

Development through interruptions and reparations – A case study of a dual challenging psychotherapy

Marit Råbu, research fellow, specialist in clinical psychology (corresponding author)

Department of Psychology, University of Oslo

Postal Box 1094, Blindern, 0317 Oslo, Norway

Phone: +47 22845125 / +47 41234627

Fax: +47 22845001

Email: mariraa@psykologi.uio.no

Karsten Hytten, MD, PhD, specialist in psychiatry, private practice

Institute for Psychotherapy, Oslo

Postal box 4254, Nydalen, 0401 Oslo, Norway

Phone: + 47 22581778

Fax: + 47 22581771

Email: karsten@hytten.no

Hanne Haavind, PhD, professor, specialist in clinical psychology

Department of Psychology, University of Oslo

Postal box 1094, 0317 Oslo, Norway

Phone: +47 22845224

Fax: +47 22845001

Email: hanne.haavind@psykologi.uio.no

Per-Einar Binder, PhD, professor, specialist in clinical psychology

Department of Clinical Psychology, University of Bergen

Postal box 7800, 5020 Bergen, Norway

Phone: +47 55589090

Fax: +47 55589871

Email: per.binder@psykp.uib.no

Abstract

The aim of this study was to understand how relational difficulties in psychotherapy may be handled to represent possibilities for change. Temporary interruptions and subsequent reestablishment of contact were chosen as the strategic focus in one severely challenging case of long term psychodynamic psychotherapy where outcome was known to be good.

Interruptions and reestablishments were conceptualised by how the informants gave meaning to them. The choice of focus represented a strategic selection of events in the course of therapy where the regulation of the alliance by the therapist as well as by the patient was at stake. A detailed case record was studied and interviews with patient and therapist were conducted. A hermeneutical-phenomenological approach was used to analyse the material..

The narrative dimension was important in structuring and interpreting the data. It was shown how important relational difficulties, such as mutual incompatible expectations and demands was handled both on a structural and interpersonal level, and some important steps and hallmarks of the healing process was identified. Close inspection of the course of events in psychotherapies is seen as a promising method for bringing a better understanding of how change processes unfold.

Keywords: Case study
Psychodynamic psychotherapy
Qualitative methods
Rupture and repair
Therapeutic alliance

Introduction

Connecting Structural and Interpersonal Aspects of Psychotherapy

In clinical work it is a common experience that dealing with many kinds of difficulties concerning the therapeutic alliance is essential to the course of therapy. The negotiation of ruptures in the therapeutic alliance is considered to be at the heart of the change process. Developing the ability to repair relational disjunctions can be considered a central therapeutic aim (Aron, 2006; Beebe & Lachmann, 1996, 2002; Benjamin, 2004; Bordin, 1979, 1994; Safran & Muran, 2000; Safran, Muran, Samstag & Stevens, 2002). In studies of change and recovery processes as experienced from the patient's point of view the therapist's personal involvement during phases of impasse is highlighted (Binder, Holgersen & Nielsen; 2010; Davidson, Borg, Marin, Topor, Mezzina & Sells, 2005; Phillips, Werbart & Schubert, 2005). Such phases of therapy is also experienced as periods where the therapists feel very vulnerable, and need support from close colleagues or others in their professional network (Moltu, Binder & Nielsen, 2010; Moltu & Binder, in press)

Long term psychotherapy will always involve temporary interruptions of various kinds and subsequent reestablishment of contact. Some interruptions are planned, some are unplanned. How does the therapeutic dyad experience and give meaning to these events? The interruptions in this paper are conceptualised by how the informants give meaning to them. The way the patient organizes and constructs her relational world and her problems are important for determining how interruptions and reestablishments are experienced and coped with. Interruptions can therefore be a strategic point of focus for studying the qualities and hallmarks of a therapeutic relationship. Temporary interruptions in a psychotherapy process

and subsequent reestablishment can probably bring about relevant and instructive experiences for both the patient and the therapist about the meaning and usefulness of therapy.

The therapeutic alliance may be conceived of as co-created (Stolorow and Atwood, 1992). It is established and develops in the interplay between the patient's and the therapist's subjective realities. The way interruptions are dealt with is something that can be principally observed and described by both therapist and patient, and by an outside observer. The patients' and the therapists' experiences can be explored by qualitative methods addressing how the participants in the relationship interpret themselves, each other, and their work together. Here, we will study the observable in relation to participants' experiences. The case in this paper is the patient – therapist relationship, and we will bring different perspectives on the therapy process: Reflections from patient, therapist, other professionals and the researchers.

A Challenging Psychotherapy Process

The case presented in this paper concerns the patient–therapist relationship in a psychoanalytically oriented therapy which is ongoing and has lasted for 13 years. At its most intensive, the session frequency was twice a week. This frequency has been successively reduced, most recently to every fourth week. The case was chosen because it has involved a very challenging therapy process, with many severe ruptures and interruptions, and because, in spite of these problems, therapist and patient have managed to develop in ways that matter to both. In therapy the relationship has been addressed directly, both on an interpersonal level, and on a structural level through arrangements outside the therapy.

When therapy started the female patient was 22 years. She had been in psychiatric treatment for the last three years with different therapists and in different hospitals. She was hospitalized in an acute psychiatric ward. The male therapist was 41 years. He worked in an

outpatient clinic and was attending post graduate training in psychoanalytic psychotherapy. The patient was diagnosed with several personality disorders and bipolar disorder type II. She has also been psychotic. Three years into this treatment, the patient was hospitalized for four months in a long term ward with no contact with the therapist, and this stay was later seen as a failure by all involved. Four years into this treatment, the hospitalizations was changed to planned, regular, short term hospitalizations, and this has been maintained over the course of the last eight years designed to prevent the escalation of acting out before hospitalizations, and regression when hospitalized. Because of these short term hospitalization the total number of hospitalization are more than hundred. In addition to psychotherapy and in-patient treatment, the patient uses antipsychotic, antidepressive and mood stabilizing medication administered by a general practitioner.

The patient now reports that she can use the therapy sessions to explore her emotions and experiences, including experiences bordering on psychosis, and that she is met with understanding, which makes her feel better. She now rarely experiences psychotic symptoms and she functions better in relationships with regard to real interaction. She is able to live alone and structure her day, and is no longer in need of long hospitalizations.

The aim of this study is to trace, within this case, what contributed to the changes and improvement in the therapeutic alliance. The inquiry has been guided by the following research questions:

- How do structural characteristics of the interruptions and reparations affect the interpersonal qualities and subjective experiences of the relationship between therapist and patient?

Method

A Single-Case Qualitative Study

A qualitative design is chosen to make an open explorative inquiry of alliance ruptures and repair in a long-term psychotherapy with a patient with serious difficulties, in a case where the outcome is known to be a good one. The research questions are meant as guiding principles in the exploration of the experiential worlds of the participants in the therapeutic dyad, and are formulated widely in order to remain open and sensitive to the material (Giorgi & Giorgi, 2003). Openness to qualitative material and reflectivity about presumptions are emphasized as important ideals in qualitative research (Elliott, Fischer & Rennie, 1999). Comparisons between patient, therapist and observer perspectives have often shown striking discrepancies (Caskey, Barker & Elliott, 1984; Elliott & Shapiro, 1992). From our point of view, discrepancies between patient, therapist, and observer perspectives are interesting in their own right and need to be understood and integrated into the broader perspective of how relational issues are handled in order that the relationship may change. To explore the first-person perspective on therapy process, a combined hermeneutical-phenomenological approach was chosen (Binder, Holgersen & Nielsen, 2009; Finlay, 2003; Gadamer, 1989; Heidegger, 1962; Lavery, 2003; Smith, 2007; Smith & Osborn, 2003). We wanted to stay as close to the informant's concrete and contextually anchored experience as possible, while exploring their views of what felt significant in the therapeutic process (Elliott & Shapiro, 1992; Giorgi & Giorgi, 2003; Smith & Osborn, 2003; Smith 2007). Even though we tried to stay as close as possible to the informants' own descriptions, in addition to avoiding theoretical concepts, both the formulation of research questions and the reading of the data will necessarily be affected by the specific experiential horizon of each researcher (Gadamer, 1989; Smith, 2007). In accordance with reflexive methodology, we used the dialogue with the

participants' views in order to explore and reflect on our own pre-understanding (Alvesson & Sköldberg, 2000; Finlay, 2003).

The authors are all experienced psychotherapists. The first, second and fourth authors have an integrative and relational psychoanalytic orientation. The third author is theoretically informed by developmental and interpersonal psychology

Design

The therapeutic process was studied in retrospect. Our design opens for the possibility of data triangulation (Denzin, 1989). A detailed case record consisting of 227 pages, covering 13 years of treatment and written from two different hospitals and an outpatient clinic, gave an overview of all interruptions and reestablishments of contact for this patient (informed consent). The first author conducted in-depth interviews with both patient and therapist. Interview questions were sent to the informants beforehand (Appendix 1). We did this in order to give the participants a chance to prepare themselves, to establish security in the interview situation, and to create a situation for providing rich narrative material and reflections upon it. The actual interviews were conducted as open dialogues based on what the informants found important after having reflected upon the received questions. The choice of focus represents a strategic selection of events where the regulation of the alliance by the therapist as well as by the patient is at stake. The different authors' contribution is part of the design: The main author (MR) has taken part in all phases of the research process and been responsible for the overview and continuity. The second author (KH) has participated both by sharing his experiences as an informant (the therapist), and by taking part in the reflexive aftermath. The patient has also read a late draft of this paper and commented spontaneously that her view was well represented, and that the meaning statements felt appropriate. The active participation of the informants helps to validate that the quality of their experience is

conveyed in the analysis and the presentation. The therapists' participation in the research team made it possible to deepen and nuance our understanding of the therapy process. The third (HH) and fourth (PEB) authors know the material only as text and have taken part in the analysis process. Their status as observers consolidates the overview and contributes to the reliability.

Interpreting Experiences and Observations

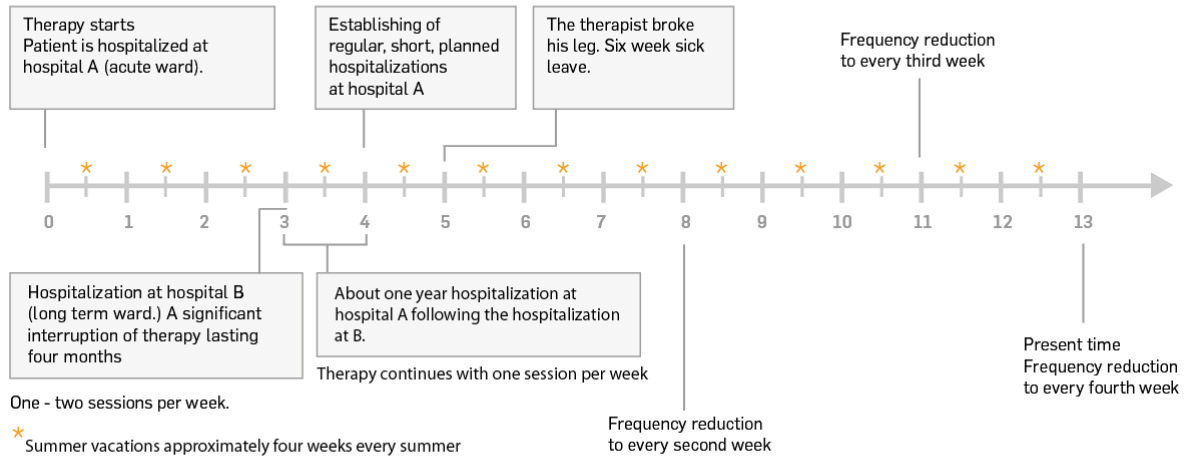
The use of interruptions and reestablishments of contact as the starting point for the interpretive analysis will organize the material in accordance with the structural characteristics of this psychotherapy, that is, an observable course of events. We searched for the meaningful domains that questioning interruptions and reestablishments in psychotherapy in practice (on an operational level) brought to attention. Transitions in meaning through the material and meaning units could then be identified through careful reading. The aim of the phenomenological dimension of this approach is to generate descriptive knowledge of events in psychotherapy as everyday experience (Giorgi, 1985; Giorgi & Giorgi, 2003; Smith, 1995; Smith, 2007; Smith & Osborn, 2003). We explored how the participants in the therapeutic dyad used the episodic format to give meaning to their experiences and, in particular, whether they described interruptions as ruptures, and whether re-establishments were perceived as reparations.

The analytic strategy used in the abstraction process consisted of three steps. These started with identifying the structural issues of interruptions and reestablishments, connecting the relational thematic domains to subjective experiences of change over time, and subsumed as models for psychological development. Since development is a central issue in psychotherapy, the ordering of events according to time is essential. The narrative dimension is important in structuring and interpreting the data (McLeod, 2001a&b). The case record

gave a fairly accurate register of events. The interviews configured some experiences in relation to other experiences. Thus, the next step in the analysis was to go through the material to look for verbal indications of time - before, after, now, then, still, anymore, since etc. - and to analyse the temporal course of the therapy based on the stories of the two informants. The interviews were read to grasp a basic sense of each informant's experience of the struggles as well as the changes in the therapeutic alliance. The first author prepared the analysis and made the first proposals for the meaningful domains. The other authors made a parallel reading in order to sort out which of the structural issues of interruptions and reestablishments actually brought forward thematic domains of relevance to the interpersonal experiences. After this, utterances from the participants were selected and transformed into statements that highlighted the psychological meaning of their experiences. A condensed set of meanings was sequentially ordered for each informant. These were further used as a basis for describing the psychological structure of the informants' experiences. As a result of this examination, several relevant themes emerged. These were grouped and summarized according to thematic focuses and the time dimension. Thereafter the material was abstracted into the patient's and the therapist's models of therapeutic change.

Figure with time line, important incidents and frequency change

TIMELINE WITH IMPORTANT INCIDENTS AND FREQUENCY



Results

In the Beginning

The beginning of this therapy was severely challenging. When reflecting on the challenges, however, patient and therapist still don't completely agree on the meaning of the events that occurred.

Patient: Then I was very angry, Hytten says, and perhaps I took that anger out on him,

which really belonged to other people. This is a point where we actually disagree a

bit ... I don't think I was that angry, and I don't think the anger was against him. But

he thinks so, that's up to him.

From the patient's perspective, it was a period with vehement emotionality for which she had few words to express and describe. Still, many years later, it is hard to know whether anger is a word that can capture her experience. But when she talks about it in retrospect, she seems to be able to both express and tolerate her disagreement with the therapist on this point. From the therapist's perspective, the beginning was a period of being challenged:

Therapist: She severely challenged the frame. She was extremely projective, accusing, raging, threatening, complaining, insulting and so on. She was hospitalized and had caused great trouble for the hospital staff. I was in doubt as to whether I would be able to achieve anything at all with her. Her relationships were so bad... In the beginning she was more psychotic, which for her was very frightening and shameful...and she thought I could be useful for her only by fighting her fight against whatever it might be. She threatened to break the whole relationship by killing herself, or by wanting much more than she could get. She wanted more frequent sessions and she wanted to stay in hospital. She once left my office, threatening to go directly to a tabloid newspaper and tell that her suicide was my responsibility. On one level, I didn't believe she would commit suicide. On another level I was really scared and became sad and exhausted. She once left a message on my answering machine threatening to drown herself. I could hear washes of the waves, and she said that this was the last sign of life from her because she was just about to drown herself. One thing that characterised her, which was frustrating, was that she leaked like a sieve. It was just like starting all over again every session.

Though this therapist is familiar with concepts such as transference and projection, the recall of that time was as an intense and overwhelming experience. He describes the feelings he saw in the patient as rage, and experienced this as directed against him. Reported feelings

of sadness, exhaustion and hopelessness capture important aspects of his mental state in relation to the patient at that time.

What Helped?

What are the informants' assumptions about what was helpful in the therapeutic relationship?

Patient: It is first and foremost the experience of being understood. The sessions have kept me alive overtime. And I have been lucky to keep the same therapist for a long time. I can tell everything without concealing anything because I feel understood and because I feel safe. Sometimes I am very depressed and that can be really heavy to bear. Sometimes I've got strange thoughts that many would call magic. To be listened to and recognized, that's important. And that it doesn't frighten the therapist. It is very important to be able to understand what lies behind strange thoughts and intense feelings.

The patient describes the experiences of being understood and feeling safe as important aspects of what helped her. Feeling understood when strange and frightening thoughts occur seems to be especially important. She also mentions the importance of time and continuity. The themes of understanding and of continuity seem to be related. When strange thoughts and experiences occur, the world feels frightening and the predictability of a stable therapeutic relationship turns out to be very important.

Patient: It still happens from time to time that he gives me responses that make me feel badly recognised, but now we can always talk about it.

Being able to talk about being misunderstood and badly recognized is something that seems to be a way bad things may turn good. This can be seen as something that contributes to continuity from the patients' point of view – the relationship doesn't have to be broken, even when something feels bad.

The therapist also marks the continuity dimension when asked about what helped.

Therapist: Time in relationship and a sustaining interest. Another thing which has changed is that in the beginning I was very concerned about being a good therapist by the book. As time went by I've become more sensitive about what she feels is useful. What is left for me to take care of is very much the frame - a predictable, solid frame. The therapy has focused on improving her understanding of herself, her own experiences and behavior. And there has been a considerable movement in that direction. She both prepared herself for the sessions and used notes to develop something on her own. I believe that was one way something at last started to get hold in her. She has brought in thoughts bordering on psychosis and totally psychotic imaginations. We have worked with translating these experiences into ordinary human feelings. I also found it fascinating myself, almost like interpretation of dreams. Over time her curiosity about such experiences has increased, and the exploration and interpretation makes her feel relieved and less anxious. She can understand the experiences as related to something in her life. All the time, the frame has remained important, existing as something solid, and as something underlined and defined again and again. The frame consists of duration of therapy, frequency of sessions, duration of sessions, limit setting against contact in between sessions and against threats. She is the only patient with whom I've lost my temper, and once I thumped the table to mark a limit against threatening. Her answer was: Now you behaved unprofessionally.

(laughs) and I answered: Maybe I did. But she has tolerated it.

Feeling bad or in doubt and then being able to go on seem to be an important part of the therapist's experience of continuity in this relationship. Moreover, being predictable and showing a sustaining interest can be perceived as complementary dimensions to the patient's experience of continuity and being understood. The setting of limits by the therapist has been important for sheltering both himself and the relationship from destruction.

Interruptions and Reestablishments

How are interruptions handled by the therapeutic dyad? How do they describe the meaning of interruptions and the ways they are handled?

The patient states that a certain level of continuity is a necessary requirement for safety, and that this level of continuity is what makes it possible to make therapeutic use of interruptions:

Patient: It might seem superficial, like idealization, but the most difficult part of therapy has been the interruptions. That is because Hytten is a very important person to me and the sessions are important. I've been in contact with a psychiatric nurse in the community who is very unstable. I can't be honest with her. I feel I have to protect her from all my trouble, I don't think she can bear it. That was an example where there's a lot of instability.

The patient seems to use the comparison with the nurse to make clear an important distinction between having a necessary amount of continuity versus a lack of it. When there is a lack of contact and continuity she experiences an inability to express feelings freely. She must protect the relationship instead of using it for therapeutic purposes.

The patient always comes to the sessions.

The patient's own effort in establishing a relationship with continuity and reliability is important. Both patient and therapist tell about the significance of the patient's reliability, meaning that she always comes to the sessions.

Patient: I have been in therapy for many years with him, and I've still not cancelled one single session, and that tells its own story about how important these sessions are to me. We are both very stable and keep appointments and I think that is essential to the therapy's success. If there hadn't been stability and continuity I would probably have dropped out rather quickly. After the first hospitalization, I was put on compulsory after care, and I had a therapist which I didn't experience as useful, so I cancelled many sessions.

The patient reports that she doesn't cancel sessions with this therapist, and she qualifies the statement by comparing it with experience with another therapist. That she does not give up on the relationship, even when very difficult emotional states occur, seems to be a possibility for emotional growth.

Hospitalization at B - an exceptional interruption.

Three years into psychotherapy there was a significant interruption when the patient was hospitalized for four months in a long term, psychiatric department at hospital B. This was her only stay at different hospital from where she has her short stays. The patient, the therapist and the case record all note this as an exceptional and severely difficult interruption, with a challenging aftermath.

Her suffering is described in the case record from hospital A: The patient tells that she has given up everything. She feels dead inside and needs silence. She feels dejected by hospital B and fears to lose contact with her therapist dr. Hytten. She feels abandoned and lonely and expresses that she has never previously felt so bad.

Patient: They decided no contact with Hytten during the hospital stay. The hospital report stated that the patient got worse during the stay. Afterwards everybody agreed that it was very unfortunate. I didn't believe in the arrangement. I didn't want to go. I lost 12-15 kg and I was extremely depressed. The most important thing in my whole life was taken away from me. We went from sessions twice a week to nothing.

This interruption appears to have been an interruption on many levels. It was an interruption in their regular schedule and the regularity of their contact. It was even more of a serious setback in the therapeutic growth process. From the perspective of the therapeutic alliance, the common goals for therapy seemed more distant than ever - a reality that was difficult to handle for both therapist and patient.

How did the therapeutic dyad handle the worsening of the patient's condition? This seems to have been a tough struggle for both parties.

Patient: Then I showed up at Hytten's office after many months. I had become very thin and looked totally different. And then we started anew again, and that went well, I think, not much anger to trace. Thought I saw a hint of despair in Hytten's eyes when I showed up. I believe he was shocked because of the way I looked. It is easy to refuse someone on the basis of print on paper, but harder when you really get to see the patients and how bad they have become, that's something different. I think I have

never previously seen Hytten so sad, to the extent that a therapist shows feelings, or shock might be the right word. But we managed to continue therapy afterwards without serious problems. It went well as far as I remember.

The statement that it went well is in contrast to how difficult that period seems to have been according to the case record at A (the acute ward), where she was hospitalized for more than one year following the stay at hospital B. Her nutritional intake was poor and there were many episodes of acting out: breaking of glass, inappropriate handling of knives, suicidal threats and suicidal attempts. She slowly and gradually gained weight.

From the patient's perspective, the crisis in the therapeutic relationship and the crisis in symptomatic status seemed closely linked.

Patient: You could always wish to get more time with the therapist. And this break at B was really unfortunate. The cause of the interruption is very important. I was probably a little angry back then after all. I felt abandoned and rejected by Hytten. I think my body spoke for itself. My somatic state was so bad. I remember one of his first comments. Someone has wondered if I felt provoked by it, but what I experienced first and foremost was the despair in his eyes - the first question he asked when he saw me was: Have you seriously set about to become an anorectic? The weight loss was because of my depression. His question might have been provocative, but I didn't perceive it that way. It was more like some sense of despair.

The therapist can confirm that this interruption was indeed linked to a crisis in the therapeutic relationship. He describes himself as having been tired and this seems linked to his perception of a lack of therapeutic progress as well as high negative affectivity in the relationship. He was involved in the decision to hospitalize her at B (long time ward).

Therapist: There have definitely been times when I was close to giving up. I believe that the hospitalization at B (long term ward) partly was about the fact that I myself had become disillusioned about the therapy. I thought that the therapy was aimless and hopeless and that I couldn't manage to continue. She wasn't allowed to be at hospital A (acute ward), where she very much wanted to be. At the same time she clearly showed that she couldn't cope with life outside of hospital, and so she was offered hospitalization at B. It was a significant interruption. I hadn't been fully aware of my own importance to her. And she expressed a very strong sense of having been betrayed by me.

So, the patient's feeling of being abandoned also reflects some emotional reality in the therapist.

Therapist: To manage to re-establish contact it was absolutely necessary to give her space to display her anger and her feelings that I had betrayed her. To show that I understood that I hadn't been aware of something important when I had let her stay in a hospital where she obviously suffered severely.

Vacations.

When a patient is seriously ill, a vacation during therapy is mainly a response to the therapist's needs. The vacations have been challenging, especially early in the therapy process. The patient describes feelings of being abandoned, and fear of death.

Patient: And there are summer vacations and Easter and such things, which are always difficult. I always fear the vacations and wonder if I am going to survive and if we are going to meet again. And I have this huge feeling of abandonment.

The therapist sees the patient's struggle, and searches for ways to strengthen her feeling of continuity. One way of doing this is arranging meetings with other professionals and another is through writing her a letter.

Therapist: There are always well planned, regular appointments with another therapist during the summer. Once or twice in connection with summer vacations, I wrote her a letter, one page where I wrote something about what I thought she had to struggle with, or how I comprehended her, how I thought about what was hard for her. I conceptualized it as a kind of transitional object that she could use during my absence.

The therapist uses the theoretic idea of transitional object as a rationale for his interventions. He offers her the possibility of using both the letter and substitute relationships to establish some continuity.

The therapist has been ill.

In instances when the therapist does not purposely interrupt therapy, the patient finds it easier to handle the interruption. She has also been able to take constructive steps to take care of her own needs.

Patient: It was some kind of illness, for instance he once broke his leg. Then he suddenly was absent. And, of course, I couldn't blame him. Then I was on my own. I wrote a letter to the outpatient clinic where I asked them to get me some other therapist until he was back.

Reduction of frequency.

The session frequency has recently been reduced to every fourth week. This change in the therapeutic frame was initiated by the therapist, who also sees a therapeutic rationale for it. The therapist wants to be less important to the patient, and he wants her to grow more independent.

Therapist: I think that she still needs a long time, but that it is important to reduce the session frequency. My reflection is that she gradually grows more able to take care of herself. But I believe she will need a therapist for a long time to come.

What is the patients' experience of these changes in their schedule?

Patient: When I arrive at his office and look at the door bell, I always fear he is absent. That would be a disaster, in quotation marks, also because the frequency of sessions is lower. A further reduction will be a great challenge.

The changes wake fears in her about losing connection with the therapist. But she uses the word challenge and not for instance disaster when she mentions the reduced frequency.

What Have They Gained?

Patient and therapist describe the results of this therapeutic work in quite similar and complementary ways.

Patient: I feel I've got more insight about myself. I am actually totally changed compared to who I was ten years ago. For instance we can now talk together as two grown up people. Relationships were difficult for me. Just to build relationships, to trust other people, and to meet another person in a calm way. I have improved in controlling impulses so the distance from thought to action is much longer. Though in many ways,

emotionally, I struggle as much as ever, but I can handle it differently. It is more controllable and understandable.

The patient's emotional pain is still there, but it has become possible to be present with her feelings, and to communicate them and this in turn seems to have made her less lonely.

The therapist also reports that there have been some more positive feelings and that this change is connected with changes in the way that he works with the patient as her therapist.

Therapist: After many years she could finally have positive feelings and tell about good experiences. She has become curious about her inner life, also the parts of herself that she previously experienced as frightening and bizarre. She doesn't have much of psychotic experiences any longer, but still some magic thinking. Experiences of madness can be translated into something understandable that can be shared in a relationship. After some time she became increasingly sad. She experiences a lot of grief that she is able to explore, but not at all reconcile herself with. She has reached contact with something genuine, and she can now bear it without becoming psychotic. We have developed a ritual at the end of every session where she asks: How do you think I feel now? And I give an answer, which in a way sums up the session. I think she wants to be assured that what she has shared has reached me. Now she is curious about my thoughts, and I can be curious about hers. She has become more able to carry the burdens.

Discussion

The Models of Therapeutic Development

We will now sum up and condense the meaning of the previous data to create two models of therapeutic development at a higher level of abstraction. The connections between the two models will then be discussed.

The Patient's Model: To be Understood in a Relationship that can Hold her

The patients' model is about a good therapeutic relationship. She tells about how this therapy and thereby her own development has become possible. She generalises experience about what a developmental forwarding relationship is like. She compares the therapeutic relationship with other relations and other helpers she has known. The important hallmarks are stability, reliability, to keep appointments, to listen, to not overrun her by knowing better or provide her finished solutions but to talk about and come to solutions together, to take her seriously and to try to understand her. It is also important that the therapist can bear that she shares her difficulties and the pain with which she struggles - including bizarre and psychotic experiences - without being frightened. The patient also points out what is not helpful: instability, unreliability, diverting of attention from difficulties, giving advice without listening, being unable to bear pain or being scared of bizarre thoughts. The different interruptions are seen to have different meanings in the building of the relationship. She uses the experiences with hospitalization at B as an anchor, a generalized experience which represents her understanding of how it should not be (decided totally by others, herself not being taken seriously and understood), and how it is now. She perceives this period as a turning point when she saw real despair in the therapists' eyes. To be able to talk about

misunderstandings and feeling sometimes badly recognised by the therapist seems to be a way something bad can become better: The relationship can continue even if the parties sometimes disagree, or if the therapist misunderstands her or says or does things she doesn't like. They are able to repair ruptures in their relationship.

The Therapist's Model: To Understand the Patient's "Madness" and to be Sensitive Towards her Suffering Though Setting Limits

The therapist emphasizes the importance of keeping a safe relationship for a long time, and a predictable, solid frame. He also emphasizes the work of translating strange and confusing experiences into meaningful and understandable human emotions and phenomena. The experience of being the therapist in this relationship has changed. It has been strenuous, and he has earlier felt great despair, despondence and hopelessness. The therapist thinks he contributed to the hospitalization at B. He was close to giving up and felt the therapy was hopeless. He was tired of being the target of the patient's destructivity. The therapy process has, though, brought a feeling of taking part in something meaningful and professionally instructive. He has learned important lessons about endurance, and that development can come about even when it feels hopeless for a long time. One important therapeutic condition that has helped him bear the heavy parts of the therapy has been the setting of limits against insults and suicidal threats. He has received help from colleagues at work and from postgraduate studies in psychoanalytic psychotherapy, which include supervision, personal psychotherapy and literature studies. These have contributed to his understanding of the patient and the relationship. He feels he has grown more free and courageous in the relationship over time. His focus has turned more towards how he can be useful for the patient, rather than how to improve her condition or heal her. For instance, he has seen that it

has been useful for her to bring notes for the sessions, and he gratifies her wish to know how he thinks she feels at the end of every session, instead of, for example, interpreting the wish.

The two Models Together – Implications for Practice

The patient and the therapist have separate models of development. To what extent are the models shared, as different positions in the development of a relationship? What makes it meaningful and important to take part in such a challenging relationship?

Both therapist and patient see that the patient still suffers from severe psychic pain, even if she has undergone important development. There are differences in their perspective considering her anger in the beginning. The patient doesn't remember that she was angry towards the therapist.

The patient has developed an ability to challenge her mistrust and to use the relationship. There have been huge crises in establishing and maintaining the therapeutic relationship: crises that have been potentially destructive, but which have also contributed to development (of the patient, the therapist and the relationship). What are the reasons that, in spite of the difficulties, this relationship became a relationship that facilitated development?

The patient and the therapist have handled relational strains, both on an interpersonal level, and on a structural level through arrangements outside the therapy. The hospitalization at B was considered a failure by all involved. Nevertheless, it was possible to repair this rupture in a manner that seems to have contributed to development. The therapist received the break that he needed. He saw that the patient suffered because of the interruption, but he also experienced that she survived. She suffered severely, but there was a difference in how much the therapist was blamed for this. The patient was able to see that the therapist saw that she suffered. That she saw despair in the therapist's eyes seems important. She was able to interpret a comment from the therapist that might have been seen as provocative, as instead

indicating a capacity for concern (Winnicott, 1963/1990), based on the non-verbal signals conveyed by the therapist's eyes and gaze. When reflecting upon the re-establishment after this break, the patient describes it first and foremost as a relief. Could she have recognized that the therapist saw her suffering, and that he cared about her, if they did not have an important relationship and then an interruption of this relationship?

Safran and Muran (2000) have found that in handling of relational difficulties, it is important for the therapist to be open toward self exploration and evaluation and to be able to tolerate her/his own anxieties and negative feelings as they arise. The present therapist has, from the start, worked actively to address the relationship and the ruptures directly. He has endured the patient's attacks without being destroyed and without seriously counter attacking, and he has set limits to protect the relationship. Winnicott (1969) describes the movement from object relating to object usage. This can be seen as a movement from omnipotent control to a sense of intersubjectivity (Benjamin, 1990) in relationships.

Limitations of the study and possible future directions

This paper contains a condensed and strictly prioritized version of a psychotherapy lasting for more than 13 years and important elements are necessarily left out. Quantitative data (for instance measures of the alliance, pathology and outcome) could have contributed to a further validation of the findings. To study both patient and therapist makes room for different perspectives on the same process. Exploration of other cases and comparison can contribute to further nuances.

Conclusion

By close inspection of a comprehensive case record and separate in depth interviews with patient and therapist about their experiences in therapy, we have shown some important steps and hallmarks of the healing process. We have shown how important relational difficulties such as mutual incompatible expectations and demands was handled both on a structural and interpersonal level. Close inspection of the course of events in psychotherapies is seen as a promising method for bringing a better understanding of how change processes unfold. To combine description and analysis of the course of events in a therapy processes can be used to analyse other cases marked by severe difficulties and incompatible expectations. Such analysis can make it possible to differentiate more precisely between therapeutic processes where relational development contribute to make the treatment more effective, and courses where attempts to develop the relationship fails. Such studies can explore how long term therapy can bring about important changes in both the patients symptomatology, changes in life patterns and relationships. The study also show the importance of addressing the therapists struggles and relational needs during such therapy processes.

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Appendix 1

The questions patient and therapist got before the interviews

The instruction they both got was that we wanted to understand both her/his experience of being a patient/therapist in this therapy, as well as her/his thoughts and reflection about what had been helpful, what had been difficult, and how they had worked with difficulties. They were informed that the questions were meant as a starting point, and that the interviewer was interested in her/his subjective experiences and reflections about what was important in the therapy process, beyond the questions.

The questions to the patient was:

- What has happened in the session that has been helpful?
- What has happened in the therapy that have been difficult?
- In this therapy, there have been periods with breaks in the contact. Please think of examples. How did the breaks come about?
- Have there been conflicts between you and the therapist? If so, please think of examples. What did you eventually do to resolve conflicts?

The question to the therapist was:

- What has happened in this therapy that has helped the patient?
- How has this therapy been for you?
- What has been difficult for you as a therapist? Please think of concrete situations and happenings.
- How have you managed to establish contact and cooperation after breaks?
- Have there been explicit conflicts between you and the patient? If so, please think of examples. What did you eventually do to resolve conflicts?
- Why was the therapy (and the rest of the treatment) designed the way it was?