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THE REAL RELATIONSHIP AND OTHER DILEMMAS

The challenge of being a skilled practitioner lies in having a relationship to technique whereby it is our servant rather than our master. This requires us to be able to recognise its limitations and to evaluate how we use it. Over the years psychodynamic practitioners have become anxious about flexibility in technique, feeling punished by their own superego, or that of their professional organisation, when they are more flexible. I think this is because therapeutic work always creates a potential for acting out, due to the strength of the phantasies and longings that we and our clients work with. According to Tonnesmann (2005), some of Freud's anxiety about changes in technique was to do with the potential for therapists to enact their erotic countertransference. However, abuse of clients can be much more subtle, and a therapist's attitude towards deviations from technique or boundaries can be an indicator of unethical practice. Deviations from standard practice continue to tap into this anxiety, not least because occasionally scandals about abuse of clients come to light. This serves as an ongoing reminder that we need to maintain our vigilance about what deviations from standard practice might signify, while still engaging with technique in a way that enables us to respond to our clients and develop our skills.

Our anxiety about deviations from standard practice can lead to becoming too rigid in the application of theory, which in turn leads to a less humane interaction in the therapeutic relationship. As Safran and Muran (2000) argue, if theory is used with a light touch, it can guide and point us towards exploring aspects of the relationship that might otherwise be missed. Many of the dilemmas that we confront, that challenge our relationship to technique, are to do with how we manage the boundaries around therapy. I have included the real relationship in this chapter because it falls within how we manage the boundaries that frame our work. Especially during the early years of one's career, it can be a significant challenge to stay in touch with ourselves as people in the therapeutic relationship, at the same time as coping with dilemmas and difficulties as they come up.

THE REAL RELATIONSHIP

The concept of a real relationship allows that our clients have the capacity to see and engage with us in a way that is based in reality, that they can see us as another human being with whom it is possible to have a connection that is relatively free of transference dynamics. The different psychodynamic schools vary in the value they ascribe to this concept. Many Kleinians have less use for it because they hold that there is an isomorphism between the internal and external world. Consequently, they hold that all aspects of the therapeutic relationship are experienced through the distorting lens of the transference. They are also concerned that paying attention to the real relationship will dilute the strength of the transference.

However, other authors take the view that the transference is a more robust phenomenon. Indeed Lipton (1977) argued that a more real experience of his therapist facilitates the client in developing a strong transference. Both King (1977) and Gill (1979) argue that there are factors in the therapeutic relationship that are to do with the reality of what happens between the two people involved, and are not just a manifestation of the client's distortion. Consequently, not everything that is communicated is directly related to the transference. Indeed, some therapist reactions are those of one human being who works with another. This adds another layer to the relationship, and can contribute to rooting therapy in the real world. The following vignette demonstrates how the interplay between reality and the transferential aspects of the therapeutic relationship can become manifest.

Shortly before Tom's session Vicky received a phone-call from her friend Patrick, informing her that he had just had confirmation of a diagnosis of cancer. Vicky was very upset for him, and was still in the middle of the phone-call when Tom arrived several minutes early. She felt irritated with him for interrupting. She let him in, settled him in the waiting area, and went back to finish her conversation. She began the session on time, but was aware that she was distracted. She could not put the phone-call out of her mind and found it difficult to pay attention to Tom. Part way through the session Tom complained that he felt Vicky didn't really want him there any more. The material of the session had been about Tom not feeling wanted by his brother, with whom he was having a difficult relationship at present. In an attempt to be more social, he had agreed to accompany his brother to a party, but his brother had gone without him. Since Tom had also been talking about his difficulties regarding a forthcoming break in recent sessions, Vicky took up the transference aspects of what he was saying by making links to the break, and that he might fear that she would be glad to 'go off and party' without him.

Kate felt that Tom had been responding to something about the real relationship. In arriving early he had interrupted the phone-call with Patrick, and, given how distressed Vicky was feeling, he would no doubt have seen it on her face as she answered the door. His perception of not being wanted at that moment

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was accurate. Vicky acknowledged that she resented him being there because she had wanted to carry on talking to Patrick. Kate pointed to the fact that, while the transference relationship no doubt coloured his experience of her unavailability, nevertheless it would have been helpful to acknowledge the reality of his perception that something had distracted her. She suggested that Vicky could have done it without impinging on Tom with information from her private life if she had said that she was aware she was distracted that day.

It is important to help your client to differentiate between his accurate perceptions and the distortions that are the result of his internal object relationships. It is part of our objective to help our clients be more in touch with reality, and in my opinion not acknowledging events in the real relationship further distorts their perception of that reality. In this instance Vicky treated Tom as though his communications to her were based on his inner world, rather than on his ability to perceive her actual state of distress. If she did this on a regular basis it might contribute to reducing Tom's confidence in his own accurate perceptions, and therefore his capacity to differentiate inner and outer reality. This would ultimately be unhelpful to his development.

Kate's opinion that Vicky should have acknowledged Tom's accurate perception of her distraction was not an invitation to violate the frame. Vicky could have acknowledged that she was distracted without telling him why. This would have served the dual purpose of acknowledging his realistic perception of her state of mind, without burdening or over-exciting him with information about her personal life.

SOME COMMON DIFFICULTIES WITH BOUNDARIES

During the course of your work you will meet situations which challenge the frame of therapy, resulting in dilemmas about how to react. When these things happen we can't always wait for supervision to discuss how to handle them, and at times you have to make a decision in the moment. The main things we call on at those times are our internal frame, as discussed in Chapter 4, and the supervisory functions we have internalised from our therapy and supervision. I have already discussed some of these challenges as they have arisen in other chapters, but I want to pay attention to some that I have not addressed so far.

Setting limits

A number of clients who come for therapy have not had a good enough experience of parents who can set limits in a way that is both containing, and that takes their

needs into account. Inconsistent or over-harsh limit-setting in childhood can lead to later difficulties in managing relationships with people in authority. These clients are more likely to push the limits in therapy.

If others' rules are always seen as the senseless exercise of power, your client is going to resent the boundaries around therapy. Clients who push the limits for this reason quite often demand a more quid pro quo relationship, in which confidences are shared; they resent the asymmetrical aspect of the relationship. Their resentment might be about having a specific time when they can see you, the length of sessions, or in private practice, the fact that they have to pay for missed sessions. Early in therapy it is hard for such clients to see any benefit to themselves of the boundaries that are part of the analytic frame, and asking them to take this on trust is likely only to arouse their suspicion further.

McWilliams (2004) advocates emphasising the therapist's needs for the boundary. She proposes that framing the need as being in the client's best interest can be experienced as like the child who is told 'this is for your own good.' She argues that since the boundaries do, in part, act to protect the therapist, with such clients one might as well make it clear. For example, in response to a client who wanted between-session contact at the time of his choosing, she pointed out that doing so would leave her feeling over-burdened and resentful. Having done something similar myself on occasions, I can testify to the relief with which clients later come to realise that I will not put them in a position where I resent what I give them. This can be particularly important for people whose parents have combined an authoritarian attitude with grudging giving. They begin to have confidence that what I give them is freely given, not dragged from me, which ultimately constitutes a new experience.

Client acting out

Acting out is when your client communicates something of importance to you through action, rather than through talking about it. Freud made the observation many years ago that, when something is being acted out, it isn't analysable. Acting out may therefore have to be worked with directly, through the use of the symmetrical relationship, if it involves a threat to the viability of the therapy. The aim of working with acting out is to help your client to the position where he can engage in a reflective conversation about his inner world rather than communicating through action. It is always important to hold in mind that clients can be shamed when faced with their acting out, and it is important to maintain empathy for the predicament they are in. This can be a significant challenge, particularly if their behaviour touches something in you that has not been fully worked through. Occasionally acting out has to be contained through you doing something that creates a boundary around it. At other times it can be contained through normal therapeutic work, since as a healthy ego develops, your client will be increasingly able to think rather than act. Tyndale (2002) described someone who acted out by using a baby voice in her sessions. Eventually therapist and client were able to reflect on, and later understand, what the acting out was communicating. This kind of acting out is usually managed routinely in therapy, and therapist

countertransference reactions processed with the help of supervision. However, there are other types of acting out within the session that are less easy to cope with.

Presents

I have put presents in this section as giving gifts can constitute a form of acting out, as well as presenting us with an ethical dilemma. It is not unusual for clients to want to give us presents. Those that are given at Christmas, after a holiday or before a break are different from the ones that are given at the end of therapy. The latter can signify real gratitude for the work done, which itself is an important development for some clients. Of course there is also the concretisation of the message that says 'don't forget me'. One client gave me a door-stop as a parting gift, and we reflected on her hope that I would keep the door open for her to return if she needed to. However, gifts given during therapy can have defensive underpinnings. A Christmas gift might signify difficulty in recognising the professional nature of the relationship, instead treating you like a friend. A gift just before or after a break may be a reaction formation against your client's anger that you are about to leave, or have left him.

There is considerable variability in how therapists deal with gifts. Some accept no presents and will insist their client takes them away, others interpret the meaning of the present as it is given, and others don't interpret, seeing the giving of gifts as a form of acting out which will cease when the client can verbalise his feelings. My own stance is generally to accept the gift, unless it is expensive. Whether I interpret the giving of the gift in the session or not will depend on whether I think that the interpretation can be received without humiliating my client. If my client's ego is sufficiently strong to be able to think about the meaning of the gift, an exploration of his underlying motivation is always useful. If, however, my client has significant deficit problems, I do not interpret unless I am given a specific invitation to do so. This is because an uninvited interpretation in such circumstances can be experienced as an attack, and will disturb trust.

Non-payment of fees

If you are in private practice, and your client regularly postpones payment by forgetting his chequebook or paying very late, there are two factors you need to attend to. One is that you have a contract which is the basis on which you and your client meet. The other is the exploration of the meaning of the late or non-payment. At a practical level your client needs to be reminded of the reality of the contract and, in the event of non-payment, you have to decide whether you are going to continue seeing him. This is never an easy decision, but it is important that you have a guide in your mind as to how much leeway you feel comfortable with. This internal boundary is transmitted unconsciously to clients, through an attitude regarding the value you put on your work. It is not uncommon for psychodynamic practitioners to privilege an understanding of the dynamic roots of a client's non-payment and lose sight of the fact that, unless the fee is paid, the contract has been violated. I think

part of the reason for this lies in the extent to which we have resolved our own feelings about being paid for the work we do. Both our clients, and those who write about money, draw our attention to the parallel between therapy and prostitution (Taylor, 2002). This can be an uncomfortable dynamic for therapists to adjust to. Also, the depressive dynamics that take us into therapeutic work can make it difficult for us to ensure that our own needs are as important as those of our client.

Very often a partial resolution is forthcoming if you and your client are able to understand something of his difficulty in paying you, in the context of a clear message that there is a financial contract that he has to honour. While taking up the meaning for him, it is also important to reflect on your own relationship to being paid. The client, in withholding payment, may not only be communicating something about his early difficulties. He may also be communicating his feelings about how the fee was set, the amount he is being charged, or an unconscious awareness of your attitude towards being paid.

Contact outside the session

Therapists occasionally describe being overwhelmed by a client whose needs for additional contact lead to a deluge of letters, phone-calls, faxes or emails. As with much in therapy, there is no formula setting out a specific course of action. How you manage the situation will depend on your client, the specifics of what is happening, your formulation as to why he is behaving in this way, and the setting in which you work. Your formulation about the underlying dynamics will help guide you as to how to proceed. If the predominant dynamic is sado-masochistic and involves punishing you, it is more important to put a firm boundary around the behaviour. This serves to protect both you and your client from the cruelty of what he is doing. However, it is important that you set the boundary in a way that acknowledges his humanity, so that you do not enact the sadistic position, which would only serve to perpetuate the sado-masochistic cycle. The invitation to engage in a sado-masochistic relationship is a very powerful one and, if you find yourself in this situation, it is important to take it to supervision in order to avoid a relationship dominated by punishing your client or being punished by him. Managing this kind of dynamic can be particularly challenging if elements in your own experience have involved cruelty by your objects.

A formulation indicating that your client is unable to contain massive anxiety, that has been stirred up as a result of his therapy, requires a different response. If you deny him all additional contact you may repeat an early environmental failure, which could reinforce rather than ameliorate his difficulties. You may first consider whether you can, or whether it would be helpful, to increase the number of sessions he has in a week either temporarily or permanently. If this is not possible or appropriate, it may be important to establish a contract with your client that allows a limited amount of additional contact for a specific length of time, which can be re-negotiated if necessary. This is one of those occasions where it is important to communicate through the symmetrical, rather than the asymmetrical, relationship in order to re-negotiate the boundary. Doing so will help prevent further infantilisation, and reduce his humiliation. It also is important not to get drawn into punishing your

client for his neediness by using interpretations that emanate from your superego. Quite often such clients elicit powerful negative transferences from the people who work with them. This is particularly the case when working in a team, where they can be labelled as 'manipulative'. It is often the job of the psychodynamic therapist to help other team members to see the client's behaviour as an expression of a request for help and to think about the realistic steps that can be taken to meet his needs.

Aggression within the session

Verbal hostility and aggression are part of therapy, although it is important not to allow yourself to be verbally bullied, and for your client to be aware of the impact of his verbal aggression on his objects. However, it is a different matter if your client threatens to enact his hostility. Powerful transferences can lead to this kind of acting out, which can occur in both intensive and less intensive therapy. It often happens when psychotic functioning threatens to overwhelm a client's capacity to stay in touch with reality. At such times your first duty is to keep both your client and yourself safe. Very often this is achieved through attending to the reality aspects of what is happening before thinking with your client about the meaning of his actions.

Many years ago one of my weekly clients, whose functioning was dominated by her internal world, brought a knife to therapy and began to play with it in front of me in a way that frightened me considerably. I was unclear whom she might harm and she was unable to tell me. What was clear, however, was that work could not proceed until she surrendered the knife and I had put it out of sight. Only once the knife was safe did I begin to look at what bringing it had meant to her. In this instance I returned the knife at the end of the session, but with the clear injunction that if she brought it again I would not be able to continue therapy. Putting a firm boundary around the acting out, both by taking the knife, and saying that I could not continue seeing her if she brought it again, enabled her to feel safer. She later said that she had been relieved that I had not allowed her to keep the knife during the session, and had taken from her the responsibility of managing the violent fantasies that had overwhelmed her.

THERAPIST ACTING OUT

None of us is immune to acting out under the pressure of the countertransference, or when unanalysed parts of us are triggered by powerful dynamics in therapy. Furthermore, we are all capable of using the frame defensively as a way of protecting ourselves. In itself this is not necessarily problematic, unless we rationalise it rather than recognising that we have done so for self-protection. Sometimes we only become aware of how we are enacting something that can't be thought about when we present our work in supervision; other times we are aware that we feel uneasy about a course of action, but manage to rationalise it. The full range of therapist acting out would take a book in itself since, like defences, this can become manifest in any area of practice. However, I have outlined some of the more common ways in which it happens.

At one end of the scale I include not starting on time or finishing the session early; not giving adequate warning of breaks; cancelling sessions at short notice because we want a day off; answering the phone or the door; giving interpretations that meet our need for self-protection rather than the client's need to be understood; not properly addressing it when your client acts out, for example by missing sessions. In the mid-range I would include dressing in a sexualised way that over-stimulates your client; raising fee levels to the point that your client can no longer afford to pay them; using your client's ambivalence as a pretext for ending therapy prematurely; giving your client personal information that he does not need and which will over-stimulate him; touching him because of your own need or because you have rationalised it would be good for him; keeping him dependent when his developmental trajectory propels him towards increasing independence. At the top end of the scale there is the kind of emotional, physical or sexual abuse that is under-reported, but which is massively damaging to clients and leads to therapists being struck off or in some cases prosecuted when it is.

Tom had been in therapy for about two years and was making steady progress. Vicky began to think that Tom no longer needed to come twice a week. So when he began to wonder about reducing his sessions, in preparation for his final year of studies, she accepted his proposal without an exploration of what lay behind it. She took it very much as a symmetrical issue and was practical about thinking with him which session to drop. It was only when she was challenged by Kate, about not taking up Tom's underlying reasons for wanting to reduce his sessions, that she came to question why she had not done so. The realisation that she would be happy for Tom to reduce his sessions because it now suited her was very uncomfortable. Vicky had just completed her training and was building up her private practice. Tom's sessions were in the evening and these were times that other people wanted, and for which Tom paid a reduced fee. Vicky needed the money from clients who paid full fees, but had not considered or processed her resentment towards Tom that he prevented her from offering these times. Vicky was grateful to him for enabling her to complete her training, and found it difficult to see herself as someone who would resent his continued use of these session times. This led to her enacting her resentment by encouraging him to reduce his sessions because she could not process her feelings through thinking.

REFERRING ON

Knowing the limits to your skill and experience is an important competency. It is a particular challenge in psychodynamic work because the reasons for feeling incompetent, or believing that someone else would do a better job, can be understood concretely, as a fact, or can be viewed as part of the transference-countertransference matrix of therapy. If it is clear from the outset that your client needs to see someone else, the issue is straightforward in that you need to determine whether you can refer and to whom.

However, because clients also project their feelings of incompetence into us, we need to unpick what has been projected and what actually belongs to us. You need to keep an open mind about whether you have the competences to work with him safely until you have considered whether you are reacting to projective mechanisms. As is often the case with projected material, the reason it 'hooks' is because it touches on something that we actually feel or fear. This is especially so if you are relatively inexperienced, since you will not have developed a reliable sense of your own limits as part of your professional identity. The only way to deal with these projections properly is to reflect on them both internally and in supervision. Only once you have done so will you be able to determine what, if anything, to do next.

The question of referring on is complicated by a number of factors. One is interprofessional rivalry. Many years ago Freud set the seeds when he made the distinction between the 'pure gold' of psychoanalysis and psychotherapy, which he regarded as a lesser intervention. At the time psychoanalysis was one of the few psychological treatments, and neither psychotherapy or counselling were professions in their own right. However, there is still a sense of a hierarchy in which psychoanalysts are seen to occupy the top echelons, with everyone else in descending order. This tends to be reinforced in the UK public health sector, where often psychoanalysts occupy the senior posts.

The way practitioners deal with this will depend on their own relationship to hierarchy. Unfortunately, a number of therapists from all sections of the wider profession do not manage it well. At its worst some psychoanalysts can be patronising towards those who have undergone a less intensive training. It is as though having a more intensive training automatically makes them better therapists. This fails to appreciate the quality of the training other practitioners have had or their personal capacity for being therapeutic. At the same time some therapists and counsellors can become envious of the psychoanalysts' higher status and take the view that 'I'm just as good as her' in a way that denies the difference in length and depth of training. This attitude is untherapeutic, especially if clients are treated for a long time in non-intensive therapy when they need the kind of developmental work that could only be undertaken by someone who has been trained to work intensively.

Sometimes we will continue work with clients who we know we should refer on for more intensive work because we identify strongly with what it would mean to them to lose us. At other times this is out of ignorance of what someone's needs and underlying difficulties are, and how they can be helped by more intensive work. Occasionally I fear that it is about a difficulty in acknowledging that someone else has skills that are beyond those of the less intensively trained therapist. This refusal to see the value of what other practitioners can offer can go both ways. It is rare for someone who has been trained to deliver three, four or five times a week therapy to suggest that someone trained to do once a week work would be more suitable for clients who want weekly therapy. This kind of therapeutic arrogance, that the skills one learns doing intensive therapy can be easily translated into doing less intensive work, helps to feed resentment and envy. In turn this makes it more difficult to value the skills that each section of the profession has, which is ultimately to the detriment of our clients.

Another issue is to do with our own internal world. Feelings of omnipotence, that we can take on anyone's difficulties, or a belief that we have to struggle on with clients who stretch us beyond what we feel we can manage, are equally unhelpful. In both

cases our inability to recognise the implications of the limits of our competence can mean continuing with clients who might be made worse because we do not recognise they need to see someone else. One of the areas that is particularly difficult for mental health practitioners to identify is when we are not fit to practise. Sometimes this can lead to taking on clients whom we should not see because their developmental needs are congruent with our own. Good supervision often helps us avoid these difficulties, but we also need to be prepared to be honest with our supervisors about the kinds of difficulties we are in or might encounter.

Once the decision to refer on has been made, you need to be able to help your client to deal with the sequelae. Sometimes this is a decision that is reached mutually, but even so, your client will have some ambivalence about leaving you. It is much more difficult if you feel that he needs to see someone else, and he doesn't want to change therapists. In referring on, you need to give your client the time to undertake the tasks of mourning and leaving as in the ending of any therapy. Often the ending takes place over a shorter period of time than it would if it was a planned ending of a complete therapy. And, in circumstances where both of you are feeling sad that the referral on has to be made, it is more tempting than usual to truncate the ending as a way of defending against the sadness of loss. However, for the referral to have the best chance of success you and your client need to properly address issues such as your client's anger with you for not being able to undertake the work yourself; his distress about having to see someone else, who he will inevitably regard as a 'stepmother'; a proper acknowledgement of what you have accomplished together; a decision about whether you will have any future contact.

With regard to the last issue, I have very occasionally maintained contact with a client who I have referred on, usually for developmental reasons. However, it has been with the explicit agreement of the therapist to whom I have referred, and also with the explicit understanding that my client and I will not be a therapeutic couple in the future. However, this is not my normal practice and, if done, needs to be carefully thought about both in supervision and with the therapist receiving the referral, to ensure that such contact does not compromise the client's future therapy.

FURTHER READING

Alfille, H. and Cooper, J. (eds) (2002) *Dilemmas in the Consulting Room.* London: Karnac.