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How does therapy cure?

The relational turn in psychotherapy

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Abstract

The history of psychoanalytic psychotherapy has been marked by different emphases on intrapsychic and relational factors in the potential cure of patients. Until recent decades, the intrapsychic domain was privileged over the relational. The recent relational turn in psychoanalysis, especially evident in the United States (but also in Australia) has seen this weighting reversed. In this paper I give an historical overview of this divide in psychoanalytic psychotherapy. I conclude with a case-study of a broadly relational therapy.

Keywords: psychoanalytic psychotherapy, psychoanalysis, relational psychotherapy, counselling, intrapsychic.

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Introduction

The question of cure in psychodynamic practice and theory is a fraught one. As Stephen Frosh notes bleakly, 'Looking at the major studies of outcome of psychoanalytic psychotherapy carried out by researchers sympathetic to the aims of such therapy, there is precious little evidence to suggest it works.' (Frosh 1997, 125) The most extensive and rigorous outcomes study of psychoanalytic psychotherapy remains the Menninger Project, a research project which surveyed a cohort of 1950s patients for up to thirty years after their initial treatment. Much to the dismay of the analytic community, the Menninger Project concluded there was no evidence that psychoanalytic therapy had greater efficacy than supportive psychotherapy: 'In fact, psychoanalytic psychotherapy had poorer outcomes than expected, while supportive psychotherapy had better effects' (Frosh 1997, 127). More recent studies appear to consolidate this finding. A 1984 study by Orlinsky and Howard nominated the quality of the therapeutic bond between therapist and client as a crucial determinant in client improvement. In other words, it is not so much the model of therapy practiced which is curative but the relationship forged between the patient and client.

At the same time, it should be acknowledged that the style and texture of therapeutic relationships are at least partially determined by the model of therapy. For example, we could reasonably surmise that a Lacanian therapeutic relationship would differ considerably from a Rogerian or a Winnicottian relationship.[1] This qualification

[1] In contrast to a Rogerian goal of realising full human potential, or a Winnicottian objective of facilitating play and spontaneity, the Lacanian emphasis upon 'well-saying' rather than 'well-being' must surely entail a different style of therapeutic relationship. Esther Faye, a Lacanian analyst in

notwithstanding, the view that a therapeutic relationship is at the heart of client change has won many adherents, especially in the United States where a school of psychoanalytic thought and practice - the Relational School – has developed around this exact premise. Even in more traditional schools, the relational turn in psychoanalysis has substantially impacted upon clinical practice, if not equally psychoanalytic theory. Writes one historian of psychoanalysis, perhaps with a hint of the partisan: 'Within psychoanalysis, the polarization of views between instinctual and relational conflicts as the source of human psychological distress has been to an extent resolved, with every school of psychoanalysis adopting its own version of a relational paradigm.' (Schwartz 1999, 275)

The objective of this essay is to trace the origins of the relational turn in psychoanalysis; flesh out some of the clinical implications of the this move to the relational, especially as it pertains to the classical clinical dyad of interpretation and insight, and the prospect of cure; and to review my own clinical practice through a broadly relational lens of one client's therapy.

Overview

While relational strands of psychoanalysis may have gained stature in recent decades, the prognosis for a two person psychology did not look overly promising in the first half century of psychoanalytic thought and practice. In retrospect, the first major skirmish between the intrapsychic and relational strands of psychoanalysis came in

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Melbourne explains her vision of therapy: 'In other words, there is no cure for unhappiness. In opposition to many therapies that seem to be founded on the promise of a cure, becoming a Lacanian analyst has required relinquishing this seemingly foundational belief and directing the analytic treatment towards a very different end.' (Faye 2004, 155)

the 1920s. Before this, however, the scene was set with Freud's renunciation in 1897 of his briefly held seduction theory (Rycroft 1995, 165). By moving the focus of his theories from the environment (the childhood sexual abuse of adult neurotics, usually by their father) to the intrapsychic (drives and the effects of unresolved oedipal conflicts) psychoanalysis was born and weighted in favour of a one person psychology. The clinical work of psychoanalysis, as it developed over the following decades, was thus to make these unconscious conflicts conscious in transference interpretations to the patient. In this model, insight was the goal of the therapy. Jan Resnik (2004, 55) summarises this drive structure model of therapy quite succinctly: 'So, the aim of analysis is self-knowledge largely achieved by the analysis and interpretation of defences against the underlying impulses, drives, urges, fantasies and so on.'

In this orthodox Freudian model of therapy, the therapist operates as a blank screen. Like a skilled and dispassionate surgeon, she dissects the patient's transference, and, with her timely interpretations, brings to the patient's attention his conflicted unconscious. Through these repeated interpretations, the patient works through unresolved oedipal issues and comes to accept 'common unhappiness' as the lot of being human. In the process, he relinquishes his neuroses and the hysteric demand for gratification. It is a theoretically brilliant - if clinically cold - model of therapy. Few therapists today would adhere to it scrupulously; fresh cohorts of narcissistic patients simply could not tolerate it.[2] There are enough examples of Freud himself bending

[2] Again, I suspect Lacanian therapy may come closest to this Freudian ideal. Certainly Lacanians proclaim themselves as the true Freudians. Esther Faye (2004, 155) gives us a small taste of what this might look like in the clinical setting: 'Lacanian psychoanalysis refuses to subscribe to the dominant

this classical frame to suggest that it always operated better as a theory than a clinical practice (Gay 1988). As Greenberg and Mitchell comment, 'there is often (perhaps always) a considerable gap between the way any given analyst thinks about what he does and how he actually operates' (Greenberg and Mitchell 1983, 397).

Sandor Ferenczi was one of the first analysts to challenge openly the classical orthodoxy of one person psychology. Theoretically, where Freud's interests lay in the explication of psychosexual neuroses, and what this said about being human, Ferenczi was drawn to the study of narcissistic neuroses, no doubt partly to explain his troubled history and personality. Accordingly, during the 1920s, Ferenczi began to place greater weight on early environmental trauma as a cause of many of his patients' ills. (And in this, perhaps, we can see an unconscious rebuke of Freud. i.e.: Ferenczi's 'second chance' of a non-traumatizing environment – his analysis with Freud during World War One - had failed him.) For Ferenczi, it was not so much intrapsychic conflict but a deficit in the infant/child's environment - usually inadequate parenting – which plagued the adult narcissist. This position put him radically at odds with Freud both professionally and, inevitably, personally. By returning to environmental failure, Ferenczi earned the scorn of his psychoanalytic contemporaries. This included persistent rumours that in his final years Ferenczi was suffering from a psychotic illness, thus invalidating his deviation from classical theory/technique. Such scuttlebutt, spread assiduously by Ernst Jones, contributed to Ferenczi's exclusion

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psychotherapeutic tendencies of leading the patient towards the Sovereign Good – refuses, in other words, to direct the treatment with the aim of satisfying the patient's insistent demand for happiness and satisfaction. Rather than plugging the hole, stuffing the gaping demand (as the myriad products of capitalism do), the treatment is directed at keeping desire open. To satisfy the patient's demand would be tantamount to attempting to satisfy her drive, which in its relentless and repetitive and inextinguishable push to satisfaction is always the death drive. To satisfy this drive puts the analyst or therapist on the side of death, not life.'

from the psychoanalytic pantheon for much of the 20th century. He has only recently been rehabilitated.[3]

Perhaps more than theory, it was Ferenczi's clinical innovations which drew the ire of his peers. In orthodox psychoanalysis, narcissistic patients were deemed unsuitable for analysis because they could not form a solid analytic transference. And without such transference, the analyst could not make her objective interpretations, painstakingly correcting the patient's view of the world. Driven by his own demons, Ferenczi took on patients who had been refused analysis elsewhere. Working from what self-psychologists would later call an 'experience near' perspective, Ferenczi adapted psychoanalytic technique to this group of narcissistically disturbed patients. What did this entail? Ferenczi's basic innovation was that the analyst had to adjust the analytic situation to the patient's needs. As Lee (1991, 67) notes, with admiration, this was some 40 years before Winnicott's 'facilitating environment'. At its very crudest – and at times it was very crude – Ferenczi's technique opened the door to a two-person psychology by emphasising the active role of the analyst in the therapeutic setting. This was in startling contrast to the analyst as blank screen.

It was also an implicit critique of classical technique. With his interest in early trauma, Ferenczi came to view orthodox technique as potentially retraumatizing for the patient. He wrote: 'The deliberate "restrained coolness," "professional hypocrisy,"

[3] It is hard not to note how ruthlessly psychoanalysis has purged dissident thinkers. Douglas Kirsner (2000; 2004) has written persuasively about the cultish behaviour of psychoanalytic institutes. Janet Malcolm's *Impossible Profession* (1981) is another eloquent investigation into how classical psychoanalysis patrols its borders. Certainly acolytes like Ernst Jones pursued the advancement of Freudian ideals with almost religious fervour. The same could be said of Klein's disciples. Kohut was not beyond encouraging such devotion either.

the focus on the patient's criticisms of the analyst as resistance, the clinical façade behind which an analyst hides from a genuine interpersonal encounter, all contribute to producing an ungenuine and therapeutically limited experience [and akin to the patient's childhood trauma].' (quoted in Lee 1991, 71). Ferenczi suggested, among other techniques, that analysts pay great attention to 'tact' and 'empathy'; tread lightly with their interpretations; admit their errors; and encourage their patients' strengths (Lee 1991, Chapter 6). All of this is the stuff of today's relational psychotherapy. And it goes to the heart of the question of psychoanalytic cure. For Ferenczi, in short, it was the analyst 'love' that cured. For Freud, it was the analyst's skill, akin to that of a surgeon's. In different ways, both approaches have the potential to encourage analytic omnipotence. The Freudian stance nurtures a cast iron model of split and tragic subjectivity; the Ferenczian approach a belief that love can cure all.

Psychotherapist and author Lavinia Gomez (1997) expands on these differences. Freud, she argues, was mostly concerned with developing a coherent theory of the mind using psychoanalysis as a method of research. She cites his simple declaration, "I have never been a therapeutic enthusiast" and contrasts it to Ferenczi who, she argues, '*was* a therapeutic enthusiast' (Gomez 1997, 126). These contrasting positions spawned different analytic ambiences. Freud's insistence that insight was the agent of change meant his therapeutic offering was 'a relational arena in which the patient can carry out research into herself'. In contrast, Ferenczi's emphasis on trauma and emotional deprivation suggested that 'the patient needed a real new experience rather than simply to find a way of seeing herself more fully and truly' (Gomez 1997, 126). Put crudely, it was research versus reparenting.

The history of psychoanalysis since Ferenczi's death in 1933 is too utterly complex and labyrinthine to capture in this essay. But I've gone back to the Freud-Ferenczi split because I think it remains a fault line in contemporary psychoanalysis. Put simply, I think it is possible to draw a (jagged and blurred) line between psychoanalytic schools. On one side of the therapeutic endeavour there are those schools which ultimately privilege intrapsychic processes as the raw material of therapy; interpretation as the coup de grace of technique; and insight/integration as the goal. (Freudian, Lacanian, Kleinian) In the other column there are those schools which ultimately privilege early environmental failure as the raw material of therapy; the therapeutic relationship as the engine of change; and an expanded/playful self as the goal. (British Independents, Self-Psychology, Relational, Conversational) I realise this division is crude. Winnicott (1965, 1971) and Balint (1968), for example, put greater emphasis upon instincts than Fairbairn and Guntrip who stressed environmental failure. Kohut (1971, 1977, 1984) tried to marry drive theory with his extensive remapping of narcissism and self-object transferences. Mitchell (1993) attempted to maintain a space for aggression within the relational schema which did not always reduce aggression to a product of self fragmentation. Today, I have great admiration for those therapists who refuse to tie their colours to one analytic mast. But at some point, in each therapeutic exchange, the therapist must make a decision from which broad position to advance (or withdraw).

[As an aside, this essay was born of my frustration with Kleinian supervision - provided as part of a Master of Counselling - where I felt the broad brush of relational

psychoanalysis was not given its due. To be frank, I'd go further and claim that relational psychoanalysis was not presented as properly psychoanalytic; therapeutic, to be sure, and even as 'supportive psychotherapy', but not psychoanalytic psychotherapy. I put this to our supervisor in a feedback session. Whatever her thoughts, she did not disagree.]

Given that Ferenczi was Klein's first mentor (Grosskurth 1988), it might seem surprising that I've lined up Klein in the tradition of Freud. Undoubtedly, because of her theory of object relating, I would place Klein just aside the relational divide. Indeed, Klein is often nominated as an important early theorist in the relational turn, despite her stated allegiance to Freud. (Winnicott, just over the other side of the relational border, is, in may ways, Klein's theoretical cousin.) The post-Bion imagining of the analyst as a 'container' nudges contemporary Kleinians even closer to relational psychoanalysis. As Mitchell and Black note, while Kleinian analysts use the same terms to describe analysis as Freudians, 'The patient and analyst are much more fundamentally enmeshed than in Freud's view.' (Mitchell and Black 1995, 106) Ultimately, however, it is the projection of drives into part objects, and their introjection, which propels Kleinian thought - the role of the environment comes a poor second. For this reason, I place Klein under Freud in my Freud - Ferenczi ledger, certainly as she pertains to technique.

If Klein and Winnicott are at arm's length across the relational divide, it might be useful to conclude this section with a very brief inventory of their therapeutic techniques. This will give us some sense of what is at stake in the relational turn. For

Kleinians, interpretations of considerable 'depth' are made early in analysis, with the initial aim of containing the primitive feelings unearthed in an analytic setting. There is a considerable emphasis upon interpreting negative transference, especially feelings of hate and destructiveness projected unconsciously into the analyst (projective identification). Kleinians do not dispute the importance of the therapeutic relationship, for the analyst must act as a container of the patient's intrapsychic conflicts, digest them, and then return these primitive feelings to the patient through interpretations. But ultimately, for a Kleinian, containment is not enough. The goal of therapy is the integration of hate and love; the capacity to tolerate the violence one inflicts (unconsciously) on others; and the ensuing move towards a reparative gesture. In short, the criterion for success in a Kleinian analysis is 'a more integrated state of mind' (Frosh 1997, 110). For the Kleinian, therapy without insight signals to the patient that his destructiveness cannot be named and is therefore unmanageable. Containment without insight is regressive; it feeds the patient's narcissistic and unconscious hope for a world without loss, conflict and pain. And as one Kleinian therapist and social theorist notes, 'it is precisely the suffering entailed by our internal divisions that pushes us into our individuality and creativity' (Craib 2001, 133). We might call this approach to therapy 'tough love'.

For analysts in the Winnicottian tradition, the emphasis on clinical technique is reversed; the provision of a good enough analytic environment slides past interpretation as *the* locus of change and cure. Here therapy operates as a 'second chance'; the opportunity to revisit, relive, and, finally, mend the deficits of the patient's (less than adequate) early interactions with care-givers. In this 'facilitating

environment' (Winnicott 1965), interpretation takes a secondary place to 'holding' and 'management' of the patient (Winnicott 1988). When he first formulated these techniques in the 1950s, Winnicott was acutely aware that this was not standard analytic practice, especially within the prevailing Kleinian circles of British Psychoanalysis. His argument was that a category of patients (what we might call narcissistic personalities) could not tolerate classical analytic technique. With these patients, according to Winnicott (1955, 279), 'the accent is more surely on management, and sometimes over long periods with these patients ordinary analytic work has to be in abeyance, management being the whole thing'. In recent decades, therapists from relational schools have argued that the majority of contemporary patients fit this category, with narcissistic patients far outnumbering classical neurotics (Kohut 1971, 1977, 1984; Wolf 1988; Lichtenberg 1989; Lee 1991; Stolorow & Atwood 1992). You might say, to rework a phrase, 'we are all narcissists now'. In this new analytic world, holding and management of the narcissistic patient through empathic attunement is not the precursor to analytic work, it is *the* work of therapy (Kohut 1984; Meares & Hobson 1977). From such a perspective, the classical technique of interpretation and insight is viewed as potentially punitive and prohibiting the true self's spontaneous will to health in a good enough environment (Meares & Hobson 1977). The goal of therapy in these strands of psychoanalysis is described variously as the capacity to play (Winnicott 1971); the development of unrealized potentialities (Meares & Hobson 1977); and an expanded sense of subjectivity (Mitchell 1993). It is not that insight is unimportant; rather it will developmentally follow a repair of the self.

As Stephen Frosh (1997, 109) has observed, the debate between these different traditions of psychoanalysis 'is a fierce one'. Too often, I suspect, this debate is reduced to caricature - unyielding and punishing Kleinians versus soft and indulgent relational therapists. The couch versus the bean-bag. Frosh (1997, 110) also muses that 'it is perhaps the polarisation of these views which prevents progress'. With these words in mind, I now want to turn to a case study [from my process notes] of establishing a therapeutic relationship.

Clinical Case Study

Wayne first presented at my private practice in February 2005. He had been referred by a female therapist who believed he would be better served in counselling/therapy by a male therapist. Wayne is a young gay man who is HIV positive. He presented with depression and anxiety. He was highly agitated during our first meetings, often perching on the edge of his chair until well into the session. He spoke of a deep despair, hopelessness, and a sense of chaos. He had great difficulty sleeping and had lost interest in his usual past-times. He had no appetite for food. Wayne found it difficult to motivate himself around his apartment and at work. He feared that he was 'falling apart'. Nor did Wayne want to contemplate taking anti-depressants. He had friends who were on anti-depressants and distrusted the way it smoothed out their distress. "It's like they go stable but they don't have any highs, any excitement. And I want the highs."

In the first session I attempted to establish if Wayne was at risk of suicide. He admitted to thinking about it. He had not, however, thought about how he might kill

himself. Rather, he thought about his funeral and the nice things people might say about him. I took this to mean that he was trying to maintain contact with the "good" inside himself, even if this had to be done vicariously. This was confirmed when he concluded that "there was too much good to be had in the world" to kill himself. We can see in these comments, I believe, both the importance of the intrapsychic (Wayne's good objects projected into his imagined mourners for safe-keeping and then reintrojected) and a belief that the world could match and nourish this sense of goodness. Despite a prevailing sense of impending doom in the first session, of holding something "bad" at bay, I decided that Wayne was not currently a suicide risk.

Wayne's presenting problem was complex and distressing. Six months earlier Wayne had been sexually assaulted by a close friend of his ex-boyfriend. After a night out drinking, Wayne and the friend had "crashed" at Wayne's apartment. Wayne invited the friend to share his bed rather than the couch. The friend mistook this offer as an invitation to sex. Wayne at first jokingly resisted, but as the advances became more insistent, froze. The friend penetrated Wayne and they had unprotected anal sex. The next morning the friend commented that he had always known Wayne had fancied him and that they should keep their encounter secret.

Illness, however, soon overtook both of them. Wayne was diagnosed with a sexually transmitted disease, as well as tearing of the anal walls which required surgery. A second day operation was then performed, about a month after we commenced therapy. Since the sexual assault, Wayne has been in constant physical pain. He is

greatly distressed and embarrassed by the daily discharge to which he must attend. He no longer feels physically attractive and has not had sex since the assault.

In the week that followed the rape, the friend fell ill with a flu like illness. After a visit to a doctor and an antibodies test, it was confirmed that this was a seroconversion illness. The friend told Wayne's ex-boyfriend that he had had unprotected consensual sex with Wayne, and that Wayne had failed to inform him of his HIV status. Wayne's ex-boyfriend has sided with the friend and cut all contact with Wayne. In Wayne's initial sessions, it was this excommunication that distressed him most. Although Wayne and his ex-boyfriend had separated some years earlier, they had remained in close contact. Wayne was considered part of the ex-boyfriend's family, welcome at family functions and celebrations. They, too, have cut contact with Wayne. Wayne's mother lives overseas and his father is dead. In our early sessions, Wayne clearly idealised both his father and his ex-boyfriend. Of his father he remembered, "I was his favourite boy." Of his ex-boyfriend he said, "He shone. He could just light up a room by entering it. And I was his boyfriend."

In contrast to these men, Wayne felt small and helpless, powerful only by association. Now estranged from his ex-boyfriend, Wayne presented as insignificant. More than insignificant, I suspected Wayne felt dirty and bad, the discharge leaking from his body a potent metaphor for his internal state. Rape, post-assault illness, rejection and HIV status had converged in a dreadful bodily and psychic cocktail. In our early sessions, Wayne spoke frequently of the effort required in "keeping up appearances". He would awake at six in the morning and spend a couple of hours grooming himself

to face the world. "And if only people knew. That I'm not as perfect as I look". Wayne also maintained a certain style of gay male sociability, of being, in his words, "fabulous and entertaining". This, too, was taking its toll. When I asked him to imagine what his social life might be like if he didn't always carry the burden of being fabulous and entertaining, he responded unhesitatingly, "Not an option". Wayne's manicured appearance spoke of how important it was for him to maintain, in his words, "a façade".

What were my initial thoughts after these early sessions with Wayne and how did I proceed? It was evident that Wayne was highly agitated and distressed. The rape, his illness, and his HIV status were all in themselves deeply upsetting, indeed traumatic. But it seemed to me that it was the estrangement from his ex-boyfriend which had toppled Wayne into a sate of crisis. I speculated that the ex-boyfriend may have provided Wayne with an idealised self-object (Kohut 1971, 1977), and that with this source of unconscious self-structure withdrawn, Wayne had begun to crumble; at least, he had begun to fear that he would crumble. I guessed that it was important that I provide this idealising self-object function. Soothing is one product of an idealised transference, although this does not mean the therapist must utter words of honeyed comfort. Rather, the therapist remains still, calm, warm, and attentive to the client's distress, perhaps even allowing (at times) a sense of merger. This transference, then, is not interpreted; certainly not in the opening stages of therapy, and quite often not at all.

For example, I have noted over the months with Wayne that his facial hair has matched my own. I have a beard, and after a month or so, Wayne grew a beard. In

preparation for a trip to the United States I shaved my beard. A week later, Wayne had shaved his beard. There may be nothing in this but Wayne's capriciousness. Alternatively, it might be an example of a silent idealisation. Whatever the case, it is not something that I believe warrants interpretation. Developmentally, the theory goes, this idealising transference will (substantially) take care of itself, as through the relationship with the therapist the patient becomes adept at soothing himself. Indeed, to interpret such an idealising transference too readily can be experienced by the client as a rejection or distancing of the emergent relationship.

While I have couched this therapeutic development between Wayne and myself in self-psychological terms, in reality, my responses to Wayne in those first sessions were more instinctive than theoretical. In other words, I saw his distress (a simple enough observation); sensed he needed a calm and soothing environment; and decided that it would be disruptive if I pointed out the relational dynamics already at play in the room. There was, of course, more than this going on. I had noticed Wayne's extreme discomfort in talking about the sexual assault. He could barely bring himself to mention the discharge he suffered. When he did, the disgust was writ large on his face. And there seemed something a little 'fuzzy', for want of a better word, in the way he described the night of the assault. Without doubt, these were distressing 'real' events, but I wondered if there was more to be said about them. I suppose, at this point, I was speculating (to myself) about the intrapsychic meanings of these things. Again, the great grief Wayne was suffering over the split from his ex-boyfriend's circle seemed to offer some clues. "What upsets me most is that they don't believe me. That they think I could do such a thing. That I am that sort of person." (ie: someone who would infect another man with HIV)

I wondered if Wayne did indeed fear that he *was* that sort of person. Or, more accurately, I wondered if this was a thought that Wayne could not allow himself to contemplate, for fear of the answer. Did he fear that the mucus which seeped from his body was a sign of his badness? Our following sessions seemed to bear this speculation out. Wayne mentioned a number of times his conviction that the friend could not possibly have contracted HIV from him; that as the friend was a "root-rat" he must have contracted it from another sexual encounter. The possibility that the friend did seroconvert after sex with Wayne seemed unbearable. In one session, Wayne spoke of a close female friend who was supporting him through the trauma. While he spoke of her with great fondness, he also added, "If she thought I infected him, then I couldn't be her friend." More than once, I felt Wayne was inviting me to agree that it was impossible he had passed on the virus. I didn't agree – how could I know either way – but nor did I interpret his quiet demand. I believed that Wayne needed to gain greater trust in our relationship before we ventured into that territory, for my suspicion was that it would reveal phantasies of inner badness that could not easily be shared. In a Winnicottian sense, I wanted Wayne to discover this spatula rather than thrust it upon him. Put simply, I hoped that through our therapeutic relationship (the holding environment) Wayne would begin to have the confidence to explore his fears on his terms, not mine.

This approach seemed to work, despite the relative lack of interpretations which troubled my Kleinian supervisor. By the fifth session, Wayne was considerably less anxious. He no longer sat on the edge of the couch, he roamed more in conversation, and he was showing greater interest in the world. To my surprise, he had told me that he liked to paint and that he had begun to draw. (I hadn't pictured him as artistic, but,

really, as he assembled his appearance with the care of an artist, I shouldn't have been so surprised.) And in this fifth session, there came a moment where Wayne decided to test our nascent relationship:

Client: But in here, yeah, I just want somewhere where I can be real. I mean, I actually think things are getting better, although I can't be sure. It feels like they are getting better, but it could all disappear tomorrow. And maybe I want some direction on that. Whether things are getting better. And actually I *was* going to ask you something. I don't know what you think of naturopathy, but if you think it is stupid, I don't think I can stay here. Cause I've always, always been interested in alternative medicine, even when I was young. And if you are sitting there thinking deep down "Oh, he shouldn't be doing this stuff," then I would have a big problem with that. I don't want someone looking at me from up high thinking I'm being stupid.

Therapist: Let me answer that in two ways. First, as you were speaking, I was thinking that this point is especially important to you, because, from what we talked about last week, when you were growing up, your family didn't appreciate your interests – what you did well, your artistic abilities - important parts of who you were were not getting acknowledged and appreciated. And I wonder if you are worried that I will be like that too. That I won't recognise the things that are important to you.

Client: Exactly! And I'm sick of fitting into what other people think is important.

Therapist: And what do I think of naturopathy …? I think I have enormous respect for the different ways people look after themselves. And I can see naturopathy is very important to you. Even in our first session, you were very clear that you didn't want to go on anti-depressants. And the way you have spoken about your life before the rape, with the alternative medications you were using, it sounded like you were very committed, as a HIV positive man, to living that lifestyle.

Client: I was. And I want to get back to that.

My Kleinian supervisor, in the tradition of Freud, suggested that this exchange, though supportive, was a lost opportunity; that by remaining on the "surface" and not making a deeper interpretation or observation, I had passed up an opportunity for Wayne to gain greater insight about himself. Perhaps, it was suggested, I could have responded, "I'm interested in knowing why you think I might be judging you." Perhaps, although to be honest that wasn't what I found of interest. In the tradition of Ferenczi, I was interested in providing Wayne with a different relationship in which he (and I) could feel "real", to use Wayne's language. Perhaps Wayne's demand that I share his opinion of naturopathy was a denial of difference, as my Kleinian proposed, but it was not how I chose to read it. I saw it more as Wayne's relational template: "I have been crushed before by those I trust – will this relationship be any different?" Of

course, this relationship won't be completely different; both Wayne and I will see to that. But hopefully it will be different enough to allow us to begin untangling past from present. And this deepening of a therapeutic relationship, far more than my interpretative skills, is where I see the focus of our work.

The following week in therapy produced a brief but vivid signal that such untangling may have commenced. Wayne had been speaking of the different ways his friends were dealing with the aftermath of his assault:

Client: And he keeps on and on about the rape. He just won't shut up about it. He wants to know what happened and how, and I said to him, "Frank, it didn't happen to you! Right? It happened to me and you have no idea! So don't go on about it like it happened to you. It didn't!" And then there are others who hardly mention it. They just refer to it as "the incident".

Therapist: Would you like to be able to talk about the rape Wayne?

Client: I don't know.

[Client goes quiet and he feels a little removed from the room - distant. He has gone into himself a little. There is a long pause.]

I guess I'm frustrated and sad and guilty.

Therapist: Guilty about the man who raped you?

Client: Yes. That I didn't tell him afterwards. And I could have, but I didn't. [Pause] I know it wasn't me, that he was already HIV positive when we had sex. There was no blood and I didn't ejaculate, so it is impossible. But just the thought ….

Therapist: It feels like this thought is unbearable, Wayne. There is something unbearable in the thought that he may have contracted HIV from you.

Client: [very quietly] Yes.

Therapist: Can you help me understand this Wayne? Can you explain what is unbearable about that thought?

Client: That maybe I'm not such a nice person after all. That maybe I meant for him to get it.

Therapist: Yes. And that is a pretty hard thought to bear.

Client: Yes.

[I decide to push things a bit further]

Therapist: You know Wayne, in our sessions I've felt that there was something unbearable in the room, just sitting here, making its presence known. And I haven't been able to put my finger on what it is.

Client: [again quietly and now a little teary] I know. It is just out of reach. I can feel it but I can't reach it. And I think it has always been there.

Therapist: Yes. I think it has.

Client: It is like I have a cancer in me. In my gut. And that if people find out I have it I will be alone. And I always have been alone. Even when I was growing up I didn't fit in. I had this big extended family and I didn't fit in.

As these exchanges show, Wayne's progress has been substantial. No longer highly agitated, Wayne has found (or rediscovered, I can't be sure) a marked capacity for self-reflection, or 'mentalization' as Fonagy (2001) would describe it. He has begun reflecting on his adult intimate relationships; their successes, failures and patterns. He has begun to wonder what role his childhood has played in these adult attachments. "I no longer expect Mr Right to come along and make things better," he tells me, "and that makes me sad." Nor does Wayne feel compelled to be the centre of attention in social occasions. "I'm feeling happier going with the flow. When I first saw you I told you I had to always be glamorous and exciting, but now I'm enjoying sitting back and letting someone else run the show." The huge grief he feels at losing the friendship of

his ex-boyfriend has abated, and sometimes sessions go without Wayne mentioning him. In our most recent session, the ex-boyfriend did arise but in a way quite different from before. "I was walking here this morning, down the street where he and I used to live, and I had so many memories of our years together. I almost expected our cat to run out from a house!". "Were they good memories," I ask? "Yes, mostly," Wayne responds with a quiet smile. And later, as the session draws to a close, Wayne relates an activity of the previous week that nicely illustrates his progress and, hopefully, points a way forward. (And perhaps, as I think about it, it also demonstrates why - despite valuing the insights of Melanie Klein - I am not a Kleinian.)

Client: I was sitting on the floor looking though a box of old photos from under my bed. And there were all these photos of my ex and I. Other times, when I've looked at them, all I can think about is when did things go wrong? By the time this photo was taken? Or that one? But, you know, despite the fact things went so bad, there were good times. And it was nice to be able to think about the good times without becoming obsessed by the bad ones.

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