A Comparison of Audio Recordings and Therapists' Process Notes in Child and Adolescent Psychoanalytic Psychotherapy

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Abstract

Therapists' process notes - written descriptions of a session produced shortly afterwards from memory - hold a significant role in child and adolescent psychoanalytic psychotherapy. They are central in training, in supervision, and in developing one's understanding through self-supervision and forms of psychotherapy research. This thesis examines such process notes through a comparison with audio recordings of the same sessions. In so doing, it aims to generate theory that might illuminate the causes of significantly patterned discrepancies between the notes and recordings, in order to understand more about the processes at work in psychoanalytic psychotherapy and to explore the nature of process notes, their values and limitations.

The literature searches conducted revealed limited relevant studies. All identified studies that compare process notes with recordings of sessions seek to quantify the differences between the two forms of recording. Unlike these, this thesis explores the meaning of the differences between process notes and recordings through qualitative data analysis. Using psychoanalytically informed grounded theory, in total nine sets of process notes and recordings from three different psychoanalytic psychotherapists are analysed. The analysis identifies eight core categories of findings. Initial theories are developed from these categories, most significantly concerning the role and influence of a 'core transference dynamic' between therapist and patient. Further theory is developed on the nature and function of process notes as a means for the therapist's conscious and unconscious processing of the session, as well as on the nature of the influence of the relationships – both internal and external – within which they are written.

In the light of the findings, a proposal is made for a new approach for learning about the patient and clinical work, 'the comparison method' (supervision involving a comparison of process notes and recordings), and, in particular, for its inclusion within the training of psychoanalytic psychotherapists. Further recommendations for research are also made.

Table of Contents

Acknowledgements

Chapter One: Introduction

Background to Research Study

My interest in the role of memory and recordings in psychotherapy began when, during clinical training in child and adolescent psychoanalytic psychotherapy, I became ill with Myalgic Encephalomyelitis (M.E.), a condition which can affect the sufferer's memory. In the light of Bion's encouragement to 'aim at a steady exclusion of memory and desire' this might perhaps not have been seen as a problem (1967, reprinted 1988:19). Bion encourages the analyst to shed memory and desire to better open oneself to the core of the analytic endeavour – the emotional experience of making contact with the patient. However, the practice of psychotherapy does depend on memory, not least in the central role process notes play in training, supervision and in developing one's own understanding of the patient through self-supervision.

Psychotherapists typically use process notes – written descriptions of a session produced shortly afterwards from memory – to record their work. These process notes aim to capture, in as much detail as possible, both the external action of the session (what the patient and therapist said and did) and the internal action from the therapist's perspective (what the therapist thought and felt). Through this, process notes should provide insight into what happened in a session and into the therapist's internal thought processes and emotional reactions during the session. Such notes are relied on for basic knowledge within the discipline, both as the basis of training and supervision, self-supervision and as the raw material in clinical research. Within child and adolescent psychoanalytic psychotherapy in the United Kingdom, the use of audio or video recording is not common practice.

As I began to think about memory, I began to consider how reliable process notes were, what they might manage to capture and what would, inevitably, slip away from the therapist before it could be captured. Process

notes provide a rich depth of data, but they rely on the therapist's perception and recollection of the session, leading to some criticisms of the single case study, the extreme of which is represented as follows by Spence: 'Although the traditional method of case reporting may produce entertaining accounts of clinical happenings, they are almost certainly a mixture of fact and fiction and probably belong more in the pages of *Good Housekeeping* or *Redbook* than any refereed psychoanalytic journal' (2007: 612).

This study started with a basic assumption that differences between what was said and thought in a therapy session and what the therapist managed to record afterwards were inevitable; it seemed impossible that anyone would be able to remember an entire fifty-minute session with all its twists and turns, and one in which they had been a participant, and then record it accurately afterwards. The assumption that there are limitations to the therapist's memory has led some commentators to argue that process notes cannot, therefore, form a viable base for psychotherapy research (Wallerstein and Sampson, 1971; Seigel et. al., 2002; Spence, 2002, 2007). Whilst others in the psychoanalytic community have argued against the idea that tape-recorded analytic sessions are more reliable, championing instead the importance of the process note (Quinodoz, 1994; O'Shaughnessy, 1994; Tuckett, 2002), it is clear that process notes provide observational data which are not present in audio recordings, as well as comments on the therapists' responses to the patients which is unavailable in either audio or video recordings. These debates will be discussed further in the literature review, and, as that review will also demonstrate, earlier research into the accuracy of process notes indicates that they do indeed include high levels of distortions and omissions when compared to recordings of the sessions.

Aims of the Study

As discussed above, process notes form a central part of psychotherapy training; they are the main vehicle through which trainee psychotherapists learn their craft, and through which supervisors can monitor their progress. Furthermore, process notes have traditionally formed the basis of much psychotherapy research, typically in the form of the single-case study (Midgley, 2006). Diverse criticisms are levied against the single-case study, as well as criticisms of process notes per se: one such criticism is that no one other than the therapist has direct access to the sessions in question and, therefore, the ability to test, question and validate or discredit the findings made within the research is significantly restricted (Wallerstein and Sampson, 1971; Midgely, 2004, 2006). Thus research which expands the understanding of process notes should be able to contribute to both psychotherapy training and research.

I believe this study to be original in two ways: first, in its research population and secondly, in its research aim.

All the previous research identified in the literature review studies therapeutic work with adults. In a departure from this, this study examines the process notes and audio recordings of sessions undertaken by child and adolescent psychotherapists working with adolescents. The sessions were carried out as part of the Improving Mood with Psychoanalytic and Cognitive-Behavioural Therapy study (the IMPACT study), a national randomised controlled trial into treatment of adolescent depression comparing the outcomes of Cognitive-Behavioural Therapy, Short Term Psychoanalytic Psychotherapy and Standard Clinical Care.

Furthermore, the primary research aim of all the earlier studies identified was to quantify the changes contained in the process notes. This study does not, however, seek to quantify differences: instead it aims to generate theory that might illuminate the causes of significantly patterned

3

discrepancies between the notes and recordings, in order to understand more about the processes at work in psychotherapy and to explore the nature of process notes, their values and limitations.

Chapter Two: Literature Review

This chapter reports the systematic literature review undertaken of studies that compare audio recordings of sessions with process notes from those sessions. This review is followed by background literature reviews that relate to the study's aim: the second section of the chapter considers the literature on process notes, both their role within the evidence base for psychotherapy and within psychotherapy training. The third provides a brief overview of memory functions. The fourth reviews the background psychoanalytic literature that provides a context for this research: technique in child and adolescent psychotherapy, the concepts of countertransference, transference and the mechanism of projection, as well as an understanding of enactments and the idea of selected facts.

II.i. Comparisons Between Process Notes And Recordings Of Sessions

The aim of this literature review was to find all studies that compared therapists' process notes with audio recordings of the same sessions. In order to achieve this, searches were conducted across a range of research databases; including the *Psych*Info and PsychArticles databases from the American Psychological Association, the PEP Archive which specializes in psychoanalytic articles, and the Psychology & Behavioral Sciences Collection, which is a comprehensive database covering studies in emotional and behavioural characteristics, psychiatry & psychology, mental processes, anthropology, and observational & experimental methods. In addition, searches were carried out using the Google Scholar database. The search terms used were: 'comparison', 'process notes', 'therapist notes', 'therapist process notes', 'notes', ' case record', 'audio recordings', 'video recording', 'recordings' and 'psychotherapy transcripts'; with different combinations of the above terms searched for prior to the individual terms being searched for. The database searches identified three studies that compared process notes with recordings of the sessions. Additional studies were identified via reference lists from related studies.

No research published within the child psychotherapy discipline comparing process notes with audio recordings was found. Furthermore, the studies identified all focus on the accuracy of process notes when compared to the recordings; in this they differ substantially from the research aim of this study, which is to analyze the differences between therapists' process notes and audio recordings of the same session in order to generate theory about the processes at work within sessions that led to those changes and to explore the nature of process notes, their values and limitations.

Covner, in papers published in the 1940s based on his doctoral thesis, compared recordings of sessions by counsellors with their notes written after the session. He studied 51 sessions from 20 different counsellors who came from four groups – more experienced and less experienced directive counsellors and more and less experienced non-directive counsellors (where more experienced could equate to only one year's post-qualification experience). The counsellors were undertaking 'counselling interviews' with their clients, ranging from 16 to 64 minutes long. The counsellors knew the notes were going to be studied for accuracy. Covner found that between 75% and 95% of the material in the notes was accurate, but that more than 70% of the session material was missing from the notes (1944a). He also found distortions in the sequence of events within sessions and a lack of clarity in who said what in the notes. Covner indicated how changes in the notes could lead to striking differences in how the counsellor was presented in the notes from how they appeared in the sessions, for example, he demonstrates how the following discussion only featured in the notes as 'Also urged him to see Dean' (1944b: 92):

C. [counselor] – [Trying to convince patient to visit a University Dean] Incidentally he has a very good-looking secretary, very good. S. [subject] – He does? Is she young?

6

C. – She is young. S. – Well, I do declare.

C. – So if you just went over there to look at the secretary, you wouldn't be wasting your time. S. – "Beauty is where you find it, my boy."

C. – Well, I would say, "Approach beauty." S. – (laugh) Say, you didn't fall for her, did you?

C. – No, no, nothing like that. Not a married man like me. S. – Are you married?

C. – Sure. S. – Well, I'll be darned! I'm glad I discovered it. (ibid.: 91).

Covner argued that whilst notes should, ideally, be replaced by recordings, this was impractical. He did believe that recordings should be used for research and in the early stages of psychotherapy training.

In 1966 Knapp et. al. (cited in Wolfson and Sampson, 1976) compared one ten-minute section of a transcript from an analytic hour with notes written during the session. They found that whilst the order of the material in the section studied had been preserved there was significant distortion. Wolfson and Sampson, as part of their larger study examining thematic shifts in psychoanalysis, compared taped patient-reported memories with the patient's memories as recorded in the analyst's notes. The purpose of this study was to explore whether process notes could function as research data (as was the case in their larger thematic study). They used the recordings and notes from one 20-year-old male patient. The experienced analyst wrote the notes after the sessions. They focused on memories of the patient's father, mother and repeated memories, and, as in their larger study, were interested in the thematic shifts of the memories, such as a shift from memories of an idealizing father to memories with a loss of that idealization. These memories were then scored by three independent raters and the scores for the notes and recordings were compared. The researchers found that although there were fewer recordings of memories in the analyst's notes and significant condensations, as well as some distortions, nonetheless the analyst's

notes did pick up on the thematic shifts. They argued that process notes provided particularly good data for research into long-term change in psychoanalysis as they presented the data in a more manageable form than the recordings.

Kieffer Bailey (2000) in his dissertation: 'Comparison of Verbatim Transcripts and Psychoanalytic Process Notes for Emotion Tone, Abstraction, and Referential Activity Using Computerized Text Analysis Methods' compares transcripts with process notes. Crucially, these are notes written during the session, as opposed to the practice of writing notes afterwards, the method used in the IMPACT study whose notes form the basis of this study. He finds that the notes average 35% of tape word volume, and on whole preserve speaker identification, speaker proportions, vocabulary and connotation and therefore deems them reliable. Siegel in 'Where's the Text?: The Problem of Validation in Psychoanalysis' says that 'some analytic researchers, Marc André Bouchard in particular, have already begun to look at the relation between an analyst's countertransference process notes and verbatim transcripts of the psychoanalytic dialogue', but he does not list any work by Bouchard in his bibliography and no published work from this study is recorded (2002: 416).

Most relevant to this study is Bonnin's 2011 doctoral thesis 'Therapeutic Memory: A Study Of Therapists' Process Notes'. Bonnin studied six process notes each from three student psychotherapists in the United States who were predominantly from a psychodynamic and integrative theoretical orientation. Their work was with adult patients suffering from depression and anxiety. The main purpose of the study was to test the accuracy of the therapist's memory based on the numbers of omissions, insertions and distortions in the process notes. This was followed up with interviews with the therapists to explore why they felt such changes had occurred.

The session notes and transcripts were studied by Bonnin and four research assistants, looking for units of 'verbally communicated information', which she described as a clinical fact; at least two researchers had to agree for a unit to be counted as a clinical fact (2011: 44). Bonnin found that on average there were 358 clinical facts per session and of those nearly three-fifths were omitted from the notes (57.2%). There was an average of just under three insertions per session, nearly three facts in the notes that were not in the recordings, and an average of nine distortions per session. Bonnin had given the therapists in her study a strict half-hour time frame to write their notes and found that the accuracy / inaccuracy levels for all the therapists in the study was very similar, which may have related to the set writing time.

Bonnin carried out semi-structured interviews with the therapists, which were then analyzed using Interpretive Phenomenological Analysis. She records that the therapists were initially both surprised and defensive when they learnt of the errors made. However, they later came to view such changes as inevitable for a number of reasons: an inherently fallible memory and one which would be affected by their own personal factors, such as fatigue; the need to provide a sense of the wider context in the notes; the need for the therapists to highlight what they felt were the most important aspects of the session and to paraphrase when writing notes; a desire to impress others reading the notes; anxiety relating to themselves and their patients and what they might have understood about the patients that was not expressed in words during the session. The therapists also noted that the changes might have related to dynamics such as transference, countertransference and projection.

In addition to the above studies, Trowell et. al.'s study into treatment of adolescent depression involved audio recording psychotherapy sessions with adolescents and therapists writing their own process notes for supervision (2007, 2011). Writing about the findings of that study, Rhode reports that 'a comparison of those sessions so far transcribed with the process recordings

of the sessions suggests that these process recordings were an essentially accurate account of themes, sequence, and "orthodox" interventions, but that some of the less orthodox interventions were not included when the therapists wrote their process notes' (2011; 127). In particular, she stresses how listening to the tapes allowed therapists to notice 'aspects of the countertransference that would normally have escaped their attention' (ibid.) Exploring this in more detail, Cassidy, one of the therapists whose work formed part of the study, writes about how on listening to the tapes for one patient a few months into the therapy she was 'highly surprised to find how the actual session was, at times, quite different from my overall recollections … My recollections and session notes did not convey the atmosphere in the room as when I heard it live on tape' (2011: 64). Cassidy notes that for this particular patient listening to the recordings of the sessions provided invaluable insight into how her painful countertransference experiences had led to changes in how she related to him that she was not aware at the time: 'Listening to the tape, I realized that I had begun to relate to him the same way as his mother' (ibid.).

Despite these indications that the recordings and process notes had been reviewed together, the findings from Trowell's study focused on the nature and treatment of adolescent depression and there is no methodology for a comparison of process notes and recordings nor any further, more detailed findings given.

Given the findings of this literature review, I believe that my study is original in two main ways: the research aim is not primarily concerned with testing the accuracy of the process notes but rather with understanding the meaning of points of difference between them and thus the findings are rooted in a close qualitative reading of the sessions in combination with the transcripts (as opposed to Bonnin's qualitative exploration of the therapists' ideas about why changes may take place); and, secondly, it is the first which studies

child and adolescent psychotherapy rather than adult psychotherapy and psychoanalysis.

II.ii. Role of Process Notes within Psychotherapy
II.ii.a. Process Notes as Evidence Base

The process notes which form the data corpus for this study are the typical way a psychotherapy session in the United Kingdom is recorded for the purposes of supervision, training and often research. Process notes, such as those studied here, are written from memory after the therapeutic session with no notes made during the actual therapeutic encounter. Although this study does not focus specifically on testing the accuracy of process notes as a record, the findings are anticipated to have a bearing on the debate around the validity of process notes as part of the evidence base for psychotherapy. The reliance of psychotherapy and psychoanalysis on such reports has led to several significant criticisms, with writers pointing to the fallible nature of human memory and to the inevitability of selection when writing process notes (Wallerstein and Sampson, 1971; Spence, 2007). Spence, in particular, makes reference to Loftus's experiments proving the unreliability of eye-witness accounts, which demonstrated that eye-witness reports could be permanently altered by something seen or heard after the incident (1979). Drawing a parallel between Loftus's findings and process notes, Spence argues that the analyst's or therapist's memory is likely to be altered after the session as it becomes shaped in accordance with the analyst's dominant theories (2002). He maintains that the analyst's memory is influenced subtly in order to fit with the received theory, as the parts of the session that fit with theory become remembered and reinforced whilst other aspects of the session which might challenge certain aspects of theory become forgotten (1982, 1998, 2002, 2007). Thus through this mechanism, the therapists' sense of what they should be doing might serve to inhibit their ability to remember what they actually did (2000). Perhaps in keeping with this, there is also the charge that mistakes or technical errors in particular will be forgotten when writing up the notes (1998, 2002, 2007).

Spence also draws our attention to the narrative pressure underlying both process notes and those more substantial case reports in which the analyst is conceived as a 'performer' rather than an 'historian', telling a story of analytic endeavour and struggle which leads, ultimately, to success (2002). This is felt to operate on a detailed level in which 'broken accounts that seem hard to follow during the hour might easily be changed, in memory, to complete sentences' (2007: 609), as well as on a meta-level in which the overall session or indeed the whole treatment, is given in memory a more coherent and persuasive argument. The irony for Spence is that the pull towards a more persuasive argument ensures that case studies become less persuasive arguments for psychoanalysis, by actually restricting access to the raw data of the sessions (1982). In turn, this lack of access to raw data and the narrative pressure are seen to limit the development of psychoanalysis as a theory by restricting access to new discoveries, which remain unnoticed (ibid.; Wallerstein and Sampson, 1971).

One possible way to counter this objection would be to use audio recordings of sessions, on the understanding that whilst audio recordings cannot capture the full level of non-verbal communication – gestures, facial expressions, dress – they do provide an accurate recording of some of the facts – from the Latin 'fact-um' literally 'the thing done' (O.E.D) – in this case: who said what, when, and how. Wallerstein and Sampson indicate that psychoanalytic sessions were first recorded in 1933 (1971). Thirty years later Gill suggested that recordings of analytic sessions would enable the raw data of psychoanalysis to be captured (1968). However, analysts and therapists have been sceptical about the value of audio recordings, as O'Shaughnessy writes: 'In despair over these troubling problems of subjectivity in the practice of psychoanalysis we may be tempted to clutch at "objectivity" through methods such as tape recordings...which I believe to be misguided'(1994: 943). Analysts have

raised concerns that recording would change the analysis or change the analyst's behavior and lead to the analyst feeling exposed to criticism (Gill, 1968; Wallerstein and Sampson, 1971). For Spence, too, recording psychoanalytic sessions does not resolve his criticisms; he raises concerns about using the 'bald transcript' of sessions for they lack any insight into 'how the analyst is hearing and processing the material and draws a veil over his or her context of consciousness' (2007: 612-13). Indeed, Spence stresses how for him a central failing of process notes and case reports is the lack of the all-important context that is the analyst's and patient's minds – how they are both hearing what is said and the multiple layers of conscious and unconscious meanings attributed and associations generated (1982, 1998). Likewise, Boeksy, in the recent *International Journal of Psychoanalysis* series of papers on presenting case material, argues that contextualization is key and without this it is 'like watching a movie of a moving car that turns one way and then another. We know the driver has turned right or left but we do not know why' (2013: 114). For Boesky contextualization includes the analyst's theoretical orientation, the wider context of the session within the treatment — for example, where it sits in relation to a holiday break — transference elements and aspects of the patient's early history. Likewise, Quinodoz finds 'it hard to imagine what benefit a psychoanalyst thinks he can derive from recording sessions ... no recording could possibly do justice to the wealth of underlying latent content.' (1994: 972).

Such arguments create a dichotomy between objectivity and subjectivity as represented respectively by tape recorders and process notes, raising doubts about the analyst's ability to act as a participant researcher. This distinction relates to current thinking about evidence hierarchies. For example, Alan Carr positions narrative accounts at the bottom of the evidence hierarchy, explaining that 'the main limitation of much case study evidence is [amongst other factors] biased observation by the therapist.' (2009: 9). It is clear, however, as O'Shaughnessy's quotation marks

13

around 'objectivity' imply, that such a distinction between objectivity and subjectivity is questionable. Moving from an empirical distinction between objectivity and subjectivity towards a more relativist stance, O'Shaughnessy turns to Kant's idea that 'objective reality is known only through the knowing mind' (1994: 941), so there is no such thing as an objective reality independent of interpretation by someone. In psychoanalysis this is particularly true, for the essence of the analysis and therapy lies in the meeting of two minds, those of the patient and the analyst. Thus, as O'Shaughnessy says, clinical fact is the 'immediate emotional reality of the session' created between patient and analyst (ibid.: 945), or as Paul and Anna Orstein express it: 'In psychoanalysis, clinical facts are "created" by both participants ... it is this on-going negotiation between patient and analyst (with all that its turbulence entails), that shapes the clinical facts and captures their meaning(s)' (1994: 978). Thus clinical facts are located both within the relationship between patient and analyst, and also, as Paul and Anna Orstein make clear, within the unfolding process of the session. During this unfolding process it is the mind of the psychotherapist, particularly the ability to observe both self and patient, which acts as the investigating instrument, however, one where the analyst's listening is felt to modify and shape what is heard (Chabert, 2013). Tuckett concludes that: 'It may well be interesting to use [recordings] to see what is noted and what is not and to explore what the analyst has to say about that. But the essence of psychoanalysis is that the analyst…unconsciously (as well as consciously) picks up the data within a framework of meanings' (2002: 407).

As we have seen, one of Spence's criticisms of process notes is the lack of context provided. Wallerstein and Sampson, however, stress the advantage of process notes through the insight they provide into the activity of the analyst's mind (1971). Spence argues: 'As we listen between the lines, we become silent participants in the hour and add our private context to what the patient is saying. But this context, of course, is never

revealed in the record of the session, even though they clearly form part of our memory of the course of the hour. For this reason, we never remember the hour as it actually happened and our clinical reports must always be viewed with suspicion; they are poetic renderings of things that were never said' (2007: 609-610). For Da Rocha Barros the poetic nature of process notes is fundamental. According to his argument, process notes seek to enable the reader to 'relive an experience they did not have' (2013: 1146). In this process notes are seen not as an attempt to capture an external list of facts but to bring to life the experience the analyst and patient had together in the session by evoking a similar experience in the readers as they read the notes. He argues this is not about creating an accurate record of when things happened, but rather helping to recreate the 'chains of meanings' in the session and, crucially, it is poetic skills in the analyst that are called upon to achieve this.

Da Rocha Barros' emphasis on the experience of the reader implies that process notes do not exist in a vacuum, but rather within the context of a relationship in which another reading the notes exists in the author's mind. This other may be a wide audience if publication is anticipated, or it may be limited to just the case supervisor.

In the British tradition of training child and adolescent psychotherapists, process notes play a crucial part; they are the primary, and sometimes only, way in which supervisors are exposed to their trainee's clinical work. However, this relationship may in itself effect what is and is not included in the notes (Chabert, 2013); as the therapists in Bonnin's study argued, the changes in their notes from the recordings may have related to a desire to impress the audience, in this case their supervisors (2011). The supervisory relationship is one which has its own transference dynamics, partly re-enacting the dynamics of the analysis – the 'parallel process' (Doehrman, 1976; Searles, 1965; Bradley, 1997; Berman, 2000; Brenman

Pick, 2012), and which may, therefore, impact on what is remembered in the notes.

II.ii.b. Process Notes within Training

As discussed above, training for child and adolescent psychoanalytic psychotherapy in the United Kingdom involves significant use of process notes. A core element of the psychotherapy training is working with three patients intensively (cases seen three times a week). The trainee receives weekly supervision for these cases, bringing their process notes as the source material for the supervision. During the supervision the notes may be accompanied by the student's wider recollections from the session and their own associations and responses to the material in the session. Aveline writes: 'A supervisor of dynamic psychotherapy may concentrate on one of three foci during the supervisory hour: (1) the process and content of the patient's concerns and communications, (2) transference and countertransference reactions between patient and therapist and (3) the supervisee-supervisor relationship as a mirror image of the psychodynamic relationship between patient and therapist.' (1992: 348). He argues that the more psychoanalytically orientated supervision concentrates on the second two areas of interest and this leads to an increased interest in the patient's associations and interaction between patient and supervisor, with somewhat less focus on what the patient actually said or did. There is within the literature on supervision, however, an interest in locating what it is the patient did say or do and a corresponding concern about the reliability of process notes (ibid.; Bernard and Goodyear, 2009; Schuster et. al., 1972; Goldberg, 1985).

Such studies note that there are concerns about recording sessions: both from the perspective of the patient, where there are particular concerns about ethics and confidentiality, and also from the perspective of the supervisees. Concerns have been raised that for supervisees, and particularly trainees, recording sessions would lead to increased anxiety

which would have a negative effect on the therapist's capacities (Levenson and Strupp, 1999; Aveline, 1992). Ellis reports that historically 'some researchers found that taping therapy is incredibly anxiety producing and is detrimental both to the client and to the therapist, whereas others did not find any effects of taping sessions', yet Ellis maintained that his own research clearly demonstrated that recording sessions did not relate to increased supervisee anxiety (2010). Indeed, many studies make claims for the positive effect of recording sessions for supervision on trainees: studies demonstrate that recording helps trainees improve skills and helps supervisors more accurately evaluate their work (Huhra et. al., 2008); allows for micro-analysis and help in learning to use theoretical concepts (Hilsenroth et. al., 2006); helps the therapists with learning their craft (Aveline, 1992) and video recording allows the non-verbal aspects of communication to be studied in greater depth (Haggerty and Hilsenroth, 2011). Indeed, as Brown et. al. point out, some forms of psychotherapy training require recordings; they cite the Improving Access to Psychological Therapies training's emphasis on recording sessions, and the British Association of Counsellors and Psychotherapists and the British Association of Behavioural and Cognitive Psychotherapies's requirement that accredited trainings involve recording trainee sessions (2013).

Although an adversarial position between tape- or video-recorded sessions and process notes can exist, the consensus does seem to be that the two different forms of recording are complementary (Goldberg, 1985). As Aveline says, recording is 'a useful, if not essential, aid in the supervision of dynamic psychotherapy' (1992; 357). Goldberg argues that that there are different benefits to each form of recording; process notes, he believes, have the benefit of providing direct access to a trainee's way of thinking and their difficulties in learning whilst tape- or video- recorded sessions have the benefit of making the session more directly available to the supervisor. Indeed, Goldberg believes that process notes and audio or video recordings can be used in a 'mutually enhancing way' (1985: 4).

Finally, it is interesting to note that three of the five studies comparing process notes with audio recordings identified in the comparative literature search were doctoral studies. It may be that given the high level of supervision trainees have, they are more likely to be interested in the nature of just what it is that they bring to supervision when they bring process notes. As discussed in the introduction, the genesis of this particular doctoral study lies in just such an interest.

II.iii. Memory Function

The human memory is a function of many systems; it is generally agreed that memory falls into two broad categories: explicit or declarative memory and implicit or procedural memory. Declarative memory refers to memories that can be explicitly recalled consciously, whilst procedural memories are those which 'influence experience and behavior, but typically cannot be explicitly or consciously recalled' (Fosshage, 2005:519) – typically learnt activities such as riding a bike, but also relational patterns. These systems hold within them multiple further systems, such as working memory, short and long-term memory, and narrative memory (Hart, 2008). LeDoux (1996), referenced in Fosshage, 'distinguishes between emotional memory and the declarative memory of an emotional situation. Declarative memory entails facts of the situation; emotional memory refers to emotional responses during an event' (2005: 520). Thus, when a therapist writes process notes, their declarative and emotional memory systems must be called on, in part as an attempt to bring unconscious or implicit memories into the declarative memory. Furthermore, memory function is not objective but rather subjective, for 'memories are records of how we have experienced events, not replicas of the events themselves' (Schacter, 1996: 6). In the case of the process notes, these memories are constructed at the time of writing when the therapist is deliberately seeking to provide a narrative structure for the session being recorded. Furthermore, emotional states impact upon memory function. High

emotional arousal events help the memory encode them, thus making them easier to remember. However, if the state of arousal is too high and therefore overwhelming, chronic explicit (but not implicit) memory function is inhibited (Hart, 2008). Within a psychotherapy session it seems likely that the most emotional moments, or times of greatest emotional connection, will be those that are easiest for the therapist to recall. However, it may be that there is an equivalent of overwhelming emotional experience in the session that could inhibit the therapist's explicit memory.

Studies, such as Diener and Thomas's work on students' recall of the emotions during the day, have indicated that 'if any general statement can be made, it is that retrospective reports of one's emotional experiences over time tend not to be extremely accurate' (1990: 295). In this particular study, the researchers asked two groups of undergraduates to rate their emotions – the first group rated them at random points during the day, whilst the second rated them in a diary at the end of the day. The participants were then interviewed about their emotions at the end of the period of recording their emotions (three weeks for those recording during the day and six weeks for those recording at the end of the day). The study indicated that people tended to overestimate the intensity of their emotions and that 'people tend to recall negative times more readily than positive times' (ibid.).

In their 2001 study, Lundblad, Christiannsson and Engleberg compared the memory of emotions within a two-and-a-half-year psychoanalytic psychotherapy by both the patient and the therapist. The patient and therapist wrote process notes after each session; then in the last month of the treatment they were asked to comment on the emotions they recalled from the therapy, which were then compared with the process notes. The research found that there was no consistency between the patient and therapist, 'neither in their perception of emotional reactions during sessions, nor in their recall' (p.42). They found that at recall the therapist

overestimated the patient's emotional reactions, whilst the patient underestimated the level of her emotional reactions in the sessions. The researchers suggest that this is because of the therapist's containing function, in which the therapist takes 'over a part of the patient's emotions'. As a result, 'when remembering the patient's emotional reaction in therapy, the therapist overestimates them' (p.43). This statement, however, may require further exploration in relation to the therapist's containing function, for it may be that the two different roles within the container/contained dyad experience and recognize emotion differently precisely because of the different nature of those roles. Indeed, one reason why there may be such difference in recall of emotion could lie in the patient's use of projective identification, in which the therapist experiences the split off projected emotions which actually belong to the patient but are currently disowned by them (see later in this chapter for a discussion of projective identification.) Furthermore, in Lundblad et. al.'s work the recall of emotions possibly several years after they took place is being studied, whilst here in this study it is process notes written as close as possible to the session that are being studied.

II.iv. Background Literature
II.iv.a. Technique in Child and Adolescent Psychoanalytic Psychotherapy
In comparing process notes with recordings of the same session, it is anticipated that issues of technique will become relevant. Central to psychotherapeutic work with children and adolescents is the establishment of the therapeutic frame (Hoxter, 1977; Joseph, 1998). This is both the physical setting — for adolescents a simple consulting room made available to them at the same time every week — and the mental setting: 'The most important part of the whole setting lies in the receptivity of the analyst's mind' (Hoxter, 1977: 209). Or as Joseph puts it, 'We could describe our aim when thinking about the setting for the analysis, or indeed the psychotherapy, of the child or adult as that of providing an environment

physical and psychological where the individual can feel able to bring all of himself' (1998: 360). Thus the therapist's state of receptivity to the adolescent's communications is key. The psychotherapist's observational skills form a central part of this; observation skills are central to the training of a child and adolescent psychotherapist, and this begins with two years of infant observation and a year of young child observation (Miller, et. al. 1989; Sternberg, 2005). As well as learning to observe others, the child psychotherapist must learn to observe their own feelings, aiming to develop the ability to 'observe what comes from the child and what is stirred up in him or herself' (Joseph, 1998: 360). In the IMPACT manual which was used by the therapists in this study, therapists are not only advised to adopt a receptive and observational stance, but also to relate to the patient in a 'non-judgemental and enquiring' manner (Cregeen, S. et.al. 2010: 24).

Thus one aspect of technique involves creating a receptive physical and mental setting. A further aspect of technique lies in what is communicated to the patient and how that is communicated. The IMPACT Manual lists positive markers for Short Term Psychoanalytic Psychotherapy (STPP); aspects of technique included in this are the therapist's allowing the young person to initiate the discussions, encouraging the exploration of feelings, wishes, fantasies and a discussion of the transference relationship between the therapist and patient. The manual discusses several aspects of technique in greater detail: the range of different interpretations which could be made (defence interpretations, process interpretations, interpretations in displacement, feelings displacement), the careful management of the transference and related interpretations so that they are well timed and avoid being felt to be too trapping or threatening to the adolescent. Other techniques discussed include using description and mirroring techniques which aim to ensure that the young person assimilates the fact that they are being thought about by a therapist who is seeking to understand them, and confrontation, which firmly draws

attention to the young person's self-destructive thought processes or behaviours. The manual also includes markers of therapy which are deemed not characteristic of STPP but which are aspects of Cognitive Behavioural Therapy – the other treatment investigated in the IMPACT study – such as giving explicit advice or direct suggestions, interacting in a didactic manner and initiating topics of discussion (2010).

As will be discussed in the following chapter, the context for the analysis undertaken in this doctoral study involves the framework of several key theoretical ideas about the nature of the relationship between therapist and patient and how that relationship is shaped. These are ideas about transference and countertransference, projection and projective identification and enactments; an overview of these concepts follows.

II.iv.b. Countertransference

The understanding of the nature and role of countertransference has changed and developed over the history of psychoanalysis. It is beyond the scope of this chapter to delineate all the multiple interpretations and proposed subsets which divide various aspects of countertransference (Racker, 1968; Laplance and Pontalis, 1973; Tonnesmann, 2005); instead I propose to provide a brief overview of the main developments in the understanding of countertransference.

Freud considered countertransference an impediment which needed to be overcome, writing: 'We have begun to consider the "counter-transference", which arises in the physician as a result of the patient's influence on his unconscious feelings, and have nearly come to the point of requiring the physician to recognize and over-come this counter-transference in himself…we have noticed that no psycho-analyst goes further than his own complexes and resistances permit; and consequently we require that he should begin his activity with a self-analysis' (1910: 144-145). Thus Freud locates the therapist's countertransference feelings solely within the

analyst's own neuroses as something to be worked on in the analyst's analysis and through that overcome. However, it is important to note that elsewhere Freud also writes about the central role that the analyst's unconscious plays in understanding the patient's unconscious, describing the analyst's unconscious as a 'receptive organ towards the transmitting unconscious of the patient' (1912e: 115). So whilst countertransference feelings are to be worked through and thereby reduced, Freud does also foreshadow later interpretations of countertransference in which the feelings evoked are indications of the analyst's unconscious understanding of the patient.

Klein, like Freud, does not focus on countertransference in great detail, according to Hinshelwood and Spillius only mentioning it once in her published work (2011). This reference describes the analyst's technique being negatively influenced by countertransference to provide early reassurance rather than 'analyse the infantile roots' of the patient's presentation (Klein, 1957: 226). Although, as Klein said to a group of London analysts: 'the patient is bound to stir up feelings in the analyst' (1958: 12), in keeping with Freud, countertransference is seen as rooted within the analyst. Klein continued: 'I have never found that the countertransference has helped me to understand my patient better; if I may put it like this, I have found that it helped me to understand myself better' (ibid.). This understanding of countertransference, as a phenomenon that stems from the analyst's own pre-existing internal state, continues to the present day. In some accounts the analyst's countertransference is seen as a counterpoint to the patient's own transference, in which the patient becomes a representation of a past object upon 'whom past feelings and wishes are projected' (Reich, 1951: 26). Others emphasise the role the analyst's own unresolved conflicts play in this: 'To study countertransference meaningfully one needs to be confident that therapist reactions stem from areas of personal conflict' (Hayes, 2004: 32). Following Hayes, Tishby and Vered, in a recent study

of countertransference in work with adolescents, state: 'We adopted the "integrative" definition of countertransference, which has served as the basis for most research in this area…[this] pertains to therapist's unresolved conflicts as the basis for countertransference reactions' (2011: 621). In this study the researchers investigated how the therapists related to their patients, connecting these relational patterns to the therapists' relationships with their own parents.

As Wolstein records, the 1950s saw an explosion of interest in countertransference: 'This decade recorded a sudden outpouring of books and monographs, papers and reports, symposia and lectures on practically all variations of this theme imaginable' (1988: 6). Wolstein argues that the increased interest in countertransference developed out of the growing focus on the relationship between the analyst and the patient. New interpretations of the genesis of countertransference and its role within analytic sessions now became possible. Paula Heimann's seminal paper 'On Counter-Transference', published in 1950, outlines this new perspective. She locates countertransference within the relationship between analyst and patient, arguing that rather than being 'nothing but a source of trouble', the analyst's feelings – his countertransference – are 'an instrument of research into the patient's unconscious' (1950: 81). Rather than locating the countertransference solely within the analyst's own psyche, she suggests 'that the prefix "counter" implies additional factors', which instead locate countertransference as a response to the patient's presentation (ibid.: 81). In this model, the countertransference feelings experienced by the analyst are 'the patient's *creation*' rather than a reaction generated by the analyst's own conflicted feelings and, as such, are an important source of information about the patient's state of mind (ibid.: 83).

Heimann gives the example of a patient she worked with who, shortly after the start of his analysis, announced that he was going to marry a woman he had only recently met. This woman was described as having

experienced difficulties, in particular as having had a 'rough passage'. Heimann initially felt that her patient's decision to marry was linked to his experience of starting an analytic relationship, and in particular, his resistance to it. Despite her understanding of this and sense that such attempts to 'short-circuit analysis' were not infrequent, she reports that she was troubled, saying: 'I felt that something more was involved in his situation, something beyond the ordinary acting out, which, however, eluded me' (ibid.: 82). Later in the session the patient reported a dream which shed more light on his disturbance: in the dream he had bought a good foreign second-hand car that was damaged, he wanted to repair it but another person wanted to stop this on the grounds of caution. The patient felt he had to confuse this person in order to be able to continue with his plans to repair the car. Heimann argues that this dream indicates the operation of a powerful sado-masochistic system in which the patient felt compelled to make reparation for his sadistic urges through masochistic means. In this understanding, his intention to marry his friend (who had had the 'rough passage') linked with his sadistic determination to see Heimann as a damaged refugee. The urge to marry, therefore, stemmed from a wish to make reparation for the desire to see the other damaged, but the reparation was felt to be masochistic by overriding any caution (hence the quick marriage). Heimann argues that in this case her initial sense of worry when her patient told her about his marriage plans linked to her unconscious understanding of the patient's serious sado-masochistic system underpinning those plans. She argues that at the start of the session her unconscious had grasped this whilst her 'conscious understanding lagged behind, so that [she] could decipher the patient's message and appeal for help only later in the hour, when more material came up' (ibid.: 83). In this she seems to build directly on Freud's idea that the analyst's unconscious is a means to understand the patient's. However, unlike Freud, she posits this in the realm of the countertransference feelings, arguing that they are the means of knowing about the analyst's unconscious understanding of the patient. Despite her

strong argument for the role of countertransference as indicative of the patient's state of mind, Heimann does not claim that all feelings experienced by the analyst within the session stem from the patient's own unconscious. The analyst's countertransference can also be generated by unanalyzed aspects of himself and thus care must be taken to differentiate between the two types of feelings: those generated by the patient and those stemming from the clinician.

In 'Normal Counter-Transference and Some of its Deviations', Money-Kyrle brings the two aspects of countertransference – rooted in the analyst and rooted in the patient – closer together. For Money-Kyrle normal countertransference is a process of introjection and projection in which the analyst introjectively identifies with his patient and through this understands something about the patient; he then projects this understanding to the patient in the form of an interpretation. He feels it is inevitable that the patient will represent something for the analyst: 'The damaged objects of the analyst's own unconscious phantasy' which need to be taken care of in order to satisfy 'parental and reparative drives' (1956: 360). At times when there is too great a correspondence between what the patient represents for the analyst and 'some aspect of himself which he [the analyst] has not yet learnt to understand', the normal processes of countertransference can become shifted to abnormal countertransference (ibid.: 361). In times of abnormal countertransference, the alignment of the patient with the analyst's unanalyzed aspects impinges upon the analyst's capacity to understand his patient; this lack of understanding then increases the analyst's anxiety, which in turn makes it harder for the analyst to understand his patient. Thus Money-Kyrle repositions the earlier understanding of countertransference — in which it is rooted in the analyst's own unresolved conflicts — as a deviation from normal countertransference, characterized by a break in the analyst's understanding of his patient. He does not propose, however, the simple equation that unanalyzed aspects of the analyst cause abnormal

countertransference; indeed throughout this paper he stresses the joint role the analyst and the patient play in the movements from normal to abnormal countertransference.

Money-Kyrle gives an example from his own work with a neurotic patient: the session began with the patient feeling useless and confused; as the session unfolded Money-Kyrle began himself to feel unsure of the interpretations he was giving, and this corresponded with the patient rejecting these interpretations in an increasingly angry manner whilst simultaneously accusing him of not helping. By the end of the session the patient felt 'angry and contemptuous' whilst Money-Kyrle felt 'useless and bemused' (ibid.: 363). The difficulties in this session are presented as being created by the analyst and patient together: Money-Kyrle's contribution sprung from his difficulty in recognizing what he had introjected from his patient as relating to something he had understood in himself, whilst the patient's frustration at not receiving helpful interpretations led him to project his sense of uselessness into his analyst and then attack the analyst for it. The session ended before Money-Kyrle felt he had fully grasped this dynamic. The patient started the next session in a similar vein, by this point Money-Kyrle had been able to undertake 'a silent piece of self-analysis involving the discrimination of two things which can be felt as very similar: my own sense of incompetence at having lost the thread, and my patient's contempt for his impotent self, which he felt to be in me' (ibid.: 363). As with Heimann, there is an important stress on the analyst's ability to separate his own feelings from the patient's. This leaves the analyst with a multi-layered task: 'First to become aware of this defensive mechanism in himself, then of his patient's part in bringing it about, and lastly of its effect on him [the patient]' (ibid.: 364).

Despite the work of Money-Kyrle, there remains some distance between the two views about the genesis of countertransference: on the one hand there stands the view that the analyst's unanalyzed unconscious creates

stumbling blocks in the process of the analysis which manifest as countertransference feelings; on the other hand countertransference is positioned as the way the analyst's unconscious grasps something central to the patient as a response to unconscious communication from the patient, and is in part created by the patient. In her lecture 'Working Through in the Countertransference Revisited' Brenman-Pick aimed to break down the division between pathological countertransference and the idea of countertransference as a communication, arguing that a pathological countertransference reaction on the part of the analyst does not only belong to the analyst's own pathology but can stem from a very primitive aspect of patients which both attacks the analysis and acts as a communication (2012).

The theoretical orientation of this doctoral study is consistent with the understanding of countertransference as rooted in the patient and constituting part of the patient's communication to the therapist. However, throughout the study awareness was kept that some countertransference aspects related to the therapists as individuals. Accordingly, interviews were conducted with the therapists with the aim of exploring their feelings towards their patients.

There is debate about how much of the countertransference the analyst or therapist can really be aware of. In 'The Dawn of Oblivion', Bion has P.A. say: 'Do not forget that the "counter-transference" is by definition unconscious; it follows that I do not know the nature, in reality, of my counter-transference. I know theoretically, but that is only knowing *about* counter-transference – that is not knowing the "thing itself"'' (1979 reprinted 1991: 515). Segal follows this, arguing that if much of the countertransference is unconscious, much of the analyst's conscious feelings about the patient will be derived from unconscious ones. In the light of this, she argues that caution must be taken when working with the counter-transference: 'We must be very aware of the dangers of trusting

our counter-transference too much. I think the idea of the counter-transference has become a bit too easy…The over-trust in our counter-transference, without sufficient objective backing, can often be misleading. Our conscious feelings are not always as trustworthy as we would wish them to be' (1997: 117). She finishes her paper by cautioning that although 'counter-transference is the best of servants…it is absolutely the worst of masters' (ibid.: 119).

II.iv.c. Transference

In investigating the workings of the countertransference, I explored key concepts about how the experience of being with a patient impacts on the therapist: namely, transference and projection. The phenomenon of the transference describes how the patient's past relationships are brought to life within, or transferred to, the current relationship with the therapist. It is closely interlinked with countertransference, as Betty Joseph argues: 'Much of our understanding of the transference comes through our understanding of how our patients act on us to feel things for many varied reasons' (1985 reprinted 1989: 157). The countertransference thereby provides a crucial guide to what is happening in the transference.

As with countertransference, this section presents an overview of the development of the concept of transference; from a view of transference in which it was felt to be an obstacle to one where transference is seen as the key element of the psychoanalytic process. In 'Fragment of an Analysis of a Case of Hysteria' Freud first explores the concept of transference, which he describes as 'a whole series of psychological experiences [which] are revived, not as belonging to the past, but as applying to the person of the physician at the present moment' (1905: 116). Thus for Freud the transference was akin to a reconstruction of the past enacted within the analytic relationship rather than 'reported' verbally to the analyst (1940: 176). Freud describes how 'all the patient's tendencies' (1905: 117) are aroused in a treatment, not just 'friendly' tendencies which support the

progress of the analysis, but 'hostile' ones too, which act as a resistance to the analytic work. In the work with his patient Dora, described in 'Fragment of an Analysis of a Case of Hysteria', Freud used the idea of such hostile tendencies, or negative transference, to explain her abrupt termination of her treatment, in which her wish to revenge herself on Herr K by whom she felt jilted became enacted in her decision to leave Freud. Freud came to believe that the threat posed by transference to an analysis had to be tackled by convincing the patient that their feelings towards the analyst had belonged to earlier relationships, and it was this that allowed the transference to change 'from the strongest weapon of the resistance into the best instrument of the analytic treatment' (1925: 43). The case of Dora presents clearly transference as a force of resistance in psychoanalysis. However, transference is not created by analysis, nor does it exist solely within analysis.

In her paper 'The Origins of Transference' Klein took this understanding of re-enactment of past experiences and expanded it beyond re-enacting a relationship to re-enacting '*total situations* transferred from the past into the present, as well as emotions, defences and object relations' (1952a: 55). Thus Klein broadened the scope of the transference, so that it no longer solely pertained to direct reference to the analyst but included the '*whole material*' of the session, including reports of the patients' day-to-day lives. Crucially, this expanded the transference so that it encompassed more than past experiences but also included current unconscious phantasy. Thus transference becomes 'part of the continuous stream of unconscious phantasy accompanying all libidinal and destructive impulses, with the therapist now as their object' (Rosenbluth, 1970: 74). Klein points out that the transference is not static but shifts within a single session, so that at one point the analyst may stand for the internal mother and at another for the father. This sense of the mutability of the analyst's role in the transference is emphasized by Betty Joseph, who describes the

transference and the corresponding interpretations as 'living, experiencing, and shifting – movement' (1985: 160).

II.iv.d. Projection and Projective Identification

Transference and countertransference, as discussed above, describe different aspects of the relationship between therapist and patient. The mechanisms of projection and projective identification discussed below are central in how those relationships are experienced and to how the patient communicates emotional states to the therapist.

Although Freud used the term projection in various ways, the dominant sense was of the 'search for an outside cause rather than an internal one' (Sandler and Perlow, 1989: 2). In particular, this was seen as a defence based on repression, seeking to rid the psyche of unwanted aspects of the self (Kernberg, 1989). Following Freud, Klein also focused on the defensive function of projection, linking it in particular to the death instinct, arguing that projection came 'from the deflection of the death instinct outwards [which]…helps the ego overcome anxiety by ridding it of danger and badness (1946: 5). In addition, Klein introduced the idea of projective identification as distinct from projection. In projective identification, parts of the self are projected into the other and felt to belong to the other (1946). Central to this is the understanding that the projection has an impact on the other: 'In projective identification parts of the self and internal objects are split off and projected into the external object, which then becomes possessed by, controlled and identified with the projected parts' (Segal, 1973: 27). Thus the key difference between projection and projective identification lies in the relation to the object; in projection a distance from the object is maintained and no effect on the object seen, whereas in projective identification there is a link with the object and what is projected is 'unconsciously induced' in the object (Kernberg, 1989).
 Bion developed projective identification in his theory of container/contained, expanding the use of projective identification beyond

solely an expulsive defence to something which has the potential to be a means of communication (1962b). In this model, the infant's use of projective identification of unbearable feelings into the containing mother acts as a communication of those feelings, so enabling the mother to react to her infant's needs. Rosenfeld later stressed the dual function of projective identification, arguing that it can function in two simultaneous ways: both with an expulsive quality and as an attempt to communicate (1987 republished 1995). Meltzer further expands the understanding of the workings of projection by emphasising a distinction between 'intrusive identification' and 'projective identification', where intrusive identification 'catches the essential motive of invasion of an alien personality and body' (1986: 66) and acts as an 'unconscious omnipotent phantasy' (ibid.: 69), while projective identification serves as an unconscious communication which lies at the heart of learning through experience.

Projective identification is thus a key mechanism for both communicating the transference and creating countertransference feelings within the analyst (Meissner, 1989). As Segal indicates in projection, where a patient projects '*on*to' the object the patient's false perceptions of the analyst which stem from feelings which in phantasy he has projected on to the analyst, there is no effect on the analyst's state of mind, whereas in projective identification where the patient projects '*in*to' the object the patient's aim is to create an impact on the analyst's state of mind, which will evoke countertransference emotions (1997: 111). Brenman-Pick argues for further differentiation of the projection into the analyst, emphasising that the patient projects into different aspects of the analyst: 'into the analyst's wish to be a mother, the wish to be all-knowing or to deny unpleasant knowledge, into the analyst's instinctual sadism, or into his defences again it. And above all, he projects into the analyst's guilt, or into the analyst's internal objects' (1985: 161).

As Rosenfeld demonstrates, projective identification 'makes the analyst's task very difficult' (1987 reprinted 1995: 161). It can lead to the breakdown of verbal communication as the analyst's interpretations become misunderstood by patients whose own communications in turn assume a more concrete quality. This happens through the merging of self and object which takes place in excessive projective identification and leads to an accompanying blurring of symbol and symbolized. This links to what Rosenfeld argues is possibly the 'most important point to understand about projective identification…the way it can be used by a patient to get into a confused, merged or fused state of relating to the analyst' (ibid.: 166). In turn, this can lead to the patient feeling as if he were at the mercy of a 'symbiotic object' from which he cannot escape; he feels trapped by the analyst and utterly un-helped by him. In addition, this state is felt by the analyst as a paralyzing countertransference. Finally, Rosenfeld sets the analyst a difficult task, to allow patients, particularly depressed patients, access to 'one's own deeper feelings as one willing to experience their feelings alongside them' whilst still managing to transform projections (ibid.: 173-174). It is this transformation that enables the analyst to remain unchanged by the patient's projections rather than being transformed by them, for example, by becoming intensely sleepy.

As Rosenfeld indicates, the analyst's ability to respond to projections is crucial: not all analysts or therapists react in the same way to the countertransference pressures that accompany this. Segal emphasizes the importance of the analysts having a 'good counter-transference' disposition which allows them 'to be receptive to projections without becoming identified with them' (1997: 116). This depends on the analyst's ability to both receive and respond to the patient's communications whilst simultaneously maintaining an observational stance on the interaction, which depends on an internalized good parental couple in the analyst's own mind.

II.iv.e. Enactments

The context for this study also includes an understanding of the phenomenon of enactments within therapy. The 'Comprehensive Dictionary of Psychoanalysis' points to five different meanings for enactments: i) the patient acts out their transference phantasies; ii) the analyst is induced to acting out the patient's phantasies; iii) co-created dramas by the analyst and patient together; iv) the analyst enacts their own countertransference phantasy and v) 'interpretive enactment' in which the interpretation contains countertransference feeling (Akhtar, 2009).

Whilst the analyst or therapist strives to maintain an observational stance towards patients' communications, the projections often seek to create an impact on the analyst which can threaten this very stance. Feldman states: 'It has become apparent that patients often attempt to use the object for the projection of unbearable mental contents by inducing feelings or thoughts in the object, or by drawing the object into forms of enactment' (2009: 23). This study seeks to explore such moments of enactment if they occur in the session, in particular, any enactments that the therapist has not been consciously aware of, as captured in the differences between the process notes and recordings. There are two main causes of enactments: the first, as described above, stem from an active wish on the part of the patient to pull the analyst or therapist into 'acting-in' to the transference (Canham, 2004), where the pressure is on the therapist to take on the role prescribed in order to minimize the difference between the internal object and the experience the patient has of the therapist. The second form of enactment is more rooted in the therapist, as Steiner explains: 'A boundary between thought and action is central to the analytic attitude where we try to base interventions on thinking and on verbalizing that thinking and try to refrain from action, particularly action which is motivated by tension relief on the part of the analyst' (2006: 316). The analyst's own unresolved 'pathological internal object relations' contribute to the propensity to

enactment over containment (Feldman, 2009: 44), and all enactments shift the analyst or therapist away from a containing function.

The process of the session is shaped by the therapist's reactions to their countertransference experience and is therefore open to be influenced by moments of enactment as well as insight.

II.iv.f. Selected Fact / Overvalued Idea

In 'Second Thoughts' Bion describes the process by which 'from the material the patient produces, there emerges, like the pattern from a kaleidoscope, a configuration which seems to belong not only to the situation unfolding, but to a number of others not previously seen to be connected and which it has not been designed to connect' (1967: 127). He terms this emerging pattern the 'selected fact' that gives coherence to the whole material from the session. Britton and Steiner draw attention to an alternative entity which they term an 'overvalued idea', when a mistaken or incorrect idea becomes used as if it were a selected fact (1994). They argue that an overvalued idea develops from the analyst's defensive needs as a way to manage the doubt and confusion generated within sessions, so that it becomes 'used by the analyst to give a sense of integration to otherwise disparate and confusing experiences' (ibid.: 1070). Differentiation between a selected fact and an overvalued idea is complex as both can stem from an apparent moment of insight on the analyst's part. Britton and Steiner stress the importance of playing close attention to the patient's reaction to the interpretation as a guide; thus the act of giving interpretations is always followed by an attempt to gauge the patient's reaction to them. The use of an overvalued idea can come from something unanalyzed in the analyst or be a 'specific countertransference to his patient' (ibid.: 1077). Given the fact that an overvalued idea stems from the therapist's defensive needs, it is likely that therapists may be unaware that they are using an overvalued idea.

The range of psychological mechanisms and processes described here will form the context for the analysis of the data generated in the comparison of therapists' process notes and audio recordings of the session.

Chapter Three: Methods

This study compares therapists' process notes and audio recordings for a series of psychotherapy sessions. The aim of the study is to generate theory that might illuminate the causes of significantly patterned discrepancies between the notes and recordings, in order to understand more about the processes at work in psychotherapy and to explore the nature of process notes, their values and limitations. The aim of the research method is, therefore, to identify differences and then allow for an exploration of potential meaning of any such differences and from these to facilitate theory generation.

III.i. Epistemological Frame

Given that the research aims of this study concern a search for meaning – analyzing the meaning of the differences, rather than quantifying them – the study was undertaken within a qualitative interpretive framework. Furthermore, the research aims seek to develop theory rather than test existing theory. An inductive framework and theory development both benefit from qualitative research methods, which allow research questions to develop and respond to the data as they are being interpreted (Holliday, 2002). The researcher's role as interpreter of data is, therefore, central, as Charmaz writes: 'It is *our* view: we choose the words that constitute our codes. Thus we define what we see as significant in the data and describe what we think is happening' (2006: 47). The conceptual framework for the analysis was psychoanalytically informed (see discussion later in this chapter).

III.ii. Research Design

The audio recordings and process notes studied for this thesis were produced as part of the Improving Mood with Psychoanalytic and Cognitive-Behavioural Therapy study (the IMPACT study), a national randomised controlled trial into treatment of adolescent depression, which compared the outcomes of Cognitive-Behavioural Therapy, Short Term

Psychoanalytic Psychotherapy and Specialist Clinical Care. The study was led by Professor Ian Goodyear of Cambridge University and funded by the National Institute of Health Research Health Technology Assessment programme (Goodyear et. al., 2011). The IMPACT study offered adolescents with a diagnosis of moderate to severe unipolar major depressive disorder 28 weekly sessions of psychoanalytic psychotherapy (Short Term Psychoanalytic Psychotherapy (STPP)). The diagnostic criteria for unipolar major depressive disorder are: depressed mood or a loss of interest or pleasure in daily activities for more than two weeks; this mood represents a change from the person's baseline; impaired function across social, occupational, educational interests; and five out of a possible nine specific symptoms – including depressed mood, irritability, change in sleep and suicidality (American Psychiatric Association, 2000).

As part of the study the psychotherapy sessions were recorded by a dictaphone in the room. The therapists also produced process notes of each session, written after the session and without the use of the recording as an aid to memory. These process notes formed the basis of the therapists' supervision of these patients. Therefore, the data analysed for this doctoral thesis were not gathered specifically for it and the therapists at the time of writing their notes were not writing with a study comparing the notes and the recordings in mind.

Additional data for the study came from interviews with two of the therapists. These interviews aimed to gather data on the therapists' understanding of their patients, and their experience writing the notes and of being in a research study.

III.iii. Ethical Considerations
Full ethical clearance for the IMPACT study was obtained from the National Research Ethics Service, REC reference 09/H0308/137. The IMPACT Principal Investigators gave specific permission for me to conduct

this doctoral study, a sub-study of the IMPACT study, using process notes made by the IMPACT STPP therapists as part of the trial. These process notes were part of the trial data, but it was stipulated that therapists needed to be asked for their specific permission to access them. The interviews with the IMPACT STPP therapists conducted as part of this doctoral study constituted an additional element of my doctoral study. I therefore sought and obtained permission from each of the three therapists to conduct an interview with them and use their process notes (see appendix for my information sheet and consent form for therapists.) Throughout the thesis, every attempt has been made to protect the identity of both the patients and the therapists; all names used are pseudonyms and the names of locations have been altered.

III.iv. Sampling

The key criterion when sampling was to identify therapists who had not used the audio recordings to prompt their memory when writing the process notes; several therapists approached to take part in this study were excluded for this reason. A further key sampling consideration was to include therapists with different levels of experience. In so doing, the study aimed to avoid assumptions about how the therapists' level of experience affected their process notes. The therapists were initially approached by a senior supervising psychotherapist involved in the IMPACT study; interest in taking part in this doctoral study was then followed up with emailed information and telephone conversations, where necessary.

III.v. Data

The data for the study comprise nine recordings of psychoanalytic psychotherapy sessions and the accompanying process notes. These sessions are from three psychoanalytic psychotherapies undertaken as part of the IMPACT study using Short Term Psychoanalytic Psychotherapy (Cregeen et. al., 2010). The therapies were conducted by a male therapist in his final year of training and two female therapists, all working in the

NHS. Three sessions from each therapist are examined. The three sessions used from each therapist were all from the same case and, as far as possible, were spread across the duration of the treatment. All the cases were completed prior to this study starting. Although the sessions studied aim to cover an early, middle and late session they were essentially chosen at random, and were not read before being chosen. All the patients whose sessions were studied were female, but were different ages: 14, 15 and 17. I transcribed the psychotherapy sessions from one of the therapists (Therapist 3). An external agency transcribed the sessions of the other two therapists — however, I listened to the recordings several times and checked all the transcriptions for accuracy.

A further data set was provided by interviews with two of the therapists. The aim of the interviews was to explore with the therapists their experiences of using STPP and working as part of a research trial, their experiences of writing the process notes and their reflections on their patients and what it was like to work with them. The interviews were carried out after the psychotherapies had finished; Therapist 1's interview took place two months and Therapist 2's interview seven months after the end of their work. The interview data are used only in a limited way, specifically to further illuminate the findings identified in the grounded theory analysis of the process notes and audio recordings, rather than to generate new findings.

III.vi. Research Method

As the study aim was to compare process notes and audio recordings of the same session and analyze the differences between them with the aim of generating theory, it was essential that the research methodology enabled a constant focus on the comparison between the two forms of recording and facilitated theory generation.

Given this, it was felt that grounded theory would provide the best method to keep the comparison between the two forms of recording central and to facilitate theory generation. Glaser and Strauss developed grounded theory as a means of 'systematic theory discovery' (1967). In so doing, they presented it as a response to the emphasis they perceived within sociology at that time on theory verification, which was felt to be 'curbing theory generation' (1967: 28). The purpose of this methodology is to allow theory to emerge from inductive research into the data rather than to use the data to test existing theory. Grounded theory consists of stages of coding data, starting with codes that are tied tightly to the data before moving through to more analytic, higher level codes. Coding typically starts with line-by-line coding of each line of the interview. Codes are created by focusing on actions (Charmaz, 2006) or 'gerunds' (Glaser, 1978) in the data. As such, the codes seek to define what is present in the data, examining it closely, thus mining it for unanticipated ideas. Initial coding is followed by later stages - focused, axial and theoretical – which seek to elevate the data to a higher analytic level by searching out the larger story contained in the codes. These forms of coding allow the researcher to synthesize larger sections of data by only looking for the most significant of the earlier codes. This process leads to the development of categories — a more conceptual version of these initial codings — and these form the beginnings of theoretical ideas. Central to Charmaz's interpretation of grounded theory is the understanding that the grounded theory analytic process consists of principles rather than rules and that not all stages are automatically necessary (2006).

The coding process is accompanied throughout by 'memo-writing', which seeks to capture the researcher's analytic thoughts and reactions to the data as their research progresses. They can be either a brief thought or a longer piece of writing that will go on to form a substantial piece of the later writing. Memos primarily seek to support the development of categories, helping the researcher bring different codes into connection with the category, explore different ideas about the categories and to compare the

different categories (ibid.).

Grounded theory research is an iterative process that continues adding to the categories through the constant comparison model until all the data have been thoroughly examined and there is nothing further to add to the particular concept or category (Anderson, 2006; Lepper and Riding, 2006) – the point termed 'theoretical saturation' by Glaser and Strauss (1967). Theory developed through the grounded theory method can take two forms: substantive or formal. Substantive theory is grounded in the research of one particular area, whilst formal theory expands substantive theory out of its original substantive area and into new areas. Thus for Glaser and Strauss's original research on dying, their substantive theory related to the effect the perceived social loss of the dying patients had on the nurses' treatment of them. This was then expanded to a formal theory that went beyond the original hospital setting, developing ideas about how professional people provide a service to their clients according to their social value (1967). Grounded theory research does not have to progress to the level of formal theory; this is dependent on the amount of data available and the scope of the research project. This study remains within the original area of research of comparison of process notes and recordings, and so focuses on the development of substantive theory.

Grounded theory was also indicated as the methodology for this study because of the small sample size available. Glaser and Strauss argued that when the goal of the research was theory generation, having a large sample size was not crucial, for 'a single case can indicate a general conceptual category or property' (1967: 30).

V.vii. Analysis of Study Data Using Grounded Theory

Grounded theory is usually applied to sociology research in the form of depth interviews or field observations, in which each interview or observation is analysed in turn and only then are the data from one interview compared with the other interviews. In contrast, this study

required the methodology to be able to facilitate the comparison of the two forms of recording (session notes and transcripts) so that they were analysed together. Individual analysis of the recording or the session notes would have led to a study about the particular psychotherapy session, but this study required a methodology that could examine the points of comparison between the two. Given that there can be no expectation that process notes capture everything in the session (Bailey, 2000; Bonin, 2011), I had to identify missing material that I felt was significant enough to form the raw data for my grounded theory. Such material fell into three groups: 'material not found in the process note', 'material not found in the recording', and 'material which appears in both, but with significant differences'.

The data from these three categories were then analysed, with material from the third category ('material which appears in both, but with significant differences') contained in a chart so that the two forms could be examined in tandem. A straightforward application of line-by-line coding, again, appeared to lead the study away from the comparison between the two forms of recording and into an analysis of the sessions themselves as represented by each. Instead, it became necessary to develop a form of 'incident-by-incident' coding, which is described by Charmaz as a 'close cousin' of line-by-line coding, in which incidents rather than lines become the unit analysed (p. 53). In this development of analytic technique, each unit of information that was missing, inserted or different became an 'incident' for coding. The example below indicates this initial coding process from the third category:

Recording	Therapist's Process Notes	Incident by Incident Code
Therapist And I think sometimes, you know, you need to first of all look at the situation, what is it, and quite often, you know, the situation is that the negative seems to sort of be on top and we need to look at that first and sift it out and then, you know, then let's see what happens. You know? But it's important you say that that's what it feels like. It's important to be aware of that. Patient Yes, because I think I've tried, I've been trying to like think about all those different situations and things and, in each of them, I feel like there's nothing going right so let's try and think of the things that are going right.	[Follows a section about Patient's fear of focusing too much on negative stuff.] I said I was glad she was able to say that as it was a really important topic for us to think further about. She asked me how she could find a positive way forward. I said I thought maybe we were still at the stage of looking at and trying to understand and disentangle all the things which were troubling her, which was sometimes necessary before being able to see beyond that. This seemed to make some sense to her.	Therapist in notes expressing satisfaction with patient (glad). Therapist in notes encouraging patient that this is important topic. Patient in the notes asking therapist for help. Therapist in the recording advising the patient. Therapist in the recording reassuring the patient.

Memos were captured during this process. The extract below features sections of the memos which stemmed from or related to the material above. In order not to pre-empt the findings, I have only given examples of brief memos and not longer ones:

Recording	Therapist's Process Notes	Memos
Therapist And I think sometimes, you know, you need to first of all look at the situation, what is it, and quite often, you know, the situation is that the negative seems to sort of be on top and we need to look at that first and sift it out and then, you know, then let's see what happens. You know? But it's	[Follows a section about Patient's fear of focusing too much on negative stuff.] I said I was glad she was able to say that as it was a really important topic for us to think further about. She asked me how she could find a positive way forward. I said I thought maybe we were still at the	One of the key differences in this is how active the two participants are. The patient in the process notes more actively seeks a positive solution than in the recording. In addition, in the process notes the patient is making a more active, positive link with the therapist as she *asks* her how she could find a way forward. Where does this come from? This could be the therapist

important you say that that's what it feels like. It's important to be aware of that. Patient Yes, because I think I've tried, I've been trying to like think about all those different situations and things and, in each of them, I feel like there's nothing going right so let's try and think of the things that are going right.	stage of looking at and trying to understand and disentangle all the things which were troubling her, which was sometimes necessary before being able to see beyond that. This seemed to make some sense to her.	responding to something she felt in the session from the patient, or the therapist writing in a wish that she might unconsciously have for a patient straightforwardly seeking help. Could therapists want more engaged helpful patients? Why might that be so? Could it relate to the IMPACT study? Is there something about the notes capturing unconscious comments but not making this explicit? The notes in this form may be working through what has been registered on an unconscious level. There seems to be something about the differences in the relationship between patient and therapist as represented in the notes and as represented in the recordings. What would shape this? Desire in therapist? Or patient? Or something in the dynamic between them?

The memos informed the analysis of the data for the focused, higher-level codes and categories which were generated:

Recording	Therapist's Process Notes	Focused Code	Category
Therapist And I think sometimes, you know, you need to first of all look at the situation, what is it, and quite often, you know, the situation is that the negative seems to sort of be on top and we need to look at that first and sift it out and then, you know, then let's see what happens.	[Follows a section about Patient's fear of focusing too much on negative stuff] I said I was glad she was able to say that as it was a really important topic for us to think further about. She asked me how she could find a positive way forward. I said I thought maybe we were still at the	Change in how patient is presented – actively seeking a solution. Therapist presented as both more encouraging and less encouraging. Something implicit made explicit.	Differences in how therapists represent patients Differences in how therapists represent themselves Nature and function of process notes

		Therapist's feelings towards the patient.	
You know? But it's important you say that that's what it feels like. It's important to be aware of that. Patient Yes, because I think I've tried, I've been trying to like think about all those different situations and things and, in each of them, I feel like there's nothing going right so let's try and think of the things that are going right.	stage of looking at and trying to understand and disentangle all the things which were troubling her, which was sometimes necessary before being able to see beyond that. This seemed to make some sense to her.		Aspects of the transference and counter transference

III.viii. Reflexivity

As discussed above, this study was undertaken within an interpretive framework. As such it is important to acknowledge that the data analysis undertaken represents my interpretation of the data, rather than an empirical discovery of independent results – thus the categories should be read with the suffix 'as perceived by the researcher'. Unlike in the majority of sociology studies, I did not interact directly with the therapists during the period in which the data were generated and they had no knowledge of the study at the time they wrote their notes. Nonetheless, as the researcher in this study, I have, inevitably, influenced the findings.

The researcher's role in shaping the findings was seen in two main ways: first in the identification of the data, i.e. in identifying the differences between the two forms of recording to be studied. In order to compile these classifications I had to judge what I felt was a significant difference in the following classifications: the emotional tone or the meaning or the location of the material within the order of the session, or a combination of any of these. It is important to acknowledge that in this, as in the generation of categories, I played an active role.

Secondly, my own interpretive stance and conceptual framework influenced the analysis of the data. Classical grounded theory requires the researcher to approach the field of enquiry without preconceptions (Glaser and Strauss, 1967; Glaser, 1978; Holton, 2009). However, research within the psychotherapy domain, rather than sociology, acknowledges that therapists as researchers will bring a high level of theoretical knowledge to their understanding of the data. As Rustin explains: '[Psychoanalytic researchers using grounded theory] have usually chosen to work within a psychoanalytic frame of reference from the start, while remaining open to new conjectures or "grounded theories" that are informed by it' (2009: 46). Indeed, Bursnall argues that 'every researcher, equipped with the basic premises of grounded theory methodology, goes on to develop their own variation of grounded theory technique, adapted to the context and purposes of the study and the individual's mind-set' (2004: 81, cited in Wakelyn, 2011). Inevitably, it could be argued that approaching the data with a psychoanalytic framework would limit theory development. Even so, given that the research aims specifically set out to explore the processes at work in psychoanalytic psychotherapy, it was felt to be essential to maintain awareness of such concepts whilst analyzing the data. Theoretical ideas of particular importance which informed the interpretation of the data in this study include: an appreciation of the importance of the relationship between the therapist and patient and of what type of relationship that should be; the understanding that key aspects of the patient's internal situation can become re-enacted within the relationship between therapist and patient; a central understanding of the presence and function of an unconscious part of the mind; and an understanding of psychoanalytic ideas about how difficult or painful ideas are managed. These ideas form part of my own psychoanalytic, transference-informed approach to clinical practice as a child and adolescent psychoanalytic psychotherapist and therefore inform my data analysis. The study as a whole was also underpinned by a basic assumption that the points of difference (or at least some of them) would be more than just random

failures on the part of the therapists' memories, but rather might relate to the above theoretical ideas.

Charmaz advises that, when analysing within an area which has preconceived theoretical understanding, the researcher must consider whether and how the concepts help the researcher understand the data and whether it is possible to adequately interpret the data without these, in order to identify what the concepts add (2006). These guidelines were followed during the analysis undertaken in this study.

III.ix. Limitations of Study

This study examines a total of nine sessions, although it had originally intended to have a greater amount of data by including more therapists. It proved, however, hard to find therapists who were willing to be involved in the study, who had finished work with their IMPACT clients and who had not used the recordings as prompts for their process notes. It was important that their work was finished, so that none of the process notes studied were influenced by involvement in this research. The nine sessions studied represent the work of three different psychoanalytic psychotherapists. This is a relatively small sample and therefore does not represent a broad range of therapists or individual therapies. However, this brings the benefit of significant depth of analysis and ensures that all the data were thoroughly examined. Having studied three therapies also ensures that the results can be triangulated; in order to be counted as a significant enough finding to be elevated to a higher-level code, I aimed to have the finding present in all three therapists' notes. Whilst the emphasis on similarities between the therapists is important for generating theory that illuminates significantly patterned differences between notes and recordings, it does mean that differences between the individual therapists in what is recorded or forgotten are not explored here. The therapies studied were all with adolescent girls meeting the DSM-IV criteria for depression and receiving therapy as part of the IMPACT study. It is

therefore unknown whether other patients with other presentations might lead to different results. Although the participant therapists were different ages and genders and had different levels of experience, they had trained at the same institution, The Tavistock and Portman NHS Foundation Trust, and were, therefore, likely to have a similar theoretical and clinical orientation.

Although every effort was made to study sessions from across the entire duration of the therapy, there were complications. One therapy broke down after the 15th session. Although the other therapies studied did last the full duration of 28 sessions, it was not possible to access recordings from the final stages of those two therapies. Thus for Therapist 1 sessions one, four and eleven were studied, for Therapist 2 sessions one, nine and fifteen and for Therapist 3 sessions one, ten and fourteen. One effect of this is that changes in the mid to later sessions in how the transference relationship was understood and worked with by the therapists is not included in this study (see Rhode 2011 for a brief discussion of how therapists in the Childhood Depression study became more able to focus on the transference from sessions 12-15 onwards).

For this study the views of two of the therapists were gathered in individual interviews, and the interview material did both inform and confirm the findings of the study, but it was not possible to meet with the third. Furthermore, there were no interviews with the patients, meaning their views on their therapy are not represented. It is worth noting that as part of the IMPACT study the patients', their families' and the therapists' experience of the psychotherapy was researched in a separate project called IMPACT-My Experience (IMPACT-ME), the results of which are yet to be published.

As discussed above, there was a degree of selection made as to which differences in the notes from the recordings were significant enough to

merit inclusion in the study, meaning that not all the differences were exhaustively examined. In addition, the analysis only focused on points of difference, rather than points of similarity between the process notes and recordings. A broader study which included similarities as well as differences would, no doubt, have been able to elucidate these issues further. However, this was not possible in this study, given the space restrictions.

Chapter Four: Findings

As discussed, the aim of the study is to generate theory that might illuminate the causes of significantly patterned discrepancies between the notes and recordings, in order to understand more about the processes at work in psychotherapy and to explore the nature of process notes, their values and limitations.

The grounded theory analysis generated eight core categories of differences between process notes and audio recordings:

1. Emotional nuances of summarising
2. Impact of being in a research study
3. Differences in how therapists represent themselves in process notes from how they are in the recordings
4. Differences in how therapists represent the patients in process notes from how they are in the recordings
5. Influence of aspects of the transference and countertransference
6. Relationship between the external parents and the transference
7. Evidence of the workings of overvalued ideas
8. Nature and function of process notes

The first category – emotional nuances of summarising – identifies that not only are there are omissions, but that omissions may stem from the significant summarising which therapists use when writing process notes rather than something being completely forgotten. This category is formed from codes relating to two qualitatively different forms of summarising: one which is emotionally congruent with the recording and one which appears less so. The second category – impact of being in a research study – stems from codes concerning the influence of the therapists' feelings about being in a study and particularly relates to how ambivalence about a desire to be helpful is evidenced in the differences between recordings and notes.

The third category – differences in how therapists represent themselves in process notes from how they are in recordings – is formed from codes which cohere around the therapists' presentation of themselves, such as 'more reflective therapist' and 'more psychoanalytic therapist'. The fourth category demarcates a similar process but in relation to the patients – differences in how therapists represent the patients in the process notes from how they are in the recordings. This category stems from codes such as 'more grateful patient', 'reduction of negative emotion' and 'more complaining patient'. Links are made between the differences identified and the nature of the relationship the therapist believes they have with the patient. Category five – influence of aspects of the transference and countertransference – is derived from codes which capture the influence of the prominent transference and countertransference positions on what is recorded or omitted. The sixth category – relationship between the external parents and the transference – delineates how complicated feelings about the patients' parents are evidenced in the differences between the two forms of recording and stems from codes such as 'aware of parents' limitations', 'wish-fulfilment parents' and 'therapist as parent'.

The final two categories broaden the focus beyond the immediate therapeutic relationship. Category seven – evidence of the workings of overvalued ideas – focuses on codes which identify the presence of an overvalued idea in the differences between recordings and process notes, whilst category eight – nature and function of process notes – considers how process notes work and what it is that they offer the therapist. This is derived from codes such as 'implicit emotions explicit', 'therapists' observations' and 'therapists' worked through thoughts'.

Given that the comparison between the two forms of recording is central to the data analysis, quotations from the process notes and transcripts of audio recordings are presented in table form throughout so that they can be read side by side, allowing the reader to hold the texts together. The

appendix can also be referred to for a complete analysed session. The data presented in this findings chapter is qualitative and, as such, is accompanied by brief analysis which explains the particular finding presented in the extract (for a full discussion of the findings please see chapter five).

This study's findings come from recordings of psychoanalytic psychotherapy sessions undertaken by three therapists – here called Therapist 1, 2 and 3 – compared with process notes of the same sessions. Therapist 1 is a senior child psychotherapist, Therapist 2 is in his last year of child psychotherapy training and Therapist 3 qualified relatively recently. Therapist 1's patient is a 17 year old girl, while Therapist 2's patient is 14 and Therapist 3's patient is 15. All patients were diagnosed with unipolar major depressive disorder according to DSM-IV's diagnostic criteria. All names used are pseudonyms.

IV.i. Emotional Nuances of Summarising

For the psychotherapist, writing process notes is, in some ways, a routine task; however, despite this regularity, it remains a formidable one. To expect the psychotherapist's notes to capture the psychotherapy session fully would be to expect therapists to engage simultaneously with their patients' material and the complex web of transference and countertransference in the moment of the session whilst carrying out a significant feat of memory by remembering the entire session. The sessions included in this study averaged around 9,000 spoken words per session, or roughly 180 words per minute. In contrast, the therapists' process notes studied are on average 2,100 words with a wider remit of reported speech and descriptions of body language, setting, and the therapist's own feelings and thought processes. All of the patients whose sessions were studied were particularly vocal, as one of the therapists reported:

When I came out and sat down to try and write the sessions, it was a real struggle and I had to do them directly after the sessions 'cos I wouldn't have remembered otherwise and it took me a long time, much longer than it normally would, trying to put them in order, the chronology of them was tough … with her it didn't feel like it had really lodged and there was no hook so I had to really work hard at just trying to remember what had happened in what order, and as I would do that I would remember more things so I would have to go back and put new things in the sequence.
Therapist 2 interview, July 2012.

Unsurprisingly, given the sheer volume of information that the therapists were exposed to in the sessions, this study is consistent with earlier studies which found that a significant proportion of material from psychotherapy sessions is not recorded in process notes (Covner, 1944; Knapp et. al., 1966; Wolfson & Sampson, 1976; Bailey, 2000; Bonnin, 2011 – see literature review for a full discussion of these). In particular, this current study has shown that therapists use significant levels of summarising when writing process notes, for example:

Recording	Process Notes
Therapist Do you think that the fight was the reason that you're so close now, because it sounded like things got really serious, and yet you've made up and actually…? [cut off by patient.] Patient I think it is probably why we've got close like, because when we mess about, like, normally before we used to like, when we was good mates before like in primary school, we would be able to punch and slap each other, but obviously not hard, as a joke, we can't do that no more. If we want to have a joke we have to tickle each other, she can't hit me, it's not that I tell her not to, like I always say like	I said that I thought she was telling me that they had seen the worst of each other, and that perhaps there was also a worry about showing me the worst bits of her. Lucy [best friend] had shown that the worst of Rachel was still manageable, and vice-versa, but would I be the same? She agreed and told me more about how close they are, pausing to talk about how "she even asks me about opinions, cos obviously she's a really stunning girl and all her ex's [sic] are still coming up to her, and she has to choose who she wants, but I don't know why we're still close, but I think it is because of what you said."

you can hit me if you want, because we're just messing about, it's nothing serious. And she can't no more.

Therapist   But maybe you feel that you've seen the worst of each other, and actually it was all right, you've kind of come through that.

Patient   Well I think it was because like I used to be scared of her, and when she beat me up after everyone like started to think like she's getting bullied, all of this. And I used to just sit in a room, and then after I just thought, why am I scared? The only person I should really be scared about is me, because I don't know my own anger limit. But now I saw Lucy's anger when she was hurting me, and Lucy's seen my anger when I was hurting my cousin.

Now I find it funny because now we're so close after we've both seen each other's anger limits. But it's just weird, it's mental. And we're both the same as well, like we both get hyper off the same sweets. Like we just had sweets while we were sitting there, and we both had to stop, we both got sick at the same time, but it made us both hyper. And a stimulation drink gets us extremely hyper or aware, her ex saw us and thought we were drunk. It's like, no, we've just had a stimulation drink, like a 35p drink. It was like I can get hyper off little things, just makes me laugh.

But she tells me everything like. She even asked me for opinions, like obviously she's a really stunning girl, and randomly all of her exes come up to her and like, do you want to meet up with me? Dah, dah, dah,

dah. And she went and spoke to me and her went and spoke to her mum about it, and her mum said obviously something good is going to happen, because now she's got all three of her exes coming up to her, and then she's got these two boys that actually really do like her. They're not her exes, they just like her. So something, like she's got to know what path to take, and something good is going to happen. Now basically her mum says it's between Paul and Richard, these are the two boys that like her. And she has to, like, choose on her own what she thinks is best for her, like what best path, and lo and behold something good will happen. But I don't know why for some reason we've just got so close, but I think it is because of what you said, like we've both seen each other's anger limits and stuff, because like we both like the same music, both like the same outfits, and we stop at like every three cars we stop and make sure we look nice. It's just weird. And normally, we're exactly the same as well, like I don't get along with girls, and neither does she, we're normally just with all boys, but now for some reason me and her have connected, and now we all get… us two get along. And her, my friend, is exactly like Lucy, and that's why I feel like I get along with her as well.	

Therapist 2, 9th session

In this example there is a combination of significant summarising with a phrase remembered almost word for word. This is typical of the summarising seen in this study, in which particular phrases are made to stand out; in this case, 'She even asks me about opinions, cos obviously she's a really stunning girl and all her ex's [sic] are still coming up to her'

from the process notes nearly matches the recording: 'She even asked me for opinions, like obviously she's a really stunning girl, and randomly all of her exes come up to her'. It may be that this phrase resonated with the therapist and became, in his words, 'a hook' to hang the summary on. As the therapy progresses, it may become easier for therapists to remember particular phrases almost perfectly because they are phrases commonly used by the patients, or because the phrase particularly fits with a key idea of the therapists'.

In the sessions studied there are two different types of summaries identified: those that appear to retain the emotional tone of the summarised section and those where the emotional nuances are less apparent in the summaries. This extract from the 11th session of Therapist 1 and her patient demonstrates the former process:

Recording	Process Notes
Patient Yes. For example, it was the other day when it was my late day to start and I thought I'll wake up later and I'll leave myself just enough time so I have time to get ready in time and relax and things and then I woke up and my mum was still asleep. And I woke up at 7.15. She had to leave the house by half seven and I heard her alarm go off like earlier in the morning but she must've turned it off and fallen asleep. So I woke her up and then she was panicking and then, because she had my sister's phone at the time, my sister was asleep and then my sister was panicking. So I had to wake everyone up and my mum told me to make their lunches. Therapist So, instead of you having a lie in and sort of a bit of a free time, you ended up looking after everybody?	One morning in the holidays she had wanted a lie in but her mum had slept through her alarm so she ended up waking her up because otherwise she'd be late for work, and mum had been really angry and grumpy and rushed, and had asked Pavni to make her siblings' packed lunches. Pavni had been really cross. To her surprise though, her sister had said it was okay she was going to eat when she came in after school, and when she asked her brother to make his own lunch as he had plenty of time, he did.

Patient   Yes, because my mum was like really angry and stuff, saying I have to leave at this time, I don't have the time to have a shower or anything, and she wanted me to like take care of my brother and sister and everything was quite a rush but, in the end, I set up... My sister, she doesn't have much lunch until after school anyway. So my sister decided she'll have hers when she comes home and make it herself but my brother, I told my brother, my brother's got ages until he leaves, he always has ages so I told him to make it himself and he did. So that was good.

Therapist   He did?

Patient   Yes.

Therapist   Oh well, that's good.

Patient   Yes. I thought I'd just, like, not do it and he'll have to do it eventually, if I have to force him.

Therapist   And were you surprised?

Patient   Yes, I was a bit because I was getting ready and, just as I got ready, I was going to do it and I found he was doing it already. So that was nice. I sorted of relaxed, even though the house was a bit frantic.

Therapist   Well, and that's two... So your sister said I'll do my own when I come back and your brother actually did respond to you and made his own so...

Patient   Yes, that was quite nice. I think it was just my mum who

was a bit crazy and all over the place probably. Therapist So, I mean, I suppose that's also something quite important for you to take on board.	

Although significantly reduced, the process notes capture the sense of panic within the household that morning and the patient's frustration with it, as well as her relief that her siblings managed their own lunches. Although there are points of difference – for example, the therapist writes that her patient was cross, which is not something the patient says, but something that she conveys – the overall impression is of congruency.

Likewise, this extract from Therapist 3 and her patient demonstrates the potential for summary to retain the emotional tone of the session:

Recording	Process Notes
Therapist And you can't talk to the teacher that you just don't like if you want help and then he treats you a bit like as if you haven't got anything. Patient There's no point. Therapist Why? Patient Cos there's never any point, there's never a point to start an argument, even though I do when I'm really angry but… Therapist It would not be an argument, I mean you just could inform him that you don't need you know the help as if you haven't understood everything you just need the help that whatever the question is. Patient The last time that I tried to talk to teach about something she started having a go at me because I went to her and said, this was like	Her IT teacher is embarrassing her. Could she not talk to him? She is reluctant, tells me about her lack of confidence. Talking ends up badly all the time. Everybody argues back every time. She then gives me an example when she was in year four. Since then she has not argued with a teacher again apart from supply teachers or she knows she gets the point across. Supply teacher[s] are not long around. What can happen when she tries to speak up for her? Bad report and Mum has a go at her. I try to explain that if she can explain to the teacher how she feels, she could help him to understand her better and act differently. I can't! She feels bad afterwards. If she chooses the right words without confrontation, basically

year 4, we used to have set jobs, there were two classrooms in year 4, we had Mr Sinclair's class and Mrs Garratt's class. Mrs Garratt's class was the only one that was allowed in my mum's office and do the phones and everything when mum was at lunch and Mr Sinclair's class were only allowed to do the overhead projector in the assemblies and everything and sometimes, like a lot of time, Mrs Garratt's class had been doing the telephones and the OHP, and I didn't think that was fair so I confronted her I said 'I don't think it's fair that your class always gets to do the phones and our class never do and then every now and then your class gets to do the OHP as well, I just don't think that's fair I think we should have chances to go do the phone as well'. She turns round and was like 'No my class do the phones' and started shouting at me, I was like 'whoa', I was just constantly trying to get my point across, every time I try to get my point across to anybody everybody like always argues back, I'd not even started arguing, I was, that is actually what I'd said, I still remember this argument cos urgh…

Therapist   And that was the last time you argued with a teacher? In year 4?

Patient   I never put my point of view across ever again, unless I have a really good argument for it. Like the other day we had a supply teacher who said 'Right you all need a computer to do this work or you can, when you've done this work you got to finish your composition'. I said 'Sir can we go finish our composition please, can me and Beth go and finish our composition?' and he goes 'But you've got to go on the computers first', I go 'But there are no computers left', he

she just cannot say patronizing. Describe in another word. She really doesn't like him to treat her like a retard. Why can she not find words for that. She stopped in yr 4 but she needs to communicate with adults who do not treat her in the right way or do not understand. Important also for the future. Overcome the anxiety what she has with her mother. Silence. Then I could make a joke of it. I encourage her to do so. I could say Alright alright I am not a child. I point out that this not her mother but her IT teacher.

goes 'Fair dos', he just goes 'yeah that's a good point actually', and he goes 'Go and see if any of the practice rooms are open' so me and Beth went there and the one that we usually go in was open and none of the other ones were, we were like 'yes.'

Therapist   Was this because this was a supply teacher that you tried, or that you were able and confident enough to argue?

Patient   I always argue with the supply teachers, they're twats, I hate them.

Therapist   But that means it's only really your confidence which doesn't allow you to argue with adults.

Patient   I don't want to have an argument with somebody who I see everyday. That's why I usually argue with supply teachers or friends because I can easily avoid friends but supply teachers are just…

Therapist   For a while, a little while. They are only around for a little while

Patient   Yeah

Therapist   But what is the fear if you argue with somebody you see everyday?

Patient   Well, teachers you get a bad report and then it goes back to my mum and she goes 'Why have you got a bad report, you're so much better than this Casey' it's like 'Shut up, I don't care'. It's like earlier, I was just like, we were sitting there she was reading the cooking magazine and she got to this page with quiches on them, I was going 'Mine are better', she goes 'I'm sorry what?' 'Mine are better' 'I'm

sorry what?' 'Mine – are – better' and she just goes 'It's better', I care. She just goes, I was like 'Ohh' it's funny.

Therapist   But I guess you know with the example of the IT teacher who comes now whenever you say you need help and treats you as if you haven't understood anything it would not be really an argument, you just could tell him how you feel when he comes like that and you only want a single question to be helped with or something like that, it would perhaps help him also to understand you better, you know, what you want because at the moment I think his understanding is that you haven't got it, that you can't understand it and so he tries to go from A to Z.

Patient   Sometimes he'll make it sound like a joke, but this was before and now it's just getting old if you see what I mean, he'll talk to you really patronisingly just like 'Oh right, so you've got to do this.' He does that for a joke and everything, well we used to laugh and everything at it but now cos I've always got my hand up it's just getting on my nerves, so basically I just, I can't, I actually can't talk to him.

Therapist   Why is that? Why can't you talk?

Patient   I don't know, I just can't, cos I feel bad afterwards.

Therapist   I mean you only would have to feel bad if you tell him in a way that is confrontative [sic], but if you only tell him what you feel you know in a way that's nice [indistinct] it might change the situation. Is it because your when you think, your imagination, that when you start talking to him you might get angry with him and then you might say things which

he would then would understand as being criticised or being angry with you?

Patient   Basically I just don't want to call him patronising.

Therapist   Ok we can find another word.

Patient   But that's what he's being and then if I say another word it's like lying!

Therapist   But no you can describe it you know it another.

Patient   'I'd really appreciate it if you could stop talking to me like I'm a retard'.

Therapist   Yeah but if you know find a little bit softer words for that you know…'as if I haven't understood every', you know or something like that and I think that's acceptable you know, without…

Patient   Just the thing is from experience with my mum every time I try to like confront her and I've used nice words about it, she's always like…

Therapist   … it just ends up in a big argument or something. But I guess that's the difficulty you know, if you've stopped in year 4 to tell people what you think you know it doesn't help you really, you know, to get forward with things, and I think also for your adult life you have to tell people when they do things which you can't accept really, and it's really, you know, if you find the right words, because you said your IT teacher is quite understanding, isn't he? So I don't think he feels massively criticised, you know, and perhaps he feels even, you know, appreciative about it because you help

him understand about you…but you have to overcome the anxiety what happens with your mum. Patient I could just make a joke out of it like when he comes over and starts talking to me really patronising I could go 'Alright, alright, not a child!' Just as a joke and everything I could do that but then who knows… Therapist: You can think about it and the one you're feeling most confident with you can try because he's not your mum, he's your IT teacher.	

The therapist greatly condenses this interchange with her patient and in this certain aspects are lost, in particular the patient's lively explanations. However, the therapist's determination to help her patient find a way to talk to her teacher remains in the summary. The therapist writes her own suggestions in short sentences which convey something of the therapist's insistence that the patient will find a way to tackle the teacher.

There are, however, times when the process notes summary whilst technically correct does not appear to capture the emotional tone of the session. In the extract below the summary contains the correct factual information, but misses the emotional thrust of the recording: the patient's awareness that she is being provocative towards her mother and her rather fatalistic determination to do so despite the trouble it will cause:

Recording	Process Notes
Patient One minute. Hi, Mum. I'm sat in the meeting with [Therapist]. Bye. She got angry. Therapist You think she was angry? Patient I know she was angry by her voice because she was, like, where	Towards the end, she spoke to Lucy on the phone and then her mum phoned as well. Afterwards, she explained to me that her and Lucy were going out, but that she wasn't allowed, so it was probably going to result in an argument with her mum. She talked about how she was going

are you? And then I was, like, at my meeting, she was, like, oh, sorry.

Therapist   What do you think she'll be angry about?

Patient   Well, she said yesterday that I'm not allowed out because I was five minutes late, but I'm going out today and she's going to get angry with that. She said I wasn't allowed out today, but I am going to go out, so she'll probably get angry with me now.

Therapist   Probably. I would have thought that's a dead cert, isn't it?

Patient   Yes, but if she does get angry or anything, I'll just go to my aunt's and just explain it. I'll just wait there, I'll sit there and I'll wait for either my auntie or my Dad to come back. If it comes to a point, then I'll just have to move out and move in with my Dad or something because she just gets angry so quickly.

Therapist   We don't have much time left, but would it not be a good idea to keep the peace at the moment?

Patient   There's no point because I'm just going to be in my room and she'll just be upstairs, and then if I don't do what she asks, she'll just get angry. That's why I texted my auntie, I was, like, Mum said that I can't go out because I was five minutes late and I think that's a bit to the extreme. And she even agreed. She even tried to tell me to go home, but I won't go home. She'll just get angry, whether I'm at home or not. She'll probably, after when she finds out that I haven't gone home straight away, she'll be, like, where are you? And I'll go out and she'll get angry, she's, like, where are you? And I won't tell her where I am.

anyway – it would end up with an argument if she stayed in too, so it was better to go out. Then she had an idea that she might stay at her Dad's again, that it might be a better place to stay at the moment.

65

| And then she'll get even more angry. And then she'll probably ring my Dad, then my Dad will ring me – where are you? But the worst thing that… the thing is, if my Mum did call me and say where are you? I'll be, like, out; I'm not going to be late. This is my last chance and I know it and if you're just going to get angry with me, then I'll just turn off my phone. She shouldn't get angry with me because I was five minutes late yesterday. Five minutes. That's a bit extreme. And even if I did go out today, she won't find me. | |

Therapist 2, 15th session

Thus we have seen that summarising within process notes is both necessary and inevitable. In some cases the summary takes place without being to the detriment of the notes as a record of the emotional tone of session, although this is not always the case.

IV.ii. Impact of Being in a Research Study

The IMPACT study is the first large-scale randomly controlled trial of Short Term Psychoanalytic Psychotherapy and as such is regarded as highly important by the child psychotherapy profession. Interviews carried out in July 2012 with Therapists 1 and 2 indicated that aspects of taking part in the study provoked anxieties, although there were differences depending on the therapists' level of experience.

Both therapists talked about wanting their patient to do well, not only for the patient's sake, but also for the sake of the study: 'There were a couple of sessions she didn't come for and again I was thinking: "Oh no, I don't want her to drop out" because, not only because of her, but also because of the study' (Therapist 1) and 'The pressure that if I did get something wrong how did that affect the study, wanting psychotherapy to come out well … I didn't feel [it affected my work] especially the more and more it went along, I suppose in one way my motivation to do well for the study

66

might of hung around, but as you get to know the patient more and more it becomes wanting to do well for them' (Therapist 2). Whilst one therapist felt more familiar with the idea of having a Dictaphone in the sessions than the other, both indicated in their interview a sense that they, as therapists, were somewhat exposed by this; as Therapist 1 said: 'I remember sometimes in the sessions when I sort of caught myself saying something that wasn't strictly adhering to technique, I did think: "Oh no, that's going to be on that tape and people are going to be listening to that and you, what are they going to think about me as a therapist?!" So there were the odd times when it would come to mind, but I didn't feel it was…it didn't affect me a lot. It was just odd moments'. Therapist 2 referred to mistakes more explicitly than the more experienced Therapist 1: 'You've got this whole idea of having a Dictaphone next to you, worrying about was it going to work, was I going to make mistakes, especially as a trainee.' Therapist 1 also highlighted concerns that the interviews with the researchers would make her patient feel like a 'guinea pig' and felt that these were more disturbing to the therapy than the presence of a Dictaphone. She reported that the patient did mention these interviews frequently in sessions with apparent concern about confidentiality. This therapist also mentioned some concerns that the manual developed for Short Term Psychoanalytic Psychotherapy would be very prescriptive. Nevertheless, she reported that when she read it she 'thought it was actually an excellent manual and I found it very positive actually reading that and I did read the sections … to have a map in mind of where I was heading, and I did feel that helped.' Finally, Therapist 1, as the therapist no longer in training, expressed particular enjoyment of the regular supervision provided as part of the IMPACT study, which was felt to be 'very nourishing' to her.

The presence of the Dictaphone seemed for the therapist still in training to bring the idea of his supervisor more actively into the therapeutic space: 'It did feel like I focused more on the unconscious than perhaps I would normally, but I don't know if that's because I had a Dictaphone sitting next

67

to me and the internal supervisor is even more present because you know what goes on to that tape is going to be written up as best as you can and taken to supervision'. This seemed for this therapist to be both a helpful presence in the room – enabling him to retain a focus on the unconscious – and also a judgemental presence. This was seen clearly when the therapist learnt that his patient had been hit several times recently by her mother: 'You can't avoid it when it's there on a Dictaphone, so I guess it did feel more pressurised, "Right, I've really got to get this one spot on."' Here the presence of the Dictaphone seems to have increased the idea of a 'right or wrong' way to approach the safeguarding concerns; and the idea of a somewhat persecuting other as represented by the Dictaphone listening and judging dominated. This, in turn, may have influenced the therapist's ability to be with the patient's 'here and now' experience of the session, as the extract below demonstrates:

Recording	Process Notes
Therapist Well, that's made me think about social services again. Patient What about them? Therapist Well, they don't just take children away. Patient I don't want social services involved. Therapist I understand that, but I'm not sure I understand quite why. Patient Why? Are you going to get them involved? Therapist Well, I don't know. Patient Why do you want to? Therapist Well, it would be one option I would have, yes.	I moved the conversation back to social services again and we talked about the different options. She pleaded with me not to call social services, so I said that I wasn't sure that that needed to happen just yet. I said that I would speak to Dr Ford and that we could make a decision together and get back to her. I got her to write her mobile number down so that I could contact her. She was very worried about me calling social services so I told her that I wouldn't do that without calling her first, but that my priority was to keep her safe and that home didn't sound 100% safe at the moment. We talked about how another way would be to keep going as we were, with Dr Ford talking to her mum about what was happening. She was

Patient Please don't. Therapist Well, I was thinking another way round it. Patient What do you mean? Therapist Well, I think I would like to take your mobile number. And I think I would need to speak to Dr Ford. Patient Who's that? Therapist Do you remember when we first met? There was another lady who also sees your Mum at the moment, and that was Dr Ford. And I might speak with her and we can make a decision together and then I could phone you back to talk about it more, if anything needed to be done before next week. Patient But are you going to get social services involved? Therapist I wouldn't do that before talking to you about it. Patient I don't want them involved. Therapist Okay. Well, at the moment, I'm not sure that we need to get them involved. Patient Even if it gets worse, I don't want them involved. I've got my family there and I don't want social services. I don't really like strangers, to be honest, and that's when I get annoyed when a stranger tries to tell me what to do. Therapist And I don't want to do that. Patient No, because I'll lose my	worried about making things worse, "what if my mum gets angry because I've told you." She promised that she would run away if social services were called, and that she would run away from anywhere that they put her. She told me that SSs [social services] had been involved with Lucy's family – an allegation had been made by someone outside of the family and SSs had come around while Rachel had been there and tried to take Lucy and her sister away. I said that she needed me to understand that she didn't want to make things worse. She talked about her friend who has been placed in a hostel and how she could provide for herself – she was quite upset and was trying to hold herself together. At some point she said that she would "just go" if SSs were involved. It sounded like a threat to kill herself, so I picked this up with her but she was clear that she meant running away rather than suicide.

temper, I know what I'm like.

Therapist   You'll lose your temper.

[…]

Patient   But, to be honest, I don't want social services involved in anything because it's bad enough that I've got a lot of troubles already. And then if they come in, I'm just going to get more angry.

Therapist   You're going to get more angry or did you say you're going to get your Mum angry?

Patient   No, I'll get angry and I can't control my temper at the moment, so I don't really know if I…

Therapist   Who are you worried about getting angry with?

Patient   If social services got involved.

Therapist   Yes, does that mean you'd be angry with me or with them or with your mother?

Patient   I'd be angry with everything. I'll run away, I can promise now, nobody will see me, not even Lucy. I don't like social services and if I find out that they've already… like, if I find out that they're trying to get involved in my business, that's when it gets worse. I don't like them and I never have and I never will.

Therapist 2, 15th session

By comparing the two forms of recording it becomes possible to see the influence of the therapist's anxieties about being in a study. The therapist's interview indicated that the Dictaphone increased the pressure to manage the safeguarding issues in this session 'correctly'. In the recording, this

pressure seems to present as a preoccupation with his ideas: he talks about what he is thinking or what he might do five times. This focus on what he needs to do may link to the fact that he appears less connected with his patient. In the recording the patient says four times "I don't want social services involved", and whilst the therapist says he understands it, the patient's repeated stress may indicate she does not feel he has. The patient's concern about social service involvement is in the notes, however, the sense of disagreement between them is minimised; and his ideas become mutual discussion: "We talked about how another way would be to…" The notes also serve to make the therapist appear more in touch with his patient than the recording. The therapist writes: 'I said that she needed me to understand that she didn't want to make things worse'. This comment, in which the therapist actively seeks to make the patient feel understood, is not in the recording. Indeed, the therapist's overall difficulty in registering what is going on between him and his patient when faced with the safeguarding preoccupation becomes clear in the comparison between process notes and recording. The comparison demonstrates missed opportunities for working with the relationship between therapist and patient, for example, when the patient talks about running away, the space to consider that she might also run away from therapy is lost. This was, in fact, the last session the patient attended despite having thirteen more available.

Therapist 1 indicated a worry that the interviews with the researchers were unhelpful for her patient. In the fourth session of their therapy the patient talked about these interviews, however, this is not mentioned in the process notes at all:

Recording Not in Process Notes
Therapist   Right. So they actually came to see you at home? Patient   Yes, they come at home every six weeks or something.

> Therapist   Okay. And this was the first time they were doing that?
>
> Patient   The second time. They came before but that was just to introduce themselves really.
>
> Therapist   Okay. Yes. I didn't know that took place at home actually.
>
> Patient   Yes.
>
> Therapist   Yes. But that must... was it a bit hard, sort of, to talk about what went on in therapy but to be careful not to use my name, and... yes?
>
> Patient   Yes, either had to say 'he' or 'she'.
>
> Therapist   Yes, that. Really! That's how they use to...?
>
> Patient   You can't say anything that will let them know. But it was okay. I think they're going to send me some more questionnaires to fill out.
>
> Therapist   So there's quite a lot for you to do in the background as well as just having your therapy, isn't it?
>
> Patient   Yes.
>
> Therapist   Does it feel a little bit strange to have to do all that stuff?
>
> Patient   Yes, it does. Yes, every six weeks. It'll become a routine I suppose, to do all that. But I had to kind of rush on the day because on the same day I had to go back to college because there was a showcase that I was watching, so I couldn't be late for that.
>
> Therapist   So it was quite a rush or a squeeze, yes.

Therapist 1, fourth session

It is striking that the aspect of being in a research study which the therapist recalled in her interview as most concerning is completely forgotten in the process notes. It is not that the therapist has forgotten the importance of this issue for her patient in general, rather, it seems that in the immediate writing up the unwelcome factor, felt as a potential cause of difficulty for both the therapist and patient, has been dealt with by being forgotten. This pattern of the therapist unconsciously managing uncomfortable aspects of the relationship between the clinician and the patient by suppressing them and so writing them out of the notes will be explored further in section IV.v.

It is evident in the process notes and the session recordings – as well as in the therapist interviews – that the therapists want to do well by both their patients and by the child psychotherapy discipline in the IMPACT study. The comparison of process notes and recordings adds a further dimension to this, as it seems it is often the moments when the therapist is most clearly seen to want to be helpful in the recordings that enter the notes in a different form, if at all. It is as if there is something about wanting to help that makes it difficult for the therapists to observe:

Recording
Not in Process Notes
Therapist   But how can I help, what's going to make you go away at the end today thinking, actually that was helpful? Patient   Well, I'm going to start coming, because like obviously I think my mum likes the fact that I come here...

Therapist 2, 9th session

Here the therapist's direct question about how he can help his patient is not included in the process notes.

The pattern of the visible desire to be helpful omitted from the process notes is continued in the following extract from Therapist 1 in a subtler form:

Recording	Process Notes
Therapist […] It's also something that's got inside of you, hasn't it? Patient It has. Therapist It's become such a habit that you are the one who's got to take responsibility and, I suppose, it might be an idea to sometimes question that, or do you? Patient Exactly. Therapist You know, people can look after themselves, you know, if	I wondered whether the expectations were sometimes more in her own mind then, she had such a strong sense of duty which had become a habit...yes well, she just wanted to be respectful to her parents she said.

they have to.	

In the above extract the therapist has adopted a stance that appears to seek to convey something to her patient. The therapist asks semi-rhetorical questions: 'Hasn't it?' and 'Or do you?', which serve to make the therapist sound more urgent and more determined to ensure that the patient engages with what she is saying. The therapist also actively suggests that the patient questions her assumptions about needing to take responsibility for others, as well as giving her advice: 'People can look after themselves'. This is represented quite differently in the process notes; the level of urgency and the impression of didacticism are absent, although the central issue of the patient believing she has to look after everyone remains the same.

This is also evident with Therapist 3, as in the extract below:

Recording
Not in Process Notes
Patient   I've got parents' evening with her soon, so she's going to be bring that up again with my mum, that's going to piss my mum off just when things were getting better it's going to get worse again. Therapist   But could you not talk beforehand with your mum?

Therapist 3, 10th session

Here the therapist's helpful suggestion aimed at supporting her patient in parents' evening is not recorded in the process notes. This pattern of therapists representing themselves differently in the process notes will be explored further in IV.iii.

The pressure of being in a study and therefore wanting the patients to do well may also be seen in subtle changes in how the patients are represented in the process notes:

Recording	Process Notes
Patient Exactly. There isn't a cure for it. It's like deal with it	Pavni hesitated, then said sort of she supposed – but the

one way or deal with it the other. But, then again, when I look back, every time I come here, sometimes I think I just keep like badmouthing people and I kind of feel a bit guilty because I feel like I'm kind of acting as the damsel in distress in a way and I feel like I shouldn't be because there are so many other people that are worse off and sometimes I feel, like, I should be grateful. Therapist And I think sometimes, you know, you need to first of all look at the situation, what is it, and quite often, you know, the situation is that the negative seems to sort of be on top and we need to look at that first and sift it out and then, you know, then let's see what happens. You know? But it's important you say that that's what it feels like. It's important to be aware of that. Patient Yes, because I think I've tried, I've been trying to like think about all those different situations and things and, in each of them, I feel like there's nothing going right so let's try and think of the things that are going right.	trouble was that when they talked, it was always about something bad, and she felt like that coming here sometimes too, that all she was doing was badmouth her parents and her family all the time, and being negative, with no solution to it. She didn't want to do that, it felt self-indulgent (she didn't use that word but that was the gist of it, I've forgotten her wording), she needed to find a positive way forward, but all there seemed to be was all this negative stuff... I said I was glad she was able to say that as it was a really important topic for us to think further about. She asked me how she could find a positive way forward. I said I thought maybe we were still at the stage of looking at and trying to understand and disentangle all the things which were troubling her, which was sometimes necessary before being able to see beyond that. This seemed to make some sense to her.

Therapist 1, 11th session

In the recording the patient ends this extract saying that she wants to try to think positively and focus on things that are going well for her. In the notes, this impulse appears heightened so that the patient presents as more 'solution-focused' than in the recording. She wants a 'solution', a 'positive way forward' and is made to actively seek this from the therapist. One factor influencing this change in the presentation of the patient may be the pressure of participating in the IMPACT study, which is designed to test the efficacy of different treatments. In the light of this pressure, the change in the notes may represent an unconscious wish on the part of the therapist to have a patient who seeks to make herself better in a way that

fits with the current emphasis on solution-focused treatments and goal-setting within children's mental health services.

The fact that the therapists knew their patients were in a study particularly about treatment for adolescent depression may also have influenced how the patients were seen. How the patients are represented in the notes seems to change in order to bring out what the therapists feel to be their key feature; so that in the extract below at the start of Therapist 1's fourth session the sparkly make up and end of year celebrations are lost in the focus on the more depressed complaints about the weather and the bad effect that has on the patient's hair:

Recording	Process Notes
Therapist You're looking sparkly today, your eyelids look sparkly. Patient Oh yes, because it's the last day of college, so it's like everyone was dressing up and everyone's wearing sunhats and I didn't wear one, so I just put glitter on. It was snowing ago [unclear] so it probably could [overtalking]. Therapist It was, yes. I saw that. Patient It was raining at first, wasn't it? Therapist Yes, and then it turned into snow. Were you pleased? Do you like the snow for Christmas? Patient I was pleased there was snow but I got caught in the rain, so like I straightened my hair and then it got curly, then it snowed. It was nice, it was. Therapist You straightened your hair, would it usually be curly?	Pavni arrived few minutes early, looking quite subdued. She talked about the rain and snow and cold as she sat down, saying the weather had made her hair curly when she had just had it straightened. There was an awkward pause – I thought I'd wait a bit longer today before saying something to make her feel more at ease. Her false smile returned as she became anxious about the silence.

Patient Yes.	

It may, in fact, be that the therapist's awareness of the patient's subdued nature, as evidenced by the process notes, lay behind her starting the session by commenting on the patient looking sparkly, perhaps as an unconscious attempt to enliven her patient, or an expression of her wish for a more lively patient. Changes in how patients are represented within process notes will be explored further in section IV.iv.

IV.iii. Differences in How Therapists Represent Themselves in Process Notes From How They Are in Recordings

As discussed in the preceding category, there are differences in presentation between the therapists in the process notes and the therapists in the recordings. As discussed above, the more didactic or actively supportive aspects of the therapeutic discourse were minimised in the process notes, so in all process notes studied the notes are marked by an absence of the lively, individual presence of the therapist that is apparent in the recordings:

Recording	Process Notes
Patient   […] [Dad] loves chocolates. He actually has an addiction to chocolate. He does. In, like, there's some subconscious part of him, what he doesn't know is, he doesn't want to tell anyone this but we tell people this anyway, is he sleepwalks to the cupboard and he grabs anything sweet and he'll eat it and in the morning there'll be chocolate all over him.

Therapist   Really?

Patient   Yes, and he'll feel sick and moan how he's grumpy and how he feels sick and he'll never eat a chocolate again but the night after he'll do the same thing. | She usually got him chocolate as he really liked that, in fact he was addicted to it. Sometimes at night he sleepwalked and ate all the chocolate and sweets in the cupboard without realising, making himself feel sick, and he'd be covered in chocolate in the morning all around his mouth – she laughed. Once he had bitten a piece off a playdoh figure of a lion her sister had put in the cupboard overnight to dry, by accident, and they had found it in the morning, a chunk bitten out of the lion's head, really weird...I felt quite horrified at the level of this man's disturbance, and hoped it wasn't showing in |

Therapist So he'll eat quite a lot? Patient Yes, anything sweet, and even if it's like chocolates that me and my sister, they belong to us, like say we got a present or something, he'll have eaten it and he'll say 'Oh I didn't realise' or something like that. And once it got so bad that my sister, she had this little plasticine model and she put it in the cupboard and he bit into it. Therapist Wow, when he was looking for sweets. Patient Yes, and he spat it out straightaway and early in the morning I saw a little figure and it was like a lion with a bite taken out of its head. So that's how bad it is. We actually have to hide things from him and, even if I hide things, in the middle of the night or at three o'clock in the morning, he'll wake me up and say where are the chocolates, give me the chocolates, and I'm like, I don't know what's going on, and because I'm half asleep still I give him the chocolates. In the morning I realise was that just a dream or did I actually do that and it turns out I actually did. And he says oh just tell me where it is and I'll get it but I actually have to get up and get it because it's in somewhere where I don't really want him to know. Therapist Wow. That's very extreme, isn't it?	my face. I said she was remembering really sad and disturbing things from her childhood today, and she nodded.

There is a different sense of the therapist in the process notes from the recording, where the therapist appears both more and less prominent. In the recording there is a sense of the therapist's own personal reactions in quite a lively way as she comments 'wow' twice and adds: 'That's very extreme, isn't it?' In the process notes the therapist is presented in a more

neutral position, making a more summarising, reflective comment: 'I said she was remembering really sad and disturbing things from her childhood today'. This change makes the therapist a less alive presence – less prominent – however, at the same time we have more direct access to the therapist's own feelings: 'I felt quite horrified' and through this the therapist is also a more prominent presence.

This pattern is seen in other sessions where again the therapist's intuitive reactions demonstrate her to be a much livelier presence than the notes do:

Recording	Process Notes
Therapist And do you mind me asking, so what's your religion? Patient I'm elective pagan. Therapist Oh really? Wow. Patient No one really has heard of it that much. So every time I have a talk about religion or we talk about religion in college or school they're like, what's that religion, and I have to go through a whole thing saying what it is. Therapist No, I have heard about it.	I asked whether she could say a bit more about her own beliefs? She said this would probably sound strange and usually people hadn't heard of this but she was an 'elective pagan'. She usually had to go through a long explanation of what this meant, she said wearily. I said perhaps she was wondering was I one of those people who had never heard of such a thing? She scrutinised me, her false smile almost gone. I said I had heard of paganism although I didn't know that much about it.

Therapist 1, 1ˢᵗ session

Likewise, Therapist 2's notes also demonstrate a reduction in the sense of the therapist as an active or lively presence:

Recording	Process Notes
Therapist Well, obviously, that is serious. Patient Yes, but I don't want anyone involved really. It's bad enough that… I haven't even told my Dad that Mum's started again. My	I said that it sounded as though it was serious. Rachel replied that she didn't want anyone involved and then told me some more. She said that she had been talking to her aunty (dad's sister) about it using text

auntie wants me to tell him, but I don't want to. I don't want anyone involved. I just want to leave it as it is. Therapist So this is your auntie. Is this your Dad's sister or your Mum's sister? Patient Yes, my Dad's sister. I'm going to go and stay with her for a weekend. Therapist And does your Mum know about that? Patient Yes, it was my Mum's suggestion to stay with her for the weekend and just tell her everything. I can't talk to my Mum. I mean, physically cannot talk, because one of us would just get angry. Or if I say something, she'll just get angry at me.	messages, which was why she needed to text her back and her aunty wanted to tell her dad.

Therapist 2, 15th session

By saying that the patient 'told me some more' the therapist serves to occlude his own role and child-protection led questioning; thus leaving the reader with less sense of the therapist's actively enquiring presence.

Again in the following extract, the therapist's use of the word 'indicated' implies something less than the direct question he actually used:

Recording	Process Notes
Patient […] Like, my dad paid for these but they're already, like, mashed up because I fell in the river. Therapist You fell in the river? Patient Yes, in [unclear] river, by Linton Road, I fell in. It was kind of funny though. Therapist [Overtalking] what happened?	[She said] "I don't ask her for loads, mostly I ask my dad for money, like he bought me these (pointing at her trainers) but they're already a bit mashed up 'cos I fell in the river." I felt she was trying to shock me a bit, but indicated she should go on.

80

Patient There's, like, this rock bit and then…	

These changes imply a tension in the therapists' beliefs about how they should be relating to their patients. On the one hand there is the understanding, as evidenced by the recordings themselves, that the therapists perceive their role in part to be about drawing their patients out and making enquiries of their patients, yet at the same time there appears to be a different understanding, expressed more in the process notes, in which the therapeutic role seems to be felt to lie in adopting a more reflective or descriptive stance. This is evidenced in the following where a question about how the patient feels about her mother is represented in the process notes as a reflective comment about what the patient felt in herself:

Recording	Process Notes
Patient Well, I mean, I know a lot of stuff's going on with her but it's not fair. Therapist And was she angry with you, or is she angry with you? Patient There's no reason why she should be. Therapist And that she doesn't allow you all these different things...is this because she wants to protect you or she wants to? Patient I don't know, I struggle with her being angry with me again, she's like, it's changed and now ...she's very...she's changed the rules...so…what's the point really? I don't get it.	Although it had not much effect at school (that was my understanding, she mumbled a bit), her mother threatened to ground her. What difference would it make, anyway? Casey says. I say that she seems very angry with her mother.

In this example, the therapist's question about the patient's mother and interest in her in the recording becomes a reflective comment on the

patient's own emotional state in the notes. These findings raise the question of how much therapists feel able to notice and write up both the enquiring and the reflective aspects of their interactions with patients.

For Therapist 3 one of the most noticeable reductions in the sense of the therapist's lively presence is found in the representation of laughter:

Recording	Process Notes
Patient I'm going to bring Amytiville horror over to hers. Therapist Horror really? Patient It scared the living daylights out of me when I watched it first so I'll make her watch it (*Therapist laughs*) and I won't let her cover her eyes. 'No you're watching it now!' *(laughs)*. No I couldn't watch it was funny, there was one part where he looked through a key hole and that's the part where I was like 'No I can't watch'..it's like…it's not good *(laughs)*. Therapist What is the horror about? Patient It's about a house called Amytiville house and these people are searching for a new house and they find this house and it's really cheap and they're just like ok what's the catch why's it so cheap so he goes, the person who's selling the house goes, 'well the family who used to live here well the husband killed his wife and all his children' and basically when they move into the house loads of stuff starts happening and the guy, the husband, becomes possessed by this other husband's ghost and tries to kill this family. Therapist (*chuckling)* Wow sounds very scary.	She tells me about a film which she really likes: Amityville Horror. She tells me the story line and I later look it up in the internet. A family buys a home where a year before a murder happened. The family father killed the rest of the family. They only live there for about a month but ghosts come from everywhere. The scariest bit is when she looks through a keyhole. She likes that. There is an element of wanting the friend but also me being scared up to the bones. She laughs.

Patient   It's brilliant, it's a remake of a very old one which is crap. *(loud banging noise in the room – both laugh)* That made me jump! That other one's so much better. I'm going through a list on the internet top 50 scary movies. Therapist   *(laughs.)*

Here the therapist's laughter and the joint laughter when discussing scary films becomes represented as the patient's laughter. This is striking again in the following example:

Recording	Process Notes
Patient Oh no, no, no, no, no! *(Therapist laughs).* Oh I've just remembered something they've got a nasty cat, nasty, oh it's horrible, they've got a horrible cat, seriously I don't want to go there now. *(Therapist laughs).* No, it's fine, I'll kick it. *(Patient laughs).* It's like 'come near me'! My cousins, they're both twins, one of them's got a massive scratch going down there from the cat, they're like three and they don't keep away from the cat. Ellen will just let them run around the cat, whoa the cat, feisty, it keeps on clawing and biting everybody and if you're just standing there it'll come and attack your legs. It's horrible! I was just sitting on the sofa with my legs up, the cat was under the sofa and I didn't know it. I put my legs down and ended up with claw marks all over my legs, it bloody hurt. I'll just stay up in my room all day. *(Therapist laughs).* I won't be there most of the time. *(Patient laughs).* Therapist That won't be much difference then. *(Therapist laughs).*	Grannys, My aunts face and cousins massive scratches from cat [sic]. She doesn't want to go there anymore. She laughs. She stays in her room all day. Won't be there most of the time. Not much difference then. But then she laughs and says she will go out and meet Ben.

Again, the only laughter in the process notes is that of the patient, and the therapist's repeated laughter is omitted. This serves to create a very different sense of the atmosphere in the room and the tenor of the relationship, changing it from one in which both parties laugh together to one in which one member laughs and the other remains a blank. It may be that this occurs because on some level the therapist believes that such laughter is not, perhaps, part of the therapeutic stance.

That process notes, at times, express what therapists aspire to say or believe to be the appropriate thing to say is further indicated by the increase in direct transference interpretations reported in the notes than are made, for example:

Recording	Process Notes
Patient　　　Yes, this week there was, like, a little example. My dad was out and I was just looking through the drawers, my drawers, and I was looking for something that I left there, which was like a personal... because I've recently started doing song writing, just as a hobby when I'm bored, and I couldn't find what I was looking for. So I went to the front room and I opened the drawers and I found a big pile of my books and stuff, and they were in my bag which my dad brought from my mum's, but I told him not to look in them and the fact that all my songs and everything that I wrote that's personal, almost like a diary, just a bundle of stuff was just out in the drawer. Then I knew my dad saw them and I just felt like my privacy had been really badly invaded because even my brother said to me he'd seen my dad go in my drawers which I tell my dad not to go in, specifically this one drawer, and he always goes in my brother says. There's just little things like that. It's like he's keeping tabs on	She gave me the example [of her father's paranoia]. I said I could see why she had used the word paranoid. Pavni added that what annoyed her most was her dad going through her things although she had asked him lots of times not to. She had recently started song-writing (!) and put her lyrics and other things she'd written in her drawer in her room at dad's house. He had taken them out and she'd found them in the lounge, so she knew he'd been all through her stuff. He may or may not have read it, but the fact he had been through it was such an invasion of her privacy (her words) that she just ended up sticking the whole lot in a rubbish bag and chucking it out. I said so his having looked at it made it seem all spoilt somehow? Yes she said – it felt like it wasn't worth keeping it because he might do it again, wherever she put her stuff he'd

us, almost. Therapist And does he do that with all of you or particularly with you, do you think? Patient I think he does it with all of us but me and my sister especially. I don't think he worries about my brother because he's a boy, probably. Therapist So you think he does it because he worries about you? Patient Yes, I think he's very paranoid. Therapist But as you say, it is an invasion of your privacy, isn't it, particularly if you've told him specifically not to look there and those are private things that you might have been writing.	just go through it. I wondered whether she was a bit worried about this being a place where I would go through all her private stuff and somehow ruin it? She pondered this for a moment.

Therapist 1, 1st session

In the recording above, the patient describes how she feels her father invades her privacy, whilst the therapist asks more about it, wonders if he does it because he is worried about her and affirms that it is an invasion of privacy. The crucial difference between the recording and notes is that in the recording there is no attempt to link what the father is described as doing to a potential fear the patient has about what the therapist is doing.

A further example demonstrates the same point:

Recording	Process Notes
Therapist Do you think that the fight was the reason that you're so close now, because it sounded like things got really serious, and yet you've made up and actually…? [cut off by patient] Patient I think it is probably why we've got close like, because when we mess about, like, normally before we	I said that I thought she was telling me that they had seen the worst of each other, and that perhaps there was also a worry about showing me the worst bits of her. Lucy had shown that the worst of Rachel was still manageable, and vice-versa, but would I be the same? She

used to like, when we was good mates before like in primary school, we would be able to punch and slap each other, but obviously not hard, as a joke, we can't do that no more. If we want to have a joke we have to tickle each other, she can't hit me, it's not that I tell her not to, like I always say like you can hit me if you want, because we're just messing about, it's nothing serious. And she can't no more. Therapist But maybe you feel that you've seen the worst of each other, and actually it was all right, you've kind of come through that. Patient Well I think it was because like I used to be scared of her…	agreed.

Therapist 2, 9th session

The point is not that what is written would have been better than what was said – indeed the first example given is from the first psychotherapy session for that patient, so a direct transference interpretation may well have felt too threatening – but rather that those are the kind of interpretations that therapists write more than they actually say. They may, therefore, write such interpretations precisely because they feel they should have said them. Such changes to the amount of transference interpretations made in the notes have an impact on how the therapist and patient appear to talk about the nature of their relationship, perhaps serving to make the therapist appear more focused on the relationship or more confident in dealing with it in the process notes than in the recording. It may also be that be that process notes conflate what is said at the time and what is thought later (see IV.viii for a fuller discussion of this.)

The changes between recording and process notes in how the therapist talks about their relationship with the patient can also imply subtle differences in the nature of that relationship:

Recording	Process Notes
Patient Nobody else knows. Lucy knows everything that's happened, she's like my best mate, I tell her everything, and she'll tell me everything. Like I know nearly everything about her family, I even know about her mum's past, like her mum's old childhood, she knows about my mum's childhood, obviously my mum used to be her TA, what's wrong, there's nothing wrong with it. Just stressed about… [Pause] Therapist Are there things that you haven't told me? Patient About? Therapist I don't know. It's just the way that you said you know everything about Lucy, and she knows everything about you, and she's the only one that knows. Patient Well I don't… just like my family stuff, like finding out that my granddad thought he had cancer, then he went for the treatment and gladly he come out with the all clear, he never had nothing.	She inflated herself by talking about Lucy, and how Lucy knows everything about her and she knows everything about Lucy. There was a longer pause, while she allowed me to think about this – I felt she was saying that there might be things she hadn't told me, so I asked if that was true. She looked at me and said, "like?" I said I didn't know, since she hadn't told me them, and she laughed and carried on. She said that she tells Lucy everything during the week, so tries to talk about things that she hasn't said to Lucy when she comes to see me, so that it's different, but then it doesn't feel right.

Therapist 2, 9th session

In both the process notes and recording the therapist asks the patient if there are things she has not told him and in both she asks what these might be. There is, however, then a change in which the therapist of the process notes speaks more directly with the patient, causing the patient to laugh in return, whilst in the recording the therapist's comment that he does not know conveys a greater sense of trying to work something out about which he is unsure and is not followed by laughter. The therapist also writes in the process notes that the patient is 'allowing' him a pause in which to think. This posits a relationship in which the patient is actively helping the therapist. These changes create a more confident therapist, a

livelier interchange and a sense of a collaborative relationship between patient and therapist. Interestingly, in the process notes the therapist writes that the patient returns to talking about her friend Lucy, whilst in the recording the therapist's question actually leads to the patient telling him about her grandfather having cancer, which her mum had hidden from her (for the first time this session, though I do not know if this had been discussed previously). Indeed, this idea of what the therapist 'should' be saying here seems to have served to obscure what he actually did achieve.

It is important to stress that such changes are unlikely to be done deliberately, as Therapist 1 commented in her interview:

I think of myself as quite honest when I make the notes, I try to make them as soon as possible after the session, if possible the same day and I have quite a good memory for dialogue of how things follow on from each other, but the fact that it was recorded did make me wonder about it: "Am I making it a nice neat story or am I distorting things?" but I think, I mean, I do, I've always valued supervision and I did know [my supervisor] so I didn't feel I had to make a great impression on her and I did want it to be useful, so I did anyway want to put things in for example when I gave advice or when I missed something, you know when you write up notes and you think 'oh God' and you can see what you've missed.

Although the therapist said in her interview that she attempted to include times when she gave advice in the process notes because she felt comfortable with her supervisor, we have seen examples from this therapist in which the helpful comments were not in them (see page 73). Whilst such changes may not happen because of a deliberate attempt to impress the supervisor, process notes are not written within a vacuum, but are written as part of a relationship with the other in mind. Therefore,

changes may be made as an unconscious reaction to the supervisor the therapist is relating to internally as they write the notes.

IV.iv. Differences in How Therapists Represent the Patients in Process Notes From How They Are in the Recordings

This study has found differences between the process notes and recordings in how the patients are presented: certain aspects of the patients may be omitted in the notes whilst other aspects may be given greater weight than they appear to have in the recording. One factor which may influence this is the nature of the therapeutic relationship the therapist believes they have, or wishes to have, with the patient at any given time. For example, as we saw earlier, patients may be presented as more actively seeking help than is apparent in the recording. In keeping with the presentation of a patient who wants to get better, the notes can represent patients who seek to work more collaboratively with the therapist than in the recordings:

Recording	Process Notes
Therapist I'm just thinking about people robbing things because they need something that they feel they don't have. Patient Some, most of the time, like the people that I know, most of the time when I see them try rob, like I stop it, but the only reason why they want to rob is so that they can sell it to other people because loads of people want to buy stuff lately. They can sell it to other people and then they get money. Therapist To spend on other things that they really want.	I had begun to think about deprivation, the robbing and the slightly unkempt way she was dressed. I said that I was thinking about how people rob because they feel there is something they don't have. She took the baton up, "the only reason is so they can get money. They want something, don't have the money, rob something and then sell it to someone else so they get the money for what they really want."

Therapist 2, 1ˢᵗ session

The phrase the therapist uses: 'She took the baton up' could be seen to convey a sense of the therapist and patient working together as part of the same team. As this was the first session, it may have been particularly

89

important for the therapist to feel he and the patient were going to have a functioning therapeutic alliance.

In keeping with this, indications of negative transference may become harder to see:

Recording	Process Notes
Therapist What was the giggle for? Patient I'm just tired. I had to get up proper early. Therapist For something in particular? Patient I got excluded from school for two days, so I had to go and have a meeting. Because if I don't have the meeting, I won't be allowed back in. Therapist What happened? Patient Basically, we've got a new teacher in the course that I'm doing and he doesn't know anything at all about me, but he pinpoints me. Where there's three of us in a class, and he pinpoints me and victimises me out of three of us.	In the room, she sat down, took her phone out of her pocket and placed it beside her on the sofa. She looked up at me, giggled, then looked away again. This happened a couple of times – the atmosphere felt thick, then light for a few seconds until she looked away again and the atmosphere would return to heavy again. When she did it again, I asked what the giggle was for. She said she was just tired. She stopped and sat in silence for a little while, but then went on to tell me that she had been up early for a meeting. With a little encouragement, she told me that she had been excluded from school for two days last week after having an argument with a new teacher at school. She felt that this teacher "pin-points me, victimises me" and this had resulted in her losing her temper.

Therapist 2, 15th session

The therapist clearly conveys that there is a very difficult atmosphere at the start of the session, but does not link it to a possible unacknowledged negative transference in which the therapist's interest in the patient is felt to be equivalent to the teacher's persecutory 'pin pointing' interest.

Again, in this example from Therapist 3's first session, potential negative transference does not appear to be registered:

90

Recording	Process Notes
Patient I was so cold and cos I've got my mum's crappy blood circulation, my hands are so cold, it weren't pretty. Therapist I thought you were shivering. Patient I'm starting to warm up now. I swear I'm like the Simpsons cos I go yellow…it's really not good. My hands are still freezing though. Therapist The heating will not be on at all until the first of October, so we hope they turn it on. Patient Next week the heating will be on and I'll probably sit next to the heater.	She felt so cold. Stupidly she has still her summer duvet. She hang on to her warm water bottle. She started thinking and then she cried. She also got Mum's crap blood circulation. She needed three coffees this morning, she had not much sleep.

Therapist 3, 1ˢᵗ session

Immediately prior to this the patient had described how cold she was at night as she still had her summer duvet, before then talking with the therapist about how cold she feels at that moment in the therapy session. In the process notes, however, the focus remains external to the therapy session as the only mention of cold is at home with her duvet. This means that the patient's discomfort in the session – both the literal discomfort of a cold therapy room as well as any potential emotional discomfort expressed through it – is not captured in the process notes, and may, therefore, not have fully registered with the therapist.

Conversely, this study has also identified occasions when patients are presented in process notes as complaining more about their therapy and therapists than they appear to in the recording:

Recording	Process Notes
Therapist Yes, your mum explained that actually your attendance has gone	I replied that I had spoken to her mum, who had mentioned that

Recording	Process Notes
up a lot. Patient Yeah, it was down to like 52, and it's probably up to 100 again, or it was 92 before. So that's why they want me to stay in, because my attendances would be better. Therapist And there was some sort of reward system that your mum mentioned? Patient Yeah. I could win £25 if I'm in for two weeks. Been there more than two weeks, but… Therapist But this gets in the way, is that what they're saying? Patient Yeah, because even though it's an arranged thing, it still takes up half of my day as well, that's what they're querying about, even though my attendance is getting better, and it still takes time [unclear]. So that's why I only have 92.	Rachel's attendance had been very good recently, and that she was trying to get some sort of reward system. She grinned, "Yeah, I could win £25" she said and explained that her attendance has gone up to 92% from 54%, "and I ain't gonna lie, the only bit left is because I come here."

Therapist 2, 9th session

The addition of: 'I ain't gonna lie' to the process notes serves to make the complaint against the therapy more obvious. In the recording it is the therapist who names the difficulty therapy causes to the patient's school attendance, but in the process notes it is the patient who does this, with the effect of making the patient take ownership of the complaint. A further example:

Recording	Process Notes
Patient Lucy skipped work and stayed with me at the church, and went for work for like an hour after, just that her attendance weren't bad. So she is a good friend, but my mum don't like her, because when I was in secondary school she beat me up. But I mean, like, it was childish, and we both put it behind us, but my mum can't seem to, to the point that she's even	She had gone out with her friend Lucy, who had also taken the day off work today so she could be with Rachel, "so she is a good friend, but my mum really don't like her." She explained the story about Lucy beating her up, bullying her and how her mum hates her and tells her family not to let Lucy in their

said to my auntie that she doesn't want me or Lucy in the house, but obviously my auntie's not horrible. But my auntie mentioned it to me, and Lucy, but she still lets us in her house because to be honest, like, Lucy hasn't done nothing to no one, she done something to me, she didn't do nothing to my mum. [Small pause] So it's hard.

Therapist   It is, and it's really complicated.

Patient   Because she's my best mate now, and that's my mum. And Lucy doesn't mind my mum, she actually does like my mum, but my mum don't like her.

Therapist   But you must feel kind of stuck in the middle.

Patient   Well I do, because when I'm out, if I do something wrong my mum blames Lucy, and it's not Lucy's fault. If I do something wrong it's my fault, like you can't really blame her just because you don't like her. I don't like most of my mum's friends, but you don't see me blaming stuff on them. Like I was meant to stay at my nan's the other week, and Lucy was going to stay with me, but my mum had called my nan and said not to let her. But I can't confront my mum, if I confront her she'll get pee'd off with me. Sorry.

Therapist   And what happens then?

Patient   She probably won't let me go around with Lucy again. That's why I'm hoping soon I can go and move in with my dad, or when I'm 16, Lucy's mum trusts Lucy a lot, she's going to get her own hostel, because at 16 you're allowed one.

Therapist   Her own hospital?

houses if Rachel goes round for the day. She said a lot, and I was just trying to keep up, but it was hard – it just seemed that she feels stuck in the middle, torn between her friend and her mum. When I said this to her, she barely paused and carried on talking about how Lucy wants to get her own 'hostel' so she might go and stay with her etc… I began to think about Betty Joseph's description of 'chuntering' and wondered if this might be what she meant.

93

Patient	Hostel.	

The therapist clearly feels that the patient is not talking with the purpose of really seeking to understand and engage with herself, but is instead involved in a defensive activity, 'chuntering' on. On listening to the recording it is clear that the patient talks with a steady fast rhythm that could add to the sense of 'chuntering'. However, in the recording the patient leaves a small pause, which seems to be reflective, and leads her to comment on how hard things are. In addition, whilst the therapist writes in the notes that he does not think the patient takes notice of his comment about being stuck in the middle between her friend and mother, in the recording she actually agrees with his comment and brings a further example, as if building on what he said because it made sense to her. It may be that the therapist is aware of something which feels intractable in the patient's sense of stuck-ness that means he does not notice her use of his comment. Furthermore, the therapist's sense that the patient is attacking him, as well as her own thinking, may mean that the brief moments in which the patient is able to take something in from him go unnoticed.

Thus at times therapists present their patients in the notes in a more challenging, or depressed light than they appear in the recordings. It is not always clear why these changes take place; there may be an idea that this is felt to be what is wanted in psychotherapy; it may relate to an understanding that working in the negative transference is very important, perhaps in part because it is emphasised in the IMPACT manual as of particular importance within short-term work, it may be that being part of research into therapy with depressed adolescents meant that depression became highlighted in the therapists' minds, or it may be that it has captured something they felt in the session but which is less clear on the recording. There may, of course, be other reasons. At other times, a contradictory version of the 'wanted' patient seems to be present in the notes; one in which the patient actively seeks help and relates

collaboratively with the therapist. Many of these differences seem fleeting, residing in a particular moment within the therapy; for example, Therapist 1's patient who was presented as more solution-focused in the notes than the recording did go on later in the same session to speak about a feeling that she was beginning to change and behave in new ways, but that conversation was not captured in the process notes, and it is not clear why this may have been forgotten. It could have been that the later discussion about changes felt unconvincing to the therapist, or alternatively that the positive developments felt too tentative and so were forgotten in some way, perhaps, to be kept safe from being overly focused on in a way which could have felt threatening.

This study did find examples, especially with Therapists 2 and 3, of a more enduring perception of the patient, in which certain aspects of their presentation seemed to be privileged above others. Across Therapist 2's sessions, apart from in the final session where the patient was very clearly the victim of being hit by her mother, there is a pattern of the process notes minimising the levels of violence in the patient's behaviour and in her environment:

Recording	Process Notes
Patient But I am quite aggressive; I'm not going to lie. Like, some girl that I knew, well, like we're friends but she annoys me a lot, she grips me up and tried to push me, so I slapped her really, really hard on her face and she had my hand mark right there. And then she was like, 'Why are you slapping me?', I was like, don't ever, ever, ever, grip my arm. Therapist I wonder if that's, kind of brings us on to the second thing that I was thinking. You know, the first is that it's hard to show people how you really feel. But the second is, it's almost as if you're giving me some little warnings, you know, I'm a fidgeter, I	[It is hard to find the parallel for this section in the process notes. The discussion about a warning which follows is located alongside a discussion about the patient feeling scared about coming to therapy but wanting to access it, which takes place earlier in the session.] I said that I thought there was [sic] two parts of her, one that wanted to come and talk, but another that didn't want to look at the past. She replied: "I'm scared to talk though." I agreed, and said that she was telling me not to get too close just yet. She said, "I ain't gonna lie, when

95

don't talk much, I'm aggressive...

Patient   No, not towards you. I am aggressive though, I can get angry quite quick.   But, like, when she grips me up, she proper grips, like grabbed me, out of my hair and everything, and I was thinking, no you're not being serious. And she cut, tried to swing me, so I just went bang. And my friend was there as well and she just saw the hand mark. And then my friend was talking to a boy that we both knew and his friends were behind us. I didn't mean to slap her on purpose so the boys could see her, but she grips me up and tries to act hard in front of them, I was like, it's not happening and then I slapped her, but she was like.

Therapist   Well, it sounds like you were protecting yourself.

Patient   I was. Like, I don't like it when people... Like, I used to be proper scared to hit someone, I couldn't hit no one, da, da, da, da, da, but now if someone grips me up or if someone punches me my instant reaction is to hit them back because you can't just hit me and think you're going to get away with it. Like, there's my friend, he's bisexual, and he tried punching me today and I caught his wrist and I twisted it. I was like, don't try and punch me. And then he slapped me so I punched him in his back. I am aggressive to other people. I'm not aggressive to adults, I would never do it, but if someone, if a kid my age is being aggressive to me I will hit them back.

Therapist   But I was thinking about ways we all have of protecting ourselves and I wondered if not showing people how we really feel is another one?

people push me and hit me, then I hit em back." I said I felt there was a bit of a warning to me again. She got slightly embarrassed and said that she wouldn't ever get violent to an adult.

96

Patient I don't, if I'm angry with someone then sometimes I keep it in. Otherwise, if they proper, proper, proper frustrate me I'll hit you, it's just that serious. But I think it's not just me hitting them, because the thing is, because I hit, as they start doing stuff to me over my mind and all my past and then it gets me even more angry and then I slap them to get anger out of me if they're like, if they're proper hurting me though. Like, when that girl tried swinging me it just reminded me about other things that's happened in the, in my family, so I got a bit mental and that, slapped her.	

Therapist 2, 1ˢᵗ session

The patient's repeated declarations that she is aggressive – that she will explode, hurt people and leave a mark – are strikingly absent from the process notes. Indeed, it is hard to find any parallel in the notes for the descriptions of what she believes herself to be capable of. This is seen again in the following extract:

Recording	Process Notes
Patient ….And my little cousin, he's 13, he wouldn't do nothing because of his dad. I got there, he strangled me, and I went bright red, and I don't know why I just lost my temper. And then I see him trying to strangle Lucy, and I just like I had to double look to make sure I was right, and I lost it. He just went total mad, because his dad weren't there, he thought he could take advantage of his mum. And then he's obviously got two older brothers, and it took both of them to take me off of him, I was that angry. And normally all they'll have to do is stand up and he'll stop, and he never stopped like when I stood up. So as they went to stand up he went to stop	She was talking about being at an Uncle's and her cousin had strangled her and there had been a big fight between her and her cousin where she had lost her temper.

but then carried on because he saw that I was going to stand. So I lost it. And all they were going to do was punch him so that he knew to let go, because she's a girl, you can't really do that to people that you don't know. Obviously I know he's younger, but he fancies her as well, which made it harder, and then I just lost it and I just started like beating him up, not bad, not like he had bruises or anything, but I just went mad at him and started pushing him off of her, slapping him. He booted me in my stomach. I just went mental.	

Therapist 2, 9th session

The level of violence is greatly reduced, for example, 'I just went mental' becomes 'she lost her temper'. The patient's language is quite rich as she describes this violent altercation, with words which convey the physicality of the fight: 'beating', 'pushing', 'slapping'. Such words imply some element of savouring the violence. This possible enjoyment, or indeed excitement, in the physicality of the violence is lost in translation to the process notes. The therapist seems determined to keep his patient out of the perpetrator role; moving her from the one who is launching the attack in order to protect her friend to keeping her as the victim who is strangled. Whilst it may have been difficult to follow the level of detail as the patient talked fast, it is consistent with the wider push to downplay the level of the patient's violence:

Recording	Process Notes
Patient ….Lucy was kind of shocked, because even girls when they look at me in the street and they try and pick an argument, I'm like, I'm not being funny but if you want to pick an argument then start because I will. I may look skinny, but I'm really not. And now Lucy's even scared of me when I stand up and she knows that someone's trying to start on me. I	[She had] surprised everyone with how angry she had been.

don't know why. I think cos I've got so much stress and anger in my body, I just lose it out on people that are trying to think that they can like step on me.

In the recording the patient expands from talking about one specific angry incident with her cousin to talking about herself as generally very aggressive – describing how she fights and responds to threats despite her small size. In so doing she expands beyond emotions into action. In the process notes, however, the focus remains on the emotions, on feeling angry, whilst the threat of violence and actual violence becomes lost.

In tandem with a reduction of the level of the patient's own violence in the process notes, there is a reduction of the level of violence in the world around her:

Recording	Process Notes
Patient I ain't being threatened. I did get threatened ages ago but police and everything got involved. Some girl wanted to stab me to death. But obviously, like, I don't see her about no more, I'm way, I'm way out of her way. And, like, she, I bumped into her one day with my friend and she was like, 'you two come round here', and then I was like, 'why can't we just talk here if you want to talk', and it, like... Basically there's a big road, yeah, and my friend's house was there and we was all standing here and she was like, come over here, so we walked down to about here, yeah. And she was like to us, 'come round the corner', and then the corner's like literally all the way round, I was like, 'why can't we just talk here'. And it was kind of dark so I knew what she wanted, and she was like, no matter what, you two are getting battered.	She told me that she wasn't putting herself at risk, but then went on tell me about how someone had threatened her some time ago. A girl from her area had seen her in the street and had called to her to come round the corner. Knowing that where the girl wanted her to go was a dead end alley, Rachel had avoided it. The girl had said she just wanted to talk to her, but Rachel felt there was something bad going to happen. When she refused the girl told Rachel that she was going to get stabbed either way, so she may as well come round the corner and get it over with … I said that it all sounded quite worrying, that there was a lot of violence in her stories.

Therapist   So you thought she was trying to trap you?

Patient   She was. She wanted to beat us up, both up. I was like, 'why do you want to beat me up?', she goes, 'I don't like you or your family'. I was like, 'that's not an excuse to beat me up, it's an excuse to dislike me but not to beat me up'. And then my friend was like, 'why do you want to beat me up?', and then she was like, 'you showed my boyfriend a picture of my cousin'. She was like, 'yeah, I asked if he knew her, that was it, and it wasn't a horrible picture and it weren't a dirty picture, it was just a picture of her face, that was it'.

And then she was like, well, and then I was like, 'I suppose we have to go in [friend's name]', and she was like, 'yeah', so we walked back to about here, yeah, and she was like, 'if you lot walk in that house you're getting knifed up tomorrow', which basically means stabbed to death. And then we were, me and her carried on walking and we walked in the house. And then my friend came back out because everyone was outside her house, literally just stood at the door, she was like, 'what's wrong?'

She was like, 'tell Rachel to come out here so I can stab her up with my keys'. And I was like, 'I'm not coming out'. I was like, 'I'm staying in the house'. Her mum, her dad and her uncle and obviously her little brother and sister and the dog was in the house, I thought, 'I'm not going out, I'm staying here'. And then she was just like, 'you're both getting stabbed up, da, da, da, da, da, watch when I next see you'. And that back, I never... I saw her once but then I ran all the way back to my friend's house.

100

I was going to go to my cousin's but she was there so I've run back. She never chased me though. My friend did to make sure I was all right. I was like, 'yes', I was just [unclear]. Therapist Again, it sounds really quite worrying and there's a lot of violence around. Patient We got it sorted out though. Like, not proper sorted out, like the police was involved, the police know of everything.	

Therapist 2, 1st session

Whilst the therapist comments to the patient on the violence in both the recording and process notes, the effect of the summarising in the process notes is to reduce the power and emotional impact of the patient's story. The sense of threat and threatening swagger with which the patient conveys possible excitement is diminished, as is the impression of nerves in the patient's rapid speech. For example, the stabbing is not recorded in the notes as a threat to stab 'to the death' and the evocative word 'battered' is missed. A further example continues to demonstrate this process of minimising violence:

Recording	Process Notes
Patient Two of my cousins got, yes, two of my cousins got rushed proper bad and that. My little cousin, he's only just gone into Year 8, got rushed so bad, broken ribs, and had to go to hospital for it by a well-known gang. And it got me frustrated to the point where I was so angry I did cry. And then I found out that my friend who used to go out with my cousin set my cousin up and I was angry with her, and I haven't spoken to her since. Therapist There's lots going on.	This somehow launched her into a story about her cousin being beaten up, but Rachel had found out that a friend of hers had set her cousin up, so she hadn't spoken to the friend since. I was struck by the losses, which seemed to be slowly adding up. The dog, her dad, her mum, her friends. There was a long pause and she held her head in her hands. I said "there's lots going on."

Therapist 2, 1st session

101

The process notes convey a sense of the patient as upset – her head in her hands – which the recording cannot capture. There is also less sense of a pause in the recording than in the notes. It may be that the therapist is in touch with more pain than the patient can allow herself to be in touch with and it is this which lies behind the changes. However, again the real physical violence of the attack on the cousin is missing in the notes. This brings out the wider scope of the therapist's observation, but also demonstrates how being in touch with the emotional pain of the patient's situation seems to limit being in touch with the details of the violence.

There is also a general reduction of the physicality of the body in these process notes:

Recording	Process Notes
Patient   [Talking about how the patient doesn't cry when hurt.] I had some boy, yes, and he was like, 'do you really laugh when you fall over?' I was like, 'yes', and I was like 'push me' and he pushed me full hard, I didn't think he would push me that hard, but he pushed me proper hard and I cut my hand a tiny bit, yes, and I got up and I started laughing, like proper uncontrollably. And they was like, 'why are you laughing?, like, you've cut yourself', I was like, 'it's funny', and that. Even though it hurt, like, I can't cry, I just laugh.

The last time I cried is when I got bit by a dog and it took that whole bit, where is it?, yes, you see that lump, it took that whole bit of my hand off and it was hanging. It looked disgusting. It was horrible at the time. It hurt, yeah, but they got rid of the dog after because it bit my cousin as well and it chased me and my mum. So it was kind of a violent dog so they had to get rid of it. | [Talking about how the patient doesn't cry when hurt and the patient says] "This boy didn't believe me, so I told him to push me, but I didn't think he would push me so hard and he pushed me over so it really hurt, but I just started laughing. He thought I was really weird, but even though I was hurt, I couldn't cry. The last time was when I got bit by a dog."
She then went on to tell me about how she had been bitten and the owners had felt so guilty that they had "got rid" of the dog. |

Therapist 2, 1ˢᵗ session

102

Once again the therapist's detailed observation of the patient leads him to be in touch with something more depressed in her – her lack of affect and momentary slump – at the apparent expense of the violence. It is noticeable that the cut hand is missing and the rather graphic image of the dog bite is summarised and sanitised with the gore removed. It is also striking that the therapist's own reaction to this is missing from the notes, as if the whole interaction has been flattened.

A comparable process, in which the process notes appear to diminish the extremity of the patient's painful emotional experiences, is also seen with Therapist 3 and her patient. In the following extract the patient tells a very lively story about how her friends threw her shoes out of the window into the snow:

Recording Not in Process Notes
Patient   My friends threw my shoes out the window. *(Patient laughs).* Therapist   You what? Patient   My friends threw my shoes out the window. *(Therapist laughs).* It proper annoyed me, I mean like Kate, Mike and Carys, they're starting to get on my nerves, I never thought I would say this, but they're really starting to annoy me. Therapist   You said last week that Mike and Carys are quite annoying. Patient   I mean, yeah, don't…It's not Kate, it's Carys and Mike, they're so annoying, like Carys was just like holding my shoe out the window, and Mike went up to her and went like that and my shoe went flying out the window and then Carys throws the other one out. I was like: 'Cheers guys, do you want to go get my shoes?, 'No, no', 'Go and get my shoes', 'No, I can't go out there', she just goes 'Why not?, 'Cos one, I don't have any shoes and two, look who's outside, I'm not going anywhere near them thank you very much!' And, yeah, she wouldn't get my shoes.

Therapist 3, 10th session

As the patient relays this story in a laughing, lively manner as if telling an entertaining tale, she does not acknowledge how unpleasant it could be to

103

have had her friends gang up against her and force her into the snow in her socks. It may be that the patient's determinedly jovial retelling is so powerful that it draws the therapist into it; the therapist also laughs and her comment actually moves away from the incident. This process of moving away from a painful incident is furthered in the process notes as the interaction does not feature in the notes at all. In fact, the entire process notes from this session concentrates solely on the patient's improved interactions with her mother.

A similar movement away from painful experiences in the process notes is seen below:

Recording	Process Notes
Patient I've got to sit with Jack, yeah whatever his name is, who'll sit there and just like touch me up and stuff and I was like 'get your hands off me' he was 'like calm down' [indistinct] cos he knows Mike and their cousin, which is slightly weird. Therapist The cousin of? Patient Mike...I've got Jon too who's one of my exes, Ali's one of my exes, so *(patient and therapist laugh)* [indistinct] but there's me with a get round! Therapist So you've had quite a lot of boyfriends *(Therapist laughs).*	Then she tells me about other boys and I learn that she started to have boyfriends after primary school. She had seven boyfriends so far. She smiles partly embarrassed but also a bit proud of herself. Mike was the most important one.

Therapist 3, 1st session

Again, in this later extract from the same session, the process notes privilege a positive experience – feeling protected – over the more intrusive being 'touched up':

Recording	Process Notes
Patient …Cos this one time like his cousin Jack was being a right	She goes on telling me how hilarious Mike is, that she felt

idiot, he was sitting there touching me up right in front of Mike's face and I was blatantly telling him to get off me so Mike could even hear, so Mike spoke to him after the lesson, he didn't threaten him or anything, he just spoke to him, sort of threatened him in a way, and, yeah, that made me feel important to somebody. Therapist This was recently or longer ago? Patient Longer ago when we were going out and then like.... He's so mature, but he makes it funny.	still being herself when she was with him and he was very protective of her.

Therapist 3, 1ˢᵗ session

Here the difficult feelings around being touched up and any potential sexual excitement in her boyfriend's threats remain unremarked in the notes.

We saw with Therapist 2 that the patient's own level of violence was minimised in the process notes. There is a similar, though far less marked, process with Therapist 3's notes:

Recording	Process Notes
Patient Well I hold it inside, and then sometimes I'll like if I'm angry I'll hit the walls and stuff, like the other day but that really hurt.	After a silence, I ask her how [she] deals with anger. She holds it inside. Depends when someone else outside makes her angry, she would talk or making feeling them bad.

Therapist 3, 14ᵗʰ session

Here the process notes have reversed the patient's furious acting out of her anger – hitting walls 'and stuff' – and turned them into acts of repression.

To understand this and the reasons behind these changes further, we need to consider how these changes relate to the transference relationship, and in particular what the comparison between recordings

and process notes can indicate about the nature of the transference relationship.

IV.v. Influence of Aspects of the Transference and Countertransference

Although transference dynamics can shift several times within a psychotherapy session, there are dominant transference positions visible across the sessions in this study. Whilst some element of these transference positions may have been apparent from a study of just the process notes or just the recorded sessions, the comparison of the two elicits a deeper insight into the power of the transference to pull therapists unconsciously out of their role. This can lead the therapist to 'act-in' to the transference position offered by the patient in ways that they do not seem aware of, but which become clear through the comparison. It is at these moments of being pulled out of the therapeutic role and too strongly into transference positions that change occurs in the notes – as if being pulled out of role involves a temporary inhibition of therapeutic observation skills. It also becomes clear that the transference relationship – as evidenced by the comparison – creates the lens through which the patient is seen and therefore lies behind some of the changes in the presentation of patients discussed above.

The clearest examples of this phenomenon are the consistent reduction in the presentation by Therapist 2 of his patient's level of violence and the changes in the emotional tone of sessions in Therapist 3's process notes. For Therapist 2, the changes correspond to an emphasis on the patient's vulnerability, which the therapist noted from the very start of their work together:

| Process Notes |
| Not in Recording |
| Rachel was 10mins early for her session. When I collected her, she was hidden in a corner in the busy w/a [waiting area] but got up straight |

away. She was dressed in tights jeans and an oversized black jacket with the sleeves rolled up, revealing a white long sleeved top underneath. Her hair was greasy and I immediately felt she needing [sic] caring for.

She followed me to the room and seemed to be quite pleased to be in the clinic, eagerly looking around as we walked. Suddenly aware of how long the route to the room is, I was anxious to get there and start.

In the room, I sat down and waited as she stood in the middle of the room, quickly took a look around, then slumped on to the sofa. As she did so, she stretched and yawned, looking much younger than she is.

Therapist 2, 1ˢᵗ session

This emphasis on vulnerability continues through to what was to become their last session together:

Process Notes
Not in Recording

When I went to collect her, I was surprised to find her sitting on her own in the w/a, looking quite sullen without her friend Lucy, who has become her regular companion to the sessions. However, she also looked as if she was taking better care of herself than usual. She had make-up on, lots of mascara and dark eye-shadow accentuating her big brown eyes. Her hair was shiny and clean, though she had wrapped it around her forehead into quite a strange style – I wasn't sure if she meant for it to be this way – which made it look like she could pull down a kind of hair-visor over her face and hide if she wanted to. She was dressed in her usual coat zipped up tight as always, but this week she had thin black leggings on, which made her look even skinnier than her usual jeans do whilst showing off more of her body than I felt most fathers would want their daughters to be showing off. I wanted to give her some proper clothes to put on.

Therapist 2, 15ᵗʰ session

As we have seen, Therapist 2's process notes diminished the level of violence his patient described. The above extracts indicate a parallel process of highlighting her vulnerability. It would appear that these two processes may interconnect, and that the very awareness of vulnerability limits awareness of violence. This tendency to notice the patient's vulnerability at the expense of recognising her violence appears to be determined by the transference dynamic. In the extract above, the therapist's mind goes to how fathers would want their daughters to be dressed; indeed he himself seems to be regarding her with a paternal eye

– taking pleasure in the fact that she looks better, but wanting to protect her by making her cover her body more. The therapist seems, in this, to become an ideal father who is able to both appreciate and protect his daughter. This is the transference position which appears to dominate the therapy: a vulnerable daughter relating to an idealised, protective father. The therapist was, to some extent, cognisant of this position, as he said in his interview:

I was aware of lots of feelings of really wanting to take care of her and it felt more paternal, but given her family I wondered actually if it was actually much more maternal side … very parental, I would have been quite happy in one way to sort of take her home and look after her properly.

What he was less aware of – what is therefore unconscious – was what the powerful pull of this transference position restricted his capacity to notice. For it seems that the very fact of being in the idealised father position serves to impinge on the therapist's ability to take enough note of the other more aggressive aspects of the patient, as demonstrated by their absence from the process notes. As the therapist said in his interview: 'I got the sense that the violence was more around her and she was the peacemaker when the boys were fighting.' This is not necessarily a failure on the part of the therapist, so much as an indication of just how powerful transference dynamics can be.

As with Therapist 2 and his patient, there are clear implications of links between the transference relationship and what remains unnoticed in Therapist 3's sessions, but this time with the pull towards an ideal maternal transference. The patient's mother has a significant presence in the sessions, with the patient often talking about her and, importantly, the therapist often introducing her in to the conversation (for a fuller discussion of this see IV.vii.). The patient represents herself as consistently ignored by a mother who is only interested in her brother. In the long extract in

section IV.i. (see page 59) where the therapist seeks to persuade her patient to get more help from the teacher, it is clear how keen the therapist is to help her patient talk successfully to her teacher. She does this by challenging the patient's objections and coaching her in alternatives. The thrust of the interaction is to guide and suggest practical solutions, much as a helpful parent would. In the course of this she makes nine suggestions about what could be said or how the teacher could be approached: 'But if you know find a little bit softer words for that you know…as if "I haven't understood every" […] I think that's acceptable' and 'You can think about it and the one you're feeling most confident with you can try'. In doing so, she positions herself on her patient's side: '*we* can find another word' (my emphasis) thus acting much as the patient seems to wish her mother would; as engaged and supportive.

As discussed earlier, the recordings from Therapist 3's sessions demonstrate high levels of mutual laughter, which is not recorded in the notes (see page 82-83). A further example:

Recording	Process Notes
Patient That's why I've always had a belief in ghosts. *(Both patient and therapist laugh)*. But Beth, oh my god, Beth's got a ghost it always follows her. She's like, she slept at Richard's house, her boyfriend's house, Richard woke up in the middle of the night and he was just like: 'Beth there's a black shadow', oh it's freaking me just thinking about it! I won't be able to sleep again. *(Both laugh).* Cos Beth's like telling me there was this person who used to live next door who died and he used to hate her brother, she always sees this black shadow standing by her brother's bed who'll then like kneel down by her brother, staring at her brother, and like now that they've got separate rooms she'll always like wake up in the middle of	Beth got a ghost. She will not be able to sleep this night if she tries to remember but she goes on anyway. Black shadow.

night and there'll be this black shadow standing at the foot of her bed and she thinks it's the man who used to live next door because he used to hate her brother and he used to love her and everything he used to give her sweets and stuff ,'hello!' *(Patient laughs)*. And just stuff like that and Richard woke up one time and was like 'Beth there's a black shadow staring at us.' Creepy, but, yeah, Beth wants me to go sleep round hers one day, I'm just like 'but the ghost'. *(Both laugh)*. But it's all right, Beth's my piss up buddy. *(Both laugh.)* Mum'll have to talk to her and she'll be like: 'She's not going out'

Therapist   Is she accepting of the friends?

Patient   I don't know I talk about her a lot in good ways. *(Patient laughs)*. 'Oh my god, I love Beth, we had so much fun today.' *(Therapist laughs)*.

Therapist 3, 14th session

There is much laugher on the part of both the therapist and the patient. The overall impression is of a friendly, indeed even cosy, interchange enjoyed by both parties, yet this quality of the interaction is entirely omitted from the process notes, as is the sense of therapist's laughing presence. The mutual laughter conveys a sense of closeness, and when taken in combination with the supportive approach, this could indicate a pull towards an idealised maternal transference. Furthermore, the topic of a scary ghost remains unexplored, possibly because its darker implications jar against the dominant emotional tone in which the patient invites the therapist to share in an entertaining story with her.

As with Therapist 2, the idealised parental transference seems to linked to 'blind spots' for the therapist: first, noticing the presence of the idealised transference in action (the omitted joint laughter in the notes), and secondly, noticing aspects of the patient's personality which do not fit

within this paradigm. Thus, as we have seen, violence, painful experiences with friends, scary ghosts and sexualised interactions – being 'touched up' by peers – become lost or diminished in the process notes.

Although the main pull appears to be to enact an idealised transference, there is a further maternal transference at work in these sessions. As the therapist notes in the first session:

Recording	Process Notes
Therapist Does she realise that you are angry with her? No? Patient I don't even want to bring it up in conversation cos I know how that will go. Therapist I think that's still a striking thing for me, you know that your mother is not aware of how you feel, how you, what's going on in yourself and that must make you angry I guess. Patient It used to. I got used to it. *[Long pause]* Therapist What do you think?	But does it make her not angry that mother doesn't realize how she feels inside? Not anymore, she got used to it. During a long silence I am thinking what it means for me, am I the mother who does not realize how Casey feels?

Therapist 3, 1ˢᵗ session

The second, underlying maternal transference posited here is a re-enactment of the patient's external mother as she perceives her. Indeed, the presence of the more prominent ideal mother transference actually, in utter contradiction, enacts this second transference. Thus the patient's complaints that her mother ignores her become partly re-enacted within the sessions for, as we have seen, the ideal transference seems to make it harder for the therapist to note some more painful experiences. In addition, the dynamic of turning away from the patient appears to enter into the sessions in more subtle ways; for example, the therapist represents others

to the patient quite a lot, but seems to spend less time presenting the patient to herself, as here: 'And what do you think your brother means that you can do better, what does he think?' and 'Do you think she [mother] was quite scared, from what happened?' (1st session). These questions are not recorded in the process notes; perhaps indicating that this is not something the therapist is consciously aware of.

Analysis of the recordings and process notes from Therapist 1 and her patient also indicates a pull into an idealised relationship. The transference relationship with the strongest pull in Therapist 1's sessions seems to be between the patient and an idealised mother whom she can only imagine being an elder sister, rather than a mother from a different generation. Thus, in this maternal transference, the therapist is positioned more as an idealised elder sister who will chat in a friendly way with the patient. The therapist in her interview seemed to be aware of this to an extent:

Her transference, I think to me, was a friend, that was the first, she was relating to me like an older, wiser friend and she was having very overblown hopes which she directly voice[d] of this turning her life around and at the end of the therapy living happily ever after.

The therapist is aware of how hard this transference made it for her to 'elicit the negative transference' and reported very much enjoying working with the patient, saying 'I did feel quite energised and I did look forward to [the sessions], she was really a pleasure to be working with, because you could really see from each week, I could see a development.' Whilst the therapist was clearly aware of the need to seek out negative transference, as well as negative countertransference, it may be that this pleasure in a patient who developed and the pull into the idealised transference role made it harder to notice the uncomfortable aspects of this position. Again this transference relationship relates to elements of the sessions which become forgotten in the process notes, for example:

Recording	Process Notes
The patient says 'exactly' 35 times throughout the session in response to the therapist's comments.	There are four times the patient says something like: 'yes she thought that was right' or just 'yes' in the process notes.

Although the patient does agree with the therapist in the process notes, the word 'exactly' does not appear in the process notes and there is no sense of the frequency (on average every minute and a half). In the light of the idealised elder sister transference, it may be that the repeated 'exactly' becomes uncomfortable, as if the patient is trying to adhesively identify with the therapist, by agreeing too quickly with the admired older figure (Meltzer, 1975). The patient's use of 'exactly' may also convey her search for an 'exact match' with her therapist, in which she would not be disappointed by her therapist.

From the start of this therapy it seemed to be hard to end the sessions on time, as if the reality of the limit of 50 minutes was difficult for this patient:

Recording	Process Notes
Patient Yes, I don't want to turn out like he is. I think I'm more like my mum. Oh, wow, we've gone over our 50 minutes. Therapist We've gone over a minute, but we were in the middle of conversation, but yes, we're going to have to stop there. Patient That's fine. Therapist So I'll see you again next week and we'll always be meeting in this room, each Friday. Patient Okay. Therapist What I'll do next week is I'll	We both noticed at this point that we had gone a couple of minutes over time, which surprised and delighted her. I felt very hopeful about her at the end; it feels as if the timing of the therapy is right for her and she's not actually currently in the grip of depression but determined to free herself from it and move forward.

Recording	
bring a calendar in because I need to tell you about my Christmas break, because Christmas is coming up in about a month, so just to let you know the dates. Patient Yes.	

The notes emphasise the patient's pleasure in having gone over the end of the session, and, as the following extract demonstrates, it continued to be hard to end at the correct time:

Recording	Process Notes
Therapist We're going to have to stop talking. We've done it again, haven't we? Patient It's always the same. [Overtalking]. Therapist We've decided to always go two minutes over. Patient Yes, it's becoming our routine now. Therapist So I'm going to see you not next week but the week after. Patient The week after, yes. Therapist Okay.	We had to stop there – having gone a minute or so over time as seems to have become a pattern.

Therapist 1, 4th session

This struggle with the therapeutic boundaries may represent a pull towards the more relaxed, informal sibling mode and a conversation that is not bounded by a professional time frame.

In keeping with this there is also a pull towards being very conversationally chatty with this patient. This is not captured in the process notes, which may indicate that the therapist is less aware of this aspect of the transference dynamic:

Recording	Process Notes
Patient No. I think I know where it is, though. I think it's at my mum's house. Therapist And whose house are you in this week? Patient This week coming now I'll be going into my mum's week, but I was at my dad's week. Therapist It's quite extraordinary. I've never quite heard of anything like that; somebody staying one week at their mum's house and one week at their dad's house. It must get quite confusing. Patient It does sometimes.	I asked whether she was at her mum's or dad's this week. She said she had been at her dad's all week but was now going to her mum's.

Therapist 1, 1ˢᵗ session

The unnoted use of a more conversational tone seems linked, in part, to times when the therapist may have anticipated potential criticism from the patient, here about a perceived failure to give the patient enough time or letting her down and leaving her on her own – actions which would not fit into the ideal elder sister transference:

Recording	Process Notes
Patient I'm really sorry I couldn't come last week. I was just so busy with work because they gave us extra work to do because we didn't have college. Therapist Is this over the half term? So you had more work than usual? Patient Exactly, yes, because as well as that we had to catch up on other things that we were doing. So it was just so much I didn't get time for anything. I certainly didn't hear from any of my friends last week. Therapist Really? And you were going to do quite a bit of that, weren't	She went into a lot of detail about her different projects and I was finding it hard to think, it felt like being bombarded with a barrage of words.

you?

Patient   Yes, I was. There was just no time for it.

Therapist   Didn't have a proper holiday.

Patient   Exactly. It was just a lot of work, and I think it went really quickly as well because, usually, we need like a week to get into the whole like holidays and then have a holiday but I think there is one coming up soon, Easter holiday.

Therapist   The Easter holiday is coming up in April. That's right, yes.

Patient   Ah, it's still quite far.

Therapist   So there's still a whole month to go.

Patient   Yes.

Therapist   That's quite bad though, isn't it, that they give you so much work over the holiday?

Patient   I know. They do give us a lot.

Therapist   I mean, just to say from the point of view of the therapy, because it was a session cancelled by you but offered by me, we do need to count it. But that session... Like next week, I don't know if you remember that next week is a week when I'm not here. So that won't, that's not counted in the numbers.

Patient   Okay.

Therapist   So you've spent the whole week just doing work, obviously?

116

It is interesting that at the point when the therapist feels most under attack by what the patient is saying — and I would argue by the unspoken attack in the missed session and complaints about the cancelled sessions — she starts asking lots of questions herself and involves herself in quite a chatty way with the patient's world. It could be that the questions are the therapist's attempts to protect herself against the feeling of bombardment or her way of seeking to make the bombardment manageable; alternatively it could be that in the questions the therapist has unconsciously become drawn into the patient's own transference-wish to be sisters chatting together about the difficulties. In the recording the therapist also seems to join in with the patient's view – criticising the college for giving them so much work. This is not captured in the process notes, as if perhaps the therapist did not realise that she had entered this position or did not wish to reveal it.

Thus, we have seen that being pulled strongly into a transference position can lead to discrepancies between the process notes and recordings which reveal how hard it is to notice such pressure. The comparison between process notes and recordings has indicated that changes also occur when there is an element of the transference and resulting countertransference that is too difficult or painful for the therapist to consciously accept. To return to Therapist 2 and the problem of his patient's violence: as discussed, the patient's descriptions of violence are marked by a prominent sense of a physical presence that the summaries in the process notes tend to diminish. There is a further example of physicality in these patients' sessions, which though far less frequent is striking: that of the patient's sexuality and sexual transference. There is one instance of this that is strikingly present in the process notes, where the patient's body language is captured:

Recording	Process Notes
Patient And I don't even have privacy when I'm in my house. If my	She stretched back, arching her back in a seductive way

door's closed people just open the door, I'm like, 'where's the knocking?' I was like, 'for all you know, yeah, I could have been getting changed and you lot have just walked into my room, you can't be doing that'. And like, if it's to my mum's room, if I walk in she has a go at me, so I have to walk back out and knock. I'm like, 'then why can't you lot just start knocking on mine?'	whilst looking me in the eye, then carried on. "When I go into her room without knocking, I have to go out again and knock, but she just walks straight into my room. I don't have my bubble anymore."

It is interesting that the therapist does not record how he felt in response to what may have been quite an awkward moment. Furthermore, the connection between her 'seductive' body language and what the patient is talking about is not commented on or brought into the transference. The patient discusses intrusions into her bedroom, as if both testing whether the therapist would be as intrusive as her family is described to be, and inviting him to some form of sexually tinged intrusion, testing perhaps whether she can excite him.

Whilst it is mainly violence that carries excitement, there are other brief indications of something more explicitly sexualised as part of this violent excitement, not captured by the process notes:

Recording	Process Notes
Patient [Discussing cousin's attack on Lucy where he attempted to strangle her and other cousins intervened]… And all they were going to do was punch him so that he knew to let go, because she's a girl, you can't really do that to people that you don't know. Obviously I know he's younger, but he fancies her as well, which made it harder.	She was talking about being at an Uncle's and her cousin had strangled her and there had been a big fight between her and her cousin where she had lost her temper.

The elements of sexual attraction, fancying, and violence become intertwined in the cousin's attack on Lucy and may contribute to the intensity of the feelings around the attack. It is noticeable that the element

118

of sexual attraction is not captured within the notes, as if that were hard for the therapist to observe.

The recordings also capture moments in which the patient shows awareness of the therapist's physical presence:

Recording	Process Notes
Patient Like obviously you're young, well I'm young, you're not, I am young, so… and like people, like my mates their mums really trust them, like obviously if they're in the house their mum will give them like a can of one beer, that's it, because she trusts them, she knows that she's not going to be stupid. My mum won't even give me a drop, that's how bad it gets. My mum doesn't trust me.	She still feels that her mum doesn't trust her. She said that she didn't really understand why, although she thought that it was something to do with her mum finding it hard to let her go. We paused to think about what she had said, but I found it hard to think. All I could say was that it reminded me about her telling me before that her mum called her a lot when she was out, which made her feel like a kid.

Therapist 2, 9th session

The patient comments on the therapist's age; trying to work out which generation he belongs to, hers or her mother's. Whilst this is not overtly sexual, it does relate to physicality – what the therapist looks like – and the fact that on some level she is trying to identify where he sits generationally could relate to how possible it would be for her to be his partner. This discussion of age also relates to boundaries being broken – underage drinking – and therefore could imply a question of whether the therapist too would break boundaries or whether he, like her mother, would maintain them. This becomes forgotten in the notes, perhaps because it feels uncomfortably close to the therapist. In a different session the patient also comments on the therapist's height:

Recording	Process Notes
Patient [Discussing times she has interfered with attempts to rob people]. And then I was with, my friend was with two of her friends, and one of them was the one that wanted to rob people, and I was with two of my friends and my friend had, like, you know them Doctor Dre Beats headphones, and he had a Blackberry Torch and they wanted to rob him. I was like, you're not going to rob him because he's with me, you don't see them robbing you, like, and like the guy that wanted to rob him was like, your height but he's only, what, 15, but we stopped him.	She went on, "two weeks ago, I was with this boy who was proper mad and just decided he was gonna rob another friend of mine – they had them Dr Dre Beats headphones and a Blackberry – but I told him that this boy was with me, so he couldn't rob him and told him to pick someone else. He said 'you all need to stop stopping me' and got all moody, but we stopped him. So I guess it was ok."

Again the mention of the therapist's physical presence is not recorded in the process notes, and again it is mentioned in connection with the threat of breaking boundaries – this time through stealing from others.

In the following extract the patient's physical presence and the attention she draws to it is felt by the therapist to be a distraction which he wants to move away from. It may be that this is part of the same difficulty with noticing anything that could be sexual within the sessions:

Recording	Process Notes
Patient   Now what am I looking for? But I was just in the shop looking about 10 minutes for my 50p, I couldn't find it. And now I can't find my other thing. I bet she's got it.

Therapist   She being Lucy?

Patient   Yeah, ooh, I've got a missed call, my mum. Whoops! I've really lost it.

Therapist   What are you looking for?

Patient   My Vaseline, she's got it. She gave it back to me though. I can't come out without Vaseline, I found it, I | While I was speaking, she was fiddling in her pockets, pulled out her phone and noticed she had a missed call from her mum. She said "oops" then put her phone back in her pocket and told me how her cat had scratched her in her sleep during the night. She pointed to her lips to show me where and started to put some Vaseline on it. I felt we were getting distracted, so I brought her back to the issue of change in time, and told her that I don't actually have another time |

can't come out without my Vaseline. And my cat scratched me last night, there. Therapist What happened? Patient Well I was sleeping and I think that my cats were hungry, and they were all in my room, because I was the only one asleep, I mean the only one that was awake in my bed. And then as I was just about to fall asleep, one of them jumped up and just scratched my face. So I weren't happy. My mum just laughed at me. So I woke the whole house up anyway.	after school/work at the moment, and at least until Christmas.

Therapist 2, 9th session

There does seem to be a question about how much physicality and sexuality can be thought of; in his interview the therapist said:

The only time I would have been shocked [in the session] was when she was fiddling with her clothes and exposing herself in a minor way. When she initially did that I thought: "What's going to happen here?" and then it became clear that it really wasn't that, so then the shock goes away.

When asked more about this he said:

I think it was more infantile, there were times when she'd pull her top up and play with her belly button, but it never felt like she was trying to seduce me at all, it was more like a little kid getting to know their own body, but it obviously still feels awkward being in the room with that as a man with a teenage girl on your own.

For the therapist this disturbing sexuality is briefly acknowledged and then moved away from: 'She just didn't seem aware of her adolescent body'. It seems striking that whilst the therapist acknowledges his own anxiety about her physical presence he is quick to move away from anything sexual in it. It, therefore, seems likely that the therapist's

countertransference response to these physical behaviours was one of discomfort, which would link to the differences between the recording and process notes. In addition, it may be that the undercurrent of unmetabolised sexual transference acted as a further pull for the therapist towards the idealised father transference, as the father position would have helped protect against any possibility of the sexual trends. The ideal father position would, in turn, serve to restrict the therapist's capacity to note any potential sexual transference.

For Therapist 1 the pull of the idealised transference also provoked painful or difficult countertransference feelings which may have led to the therapist forgetting certain aspects of the sessions. These countertransference difficulties seem to have cohered primarily around the potential for guilt about not being able to provide the patient with enough, for example, the difficulty of finishing sessions on time. In the session studied which did not run over the therapist records the following:

Recording	Process Notes
Therapist We're going to have to stop. Patient Yes. Therapist But, so, we're going to meet again in two weeks time, yes? Patient Okay.	I felt cruel for having to interrupt her in mid-flow to say it was time to stop – and guilty for not being here next week.

Therapist 1, 11th session

By phrasing the reminder about the next session date as a question the therapist creates some sense of reassurance that the end of the session is not a permanent ending, for she reminds the patient about the next session and receives the patient's agreement. This need to create reassurance could be a response to guilt on the therapist's part, both about the unusual break in sessions (she took holiday that did not fit within the normal school holiday pattern) and about stopping the patient before she appeared ready to finish. That this need to reassure and remind is not

included in the process notes supports the contention that the painful feeling of guilt is managed by being forgotten. In an earlier session, the therapist also had to face difficult feelings in relation to cancelling sessions at times which, again, did not fit with the school calendar:

Recording	Process Notes
Patient Yes. I got the letter and I talked to my mum and she said that I couldn't do 30th December. Therapist Okay. Patient Not that day. Therapist Okay. But maybe not next week. Patient Oh no. Therapist Okay. Is anything happening next week? Patient I think it's just because it's Christmas Eve, isn't it? Therapist It's not quite Christmas Eve. Patient Isn't it? Therapist Well, it's the day before Christmas Eve, it's 23rd. Patient Yes. I think that she wants to take me out or something. Therapist Okay. That's why [unclear]. And are you okay about that? Patient Yes, I'm okay. Therapist Yes. I think that's still... that's good that you can do one of the weeks because otherwise it would be really quite a long break, and it might	Her false smile returned as she became anxious about the silence. Oh yes, she said, she had got my letter with the holiday dates and she'd talked to her mum about it, who had said she could come on the 30th, but not next week because that was xmas eve. I said actually it was the day before xmas eve but I could see it was perhaps too close to xmas – though I wasn't quite sure whether for Pavni or for her mum. Pavni said she thought her mum wanted to take her out that day, she'd arranged it all. The fixed smile stayed in place. I said I thought she was talking about something being wrong and annoying in a roundabout way – the weather for one thing, ruining her hair (she laughed), but also my holiday which was all out of synch with hers. She nodded very slightly then put her fixed smile on again and asked was it okay then for her to not come next week but to come on the 30th? I asked was that what she wanted to do? Yes it was, she said quite definitely. I said in that case I wouldn't count next week's session as one of her 28, as it was true that my holiday dates were quite

feel a little bit strange, we have a fortnight's gap then between now and next time and then we'll have another fortnight's gap but I think at least you've got that session in between. Patient Yes. Therapist Good. Okay. And what we'll do is, because it is partly because I'm taking my holiday at quite a different time than people usually would, so we won't count next week's session as one of the 28, you know we're going to have 28 of the sessions, so we won't count next week's. We'll just have that as an extra week, yes. Patient The research workers came this week.	awkward. 'So I'm getting an extra one!' Pavni beamed with delight. I said that was one way of looking at it I supposed although not strictly true – it looked as if she wanted to look at it in a positive way. Pavni insisted this was what it felt like, so she was happy about that. I said I was glad she could come on the 30th, because that way she wouldn't have a very long gap when we had only just recently started. She nodded.

Therapist 1, 4th session

In both the notes and recording the patient introduces the idea of cancelled and missed sessions via the letter about Christmas break dates, however, they are dealt with very differently in each. In the process notes there is the transference interpretation about the patient's annoyance, but any idea of annoyance is then outweighed by the patient's reaction to hearing she has a replacement session, behaving as if this were almost better than never having had the session cancelled ('beamed with delight'). This interchange does not have any parallel in the recording, where neither annoyance nor pleasure at the change in sessions is commented on. Whilst it may be that the therapist has written in undercurrents that were present, it also seems likely that the pleasure the patient is given in the process notes at the extra session is a way of mitigating any feeling of guilt the therapist may have had about the cancellations.

The material relating to guilt about not being there enough for the patient finds a parallel in the patient's own yearning to be close to her family:

Recording	Process Notes
Patient   Exactly. There's not enough time in the day. Because I wish that we could, like, spend more time but sometimes it feels like the boys that my mum looks after, they're kind of like, they spend more time as a family than we actually spend. So it doesn't really feel like we are a family because, even at my dad's house, my dad's always in and out of the house or, if he's not, there's always [unclear] or someone's always in a bad mood

Therapist   Right, so you don't really get any time where you can enjoy it [overtalking]?

Patient   Exactly. The only time we really enjoy ourselves is apart from each other and I think the other week, when I was at my dad's, and we were supposed to be going to mum's, he was talking to me the night before and he kind of admitted that he was in the wrong because he said that, whenever we come to his, he's okay for the first like day and then he says that he notices he gets grumpy and then the last day he'll realise that he made a mistake and he'll, like, be in a better mood, and he says to me that he is really happy when we're going or we've just come. | She said she was thinking about her dad – he had talked to her the other day about how he realised that he was stressed a lot of the time, and expecting a lot from her, and how he was sorry about that. Pavni had felt so guilty about that, she didn't want him to feel bad. She knew he hadn't said it to make her feel guilty but she still did, she didn't know why – she looked confused. |

Therapist 1, 11th session

The desire for quality family time is less present in the process notes than in the recording. In the process notes the patient is represented as looking after her father, whereas in the recording the patient is longing for parents who could look after her. It may be that it is too painful for the therapist to be close to this desire to spend more time with the people that matter because it reflects on the therapist's own feelings that in a time-limited study she is not able to give the patient all she needs. This yearning, whilst present in the notes, is significantly reduced.

There are several possible reasons why such a yearning may be reduced; it could relate to the therapist's sense that development would involve a healthy separation for this young person from her parents, but it could also relate to the therapist's transference position and accompanying countertransference feelings of guilt that she is not able to be there as much as the patient wants. As the therapist said in her interview:

At times countertransference wise there were a few sessions which were very very heavy and where she absolutely wanted to deny that there was going to be an end to this therapy and where she seemed to have put herself in the position where she would quite like to be dependent on me for ever more and I did perceive her as being quite cloying and really wanting to push her away and I really had to watch myself not to be quite rejecting of that aspect of her.

This shows the close working of the transference – a pull towards an ideal elder sister relationship – and the countertransference – guilt about the limitations that short-term psychotherapy involves – and how the resulting conflict is played out in the process notes as uncomfortable feelings remain unrecorded.

We saw earlier that more direct transference interpretations were written into the process notes than were made in the recordings. There are also examples in which potential transference interpretations remain unsaid, possibly due to painful transference feelings for the therapist:

Recording	Process Notes
Therapist So there's... yes, there's quite a discrepancy in, you know, what you're talking about and how you're talking about it, as... but I wonder if it's because you... you know, it's a bit difficult to actually allow yourself to feel the feelings, because if you talked about it in a serious voice, you'd probably think	Pavni had found this [an expectation that she would cook] too much – she was tired too from College, her mum didn't seem to realise this, she always said she was doing everything but that wasn't true...

well actually, that is pretty horrible. It must feel... make you feel quite angry with your mum actually. Patient Yes, I was last night and this morning quite angry because [overtalking] this morning and I did get quite upset and like tearful, so then I just had to, like, quickly get out of the house and go to college. I got here really early, been sitting for an hour. Therapist Because you didn't want your mum to see you tearful? Patient Exactly because then she starts moaning even more. Therapist Is that what she would do? Patient Yes.	I said that sounded really upsetting; Pavni must have felt upset and angry with her mum. Yes she did, Pavni agreed, with a big grin on her face. I said it was a bit confusing for me to hear her talk about what sounded like very painful and upsetting things with a smile on her face and a laugh – was she aware of that? Yes she knew it was weird, other people had told her that she kept on doing that; she couldn't stop it for some reason – she was trying to stop smiling now but couldn't...she looked quite distressed when she eventually did manage to stop smiling.

Therapist 1, 4th session

In the recording this section follows a general discussion about how the patient smiles when she talks about painful things. This then leads to a more detailed discussion about how the patient was actually angry and upset that particular morning and because of this had arrived at the clinic an hour early for her therapy session. Thus the movement in the recording is away from something habitual (albeit discussed as it's happening in the here and now of the session) to something very particular and close to the therapy that morning. However, in the process notes the opposite happens; the therapist's observation about the patient feeling angry does not develop into a discussion about how the patient felt coming to the clinic that day, but rather reverts to the general observation about the discrepancy between smiling whilst talking about sad things. This difference between the recording and process notes indicates a potential difficulty with allowing the idea of anger into the immediacy of the therapy. The therapist was aware of this difficulty, as quoted already from the therapist's interview: 'I did perceive her as being quite cloying and really wanting to push her away and I really had to watch myself not to be quite

rejecting of that aspect of her.' Once again, if the process notes were studied on their own this aspect of the countertransference struggle for the therapist would not be so apparent.

Again, with Therapist 3, we see a similar pattern of potential negative transference interpretations not being registered in the process notes (as in the sessions):

Recording	Process Notes
Therapist So he's only interested in the ones who are really participating and good and the rest is ignored again. Patient Yeah, I find his lessons boring as well because he'll be talking and I'll be sitting there just like nearly falling asleep, I'll be like 'bored now, bored now stop showing the power points and give me some work to do', it's so annoying. Therapist It seems to become a major point you know in what I can see if someone ignores you or you feel ignored it really makes you angry doesn't it? Patient I can't stand being ignored. I swear everybody's got like selective hearing in my house. It's like I'll hear everybody else and not me, cheers! Therapist But [step father], does he?	I say that ignoring seems to be a theme today since it has come up quite a bit now. She hates being ignored. [Step father] does listen to her, is brilliant, always included her.

Therapist 3, 14th session

The opportunity to explore whether the patient can allow herself to feel really heard by the therapist is hard for the therapist to notice in both the session itself and as the notes are written up. Could it be that this potential negative transference is hard to register as it is so contrary to the core transference dynamic of the idealised mother and daughter?

We have seen how complications in the transference relationship – such as too strong a pull into a particular transference and the consequent 'acting-in' to the transference, as well as therapists' unconscious attempts to avoid a painful countertransference situation — can lead to omissions from or alteration in the process notes. It is also apparent that the opposite can happen; that painful aspects of the countertransference can be given a more prominent position in the process notes and can again lead to alterations in what is noted. It may be that these painful aspects of the countertransference are more conscious than those previously discussed and are, therefore, more able to assume a dominating role in the therapist's mind. For example, Therapist 2 seems to be particularly aware of feelings of exclusion, especially in relation to the patient's best friend:

Process Notes Not in Recording
Rachel was 20mins early. When I went to collect her, I found her sitting, giggling with a friend, both engrossed in something. When I said hello, she stood up immediately, said sarcastically to her friend, "I'll see you in 50mins" and still giggling, came with me. I felt a little awkward, the giggling and their apparent closeness made me feel excluded but I was also relieved, as I had wondered for a moment if she would want to bring her friend into the session. She composed herself pretty quickly as we walked down the corridor and by the time we got to the room she was calm and her normal self again.

Therapist 2, 9th session

The therapist notices his feelings of exclusion and is aware of a worry that the patient will not want to come on her own with him; the friend seems to be felt as a threat to their therapeutic relationship. In his comment that the patient returned to her 'normal' self once she left her friend behind there is implicit suspicion about this friend, that she is doing something to his patient and making her abnormal. The process notes next indicate that the therapist then becomes very sensitive to the idea of being excluded or having things withheld from him during the rest of this session:

Recording	Process Notes
Patient   And obviously when I say to my mum that like today I was like, 'do I have to go [to therapy]?' And she was like, 'well yes'. And I was like, 'but why, what am I doing? I'm like I sit there and I talk to [therapist], not that it's a bad thing, it's just I don't feel like I'm doing nothing, but just saying rubbish'. And she'll just like, 'well, you're still going to have to go'. 'Do you know what, I'll go but at the end of the day just know that if I have to go, you have to go'. She was like, 'I'm not really bothered'. 'Fine, don't be bothered, I'm not bothered either'. And I just came.

Therapist   When you said you just feel like you come and talk rubbish?

Patient   Yeah, I do that I really talk a lot of that stuff. But I just come here and talk for no reason. [yawning].

Therapist   Well maybe it's hard to let me know what's really going on under the surface.

Patient   I don't know. I just struggle so much, you know.

Therapist   Because we could look at it in different ways, couldn't we? You're saying you've got a lot on your mind, and it does sound like there's a lot going on. So in that way it would be helpful probably to have somewhere, somebody, to kind of talk to, to try and understand things a bit more. But at the same time you're saying, well, I'm not getting enough of this, so it's not worth my while coming, you haven't been for the last two weeks. | She said that she had had a conversation with mum about coming today – she had told her mum that she felt all she does is come and talk rubbish to me. Her mum said she still had to come, so she had told her mum that if she was going to come, then her mum had to remember to go to her sessions too.

I drew her attention to 'talking rubbish' and how in one way, it seemed there was a lot on her mind, so it might be good to have a place to put some of those worries, but at the same time she feels she comes and talks rubbish, so perhaps she wasn't saying what she really wanted to, or was keeping things from me that might be the things that would help to say. |

Therapist 2, 9th session

It is clear that there is an attack taking place against the therapist in this section of the session; the patient talks about not wanting to come and only talking rubbish when she does. In the recording the therapist

responds to this attack by linking it to her difficulties with speaking to him and also to a sense that she is not getting enough therapy which makes it hard for her to engage. In the process notes, however, the emphasis has changed to what is not said and the idea that things are withheld from him. This seems to subsume other aspects of attack; it is in such a position because the idea of exclusion is dominating his countertransference:

Recording	Process Notes
Patient Nobody else knows. Lucy knows everything that's happened, she's like my best mate, I tell her everything, and she'll tell me everything. Like I know nearly everything about her family, I even know about her mum's past, like her mum's old childhood, she knows about my mum's childhood, obviously my mum used to be her TA, what's wrong, there's nothing wrong with it. Just stressed about… [Pause] Therapist Are there things that you haven't told me? Patient About?	She inflated herself by talking about Lucy, and how Lucy knows everything about her and she knows everything about Lucy. There was a longer pause, while she allowed me to think about this – I felt she was saying that there might be things she hadn't told me, so I asked if that was true. She looked at me and said, "like?".

Therapist 2, 9th session

The theme of exclusion continues later in the session:

Recording	Process Notes
Patient ……And obviously I told Lucy that, nobody's ever seen me crying. I don't know why that bothers me, like obviously 'cause I'm older now, you've still got to have like your pride and dignity, like she's the only one that's actually seen me break down out of nowhere. It's just a lot on my shoulders like my family don't ever notice. My dad hardly ever talks to me, whenever I ask my dad if I can stay at his, he's always ill, or he's always	I started to feel that there was a grievance against me, but was feeling quite admiring of her honesty. At the same time she was talking again about how her parents don't notice her, or spend time with her and how angry it makes her. She carried on for a while and I began to think that this might also be an example of her 'talking rubbish' or at least talking about things

busy, and then the next time I call up he'll be playing golf with his friends at his house. He was that busy, he can't spend your own time with your kid. You'd rather play golf. Therapist Well all of that might be another reason for coming. Patient I just… I don't know why, I just have so much, and then I get angry.	that weren't the 'core issue'.

The therapist feels excluded from a working relationship with the patient and believes that she is only talking rubbish. Listening to the recording offers a different interpretation; one in which the patient talks with what sounds like genuine feeling about extremes of emotion and distress at her father's perceived rejection of her. Whilst she conveys the impression that she is talking about things which matter to her, the terminology of 'grievance' (Steiner, 1993) and the therapist's apparent tacit agreement with her concern that she is talking rubbish seems to minimise the importance of what she says. It could be that the therapist's on-going struggle with the sense of being excluded serves to colour how he reacts to what his patient says; where he focuses on their relationship in order to counter his feeling of exclusion and therefore somewhat minimises what appears to be the patient's focus. It is almost as if the therapist cannot shake off the feeling of exclusion and this serves to empower the idea that the patient is attacking him. In this sense, the strong feeling of exclusion would appear to become a powerful countertransference more along the lines of Reich's understanding, where it is rooted in the therapist's own self (1951).

On the other hand, one could relate the countertransference to the patient's own feeling of exclusion from her parents' spheres of interest (a Heimann-esque reading of the countertransference in which the patient's experience of exclusion by her parents is projected (1950)). It seems that,

in fact, both interpretations of countertransference may be functioning at this time: the patient may be projecting her feelings of exclusion into the therapist's own vulnerability to feeling excluded, as in Brenman Pick's understanding of countertransference (1985).

A further aspect of countertransference identified in this study is the projection of the patient's wider state of mind into the therapist. As we have seen, Therapist 3's patient spoke in a determinedly lively and vivacious tone, acting out different voices and laughing frequently. We have noted that her therapist was also lively; making suggestions, representing the patient's family members' possible motivations to her, and laughing repeatedly. It may well be that in doing so the therapist was responding to a significant projection of the patient's 'manic defence' of liveliness and invitation to collude with it (Klein, 1935). As we have seen, in the process notes joint laughter is represented as belonging solely to the patient. This could indicate that there is some confusion between the patient and the therapist occurring, in which something joint becomes located solely in one side of the therapeutic dyad. In addition to these examples of shared laughter being attributed to the patient, there is an example of the therapist's laughter being misattributed to the patient. In this session, which is the first session of the therapy and follows the patient having had recent involvement with the police:

Recording	Process Notes
Therapist So I hope that next week the police is not running in our time. *(Therapist laughs).*	At the end I say that I hope the police is [sic] not getting in the way of our session next week. She laughs.

Therapist 3, 1st session

It is possible that the laughter links to the anxiety the therapist clearly, and understandably, feels about the incident in which her patient was involved with the police but which for legal reasons they cannot discuss. At the start of the process notes the therapist is in touch with this anxiety; she records that the police incident 'hangs awfully in the room without being allowed to

be touched'. Yet by the end of the session and the point of misattributed laughter there are no more comments in the process notes about the therapist's anxiety; it is as if knowledge of that has been lost. The recordings indicate that the patient seeks to defend against her own anxiety by covering it with the lively discussions about boyfriends that take up much of the later part of the session. The movement away from awareness of anxiety within the process notes could indicate that the therapist has also become involved in this; so that she no longer mentions her anxiety, nor captures her own laughter (which functions as a defence against anxiety) as she talks about the police, locating it instead with the patient.

There are further indications of possible projection from the patient to the therapist leading to confusion between the two, as evidenced in the misattribution of the therapist's ideas to the patient in the notes:

Recording	Process Notes
Patient But I had like three coffees this morning, so I'm buzzing, then I'm coming to you when I got home, sorry I'm a bit giggly. I go a bit hyper on caffeine. Therapist And too little sleep always contributes to this as well.	She needed three coffees this morning, she had not much sleep. But this night she takes her winter duvet. It makes her also more giggly when she has not enough sleep she explains almost as if she is trying to apologize for giggling here.

Therapist 3, 1ˢᵗ session

In this example, the therapist's own idea that lack of sleep is a factor in the patient's giggles becomes the patient's idea.

The comparison of recordings and process notes for Therapist 1 indicates a similar process of projection of a wider state of mind. In their first session the patient talked about her 'poor' memory, and confusion about whether some things she remembered were actually dreams rather than memories:

Recording	Process Notes
Patient So I think I'll just leave those memories and pretend it never happened, just in case it was a dream. Therapist But it sounds like you've got some of those things, sort of, going round your mind over and over again. Patient Yes. Therapist And they're hard to let go of. Especially then if you're also wondering, did it actually really happen or was it just a dream? Or I don't know, was it just a dream? It sounds like also sometimes it might be worse in your mind if it was a dream, maybe it was a really weird dream. Patient Yes, sometimes it would be, like, that weird. But I try not to think about those now. Therapist So, is this something that used to happen to you a lot but not so much anymore? Patient Yes, but not recently. Because I think if it did happen or if it was a dream, it was a long time ago, so I just have parted with that memory or that dream, whatever it is. I try and think, yes, it was a dream, just so I can part with it.	However, her memory was very bad, she didn't really remember very much from before the time they split up for good (when she was 11). Sometimes she remembered bits and then wasn't sure whether these were memories or dreams – if they were dreams they'd be weird dreams so she sort of hoped these things had really happened but at the same time she hoped they hadn't...that probably didn't make much sense, she said, glancing at me nervously.

Therapist 1, 1st session

This sense of confusion can be seen to pervade the process notes which are marked by high levels of distortion in the order of the sessions. When the process notes are read in conjunction with listening to the recording, this level of distortion lends the process notes something of a dream-like quality in which the logical links between things have become disrupted. At times the therapist comments in the notes that she cannot quite remember the session order, but it seems likely that this was not the dominant experience when writing up notes as she said in her interview: 'I have a

good memory for dialogue of how things follow on from each other, but the fact that it was recorded did make me wonder about it: "Am I making it a nice neat story or am I distorting things?"' The most striking level of distortion in the area of dream and memory comes in the 11th session where an entire dream is omitted from the notes:

Recording
Not in Process Notes
Patient   Yes. I actually had a dream, I think it was last night or the night before, that I was late to a lesson and it really worried me.
Therapist   You were worried in the dream or the dream worried you afterwards?
Patient   Both of it, because I think previously I was worried about being late to my art exam which is when we come back from Easter holidays, they want us to get to our lessons 15 minutes early for art so that we can get prepared for our exam in silence, and I think I was worried about that maybe.
Therapist   And that's what caused the dream?
Patient   Yes. In the dream I was late for my art lesson and it's a double lesson so if you're late to the first lesson you can't come in. You have to wait for the second lesson.
Therapist   Goodness.
Patient   And I managed to sneak in with, I was with someone in the dream but we managed to sneak in and she didn't notice that we'd snuck in. So I was okay afterwards. But then today I was waiting for my friend because we were going to go to art together and she took quite a long time to do her chemistry work. So I was getting a bit worried is my dream coming true.
Therapist   I don't know [overtalking] your dream would come true and you would just sneak in.
Patient   But we got there just in time so that was good. That was lucky. Yes, I think I dream about things quite a lot like that and I dreamt quite a lot about being late to college.
Therapist   So lots of dreams about being late.
Patient   Yes.

> Therapist   And it's not a new theme in your dreams, do you think, about worries about being late?
>
> Patient   Yes, I think I've always been worried about being late but it's more important now. It kind of comes out now.

There may be several reasons why this dream is not included in the process notes: it comes near the start of the session where the therapist has noted a feeling of being bombarded, which may have meant there was too much for the therapist to hold on to; this session also took place between missed and cancelled sessions and the dream with its concern about being late and not getting in may be the patient's way of talking about her anxieties about these sessions, in which case the dream may have been forgotten because it touched too closely on the therapist's feeling of not being able to provide enough. Finally, it may have been forgotten by the therapist because the therapist has had the patient's own state of mind of confusion over dreams and reality projected into her and is acting-in with that.

The final aspect of the countertransference which may lead to material from the sessions not being included in the process notes is when countertransference belongs just to the therapist; in particular where there is significant overlap with the therapist's own life. It appears that at these junctures the similarities may pull the therapist out of role and therefore lead to things being forgotten:

> Recording
> Not in Process Notes
>
> Patient   Exactly, and it feels like, because especially now with vegetarian, because I have different dinners from everyone else, it seems like they get theirs made but I have to do mine separately at both my mum and my dad's house because they don't really cook vegetarian food. So they're buying the stuff but they expect me to do it. Like my mum, she bought loads of vegetables without telling me but she didn't specifically buy the vegetables that I eat or that I asked for because, if she'd asked me, I would've told her stuff that I would know how to cook with. So she bought stuff that I don't know what to do with. So she was moaning at

me, saying 'I've got all these vegetables for you and you never really eat any of them'. I don't know what to do with them. Because she was supposed to make, or for the last three days she's been saying how she'll make, that she bought this fish and she's going to make it for us, or for me because I don't eat the meat that she makes, and it's still there. And now I'm going to my dad's house so...

Therapist   Yes, so she hasn't made it.

Patient   Yes. So I've been making my own kind of stuff, like bells and crabsticks. My mum brought home vegetable rice so I just throw some crabsticks in there and eat that.

Therapist   But that's difficult as well because you're changing and then your mum and dad find that difficult, I suppose, as well to accept.

Patient   Yes, exactly. Yes. And it still feels like I'm pushed towards eating meat, like I'm always offered, like, to eat meat if I'm ill. My mum and dad will be like I think it's because you're not eating meat, have some meat, and it's really hard.

Therapist   But you've really stuck to it.

Patient   Yes. It's been almost two months so I'm quite happy with that.

Therapist   Yes

Patient   I have to keep doing it.

Therapist   And you're feeling, are you feeling better for it?

Patient   Yes, I think I am.

Therapist   It's harder because you have to do your own food.

Patient   Exactly but, because it's, every time I like try and mention how happy I've been doing this to my family, they're like, well, it's not really anything because you're going to have to do this for the rest of your life if you want to. So it feels like it's nothing. I've got loads of time, I've got a long way to go. I feel okay about that but I'm still trying to justify.

Therapist   That's hard though, isn't it?

Therapist 1, 11th session

The substantial discussion of vegetarianism is not mentioned in the process notes. The therapist adopts a sympathetic and indeed encouraging stance towards it: 'But you've really stuck to it', 'It's harder

because you have to do your own food' and 'And you're feeling, are you feeling better for it?' In this the therapist could be seen to become the supportive mother whom the patient is clearly missing, and one could argue that having been pulled into that role the discussion has been harder to observe and is not recorded in the process notes. But it may also have been forgotten because it represents a moment of strong parallel with the therapist's own life; the therapist is a vegetarian, and this genuine personal shared interest in vegetarianism might mean that the therapist is out of role for personal reasons – no longer observing as a therapist – and therefore less able to remember the discussion.

IV.vi. Relationship Between the External Parents and the Transference

Money-Kyrle writes that 'the analyst's unconscious can hardly fail to respond in some degree by regarding the patient as his child' (1956: 360). This study has seen that to be particularly the case with Therapist 2 and Therapist 3, where the dynamic appeared to be quite directly that of an idealised parent / child relationship. All the patients whose sessions form the basis of this study were experiencing insufficient parenting and it is clear from their interviews with Therapists 1 and 2 that they were aware of this; Therapist 1 commented:

There were a lot of external family factors which were contributing to the way that she was feeling … She had depression but there was a lot, I mean, really completely inadequate parenting; a father who was really quite seriously mentally ill as well as possibly smoking marijuana in quite a big way and a mother who was functioning on the level of a teenager.

Therapist 2 stressed the level of deprivation his patient had suffered with an absent father, a mother who was 'out of it', and her experience of needing to 'grab whatever scraps of nourishment' she could from her parents. This raises the question of how much of the transference

relationship stems from the therapist's awareness of the external parent's failings, as well as from the unconscious needs of the patient. In this it may be that the child psychotherapist is faced with a more complex task than the adult analyst, since a more conscious impulse to mitigate the – often on-going – limitations in parenting combines with an unconscious impulse to see the patient as one's child, so creating a transference / countertransference dynamic strongly influenced by the therapist's relationship in their mind to the parents. This powerful combination may have even greater power to induce the therapist to 'act-in' to it, in some hope of rectifying the external poor experiences.

We saw that for Therapist 3 the core transference dynamic was an idealised maternal relationship. The comparison of process notes and recordings appears to indicate that this pressure was not consciously registered by the therapist; as key indicators of it such as the joint laughter did not feature in the notes. Although there is no interview with Therapist 3 to confirm her views about her patient's mother, it is clear that, at least in the early stages of therapy, Therapist 3 receives a strong message from her patient that her mother ignores her:

Recording	Process Notes
[The patient tells a story about her step father having injured himself at work and struggling to get a sympathetic response from her mother.] Therapist So how does someone usually get attention from your mum, apart from cutting their finger? Patient Oh he [Step father] doesn't get attention. Therapist He doesn't get attention? Patient I don't know.	After a small pause, I wonder how someone gets attention from her mother. Oh [Step father] gets never attention from her, she laughs while telling me so. How does she get attention from her mother? She thinks about it and then says by doing bad things. She feels often ignored by her mother. So getting Mum's attention is something she shares with [Stepfather]? Yes. And how about Josh [brother]? By making her laugh.

Therapist How do you get attention from her? Patient By doing bad things. Therapist Really, and otherwise she would not be really accessible or...? Patient No, she, always her and Josh [patient's brother], it always has been. Therapist And does Josh then attract her attention? Patient Mum's? By making her laugh. [Patient gives an example of when she felt that her mother was ignoring her and talking only to her brother whilst they were watching TV.] Therapist So you and [Step-father] are the ones who have to invent things to get the attention?	

Therapist 3, 14th session

The patient's message is clear: her mother is not interested in her and prefers her brother. In contrast the therapist is interested in the patient, asking questions about her relationship with her mother. As we saw in the long extract in which she encouraged her talk to her teacher in IV.i. (see page 59), the therapist is anything but the disinterested mother and is very involved in trying to help her. We can now consider a further potential reason for this: it may relate to the therapist's sense of the external parents; the wish to help the patient is even greater when it seems the patient will not be helped at home.

We saw that for Therapist 1, one of the transference / countertransference dynamics which seemed hardest to record in the notes concerned the patient's wanting more from her than she was able to provide. The difficulties of capturing this in the notes were considered in terms of the

therapist's attempts to manage guilt in the light of the limited number of sessions. We also saw how this dynamic may have been given extra weight through links with the patient's desire to be part of a family which spent more time together, a desire which was also reduced in the notes. To return to the earlier example:

| Recording |
| Not in Process Notes |
| Patient   Exactly. There's not enough time in the day. Because I wish that we could, like, spend more time but sometimes it feels like the boys that my mum looks after, they're kind of like, they spend more time as a family than we actually spend. So it doesn't really feel like we are a family because, even at my dad's house, my dad's always in and out of the house or, if he's not, there's always [unclear] or someone's always in a bad mood

Therapist   Right, so you don't really get any time where you can enjoy it [overtalking]?

Patient   Exactly. The only time we really enjoy ourselves is apart from each other. |

Therapist 1, 11th session

The therapist's sense of her patient's disadvantageous parenting seen in her interview may drive her to a position in which she wants to be the parent (or elder sister) who is there enough in order to rectify the parents' failings. This desire is brought into conflict with the knowledge that as the therapist she could not be there as much as the patient might want, and in turn serves to limit not only, as we have seen, how much this was taken up directly in the transference, but also how much of this patient's unmet needs the therapist is able to record in the notes.

Not only does the comparison between process notes and recordings illuminate features of the relationship between the therapists' feelings about the patients' parents and the transference, but it also indicates how the process notes themselves may become a vehicle for working out different aspects of the therapists' feelings about the parents. The notes from Therapist 1 indicate the strength of her concern about her patient's

father's state of mind, since she records her 'heart sinking' when she heard about the father's paranoia (1st session). There are further indications of the strength of the therapist's response to the father:

Recording	Process Notes
Patient   Yes, because [my sister] hates it even more there [at father's house]. She doesn't... like, dislikes it a lot more than I do, so it's even harder for her to stay there but she's only doing it to avoid her responsibilities and chores and things like that, yes, but I think she'll come round to [unclear]. Like, when my brother goes there, sometimes he does the same thing.

Therapist   Does he? | She had said she [her sister] was going to stay there for good, although Pavni didn't think she would as 'she hates it there even more than I do'. I must have looked slightly taken aback as she immediately corrected herself saying she meant her sister *disliked* staying at dad's even more than she did. She smiled fixedly. I said 'hate' was quite a strong word to use...'too strong', she decisively interrupted, she hadn't meant that. She laughed nervously, wringing her hands. |

Therapist 1, 4th session

The therapist assumes she looked 'taken aback' at what the patient said and then writes into the process notes that she said 'hate' was a strong word to use — which is not in the recording. This serves to magnify the impression of the therapist's awareness of how strong the hating feelings were and demonstrates how the therapist's feelings influence the process notes.

The most extreme expression of negative feeling towards the patient's father comes in the notes to the 11th session where the therapist writes: 'I felt quite horrified at the level of this man's disturbance, and hoped it wasn't showing in my face.' Yet at the same time as capturing the strength of her concern about the father, the process notes from that session also depict a contradictory urge in the therapist, one of presenting the father in a better light in the notes than in the recording:

Recording	Process Notes
Patient　　　　My dad's birthday is coming up and for Christmas my dad, I was going to get him something but he told me he wanted something else and to give him the money when he got it, and he didn't get it in the end. And I tried to help, still going to get it, I'm going to get you a birthday present, and he kind of got a bit like grumpy and saying that the pocket money that we give him, whenever we buy presents, we're always kind of scrimping to get money. And I'm trying to explain that I do have money because I'm saying, but not for things like this, and then he says: "Oh well, when I was a kid, I had loads of money and I saved all my pocket money and I never needed to buy any drinks or anything after school", and he'll say how he saved up £200 or something once. So I'm thinking I'm not a big saver like you. So, but I still can save and he was kind of, I think, a bit, maybe he tried to like make me feel that he wasn't upset but I had a feeling that he was upset because my brother and sister kind of started forgetting about birthdays and Christmas and stuff and he says that I'm the only one who actually gets him something and who makes a fuss of it and I shouldn't because my brother and sister don't.	She said it was her dad's and her brother's birthday soon and she didn't know what to get for her dad, it was really hard, he kept telling her off for getting him something although she knew he liked it really – he had told her she was the only one who remembered and bothered getting him something.

Therapist 1, 11th session

The changes between the recording and the process notes diminish the level of complaint from the patient's father, and make him seem more appreciative: the patient is made to say that she knows her father really does like presents, which is a stronger assertion than in the recording where her father becomes 'grumpy' and is not grateful at her insistence that she will get him a present. In the session below there is a similar subtle process of ameliorating the father's difficulties:

Recording	Process Notes
Patient …I think the other week, when I was at my dad's, and we were supposed to be going to mum's, he was talking to me the night before and he kind of admitted that he was in the wrong because he said that, whenever we come to his, he's okay for the first like day and then he says that he notices he gets grumpy and then the last day he'll realise that he made a mistake and he'll, like, be in a better mood, and he says to me that he is really happy when we're going or we've just come.	She said she was thinking about her dad – he had talked to her the other day about how he realised that he was stressed a lot of the time, and expecting a lot from her, and how he was sorry about that. Pavni had felt so guilty about that, she didn't want him to feel bad. She knew he hadn't said it to make her feel guilty but she still did, she didn't know why – she looked confused.

Therapist 1, 11th session

There is a difference between the process notes and recording in how the patient's father talks about his difficult behaviour. In the recording he 'kind of' admits that he is in the wrong because of his bad moods, but in the process notes he is given a much more thoughtful apology in which he considers his relationship with his daughter and the level of expectation he places on her. As before, it appears that the patient's father is made more grateful in the process notes than in the recording; and in both changes the father is presented as a more thoughtful or reasonable man. There is, therefore, a dual presentation of the father in the process notes: overtly the therapist notes that the father is a very damaged man. Yet when the notes and recording are compared a contradictory impulse becomes apparent in which the father is presented as more thoughtful and with more insight. This second aspect becomes evident only in the comparison between recording and notes. As such it is likely to be an unconscious wish on the therapist's part; a wish for her patient to have a better, or less disturbed father, enacted through the changes to the process notes.

IV.vii. Evidence of The Workings of Overvalued Ideas

This study has identified examples of differences between recordings of psychotherapy sessions and process notes which appear to link with Britton and Steiner's concept of the overvalued idea. In this, an idea can become used as if it were a 'selected fact' in order to help manage the

extreme difficulties raised by the experience of 'not knowing' with a patient (see literature review for a fuller discussion of this). As we have seen, the comparison indicates that therapists can adopt transference / countertransference positions that they may not be consciously aware of and that may function to prejudice which aspects of the patient's presentation the therapist is able to notice and which become forgotten, as discussed in section IV.v. There, for example, Therapist 2's appreciation of his patient's vulnerability was seen to diminish his awareness of her violence. Viewed from the perspective of the overvalued idea, such transference / countertransference positions may be seen to function in a comparable manner, so providing structure and security for the therapist when faced with the difficulties of managing being with the patient.

The workings of an overvalued idea are seen most clearly with Therapist 3. As we have seen, there is an idealised maternal transference present in these sessions, possibly linked to an awareness of the patient's mother's limitations. An interest in the patient's mother is nothing remarkable in itself, indeed, all psychotherapists would be interested in their patient's mother, and all psychotherapies will involve some maternal transference. Psychoanalytic theories of personality development are rooted in the key caregiver-infant relationships, typically the relationship with the mother. For Therapist 3, however, the patient's real mother seems to dominate and become a focal point, acting, in effect, as an overvalued idea:

Recording	Process Notes
Therapist She [Mum] seems to get into her anger and then she can't escape from it. When you compare yourself with your mother how do you deal with anger yourself? In a different way, or a very different way? Patient Well I hold it inside, and then sometimes I'll, like, if I'm angry I'll hit the walls and stuff, like the other day but that really hurt. I was like walking round going... If it's a certain	After a silence, I ask her how [she] deals with anger. She holds it inside. Depends when someone else outside makes her angry, she would talk or making feeling them bad [sic] or so but she would not dare to act like her Mum.

146

person who's made me angry like a friend or anything then I'll, like, talk to them, well I say talk, I'll make sure they know I'm angry and make them feel bad and just stuff like that. But I wouldn't dare start arguing with my mum.	

This extract indicates how central the mother has become for the therapist, to the extent that the patient is asked to compare herself to her mother. This comparison, which keeps the mother in the centre, is omitted in the process notes, in which the therapist just asks the patient how she deals with the anger. The theme of comparison does re-enter the notes at the end of the extract where the patient's comment that she wouldn't argue with her mother – a statement which serves to create distance between mother and daughter – is made into a comparison with her mother thus keeping them joined.

The recordings also indicate how interested the therapist is in the history of the patient's relationship with her mother:

Recording	Process Notes
Therapist But you don't, you go to school at the moment. Patient Yeah. Therapist Is this difficult with the others? Patient I've got to avoid people. It's quite hard because I can't really tell my friends anything either. Therapist So the only person you can talk to is your mum then or... Patient Yeah pretty much. Therapist How does this feel?	She goes to school but she is also not allowed to talk to her friends [about a particular issue]. I say that she then is only able to talk to her mother. The way she confirms it makes it clear that this is not the best solution. She usually doesn't talk to her mother about that stuff. I wonder whether it was always like this between them? She replies that it was not so when she was little but after she grew up. What made it more difficult? Her mother got disappointed in her when she got off the rails a bit.

Patient   Horrible [indistinct] cos I don't really talk to my mum about stuff. Therapist   Was this always like that? You didn't talk? Patient   It never used to be when I was like little but then I grew up and started getting more difficult. Therapist   Do you remember what made it more difficult to talk to her?

Therapist 3, 1ˢᵗ session

The therapist's interest in the mother is manifested in two ways: she has the idea that the patient's current isolation means she is only able to talk to her mother, and she also broadens the discussion to include the history of their communication difficulties. Whilst these shifts are captured in the process notes above, the historical interest in the following extract is not:

Recording Not in Process Notes
Patient   Don't get me wrong I'm grateful to mum for buying it for me but it was only Primark and that's really cushty, it's really warm and snug, I love getting new clothes, I love when my mummy buys me stuff. Therapist   And during the time when you did not get on with each other, the time you had before, she wouldn't buy you anything as a punishment or? Patient   She wouldn't buy me anything cos she wouldn't really listen to what I needed, and I needed a lot of stuff. Therapist   So what do you think made her change her mind?

Therapist 3, 10ᵗʰ session

The therapist's preoccupation with the mother finds a further form of expression, in which the therapist takes the mother as the main point of interest and focuses on her:

Recording	Process Notes
Therapist: I think I'm asking this because I wonder if you can get in some strop like your mum can get sometimes you said you bottle up the anger somehow and your mum, I don't know I don't know the situation, but it seems that she somehow bottled up anger towards [Stepfather] because he didn't come home and she didn't get a text and she got more angry and more angry with him and then he came and then her anger was already at a level when she couldn't really handle it normally. Is that right?	It seems to me there is something similar between your and your Mum's anger. Trying to hold it back but getting really angry and then it explodes

Although the process notes record the incident as a comparison between patient and mother, the recording demonstrates that greater interest lies in explaining the details of the mother's anger; as if the mother's anger is more relevant than the patient's. It is noticeable on listening to the recordings that the therapist frequently turns the discussion to mother or makes links to the mother; in session 10, for example, she introduces the mother or makes a link to her 17 times. The extract below, from that session, indicates this level of interest:

Recording Not in Process Notes
Patient   I don't know, possibly, but like I used to lie about a lot of things, like when I'd be ill and everything. I'd lie about it and say no I'm ill I can't go to school...I used to do that a lot. Therapist   Because you wanted to stay with her [Mum]? Patient   No because I didn't want to be in school. I hate school; every kid does it, skive off school. Therapist   So when you had to stay at home, she could not go to work or what happened?

The therapist's question, by using the personal pronoun 'her', implies that they have just been talking about the mother. In fact, the mother has not been mentioned for about two minutes and in that time the discussion has

centred on the patient's fights with her brother. The use of 'her', therefore, indicates that the mother may still be central to the therapist's train of thought. The fact that this discussion is not in the process notes may also imply that the therapist is not conscious of this degree of focus.

IV.viii. Nature and Function of Process Notes

The comparison of process notes and session recordings in this study has demonstrated the specific richness of process notes: this lies in the notes' capacity to bring to life the particular experience of being with the patient. Unlike the recording, the process notes capture the interactions of patient and therapist from the very first moment they are together, when the patient is collected from the waiting room. The notes have indicated how the transference is an immediate and intense phenomenon commencing from this first moment:

| Process Notes |
| Not in Recording |
| Rachel was 10mins early for her session. When I collected her, she was hidden in a corner in the busy w/a [waiting area] but got up straight away … Her hair was greasy and I immediately felt she needing [sic] caring for. |

Therapist 2, 1st session

Furthermore, the comparison between the two modes of recording has demonstrated that these opening moments can have a particular power to determine the future direction of the transference; as we have seen with Therapist 2 this early perception of his patient as someone who needed to be cared for became a powerful aspect of the core transference dynamic between them.

The process notes also provide an insight into the reflective processes of the therapist, and some indication of how the therapists arrive at what they say:

Recording	Process Notes
Patient [Talking about stealing from each other] And he was like, you lot need to stop stopping me, da, da, da, da, da, I was like, well you shouldn't be robbing him, find another way to make money. But otherwise it's all right. Therapist I'm just thinking about people robbing things because they need something that they feel they don't have.	I had begun to think about deprivation, the robbing and the slightly unkempt way she was dressed. I said that I was thinking about how people rob because they feel there is something they don't have.

Therapist 2, 1st session

The process notes here allow the reader to understand that the therapist's comment did not just relate to the story the patient was telling him about people stealing from each other, but was very much related to his wider sense of her situation. It drew on his impression of her in the waiting room, his knowledge from the first meeting with the mother (he described in his interview being struck by how 'out of it' her mother was in that meeting) as well as the story she was telling him at that moment.

The process notes provide access to the therapists' thoughts and feelings which are, obviously, inaccessible in the recordings. These thought processes and feelings matter because they are an integral facet of the experience of being with the patient and therefore form crucial information, not just about the therapeutic relationship, but also about the patients themselves. To return to an earlier example:

Recording	Process Notes
Patient I'm really sorry I couldn't come last week. I was just so busy with work because they gave us extra work to do because we didn't have college. Therapist Is this over the half term? So you had more work than usual? Patient Exactly, yes, because as	She went into a lot of detail about her different projects and I was finding it hard to think, it felt like being bombarded with a barrage of words.

well as that we had to catch up on other things that we were doing. So it was just so much I didn't get time for anything. I certainly didn't hear from any of my friends last week.

Therapist   Really? And you were going to do quite a bit of that, weren't you?

Patient   Yes, I was. There was just no time for it.

Therapist   Didn't have a proper holiday.

Patient   Exactly. It was just a lot of work, and I think it went really quickly as well because, usually, we need like a week to get into the whole like holidays and then have a holiday but I think there is one coming up soon, Easter holiday.

Therapist   The Easter holiday is coming up in April. That's right, yes.

Patient   Ah, it's still quite far.

Therapist   So there's still a whole month to go.

Patient   Yes.

Therapist   That's quite bad though, isn't it, that they give you so much work over the holiday?

Thus when Therapist 1 describes: 'finding it hard to think, it felt like being bombarded with a barrage of words', she not only sheds light on her experience of being with the patient at that moment, but also on something of the patient's own state of mind, an indication of a possible attack on the therapist that is taking place at that very moment. If this interaction were studied simply by using the recording, the impression would be of an active therapist asking lots of questions, indeed maybe even bombarding the

patient, but when taken in conjunction with the notes an understanding of the feeling – and possible defensive need – behind the therapist's questions becomes possible.

The notes also provide another level of detail, absent in the recordings, that of physical descriptions: descriptions of 'false smiles', heads 'slumping', legs being 'pushed' at with a pin, looks being directed either at or away from the therapist, smiles of relief, patients sitting curled in a ball, and so on. This again serves to bring the patient and the interaction between patient and therapist more to life. Although video recording sessions would provide a more direct way of capturing the patient's body language and facial expressions, there may be limitations to this from the camera angle and positioning. Furthermore, the point would remain that process notes are about the lived experience of the session rather than an objective recording of the session, for whilst listening and watching a video may provide many insights they also preserve the equivalent of the theatrical fourth wall, the wall that keeps the audience as observers outside the action of the play. In contrast process notes have the potential to begin to break down the fourth wall.

In particular, the comparison between the recordings and process notes creates a deeper understanding of the working of the therapist's mind as potential latent emotion in the sessions becomes written up as something more explicit in the notes. For example, in their first session Therapist 3 is very aware of the difficulty that having a topic they cannot legally discuss causes. She writes several long pauses in the notes and makes a link between these and the topic, but to the listener of the recordings these long pauses are not apparent. Similarly, Therapist 1 is keenly aware of her patient's anxiety; she writes about her patient's anxious smile and the sense of anxiety in the room and links these to long pauses which she has written in the notes, but which, again, do not register to the listener. By writing in the pauses, the therapists' experience of powerful anxiety in the

room is given a more concrete form and its effect is made more prominent than if they had simply written that they or the patient were anxious.

In the following example, the therapist writes a comment into the process notes which has no parallel in the recording:

Recording	Process Notes
Patient Yes. But he can't do the simplest things and I told... it's going to drop if you do that, but he won't listen. He's like: 'It's not going to drop, it's not going to drop'. It just dropped straight off the... And because I don't like when he spills things, because he won't clean it up, he'll just get a tissue even, and just go like that. That's it, that's his cleaning up. It'll all go sticky and everything. And he knows that it will annoy me and my mum but he won't do anything about it. And he didn't put his jumper in the wash last night like my mum told him to, so it wasn't washed so he didn't have a jumper to wear. It was his own fault though. Therapist And do you end up cleaning up after him? Do you feel...? Not really, [overtalking] just get mum [overtalking]. Patient I think sometimes mum gets me to clear up after him but...	Even her little brother had talked about wanting to move out although he'd be hopeless as he couldn't do anything for himself and was really clumsy (examples of spilling food and upending furniture etc). She fell silent again, looking at me uncertainly. I said it sounded as if this week it had felt as if things were falling apart in her family. She agreed.

Therapist 1, 4th session

The therapist writes as a given interpretation the possible sense the patient has that her family is falling apart. The therapist in the recording does not seem to have quite made that link between the falling and messing cup with the falling apart family, however, it would appear that her unconscious has found a way to think this through, and that way of thinking it through has been to write the interpretation which could have been made as if it had been. Indeed, it may have been that the very act of thinking

154

through the session in order to write it up provided the impetus for this understanding.

This example demonstrates again the capacity of the notes to show understanding of latent emotion at the point of writing up which may not have been consciously understood at the time:

Recording	Process Notes
[Talking about tidying up when she was young.] Therapist And did you feel angry about it? Patient Yes, [Patient tells a story about her mother having said she was going to make the patient dinner but then coming home late and complaining that the patient had not in fact made her dinner which resulted in the patient going to bed without dinner.] Therapist Oh, you just didn't even want to eat anything.	[Talking about tidying when young.] I said it sounded as if she had been quite sad and worried as a little girl already, trying to make others happy – yes, but it didn't work, Pavni added and looked very sad.

Therapist 1, 11th session

In the recording the therapist seems most aware of potential anger in the patient's response and it is this she asks the patient about. However, in the process notes there is no mention of anger, instead sadness and worry become the central concerns. The therapist has earlier commented on the sad appearance of her patient and perhaps now in the process of writing the sadness – which did not come to foreground at the time – is experienced as more important. To return to Therapist 2's patient's complaints about missing school for therapy:

Recording	Process Notes
Therapist Yes, your mum explained that actually your attendance has gone up a lot.	I replied that I had spoken to her mum, who had mentioned that Rachel's attendance had been

Patient Yeah, it was down to like 52, and it's probably up to 100 again, or it was 92 before. So that's why they want me to stay in, because my attendances would be better. Therapist And there was some sort of reward system that your mum mentioned? Patient Yeah. I could win £25 if I'm in for two weeks. Been there more than two weeks, but… Therapist But this gets in the way, is that what they're saying? Patient Yeah, because even though it's an arranged thing, it still takes up half of my day as well, that's what they're querying about, even though my attendance is getting better, and it still takes time [unclear]. So that's why I only have 92.	very good recently, and that she was trying to get some sort of reward system. She grinned, "Yeah, I could win £25" she said and explained that her attendance has gone up to 92% from 54%, "and I ain't gonna lie, the only bit left is because I come here."

<div align="right">Therapist 2, 9th session</div>

Previously this extract was understood as the therapist writing the patient as more complaining in the notes than in the recordings, however, it may now be seen that what the therapist could have captured and made more explicit was the degree of latent complaint that the patient was hiding. As similar process may be seen in the following extract from Therapist 3:

Recording	Process Notes
Therapist So he wanted to be looked after a bit? Patient Huh? Therapist So he wanted to be looked after a bit? Patient It's the sympathy thing. He'll sit at the table and go: 'I'm not looking for sympathy or anything'. I don't know how it came about we were talking about sympathy votes and	[Step-father] said that he never tried to get sympathy. Again she thought What? I say that it looks like that he wanted to be looked after. Sympathy! She says again as if she cannot at all understand it or finds it too much.

everything and he goes: 'It's like me and my finger, like I never look for sympathy'. I was like: 'Really, yeah sure'. [Indistinct] He'll sit there just and just go… it's unbelievable.	

In the process notes the therapist makes the patient say that she cannot understand sympathy, which was not said in the recording. This change from the session could convey the therapist's sense that the patient has a difficult relationship to sympathy. It may be that such an understanding could only be present in the process notes once the therapist's mind had had a chance to process this, and not actually in the session itself.

In section IV.iii. we saw that therapists tend to write more transference interpretations into the process notes than were made in the actual sessions. These were viewed as written in relation to the kinds of interpretations which therapists feel they should say. There is a further explanation: that the transference interpretations which are written in the notes but not made in the sessions are another example of the therapists' unconscious grappling with aspects of the session that were not fully available to them at that time. To return to an example from IV.iii.:

Recording	Process Notes
Therapist Do you think that the fight was the reason that you're so close now, because it sounded like things got really serious, and yet you've made up and actually…? [cut off by patient] Patient I think it is probably why we've got close like, because when we mess about, like, normally before we used to like, when we was good mates before like in primary school, we would be able to punch and slap each other, but obviously not hard, as a joke, we can't do that no more. If we want to have a joke we have to tickle each other, she can't hit me, it's not that I tell	I said that I thought she was telling me that they had seen the worst of each other, and that perhaps there was also a worry about showing me the worst bits of her. Lucy had shown that the worst of Rachel was still manageable, and vice-versa, but would I be the same? She agreed.

her not to, like I always say like you can hit me if you want, because we're just messing about, it's nothing serious. And she can't no more. Therapist But maybe you feel that you've seen the worst of each other, and actually it was all right, you've kind of come through that. Patient Well I think it was because like I used to be scared of her…	

Therapist 2, 9th session

In the recording, the focus is kept on the relationship between the patient and her friend, yet in the process notes the therapist relates this directly to his patient's feelings about him twice. This is seen again in this example from Therapist 1, also discussed earlier:

Recording	Process Notes
Patient So I went to the front room and I opened the drawers and I found a big pile of my books and stuff, and they were in my bag which my dad brought from my mum's … Then I knew my dad saw them and I just felt like my privacy had been really badly invaded because even my brother said to me he'd seen my dad go in my drawers which I tell my dad not to go in, specifically this one drawer [Further discussion of the incident] Therapist But as you say, it is an invasion of your privacy, isn't it, particularly if you've told him specifically not to look there and those are private things that you might have been writing.	She knew he'd [father] been all through her stuff. He may or may not have read it, but the fact he had been through it was such an invasion of her privacy (her words) that she just ended up sticking the whole lot in a rubbish bag and chucking it out. […] I wondered whether she was a bit worried about this being a place where I would go through all her private stuff and somehow ruin it? She pondered this for a moment.

Therapist 1, 1st session

These transference interpretations, may, again, be seen as thoughts which the therapist's conscious mind was unable to formulate under pressure in the session, but which are captured by the unconscious mind and only

become conscious once the session is being reflected upon through the writing process.

Chapter Five: Discussion and Concluding Remarks

This study has compared therapists' process notes and the audio recordings from a series of psychotherapy sessions. The aim has been to generate theory that might illuminate the causes of significantly patterned discrepancies between the notes and recordings, in order to understand more about the processes at work in psychotherapy, as well as to explore the value and limitations of process notes. In so doing, this study has developed a new way of examining process notes, and has contributed towards a greater understanding of process notes.

The study started with the assumption that differences between the two forms of recording were inevitable; as suggested in the five earlier studies comparing process notes with recordings of therapy sessions (Covner, 1944; Knapp et. al., 1966; Wolfson & Sampson, 1976; Bailey, 2000; Bonnin, 2011). These earlier studies all sought to quantify the differences between the two forms of recording psychotherapy sessions and had broadly consistent findings of substantial differences between the two. The earliest study identified in the literature review found that 75% - 95% of the material in session notes was accurate, but that more than 70% of the session content was missing in the notes (Covner, 1944). The most recent study by Bonnin also found that a significant amount of information was omitted from the therapists' notes; 57.2% of what she called clinical facts – units of verbally communicated information – was missing (2011). She also identified that there was an average of three facts in the notes that were not in the recordings, and an average of nine distortions per session.

Unlike these earlier studies, the research focus here has been to generate theory about potential causes for such changes, and a psychoanalytically informed grounded theory was used in order to do so. The methodology provided a fruitful framework for analysing the data and led to the development of robust categories, albeit from a small sample. The central challenge posed to the research method stemmed from the fact that whilst

researching clinicians and their process notes I continued to be a clinician, working in the same therapeutic modality and writing process notes, in keeping with my research subjects. Inherent in this lay the danger that my own therapeutic style and way of writing process notes became, unconsciously, the lens through which the sessions studied were regarded. I had to become aware of the pull towards making value judgments about both the process notes and clinical work I was studying. In order to avoid such judgments, I had to reflect upon my own assumptions about clinical work, as well as observe the pull to judge the work I was studying. I hope this self-reflection enabled me to avoid such judgments. Nonetheless, it remains true that my belief that the transference and countertransference are central to psychotherapy did inform my analysis.

Prior to starting the analysis, I had been concerned about the sample size limiting the viability of the study. Whilst the results remain limited by the sample, the fact that there were sessions from three therapists allowed for triangulation of the findings, and the intensive data analysis facilitated by grounded theory enabled the research to generate findings that were seen multiple times across all three therapists. The analysis identified eight core categories of differences between process notes and audio recordings: emotional nuances of summarising; impact of being in a research study; differences in how therapists represent themselves in process notes from how they are in the session recordings; differences in how therapists represent the patients in process notes from how they are in the session recordings; influence of aspects of the transference and countertransference; relationship between the external parents and the transference; evidence of the workings of overvalued ideas, and nature and function of process notes.

This study confirms that in order to manage the sheer volume of what is said in sessions therapists must use significant amounts of summarizing when writing process notes. For example, one long interaction consisting of 1,047 words was captured in just 193 words. Such a significant

reduction in words will, inevitably, mean that units of information are missing. This study suggests, however, that such reduction is not automatically a problem, for some summaries do succeed in capturing the emotional tone and key aspects of the interaction, even though other summaries were not able to do this. It was not possible to identify why some summaries were able to capture the emotional tone whilst others were not. It seems likely to relate to the therapist's ability to make contact with the patient's emotional state in the session – which may relate to the therapist's level of experience, the dynamics of the transference relationship, and the patient's individual defence mechanisms, amongst other factors. In addition, it may be that some therapists find writing evocatively easier than others, which may enable them to capture more nuances. This remains an important question, not least because there were examples from the same therapist of both more and less emotionally congruent summarising.

The analysis of findings in this study works on the assumption that therapists had not made deliberate additions, changes or omissions to their process notes. This assumption is supported by the findings in Bonnin's study, where the therapists interviewed were initially both surprised and defensive when they learnt of the errors present in their notes. A brief review of the literature on memory function indicated that 'memories are records of how we have experienced events, not replicas of the events themselves' (Schacter, 1996: 6). Given that the therapist's experience of the session would inevitably not equate to an exact replica of the session, the central question is then, why are particular things remembered whilst others are not? As this is a psychoanalytic psychotherapeutic study, Freud's understanding of forgetting as a form of 'parapraxes', or unconscious slip, which informs on the subject's unconscious meaning or experience, is central (1901).

The sessions and process notes used in this study were written within a particularly significant context; they were part of the first large-scale randomised controlled trial for Short Term Psychoanalytic Psychotherapy, as part of the Improving Mood with Psychoanalytic and Cognitive-Behavioural Therapy study (the IMPACT study). There are two pertinent aspects to this context: first, as part of the research project (as discussed on page 66) the therapists spoke about a wish to do well by the child-psychotherapy discipline in the study, as well as expressing some anxieties about the recordings of their sessions being listened to; and secondly, the nature of the relationship with their supervisor. Taking part in the study meant the therapists received in-depth supervision on their work; for two of the therapists (1 and 3) this experience provided more specific session-by-session supervision than is normal in post-qualified practice in a mental health setting.

Although the therapists spoke about wishing to do well by the discipline, the analysis indicated that the therapists' notes had a tendency to omit something that might appear more straightforwardly 'helpful', despite its clear presence within the recordings. Such absence may indicate a degree of ambivalence about whether such a style is appropriate within psychoanalytic psychotherapy and represent some form of self-censorship (possibly unconscious) because of that. The overt desire to be helpful fits very much within the approach of a modern Child And Adolescent Mental Health Service (CAMHS), with the emphasis on routine outcome measurements, in particular session-by-session outcome monitoring. In addition, shorter-term psychotherapy may require a change in technique, so that the therapist does need to work in a more actively enquiring manner with the patients, and may need to bring aspects of their presentation directly to their attention sooner than in longer-term therapy. However, such an approach appears to stand in direct contrast to Bion's famous injunction to avoid memory or desire in sessions with patients, because desire to help is felt to become a barrier to engaging with the

patient as they are at that moment (1967). The absence in the process notes of more helpful interactions may stem from a conflict between what the therapists feel to be 'correct' technique in relation to patients and what actual technique is. Such a conflict then becomes enacted in the differences between the recordings and the notes.

The context of the supervision provided in the IMPACT study is significant as it introduces the idea of whom the therapists relate to in their minds when writing process notes in preparation for supervision. I believe there are four relationships present when process notes are written. First, the external supervisor for the case, with whom they will discuss the session and with whom there will be a complex relationship, intimately connected to the relationship between patient and therapist (Searles, 1965); secondly, the internal supervisor; thirdly, the idealised therapist they aspire to be; and fourthly, the denigrated therapist they wish to avoid.

Therapist 2 referred in his interview to the 'internal supervisor' as represented by the Dictaphone. The internal supervisor would be the aspect of the self identified with the external supervisor, on whom the therapist can draw for support during the session. This internal figure would be – as in the case of all internalised objects – mediated by the therapist's own internal world. Within a session the internal supervisor acts as the third party along with the therapist and patient to create an internal space within which the therapist can explore his thoughts about the session as it happens (Britton, 1989). In this, there is a parallel to Casement's descriptions of the 'internal supervisor', for him a descriptor of the therapist's capacity to reflect on themselves within a session (1985). Casement argues that this is a development on from an 'internalized supervisor' to a more autonomous capacity within the therapist. Yet, given that the internal supervisor develops through internalised external object relationships, it seems likely their influence will remain. As an internalised external figure the internal supervisor also assumes a function akin to that

of the superego, typically the 'you ought to be like' your father superego rather than the 'you may not be like' your father superego (Freud, 1923: 34). Nonetheless, it would be possible for the internal supervisor to assume the more critical 'you may not be like' aspects of the superego, thereby becoming a critical, rather than helpful internal figure, akin to Horne's conception of the 'Great Child Psychotherapist in the Sky' (2006). Many of the changes identified in this study in the therapist's representation of themselves may be written with this internal supervisor in mind, whom on one level the therapist may seek to please through emulating what is felt to be their 'correct' therapeutic style. Thus, as we have seen, the notes for all three therapists presented them as much less vivid and active presences; instead they appeared more like a neutral, blank slate. We have also seen that therapists tended not to record instances of behaving in a more overtly helpful or didactic manner. This, again, seemed to indicate that there was a difference between how therapists felt they should be whilst they were in a session – enquiring, lively, supportive – and how they seemed to feel they should have been whilst writing up the notes – reflective, working more directly in the transference. In these changes, the therapists may write themselves as the kind of therapist they aspire to be; in so doing, they also write in relation to the third figure: the idealised therapist.

The idealised therapist is akin to an ego-ideal, which 'finds itself possessed of every perfection that is of value' (Freud, 1914: 93), but this time a representation of the self, rather than a representation of another, as in the internal supervisor. Whilst the therapists may strive to present their perceived mistakes within the notes, it would appear that the urge to comply with a belief about what it is they, as therapists, should be doing leads to changes in the notes depicting a more reflective therapist and neater interpretations. Again, these changes seem to be made with no deliberate intent.

The final figure in relation to whom the therapist writes process notes, I suggest, is a denigrated therapist, whom the therapist seeks to avoid becoming. As such, moments when the therapists were pulled out of their psychotherapist role are less represented in the process notes — as if they have remained unnoticed by the therapists.

As discussed, this study identified a common theme across all three therapists examined in which the therapists represented themselves as more neutral presences than the active and lively therapists they appeared to be in the recordings. The analysis of the recordings suggested that, not only were all three therapists livelier than they appeared in the notes, but that they were actually more varied in their therapeutic styles than reading the process notes on their own indicated. This was seen most clearly with Therapist 3's high levels of joint laughter in the sessions, which was contrasted to the lively but more restrained approach of Therapists 1 and 2. In order to develop robust categories, this study focused on findings which were evidenced across all three therapists, yet there are variances in the therapists' points of difference between process notes and audio recordings, for example, Therapist 1's process notes were marked by a high level of distortion in the order of session material which was not as visible in Therapists 2 and 3's notes. In addition, the findings identified across all the sessions were also weighted differently across the therapists. The comparison of process notes and recordings for Therapist 2 displayed a striking reduction of the levels of awareness of violence and aggression in the patient, Therapist 1's sessions evidenced a greater impact of being in a research study, whilst Therapist 3's sessions were marked by a greater emphasis on the external mother, which, whilst present in Therapists 1 and 2, was not nearly as central to their sessions.

Finally, there were clear differences in the therapists' writing style, and – perhaps – their fluency of written English, which may have contributed to the differences between the process notes and audio recordings. For

example, Therapist 2 – the only therapist still in training – seemed most able to clearly follow the order of the session and demarcate what he thought and said, whilst Therapist 3's style of writing in brief, incomplete sentences contributed to a sense of confusion between the therapist and patient; in Therapist 3's notes it was hard to identify whether the therapist or patient had spoken, or indeed whether what was written had been spoken aloud or just thought.

This study also indicates that, as well as therapists presenting themselves differently in process notes, there were also times when the representation of the patients diverged from the sessions. The first proposed explanation for this is that in the changes the therapists actually register and capture the unconscious undertow of the patient's communications. The second is that these changes represent the types of patients therapists believe they should have. Thus, we saw that Therapist 1 made changes in the notes which served to present her patient as more solution-focused and seeking to get better, in a manner that may be seen to fit more within the current goal-oriented Child and Adolescent Mental Health Service approach. Conversely, there were also indications of times when patients were written as more attacking of the therapy, as seen with Therapist 2's patient, who was presented as more complaining than she appeared in the recording. This may have been influenced by an idea that working with the negative transference – as is explicitly encouraged within the IMPACT Short Term Psychoanalytic Psychotherapy manual and may have been explored in supervision – is central to psychotherapy.

This study also suggests that the most significant reason for changes in the representation of patients lay in the therapist's and patient's core transference dynamic – by 'core transference dynamic' I refer to the transference / countertransference position witnessed more frequently across all the sessions studied, which may, of course, be accompanied by fluctuations with other transference positions. We have seen how such

core transference dynamics function as a lens through which the patient is seen, meaning that some aspects of the patient become focused on, whilst others which do not fit within this picture become harder for the therapist to capture in the process notes. In particular we have noted that overtly 'positive' relationships seem to restrict the space for noticing 'negative' emotions. Thus for Therapist 1, the core dynamic of idealised elder sister / younger sister relationship was seen to limit the capacity to observe certain aspects of the patient's presentation. This was seen most clearly in the absence of the patient's repeated 'exactly', understood here as an attempt by the patient to adhesively identify with the therapist. This wish to be 'stuck to' the therapist was then seen to link to the difficulty the therapist had in ending the sessions on time, as if breaking the illusion of closeness was too painful. The core dynamic identified for Therapist 2 was the idealised father / daughter relationship, which was seen to link to the therapist's keen appreciation of the patient's vulnerability. Yet this very appreciation of vulnerability was seen to impinge on the therapist's capacity to see the patient's non-vulnerable violent and sexual aspects. For Therapist 3, we noted an idealised mother / daughter relationship, evidenced by the strong didactic impulses in sessions, the warm mutual laughter and repeated focus on the external mother. As with Therapist 2, this idealised parental transference was inexorably linked to a difficulty in noticing the patient's pain hidden behind the laughing, lively atmosphere.

This study indicates that one of the main ways strong transference dynamics impact a therapist is through a pressure to enact, or act-in with, them. Furthermore, an aspect of enactment, it appears, is that it is very hard for therapists to notice and record in the process notes. Thus, the moments of collusion can only truly become noticeable when the process notes are compared with the recordings. A clear example of this is seen in the joint laughter between patient and therapist in Therapist 3's sessions, which is not recorded in the process notes. The joint laughter is seen as a moment of enactment, as the therapist is drawn into a jovial relationship

168

with the patient that is rooted in the patient's own lively laughing defences. The joint laughter in turn functions to make it harder for the therapist to observe and record the pain hidden in the patient's stories.

The transference is, of course, a subtle multi-layered phenomenon, and whilst the idea of the 'core transference dynamic' was most evident in this study, there were also examples of multiple transferences. This was seen most clearly with Therapist 3, where the constraints created by the idealised mother position – the difficulty in noticing the pain – essentially caused a form of re-enactment of a different transference, that of the actual – or described as actual – relationship between the patient and her mother. The patient represented her mother as someone who had habitually ignored her needs; the therapist aims to be – and to a large extent is – the opposite, interested in and focused on her patient. Yet, as the therapist's acting-in with the idealised mother transference restricts her capacity to notice the more hidden pain, on one level she becomes a mother who ignores (aspects of) her daughter. This was most marked when the therapist laughs as she is told about the patient's friends ganging up on her and throwing her shoes into the snow (see page 103).

As we have seen, for all the therapist-patient dyads in this study, a core transference dynamic featuring an idealised relationship was observed. It would be interesting for further research to explore whether this is usual for adolescents presenting with depression, and how that compares with patients with different presentations. Although the transference would be predominately rooted in the patient's psyche, this study also indicates a further source: the therapists' feelings about their patients' parents. This is in keeping with Money-Kyrle's statement that 'the analyst's unconscious can hardly fail to respond in some degree by regarding the patient as his child' (1956: 360). The interviews with Therapists 1 and 2 indicated that both were aware of the parents' limitations; in the light of this, the 'parental' response to the patient seems likely to foster an unconscious wish to

169

mitigate the actual deprivation, in turn predisposing the therapists to act-in to the idealised relationship offered by their patients. Indeed, the therapist's role in relation to their patient's external relational deprivation has led to debate about whether psychoanalytic work resides primarily in interpreting the transference or in the possibility for the patient offered in the therapist as a real, developmental object (Strachey, 1934; Greenson, 1967; Freud, 1978; Joseph, 1985; Hurry, 1998).

The comparison of Therapist 3's process notes and recordings denotes most clearly how powerful a presence the parents could become in the therapists' minds. The findings indicated that for Therapist 3 the idea of the patient's mother assumed a function akin to an overvalued idea. According to Britton and Steiner, an overvalued idea develops from the analyst's defensive needs as a way to manage the doubt and confusion generated within sessions, becoming 'used by the analyst to give a sense of integration to otherwise disparate and confusing experiences' (1994: 1070). The use of an overvalued idea can come from something unanalyzed in the analyst or be a 'specific countertransference to his patient' (ibid: 1077). Thus an overvalued idea can be rooted in the therapist or the patient (via the countertransference to them). For Therapist 3, the overvalued interest in the external mother may, therefore, have been rooted in the therapist – a possible need for a stable frame of reference within the sessions to which she could refer – or in the patient herself, in which the patient had a similar, though hidden, preoccupation which she projected into the therapist. In addition, this study has suggested that the core transference dynamic may in itself be used as an overvalued idea, in which patient and therapist remain in a set frame of reference that serves to provide a structure to understand the patient, but in so doing restricts the space for development of new perspectives. This was, perhaps, seen most clearly with Therapist 2 and the strong sense of the patient as a vulnerable daughter that restricted his capacity to notice her paradigm-disturbing violence.

The very act of writing process notes may also lend itself to the formation of a defensive overvalued idea. The writing process requires the creation of a narrative structure for the session. Even if the therapist acknowledges being unsure of the order, nonetheless the creation of an order is unavoidable. It may be that the need for structure and order when writing process notes is similar to the therapist's defensive need to manage the doubt and confusion in sessions. In this, parts of the session remembered clearly by the therapist become used like an overvalued idea to provide a sense of order.

Whilst this study identified examples of overvalued ideas, it did not find any indications within the process notes of material which the therapists recognised as a selected fact, 'like the pattern from a kaleidoscope, a configuration which seems to belong not only to the situation unfolding, but to a number of others not previously seen to be connected' (Bion, 1967: 127). This may be because the therapists did not clearly spell out moments in which a new, significant idea was felt to act as a unifying force. It is also likely, that such 'selected fact moments' are not present in every session and so their absence from the process notes studied may relate to the limited number of sessions in this study, especially as one of those sessions was the very first. As the IMPACT manual clarifies, the initial session in the project was somewhat different to a typical first session of psychotherapy, as it was not preceded by an assessment for psychotherapy. It is therefore unlikely that a selected fact would occur in the first session. It may be that the ideas discussed by the therapists with their patients during the sessions studied were felt at one time to be a 'selected fact', but by the time of the sessions they may have become more integrated into the therapeutic discourse. Bion's description indicates that the selected fact is something which helps apparently disparate ideas to cohere and focus for the therapist, thus providing a new level of understanding. I would suggest that there is an initial 'selected fact

moment' in which they cohere for the first time and that this moment may be indicated within the process notes. The 'selected fact moment' would then be followed by later use of the selected fact within the psychotherapy, however, the process notes which report such later use would be unlikely to indicate that the idea captured was once a 'selected fact'.

This study has indicated that the therapist's countertransference can also inform what is not recorded in the process notes: incidents that related to particularly painful facets of the therapists' countertransference were less recorded. This was seen most clearly with Therapists 1 and 2. Therapist 1 spoke in her interview about how difficult she found the patient's apparent wish to deny that there was going to be an end to the therapy and acknowledged an urge to reject the patient as a response to this. When comparing the process notes with the recordings, these countertransference difficulties with managing the patient's desire for never-ending therapy seemed to cohere primarily around guilt for not providing the patient with enough – and possibly a feeling of guilt about the wish to reject her. This was seen most clearly in the changes to the process notes when cancelled sessions were discussed. In the process notes the therapist makes a transference interpretation about the patient's annoyance because of cancelled sessions, but any idea of annoyance is then outweighed by the patient's reaction to hearing she has a replacement session, behaving as if this were better than never having had the session cancelled ('beamed with delight'). This interchange does not have any parallel in the recording, where neither annoyance nor pleasure at the change in sessions is commented on. Whilst it may be that the therapist wrote in undercurrents that were present, it also seems likely that the pleasure the patient is given in the process notes at the extra session may be to mitigate guilt about the cancellations. For Therapist 2, there were indications that potentially difficult countertransference experiences relating to his patient's brief flashes of a sexual transference were written out of the process notes (see page117).

As discussed in the literature review, analysts have proposed different forms of countertransference: countertransference that is in keeping with Heimann's interpretation, in which the countertransference stems from the patient and their pathology (1950) and countertransference in keeping with Reich's interpretation, that is, countertransference as located in the therapist's own transference and needs (1951). This study has found examples of both these forms of countertransference becoming excluded from the process notes, but has proposed that this second type of countertransference may be easier for therapists to observe and record in process notes than the first. For example, we have seen how Therapist 2's feeling of exclusion came to dominate the session with his patient (see page 129). Of course, it is likely that most countertransference includes elements of both Heimann and Reich's interpretations of the phenomenon; thus Therapist 2's feelings of exclusion by his patient could both reflect the patient's feelings of exclusion from her parents, as well as the therapist's own potential susceptibility to feeling excluded.

Although this study is in keeping with previous quantitative studies in finding that process notes when compared to audio recordings of sessions contain a significant amount of changes, omissions and points of difference, the study also finds significant richness in process notes. Such richness lies in the notes' capacity to bring to life the particular experience of being with the patient. Well-written process notes allow the reader access to the therapist's thought-processes and experience of the session, as well as providing information about the patient's appearance and movement. These thought-processes, feelings and observations matter because they are an integral feature of the experience of psychotherapy; they provide crucial information, not just about the therapeutic relationship, but also about the patients themselves. Thus, as we saw, when Therapist 1 describes: 'finding it hard to think, it felt like being bombarded with a barrage of words', she not only sheds light on her experience of being with

the patient at that moment, but also on something of the patient's own state of mind, an indication of a possible attack on the therapist that is taking place at that very moment. If this interaction were studied simply by using the recording, the impression would be of an active therapist asking lots of questions, indeed maybe even bombarding the patient, and if it were studied using only the process notes, there would be no sense of how active the therapist becomes. When the recording is taken in conjunction with the notes an understanding of the feeling – and possible defensive need – behind the therapist's questions becomes feasible (see page 152). This insight into the therapists' feelings and thoughts – as they recorded them – allows process notes to remove the theatrical fourth wall between the session and the reader of the notes.

Yet, despite these benefits, this study suggests that process notes do not exist as a final record of a session; rather they are part of the therapist's on-going processing of that session. The psychoanalyst Thomas Ogden describes the process of supervision of an analysis as one in which the supervisor attempts to 'help the supervisee dream the elements of his experience with the patient' (2005: 1266). Ogden here describes dreaming as 'the unconscious psychological work that the individual does (both while asleep and in waking life) with his lived emotional experience' (ibid: 1266). In this, the process of dreaming – and of supervision – is the process of metabolising and understanding what the analyst has lived through with his patient. This process, Ogden argues, results in the analyst and supervisor 'dreaming up' the patient, not with the aim of recreating the patient within the supervision per se, so much as with the aim of bringing 'to life in the supervision what is true to the analyst's experience of what is occurring at a conscious, preconscious and unconscious level in the analytic relationship' (ibid: 1267).

This study suggests that process notes in themselves form a similar 'dream process' as the supervisions described by Ogden, capturing

aspects of the 'conscious, preconscious and unconscious' facets of the therapy. We have seen how latent emotions and transference possibilities are captured by the therapist's unconscious as they are written into the process notes as if they were something that happened. In this reading, process notes are more than just 'nouns' – the records of the process of the session – but rather they are also 'verbs' – an active processing by the therapist's conscious and unconscious minds of the session through the act of writing. This is a new understanding of how process notes function, and the possibilities they offer to therapists for understanding their patients.

This study shows that the comparison of process notes and audio recordings provides greater insight into the processes present during the session than either form of recording on its own; in particular, the comparison allows a far deeper understanding of the transference dynamic's impact on therapists and their capacity to perceive. Indeed, if process notes alone can be said to remove the fourth wall between the reader and the experience of the therapy session, then the comparison of process notes and recordings goes one step further: it captures aspects of the patient-therapist relationship which the therapists were not conscious of as they wrote the notes, and so invites the reader inside an aspect of the session which would normally remain hidden. Thus, the comparison of process notes with audio recordings affords the therapist, supervisor, and researcher access to something greater than the sum of the parts, indeed, something far greater than a simply more rounded record of the external facts of the session. The comparison is an entry into the core of the therapeutic experience, that of the complex, interwoven experiences of therapist and patient.

This study aimed to generate theories that might illuminate the causes of significantly patterned discrepancies between the notes and recordings, in order to understand more about the processes at work in psychotherapy. I

believe that this study has contributed to the understanding of these areas. Initial theories have been developed, most significantly concerning the role of a 'core transference dynamic' and how that influences the therapists' capacity to observe themselves in relation to their patients and so record it later in the notes. The study also aimed to explore the value and limitations of process notes, and has developed initial theory about the nature and function of process notes as a means for the therapist's conscious and unconscious processing of the session, as well as the influence of the relationships – both internal and external – within which they are written. Nevertheless, as the sample size was small, these theories remain at initial stages and require further investigation.

There are several possible avenues for further research; not just with a larger sample size, but also research that involves male as well as female patients, patients with different presenting problems, studies which explore the differences between different therapists not just the similarities, studies which involve the patient's perspective on the sessions as well and studies which use the supervisor's notes from supervision. As discussed earlier, this study is based on sessions undertaken as part of a much larger research project; it would be interesting to investigate if there were any differences in the results if the sessions studied were from routine clinical work. Further studies in to the unconscious communications contained in process notes would also be interesting to pursue; for example, potential parallels with the Adult Attachment Interview's interest in incoherence and inconsistencies in discourse which are thought to express unconscious meaning could be explored (George, Kaplan and Main, 1985).

Finally, this study suggests a new approach for learning about the patient and about clinical work, here termed 'the comparison method'. The study has shown that a comparison between process notes and audio recordings offers a deeper level of understanding of a session and a much rounder appreciation of what actually occurred on a conscious and

unconscious level in the session than looking at either process notes or session recordings on their own. The comparison method's ability to bring to light how the transference is functioning as it influences what is and, crucially, is not seen in a session in central to this. As such, the comparison method has implications for the training for child psychotherapists, in which supervision is currently based on the use of process notes alone. Given the power of the comparison method to bring a deeper level of understanding, it would be interesting, indeed important, to incorporate it into the training of psychotherapists.

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Appendices

Appendix One

**University of East London &
The Tavistock and Portman Clinic**

University Research Ethics Committee
If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact:

**Joanne Wood, Quality Assurance and Enhancement (QAE)
External and Strategic Development Service (ESDS)
University of East London, Docklands Campus, London E16 2RD
(Telephone: 020 8223 2678, Email: j.l.wood@uel.ac.uk).**

The Principal Investigator(s)
Miriam Creaser
36 Bisham Gardens
Highgate, London, N6 6DD
Tel: 07834 490867

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

A Comparison of Process Notes and Recordings of Psychoanalytic Psychotherapy Sessions with Adolescents

I am doing a Clinical Doctorate at the Tavistock & Portman NHS Foundation Trust. As part of this, linked to the University of East London (UEL), I am now writing a research thesis in which I intend to compare audio recordings and process notes of sessions in order to investigate four key areas:

- How the combination of audio tapes and process notes can contribute to our understanding of what constitutes a clinical fact, for example, if something is recorded in a different sequence from how it actually happened can the repositioning in the process note also be considered as revealing an important clinical fact?

- How the processes of a session unfold. In particular I intend to research how the 'selected facts' of a session come to prominence, primarily focusing on how the therapist's mode of observing and listening shapes the session, by, for example, prejudicing what is listened or not listened to

- How the transference dynamic impacts on the therapist and his/her ability to maintain his/her analytic stance and observational capacities

- The viability of process notes as a corner stone of child psychoanalytic psychotherapy's evidence base.

I have been given permission to approach therapists taking part in the IMPACT study to ask whether you would allow me to base my research on the audio recordings and process notes of your sessions. I intend to look at three sessions evenly spread over the twenty-eight weeks of treatment. I will change names and other details so that no-one will be able to recognise your patient or yourself. As part of this I also hope to interview the therapist in order to gain more understanding about how you found the process of working with your patient and recording your work.

The completed dissertation will be lodged in the Tavistock library, as would any subsequent publication based on it. If you are interested in seeing what has been written you will be able to contact the Organising Tutor of the Clinical Doctorate in Child and Adolescent Psychotherapy at the Tavistock clinic who will put you in touch with me. This is also the person you should contact should you wish to make a complaint about this process.

Confidentiality of the Data

The sessions recordings will be stored using Trucrpyt encryption software and the password will be known only to myself. The process notes will be fully anonymised.
The data will be kept for ten years and then securely destroyed.

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time during tests. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason.

UNIVERSITY OF EAST LONDON

Consent to Participate in an Experimental Programme Involving the Use of Human Participants

A Comparison of Process Notes and Recordings of Psychoanalytic Psychotherapy Sessions with Adolescents

I have the read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what it being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the experimental programme has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the programme at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)
……………………………………………………………………

Participant's Signature
…………………………………………………………………………………………
..

Investigator's Name (BLOCK CAPITALS)
…………………………………………………………………..

Investigator's Signature
…………………………………………………………………………………

Date: ………………………….

Appendix Two
Semi Structured Therapist Interview Questions

IMPACT Project:
How did you feel about being part of the IMPACT study?
Do you think it had any impact on the techniques used?
Were you aware of being part of a study whilst the work was on-going?
How did you find writing the process notes and the supervision?

Relationship to the patient:
Start of work:
What ideas did you have before meeting the patient?
What hopes / worries did you have for the work?
When you first met the patient what were your main impressions?

Development of therapy:
As the work progressed, what was your main sense of the patient – what was she like to be with?
How would you describe your relationship with the patient?
How do you think the patient would have described you?

Ending of therapy:
What did you think about the end of therapy?
Were there any issues / areas that you would have liked the chance to explore more fully with the patient?

Overall sense of the therapy:
Looking back, what do you think the patient was like to work with overall?
What elements of psychotherapeutic technique do you think were particularly important in this case?
Looking back what do you think the main focus of the work was?
How did you tend to feel before and after sessions with the patient?

Is there anything you would like to tell me about the work with this patient?

Appendix Three
Focused Coding for Therapist 2, Session One

Process Notes Not in Recording	Focused Code
Rachel was 10mins early for her session. When I collected her, she was hidden in a corner in the busy w/a [waiting area] but got up straight away. She was dressed in tights jeans and an oversized black jacket with the sleeves rolled up, revealing a white long sleeved top underneath. Her hair was greasy and I immediately felt she needing [sic] caring for.	Therapist's 1st response is noticing she needs caring for. Therapist believes patient is pleased to be here. Therapist believes patient is eager.
She followed me to the room and seemed to be quite pleased to be in the clinic, eagerly looking around as we walked. Suddenly aware of how long the route to the room is, I was anxious to get there and start.	Therapist feeling anxious. Therapist feels the patient looks younger (fit with noticing she needs caring for).
In the room, I sat down and waited as she stood in the middle of the room, quickly took a look around, then slumped on to the sofa. As she did so, she stretched and yawned, looking much younger than she is.	

Recording	Process Notes	Focused Code
Patient I don't answer my phone, that's why my mum took away my phone chat because I just use all the minutes for texts and go over the balance so it costs her more. I don't do it on purpose too but she seems to think I do.	[She said] "So mum's trying to stop my contract, 'cause I just use all my minutes and it costs her more, so I don't do it on purpose but she wants to take it away."	Changes in the representation of patient's parents – shifting from having taken the phone to wanting to take it away.

Recording	Process Notes	Focused Code
Patient Some, most of the time my phone's on silent, it's on silent now, so if I had any texts or calls I wouldn't know until I leave	She replied that it's because she has her phone on silent, "because the people I hang around with are idiots. Like the	Notes reduce the detail. This is unsurprising given the amount the patient talks.

or until I check my phone. But the only reason why I have it on silent is because the people that I hang round with, they're idiots like. Obviously my mum doesn't like me hanging round with the boys that we hang around with because they're getting all more boys than girls. The boys that I hang around with, they rob each other, so my phone's on silent. They wouldn't rob me but it's just in case. Like they tried to rob my friend today and then me and another girl from work stopped it because he, like, he has a gold chain which is like 22 carats and then he has, obviously, a phone, a Oyster card and his money, and they wanted to rob him. And they've already robbed him for his iPod that we tried to stop and we couldn't.

Therapist   So this was a friend of yours that was being robbed as well, or...?

Patient   Yes, he was getting, he was about to get robbed today but me and some girl stopped it. I was like, why are you going to rob each other for, rob someone your own size and then see what happens. And then when they rob someone their own size, they're beaten up for it, but they've got to

boys I hang around with rob each other. There's more boys than girls, because I get on with boys better than girls. But they tried to rob a friend today for his phone and oyster card, that means money, and they've already robbed him of his ipod, but me and another girl from work came along and tried to stop him. But I've never been robbed."

Mother's opinion is missing from the notes.

Changes in representation of patient - more swagger about her not being robbed in recording: 'They wouldn't rob me' as well as and 'I've never been robbed.'

Patient in the recording presenting herself as tough and standing up to the robbers more than patient in the notes.

The patient doesn't say here that she gets on better with boys than girls, but this something she says at other places.

learn. I've never been robbed.		

Recording	Process Notes	Focused Code
Therapist That sounds quite scary. Patient It is quite scary but because I've hanged around with them for a time I've got used to it. Like, when they rob people, if it's like someone I know I stop them, and even if it's people I don't know I try and stop them, but lo and behold they'll push us away and [unclear] me and then we'll just have an argument afterwards. Or we get the stuff off them afterwards and we go give it back to the person so they haven't really robbed them then because we get it back. Like, when I was out, like, a couple of weeks ago some boy that we was with, he was really mad and he just went to rob someone that I knew and I was like, "don't". And then I was with, my friend was with two of her friends and one of them was the one that wanted to rob people, and I was with two of my friends and my friend had, like, you know them Doctor Dre Beats headphones, and he had a Blackberry Torch and they wanted to rob him. I was like, you're not going to rob him because he's with me, you don't see them	I said that it all sounded quite scary. She said that it was, and explained a bit more about how it happens a lot, so she gets used to it and that she tries to get the stuff back afterwards so she can give it back to the original owners. Robin hood flashed into my mind. She went on, "two weeks ago, I was with this boy who was proper mad and just decided he was gonna rob another friend of mine – they had them Dr Dre Beats headphones and a Blackberry – but I told him that this boy was with me, so he couldn't rob him and told him to pick someone else. He said 'you all need to stop stopping me' and got all moody, but we stopped him. So I guess it was ok."	This follow immediately from the above point. Changes in representation on the patient - in the recording goes into more detail about how she stands up to other people. Changes in representation of the patient - in the recording she acknowledges that it's scary and then quickly says she's used to it. That slight distancing herself from things being scary does not happen in the process note. Therapist associates to Robin hood. Changes in representation of the patient - in the recording the patient finishes by saying 'Otherwise, it's all right', whereas in the process note she finishes saying 'So I guess it was ok'. Patient in the notes is slightly less sure of how ok it actually was?

robbing you, like, and like the guy that wanted to rob him was like, your height but he's only, what, 15, but we stopped him.

Then he went to rob some other guy and I was like, why are you picking people that you don't know. Obviously I knew the person but I was like, why are you picking on people you don't know, I was like, just leave him. And he was like, you lot need to stop stopping me, da, da, da, da, da, I was like, well you shouldn't be robbing him, find another way to make money. But otherwise it's all right.

Recording	Process Notes	Focused Code
Therapist I'm just thinking about people robbing things because they need something that they feel they don't have. Patient Some, most of the time, like the people that I know, most of the time when I see them try rob, like I stop it, but the only reason why they want to rob is so that they can sell it to other people because loads of people want to buy stuff lately. They can sell it to other people and then they get money. Therapist To spend on other things that they really want.	I had begun to think about deprivation, the robbing and the slightly unkempt way she was dressed. I said that I was thinking about how people rob because they feel there is something they don't have. She took the baton up, "the only reason is so they can get money. They want something, don't have the money, rob something and then sell it to someone else so they get the money for what they really want."	The therapist is very aware of the patient's deprivation. Therapist understands stealing as a compensation for deprivation. Therapist noticing how the patient is dressed (unkempt). Change in how the patient is represented - the note does not have the patient's further comment that when she sees people robbing she tries to stop them (although it has been mentioned in the process note just before this). Confusion between the therapist and patient: the therapist attributes his

| | | comment that they want to sell stolen items to be able to buy things they *don't have.* Therapist refocusing on deprivation / what they do not have.

Therapist positing alliance between the patient and him: 'she took the baton up.' |
|---|---|---|

Recording	Process Notes	Focused Code
Therapist   To spend on other things that they really want.

Patient   Yes. Because, like, my mum, I asked her for a fiver the other day. | There was a pause while she thought, then she said "like the other day, I asked my mum for a fiver." | There is no obvious pause in the recording. |

Recording	Process Notes	Focused Code
Patient But, like, I never ask my mum for money, I always ask my dad. I don't even really ask him that much either. If I need something, like, important, if I need more clothes or I need a pair of shoes... Like, my dad paid for these but they're already, like, mashed up because I fell in the river.	She trailed off and looked sad, then came back. "I don't ask her for loads, mostly I ask my dad for money, like he bought me these (pointing at her trainers) but they're already a bit mashed up 'cos I fell in the river."	Change in how the patient is represented - therapist creating a greater sense of sadness in the process note with the therapist talking about her trailing off and appearing sad.

Therapist writes the 'trailing off' when talking about asking mum for money. In the recording the moment in which she could be seen to 'trail off' comes later. In recording it's after she's talked about asking her Dad for money more than her mum. So in the recording trailing off more closely linked to ideas about her father and in notes linked to mother. |

Recording	Process Notes	Focused Code

Recording	Process Notes	Focused Code
Therapist You fell in the river? Patient Yes, in [unclear] river, by [E] Road, I fell in. It was kind of funny though. Therapist [Overtalking] what happened? Patient There's, like, this rock bit and then it had water going down it, and then I went and stepped on it and then I was walking on it for ages then all of a sudden I just slipped, but when, even if I hurt I start laughing, I can't cry. And I just left my foot in the water, I just started laughing. It weren't that one, it was that one, and I was just looking at it and I was so laughing. And obviously I pulled it out and I realised it was ruined. Like, there's a bit of a difference; or not that much there now.	I felt she was trying to shock me a bit, but indicated she should go on. "You know the river? It was down there, I was walking on the rocks for ages, but I slipped. Even then I started laughing, I can't cry you see, so I just laughed. But you can see how dirty the trainers got, well not so much now".	Change in how the therapist is represented - in the notes a little more quietly receptive and less actively questioning. Therapist feels that the patient is trying to shock him. Change in how the patient is represented - in the notes stresses the fact that she can not cry more strongly than the patient in the recording.

Recording	Process Notes	Focused Code
Therapist But, just go back a bit; did you say that you can't cry? Patient Yes, I can't cry. Therapist What do you mean by that? Patient Like, where, if I got hit normally I would cry, like, ages ago, and now, like, people, like, when they, like, mess	I interrupted and asked about her comment that she couldn't cry. Without affect she said, "Yeah, I can't cry. Like ages ago I would, you know, if someone hit me I would cry for ages, but now I just laugh. That's why people don't know when to stop. I can only cry if I'm proper proper angry, then I lose my temper then I cry and then it works." She slumped	Therapist notices the patient's moods: her lack of affect and momentary slump. Change in how the patient is represented. In the process notes the therapist writes that the boy who pushes her think it's 'really weird' that she doesn't cry. This is not in recording. Summarising. There is much less detail

about and they punch me and it hurts, I just start laughing. That's why people don't know when to stop because I can't cry now. I can only cry if I'm proper, proper angry and, like I don't have nothing to do and I can't lose my temper I just cry it out and it works, but otherwise I start laughing.

I had some boy, yes, and he was like, do you really laugh when you fall over, I was like, yes, and I was like 'push me' and he pushed me full hard, I didn't think he would push me that hard, but he pushed me proper hard and I cut my hand a tiny bit, yes, and I got up and I started laughing, like proper uncontrollably. And they was like, why are you laughing, like, you've cut yourself, I was like, it's funny, and that. Even though it hurt, like, I can't cry, I just laugh.

The last time I cried is when I got bit by a dog and it took that whole bit, where is it?, yes, you see that lump, it took that whole bit of my hand off and it was hanging. It looked disgusting. It was horrible at the time. It hurt, yeah, but they got rid of the dog after because it bit my cousin as well and it chased me and my mum. So it was kind of a violent dog so they had to get rid

momentarily. Then started again.

"This boy didn't believe me, so I told him to push me, but I didn't think he would push me so hard and he pushed me over so it really hurt, but I just started laughing. He thought I was really weird, but even though I was hurt, I couldn't cry. The last time was when I got bit by a dog."
She then went on to tell me about how she had been bitten and the owners had felt so guilty that they had "got rid" of the dog, and given her lots of presents, which she felt embarrassed by, so had eventually told them that she was fine and that they needed to stop buying her things. She added, "So it's alright now."

in the note. This is to be expected given how much the patient is talking.

Reduction of negative things - in the notes the graphic image of the dog bite is summarised, there is much less gore and violence.

Change in how the patient is represented – above change also removes the possibility of considering what impression the patient wanted to make on the therapist by talking like this or what her own interest in the gore might be.

Change in how the parents are represented - in the process note the description of the patient's mum explaining to her about her neighbour's behaviour buying the chocolate is missing. In this change, a brief moment of a more helpful mother is missed.

of it.

Therapist   When you say get rid of do you mean put down, or...?

Patient   Well, they said that they gave it a new home somewhere in the countryside, but I reckon they did put it down and they just don't want to tell no one. And they gave away their, like, they had a big dog, which was about that high, and then they had a puppy, and they got rid of the puppy as well. I was like, that puppy didn't really do nothing it was just walking around, but they said they don't want any more dogs now because, lo and behold, they'll start attacking again, fair enough.

But they gave me loads and loads and loads of chocolate to say sorry. So every time I see them they would give me chocolate bar. I was like, thanks. Or they would give me money and tell me to go buy something from the shop, and I would do it as well, like. I used to say no, but my mum said, like, their dog bit me, so they're trying to, like, make sure that you're all right. But then I told them I was fine so they said they'll stop doing those sorts of things. But [unclear] it's all right. [Pause].

Recording	Process Notes	Focused Code
Immediately following proceeding extract Patient I don't really talk that much [unclear]. Therapist I was just thinking how much you have to say actually. We've hardly said hello really. Patient I can't do it in front of my mum. Therapist Right. Patient I can't, I'll just sit there in silence. Didn't you notice last time? I just sat there while my mum was talking; I don't talk. Because, lo and behold, I'll say something and then after she'll be like, 'why did you say that?', da, da, da, da, da.	She slowed right down, and looked depressed for the first time. I felt quite rushed with the amount of information she had thrown at me, so took the time to pause as well. She looked at her feet and looked quite down, before mumbling, "I don't really talk much." I said that I had been thinking about how much she had had to say and that we had hardly said hello. She smiled and added that she can't talk in front of her mum, "Low and behold, I'll say something then afterwards she'll say 'why did you say that?'"	Therapist's feels he has had information 'thrown' at him. Therapist feels rushed. Therapist feels this moment provides the first quiet pause in the session. He pauses. Change in how the patient is represented - in the process note patient presents with greater sense of depression. Change in how the patient is represented - the patient in the recording links back to the last session: 'Did you notice?' This isn't in the notes. Therapist observes the patient smiling.

Recording	Process Notes	Focused Code
Patient …Like, last time [in the introductory meeting] when I asked to stay with my stepdad before, he's not my stepdad but I call him that, if he was staying, because she said he might and I wanted to know if he was or if he wasn't. And then when we got downstairs she was like, how could you ask if [step-dad]'s staying, I told you he would. I was like, no, you said he might. She was like, well you didn't have to ask that in front of	She used the example of how her mum had told her off for asking about when her step-dad would be staying at the house during the intro meeting. She went on to talk about her brother and how he is staying at home at the moment, but this is awkward because her brother doesn't get on with her mum's boyfriend. It later transpired that the new boyfriend is her dad's former best friend. When her dad found out about the new relationship, he stopped	Summarising. Summary seems to be to reduce the level of emotional tone captured. The therapist adds father not liking the mum's new boyfriend into the notes. (This does come later in the sessions). This introduces the father in the notes where in the recording it is just the brother who doesn't like the new boyfriend. (Is there something in this change about prioritising the father?)

them. I was like, why not? She was like, because you didn't. Well, I have a right to know. Like my brother and his girlfriend's gone away and my brother's coming back Tuesday and his girlfriend's coming back the week after, so... Therapist So you're in the house on your own with your mum and her boyfriend at the moment? Patient Well, he doesn't, he hasn't stayed that much. He stayed, what, twice while my brother's been gone, because him and my brother don't get on. Because him and my brother used to be really, really close, like well he used to take him fishing, golf, he used to take him to Spain, everything. Then him and my mum got together and then, like, my brother wasn't happy so my brother stopped talking to them both for about a year. Then my brother had money problems and asked to move back in with us and it was a bit weird. It still is a bit weird but there's nothing I can really do about it.	talking to his friend and her brother followed suit.	Change in how the therapist is represented – therapist's question is not in the notes.

Recording	Process Notes	Focused Code
Patient …And then most of the time my mum's shouting as well.	She had spoken to her dad about it, to get him to speak to her mum but he hadn't and she seemed to	Implicit emotion written as explicit. The therapist picks up on sense of being alone. This

Because I spoke to my dad about it and my dad was just like... Because it feels like my mum has troubles at work and then, well not trouble but like has a hard time at work and then when she comes home she lets it out all on me, so I get everything on my shoulders and she walks around free.	feel very alone with it.	is somewhat different to what is explicit in the recording which focuses on her mother burdening her.

Does this change of emphasis to the therapist's sense of her as alone fit with the vulnerability which he felt at the start of the session? Or is he reacting to the sense that her father did not help her out?

Change in relationship with parents – in the note the father is positioned as an intermediary. |

Recording	Process Notes	Focused Code
Patient Does my mum find everything out what we're talking about now?	[She asked] Does my mum find out what I say here?"
I was pleased she asked, and said that I had been thinking about this as well. | The therapist is pleased that the patient asks about confidentiality.

Change in representation of the patient – she talks about 'we' in recording, but 'I' in the notes. |

Recording	Process Notes	Focused Code
Patient I ain't being threatened. I did get threatened ages ago but police and everything got involved. Some girl wanted to stab me to death. But obviously, like, I don't see her about no more, I'm way, I'm way out of her way. And, like, she, I bumped into her one day with my friend and she was like, you two come round here, and then I was like, why can't we just talk here if you want to talk, and it, like... Basically	She told me that she wasn't putting herself at risk, but then went on tell me about how someone had threatened her some time ago. A girl from her area had seen her in the street and had called to her to come round the corner. Knowing that where the girl wanted her to go was a dead end alley, Rachel had avoided it. The girl had said she just wanted to talk to her, but Rachel felt there was something bad going to	Summarising.

Change in how patient is represented - diminished sense of threat and threatening swagger. The possible excitement or nerves in the patient conveyed by the patient's rapid speech not in notes.

Change in how the therapist is represented – the transference interpretation is earlier in the notes so it appears to elicit more material. |

there's a big road, yeah, and my friend's house was there and we was all standing here and she was like, come over here, so we walked down to about here, yeah. And she was like to us, come round the corner, and then the corner's like literally all the way round, I was like, why can't we just talk here. And it was kind of dark so I knew what she wanted, and she was like, no matter what, you two are getting battered.

Therapist	So you thought she was trying to trap you?

Patient	She was. She wanted to beat us up, both up. I was like, 'why do you want to beat me up?', she goes, 'I don't like you or your family'. I was like, 'that's not an excuse to beat me up, it's an excuse to dislike me but not to beat me up'. And then my friend was like, 'why do you want to beat me up', and then she was like, 'you showed my boyfriend a picture of my cousin'. She was like, 'yes, I asked if he knew her, that was it, and it wasn't a horrible picture and it weren't a dirty picture, it was just a picture of her face, that was it'.

And then she was like, well, and then I was like, 'I

happen. When she refused the girl told Rachel that she was going to get stabbed either way, so she may as well come round the corner and get it over with.
I said that she seemed to be wondering about my motives – When people try to make her talk, something bad happens, so why did I want her to come and talk to me? She told me about another time when a friend's ex had wanted to beat her up, because the boy now fancied Rachel. I said that it all sounded quite worrying, that there was a lot of violence in her stories, but underneath it was a question about what we were really going to be doing, and would I help. "Kind of" she said, "I'm not proper curious, but yeah, a tiny bit."

suppose we have to go in Sophie', and she was like, 'yes', so we walked back to about here, yes, and she was like, 'if you lot walk in that house you're getting knifed up tomorrow', which basically means stabbed to death. And then we were, me and her carried on walking and we walked in the house. And then my friend came back out because everyone was outside her house, literally just stood at the door, she was like, 'what's wrong?'

She was like, 'tell Rachel to come out here so I can stab her up with my keys'. And I was like, 'I'm not coming out'. I was like, 'I'm staying in the house'. Her mum, her dad and her uncle and obviously her little brother and sister and the dog was in the house, I thought, 'I'm not going out, I'm staying here'. And then she was just like, 'you're both getting stabbed up, da, da, da, da, da, watch when I next see you'. And that back, I never... I saw her once but then I ran all the way back to my friend's house.

I was going to go to my cousin's but she was there so I've run back. She never chased me though. My friend did to make sure I was all right. I was like, 'yes', I was just [unclear].

Therapist Again, it sounds really quite worrying and there's a lot of violence around. Patient We got it sorted out though. Like, not proper sorted out, like the police was involved, the police know of everything. Therapist But I wonder if one of the other things you're telling me really is that when people try to make you talk something bad happens and, [Patient: Yeah] of course, that's what... Patient Nothing has happened at the moment, like, I'm always in trouble. Like, even with, like a boy used to like me, and I just thought of him as my friend, like more like a brother, and he fancied me. And his ex was in [school] and when I mean ex I mean it was, like, a year ago they was going out, and I had the whole [school] after me because he liked me. I was like, that's not my problem. Therapist So she... Patient She wanted to beat me up because he liked me. I was like, 'that's not my problem'. She was like, 'yeah but I still love him, da, da, da, da, da,' I was like, 'so why did you break up with him?'	210	

Because, like, it's not like I like him. I was like, 'go do something to him and not me'.

Therapist   But I wonder if there's a part of you that's wondering why I'm asking you to come here and talk, what is it that we're really going to be doing, how am I going to help?

Patient   A tiny bit, yes. I'm not, like proper curious.

Recording	Process Notes	Focused Code
Patient And I don't even have privacy when I'm in my house. If my door's closed people just open the door, I'm like, 'where's the knocking?' I was like, 'for all you know, yes, I could have been getting changed and you lot have just walked into my room, you can't be doing that'. And like, if it's to my mum's room, if I walk in she has a go at me, so I have to walk back out and knock. I'm like, 'then why can't you lot just start knocking on mine?'	She stretched back, arching her back in a seductive way whilst looking me in the eye, then carried on. "When I go into her room without knocking, I have to go out again and knock, but she just walks straight into my room. I don't have my bubble anymore."	The therapist notes that the patient seductively arches her back and makes eye contact.

Recording	Process Notes	Focused Code
Patient I don't regret it though. I don't regret trying [to kill herself]. But people think I'm stupid when I say that I don't regret it, because every day it reminds me of it because all I do with my mum is argue. We don't	She said that she knew her school had referred her to the clinic, but "I think it's more because I tried to kill myself. I'm not gonna lie, I still remind my mum about it, when I'm angry yeah, but I don't really want to. It's just	Change in how the patient is represented - patient's lack of regret about trying to kill herself, is not included. Instead it becomes 'reminding' her mother that she tried to kill herself.

Recording	Process Notes	Focused Code
go out together. Her, it used to be her, me and her boyfriend and with me, like, in between, like.	when she p's me off […] We talked about her feeling that she has no privacy, but this was tinged with a longing to be in-between her mum and boyfriend – "It used to be the three of us, we'd do everything together, but now it's just them two."	Does this indicate that the theme of inclusion / exclusion is continuing to be uppermost in the therapist's mind, and the theme of violence (this time against the self) is less captured in the notes?

Recording	Process Notes	Focused Code
Therapist Well, yes, because on the one hand you were saying that you want more freedom, you want to do more things on your own and you want space, you don't want your mum calling you every half an hour when you're with your friends. But, at the same time... Patient Because I do look like a proper baby when I'm with my friends because all my mum does is call me and call me and call me. But it is kind of annoying. But at the end of the day I can't really argue with her because if I argue with her she just moans and moans and moans at me.	I said that she seemed to feel stuck between being a child and an adult – that part of her wanted to be a child and always with her parents, but then there was the more adult-like part of her that wanted to be able to do her own thing.	Change in how the therapist is represented - in the notes the therapist makes a full interpretation taking in both aspects of the patient. Change in how the patient is represented - in the recording the patient cuts the therapist off before he can finish speaking. Change in how the patient is represented – notes miss the patient's sense that there is no point arguing with mum.

Recording Not in Process Notes	Focused Code
Patient ….I'm a fidgeter by the way, if you've noticed. I can't sit still. Therapist Well, perhaps you're a bit nervous? Patient I'm not nervous, I just...	The comment on nervousness and the patient's disavowal is not in the process note.

Recording	Process Notes	Focused Code
Patient Two of my cousins got, yes, two of my cousins got rushed proper bad and that. My little cousin, he's only just gone into Year 8, got rushed so bad, broken ribs, and had to go to hospital for it by a well-known gang. And it got me frustrated to the point where I was so angry I did cry. And then I found out that my friend who used to go out with my cousin set my cousin up and I was angry with her, and I haven't spoken to her since.	This somehow launched her into a story about her cousin being beaten up, but Rachel had found out that a friend of hers had set her cousin up, so she hadn't spoken to the friend since. I was struck by the losses, which seemed to be slowly adding up. The dog, her dad, her mum, her friends. There was a long pause and she held her head in her hands. I said "there's lots going on." She looked at me and said, painfully "My life ain't normal."	Therapist's observation of the patient as upset – head in her hands and speaking painfully.

There is less sense of a pause in the recording than in the note.

Reduction of negative emotion - less sense of the extremity of the violence which her cousin experienced in the process note.

Therapists uses word 'launched' into story – what is the implication of this? |
| Therapist   There's lots going on.

Patient   Yes. My life ain't normal. It's not normal. Other people's lives are just so casual and they can just slip through everything whereas mine, it, I can't.

Therapist   Because something gets in the way?

Patient   I just get reminded of everything, like.

Therapist   Yes. I thought you were saying that you didn't want to remember things that have happened to you before?

Patient   No, I don't, but when it's happened | She felt that other people's lives were so "casual" and when I asked if she felt something got in the way she said that she didn't like having to remember things that had happened before, things in the past. She said, "but the problem is, when things happen and they reflect on me, it's hard to forget them." | |

and it reflects on you it's hard to forget. Like, I do remember funny things that happened in the past, but most things I remember from the past are all angry.	214	

Recording	Process Notes	Focused Code
Therapist Well, one thing you said earlier, when we were talking about you not being able to cry... Patient Yes, I can't cry. Therapist You said that when the boy pushed you over, instead of crying, showing that you were hurt, you started laughing. Patient I was so laughing. I can't cry no more. Like, I smacked my head, when I smacked my head off a wall... Like, I walked into my, when I was at my cousins I walked into a wall like five times, the same wall in the same spot, and every time I done it I would hurt my leg or my foot and I would just laugh because I can't cry no more. Therapist So there's two things there. One is that it seems it's hard for you to show people how you're really feeling... Patient My friend does it as well though. I bumped into my friend on	I said I felt there was a bit of a warning to me again. She got slightly embarrassed and said that she wouldn't ever get violent to an adult. *Comes later in process note*	The process note does not capture the patient's assertion that she is aggressive. Change in how the patient is represented - physicality of her descriptions of the violence not in notes, levels of aggression not in notes. Change in how the patient is represented – sexuality missing idea of cute boy and violence and sexuality of friend not in notes. Change in how the therapist is represented - in the recording the therapist comments that the patient might have been trying to protect herself, but this is not captured in the notes either. The discussion about the patient's possible anxiety about coming is not in the process note. Summarising.

the way here and I was wearing my blue top, she's got it though because she's walked down the way, and I went, as I've gone to take my top off I've gone like that and I elbowed her in the temple and all she done was stood there and laughed. And I was cracking up. And everyone was walking past us just looking at us. That was weird, it was so funny.

Therapist   But you thought you'd hurt her and...?

Patient   I thought I hurt her but she just stood there and she started laughing at me. But she went proper red, she was embarrassed as well because there was a cute boy in front of her. She was acting up and then I done it and it was so funny. I still picture it in my head. [Giggling]

But I am quite aggressive; I'm not going to lie. Like, some girl that I knew, well, like we're friends but she annoys me a lot, she grips me up and tried to push me, so I slapped her really, really hard on her face and she had my hand mark right there. And then she was like, why are you slapping me, I was like, don't ever, ever, ever, grip my arm.

215

Therapist I wonder if that's, kind of brings us on to the second thing that I was thinking. You know, the first is that it's hard to show people how you really feel. But the second is, it's almost as if you're giving me some little warnings, you know, I'm a fidgeter, I don't talk much, I'm aggressive... Patient No, not towards you. I am aggressive though, I can get angry quite quick. But, like, when she grips me up she proper grip, like grabbed me, out of my hair and everything, and I was thinking, no you're not being serious. And she cut, tried to swing me, so I just went bang. And my friend was there as well and she just saw the hand mark. And then my friend was talking to a boy that we both knew and his all friends were behind us. I didn't mean to slap her on purpose so the boys could see her, but she grips me up and tries to act hard in front of them, I was like, it's not happening and then I slapped her, but she was like. Therapist Well, it sounds like you were protecting yourself. Patient I was. Like, I don't like it when people... Like, I used to be proper scared to hit someone, I	216	

couldn't hit no one, da, da, da, da, da, but now if someone grips me up or if someone punches me my instant reaction is to hit them back because you can't just hit me and think you're going to get away with it. Like, there's my friend, he's bisexual, and he tried punching me today and I caught his wrist and I twisted it. I was like, don't try and punch me. And then he slapped me so I punched him in his back. I am aggressive to other people. I'm not aggressive to adults, I would never do it, but if someone, if a kid my age is being aggressive to me I will hit them back. Therapist But I was thinking about ways we all have of protecting ourselves and I wondered if not showing people how we really feel is another one? Patient I don't, if I'm angry with someone then sometimes I keep it in. Otherwise, if they proper, proper, proper frustrate me I'll hit you, it's just that serious. But I think it's not just me hitting them, because the thing is, because I hit, as they start doing stuff to me over my mind and all my past and then it gets me even more angry and then I slap them to get anger out of me if they're like, if they're	217	

proper hurting me though. Like, when that girl tried swinging me it just reminded me about other things that's happened in the, in my family, so I got a bit mental and that, slapped her.

Therapists   Yes. And when you said that you get angry when people remind you of your past, and maybe that's...

Patient   [Overtalking] happened to me.

Therapist   Well, maybe that's one thing that you were possibly nervous about coming here?

Recording	Process Notes	Focused Code
Patient I'm not going to lie, when people start, I try to act bigger than I am because then it might scare them and tell them to leave me alone, and sometimes it does or not, so if they hit me I hit them back.	She said, "I ain't gonna lie, when people push me and hit me, then I hit em back." I said I felt there was a bit of a warning to me again. She got slightly embarrassed and said that she wouldn't ever get violent to an adult.	Change in how the patient is represented - in the recording deliberately aims to scare others.

The therapist does talk about the warning which the patient is giving him, but it comes later in the recording and because of this does not follow so closely on the threat the patient seems to be making here. |

Recording Not in Process Note	Focused Code
Immediately following the previous extract Patient Like today, when I was working, that echoed, [laugh] but today when I was working, like, everyone gets along at the farm and they're all, we're all like a farm family really, so we all mess about with each other. And I was [unclear] then one of the [unclear] just went [unclear] proper hard on my back and I was like,	This is a very long extract which does not feature in the process note.

It covers the following: more mentioning about the intermingling of |

yes thank you Andy, and I hit him back on the thing and he was just like that for ages, so I started laughing.

But even he was laughing, he found it funny as well because he didn't think that I could hit that hard. And then we all started playing who could hit the hardest. So you all stick your hands in the middle and someone just went, bang, and if you could all feel it then they were the hardest, and mine was the hardest.

Therapist   Do you ever worry about getting out of control?

Patient   No. Not when I'm... I did lose control on the farm today though because one of the boys, my friend who's bisexual, his name's Richard, he started on me and he was just, like, we was meant to be working. It was me, him and some other boy, Ben, and we was meant to be cleaning out a chicken coop. Well, he was meant to clean out the chicken coop and me and my friend had to walk around and feed them, all the animals, and check that their bedding was all right.

He let all the chickens out and they were all running around and everything. For half an hour we was chasing one chicken and then he was, and he sat, he had the cheek to sit down and just watch me and my friend chasing them. I was like, you know you're going to get up and do it, he was like, no I'm not that's not my job, so I battered him. Not battered him but I punched him and then he got up and done it. I was like, you can't leave me to do something that you've made a mistake on.

Even the people at the farm weren't happy with him because he weren't meant to let the chickens out. He was meant to go in, collect their eggs, water them, feed them, spot clean it and then leave.

Therapist   And you don't like chickens, do you, so...?

Patient   No, I have a phobia of chickens. So that's, when I was chasing the chicken for half an hour and I walked into a spider web and it was, I see the spider was, like, that big and my friend said it was on my head, he said it was on my head, so I've had a little heart, like a tiny mini heart attack and, like, one of the people came, one of the adults came and made sure I was all

violence and laughter

high levels of violence phobias (chickens and spiders) and getting scared in the session thinking about them
quite a bit of discussion about how her father leaving the family and how upset she was about this
idea of the family atmosphere where she works
how she missed her father now because she does not get to see him often
the therapist's exploration of the patient's fear that people leave her because they do not like her
her dead nan / family friend
her discussion of her father and what it was like when he left the family
missing dad
the importance of her cats and her concern that her mother wants to get rid of them
a discussion about the patient's ambivalence about coming to the therapy and ambivalence about the therapist
how tired the patient is feeling
the therapist asking questions
therapist gathering up worries patient has about people leaving
patient's wish to hold family together

right, gave me water, I was like, yes I'm fine, and he still carried on saying the spider was on my head, and the man was telling him to stop it, he's like, no but it's there, it's there, it's there.

And I was going like that for ages, and then after I just slapped him and he was like, I'm sorry it was never there, I was like, but you just see, watch me have a heart attack, you can't be doing that. I'm afraid of chickens and spiders. And now I'm talking about it...

Therapist   You're worried again?

Patient   I just had a tingle in my head, but I don't like it, it's horrible. [Quieter, younger voice]

Therapist   I was just thinking about memories, and when you remember things it does give you this sort of body sensation and you get those tingles again. And I wondered if that happens when you remember other things, the bad things from your past that you were talking about?

Patient   Sometimes, yeah. Like, I got chucked out of my auntie's... Well my auntie, my dad lives with my auntie, or his sister, and I got chucked out of the house, and they live at [SG]. I went all the way from [there to home] in tears; that felt terrible.

Therapist   Yes, you must have been really upset. Is this what you were talking about last week? So your dad lives with his sister?

Patient   In SG with his sister, yes. He's going to find a house soon.

Therapist   How long has he been living there with her?

Patient   He was only meant to stay there for a couple of months, but he's been there for about five years. He left me when I was in primary school, that's what made me remember it now. Like, my sister was in work, my brother was in secondary school and my mum come and picked me up... Well, my mum called my sister and my sister went to pick my brother up and my mum came to pick me up from my favourite, I remember everything, I was in my favourite lesson of the week,

patient's awareness of therapist's height
what the patient is missing out on to be at therapy
therapist's transference interpretation about the newness of therapy
freedom to speak from mum not being in the therapy session too.

and then my mum come down and I burst out into tears when she told me my dad had left me.

I still love my dad but I don't get to see him that often obviously. [Quieter] But nothing I can do about that. Just, nothing, I can't click my fingers. I try not to, I'm scared because of arthritis. My friends do it all the time and I'm like, [unclear] stop, it's horrible. I'm going to buy superglue and fix my shoes.

Therapist   You went from talking about your dad leaving to talking about something that you find, or you think people might think is horrible about you. Does that make sense? And then talked about superglue, a fix. So perhaps you're saying that really you get worried about people leaving and you're worried that it's because they don't like you.

Patient   No, when my dad, when my dad left, my mum, I was too young. My brother and my sister were old enough to understand when he left but I thought he left because of me, so... And it's not like he took...

Therapist   Yes, you thought that it was because of you.

Patient   Yes, and it wasn't like him and my mum had an argument and then he left, they was just at home and then my dad just turned around and goes, I'm leaving, and he went downstairs to their room, packed all of his clothes and everything, come upstairs, my mum went down and watched him leave the house. And even she broke down. My mum and dad were together for ages. But now the man that she's with now, if it weren't for him then me and my sister and my brother wouldn't be born because he introduced my mum to my dad.

But I guess, in a way, I've got to thank him, but it's his fault, it's kind of his fault. Well the broke up because he started flirting with my mum. But my mum's boyfriend and my dad used to be so close, they even gave each other tattoos. And it sounds weird, but they've got lines going round the thing and it says cut here. It was a joke for them ages ago. They've got it on both things. But my mum's boyfriend done my dad's and my dad's just done his. But my dad and him have got loads of tattoos.

Therapist   But you must have wished that you had some superglue to stick everything back together again and keep him there?

Patient   Yes. Like, I miss my nan as well. She weren't really my nan but she was like my nan. I saw her the day before she died. She was ill and then I said to my mum, can we stay here for the night, and my nan said, it's best that you don't in case you catch it, and then that night, in her sleep, she passed away. So if I did stay and she still passed away I would have woke up, gone into her room, gave her a cuddle and realised she was dead, so it was best that we didn't stay. But I couldn't go to her funeral, I was too young, but my sister went and my sister knew her for 14 years of her life.

Therapist   Sorry, I didn't quite catch it. You said she's not really your nan? Who was she?

Patient   Not really my nan, no. We called her Nanny Sue because obviously she was there for my who childhood, so to me she was like my nan.

Therapist   So she was just a friend, or...?

Patient   She was a really close family friend. Well, me, like, me, my mum, my brother and my dad all called her Nanny Sue, she was still like my nan. She knew me for my whole life. I even have pictures of me as a baby and you could see her in the background. My mum thought I was weird when I said Nanny Sue is in the background, but then she saw her, so it's all right I guess.

Therapist   So another important person who's...

Patient   Gone. And my mum wants to get rid of my cat. But I don't want her to get rid of my cat, I love my cat. My cat's my world. Like, I sleep with him and everything, like I love him that much. But because we have... Yesterday I had to jump over a fence, really, really tall, like double the height of that cupboard you're, next to you, I had to jump over it and then over another one that was just about the same size as that just to go see if a little kitten was fine because it dropped off, it dropped off the roof. And it was all right, it just hurt it's back leg and it's lip was kind of grazed and bleeding a bit, but it was fine.

222

But my brother's cat gave birth to it, isn't it, so I kind of had to. But she seems all right now, but she's not allowed out now without my, without the lady seeing her.

Therapist   But it sounds as though you look after these cats as if they were your own children?

Patient   I do. But obviously, like, I don't clean up after him a lot so my mum gets annoyed, so, because I don't do nothing really. Well, what is that place? Never seen that place in my life.

Therapist   The gardens?

Patient   Yes. My work finished half an hour ago, I mean, no five minutes ago.

Therapist   Yes, so you've had to miss some of the day to get here?

Patient   Yes. Only, well I left at... I had my lunch, which was at quarter to one, and then my lunch finishes at quarter to two, so I didn't really miss that much. 45 minutes, that's about it.

Therapist   So did you have your lunch with friends and then come here?

Patient   Mm-hm, but one of my friends was in for half a day and then she went to, she had to go with her mum to a family relative, and I bumped into her walking up here. She's took my top and gone back to hers. But my mum says she's coming here tonight.

Therapist   Well I wondered if there's a bit of you that was a bit cross really that you had to miss the end of the day [Patient: mmhmm] and you weren't sure if you were wanting to come here or not, or you'd rather stay?

Patient   No, I knew I had to come here but we was meant to walk Bam Bam and...

Therapist   Who's Bam Bam?

Patient   It's a ram. We was meant to...

Therapist   The ram that's leaving tomorrow.

Patient   We was meant to take the two biggest rams for an actual, an actual walk on the road, like, but he said we'll do it tomorrow because I have to miss it [unclear], so this is all right.

Therapist   That was the bit you really wanted to do?

Patient   Yes. But he said, because I had to come here he said he'll do it in the morning before Bam Bam goes, so we're all right really. But he's got three names, Jim, Chocolate and Bam Bam. Jim because the man, one of the guys that worked there calls everyone Jim or Bob. Bam Bam because if you tease him he'll head butt the gate, or if you don't pay him attention he'll head butt the gate. There's even dents in the gate from him, so... And then chocolate, I don't know why they call him chocolate because he's not, he's not even chocolate colour. He's white, like cream-ish like them table legs, so I don't know why they call him chocolate.

Therapist   Confusing.

Patient   Yes, kind of.

Therapist   You know, that made me think about you coming here again, being so new and maybe there's questions about me and what my name is and whether...

Patient   I know your name's [gives full name]. That's all I know really because I didn't, I didn't know...

Therapist   Yes, exactly, that's all you know and maybe you want to know more?

Patient   I didn't know, like, I forgot your name and then when I went to the front desk she was like, look on this thing and see if anything, and I recognised yours, like, [name], and she was like, okay. She tried saying I didn't have a meeting but I knew I did, I was just waiting for her to tell me I did.

Therapist   So it sounds like it was a bit difficult at the beginning actually. You had to kind of stick up for yourself and say that you did have a meeting?

Patient   Kind of, but I don't really mind. But I knew

I had a meeting so it's all right.

[Pause – patient makes noise, little laugh?]

Therapist   It's been a long day?

Patient   I'm tired and my friend's asked me to come out today and I don't think I can be bothered.

Therapist   How did you sleep last night?

Patient   I didn't really sleep. My cat, I couldn't sleep, then I went and looked, got a bit of milk and looked at my cat. Got my cat, he went to sleep on my bed and I cuddled up to him and I went to sleep and woke up at one and went back to sleep. Woke up at four, then went back to sleep, woke up at six and then went back to sleep and didn't wake up until ten to nine and I have to be at work at half nine so I was rushing. I'm meant to wake up at eight but I done a snooze, no, I changed the alarm to 8.15 and it never went off, so I just overslept [unclear].

Therapist   But what happened, did you wake up yourself or did your mum have to wake you up, or...?

Patient   I still got to... My mum... I had to wake up myself. My cat actually woke me up, or the kittens, they started climbing all over me and I woke up and I was like, and I picked it up and I just put it there and she went to sleep and I went to go back to sleep and I looked at the time and I got up. I was tired. I still am but [unclear].

Therapist   I was wondering if you'd wanted your mum to come with you today?

Patient   No. I wouldn't have spoke, I would have sat here and sat here.

Therapist   I didn't mean in to this session but just to bring you here and to be waiting for you afterwards?

Patient   No, not really. I like... Because now I know that I have that bit of freedom and I can say whatever I want and my mum won't know that. Otherwise whenever I talk to a family member they always tell my mum so I don't talk to them any more.

Recording	Process Notes	Focused Code
Therapist Are there lots of secrets? Patient What, in my family? Therapist Just between you and your mum? Patient No, we just don't get on. Patient No, we just don't get on. We always argue. Because whenever I talk she says I talk with attitude all the time and, like, I'm not talking with attitude. And then when I say I'm not talking with attitude then that's attitude and then she'll say, that was attitude, I'll say, yes I know because I was showing you the difference. Then I'm rude to her because she's trying to, I hate it when people tell me I'm doing something when I'm definitely not doing it. When my mum says, why are you giving me attitude, I'm like, I'm not, she says, that was attitude, yes because you told me I was giving you attitude and I wasn't so I gave you attitude. And she's tried telling me that I don't get my attitude from her, well who do I get my attitude from? And because I'm talking about it I'm giving you attitude and I don't	She talked about how her mum often thinks that she is "giving attitude" when she is just talking normally. "And now because I'm talking about it, now I'm giving you attitude." I hadn't taken it like that at all, but said to her that she seemed to be very worried about what I would think of her. She said that she could be quite rude sometimes, and that she didn't want to come across like that. She said that sometimes she worries about what people think of her, but not "proper worried, I just get on with what I do."	Summarising. The summarising seems to down play the level of violence which the patient talks about. Summarising reduces some detail of difficult family relationships and aggression within the family. Change in how the therapist is represented - given a less prominent presence in the process note. Change in how the patient is represented – patient knows she sounds cruel not in notes, but also patient's worry about how others see her not in notes.

even mean to, I'm terrible, I'm just like...		
Therapist Well, I didn't take it that way. I didn't think you were giving me attitude at all, but...		
Patient Yes, but my mum always does. Yes, I know when I'm getting, like, I don't, obviously I don't mean to do it on purpose sometimes, but I know when I'm giving attitude. But I get attitude from my mum and my sister because if you put us all together you would know we're all related and we're all mother and daughter. We're all do like it, even my sister. She threatened to push me down the stairs but she never. She just went like that, she was like, do you want me to push you down the stairs? I was like, go on then. I am, when people threaten to do stuff to me in my family I'm like, go on then it'll make my life a whole lot easier. So I am quite rude when they say that.		
Therapist Well it's quite a powerful thing to say, isn't it?		
Patient Yes, but then I know I sound cruel but I know it hurts them and then they stop doing it. Because they need to understand that you can't just, like, they can be rude		

to me but if I'm rude back I get in trouble for it; it can't happen like that.

Therapist   So it's your way of retaliating?

Patient   Yes. I'm a cow, but...

Therapist   Well, I mean, I don't know, I've just met you today. I was thinking, when you said, I'm giving you attitude now and I don't mean to, I was thinking it wasn't the way that it came across to me, but it does seem that you worry about how other people see you and what they think of you.

Patient   I did worry about it. I do worry about a lot. I'm not that proper worried about nothing. My mum always says I give her attitude but I don't feel like I am.

Therapist   So perhaps you're careful to avoid that kind of thing?

Patient   I try to, but she just always says I'm giving her attitude anyway. I have a lot of anger.

Recording	Process Notes	Focused Code
Patient I try to, but she just always says I'm giving her attitude anyway. I have a lot of anger. I lost a pound. Oh well. Therapist Are you	She started to count some money in her pocket. I felt she was preparing to go, getting her bus fare ready. She said "I've lost a pound. I'm always losing money	Therapist's observation of patient - thinks that the patient is getting ready to leave.

sure? Patient Yes. I always lose money. I lost a tenner the other day and my mum thought I went and bought weed because I come back with red eyes. I don't smoke weed, my friends do and I happened to be in the environment. I go into [unclear] it doesn't bother me that much.	– I lost a tenner the other day and my mum thought had been buying weed." [Sic].	

Recording	Process Notes	Focused Code
Therapist Well we have about five minutes left before we stop for today. Patient I'm so tired. [Giggles] Therapist Well that's what made me think about your mum and her bringing you or not, but... Patient I'm quite happy that I got to travel up here by myself. Therapist But earlier you were saying how it used to be the three of you and now it's just your mum and her boyfriend, but I wondered if there's a part of you... Patient Obviously I want to be a part of them, but I want to have my freedom as well. Therapist Yes, there's this part of you that wants	She started talking about how she does a lot of things for herself, but her mum still thinks she's doing bad things and mistrusts her. This seemed very important for her, but we had come to the end of the session	Summarising. There are several things missing from the process note as there is a lot less detail than in the recording. These are: the discussion about the patient's conflict between wanting freedom from her family and wanting to be looked after by her parents the patient's difficulties with trust the patient saying thanks at the end patient's feeling that mum is restricting her patient going to see dad on her own patient and mum disagreeing about whether she should stay out family relationships (telling on each other, lack of privacy) lack of trust (and transference interpretation relating to this) patient feeling she can trust the therapist.

looking after but part of you that wants to look after yourself. Patient Yes, like, obviously I want my mum to look after me but she treats me like a proper baby and that's what annoys me. Therapist Has that been going on for a long time? Patient Yes, but I feel like I just get used to it, I ain't bothered, it doesn't... Well I am bothered [unclear]. Therapist Yes. I was just thinking about your age and obviously you're getting to that time when you do start going out and doing more for yourself. Patient Yes, I don't, I don't get to do that. All my friends do already. My mum's got to know where I am, who I'm with and what I'm doing every minute or every second of every day. Therapist But she does let you out? Patient Well yes [unclear]. But if my friends want to go somewhere far, like, I have to tell her, like, three days before or I can't go, like. Therapist When you say if they want to go far, I	230	

mean, how far is far?

Patient   Recently she's been letting me go west by myself. I've been travelling up to my dad's for a while by myself. I do quite a few things by myself but it's like, people think that I'm over-exaggerating. When I say I'm 14 and I want my freedom I don't just want to be able to travel somewhere, I want to have the freedom like... When my mum says, I was going to go spend time with my sister, I'm like, okay go on I'll make plans to stay somewhere else so that you can spend time with her.

If I do, if it's not, or if I'm, like I was meant to stay at my nan's, I was meant to stay at my nan's, yeah, but because it was like half nine and I never told my mum that I was going to stay at my nan's she told me that I had to come home because I was being selfish, so I had to go all the way home. But I weren't being selfish though, I never asked my nan, my cousins did, but I should have stayed that day because my cousins were stupid and rude towards my nan to the point where she kicked them out at four o'clock, at six o'clock in the morning. But I don't have to [unclear].

Therapist   Have you got lots of cousins?

Patient   I would name them for you but there's so many.

Therapist   There's lots?

Patient   My family's quite big. And that's the only way I think about it because if one person finds out then they tell another one, then they tell another one, and they keep on telling each other, it's just so... I was like, why do you have to tell each other, why can't you just keep it to yourself?

Therapist   So it's another way in which you feel you don't have privacy?

Patient   I don't have privacy in my family. If I tell my, like when, before me and my auntie fell out I used to tell her everything, and I mean everything, and now I don't tell her nothing, I don't trust her, I don't trust no one. I don't trust no one but myself.

Therapist   Well maybe that's something important for here as well, you know, can you trust me?

Patient   I think I can. Can I? [Laughs] No, I think I can because, like, all this here [unclear], obviously,

like, the only person you could talk to is my mum and you said everything's confidential. And it's not like you know all my family, and if you did I'd be quite surprised because I have a big family, for one, but... I just like, I like to know if it was someone that... Like my doctor, every time I went and met him my mum would be there, and I was like, why do you have to be here? My doctor's is literally, like, ten minutes down the road from mine, so why did my mum have to come?

And it's just like, well I live in B, I live in B, so this is quite, like, 25 minutes away and she's still not, and she, and she let me come here but she wouldn't let me go to my doctors by myself. I'm not really bothered.

Therapist   So things are changing?

Patient   Yeah. A lot though, I try not to make it change but I [unclear] a lot.

Therapist   Okay. All right. We'll stop for today. But same time next week?

Patient   Yes.

Therapist   Okay.

Patient   Thanks. [Inaudible].

Process Notes Not in Recording	Focused Code
She got a bit lost on the way out of the clinic, but made eye-contact when she said goodbye, checking that it would be the same time next week.	Therapist's observation - notes that patient gets a little lost. He also notes the eye-contact at the end, perhaps some sense of connection at the end of the session.

Appendix Three
Turnitin Receipt

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission. The first page of your submissions is displayed below.

Submission author: Miriam Creaser
Assignment title: Submit your Doctoral thesis to Tur...
Submission title: A Comparison of Audio Recordings...
File name: _422644087A_Comparison_of _A...
File size: 7 4 6.25K
Page count: 186
Word count: 61,255
Character count: 303,4 82
Submission date: 27 - Jul- 2015   10:14 PM
Submission ID: 4 621094 9

Appendix Four
Ethics Approval Letter

Ms Miriam Creaser

c/o Paru Jeram
Academic Governance and Quality Assurance
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

08 October 2015

Dear Ms Creaser

University of East London/The Tavistock and Portman NHS Foundation Trust: research ethics

Study Title: *A Comparison of Process Notes and Recordings of Psychoanalytic Psychotherapy Sessions with Adolescents*

I am writing to inform you that the University Research Ethics Committee (UREC) has received your documents, which you submitted to the Chair of UREC, Professor Neville Punchard. Please take this letter as written confirmation that if UREC had seen a full and correctly submitted application at the appropriate time, it is likely that it would have approved it. However, this does not place you in exactly the same position you would have been in had UREC approval been obtained in advance. Therefore, when responding to any questioning regarding the ethical aspects of your research, you must of course make reference to and explain these developments in an open and transparent way.

For the avoidance of any doubt, or misunderstanding, please note that the content of this letter extends only to those matters relating to the granting of ethical clearance. If there are any other outstanding procedural matters, which need to be attended to, they will be dealt with entirely separately as they fall entirely outside the remit of our University Research Ethics Committee.

If you are in any doubt about whether, or not, there are any other outstanding matters you should contact Mr William Bannister at the Tavistock and Portman NHS Foundation Trust (e-mail WBannister@tavi-port.nhs.uk).

Yours sincerely

For and on behalf of
Professor Neville Punchard