supervisor at the University of Pretoria. Our contact details are as follows:

Prof J Schoeman (Tel number: 012 420 2305)
or JC Kruger (Cell: 0836708026)
Department of Psychology
Faculty of Humanities
University of Pretoria

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For your information the proposed title of the current study is: An adaptation of Luborsky's Core Conflictual Relationship Theme (CCRT) method: a phenomenological case study.

A brief summary of the proposed research is provided in this paragraph. In this study an attempt will be made to apply a new way of analysing transcripts of therapy sessions. In order to do this, detailed transcripts of therapy sessions were required. Since detailed notes of your therapy sessions were kept, your therapy was considered for this research. In the current study the focus will not primarily be on you, the client, but rather on the interaction between yourself and myself, the therapist. Should the research prove to be successful it will provide me with an increased understanding of our interaction in therapy. Although this will not benefit you directly, the increased understanding flowing from this research, may benefit future clients seen by me in therapy. Should the new way of analysing transcripts prove viable, further research on the method may also contribute to other therapists' understanding of their interactions with clients.

In my capacity as researcher I commit myself to deal with any information provided by you in therapy in an ethically responsible and respectful manner. Your confidentiality will be protected as far as possible, by using a pseudonym as well as altering any identifying information. No-one, except myself, the researcher, will have access to unedited transcripts of your therapy sessions.

Although precautions will be taken to limit any discomfort to you, the participant, most research may potentially cause distress to its participants. In the current research no such difficulties are currently foreseen, but it may for example be that you disagree with some of the results of the study. Should this occur you will be welcome to discuss this with myself or my supervisor. It is also important for you to understand that your participation in the current study

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is voluntary and that you are under no obligation to give your consent. Further, should you at any time wish to change your mind, regarding your participation in this study in future, you will be free to do so, without any negative consequences to yourself. In such a case all evidence of your participation in the study will be destroyed.

An informed consent form is attached to this document, which should be signed by you, should you still feel comfortable to take part in the current research. The attention and time invested by you through reading this document, and your consideration to take part in this research, is dearly appreciated.

Regards
JC Kruger

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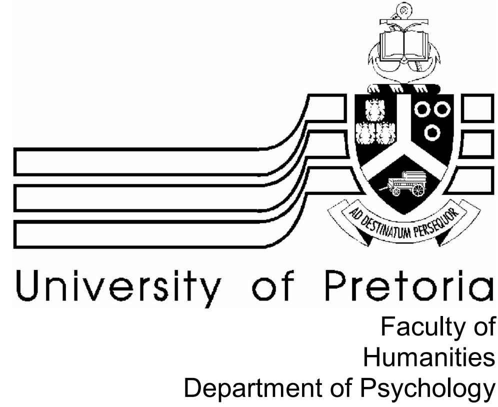

Faculty of
Humanities
Department of Psychology

Consent Form: Research Case Study

1. I, (name & surname)……………………………………..the undersigned, do hereby willingly give consent to my participation in the research study.

2. Further, I give permission to Mr JC Kruger to use the information regarding my therapy for research purposes, as well as for the publication of such information. This permission is given with the condition that all information will be handled confidentially, and that I will remain anonymous, with no identifying information regarding me being made known.

3. I understand that, in the event of me having any questions that may arise as a result of the research project, I am free to contact the researcher at the address and contact number provided in the attached document.

4. I also understand that I may at any time change my mind regarding my participation. In such an event no negative consequences will be incurred by myself and all evidence of my participation in the study will be destroyed.

If at this point or in future you have any questions or uncertainties regarding the research project, you are welcome to discuss it with the researcher.

Signature…………………………………   Date…………………

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Appendix B: Full therapeutic notes for Session 2, 5 and 8

Session 2 (1/4/2005)

Initial Observations

Mrs Smith was well groomed when I met her. She did however look a little tired. She said that her husband preferred to wait in the car and that she was afraid that she was late for her appointment. She explained that the traffic was terrible and they had to finish lunch first. She said that she had not been particularly hungry, but that it was important that her husband was given his food.

In general during the interview she went into long discussions with considerable detail. She did this especially during the first part of the interview. I did not interfere too much, because it felt to me that this was part of her defence against anxiety. Towards the middle of the session I managed to focus her attention slightly more on emotionally relevant discussions. Unfortunately I cannot remember all the details of her very detailed discussions of seemingly insignificant events.

Start of Session

Relational Experience 1

S: [She told me how they went down to Cape Town to stay in a flat. The first 2 weeks went fine until her husband's brother died. This meant that there were many family members that came to the funeral and there were many things to organize. Soon afterwards they returned, but even here she has been quite busy. Her sister form Ermelo was currently visiting and she wanted to spend some time with her. She said that the journey to Cape Town was difficult even though they slept over two times and her husband said that this was the last time he would drive to Cape Town. Apparently he gets very sore, because he is so thin as a result of the cancer.]

JC: Dit klink vir my of dit 'n moeilike tyd was en toe nie heeltemal "vakansie" soos wat oorspronklik beplan was nie.

S: Ja dit was moeilik. Ons moes gereeld vir mense kos maak en help ontvang. Was nie genoeg plek in die woonstel nie en moes later by 'n ander familielid gaan bly.

JC: [I asked for a bit more details about her husband's illness]

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S: Dit is ‘n stadige kanker. Limfoon kanker, ‘n tipe klierkanker. Die dokter sê baie mense gaan eventueel oor ander redes dood.

JC: Hoe bekommerd is u oor u man se toestand?

S: Ek is OK daarmee. Aan die begin was ek baie omgekrap, maar die dokters het gesê dat ‘n mens baie lank met die siekte kan leef.

JC: Dit klink vir my of u, al is dit ‘n ernstige siekte, op ‘n manier geleer het om daarmee saam te leef. U klink ook vir my selfs bietjie rustiger daaroor as laas keer.

S: Ja ek dink die dokters se versekering het gehelp. Ek het redelik rustigheid daaroor.

JC: Vertel my hoe dit met u mond gaan?

S: Sjoe ja (sounded as if she appreciated me asking). Dit is op die oomblik baie sleg. [She continued sharing how sore her mouth has been the last couple of days and how much it hurt when she ate fruits and anything slightly sour. Even bread made her tongue hurt.] My mond was vanoggend weer baie seer, maar die pynpille help ‘n bietjie. Dink hulle het my ook deur die vakansie gehelp. Ek het baie migraines gekry en my kake en tong pyn baie.

JC: Was die simptome onveranderd tydens die tyd wat u weg was?

S: Die eerste twee weke was dit baie beter, maar toe met die begrafnisreëlings en gaste het dit baie erger geraak. Soms wou ek net gaan lê en huil, maar dan kan mens nie met al die mense nie. Die pille help, maar my man verstaan nie. Hy wil nie hê ek moet die pille drink nie. Die dokters het egter al vir my gesê dat ek soms te lank vat om die migraine pille te drink en dat dit beter die simptome sal stop as ek dit vroeër drink.

JC: So rus en rustigheid help definitief ‘n bietjie vir die simptome, maar wanneer daar te veel spanning en mense is raak dit weer erger.

Relational Experience 2

JC: So u het vanoggend ‘n pynpil gedrink?

S: Ja en ‘n halwe kalmeerpil. Ek was laas keer so emosioneel toe ek hier was. Ek weet nie wat jy van my dink nie.

JC: U moet asb nie voel dat u emosies hier hoef te beheer nie. Ek gaan nie slegter van u dink as u hartseer of kwaad word nie. Die pille maak amper soos ‘n beskermde lagie wat dit moeiliker maak om by emosies uit te kom en wil hê u moet hier vrymoedigheid hê om te wys en sê hoe u voel. Kan u die pille se naam onthou wat u drink?

S: Ja Pynpille: Doxafien. Hulle het dit vir my voorgeskryf oor dit my nie hartlywig sal maak nie. Ek eet altyd 5 Marie beskuitjies saam om nie my maagwande te beskadig nie. Die kalmeerpil is lexotane (3mg). Ek drink net ‘n halwe.

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JC: Ek hoor u man hou nie daarvan as u pille drink nie. Hoe voel u daaroor om die pille te drink?

S: Ek hou nie baie daarvan nie. Die pille help, maar dit vat nie die pyn heeltemal weg nie. Die kake pyn. Ek weet nie waarom nie, almal anders waarmee ek al gepraat het wat die implantate gehad het sê dit werk wonderlik. Ek het ook voor die tyd met die tandarts se vorige pasiënte gepraat en hulle was almal baie gelukkig. Ek wil weer na die tandarts toe gaan, maar hy sê daar is niks wat hy kan doen nie. My tandvleis is mos baie dun en sensitief en dit is heeltemal rooi binne in die mond. Die tong is ‘n geografiese tong. Daaraan kan hulle niks doen nie. Hulle sê dit is van spanning.

JC: Is dit net u mond wat sensitief is, of dink u aan uself as sensitief in die algemeen.

S: Ek is seker maar sensitief oor die algemeen. Ek raak maklik ontsteld as iemand my net skeef aankyk.

Relational Experience 3

JC: Kan u vir my meer hieroor sê?

S: Ja soos as my man ongelukkig is vir my dan maak dit my seer en hartseer.

JC: Is dit net u man? As ander mense u skeef aankyk?

S: Meestal maar my man. Ander mense sal dit nie sommer doen nie. Sal seker ook nie lekker wees nie, maar ek is nie ‘n moeilike mens nie en daar is gewoonlik nie rede nie. My man is egter anders. Hy raak baie maklik omgekrap. Sy humeur is baie kort en hy raak maklik ongeduldig. Ek verstaan dit nie, maar ons het anders grootgeword. In my huis was ons almal emosionele sensitiewe mense en ons het nie veel spanning of konflik in die huis gehad nie. Ek dink nie my man verstaan dit nie. Sy huis was anders. Sy dogter is ook so. Baie ernstig. Ek wil soms hê hy moet ligter wees en probeer baie, maar niks werk nie. Ek sal vir hom ‘n grappie lees, maar hy sal niks sê nie. Ek het ook al vir sy dogter gesê sy moet nie so ernstig wees nie. Ek dink maar dit is die gesin waaruit hy kom. Ek het sy ma eers op negentig leer ken, en heel goed met haar oor die weg gekom. Sy was al siekerig op die stadium. Iemand wat haar geken het, het gesê sy was maar ‘n koue vis.

JC: Dit klink vir my of u ‘n sensitiewe gevoelsmens is en dit pas ook natuurlik in by die musiek-agtergrond. Ek kry die idee dat u redelik bewus is van emosies in uself, maar dat dit huidiglik vir u moeilik is om aan die mosies uitdrukking te gee….[I wonder if she is currently involved in activities where she can give expression to her emotions and whether such acitvities would not be helpful. I was more and more getting the impression that she was a very emotional person. She was also less heavy and when she talked about emotional things it

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seemed to help her to gain access to positive emotions. When she did this her eyes lighted up and her face became more expressive. I see this as a very good sign.]

S: Ja, ek wens net my man kon bietjie meer verstaan. Hy is altyd so ernstig. Hy raak maklik kwaad en dit is maar moeilik.

Relational Experience 4

JC: Dit klink of u verhouding vir u baie belangrik is, maar dat of al u behoeftes nie huidiglik aan voldoen word nie.

S: Ja ek sal reguit met jou wees. Daar is nie seksuele probleme nie. Ek probeer hard. Hulle het 'n paar jaar gelede opgehou om vir my hormoonbehandeling te gee, maar ek doen baie moeite daarmee al voel ek nie so baie seksuele behoeftes nie. My man sukkel egter baie die laaste tyd. Ek dink dit is vir hom baie moeilik. Dit is egter nie vir my 'n probleem nie. Ek probeer hard en ons kom oor die weg.

[She sounded quite proud of the effort and success she had at maintaining her sexual performance, despite her lack of sexual desire. I got the impression that she felt proud of meeting the criteria of a woman to be sexually satisfying to her partner.]

JC: Dit klink of dit in die algemeen baie doen om aan u man se behoeftes te voldoen….

S: Ek probeer baie hard. My man weet seker ek raak nie so maklik seksueel opgewek nie en dit is seker nie vir hom so lekker nie. Maar hy sukkel baie en ek probeer hard om te help. Behalwe dat hy sukkel gaan dit nie sleg seksueel nie.

JC: Buiten die seksuele…….dit klink of u in meer as net die area baie moeite doen om sy behoeftes te bevredig?

S: Ja. Hy is 'n moeilike man. Dit is soms vir my baie moeilik. Hy raak so maklik kwaad en ek is maar bang vir hom.

JC: Ek kry die gevoel dat u als in u vermoë doen om hom tevrede te stel, maar dit lyk nie vir my of hy altyd dieselfde vir u doen nie. Ek het in my kop 'n prentjie van u wat op 'n stukkie grond staan en geleidelik al hoe meer aan hom oorgee. Ek wonder of daar enige plek oor is vir u om op te staan of op te beweeg?

S: [Looked as if she could identify with the metaphor. She also became sad when talking about her relationship with her husband.]

Relational Experience 5

JC: Kan u weer vir my sê wat u ervaar wanneer u man vir u kwaad raak. U het genoem van seergemaak en harsteer. Is daar nog emosies.

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S: Ja dit maak my seer.

JC: Kan u miskien aan spesifieke voorvalle dink.

S: [She continued to give a few examples of cases when her husband was angry with her. Mostly about relatively unimportant things such as not taking the shortest route (she does all the driving). Often when there is a conflict of interests she would also give in to her husband.]

[I think it is quite important that she does the driving considering the submissive role she plays in the house. Clearly their interaction is slightly more complicated. I suspect that Mrs Smith has more resources than I initially thought. I think that she has the ability to be happy, but that she cannot express herself in her current relationship. She is in a way constricted, but in therapy I see her opening up at some stages. Showing sadness as well as happiness when recollecting positive events.]

JC: Kan u miskien aan 'n geval dink wat u self kwaad geword het vir hom?

S: Dit gebeur nie baie nie, maar ek was al kwaad vir hom. Ek onthou een keer wat ek vir die kindertjies [think at a family gathering of sorts] moes kosgee. Hy was baie ongelukkig toe ek nie sy kos betyds vir hom reg gehad het nie. Ek het twee van die kindertjies elkeen 'n stukkie ham gegee om op die sitkamer-bank te sit en eet. Ek het hulle gevra om mooi te eet. My man was baie kwaad oor ek hulle op die sitkamer-bank kos gee en oor sy kos nog nie reg was nie. Hy was baie lelik met my voor die kinders. Ek was baie seergemaak.

[Mrs Smith seems to have a very special sensitivity and affection towards children. She clearly thought that his actions were particularlty inappropriate in front of the children.]

JC: Het u iets vir hom gesê?

S: Nee nie voor die kinders nie. Dit was so erg dat die een kindjie meer as een keer na die tyd gesê het: "Oom nie so met tannie praat nie".

[Sounded as if this memory was quite vivid. Perhaps it was special to her that someone else could see her suffering and pain. Something she normally had to carry alone?]

JC: Dit klink of die kind 'n tipe broosheid in u raakgesien het. Asof die kind bang was dat u man u sou breek?

S: Ja die kindjie was baie bekommerd.

JC: Sou u iets gesê het as die kinders nie daar was nie?

S: Ek weet nie. Dit was baie erg. Ek het net weggeloop. Dinge was nie goed tussen ons nie. Hy het selfs in 'n ander kamer geslaap en dit het vir 'n paar dae so aangegaan.

JC: So dit is regtig vir u moeilik om te wys as u kwaad of ongelukkig is. Dit is vir u makliker om uit die situasie uit te kom?

JC: Hoe het dit geëindig? Het u enigsins iets met u man bespreek?

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S: Ek het later met hom probeer gesels en vir hom gesê dat ek altyd sy kos vir hom betyds reg het en dat dit ‘n uitsondering was en dat hy weer moet terugkom na die kamer toe. Hy wou egter niks weet nie. Hy het gevoel hy het die hele dag hard gewerk en was baie omgekrap dat daar nie kos was nie.

JC: Dit klink soos ‘n redelik onbelangrike voorval maar tog klink dit of u op ‘n manier uself teenoor u man probeer regverdig het? Asof u baie hard gewerk het om die verhouding te herstel? Klink of u die vredemaker is en altyd die een is wat toegewings maak?

S: Ja, dit is so.

JC: So op ‘n manier het u man gekry wat hy wou gehad het…U doen meeste van die werk om die verhouding te herstel en hy word vergewe sonder om self vergifnis te vra?

S: Ja my man vra nie eintlik ooit om verskoning of sê jammer nie. So nou en dan, maar baie selde. Dink maar dis hoe hy grootgeword het.

JC: In al die gevalle wat u nog genoem het, het u eintlik glad nie gewys dat u kwaad was nie, selfs al het dit in die laaste geval geklink of daar bietjie verwyte is? Ek wonder wat met al die emosies gebeur?......niks kom uit nie….dit moet dan seker als binne bly?

S: Ja ons gesin was nooit baie kwaad vir mekaar nie, maar ons kon met mekaar gesels en goed uitsorteer. My man is nie so nie.

Relational Experience 6

JC: Het u al ooit verskil van hom en dit vir hom gesê?

S: Ja een keer het ons gery en hy was kwaad oor ek nie die “korter” roete geneem het nie. Ek sê toe vir hom ek ry al lank die pad en dat ek nie dink sy roete korter is nie. Hy wou egter niks weet nie. Hy raak baie kwaad.

JC: So u het al dit reggekry om te sê dat u verskil van hom?

S: Ja maar ek is baie versigtig vir hom. Hy raak baie kwaad…..Hy het my al geslaan…geklap. Nie sag nie, sommer baie hard. Al drie keer. Ek wou dit nie gesê het nie….Jy moet asb nie vir iemand anders sê nie.

JC: U hoef nie te bekommer nie Mev Smith. Ek gesels net met my supervisor en dit is vir ons belangrik om u konfidensialiteit te behou. Ek dink dit is goed dat u dit vir my genoem het, want dit beteken dat daar areas is waaroor ons versigtiger moet dink…Ek wil nie hê dat dit erger moet raak nie. Wanneer was die laaste keer wat dit gebeur het?

S: Dit was laas jaar. Hy het groot geskrik en gesê dit sal nie weer gebeur nie.

JC: As u nie die fisiese vrees vir u man gehad het nie sou u dan vir hom kon sê as u ontevrede is met hom?

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S: Ek is nie seker nie...

JC: Ek kry ook so ‘n bietjie daardie gevoel Mev Smith. Dat dit dalk wyer deur al u verhoudings inwerk?

JC: Ons het voorheen oor ernstige verliese in u lewe gepraat en ek dink dit is dalk belangrik om daarna terug te kom, maar op die oomblik voel dit vir my dit is dalk belangriker om ‘n bietjie te fokus op u verhouding met u man. Dit klink of dit huidiglik vir u baie ongelukkigheid veroorsaak. Sal dalk goed wees as u plek het om hieroor te gesels aan die een kant, maar ek wonder ook of dit nie sinvol kan wees om dieper na die verhouding te kyk nie. U sê u kom van verskillende agtergronde af.

Relational Experience 7

JC: Ek neem aan daardie papiere in u hand is u familie geskiedenis.

S: Ja ek het dit vinnig gisteraand geskryf. Was baie besig en nogal moeg.

JC: Dit klink of dit vir u moeilik sou wees om te sê dat u nie daarby kon uitgekom het nie?

S: Ja....

JC: Baie dankie daarvoor, ek sou verstaan het as u nie kans gehad het nie. Dit is vir my belangrik dat ons verhouding baie oop moet wees. Ek wil hê u moet vir my sê as u ongelukkig is met iets, of as ek iets doen waarvan u nie hou nie.....Na als waaroor ons gesels het, is ek bekommerd oor hoe in u behoeftes voorsien gaan word, veral as dit vir u so moeilik is om vir mense u ontevredenheid en kwaadheid te wys. Dit klink of dit ook nie net by u man is nie, maar dat dit ‘n effense patroon in u lewe is en dat mense, soos die klein kindjie, u dalk as broos kan sien. Die feit dat u al vir u man, al is dit min, kon wys dat u nie saam stem nie, dui vir my daarop dat daar iets onder die broosheid is wat sterker is?

S: [Looked as if she accepted this.]

Relational Experience 8

JC: Ek wil graag hê ons verhouding moet van so ‘n aard wees dat ons vir mekaar kan sê as daar iets is waarvan ons nie hou nie. Klink of daar baie dinge in u huwelik is wat glad nie bespreek kan word nie. Ek sal byvoorbeeld graag wil hê u moet die vrymoedigheid hê om vir my vies of kwaad te kan word. Miskien kan u ‘n bietjie gaan dink daaroor en met my deel? Daar moet iets wees en hierdie is ‘n veilige area om te kyk hoe ons met hierdie gevoelens kan werk....

S: Nee daar is niks nie. Jy is so vriendelik. Ek kan niks fout vind nie.

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[She may be right. It is possible that I may not get it right, although she surely at a later stage would have feelings of dissatisfaction. Maybe I should try roll play, asking her to say what she would have wanted to say to her husband.

JC: Wel probeer, maar. Ons kom van verskillende agtergronde so daar moet iets wees. Al is dit iets kleins soos dat ek u onderbreek of so? Ek wil u uitnooi om die vrymoedigheid te hê om dit met my te deel?

S: Ek dink nie ek sal iets kan kry nie.

JC: Ek het seker al te hard geoefen om nie aanstoot te gee nie, maar miskien moet ek probeer om so nou en dan iets te doen waarvan ek nie dink u sal hou nie sodat ons iets het om mee te werk? [Met 'n glimlag gesê] Ek dink dit kan baie belangrik wees vorentoe, want ek is besorg dat die voorkoms van "broosheid" waarvan ons gepraat het u dalk 'n makliker teiken vir u man kan maak. Dit maak nie sy gedrag regverdigbaar nie, maar dit klink of u vir hom 'n baie veilige teiken is? Asof hy nie vir u enigsins hoef terug te staan nie. Ons sal egter baie mooi hieroor moet dink. Die feit dat u man fisies gewelddadig kan raak, beteken ons sal baie versigtig moet dink....

Relational Experience 9

JC: Gaan ek u weer volgende week 2 uur sien?

S: Ek sal graag wil kom. Weet nie vir hoe lank nie. My man is nie baie ingenome met sielkundiges nie. Hy voel hulle moet self na hulle koppe gaan kyk.

JC: U het gesê u bestuur, so u kan eintlik alleen kom?

S: Hy wil saamkom.

JC: Dit maak dit nogal moeilik. So alhoewel hy nie daarvan hou dat u kom nie, wil aan u vashou en u ook nie op u eie laat gaan nie?

S: Ja, dit is moeilik. Ek dink nie hy verstaan die nut nie. Het jy enige raad oor hoe om met hom hieroor te praat?

JC: Sjoe dis moeilik.....u ken hom al langer as ek en sal dalk beter weet.....een gedagte wat ek het is dat as dit vir u regtig belangrik is dat u redelik ferm is dat dit iets is wat vir u betekenisvol is.....dalk is dit 'n goeie beginpunt om u voorkeur vir uself te kies. Ek is egter nie seker nie. Ek hoop u kan regkry dat u weer kan kom. Ek dink regtig dit kan betekenisvol wees en ek sal u graag weer wil sien.

S: Ek sal probeer. Baie dankie.

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[If this really becomes a problem, I might tell her that it is essential for her to come again. She might then use this as a leverage with her husband, but I would first like her to attempt it on her own.]

JC: Totsiens Mev Smith.

Final comments

I think in general the session went well. A bit cluttered in the beginning, but progressively more focussed towards the end. Mrs Smith shows good insight and I think it might be possible to facilitate improvement in her interpersonal relationships. On a personal level I feel very endeared towards her. I experience her as a very "sweet" person. I wondered what she was like as a wife and how much my perception were coloured by what she shared with me. I wondered how depressed she was and whether I should evaluate this with a psychometric test.

Session 5 (29/4/2005)

Initial Observations

I met Mrs Smith in the passage. She looked slightly better and less disorientated than during the previous two sessions.

Start of Session

Relational Experience 1

S: So daar is darem nog mense soos ek?

JC: Ja Mev Smith. Ons het mos in die eerste sessie daaroor gesels. Meeste mense wat hierheen kom is a.g.v. BMS.

S: Is die ander mense se simptome min of meer dieselfde as myne?

JC: Die simptome verskil gewoonlik effens maar meestal in terme van brand op die mond. Party mense het egter ook pyn op ander dele van hulle mond soos die verhemelte, ens.

S: OK en wat sê hulle veroorsaak dit?

JC: Wel dit is moeilik om presies te sê.....[Explained the whole cause thing again. She seemed to be hearing everything for the first time so I also repeated the statistics for her.]

S: Sjoe [When she heard that some people struggle with it for a long time].

JC: Ja, sommige mense sukkel lank met die simptome. Dit is egter baie veranderlik. Sommige mense se simptome verdwyn binne 3 maande. Ek wil u herinner waaroor ons gepraat het in die eerste sessie. Ek hoor dat u bekommerd is of daar wel iets is wat daaraan gedoen kan word. Ek wil nie vir u vals hoop gee nie, maar navorsing het gewys dat sommige mense baat

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vind by terapie [explained stress hypothesis again.] Ons kan dus net ons beste probeer. Ons weet dat sielkundige faktore ‘n bydrae kan lewer tot die simptome.

S: So jy kan dan seker nie jou tesis op my doen nie nê? [I could perhaps have asked whether she feels that she is failing, but I will try to link to it in a following session.]

JC: Wel mens weet nooit nie! Ek het nie beplan nie en as ek so iets sou doen sal ek in elk geval eers u toestemming daarvoor vra.

JC: So u verstaan seker nou beter waarom ek baie keer u aandag rig op moontlike spanningsvolle belewenisse.

S: Ja ek dink nogal spanning kan’n rol speel.

Relational experience 2

JC: U het al voorheen die verband self gemaak, maar ek onthou dat u laas week minder seker daaroor gevoel het. Ek maak gewoonlik notas oor ons sessies na die tyd. Dit help my wanneer ek oor ons sessies dink. Ek het so ‘n paar goed neergeskryf. U het byvoorbeeld in die eerste sessie genoem dat u die dokters se diagnose aanvaar het, m.a.w. dat daar ‘n sielkundige komponent soos spanning kan wees. Dit is al klaar iets groots. Gewoonlik wanneer kliënte kom is dit vir hulle moeilik om die verband te maak en ons het dus op ‘n manier klaar ‘n groot voorsprong wat sal help met die proses. U het ook daarna al ‘n paar keer spontaan die verband tussen spanning en in die mond gemaak.

S: Ja....die eerste 3 weke van die vakansie was my tong amper heeltemal gesond.

JC: Maar die tandvleis en kake was nog seer?

S: Ja dit verander nie eintlik nie.

JC: Dit lyk dus as ons sou moes probeer ‘n oorsaak gee dat die tandvleis amper meer ‘n organiese probleem is en die tong ‘n effens groter sielkundige komponent het? Maar die twee is ook nou aan mekaar gekoppel. Dit is heel moontlik dat die tandvleis ook seerder sal voel as die tong seer is. Wanneer ons so praat is ek altyd bang dat dit klink asof ek sê die tongpyn is nie werklik nie. Dit is vir my belangrik dat u verstaan dat dit glad nie is wat ek probeer sê nie. Die pyn is om die waarheid te sê net so erg en kan selfs erger wees, maar ons benadering om die pyn aan te spreek is effens anders. Deur byvoorbeeld te kyk na onderliggende spanning of negatiewe gevoelens is dit soms moontlik om die simptome te verlig.

Relational Experience 3

JC: Ek het nog nie gevra hoe dit vandag met u gaan nie. Dit lyk my of u effens beter voel?

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S: Gaan OK dankie. Die mond en tong is nog maar seer, maar dalk ‘n bietjie beter as laas week. Ek was vandag by die tandarts om die nuwe tande te kry. Die tande sit effens gemakliker as voorheen, maar vandat dit in is voel dit vir my of die tong al klaar heelwat meer brand. Ek wil maar nie te veel daaroor dink nie. Ek moet positief bly.

JC: Kan u my verduidelik presies wat hulle gedoen het?

S: Die eerste stel tande het mos ‘n deurskynde rubberlagie onder gehad wat veronderstel was om ‘n helende lagie op te hê. Ek weet nie of ek allergies daarvoor was nie, maar dit het my mond baie seer en gevoelig laat word. Toe het hulle die rubberlagie met ‘n ander tipe pienk rubber vervang. Dit het ook nie gewerk nie. Nou het hulle weer ‘n deurskynende wit lagie opgesit wat baie soos die eerste een lyk.

JC: Dit klink of u bekommerd is of dit dieselfde as die eerste een gaan wees.

S: Ja, maar ek moet probeer moed hou. Dit hou nou al so lank aan. Vanaf laas jaar Augustus toe hulle die implantate gedoen het. Dit was vir twee dae verskriklik seer en van toe af nooit weer heeltemal reg nie. Ek het al met soveel mense gepraat wat almal goeie ervarings gehad het. Ek het nou die dag egter met iemand gepraat wat sê dat sy dieselfde probleem gehad het, maar dat sy voorheen dieselfde probleem met haar tandvleise gehad het. Sy sê die tande is nie veronderstel om aan die tandvleis te raak nie, maar moet eintlik op die implantate rus. Sy het vir my hare gewys en dit raak glad nie. Myne raak aan die tandvleis. Sy sê sy wou nie voorheen vir my sê nie, maar sy dink ek het ‘n fout gemaak om na ‘n gewone tandarts toe te gaan. Sy sê haar tandvleis was ook te sag en min en hulle het eers ‘n operasie gedoen om tandvleis in te plant. Die tandarts het vir my ook gesê dat my tandvleise baie dun is, maar ek het nie tandvleis-inplantings gekry nie. Ek het egter vir hulle gesê dat ek nie baie geld het nie. Die implantate is baie duur en ek moes besluit op twee of drie. Die tandarts het egter gesê dat oor my mond klein en smal is sal twee implantate meer as genoeg wees. Ek het ook vir ‘n tandarts familielid gevra en hy het saamgestem.

JC: Dit klink amper of u sal oorweeg om ook die tandvleis operasie te doen? Of u bereid sal wees om weer deur ‘n soortgelyke proses te gaan?

S: Ja, as ek net weet dat die pyn sal kan stop. Ek weet nie waar ek die geld sal uitkrap nie, maar ek sal as dit sal help.

Relational Experience

JC: U het gesê dit het die laaste paar dae bietjie beter gegaan. Het iets gebeur?

S: Wel ek was Dinsdag by die tandarts en ek moes die tande by hom los. Die 3 dae wat ek sonder die tande was het my tande begin beter voel en selfs my tong.

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JC: Dit lyk of daar ‘n konneksie tussen die tong en die tandvleis is? Asof as die een seerder is dit die ander een ook vererger.

S: Ja dit lyk so. Soos ek sê. Die tong is vandag weer seerder, maar die tande sit darem stewiger en maak nie so seer as ek byt nie. Hulle moes dit eers ‘n bietjie verander om beter te pas. Ek het nog nie geëet nie. Ek is eintlik te bang om te probeer.

JC: Ten spyte van die pyn lyk u gemoed vir my vandag meer opgewek as laas week. Asof daar meer hoop is?

S: Ja [Seemed to appreciate and lighten up at this comment]. Ek voel bietjie beter. Soms raak dit net te veel en dit is soms goed om met iemand te kan gesêls. Dit is nie so maklik met my man nie. Hy is nie eintlik een wat vra hoe ek voel nie. Hy sal sien as ek nie lekker voel nie en as mense oor die telefoon vra hoe dit met my gaan sal hy sê ek voel nie lekker nie, maar vir my self sal hy nie veel sê nie. Ek wil ook nie die heeltyd kla nie.

JC: Die trotsheid kom dan weer n bietjie deur? Dit klink of dit vir u belangrik is dat ander mense u nie as ‘n las beleef nie? Miskien veral nou met u man se siekte?

S: Ja [I think I should address this public sense of self more, because she again seemed to appreciate that I saw her effort] My man is al beter. Nog nie heeltemal beter nie, en die pille maak hom baie hartlywig, maar gaan al beter.

Relational Experience 5

JC: Ek is bly om te hoor dit gaan beter met hom Mev Smith. Ek vra nie baie na u man uit nie al wonder ek hoe dit met hom gaan omdat ek graag hierdie ruimte vir u wil gebruik. U sien u man gereeld en ek wil graag hê dat u hier ‘n plek sal hê waar u oor uself kan praat. Ek het nogal gewonder hoe u man se chemo nou julle verhouding raak? U het laas genoem dat hy nou meer afhanklik is as voorheen en dat u eintlik dit waardeer dat hy meer u hulp vra.

S: Ja, maar hy is al klaar weer so dat hy op sy eie regkom en vra nie eintlik veel nie. So nou en dan sal hy iets vra as hy regtig nie lekker voel nie, maar dit gebeur maar min. Hy was altyd baie gesond. Hy is ook baie fluks en help om die huis, bv om die wasgoed af te haal en op te hang en dan sê ek vir hom: “Ag skat dit was nou nie nodig nie.”

JC: Dit klink of u eintlik dit sou geniet of waardeer as hy meer na u sou uitreik.

S: Ja, maar hy het nie soos ek grootgeword nie. In my huis het ons baie met mekaar gesels.

JC: Tog hoor ek baie affeksie as u van u man praat.

S: Ja ek is baie lief vir hom.

Relational Experience 6

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JC: Mev Smith die tyd gaan so vinnig. Ek het laas week gesê ek gaan 'n visualiserings-ontspanningsoefening vandag met u doen. Ek het gepraat van *guided imagery*. Daar is nou net genoeg tyd oor om dit te doen. Ek het eintlik 'n brief ook vir u geskryf, maar ek wil dit graag saam met u deurgaan, so dalk kan ons die brief los vir volgende week?

S: Dit is reg so, maar dit sal die week daarna moet wees want ek moet volgende week met 'n basaar help.

JC: OK dit is reg so met my. Dit is nie 'n swaar brief nie, maar net 'n paar gedagtes oor ons sessies sover en ek sal graag u terugvoer wil hê of ek reg verstaan.....

Oor die ontspanningsoefening. Voor ek dit doen wil ek darem vir u die motivering daarvoor verduidelik en hoor hoe u daaroor voel. Die ontspanningsoefening is amper die sielkundige ekwivalent van 'n ontspanningspil. Die rede dat ons juis hierdie oefening gebruik is omdat u 'n ryk emosionele binne-wêreld het. Ander mense wat minder op innerlike emosies ingestel is sal waarskynlik minder waarde daaruit put. Dit is byvoorbeeld moontlik dat u man nie so baie soos u daarby sal kan baat vind nie. [I continued to explain roughly what the method is about...] Hoe voel u Mev Smith? Dink u dit is iets wat u sal belangstel om te leer.

S: Ja, ek dink so.

JC: Kom ons begin.....

End of Relational Experience 6

Start of Relaxation Technique (Not included in analysis)

"Poel" Tegniek:

- Ontspanningsmetode wat gebruik maak van visualiserings-tegnieke.
- Nie hipnose nie
- Baie natuurlike en menslike fenomeen
    - Bv. Wanneer ons dink aan rustige aangename beelde of herinneringe begin ons gewoonlik meer ontspanne voel.
    - Ek gaan u leer hoe om die tegniek te doen en dan kan u dit self by die huis doen, soveel as wat u wil.
- Die ontspannings-tegniek bestaan uit twee komponente
    - Eerstens: Bewuswording van u liggaam
    - Tweedens: Bewuswording van u gedagtes
- Gee u om as ek langs u sit?

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- Dit is makliker om te ontspan as iemand nie vir mens kyk nie.
- Sal graag saam met u die tegniek doen.
- Die tegniek sal ook meer effektief wees as u u oë kan toe hou.

• Begin met bewuswording van u liggaam (Begin geleidelik stadiger praat.)

- Ek wil hê u moet sit soos dit vir u gemaklik en natuurlik voel. Mense vind dit dikwels gemaklik om hulle hande op hulle bene te laat rus en hulle bene effens vorentoe uit te strek. U kan ook gemaklik in u stoel terugsit.
- Wanneer u gemaklik is wil ek hê u moet stadig, diep en rustig begin asemhaal. Asem in en dan uit....in en uit....in en uit...en voel hoe u geleidelik al hoe ligter en meer onspanne voel.
- Ons gaan nou u regterarm laat ontspan. EK wil hê u moet 'n vuis maak met u regterhand en die hele arm se spiere laat saamspan. U kan dit doen soos u inasem en wanneer u uitasem die arm weer laat ontspan. Haal stadig en geleidelik asem en maak u arm en vuis styf saam met die inasem en ontspan die arm met die uitasem.....in en uit...in en uit...in en uit...U kan voel hoe u arm geleidelik al hoe meer ligter en ontspanne voel. As u arm nie ontspanne voel nie is dit ook OK. Geniet dan net hierdie tyd om rustig te kan verkeer. U kan nou maar die arm ontspanne op u been laat rus.....
- Kom ons doen dieselfde met die linkerarm. Maak 'n vuis met u linkerhand en laat die hele arm se spiere saamspan. U kan dit doen soos u inasem en wanneer u uitasem die arm weer laat ontspan. Haal stadig en geleidelik asem en maak die arm en vuis styf saam met die inasem en ontspan die arm saam met die uitasem.....in en uit...in en uit...in en uit... U kan voel hoe u arm geleidelik al hoe meer ontspanne voel. U kan nou maar die arm ontspanne op u been laat rus.....
- Nou gaan ons die bene help om te ontspan. Ek wil nou hê u moet soos u inasem beide u bene se spiere styf maak. U kan dit doen deur u hakke effens in die grond in te probeer druk. Maak u bene styf met die inasem en ontspan hulle dan met die uitasem. In en uit...in en uit...in en uit...
- Nou die skouer. Soos u inasem probeer u skouers effens vorentoe en na binne toe druk....en ontspan dan weer met die uitasem. In en uit...in en uit...in en uit...
- U mag dalk voel of u liggaam ontspanne en swaarder as gewoonlik voel. Dit is heel natuurlik en gesond. Sommige mense voel ook 'n warm tinteling in hulle hande. Dit is ook normaal.
- U hele liggaam voel nou rustiger ligter en ontspanne...en u kan aanhou rustig asemhaal. In en uit....in en uit...

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- Ek wil nou hê u moet voor u in u verbeelding ‘n klein boksie sien. U kan self besluit hoe die boksie lyk. Dit is net u wat die boksie kan sien en dit is net u wat die boksie kan oopmaak....
    - U kan nou die boksie oopmaak om te sien wat binne in is. Binne in die boksie sien u foto’s, mooi opmekaar gepak, sodat u net die boonste foto kan sien. Op die foto is ‘n magiese woud met pragtige groot bome. Die woud lyk rustig en stil en die bome se blare is ‘n ligte groen.
    - Ek wil hê u moet die foto in u gedagtes uit die boksie haal en voor u hou. U raak net weer bewus van hoe kalm en rustig die woud is. Dit is amper of u die rustige voëlgeluide kan hoor.
    - Ek wil hê u moet nou sien hoe die foto groter en groter word....groter en groter....so groot dat dit later al is wat u sien en u voel of die woud voor u is en u amper daaraan kan raak.... die woud raak vir u so werklik dat u in die foto kan instap en voor die woud staan. U kan nou baie meer detail sien as voorheen op die foto self. Die bome is besonders groot en majestieus met donkerbruin bas en ligte groen blare. Die voëls is ook nou duidelik hoorbaar.
    - Daar is ‘n bospaadjie wat in die woud ingaan. U voel ‘n sterk behoefte om in die woud in te gaan en begin rustig op die paadjie stap. U hoor die sagte ritseling van blare onder u voete. Die woud is lig en koel maar u kan sagweg die son deur die lowergroen blare op u vel voel. Die voëls is nou nader en alhoewel u hulle nie kan sien nie, hoor u hulle in die agtergrond. Die stilte, rustigheid en kalmte van die woud is aansteeklik. Soos u verder stap voel u hoe u al rustiger en ligter word. U voel of u die blare en groen mos wat op die bome se stamme groei kan ruik. Alles gee ‘n gevoel van tydloosheid en of dit ‘n baie spesiale plek is wat nie gereeld besoek word nie.

- U stap geleidelik aan deur die woud en geniet die rustigheid en kalmte totdat u effens voor u ‘n akkerboom sien wat nog groter as die ander bome is...Dit lyk of die akkerboom verskriklik oud en wys is. Selfs as u opkyk sukkel u om die boom se hoogste takke te sien. Die akkerboom se bas is ‘n ryk donker bruin en hier en daar groei daar sagte groen mos...U is totaal betowerd deur die boom, maar u aandag beweeg geleidelik na ‘n pragtige poel onder die boom met kristalhelder water. Die poel is nie baie diep nie en lyk baie uitnodigend. Die water is so skoon dat u die bodem kan sien. Daar is niks in die poel nie.

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U gaan geleidelik nader tot u by die poel is en voel eers aan die water....Die water is sag en koel, maar nie koud nie. Die water lyk so belowend en verfrissend dat u besluit om in te gaan. U stap stadig in die poel in. Eers tot by u knieë en dan op die diepste plek tot by u middellyf. Die water is als wat u verwag het. Dit omvou u met 'n sagte omhelsing en u voel verfris en lig. Dit is so aangenaam dat u besluit om terug te lê en liggies in die water te rus. U voel rustig en kalm en soos u teruglê, kan u deur 'n opening in die woud die helder blou lug sien. U besluit om vir 'n rukkie so te lê. U sien hoe die wolke geleidelik verby weeg en patrone in die lug maak......(Sê elke paar sekondes iets en laat toe om vir drie tot vier minute so te rus.)

- Die water is so aangenaam en omvou u op so 'n sagte ontvanklike manier dat u nog lank so kan vertoef, maar u besluit om geleidelik uit te gaan. Soos u uit die poel beweeg ervaar u 'n sterk behoefte om iets van die water saam met u te neem. U steek u hande uit en bring van die water na u mond. U voel hoe die sagte en amper effens soet water in u mond ingaan en u voel hoe dit u binneste verfris en vars laat voel. U begin geleidelik terugstap en kyk weer terug na die akkerboom. U sou graag nog hier wou bly, maar om een of ander rede weet u dat u altyd weer hierheen kan terugkom wanneer u nodig het. U stap rustig terug deur die woud en geniet die rustigheid en vrede. Dit voel ook of van die rustigheid en kalmte in u agterbly en u dit met u kan saamvat. U bereik die einde van die woud en draai stadig terug. Die woud het vir u 'n baie spesiale plek geword en u weet dat u weer hierheen sal kom. Soos u kyk begin u bewus raak dat die woud kleiner word en kleiner word....kleiner word en kleiner word tot dit weer soos 'n foto lyk. U sit die spesiale foto terug in die boksie en maak die boksie toe. Net u het toegang tot hierdie boksie en u sien uit daarna om weer na die foto en ook die ander foto's te kom kyk.

- Ons is nou klaar en sodra u gereed voel is u welkom om u oë oop te maak.
- Hoe was die ervaring vir u?
- Ek wil hê u moet probeer om die tegniek ten minste twee keer 'n dag te oefen. Miskien in die oggend en in die aand. U is welkom om die dokument saam te vat om u te herhinner, maar die beste sal wees as u u oë kan toemaak soos u deur die visualiserings-proses gaan. Dit hoef nie presies dieselfde te wees nie. U kan dit aanpas volgens u eie kreatiwiteit. U is welkom om die oefening in die bed te doen. Soms raak mense aan die slaap terwyl hulle dit doen. Dit is glad nie 'n probleem nie en beteken net dat u baie rustig geword het, maar

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dit is daarom baie belangrik dat u nie die oefening in die bad of in ‘n kar of enige ander plekke doen waar dit belangrik is dat u moet wakker wees nie.

Behaviour during exercise: Mrs Smith seemed to relax. Her breathing was slow and deep and I noticed at one stage that her one hand continuously slipped off her lap. On reaching the session where she had to relax for four minutes, she suddenly said: “Jy gaan my aan die slaap laat val!”

End of Relaxation Technique

Relational Experience 7

JC: Dit is goed as u ontspan Mev Smith. Dit beteken die oefening is besig om te werk. Is u bang u val van die stoel af?

S: Nee my lyf raak net baie ontspanne.

JC: OK kan u nog so ‘n rukkie ontspan? Ons is amper klaar. [Completed the exercise]

JC: So hoe was dit vir u Mev Smith?

S: Sjoe ek het baie lekker ontspan. My bene is skoon lam.

JC: Is u darem OK om te loop?

S: Ja ek is reg.

JC: Ek sal graag wil hê u moet dit by die huis oefen. U is welkom om ‘n kopie te vat as u wil. Dan kan u daardeur lees om net te onthou, maar dit is eintlik baie eenvoudig en hoef nie presies dieselfde te wees nie.

S: Sjoe. Ek sal probeer, maar dit is lekker om jou stem te hoor. Gaan dalk nie dieselfde wees om te lees nie.

JC: Ek wil eintlik hê u moet juis nie lees nie Mev Smith. Ek het gewonder of ek dalk vir u ‘n bandjie moet maak, maar ek twyfel bietjie, want ek wil hê dit moet vanuit u self kom. Al wat ek doen is om vermoëns in uself te aktiveer wat reeds binne in u is. As u nie die vermoë gehad het nie, sal die oefening glad nie werk nie. U man sal ook dalk bietjie skepties voel oor so iets?

S: Nee wat hy is baie uit die huis.

JC: Klink of u graag so iets sal wil hê. Ek sal nog daaroor dink. Ek wil in elk geval ‘n bandjie maak, so dit sal nie groot moeite wees nie. Sal net graag wil hê dat u eventueel self die proses oorneem sodat dit nie iets ekstern is wat u ontspan nie. As u dit genoeg doen, behoort u ook net aan van die beelde te dink wanneer u meer gespanne voel en dit sal ook help om rustiger te voel.

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JC: OK, so ek sien u dan volgende week?

S: Nee, dis basaar.

JC: O ja. Dit is reg so. Sal dit so opskryf. Hoop u het ‘n aangename naweek.

S: Jy moet ook ‘n lekker naweek hê.

JC: Dankie Mev Smith. Totsiens.

Letter to Supervisor

I think this session went reasonably well. Perhaps better than I expected. It seems as if Mrs Smith enjoyed the relaxation exercise and did not mention termination again. She did however ask whether another client stopped coming, when I asked her whether she would prefer the time to be moved to another slot, because of a cancellation. I wondered whether termination was still somewhere in the back of her mind and whether her question was related to her wondering about whether other patients also struggle to improve.

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Session 8 (24/7/2005)

Initial Observations

Nothing unusual was observed

Start of Session

Relational Experience 1

JC: Middag Mev Smith jammer vir die wag.

S: Dit is doodreg, ek het nou net hier gekom.

JC: En hoe gaan dit met u, dit voel of ek u baie lank laas gesien het.

S: Dit gaan OK dankie. Was maar net baie besig. Mense in en uit. [She told me how several of her family members visited or are still going to visit in the near future.]

JC: Dit klink of u die mense geniet, maar soms is dit amper net te veel?

S: Ja, ek hou daarvan om hulle daar te hê, maar daar is soms net nie tyd nie. Kan soms nie glo dat die tyd so verdwyn nie.

JC: Ek wou nog vir u gevra het of daar 'n ander dag is wat u beter pas, want soms voel dit vir my dit kan meer sinvol wees as ek u meer gereeld sien. Vandat ek u laas gesien het kon daar al so baie goeie en slegte goed met u gebeur het, en ek sal totaal onbewus daarvan wees.

S: Ja daar was maar moeilike tye en die rug is nog baie seer, maar dit gaan nou bietjie beter. Vrydae is eintlik goed, want al die ander dae, behalwe miskien Maandae is ek daar goed wat gebeur. Dit is net soms baie moeilik, soos volgende Vrydag is daar weer 'n familielid wat kom kuier en ek moet haar een of ander tyd deur die dag (ek dink dokter) toe vat, maar ek kan nie onthou of dit in die oggend of middag is nie. Ek dink dit was die oggend, maar ek sal laat weet.

JC: Dit klink my u is regtig baie besig, maar as die Vrydae beste werk dan hou ons dit eers vir Vrydag.

S: Ja dit vat ook nogal lank om hier te kom. Ek het vandag 'n ander pad probeer wat vinniger was en dit het my 35 minute geneem, gewoonlik ry ek 45 minute.

JC: Sjoe dit is nogal lank. Jammer dit was nie effens nader nie.

S: Ja die tyd is net soms so min en jy sal nie glo hoe sukkel ek om by als uit te kom nie.

Relational Experience 2

S: En dan soms is daar nog die een engelse buurvrou wat by my kom kuier. Sy is baie alleen en kan net nie ophou praat nie.

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JC: En u sal seker nie vir haar sê dat u moet aangaan nie.

S: Nee, dit is vir my moeilik. Ek het nou die dag vir haar gesê dat dit vir my moeilik in die oggende is, want ek kry nie my kos klaar gemaak nie….

JC: Ek neem aan sy het nie daarop gereageer nie…..

S: Nee,…..

JC: Dit klink of dit in die algemeen vir u moeilik is om vir u self op te staan, maar dit is ‘n begin as u dit vir haar kon sê.

Relational Experience 3

Hoe was u mond gewees die laaste tyd?

S: Die tong is baie beter dankie.

JC: En ek het u so lank laas gesien dat ek definitief geen krediet daarvoor kan kry nie! (glimlag)

S: My familielid wat ‘n tandarts is, het mos aanbeveel dat hulle die sagte lagie moet afhaal, omdat hy dink ek dalk allergies daarvoor is. Hy het ook gesê dat as hulle dit doen, behoort die tong ook beter te raak. Die tandarts het toe mos eers die vorige sagte lagie vervang met ‘n ander sagte lagie wat nie gewerk het nie en nou laaste het hy dit met ‘n harde lagie vervang, wat baie beter werk.

JC: En van toe af is die tong ook beter.

S: Ja baie beter, ek het nog by tye gevoelige plekke op die tandvleise en ek kan nie harde kosse kou nie, maar oor die algemeen is dit baie beter.

JC: OK, maar dit is wonderlike nuus Mev Smith, ek neem aan die suur kosse en so is ook nou nie meer so ‘n groot probleem nie?

S: Nee, ek moet net versigtig wees met harde kosse.

JC: Ek is verskriklik bly om dit te hoor Mev Smith. As die rug nou kan beter word, behoort dit eintlik ‘n baie groot verskil in u lewenskwalitiet te maak.

S: O ja, die rug. Gewoonlik is dit nie in die nag so ‘n groot probleem nie, maar nou die aand het ek half twaalf pille gedrink vir die rug, maar dit vat nie die pyn heeltemal weg nie, en toe drie uur kan ek nie meer nie, en ek weet ek kan nie meer pille drink nie. Dit is ook vir my sleg, want ek moet altyd iets eet om die pille te drink. So ek eet altyd koekies of Marie beskuitjies of iets. Die pille brand my maag, ek kan hulle op my krop voel.

JC: En die pille het ook natuurlik newe effekte, wat mens na die tyd laat sleg voel?

S: Ja [Didn’t sound if she was listening to me at this stage, she was very busy with recounting her pain and suffering.] Ek het 19 Augustus weer ‘n afspraak met die ortopeut (Dr De Klerk).

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Hy het vir my gewys dat dit die rugmurg senuwees by T12 is wat vasdruk. Hy sê dit is nie so 'n groot operasie nie.

JC: Nie so ernstig nie?

S: Dit is nog steeds 'n groot operasie, maar hy sê dit is baie minder erg as wat hulle die hele rug opereer. Maar ek gaan eers net vir 'n opvolg besoek die 19de Augustus. Hy het gesê hy kan ook weer net vir my kortisoon-inspuitings gee, maar my probleem is dat dit laas niks gehelp het nie.

JC: OK, so u oorweeg die operasie.

S: Ja ek dink nogal daaraan……maar ek gaan nou eers ophou praat en vir jou kans gee.

Relational Experience 4

JC: Mev Smith ek is nou net aan die dink. U het oorspronklik hierna toe gekom vir die pyn in die mond en dit klink of dit nou baie beter gaan daarmee. Maar tog het ons gesien dat die paar dae wat u op vakansie was, was die pyn in die tong beter?

S: Ja dit was.

JC: Dit lyk dan of daar definitief 'n mediese rede is vir die pyn wat u tot dusver beleef het, maar ook asof daar ander faktore is wat u pyn kan vererger.

S: Soos spanning en so.

JC: Definitief Mev Smith. Ek het mos vandag u Rorschach resultate teruggebring. Een van die goed wat die resultate wys is dat u baie spanning het. Baie meer as wat u gewoonlik deel met my. Dit klink of u soms probeer om die spanning te onderdruk. U het byvoorbeeld al baie keer, soos laas keer met die Rorschach, vir my gesê dat u glad nie gespanne voel nie, maar dan dink ek dat dit eintlik vir my lyk of u onderliggend baie gespanne beleef.

S: Ja daar is nogal baie spanning.

JC: Toe ek die Rorschach-resultate opgeskryf het, het ek eers geskryf dat wat u meen dat u nie so besig is nie, maar hoe meer ek daaroor dink, en na wat u vandag weer met my gedeel het, besef ek dat ek eintlik verkeerd is en dat u eintlik baie besig is.

S: Dit is so, daar is baie dinge en familie. My man kan ook mos nie ry nie, so ek moet altyd ry.

JC: Die Rorschach-resultate maak ook meer sin in die konteks, want dit sê dat u eintlik te veel dinge aanpak as wat eintlik goed is vir u op die oomblik.

End of Relational Experience 4

Sharing of Rorschach Results (Not included in analysis)

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JC: Maar miskien moet ons sommer begin met die Rorschach resultate. Voorop is net 'n dekbrief en daarna is 'n bladsy wat ek gou saam met u sal deurgaan…….[I went through the first page with her, explained the clusters etc.] Ek het die verslag in Engels geskryf omdat al my notas in Engels is en ek hoop dit is reg so met u.

S: Dit is reg.

JC: In die lig van ons min tyd, miskien moet ons begin met die opsomming aan die einde, dan kan ons geleidelik die details invul. Die inligting is te veel vir een sessie in elk geval….[I read the summary at the end and we talked about it in quiet some detail]

The overall picture of Mrs Smith's Rorschach results indicate no serious problems in information processing or ideational and mediational processes, which is a positive indicator in general as well as for therapy, since it indicates her ability to use these processes to facilitate growth and improvement.

Mrs Smith does however seem to be experiencing considerable underlying anxiety and stress, which seems severe enough to interfere with the quality of her life.

[She whole heartedly agreed with this.]

Mrs Smith exhibits an active interest in people and a need for intimate interpersonal relationships. Her predominantly avoidant coping style, proclivity for correctness, and unusual concern for conventionality will however make it difficult for her to express her needs in an overt way and too experience the full benefits of interpersonal relationships.

[We talked about this and what it may mean. I suggested that perhaps some of the unfulfilled needs are what she experiences in her relationship with her husband.]

Mrs Smith also seems to be experiencing underlying frustration and resentment, which should negatively impact on her experience of general well-being, if not expressed in an adaptive manner.

[I told Mrs Smith that this was probably difficult for her to hear and that she might not even be aware of this underlying resentment, but that we should look it at it, and that the Rorschach is usually very accurate in picking up underlying feelings and emotions.]

Facilitating her expression of these frustrations and exploring her need for dealing with difficult situations in an avoidant style may also be to her benefit.

JC: Mev Smith dit is ook baie belangrik dat die Rorschach resultate wys dat u 'n "avoident style" gebruik om moeilike situasies te hanteer.

S: Ja dit is nogal so. Ek probeer, maar gewoonlik die vrede bewaar.

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End of Sharing of Rorscach Results

Relational Experience 5

JC: Ek onthou dat u byvoorbeeld genoem het dat u soms sal wegloop van 'n konflik situasie. Byvoorbeeld toe u man so kwaad was vir u oor die kindertjies wat op die bank geëet het.

S: Ja ek is geneig om dit te doen. Dink ek het meer met my man verskil in die begin, maar geleidelik het ek opgehou. Ek is te versigtig vir hom. Ek wil nie slegte goed van hom sê nie. Hy het net anders as ek grootgeword. Hy kan ook glad nie jammer sê nie en hy kan baie aggressief word. Ek het al vir jou genoem dat hy my al geslaan het.

JC: Ek onthou.

S: Hy het laas geskrik, ek dink nie hy kan dit help nie. Hy raak net verskriklik kwaad. Maar ek het laas vir hom gesê dat dit die laaste keer is, dat as dit weer gebeur ek hom gaan aangee en dit het darem nie weer gebeur nie.

JC: Ek is bly u kon dit vir hom sê Mev Smith. Wanneer was dit nou weer?

S: Nee dit is lank terug, seker meer as 'n jaar. Soos ek sê ek het aan die begin hom soms teë gegaan, maar nie meer nie. Sy vorige vrou was ook 'n baie stil mens. Ek weet nie veel van haar nie, maar ek kry die idee dat sy ook maar stil gebly het en gedoen het wat hy sê. Ek het al vir sy dogter gevra hoe sy vorige vrou dit hanteer het en wat ek verdien het om so hanteer te word. Sy het gesê dat hy so is en dat dit sy ma se skuld was. Dat sy 'n "koue vis" was. Sy sê my man se vorige vrou het op haar knieë geboer….

Relational Experience 6

JC: Dit klink regtig of u vorige man nooit geleer het om intimiteit te hanteer nie?

S: Nee ek dink nie hy het ooit drukkies gekry en so nie. My gesin was heeltemal anders. Almal het gesê hulle het nog nooit 'n man en vrou gesien wat so goed oor die weg gekom het nie. Hulle was verskriklik lief vir mekaar. Daar was altyd vrolikheid en gelag in ons huis.

JC: Dit klink of daar baie min konflik was en alhoewel dit seker baie aangenaam was, asof u kinderdae u nie voorberei het vir konfliksituasies en hoe om uself te beskerm nie? Miskien was u ook baie afhanklik van u ouers.

S: Ek dink ek en my sussie was, maar sy meer as ek. Ek het darem Stellenbosch toe gegaan om te gaan studeer.

JC: Dit klink of dit goed vir u was, of u meer selfstandig daar geword het?

S: Dit was goed vir my, ek het mos onderwys gedoen en skool begin gee, ens.

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Relational Experience 7

S: Ek het al vir my sussie gesê dat wat ook al sy doen, dat sy tog nooit weer moet trou nie. Sy het gesê dat sy glad nie van plan is om weer te trou nie.

JC: Mev Smith, het u al gedink dit was 'n fout om weer te trou?

S: Ek weet nie. Dink nie dit was 'n fout nie. Ek is nie 'n alleen mens nie…Ons het net sewe maande mekaar geken. My suster se man het my aan hom voorgestel. Hulle het gedink hy is 'n oulike mens en hy is. Voor dit was ek betrokke met 'n skoolhoof, maar hy kon nie oor sy vorige vrou kom nie. Hy het ook vir my gesê, maar hy het my baie uitgeneem en ons het baie goed saam gedoen.

JC: So hy het amper teenstrydige boodskappe gegee?

S: Ja ek het toe maar besluit ek kan nie so aangaan nie. Dinge het vir 'n ruk lank tussen ons afgekoel. Ek het hom nie gebel nie en hy het my nie gebel nie en toe het ek vir Jack ontmoet. Hy is nie 'n slegte man nie. Hy is baie fyn. Hy sal byvoorbeeld as daar mense kom alles mooi reg sit ens., maar hulle sien hom nie as hy moeilik is nie. Hulle sien net die goeie goed en almal dink dit gaan baie goed. 'n Familielid van my was nou die dag by ons en toe het sy gehoor hoe lelik hy met my is en sy het toe uit haar eie met hom gaan praat. Ek het vir haar gesê sy moes liewers nie en ek wil liewers ook nie weet wat hy gesê het nie.

JC: Mev Smith dit moet baie moeilik wees vir u om met al die gevoelens rond te loop en niks daaraan te kan doen nie. Die Rorschach resultate het genoem dat u dalk soms onderlings kwaad raak? Miskien wys u dit nie? Ons almal raak soms kwaad en dink selfs soms verskriklike dinge dat ons iemand wil wurg of iets, maar dit maak nie noodwendig van ons 'n slegte mens nie…..Ek het byvoorbeeld nog nooit gesien dat u vir my vies raak of so nie?

S: Wel ek het regtig nog nooit beleef dat ek vir jou kwaad word of iets nie….Ek raak soms vies vir my man. Darem nie so erg dat ek hom wil wurg of iets nie. Maar ek sal byvoorbeeld vir hom 'n soen wil gee en dan draai hy weg en dan raak ek baie vies. My oorlede man het sy foute gehad, maar as hy in die vertrek ingekom het, het hy altyd vir my kom groet. Pieter, doen nie sulke goed nie.

JC: Dit klink of hy u baie seer maak?

S: Ek sal soms vir twee dae sleg voel.

JC: En niks vir hom sê nie?

S: Aan die begin het ek meer met hom gepraat maar deesdae bly ek maar stil. Ek het aan die begin vir hom jammer gesê as so iets gebeur, maar deesdae voel ek nie meer so nie, veral as ek voel ek het nie iets verkeerd gedoen nie. Ek was altyd 'n baie spontane mens, maar ek is nou baie minder so.

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JC: 'n Deel van u kom glad nie meer tot uiting nie…..

S: Ja. [She became more sad at some stage, I think roughly here.]

Relational Experience 8

JC: Mev Smith dit klink regtig of dit soms vir u moeilik is om negatiewe goed van u man te sê.

S: Ja ek weet ek moet dit nie doen nie. Dit is nie mooi van my nie. Hy doen baie goeie goed ook. My vorige man wou byvoorbeeld nooit na musiekvertonings, ens. toe gaan nie, maar Pieter sal onmiddellik vra wanneer ons die kaartjies gaan koop. Hy doen ook baie mense se belasting en help baie met goed om die huis, ens. Ek wens net soms hy kon meer wys. Ek sal byvoorbeeld vir hom sê as hy baie deftig lyk, maar hy sal nooit vir my so iets sê nie.

JC: En u is altyd baie mooi aangetrek.

S: Ek probeer.

JC: En op 'n manier hoop u ook dat as u genoeg vir u man sal komplimenteer, hy ook sal begin om dieselfde terug te doen, maar dit gebeur nie.

S: Nee niks verander nie.

JC: Wel Mev Smith miskien is dit goed dat u dit met iemand deel ook die negatiewe gedagtes. U sê dat 'n deel van u verlore geraak het. U kan nie op die oomblik met u man gesels nie so miskien is dit goed as u hier daaroor kan praat. Soos ek gesê het ons het almal soms aggressiewe gedagtes as mense ons seer of kwaad maak, en dit kan baie sleg wees as ons nie op een of ander manier uiting daaraan kan gee nie.

S: Daar is 'n engelse dame wat alleen is waarmee ek soms gesels. Sy is baie oulik en ek deel soms bietjie met haar.

JC: Ek is bly dat u met haar kan deel. Die Rorschach resultate het gewys dat u meer terughoudend as meeste mense is en dat u meestal baie van die negatiewe gevoelens binne hou. Die aggressie wat nie uitkom nie kan baie skadelik vir u wees. U noem byvoorbeeld dat u nou minder spontaan as voorheen is. Ons selfbeeld word tot 'n mate gevorm deur wat ander mense van ons dink. Dit klink of u man soms oordra dat u nie goed genoeg is nie en miskien het u dit vir uself begin sê. Miskien begin u self dink dat u nie goed genoeg is nie.

S: Ja jy is seker reg. Hy raak net omgekrap oor die kleinste goed. Ek is nie perfeksionisties nie, maar ek probeer als kry soos hy dit wil hê. Maar die kleinste goed. As die vrou die huis skoonmaak en byvoorbeeld goed so na as moontlik probeer sit waar dit was sal hy na die tyd dit kom skuif tot dit presies is soos dit was. Daar is byvoorbeeld 'n lepeltjie wat langs die

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radio lê, maar ek kan nie lekker die radio gebruik waar die lepeltjie lê nie, en as ek die lepeltjie net 'n sentimeter skuif, as ek weer kyk dan het hy dit terug geskuif.

JC: Dit klink amper asof daar konstant 'n klein koue oorlog aan die gang is. Dit moet baie uitputtend wees om onder sulke omstandighede te lewe.

S: Ja, ek wens net hy kon meer oor goed gesêls. Ek sal net 'n grappie of iets maak en dan sal hy vir my kwaad wees. Soms sê ek vir hom, "My man ek dit het nou regtig net as 'n grappie bedoel."

JC: En wat maak hy dan.

S: Hy sal net niks sê nie, hy sal nooit jammer sê of so nie. Maar ek weet hy sal nooit verander nie.

JC: U het al voorheen gesê dat hy nooit vir 'n sielkundige sal kom sien nie.

S: Nee nooit, hy sê sielkundiges moet hulle eie koppe gaan lees.

JC: Wel dit is seker soms waar! Maar dit is jammer dat hy nie meer oop was nie, want dit klink of daar dinge is wat vir hom ook kan help. Dit klink of hy ook byvoorbeeld baie terughoudend op 'n manier is.

S: Ja hy kan ook nie oor goed gesels nie. Ons doen eintlik dieselfde ding, maar net op verskillende maniere.

Relational Experience 9

JC: Ek is bly dat u dit kan raaksien Mev Smith. Ek dink byvoorbeeld dit sou baie kon help as iemand saam met u en u man kon sit en kon help om oor van die goed te gesels.

S: Ja, maar hy sal nooit kom nie.

JC: Dink u dat as 'n wonderwerk sou gebeur en ons kon hom byvoorbeeld hier kry, hy met iemand soos ek sou kon gesels.

S: Ek weet nie, maar hy sal baie kwaad wees as hy weet ek praat oor hom.

JC: Hy moet seker baie nuuskierig wees waaroor ons hier gesels?

S: Ja maar hy vra nooit niks nie.

JC: Ek weet dit is vir u moeilik om oor u man te gesels, maar soos u voorheen genoem het klnk of dit of 'n deel van uself baie skade lei in die verhouding. Asof u van u man se gedrag baie persoonlik opneem en dit u meer negatief oor uself laat voel. Ek dink daarom twee goed gaan baie belangrik in terapie wees. Die eerste is dat ek u wil herinner dat u spesiaal is en dat u baie spesiale eienskappe het. Ek wil amper aan 'n skat in 'n kleipot dink, want u is ook sensitief op 'n manier. Ek kan ongelukkig nie veel met u man werk is as hy nie hier is nie,

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maar ons moet ook kyk hoe ons u kan help om uself beter te beskerm. Hoe ons die skat kan beskerm sodat dit nie beskadig gaan word nie….[I think it was good for her to hear this.]
Ons moet seker ophou want ons is al oor die tyd en ek is bekommerd dat u te laat by die huis gaan kom as u man so gesteld is op kostye ens.
S: Ja en die verkeer! Ek wil nie nog in die moeilikheid kom by die huis nie.
S: Ek sal vir jou laat weet oor volgende week.
JC: Dankie Mev Smith. Hoop u geniet die naweek. Ons het nou nie baie ver met die Rorschach gekom nie, maar ons sal weer daaroor gesêls. U kan dit vat as u wil, maar ek vind dit is beter as ek dit by my hou en dan kan ons saam dit bespreek.
S: Dit is reg so, maar wat sê dit oor die algemeen.
JC: Wel dat u meer terughoudedend as meeste mense is, en daarom is dit vir my belangrik dat u nie moet huiwer om u gedagtes, soos oor u man, met my te deel nie, want dit kan maak dat ons dan aan die einde nie sinvol met mekaar kan gesels nie.

Letter to Supervisor

I did not experience this session as successful in that she did not seem to be making progress. I felt frustrated at the pace of therapy, but comforted myself that it was in fact only our 8th session and that I often only saw her on a very irregular basis. The previous session was for example a month before. I felt that therapy would be more successful if I could see her on a more regular basis. I even considered seeing Mrs Smith at the university which was closer to where she lived.

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Appendix C: Analysis of meaning units (REs) in Session 2, 5 and 8

Session: 2		**Response: 1**	
Client		**Therapist**	
A) Person/s or object/s at which WIN/s Directed Family members, sister, life, husband, therapist		**A) Person/s at which WIN/s Directed** Client	
B) WIN/s		**B) WIN/s**	
Towards Person/s Inferred: Wish for family members to be less demanding Expressed: Wish for sister to spend more time with her Inferred: Wish for life to be less difficult, wish for life to be the way it used to be Inferred: Wish husband's health was less restricting	**Towards Therapist** Inferred: Need therapist to hear the hardships she endured Inferred: Need for therapist to acknowledge how difficult her life is	**Towards Client/s** Inferred: Intention to show empathy.	**Towards Other Person/s**
C) Response of Person/s to WIN/s Inferred: From other sections it became clear that client's subjective experience was that her family and other people did not realise that they were a burden on her and continued to be a burden Inferred: Sister's response not known here, but in other sections it became clear that she seldom spent time with her Inferred: In other sections client continued to experience life as difficult and changing for the worse Inferred: From other sections it was clear that client continued to experience her husband's illness as restricting Inferred: Therapist acknowledges client's difficulties and shows empathy		**C) Response of Client to WIN/s** Observed: Shares more information regarding how difficult the last period in her life had been	
D) Client's Response to Self Inferred: Client feels helpless and that her resources are taxed Inferred: Client feels that she loses ability to control her life Inferred: Client feels unacknowledged by others Inferred: Client feels acknowledged by therapist		**E) Therapist's Response to Self** Inferred: Therapist feels frustrated at not being able to provide a solution to client's overwhelming difficulties	
G) Client's Response to Therapist's Response Observed: Client continues disclosing information		**F) Therapist's Response to whole RE** Inferred: Shows empathy	**Therapist's WIN/s** Inferred: Intention to show that client's difficulties are being heard and acknowledged

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Summary of RE1:

This RE occurs in the context of the following wishes:

- The client expresses her wishes and needs towards her family, including her husband and sister, and the therapist. Most of these WIN/s seem to focus on her need for people to acknowledge her suffering and to place less demands on her.
- A therapist intention to show empathy was inferred.

Within the context of these WIN/s, the following responses can be identified: In most cases the client does not experience her WIN/s as being acknowledged, resulting in her feeling helpless and overburdened as well as out of control. The therapist manages to acknowledge her suffering, but possibly experiences the same frustration as other people in her life at not being able to help her. The RE ends with the therapist continuing to listen, while the client feels acknowledged by the therapist and continues disclosing.

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<table>
<tr><td colspan="2">Session: 2</td><td colspan="2">Response: 2</td></tr>
<tr><td colspan="2">Client</td><td colspan="2">Therapist</td></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Therapist</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
N/a</td><td>Towards Therapist
Expressed: Wish for therapist to acknowledge that she managed to overcome difficult circumstances to some extent
Inferred: Still not 100% and still needs support</td><td>Towards Client/s
Expressed: Intention to obtain more information regarding husband’s illness and effect of illness on client</td><td>Towards Other Person/s
None</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Expressed: Therapist acknowledges client’s success
Inferred: Boosts client’s perception of being capable</td><td colspan="2">C) Response of Client to WIN/s
Expressed: Client provides information
Expressed: Client shares that she managed to overcome her concern about her husband’s illness to some extent
Inferred: Client OK, bit still needs support</td></tr>
<tr><td colspan="2">D) Client’s Response to Self
Inferred: Self as needing acknowledgment form others for efforts and successes
Expressed: Self as feeling more relaxed and at peace
Inferred: Self as too vulnerable and fragile to continue without external support</td><td colspan="2">E) Therapist’s Response to Self
None inferable</td></tr>
<tr><td colspan="2">G) Client’s Response to Therapist’s Response
Expressed: Accepts positive feedback and feeling more at peace
Inferred: Not 100 percent, needs external support despite successes</td><td>F) Therapist’s Response to whole RE
Therapist reflects client’s successes in dealing with her difficulties</td><td>Therapist’s WIN/s
Inferred: Intention to boost client’s perception of being capable to deal with difficult circumstances</td></tr>
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Summary of RE2:

This RE occurs in the context of the following WIN/s:

- An intention from the therapist to obtain more information regarding the client's difficulties and the effect on her life.
- A wish of the client for the therapist to acknowledge her successes, but to still provide support.

The therapist responds, by acknowledging the client's successes, possibly in an attempt to boost the client's perception of being capable, but does not directly acknowledge her vulnerability and neediness for continued support and help.

Notes:

It may have been useful to place more emphasis on her feelings of helplessness and fragility, rather than trying to boost her perception of being more efficacious. This may be related to the therapist feeling too vulnerable to sit with the discomfort of her suffering and therefore attempting a less uncomfortable position of highlighting her ability to cope. Although not necessarily wrong, this may be a more superficial intervention than attending to her feelings of helplessness and vulnerability.

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<table>
<tr><th colspan="2">Session: 2</th><th colspan="2">Response: 3</th></tr>
<tr><th colspan="2">Client</th><th colspan="2">Therapist</th></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Guests, husband, therapist</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
Inferred need for guests to be less demanding and to give her more privacy
Expressed: Wish for husband to be more understanding
Inferred: Need to comfort self and maintain hope</td><td>Towards Therapist
Inferred: Wish for therapist to understand the depth of her suffering
Inferred: Wish to fully express her suffering
Inferred: Need for therapist to see that she is in trying hard, but that that her suffering is even greater</td><td>Towards Client/s
Expressed: Need for more information regarding her BMS symptoms
Inferred: Need to find exceptions to suffering and to find solutions</td><td>Towards Other Person/s
N/a</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Expressed: Husband does not understand
Inferred: Guests do not respond to her wish for fewer demands and more privacy
Inferred: Therapist tries to find solutions to her difficulties</td><td colspan="2">C) Response of Client to WIN/s
Expressed: Provides extensive detail of her BMS symptoms
Inferred: Tries to show therapist that she has tried hard, but that her difficulties are too great</td></tr>
<tr><td colspan="2">D) Client's Response to Self
Inferred: Client feels depressed and helpless
Expressed: Dependent on outside sources, such as medication
Inferred: Rationalizes behaviour as acceptable given her circumstances-tries to comfort self</td><td colspan="2">E) Therapist's Response to Self
Inferred: Feels more relaxed if solution or exceptions can be provided, but less comfortable if fails</td></tr>
<tr><td colspan="2">G) Client's Response to Therapist's Response
Inferred: Response ignored, perhaps because client did not feel understood</td><td>F) Therapist's Response to whole RE
Expressed: Interprets relationship between symptoms and anxiety</td><td>Therapist's WIN/s
Expressed: Intention to help client to see relationship between symptoms and anxiety
Inferred: Need to provide solution</td></tr>
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Summary of RE3:

This RE occurs in the context of the following WIN/s:

- Client WIN/s are expressed to people in general to acknowledge her suffering and valiant attempts to deal with her suffering.
- Therapist WIN/ to provide exceptions and solutions the client's problems.

Most of the people, however are however not experienced as fully acknowledging the client's suffering or her attempts. This includes the therapist, whom in this RE seems to partially be involved with preventing discomfort to himself. As a result the client seems to become more helpless and depressed and feels even needier, perhaps because her needs are not being met. She tries to maintain hope for the future, by comforting herself, by focussing on the small comforts, such as medication and rationalising her own need for them as acceptable given her circumstances. The therapist responds to the RE by continuing to pursue the solutions agenda, while the client starts to refrain from responding, perhaps because her hope for someone to be different from other people outside is slowly diminishing.

Notes:

In this RE, the therapist again does not attend full to the client's emerging feelings of helplessness and needs, but rather pursued a solutions finding approach.

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<table>
<tr><th colspan="2">Session: 2</th><th colspan="2">Response: 4</th></tr>
<tr><th colspan="2">Client</th><th colspan="2">Therapist</th></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Therapist
Dentist
Self</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
Expressed: Wish for dentist or anyone to be able to help her
Inferred: Need to be as fortunate and healthy as other people</td><td>Towards Therapist
Expressed: Need for therapist to not see her in a vulnerable state
Inferred: Need for acceptance
Inferred: Need to not be humiliated and accepted as she is
Inferred: Need to show therapist that she has some control over her response to her difficulties</td><td>Towards Client/s
Expressed: Intention for more information regarding medication
Expressed: Wish to provide a space where the client can express her emotions without being judged</td><td>Towards Other Person/s
N/a</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Expressed: Dentists inability to provide any more help
Expressed: Therapist expresses assurance of unconditional acceptance
Expressed: Therapist expresses need for more information</td><td colspan="2">C) Response of Client to WIN/s
Expressed: Provides more information
Expressed: Shares emotional vulnerability</td></tr>
<tr><td colspan="2">D) Client's Response to Self
Expressed: Experience self as less fortunate than others around her
Expressed: Acknowledges own generalised sensitivity
Inferred: Experience of self as weak and vulnerable to external onslaughts</td><td colspan="2">E) Therapist's Response to Self
None inferable</td></tr>
<tr><td colspan="2">G) Client's Response to Therapist's Response
Shares more information regarding sensitive nature</td><td>F) Therapist's Response to whole RE
Expressed: Encourages to share more
Expressed: Assurance
Expressed: Acknowledgment of client's sensitivity</td><td>Therapist's WIN/s
Expressed: Intention to provide a safe environment
Inferred: Wish to show unconditional acceptance</td></tr>
</table>

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Summary of RE4:

This RE occurred in the context of the following WIN/s:

- Client: WIN/s to be helped, but at the same time not to be humiliated by being seen in her vulnerable state. Linked to her need to not be humiliated is a wish to maintain her self respect, by showing the therapist some degree of control over the expression of her emotional turmoil. She also expresses a need to be as fortunate as people around her.
- Therapist: The major WIN seems to be to provide a safe environment where the client can experience unconditional acceptance.

Unlike the previous two REs, the therapist manages to stay congruent with the client's current need for someone to acknowledge her suffering without offering judgement. The therapist manages to show empathy as in the first RE. Within this context the client responds by disclosing more of her own experiences. She moves to a more vulnerable state and seems to experience herself as fragile, but also incorporates a less judgemental perspective on herself as being a sensitive person. Unlike the previous RE where the therapist's disclosure was gradually being blocked, she continues sharing her feelings.

Note: The therapist may have interpreted how difficult it is for the client to be vulnerable in his presence rather than trying to convince her of the safety of the environment. Ironically the therapist here emphasises his wish to provide a place where the client can express her emotions, without judgement, whereas in the previous two REs this was indirectly suppressed through the therapist's need to provide solutions to her difficulties. Despite these possible shortcomings the therapist seems to have become more congruent to what the client needed. This may also be what created a sufficiently conducive environment for incorporating the interpretation of herself as a sensitive person.

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<table>
<tr><th colspan="2">Session: 2</th><th colspan="2">Response: 5</th></tr>
<tr><th colspan="2">Client</th><th colspan="2">Therapist</th></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Husband
Other people in general
Therapist</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
Expressed: Need husband to understand her and in particular her sensitive nature better
Expressed: Wish for husband to not become angry so easily
Expressed: Wish for husband to be more spontaneous and less serious
Inferred: Wish for husband to be more like her own family
Inferred: Need other people to understand her sensitive nature</td><td>Towards Therapist
Inferred: Need for therapist to understand her sensitive nature
Inferred: Need for husband to understand how difficult it was to live with her husband</td><td>Towards Client/s
Expressed: Intention for more information regarding sensitivity
Inferred: Need to show that different from other people and can be empathic
Inferred: Need to show that understand client
Inferred: From reflections therapist seems again to have a need to find a solution for the client</td><td>Towards Other Person/s
N/a</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Expressed: Husband does not understand and becomes angry
Expressed: People in general more understanding than husband
Inferred: Therapist listens and reflects understanding of client’s sensitive nature</td><td colspan="2">C) Response of Client to WIN/s
Expressed: Client provides disclosed more information regarding how difficult it is to live with her husband
Expressed: Client shares difficulties and depression</td></tr>
<tr><td colspan="2">D) Client’s Response to Self
Expressed: Feels hurt and sad
Inferred: Feels hopeless and confused (does not understand)</td><td colspan="2">E) Therapist’s Response to Self
Inferred form reflections: Feels satisfied with own increased understanding of client’s problem</td></tr>
<tr><td colspan="2">G) Client’s Response to Therapist’s Response
Expressed: Reiterates wish for husband to be more understanding.
Expressed: Continues disclosing her difficulties.</td><td>F) Therapist’s Response to whole RE
Expressed: Reflects sensitivity and emotional nature
Expressed: Reflects client’s difficulty to express emotions</td><td>Therapist’s WIN/s
Inferred form reflections: Still need to formulate problem and move closer to solution</td></tr>
</table>

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Summary of RE5

This RE occurred in the context of the following WIN/s:

- Client: Wish for people in general, but in particular her husband to understand her sensitive nature better. Also need her husband to be more like her own family: less serious, more spontaneous, less easily angered.
- Therapist: Need to show empathy and understanding of sensitive nature. Less prominently expressed is probably still a wish to move closer to an understanding of the client's problem so that solutions may be found for the client's difficulties.

The therapist seemed to be more understanding of the client's sensitivity than people in general and in particular her husband. This may have allowed the client to feel safe to disclose more of her suffering. Perhaps less visible to the client, but reasonably clear form the reflections is that the therapist continues with an agenda to find a solution to her difficulties. This is not necessarily a problem, since the therapist may provide a different perspective on the client's difficulties, but it was clear form RE2 and RE3 that expression of these WIN/s led to the client feeling less free to disclose her vulnerability. In this case they were not expressed and did not hamper further disclosure.

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<table>
<tr><th colspan="2">Session: 2</th><th colspan="2">Response: 6</th></tr>
<tr><th colspan="2">Client</th><th colspan="2">Therapist</th></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Husband and therapist</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
Expressed: Intention to satisfy husband</td><td>Towards Therapist
Expressed: Need therapist to acknowledge her effort and success
Inferred: Need therapist to see how hard she tries and how she managed to overcome limitations</td><td>Towards Client/s
Expressed: Intention to understand client’s unfulfilled needs better
Inferred: Intention to show that client’s efforts are acknowledged
Inferred: Need to protect client
Expressed: Intention to show that the difficulty of living with her husband is acknowledged</td><td>Towards Other Person/s
Inferred: Possibly need for client’s husband to be more appreciative of all client’s efforts</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Inferred: Husband does not acknowledge her efforts sufficiently
Expresses: Therapist acknowledges her efforts
Inferred: Therapist takes her side</td><td colspan="2">C) Response of Client to WIN/s
Discloses more of her difficulties</td></tr>
<tr><td colspan="2">D) Client’s Response to Self
Inferred: Feelings of pride and accomplishment
Inferred: Experience self as martyr</td><td colspan="2">E) Therapist’s Response to Self
Non inferable</td></tr>
<tr><td colspan="2">G) Client’s Response to Therapist’s Response
Expressed: Becomes sad and discloses more of suffering and fear of husband</td><td>F) Therapist’s Response to whole RE
Expressed: Empathically reflects sadness through metaphor and rhetorical question</td><td>Therapist’s WIN/s
Inferred: Need to comfort client</td></tr>
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Summary of RE6

This RE occurred in the context of the following WIN/s:

- Client: Expresses intention to satisfy husband and need for this effort and difficulty of living with her husband to be acknowledged.
- Therapist: Intentions to show client that she is heard and understood, and possibly a further need to protect her from further suffering.

Within this context the client continues to disclose her difficulties and visibly displays her sadness. The therapist seems to side with the client. This may have created the sense of the therapist as an ally, which may have facilitated further disclosure, but will probably eventually result in the therapist having less capacity to have an outside perspective. Blaming the husband may also have many further repercussions such as preventing the client form taking responsibility for her own role and in terms of increasing conflict between the client and her husband. Although the client's efforts are acknowledged in general the therapist does not validate her feeling of sexual accomplishment directly. This may have been important, since she seemed proud about it and seemed to be asking for acknowledgement. Regardless the client continues to disclose her frustration and difficulties.

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<table>
<tr><td colspan="2">Session: 2</td><td colspan="2">Response: 7</td></tr>
<tr><td colspan="2">Client</td><td colspan="2">Therapist</td></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Husband and therapist</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
Inferred: Wish for husband to treat her with more respect
Inferred: Wish for husband to be more tolerant towards her and to be less easily angered
Inferred: Wish for husband to apologise when he makes a mistake
Inferred: Wish for husband to acknowledge her efforts at pleasing him</td><td>Towards Therapist
Inferred: Need therapist to acknowledge the unfair treatment she endures
Inferred: Need to be comforted</td><td>Towards Client/s
Expressed: Intention to gain access to client’s emotions in conflict situations
Expressed: Intention for more examples of conflict with husband
Inferred: Need to find solutions through evaluation of exceptions in behaviour</td><td>Towards Other Person/s
Inferred: Need for husband to be more fair towards his wife
Inferred: Need for husband to also take responsibility for his own role</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Expressed: Husband becomes angry with client and does not treat her with respect
Expressed: Husband does not apologise and does not acknowledge her efforts
Expressed: Husband rejects client
Expressed: Therapist listens and interprets her vulnerability</td><td colspan="2">C) Response of Client to WIN
Expressed: Shares emotions
Expressed: Gives examples of conflict situations</td></tr>
<tr><td colspan="2">D) Client’s Response to Self
Expressed: Feels hurt by husband’s response
Expressed: Becomes passively angry at husband
Expressed: Gives in to husband’s demands
Expressed: Suppresses anger towards husband
Inferred: Self as vulnerable and fragile
Inferred: Self as unable to successfully negotiate conflict situations with her husband
Inferred: Frustration with self
Expressed: Self as peacemaker and giving space</td><td colspan="2">E) Therapist’s Response to Self
Non inferable</td></tr>
<tr><td colspan="2">G) Client’s Response to Therapist’s Response
Expressed: Acknowledges part of the interpretation of self as peacemaker and husbands shortcomings, but refrains from commenting on other comments about her role in conflict situations</td><td>F) Therapist’s Response to whole RE
Expressed: Interprets client’s response to conflict</td><td>Therapist’s WIN/s
Inferred: Need to increase client’s insight.
Inferred: Need to provide solution.</td></tr>
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Summary of RE7

This RE occurred in the context of the following WIN/s:

- Client: Generally WIN/s towards her husband for more tolerance towards her, for respecting her, for acknowledging her efforts. Towards the therapist a wish to be comforted and acknowledgement of her unfair treatment was inferred.
- Therapist: Wish to find a solution for the client's difficulties as well as a wish that her husband would treat her more fairly.

Within this context the client continued to share her emotions. She expressed her anger towards her husband. From her responses some feelings towards herself was inferred, namely feelings of impotence, frustration towards self. When her role in conflict situations was interpreted, she did not in general respond to interpretations which may have reflected negatively on her. She did however respond to interpretations such as herself as a peacemaker which has a more positive connotation. In this RE the therapist may thus have been perceived as aligning both with and against her. The client was only able to acknowledge positive feedback as well as criticism against her husband. Again in this RE it seems as if the therapist in some instances aligned with the client against her husband, which may have repercussions further on in therapy.

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<table>
<tr><td colspan="2">Session: 2</td><td colspan="2">Response: 8</td></tr>
<tr><td colspan="2">Client</td><td colspan="2">Therapist</td></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Therapist and husband</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
Inferred: Need for husband to change
Inferred: Need for husband to be more tolerant towards her and less easily angered
Inferred: Wish for husband to stop abusing her
Inferred: Need to sometimes be right and be acknowledged for this</td><td>Towards Therapist
Inferred: Need for therapist to understand the impossibility of her situation.
Inferred: Need for someone to know what she has been through in terms of physical abuse
Inferred: Need for therapist to acknowledge her right to claim space</td><td>Towards Client/s
Expressed: Need for information regarding exceptions in dealing with conflict
Inferred: Need to provide a solution</td><td>Towards Other Person/s
Inferred: Need for husband to be more fair and give client more of a chance to stand up for herself</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Expressed: Therapist acknowledges the difficulties she faces attempting to stand for her rights
Inferred: Therapist colludes with helplessness
Inferred: Seems from other sections, husband does not change</td><td colspan="2">C) Response of Client to WIN/s
Expressed: Shares exceptions, ending in failure
Expressed: Needs therapist to see that she has tried
Inferred: Needs therapist to understand the impossibility of changing her situation</td></tr>
<tr><td colspan="2">D) Client's Response to Self
Inferred: Cannot change situation, self as "uitgelewer"</td><td colspan="2">E) Therapist's Response to Self
Inferred: Helplessness
Inferred: Anger towards husband</td></tr>
<tr><td colspan="2">G) Client's Response to Therapist's Response
Inferred: No response to interpretation was observed or could be inferred</td><td>F) Therapist's Response to whole RE
Expressed: Interprets client's general incapacity to deal with conflict situations</td><td>Therapist's WIN/s
Inferred: Need to make client aware of her own role, i.e. to increase her sense of having an influence interpersonally
Inferred: Still need to find a solution</td></tr>
</table>

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Summary of RE8

This RE occurred in the context of the following wishes:

- Client: Wish for husband to change, by becoming more tolerant towards her and giving her more space. At the same time however there is a wish for the therapist to acknowledge her suffering, but also to see that she has tried and that her situation is impossible and that she has very little control over her circumstances.
- Therapist: Still has a need to find a solution through finding exceptions in her behaviour. At the same time there is growing frustration with the husband and a need for him to provide her with more space.

Within the context of these wishes the client expressed examples of conflict situations, possibly to show the therapist the extent of her difficulties. When the therapist attempts to find a solution, the client brings into therapy even worse examples of mistreatment by her husband. It seems that while she is overly asking for people to acknowledge her and to give her more say, she at the same time rejects any attempt from the therapist to show her that she has some influence in interpersonal conflict situations. Although bringing in the extreme example of her husband beating her may be very relevant in this discussion, it is also interesting that it is brought in as soon as her own role is being investigated. She seems to ask for more power, but immediately rejects taking responsibility for her own role. The extreme nature of her example is sufficient to stop the therapist temporarily from trying to find alternative ways for her to deal with her situation. By trying to find exceptions and solutions the therapist's own wish is in conflict with one of her wishes in this RE, namely of the therapist acknowledging that she does in fact have no control and is a victim in need of comfort. Through her example she effectively manages to stall the therapist from directing her towards taking more responsibility. It may have been more fruitful to simply interpret the client's emotions and feelings and allow herself to eventually find her own solutions. Perhaps the therapist's need to find solutions is premature, especially in the context of this only being the second session.

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Session: 2		**Response: 9**	
Client		**Therapist**	
A) Person/s at which WIN/s Directed Therapist		**A) Person/s at which WIN/s Directed** Client	
B) WIN/s		**B) WIN/s**	
Towards Person/s	**Towards Therapist** Inferred: Need for therapist to acknowledge the effort she had to go through Inferred: Intention to create an excuse for the quality, should her effort not be seen as sufficient Inferred: Wish for therapist's acceptance and praise	**Towards Client/s** Expressed: Need to show client that she is more capable than she thinks Inferred: Need to create state of unconditional acceptance Expressed: Need to create an atmosphere of openness	**Towards Other Person/s** N/a
C) Response of Person/s to WIN/s (Expressed/Inferred): Expressed: Therapist acknowledges her effort Expressed: Therapist interprets her difficulty to refuse external demands Expressed: Therapist interprets her behaviour Inferred: May have colluded with her sense of vulnerability and continuous need for external confirmation		**C) Response of Client to WIN/s** Inferred from observations: Acceptance of therapist's interpretation	
D) Client's Response to Self Inferred: Feels effort accepted and more self confident in therapeutic environment Inferred: Sense of self as needing external validation in order to feel OK may have been strengthened		**E) Therapist's Response to Self** Inferable: Therapist may have felt too insecure to allow client's discomfort and therefore needed to reduce the client's anxiety	
G) Client's Response to Therapist's Response Observed: Seems to accept therapist's interpretation		**F) Therapist's Response to whole RE** Expressed: Interprets client's outward appearance of weakness Expressed: Interprets client's inner potential or strength Expressed: Interprets client's unmet needs	**Therapist's WIN/s** Inferred: Need to increase client's sense of autonomy Inferred: Need to stop her from suffering further Inferred: Need to reduce the client's anxiety

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Summary of RE9

This RE occurred in the context of the following WIN/s:

- Client: Wish for the therapist to acknowledge her effort, but at the same time build in safeguard against any possible criticism of her work.
- Therapist: Intention to create an open and safe environment and at the same time improve the client's sense of self worth. Also present is a need to reduce the discomfort the client is feeling at being evaluated.

Within this context the client seems to feel less anxious and feels safer in the environment. She is also capable of accepting the therapist's interpretation of her strength. Perhaps the therapist responded in the same way as people around her in trying to comfort and confirm, in this way colluding with her sense of not being self sufficient, but needing external validation. Perhaps it would have been more valuable for her to experience the therapist as accepting, non-verbally rather than verbally as was the case here. The therapist could also have interpreted her need for his approval, without providing the assurance as was done in this RE. It seems as if the therapist's own sense of insecurity resulted in a need to comfort the client.

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<table>
<tr><th colspan="2">Session: 2</th><th colspan="2">Response: 10</th></tr>
<tr><th colspan="2">Client</th><th colspan="2">Therapist</th></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Therapist</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s</td><td>Towards Therapist
Expressed: Need to convince therapist that he is doing well and not causing her any frustration or irritation
Inferred: Need to not show own anger and frustration</td><td>Towards Client/s
Expressed: Need for client to feel safe
Expressed: Need to create space where client may become angry and share feelings more openly
Expressed: Need to convince client that therapist mature enough to accept criticism and anger</td><td>Towards Other Person/s</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Expressed: Reiterates previous RE’s invitation for client to share her anger and feelings more openly</td><td colspan="2">C) Response of Client to WIN/s
Expressed: Acknowledges therapist’s attempts at creating a safe environment.
Expressed: Cannot accept challenge to show anger and frustration towards therapist</td></tr>
<tr><td colspan="2">D) Client’s Response to Self
Expressed: Feels unable to conform to request. Perhaps does not feel safe enough to express own frustration spontaneously
Inferred: Fear of being rejected if feelings shared openly</td><td colspan="2">E) Therapist’s Response to Self
Inferred for reflections: Doubts own ability to be neutral enough for client to express her frustration, doubts own therapeutic ability
Inferred form reflections: Doubts own ability to deal with client’s expressed anger in therapy</td></tr>
<tr><td colspan="2">G) Client’s Response to Therapist’s Response
Expressed: Comforts therapist
Expressed: Does not want to express anger or frustration towards therapist</td><td>F) Therapist’s Response to whole RE
Expressed: Reiterates invitation to share angry feelings
Expressed: Acknowledges own shortcoming in activating overt anger
Expressed: Interprets client’s appearance of vulnerability</td><td>Therapist’s WIN/s
Inferred: Need to force or manipulate client to share more openly</td></tr>
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Summary of RE10

This RE seems to still be influenced by the insecurity of the therapist inferred in the previous RE. The RE occurred in the context of the following WIN/s:

- Client: Need to convince the therapist that he is doing well and not causing any frustration or discontent.
- Therapist: A wish to make the client feel comforted and safe, but at the same time still a need to convince client and self that therapist is mature enough to deal with criticism.

In RE9 and RE10 the therapist seems to struggle with his own sense of insecurity regarding his ability to deal with negative criticism or anger from the client. Also the therapist seems to struggle to remain with the client's discomfort and has a need to reduce the client's discomfort and anxiety, probably in order to decrease his own anxiety. The result does not seem to be therapeutic and results in the client developing a need to comfort the therapist. In this RE the roles of therapist and client became very blurred.

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Session: 2		**Response: 11**	
Client		**Therapist**	
A) Person/s at which WIN/s Directed Therapist and Husband		**A) Person/s at which WIN/s Directed** Client	
B) WIN/s		**B) WIN/s**	
Towards Person/s Expressed: Wish for husband to be more understanding	**Towards Therapist** Expressed: Intention for therapist to understand how difficult it is for her to come to therapy Expressed: Intention for therapist to know how her husband feels about psychologists Inferred: Need to convey own uncertainty about usefulness of seeing a psychologist or therapist Expressed: Need for therapist to give advice on dealing with husband	**Towards Client/s** Inferred: Need to facilitate client's return to therapy (keep client in therapy) Inferred: Need to not directly interfere with client's relationship Inferred form reflections: Intention for client to take responsibility	**Towards Other Person/s**
C) Response of Person/s to WIN/s Expressed: Therapist try to find solution for client's problems, provides some direction and advice Expressed: At same time therapist tries to get client to take responsibility for own difficulties with husband Expressed: Husband does not accommodate client's need for understanding		**C) Response of Client to WIN/s** Expressed: Very vague commitment to try to resolve problem with her husband	
D) Client's Response to Self Inferred: Self as impotent to affect change in relationship with husband Inferred: Self as impotent to direct own life		**E) Therapist's Response to Self** Inferred: Possibly sense of insecurity at clients hint that she may not be able to continue with therapy	
G) Client's Response to Therapist's Response Inferred: Partially Resists therapist's attempt for her to take responsibility, but agrees to try		**F) Therapist's Response to whole RE** Expressed: Importance for client to take responsibility for own life and to realise own potential	**Therapist's WIN/s** Inferred: Need for client to grow and be less dependant on others

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Summary of RE11

This RE occurred in the context of the following WIN/s:

- Client: In general the client's WIN/s seems to be focussed on the client needing the therapist to acknowledge how difficult it is for her to come to therapy and also possibly to indirectly express her uncertainty about the usefulness of therapy. At the same time however ambivalence may be inferred from her request on advice in dealing with her husband's reluctance to attend to therapy.
- Therapist: Different wishes are apparent in the therapist's case. A new theme emerges of him trying to not interfere with the client's relationship with her husband, but this links with an older intention to increase the client's sense of autonomy and ability to affect change in her relationship. Another wish to keep the client in therapy also emerges.

Within the context of the above WIN/s, the client partially resists the client's push towards greater acceptance of her own responsibility and power in her relationship with her husband. She also does not seem to want to directly take responsibility for continuing or terminating therapy. It seems that she is still ambivalent about continuing with therapy, but prepares the therapist for the possibility that she may stop in future. This may be because of her own fear to face the anxiety of expressing the fact that her needs are not being met in therapy, but may also be because of her fear of the therapist being hurt in the process. During the last three REs the therapist's own insecurities may have become more of a burden for the client, which would make it more difficult for her to leave, but also make therapy more complicated for her, since she cannot concentrate on her own needs.

Context in terms of:

- **Initial observations**

  Client appeared tired.
- **Final Reflections**

  Therapist was capable of feeling empathy, and even endearment, towards client.

  Therapist feels frustrated at clients long detailed recounting of seemingly insignificant details.

  Therapist feels good about session and good about professionalism.

After analysis the final reflections needs alteration, indicating that the analysis added to the therapist's understanding of his interpersonal interaction with the client.

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Session: 5		Response: 1	
Client		**Therapist**	
A) Person/s or object/s at which WIN/s Directed Therapist		**A) Person/s at which WIN/s Directed** Client	
B) WIN/s		**B) WIN/s**	
Towards Person/s N/a	**Towards Therapist** Expressed: Need to know that there are more people suffering like herself Inferred: Need to know that she is not alone in her suffering Inferred: Need for therapist to acknowledge how overwhelmed she is by her symptoms Inferred: Also possibly a need to assess the therapist's ability to treat people suffering with similar symptoms and therefore herself	**Towards Client/s** Expressed: Intention to provide information regarding somatic symptoms Inferred: Intention to console in that she is not alone Inferred: Need to give hope, but also not to give false hope Inferred: Intention or need to convince client that therapist has experience and knowledge in dealing with people suffering with similar symptoms	**Towards Other Person/s** N/a
C) Response of Person/s to WIN/s Expressed: Therapist consoles and attempts to provide some hope Inferred: Therapist tries to convince client that he is qualified to deal with her illness		**C) Response of Client to WIN/s** Expressed: Client seems overwhelmed by how difficult it is to treat somatic symptoms Inferred: Seems to accept that therapist may have experience with helping other people, but possibly still doubts his capacity to help her	
D) Client's Response to Self From observations: Seems to feel that she may not be helpable Inferred: Possibly feels like a failure in therapy		**E) Therapist's Response to Self** Inferred: Fear of giving false hope and disappointing client's expectations of therapy and the therapist Inferred: possibly feels unsure about own ability to help her	
G) Client's Response to Therapist's Response Expressed: Seems to accept therapist's explanation and acknowledge interpretation that her symptoms may be related to stress		**F) Therapist's Response to whole RE** Expressed: Explains why therapy needs to explore distressful situations	**Therapist's WIN/s** Inferred: Need to convince self that there are sufficient reason to allow client to experience and explore stressful situations Inferred: Need not to cause unnecessary distress

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Summary of RE1:

This RE occurs in the context of the following WIN/s:

- Client: Seems overwhelmed by her symptoms and situation and need assurance from the therapist that there are more people suffering with the same symptoms, i.e. that she is not alone, and also to feel that the therapist is qualified to deal with people suffering from similar symptoms.
- Therapist: The therapist in turn intends to provide information, both to educate the client, but possibly also to comfort the client in that she is not alone, and that he is qualified in dealing with her illness.

Within the above context the client seems overwhelmed by how difficult it is to treat the symptoms she suffers from. Although she seems to accept that there are more people suffering with the same symptoms and that the therapist has some exposure to working with similar cases, she still seems to doubt his ability to help her, i.e. that her case may be different and more complicated than others. Although the therapist is on the one hand educating the client regarding her symptoms and their possible causes, he also seems to be trying to convince her and possibly himself of his capacity to deal with her illness. The therapist is also preoccupied with another theme of not causing unnecessary pain and in this RE motivates his reasons for asking the client to explore distressing events and emotions. In other RE's (e.g. session 8) the client's need for someone to take responsibility for her and to protect her form pain becomes apparent. Unknowingly the therapist my thus here have been colluding with a need from her side to be protected from harm. In this RE the therapist seems unsure about his own capacity to help the client and this is reinforced by the client's thoughts about herself that no-one can in fact help her. In retrospect it seems that a more profitable approach may have been to interpret the client's feelings of being alone in her suffering and also her sense of hopelessness and that no one could truly understand or help her, including the therapist. Whereas this could have lead to a deepening of her experienced emotion, the current RE remains on a more superficial level, of the client needing to be comforted and the therapist trying to do this, while at the same time trying to convince the client and himself of his capacity to help her.

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Session: 5		Response: 2	
Client		**Therapist**	
A) Person/s at which WIN/s Directed N/a		**A) Person/s at which WIN/s Directed** Client	
B) WIN/s		**B) WIN/s**	
Towards Person/s N/a	**Towards Therapist** None inferable	**Towards Client/s** Inferred: Need to consolidate client's insight regarding the cause of her symptoms-need to move towards a goal Inferred: Need to make client aware of additional work being done by the client outside of therapy by the therapist Inferred: Need to give client hope by pointing out advantages in her specific case and highlighting her own successes	**Towards Other Person/s** N/a
C) Response of Person/s to WIN/s N/a		**C) Response of Client to WIN/s** Expressed: Seems to accept stress-pain hypothesis	
D) Client's Response to Self N/a		**E) Therapist's Response to Self** Inferred: Possibly still unsure about own ability and needy of external validation of effort put into therapy	
G) Client's Response to Therapist's Response None inferable		**F) Therapist's Response to whole RE** Expressed: Explains understanding of client overall experience of symptoms	**Therapist's WIN/s** Inferred: Need to convince client that she is taken seriously and that the realness of her pain and suffering is not being ignored Inferred: Need to formulate overall understanding of problem Inferred: Need to explain process of client

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Summary of RE2:

This RE occurs in the context of the following WIN/s:

- Therapist: Exhibits a strong need in this section to consolidate and make fast client's progress up to present. There is also a need to give client hope, by highlighting the advantages in her case due to the insight she has shown up to present. Finally the therapist seems to need external confirmation of his own effort in therapy.
- Client: None inferable

This RE seems like a monologue by the therapist. There seems to be a strong drive by the therapist to overcome his own feelings of inadequacy by formulating the client's problem on a very cognitive level, informing her of additional work done outside of therapy as well as trying to provide her with hope for future progress. Whether the comfort is actually for the client or the therapist, is unclear. The fact that no WIN/s for the client is inferable form this RE, indicates a high probability that the therapist was not sufficiently acknowledging the client's needs and that it is highly likely that she did not feel heard and acknowledged. The next RE starts with a new question by the client and no opportunity is created for the client to sufficiently interact with the therapist. This RE seems to still vey much be an overflow from the previous session, where the therapist started validating himself and the reasons for the process he followed in therapy. This RE creates the impression of the therapist talking to himself and comforting himself, and nearly, albeit unintentionally excluding the client's experience.

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<table>
<tr><th colspan="2">Session: 5</th><th colspan="2">Response: 3</th></tr>
<tr><th colspan="2">Client</th><th colspan="2">Therapist</th></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Therapist, Self, Other woman, dentist, family member</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
Expressed: Intention towards self to stay positive and to not think about negative things
Inferred: Need for other woman to give her advice and comfort her regarding her symptoms
Inferred: Needs dentist's assurance
Expressed: Need family member dentist to confirm dentist's decision and to assure her</td><td>Towards Therapist
Expressed: Need for therapist to acknowledge how overwhelmed she is by the symptoms and how desperate she is and would do anything to get relief
Inferred: Need for therapist to hear how hopeless she feels and not to focus on small improvements
Inferred: Needs therapist to be acknowledge how she has tried nearly everything to ensure that the operation would be successful</td><td>Towards Client/s
Expressed: Intention for more information regarding symptoms
Inferred: Intention to focus client's attention on observable improvement
Expressed: Empathic reflection of concerns</td><td>Towards Other Person/s
N/a</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Expressed: Therapist enquires more about symptoms, empathically reflects
Inferred: Therapist let go of need to emphasis improvement seen
Expressed: Other woman previously scared to tell her what she thought, possibly because she did not want to upset client</td><td colspan="2">C) Response of Client to WIN/s
Inferred: Client does not link strongly with idea of feeling better, but rather starts talking about how overwhelmed she seems by her situation</td></tr>
<tr><td colspan="2">D) Client's Response to Self
Inferred: Feels different from others, feels sorry for self
Inferred: Struggles to stay positive and maintain hope
Inferred: Possibly regrets her decision for operation, or for not paying more, by going to a specialist.</td><td colspan="2">E) Therapist's Response to Self
None inferable</td></tr>
<tr><td colspan="2">G) Client's Response to Therapist's Response
Expressed: Client acknowledges therapist's understanding of her situation</td><td>F) Therapist's Response to whole RE
Expressed: Reflects client's desperateness and willingness to go to extremes for relief of her symptoms</td><td>Therapist's WIN/s
Inferred: Intention to try to acknowledge client's need for her suffering to be acknowledged and to let own agenda for focussing on improvement go.</td></tr>
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Summary of RE3:

This RE occurs in the context of the following WIN/s:

- Therapist: Initially the therapist intends to focus on improvement that seemed to be objectively observable. Gradually the therapist surrendered this need and empathically reflected the client's emotional state and concerns.
- Client: Desperate need for assurance and advice from external sources. At the same time an intention towards self to stay positive and maintain hope. Towards the therapist a need may be inferred for him to not neglect the seriousness of her symptoms, by addressing small improvements.

Interesting how the client initially objectively appears improved in this session, but when the therapist comments on this and starts focussing on her symptoms, she becomes progressively more distressed. Different reasons for this may be hypothesised. Either the client does not want to be seen as feeling better, because this would imply less caring from the therapist, or possibly more likely and better substantiated by the data is that she tried to look better initially, but that this was only very superficial. Her continuous mention of needing to stay positive and to maintain hope, gives some support for the latter. It seems as if I this session she has slightly more resources available, for creating an outward impression, but that this is very limited and after only some probing, she started focussing on her feelings of depression and hopelessness. In this RE the client initially tries to focus on improvement seen, but the client does not seem receptive to such interpretations, and refocuses the attention on the suffering and concern she experiences. When the therapist manages to relinquish his original intention, the client continues by disclosing her feelings of hopelessness and desperation. Some feelings towards her self is also inferable. She seems to feel sorry for herself and probably realises that she is not managing to stay positive and hopeful towards the future. Some degree of self blaming regarding her decisions may also be present. It may have been fruitful to reflect this to her, i.e. that she tried everything in her possibility to ensure that she made the best informed decision, but that regardless of this, the operation did not seem successful.

Rereading this RE initially, resulted in the therapist feeling frustrated at the client for focussing so much on her symptoms. After analysis the therapist realised that this was probably similar to the reaction of other people outside of therapy towards her. Whatever the cause of the symptoms, it seems clear that the client is under considerable distress and seeks to be heard and comforted. In the following RE it however became clear that the therapist was still driving towards finding a solution.

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Session: 5		**Response: 4**	
Client		**Therapist**	
A) Person/s at which WIN/s Directed Therapist, Husband, People in general		**A) Person/s at which WIN/s Directed** Client	
B) WIN/s		**B) WIN/s**	
Towards Person/s Expressed: Wish for husband to be more understanding, to show more sensitivity towards her and to enquire more about her wellbeing Inferred: Wish for her husband to talk and to listen to her more Expressed: Need to have someone to talk to	**Towards Therapist** Inferred: Need for therapist to stop focussing on improvements, but rather to acknowledge her difficulties, to understand her better Inferred: Need for therapist to hear how scared she is of the last procedure being a failure	**Towards Client/s** Inferred: Need for client to acknowledge improvement as perceived by the therapist Inferred: Need for client to improve Expressed: Intention to show connections between tongue and gum pain	**Towards Other Person/s**
C) Response of Person/s to WIN/s Expressed: Therapist continues to focus on his subjective perception of client's improvement, but does acknowledge that her pain is still present		**C) Response of Client to WIN/s** Inferred: Therapist perceives client as lightening up at mention of more hope. Inferred: Client partially rejects therapist observation of her improvement and attempts to refocus his attention on the distress she experiences	
D) Client's Response to Self Inferred: Does not feel heard Inferred: Experience self as unable to continue without external support-dependant on others Inferred: Feelings of shame at needing other people so much		**E) Therapist's Response to Self** Inferred: Some satisfaction at effectively reflecting client's public sense of self and her responding to this	
G) Client's Response to Therapist's Response Inferred form observation: Client seems to appreciate therapist's acknowledgment of her pride and how hard she tries not to be a burden on others despite her difficulties		**F) Therapist's Response to whole RE** Expressed: Interprets how important it is for her that other people not see her as a burden	**Therapist's WIN/s** None inferable

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Summary of RE4:

This RE occurred in the context of the following WIN/s:

- Therapist: Need for client to acknowledge improvement as perceived by the therapist. A need of the therapist for the client to improve may also be inferred.
- Client: The client mentions a wish to have someone to talk to her, to listen to her and to understand her. She wishes her husband could be more like this and could understand her better. Similarly a need for the therapist to understand and hear her better can be inferred.

This RE seems to be a continuation of the themes of the previous RE. The therapist again tries to focus on the improvement he perceived to have taken place since the previous session, while the client again tries to refocus the therapist's attention on the difficulties she experiences. She seems to resist interpretations of improvement, probably indicating that they are immature. It seems as if the therapist does not sufficiently hear what the client is asking for and her need for him to stop focussing on the improvements, but rather staying with her need to be heard and acknowledged. Although the therapist perceives the client as lightening up at the mention of her seeming more hopeful about the future, she quickly returns to discussing her distress and need to be understood and acknowledged. It may be possible that she could accept an interpretation of her seeming more hopeful as less threatening than an interpretation of an improvement in her symptoms. I.e. perhaps this could be viewed by her as something she managed despite her difficulties. In a similar vain, when the therapist interprets how important it is for her to not be a burden on others and how hard she tries, she seems to respond in a positive way and does not resist the interpretation. Overall in this RE the therapist did not seem very in touch with what the client is asking for, but continues focusing on the small improvements as perceived by him, but probably not by the client. The therapist does not, for example respond to her fear of the last procedure being a failure or to her need for him to focus more on her suffering. In retrospect, the overall impression of this RE is that of a client in extreme distress, needing external support and acceptance, but unable to ask for this directly from anyone. It seems that one way for her to obtain this support is through her symptoms. Any interpretation of improvement in her symptoms may therefore be perceived as a threat to her since her motivation for needing assistance is then removed. She seems to feel ashamed at her neediness for other people and also the therapist, but the therapist effectively forces her to push harder for his support and caring. Focussing on her symptoms in any way, except possibly acknowledging them, seems to have very little therapeutic value. The two successful interpretations in this RE seemed to have been when the therapist accurately reflected his understanding of the client and her needs.

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<table>
<tr><th colspan="2">Session: 5</th><th colspan="2">Response: 5</th></tr>
<tr><th colspan="2">Client</th><th colspan="2">Therapist</th></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Husband, self, therapist</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
Expressed: Wish for husband to need her more
Inferred: Wish to feel more of value to someone</td><td>Towards Therapist
Expressed: Need for therapist to understand that she is not unappreciative of her husband’s effort around the house his attempts to be strong</td><td>Towards Client/s
Expressed: Intention to interpret her need for her husband to need her more
Expressed: Need to show client that therapist is aware and not insensitive to husband’s illness</td><td>Towards Other Person/s
N/a</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Inferred: Husband seldom shows any needs towards her
Expressed: Therapist interprets her wish to be more needed by her husband</td><td colspan="2">C) Response of Client to WIN/s
Expressed: Client acknowledges her need for her husband to need her more</td></tr>
<tr><td colspan="2">D) Client’s Response to Self
Inferred: Feels ashamed at not being able to be as independent as husband
Inferred: Does not feel that she is worthwhile-husband does not need her</td><td colspan="2">E) Therapist’s Response to Self
None inferable</td></tr>
<tr><td colspan="2">G) Client’s Response to Therapist’s Response
Expressed: Acknowledges affection towards husband</td><td>F) Therapist’s Response to whole RE
Expressed: Interprets client’s affection for her husband</td><td>Therapist’s WIN/s</td></tr>
</table>

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Summary of RE5

This RE occurred in the context of the following WIN/s:

- Therapist: The therapist starts with a need to indicate that he is aware of her husband's illness as well as an intention to interpret how much she needs her husband to need her more.
- Client: The client in turn seems to have a wish to feel more of value to someone and her husband in particular. She also needs the therapist to understand that she is not ungrateful of her husband's effort.

After the previous RE's end, with the client referring to her husband's illness, it seems as if the therapist suddenly realises that he hardly ever acknowledges her husband's illness and suffering. In a way this mirrors what often occurred in therapy. Although her husband is never physically in therapy, he is often discussed. The client would for example often complain about her husband's behaviour, but then immediately after feeling guilty at doing this, then highlighting all his good characteristics. Perhaps in a similar way the therapist felt guilty here at neglecting her husband's needs. The therapist was probably not responding here to the client's conversation, but rather to an internal cue of not being fair towards the husband. Perhaps this also triggered the client's need to indicate that she is not unthankful for her husband's efforts. When the therapist acknowledges her wish to be needed more by her husband, she acknowledges this. Shame at not being able to suppress her needs as well as her feelings about her husband, can be inferred. It also seems that she does not feel worthwhile and does not feel that she has value in other people's lives and her husband's life in particular. In this RE the therapist could have interpreted her need to be needed by someone, to have meaning in someone else's life.

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Session: 5		**Response: 6**	
Client		**Therapist**	
A) Person/s at which WIN/s Directed		**A) Person/s at which WIN/s Directed** Client	
B) WIN/s		**B) WIN/s**	
Towards Person/s	**Towards Therapist** Expressed: Intention to indicate that she cannot come the following week	**Towards Client/s** Expressed: Intention to start with a relaxation exercise Expressed: Intention to read letter written to client in a following session Inferred: Need to reassure the client that the letter is not too serious and that she should not be concerned about its content Expressed: Intention to explain the motivation for a relaxation exercise Inferred: Intention to motivate client to buy into relaxation exercise concept	**Towards Other Person/s**
C) Response of Person/s to WIN/s Expressed: Therapist acknowledges that client will not visit the following week		**C) Response of Client to WIN/s** Expressed: Indicates willingness to participate and to try exercise	
D) Client's Response to Self None inferable		**E) Therapist's Response to Self** Non inferable	
G) Client's Response to Therapist's Response Expressed: Willingness to participate in exercise		**F) Therapist's Response to whole RE** Expressed: Permission of client to start with relaxation exercise	**Therapist's WIN/s** Inferred: Need for client to make an informed choice about participation in relaxation exercise Inferred: Need to reassure client and to not coerce her into doing something

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Summary of RE6

This RE occurred in the context of the following WIN/s:

- Therapist: Intention to do a relaxation exercise with the client and to read a letter written by the therapist to her. In both cases the therapist is very tentative and seems to need to reassure the client and to not force her into doing anything she does not feel like doing.
- Client: Merely an intention to indicate that she will not be able to attend the following week.

Within the above context, the client gives her consent to participate in the relaxation exercise. No information regarding the client or the therapist's response to self is clearly observable from the data. The very tentative way in which the therapist conveys information to the client, may however be related to his perception of her being fragile and vulnerable. From other RE's this seems to be a perception the client has of herself and the therapist may therefore here be strengthening this view of herself. A more neutral explanation of both the relaxation exercise in the letter may have been more appropriate.

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Session: 5		Response: 7	
Client		**Therapist**	
A) Person/s at which WIN/s Directed Therapist		**A) Person/s at which WIN/s Directed** Client	
B) WIN/s		**B) WIN/s**	
Towards Person/s	**Towards Therapist** Expressed: Need for therapist to provide care and nurturance and to not expect her to do it herself	**Towards Client/s** Expressed: Intention to hear how the client experienced the exercise Expressed: Need to know whether the client is OK after the exercise Expressed: Intention for client to practice exercise on her own	**Towards Other Person/s**
C) Response of Person/s to WIN/s Expressed: Therapist tries hard to get client to take more responsibility for taking care of herself Expressed: Therapist tries to boost her perception of herself as being capable of doing the exercise herself		**C) Response of Client to WIN/s** Expressed: Indicates her enjoyment of the exercise Expressed: Indicates that she is OK Expressed: Preference to not do exercise on her own, but to rather have the therapist do it	
D) Client's Response to Self Inferred: Prefers to not do exercise for herself, but to have other people do it for her Inferred: Cannot look after herself, needs other people to care for her		**E) Therapist's Response to Self** Inferred: Possibly disappointed at client's reluctance to continue exercise on own	
G) Client's Response to Therapist's Response Inferred: Indicates preference for an audio version rather than conducing the exercise by herself		**F) Therapist's Response to whole RE** Expressed: Continues trying to motivate client to use exercise, by even offering to make her a audio version of the relaxation exercise	**Therapist's WIN/s** Inferred: Need for client to try harder and to take responsibility for herself Inferred: Need for client to rely less on therapist Inferred: Need for client to continue using exercise

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Summary of RE7

This RE occurred in the context of the following WIN/s:

- Therapist: Intention to hear how the client experienced the exercise. The most important need of the therapist seems however related to motivating the client to take responsibility for doing the relaxation exercise herself.
- Client: The client in turn seems reluctant to do this on her own and indicates a preference for the therapist to do the exercise for her, or in a more abstract way to care for her.

The WIN/s of the client and therapist oppose each other in this RE. The therapist seems to however succumb to the client's need by offering to make her an audio version of the relaxation exercise. Although this results in the therapist's need for the client to continuing to use the exercise to be met, it does not fulfil his need for her to take responsibility for herself and her own nurturing. Instead it places an additional responsibility on the therapist to make an audio tape. As a result a frustration on the therapist's side can be inferred. The client probably feels some satisfaction at managing to gain the external support she experiences herself as needing, but at the same time her perception of herself as not being able to care for herself as well as other people, are strengthened. Perhaps it would have been more fruitful to interpret the client's reluctance to do the exercise on her own and her perception that she needs other people to care for her and cannot do this for herself.

Final comments:

A reflection by the therapist at the end of this session is worth commenting on, since it provides a context for the current session, in the therapist's case in particular. From the reflection it is clear that the therapist is still very much aware of his perception form a previous session that the client intends to terminate. This may have influenced the therapist to try harder to keep the client in therapy, by making it easier for her.

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<table>
<tr><th colspan="2">Session: 8</th><th colspan="2">Response: 1</th></tr>
<tr><th colspan="2">Client</th><th colspan="2">Therapist</th></tr>
<tr><td colspan="2">A) Person/s or object/s at which WIN/s Directed
Therapist, Guests</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
Inferred: Wish for more time for herself
Inferred: Wish for guests to create more space for her and to be less demanding in her resources
Inferred: Wish to satisfy guests, without sacrificing so much time</td><td>Towards Therapist
Inferred: Intention to show therapist how difficult it is for her to attend therapy
Expressed: Need for therapist to see how busy she is
Inferred: Wish for therapist to see how self sacrificing she is</td><td>Towards Client/s
Expressed: Intention to acquire more information regarding client’s wellbeing
Inferred: Intention to show that she had been missed in therapy
Expressed: Wish to make it easier for her to attend therapy
Inferred: Wish to keep client in therapy
Inferred: Wish to make a bigger contribution in therapy</td><td>Towards Other Person/s</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Inferred: Guests does not become less demanding, resulting in little time for herself</td><td colspan="2">C) Response of Client to WIN/s
Inferred: Client not strongly motivated to attend more therapy and indirectly tries to indicate that she attend more frequently</td></tr>
<tr><td colspan="2">D) Client’s Response to Self
Inferred: Feels frustrated and exhausted
Inferred: Does not feel in control of own time and resources
Inferred: Feels overwhelmed and even disoriented
Inferred: Feels partially satisfied at having resisted therapist’s attempt for a bigger claim on her time
Inferred: Feels bad at not being able to accommodate the therapist’s request for more time</td><td colspan="2">E) Therapist’s Response to Self
Inferred: Feels disappointed in ability to motivate client for more frequent attendance</td></tr>
<tr><td colspan="2">G) Client’s Response to Therapist’s Response
Expressed: Reiterates how busy she is, as if rationalising own reluctance to make a bigger commitment to therapy</td><td>F) Therapist’s Response to whole RE
Inferred: Tries to accepts client’s indication of not being able to come for more therapy
Expressed: Disappoint-ment that more therapy would not be possible</td><td>Therapist’s WIN/s
Inferred: Need to do more for client, through more regular interaction</td></tr>
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Summary of RE1:

This RE occurs in the context of the following WIN/s:

- Client: Wish to indicate how taxed her resources, in particular her time, is and that she needs more time for herself.
- Therapist: Need to motivate client and to make it easier for her to make a bigger commitment to therapy in order to make a larger contribution.

These two wishes seems to oppose each other, since the client is trying to indicate how limited her time for herself is, while the therapist is asking for more time. While therapy may be considered by some as time for oneself, it does not seem to be the experience of this client. In fact she seems to indirectly resist any requests for more time. She seems to struggle to verbalise this in a direct way, but manages to do so through a passive process. After the therapist accepts her reluctance, she still rationalizes her decision once more towards the end of the RE, which seems to indicate that although she managed to stand up for her own needs, she still struggled with this, because by doing this she may have disappointed the therapist. The therapist's disappointment is indirectly expressed through his last statement that he wishes she lived slightly closer as well as through his tentative approach through this RE in general. In fact it seems that the therapist is as tentative as the client in expressing his own needs. In this RE the client manages to claim her own need for more time, but does not seem to enjoy the full benefit of this, since she seems to also feel that she disappointed the therapist by resisting his request for more time.

Notes:

While analysing this session it seems pertinent that the client and therapist were both using very similar, tentative and indirect methods of requesting for their own needs to be met. It may be that a more direct approach on the therapist's side may have made it easier for the client to express her own needs, and therefore create a space that was of a different type of relational experience than she was used to. Failing to do this, a more accurate reflection of the client's feelings and thoughts in this RE may also have been helpful. Her need for more time as well as her inability to claim more time, could for example have been reflected and how difficult it was for her to tell the therapist that she would prefer not to have more regular sessions. Attempts to do this in other sessions, however failed in that she simply denied that she didn't want to come for more sessions. One obstacle in this therapy seems to be that the

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client is very intent on satisfying other people's needs. It seemed that the therapist's own needs are too apparent in some RE's placing a burden on the client and making it more difficult for her to express her own needs. Although the previous RE seems to have been "messy", it provided a useful opportunity to reflect on what was happening between the client and therapist. The strong underlying emotional content of these interactions could also have been explored more. I.e. she could have been asked how she felt when she perceived herself as not meeting the therapist's needs.

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Session: 8		**Response: 2**	
Client		**Therapist**	
A) Person/s at which WIN/s Directed Neighbour		**A) Person/s at which WIN/s Directed** Client	
B) WIN/s		**B) WIN/s**	
Towards Person/s Expressed: Need for neighbour to be less demanding Expressed: Need for people to respond to her hints that she cannot accommodate them	**Towards Therapist** Inferred: Intention to indicate how difficult it is for her to refuse external demands	**Towards Client/s** Expressed: Intention to interpret her difficulty in claiming her own needs	**Towards Other Person/s**
C) Response of Person/s to WIN/s Expressed: Neighbour does not conform to her need for less demands		**C) Response of Client to WIN/s** Expressed: Indicated that she tries to claim her own needs, but that she finds it difficult to do this.	
D) Client's Response to Self Inferred: Seems frustrated with herself and her own failed efforts to satisfy her own needs		**E) Therapist's Response to Self** Non inferable	
G) Client's Response to Therapist's Response Inferred: Does not respond directly to therapist's final remarks, but seems to acknowledge the therapist's interpretation		**F) Therapist's Response to whole RE** Expressed: Interprets client's difficulty to claim her own needs	**Therapist's WIN/s** Inferred: Intention to interpret results, in order to increase client's understanding

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Summary of RE2:

This RE occurs in the context of the following WIN/s:

- Client: Need for neighbour to be less demanding and for people in general to respond better to her subtle hints that she cannot always accommodate their needs. Related to this is a wish for the therapist to acknowledge how difficult it is for her to claim her own needs.
- Therapist: Seems more focussed on the client and less on his own needs as in the previous RE. In this RE the therapist seems to be busy with his professional role of interpreting and improving the client's insight into her own behaviour.

This RE seems to present a continuation of the themes of the previous session, but the therapist's own needs are less obvious, and he seems to take a more reflective position, allowing interpretation of the client's behaviour. Although this RE is less complicated by the therapist's own emotional response, some valuable opportunities seem to have been loss. The therapist could for example have probed more into the reasons for the client to not request her needs directly, and what would happen if she did do so. Further comparison of her behaviour outside of therapy and that in the previous RE with the therapist could have been extremely useful.

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<table>
<tr><th colspan="2">Session: 8</th><th colspan="2">Response: 3</th></tr>
<tr><th colspan="2">Client</th><th colspan="2">Therapist</th></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Therapist, doctors</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
Expressed: Wish for doctors to take away her pain and physical suffering</td><td>Towards Therapist
Expressed: Intention to make therapist aware of improvement of pain symptoms in mouth
Inferred form observations: Need for therapist to acknowledge her remaining suffering and pain
Inferred: Need for therapist to acknowledge the seriousness of her situation
Inferred: Intention to allow therapist more time to speak</td><td>Towards Client/s
Expressed: Intention for more information regarding symptoms
Inferred: Need to get closer to client through humour
Inferred: Need to validate positive aspects of improvement and consolidate improvement
Inferred: Need of therapist for improvement and progress and hope
Inferred: Need to show empathy through questions regarding pain</td><td>Towards Other Person/s
N/a</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Expressed: Therapist tries to respond to positive feedback regarding improvement
Inferred: Therapist shows empathy through questions in response to her remarks that her relief in pain is only temporary
Expressed: Doctors only provide partial and temporary unsatisfactory solutions</td><td colspan="2">C) Response of Client to WIN/s
Inferred: Client does not directly respond to humour, but regardless continues to share information
Inferred: Does not acknowledge therapist's attempt to consolidate improvement in life quality, but starts to focus on other somatic symptoms
Expressed: Nothing can completely take away her suffering, only temporary and partial solutions available</td></tr>
<tr><td colspan="2">D) Client's Response to Self
Inferred: Nothing or nobody can help her, situation without hope</td><td colspan="2">E) Therapist's Response to Self
Inferred form reflections: Does not feel heard by the client</td></tr>
<tr><td colspan="2">G) Client's Response to Therapist's Response
Inferred: Remembers previous request of therapist to interrupt her more and expressed wish to give therapist more time to speak</td><td>F) Therapist's Response to whole RE
Expressed: Reflects client's intention for operation</td><td>Therapist's WIN/s
Inferred: Need to reconnect with client's current state after failed attempt to lighten situation and to consolidate improvement into rest of her life</td></tr>
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Summary of RE3:

This RE occurs in the context of the following WIN/s:

- Client: WIN/s to share improvement, but also to not to be seen as healed, but rather to acknowledge the seriousness of her remaining pain symptoms. Wish for therapist and doctors to see that she still suffered and still needed help.
- Therapist: Wish to see some improvement and progress as well as hope. In line with this seems to be the therapist's intention to lighten the atmosphere.

Although this RE starts on a very optimistic note in terms of the improvement in the client's symptoms, the client and therapist's wishes are clearly in opposition here. The client seems to want to indicate some improvement, but does not wish for this to result in her being perceived as healthy or happy. She still needs the therapist to acknowledge the seriousness of her suffering and need for help. Therefore it seems that as soon as the therapist tries to generalise improvement to rest of her life, the client starts focussing on other pain symptoms. It seems that she felt that the therapist does not acknowledge the seriousness of her situation.

Notes:

The therapist may have moved faster than client in this RE. Perhaps this could be reflected, i.e. the therapist could have reflected that his focus on her improvement may feel to her like an attempt to discount the seriousness of her other symptoms and that she still needed considerable support and help.

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Session: 8		Response: 4	
Client		**Therapist**	
A) Person/s at which WIN/s Directed Therapist		**A) Person/s at which WIN/s Directed** Client	
B) WIN/s		**B) WIN/s**	
Towards Person/s N/a	**Towards Therapist** Inferred: Wish for client to acknowledge the stressors experienced in her life and that she even underreports these stressors	**Towards Client/s** Expressed: Need to re-establish stress-pain hypothesis Expressed: Intention to acknowledge client's high and underreported anxiety levels	**Towards Other Person/s** N/a
C) Response of Person/s to WIN/s Expressed: Therapist acknowledges her suffering as well as her underreporting of her symptoms		**C) Response of Client to WIN/s** Expressed: Client responds positively to suggestion that she may be experiencing more anxiety than she objectively mentioned, i.e. that she is in fact suffering more that she typically shared	
D) Client's Response to Self Inferred: Seems to feel heard and acknowledged by therapist		**E) Therapist's Response to Self** Non inferable	
G) Client's Response to Therapist's Response Expressed: Acknowledges Rorschach interpretation that she is experiencing more anxiety than subjectively mentioned		**F) Therapist's Response to whole RE** Expressed: Acknowledges client's suffering more than she subjectively mentions	**Therapist's WIN/s** Inferred: Wish to acknowledge client's suffering as real and medically related, but to also let her acknowledge the extent to which other factors such as stress plays a role

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Summary of RE4:

This RE occurred in the context of the following WIN/s:

- Therapist: Need to re-establish pain-stress hypothesis and also a need to validate client's high levels of anxiety and her underreporting thereof.
- Client: Within the context of the previous RE the client here still seem to need the extent of her suffering and attempts at dealing with it to be acknowledged. This need can be inferred form her positive response to the therapist's interpretations.

Within the context of the above mentioned wishes, the client seems to acknowledge the interpretations and to feel heard and acknowledged. Any attempt of interpreting her progress, as in the previous RE, seems to result in her feeling that she is not being taken seriously (perhaps even blamed?). It may be that the therapist's response in this case was influenced by the previous RE and was an attempt to closer reflect the client's emotional state. This RE thus seem to still be very much related to the theme of the previous session. The therapist here seems to want to acknowledge the client's suffering and to emphasise that it may even be worse than reported by her. Other than in other RE's where the client resisted interpretations of improvement etc, she seems more open to respond to interpretations of her suffering. The impression from this RE is that the client feels more heard in the context of these interpretations of suffering. The therapist thus seems to want to re-win the client's trust in his ability to hear her pain and suffering. This seems to be successful. This takes the client further away from a strong theme in the therapist's own needs, expressed in other sessions, for providing a solution to her difficulties, but seems to make the interpersonal atmosphere more conducive for the client to feel accepted and heard.

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<table>
<tr><td colspan="2">Session: 8</td><td colspan="2">Response: 5</td></tr>
<tr><td colspan="2">Client</td><td colspan="2">Therapist</td></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Therapist, Husband</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
Inferred: Ambivalent need to criticise husband, but also not to do so as a result of upbringing
Expressed: Wish for husband to be more reasonable and to apologise</td><td>Towards Therapist
Inferred: Need for therapist to take her side
Inferred: Need for therapist to see that she had tried standing up to her husband in the past
Inferred: Need for therapist to have realistic expectations of her behaviour in relation to her husband</td><td>Towards Client/s
Expressed: Intention to interpret client’s tendency to walk away from conflict
Inferred: Intention to boost client’s sense of autonomy and ability to stand up for herself</td><td>Towards Other Person/s
N/a</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Expressed: Therapist acknowledges that he hears her.
Expressed: In general husband does not acknowledge her needs or requests, although he never hit her again</td><td colspan="2">C) Response of Client to WIN/s
Expressed: Client acknowledges interpretation
Expressed: Provides rationale for behaviour and reasons why she is not to blame</td></tr>
<tr><td colspan="2">D) Client’s Response to Self
Inferred: Cannot stand up to husband, since to weak. Too afraid of husband to stand up to him. Upbringing makes it more difficult for her to stand up against husband</td><td colspan="2">E) Therapist’s Response to Self
None inferable</td></tr>
<tr><td colspan="2">G) Client’s Response to Therapist’s Response
Expressed: Rationalises behaviour as being reasonable, by giving example of previous wife and also how she had tried in the beginning, but that it was impossible to stand up to him, given his aggressive behaviour.</td><td>F) Therapist’s Response to whole RE
Expressed: Praises client’s behaviour in standing up to her husband once</td><td>Therapist’s WIN/s
Inferred: Intention to boost client’s sense of ability to stand up for herself and to strengthen this behaviour</td></tr>
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Summary of RE5

This RE occurred in the context of the following WIN/s:

- Therapist: Need to interpret client's response to conflict and to strengthen exceptions, where she did manage to stand up to her husband.
- Client: Need for therapist to understand the impossibility of her situation and to have more reasonable expectations of her. Need for therapist to acknowledge that she had tried in the past and to take her side.

Within the context of these wishes the client does accept the therapist's interpretation that she walks away from behaviour. Reflection of her successes in standing up to her husband does not seem to strengthen her sense of being able to do so again in future, but rather results in her emphasizing the impossibility of her situation and any control she may have in the outcome of conflict situations. It seems as if in effect she again does not feel heard, by the therapist and indirectly seems to be asking for the therapist to be more reasonable towards her. Similar to RE's in other session's the therapist seem goal directed and working towards finding a solution towards solving the client's difficulties, whereas the client needs someone to acknowledge her sense of futility.

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<tr><th colspan="2">Session: 8</th><th colspan="2">Response: 6</th></tr>
<tr><th colspan="2">Client</th><th colspan="2">Therapist</th></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Husband, therapist</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
Inferred: Wish for her husband to change so that their relationship could be more like her own parent's relationship
Inferred: Need for husband to show more intimacy
Inferred: General wish for more happiness
Inferred: Wish for less conflict</td><td>Towards Therapist
Inferred: Need for therapist to acknowledge her attempts to be more independent and her successes in doing this in the past</td><td>Towards Client/s
Inferred: Need to show client that she is being heard
Inferred: Need to explain behaviour in terms of conflict and to interpret her behaviour in terms of her upbringing
Expressed: Interprets dependency</td><td>Towards Other Person/s
N/a</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Inferred form other sessions: Husband does not change, conflict remains, little expression of intimacy
Expressed: Therapist acknowledges client's need to be seen as independent</td><td colspan="2">C) Response of Client to WIN/s
Expressed: Acknowledges interpretation in terms of husband's shortcomings
Inferred: Less willing to acknowledge own family as potentially having had shortcomings
Inferred: Acknowledge some dependency, but also needs to show how she has overcome this to some extent by leaving the house at a young age</td></tr>
<tr><td colspan="2">D) Client's Response to Self
Inferred: Feels good at own attempt to become more independent</td><td colspan="2">E) Therapist's Response to Self
None inferable</td></tr>
<tr><td colspan="2">G) Client's Response to Therapist's Response
Expressed: Agrees with therapist's interpretation that she is more independent</td><td>F) Therapist's Response to whole RE
Expressed: Acknowledges client's attempts and successes at becoming more independent</td><td>Therapist's WIN/s
Inferred: Need to boost client's sense of capacity for independence</td></tr>
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Summary of RE6

This RE occurred in the context of the following WIN/s:

- Therapist: After previous session seems to need to show client that she is in fact being heard. Her behaviour is also acknowledged as being influenced by her background. An intention to interpret her dependency behaviour is also present
- Client: Need therapist to acknowledge her attempts at being more independent in the past and her successes in doing this. Secondary to this need are wishes related to he husband to be more tolerant and show more intimacy.

Within the context of the above wishes and the therapist's acknowledgement of the client's attempts, the client is able to partially acknowledge the interpretation of her dependence. She does however emphasise her own capacity to rise above her circumstances. She can accept shortcomings in her husband's early family environment, but is less capable of doing the same with her own family. In this RE the client was thus able to incorporate past successes, but it is highly likely that any attempt to further focus in this capacity of hers would have resulted in her pointing out the impossibility of her current situation. The client seems to find it very difficult to accept any criticism and resists attempts to take responsibility for her own role.

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Session: 8		**Response: 7**	
Client		**Therapist**	
A) Person/s at which WIN/s Directed Sister, Previous boyfriend, Therapist, Other people		**A) Person/s at which WIN/s Directed** Client	
B) WIN/s		**B) WIN/s**	
Towards Person/s Expressed: Wish for sister to never marry Inferred: Need for previous boyfriend to make a commitment towards her Expressed: Need for other people to see and become aware of her suffering and to see that everything was less than perfect Expressed: Need for not being alone Expressed: Need for intimacy from her husband and to be more like her previous husband Expressed: Need to not criticise her husband	**Towards Therapist** Inferred: Need for therapist to understand how terrible it is to be married to her own husband and possibly her regrets at ever having met him Inferred: Need to disclose her feelings of being rejected to the therapist Inferred: Need for therapist to understand how sensitive she is, the pain she is experiencing, and how it changed her to becoming less spontaneous Inferred: Need for therapist to acknowledge that she tried, but failed	**Towards Client/s** Expressed: Intention to interpret her ambivalence towards her husband. Inferred: Intention to show empathy for her frustration at not having her needs met by her husband or previous boyfriend Expressed: Intention to interpret how difficult it must be for her to suppress underlying anger at her husband and possibly other people including the therapist Inferred: Intention to show empathy for the pain of rejection she was experiencing	**Towards Other Person/s** Non inferable
C) Response of Person/s to WIN/s Expressed: Sister agrees not to marry again Inferred: Therapist responds to indirect message of how difficult it must be to be married to her current husband		**C) Response of Client to WIN/s** Expressed: Acknowledges some limited anger towards husband, but denies any anger against the therapist.	
D) Client's Response to Self Expressed: Cannot be alone, but cannot live with current husband either Inferred: Cannot face to hear her husband's side of the story Inferred: Feelings of helplessness Inferred form observations: Becomes very sad		**E) Therapist's Response to Self** None inferable	
G) Client's Response to Therapist's Response Inferred: Client feels heard and acknowledged and discloses her feelings of helplessness and hopelessness		**F) Therapist's Response to whole RE** Expressed: Empathy at how difficult her circumstances are	**Therapist's WIN/s** Inferred: Need to comfort client

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Summary of RE7

This RE occurred in the context of the following WIN/s:

- Client: Many wishes and needs are revealed in this RE. In general however the client's WIN/s seems to revolve around her unmet intimacy needs. She also wants people to become aware of her suffering and unmet needs. In the case of her husband her WIN/s seems to take the specific form of a need for less criticism and more intimacy. She does not want to feel rejected. Her WIN/s towards the therapist seems to take a similar form to that of people in general, namely that her unmet needs and the depth of her suffering should be acknowledged, in particular in the context of her being a very sensitive person.
- Therapist: Initially the therapist had an intention to interpret her ambivalence towards her husband and how difficult it must be to live with her unmet needs as well as her suppressed anger. Gradually however this changes into an intention to show empathy at what the client needs, as well as a need to comfort her.

In this RE the therapist seems to have played a more neutral role in terms of not providing criticism or finding solutions to her difficulties, but rather reflecting her emotions, suggesting possible interpretations and showing empathy. Within this atmosphere, the client seems to feel safe enough to continue disclosing her feeling of neediness, inability to be alone and frustration as well as anger towards her husband. Her sadness also becomes observable in this session and she seems to be overcome with a feeling of helplessness and hopelessness. Unlike other REs however it does not seem as if she experiences the therapist as judging. Her disclosure seems to indicate that she felt safe enough to express her emotions and vulnerability. Unlike other RE's the therapist seems to have been capable of dealing with her discomfort here and did not provide guidance or seek solutions for her difficulties. It is also worth noting that this RE occurred straight after an initial sharing of some of her Rorschach results. Although the client acknowledged the Rorschach results, she did not seem particularly motivated to work with these results, but rather needed for her unmet needs to be heard and acknowledged.

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<table>
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<tr><th colspan="2">Client</th><th colspan="2">Therapist</th></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Husband, Therapist, Self, Neighbour</td><td colspan="2">A) Person/s at which WIN/s Directed</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s
Expressed: Need for husband to change and to show more of his feelings and thoughts and to compliment her more often, need for him to be less serious and more responsive towards her, need for him to see how unreasonable he is being
Inferred: Need to undo the criticism mentioned against her husband, by complimenting his good behaviour. This need is not specifically directed at anyone specific, but may be towards her parents or self and perception of what she should be like
Expressed: Need for other people, such as her neighbour to sometimes hear her out</td><td>Towards Therapist
Inferred: Need for therapist to see that she does not like to and tries not to criticise her husband
Inferred: Need for therapist to listen and acknowledge her, similar to her neighbour whom she can talk to</td><td>Towards Client/s
Expressed: Intention to acknowledge her attempts to always be dressed neatly
Inferred: Intention to interpret client's effort as way of seeking for appreciation from her husband
Inferred: Intention to show empathy for how difficult it must be to never feel appreciated, despite all her efforts
Expressed: Intention to provide a safe place, where client can share her thoughts, feelings and resentment
Expressed: Intention to interpret danger of suppressing resentment and level of conflict present in marriage
Expressed: Intention to interpret growing negative thoughts about herself in context of husband's criticism</td><td>Towards Other Person/s
Inferred: Need for husband to see a psychologist</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Inferred form other sessions: Husband does not share more openly
Inferred: Therapist listens and acknowledges client's needs
Expressed: Neighbour listens to client</td><td colspan="2">C) Response of Client to WIN/s
Expressed: Accepts some of the interpretations, especially her negative thoughts towards self that might have been a product of her husband's negative feedback, and continues mentioning how critical he is towards her</td></tr>
<tr><td colspan="2">D) Client's Response to Self
Inferred: Acknowledges own shortcomings and difficulty to express emotions in a constructive way</td><td colspan="2">E) Therapist's Response to Self
None inferable</td></tr>
<tr><td colspan="2">G) Client's Response to Therapist's Response
Expressed: Accepts interpretation of husband's difficulty and spontaneously acknowledges own difficulty in expressing own emotions</td><td>F) Therapist's Response to whole RE
Expressed: Assess husband's willingness to come to therapy
Expressed: Interprets husband's avoidant style and difficulty to express his emotions</td><td>Therapist's WIN/s
Inferred: Need to somehow involve husband in therapy
Inferred: Need to assist client more effectively , by including husband in therapy</td></tr>
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Summary of RE8

This RE occurred in the context of the following WIN/s:

- Therapist: Intention to interpret client's need for appreciation, suppression of resentment towards her husband and growing negative thoughts about herself. At the same time the therapist seems to try to create a safe environment where she can share her and reflect on herself openly.
- Client: Expresses a need for her husband to change, but when this is perceived by herself as being too critical toward him, another need to not be viewed as overly critical towards him, emerges. This need does not seem to relate to anyone in specific, but may be related to how she wants the therapist to see her and also what she had learned is acceptable or not acceptable. As always there seems to be an underlying need to be heard and acknowledged by people who understand her, such as her neighbour and the therapist.

Within the context of the above wishes, the client was able to spontaneously look at herself critically. During other RE's it has become clear how difficult it is for the client to experience any form of external criticism, perhaps because she views it as a form of rejection. In this RE however she manages to spontaneously look at herself critically when she feels acknowledged and in a safe environment. It seems that posing interpretations as tentative possibilities, while continuing to provide an empathic atmosphere where the client feels acknowledged, works best with this client. In this RE considerable effort was done to interpret how the therapist experiences the client without criticising her. The interpretations were also done in a way that was not threatening, but rather enquiring in nature and empathic in terms of how difficult it must be for her.

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<table>
<tr><th colspan="2">Session: 2</th><th colspan="2">Response: 9</th></tr>
<tr><th colspan="2">Client</th><th colspan="2">Therapist</th></tr>
<tr><td colspan="2">A) Person/s at which WIN/s Directed
Therapist</td><td colspan="2">A) Person/s at which WIN/s Directed
Client</td></tr>
<tr><td colspan="2">B) WIN/s</td><td colspan="2">B) WIN/s</td></tr>
<tr><td>Towards Person/s</td><td>Towards Therapist
Expressed: Need for therapist to understand that her husband is not committed to and does not see the value of therapy</td><td>Towards Client/s
Expressed: Intention to boost client's ability to reflect on herself
Expressed: Intention to motivate husband to also attend some form of therapy with his wife
Expressed: Intention to show empathy and acknowledge how difficult it must be for her to live under her current circumstances
Expressed: Need to comfort and build client
Inferred: Need to protect client against husband</td><td>Towards Other Person/s
Expressed: Need for husband to attend therapy
Inferred: Need for husband to be less damaging towards wife</td></tr>
<tr><td colspan="2">C) Response of Person/s to WIN/s
Expressed: Therapist acknowledges husband's attitude,</td><td colspan="2">C) Response of Client to WIN/s
Inferred form observations: Client seemed to appreciate therapist's praise and need to protect her</td></tr>
<tr><td colspan="2">D) Client's Response to Self
Seems to acknowledge and like metaphor of self as special, but fragile and in need of protection</td><td colspan="2">E) Therapist's Response to Self
Inferred form reflections: Satisfaction at client's response to positive feedback</td></tr>
<tr><td colspan="2">G) Client's Response to Therapist's Response
Expressed: Seems to not have heard initial Rorschach interpretations
Expressed: Fear of disappointing husband</td><td>F) Therapist's Response to whole RE
Expressed: Does not want client to get in trouble with husband
Expressed: Need to see the client again and to continue looking at Rorschach interpretations
Expressed: Need for client to be aware of her tendency to be avoidant and to try to share more openly in therapy</td><td>Therapist's WIN/s
Inferred: Need to protect client from husband
Inferred: Need for client to become more comfortable in therapy and to feel safe in therapy to share thoughts more openly
Inferred: Need to lift client's mood and to make her feel better</td></tr>
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Summary of RE9

This RE occurred in the context of the following WIN/s:

- Therapist: Intention to increase client's capacity to self-reflect, by commending her effort. At the same time however the therapist still seems motivated to include the husband in therapy and also to somehow protect the client form her husband.
- Client: The client expresses a need for the therapist to understand how uncommitted her husband is towards the therapy process.

This RE was the final one in this session and created the impression that the therapist needed to end it in a positive way. The therapist commends the client for her efforts, but goes even further to indicate how special she is. The metaphor used, indicated this, but also her vulnerability. The client seemed to respond positively to this metaphor. After analysis it seems as if this is perhaps exactly how the client wishes people to see her. Although it may thus may have been received positively, because of being an accurate perception of whom she was, it should also be considered, that this is the way she wishes to be seen by others. By being a treasure in a vulnerable clay pot, she may feel good about herself, but will also need protection from other people such as the therapist. The therapist strong urge to include the husband in therapy and to prevent her from invoking his anger through becoming late, gives more substance to the idea that the therapist is taking more and more responsibility for protecting her against her husband, which allows her to take less responsibility. The content of this RE is very different from the previous RE where the client seemed to have moved towards critical self reflection and therefore greater responsibility.

Final reflection

The reflection towards the supervisor at the end of this session is also worth noting. The therapist indicates frustration at the slow progress made and also doubts whether therapy seems to be progressing. There is again evidence of the therapist going out of his way to make it easier for the client to see him in therapy and therefore again taking more responsibility over from her. The therapist may here be experiencing what some of the people in her environment experiences; he indicates frustration, a feeling of failure and a need to comfort himself that he at least tried.

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