Being Used as a Mouthpiece: Mutual Recognition during Parental Feedback

by **Melissa Card**

Abstract

The experience of being a therapist can be both gratifying and frustrating at the same time. This article takes the form of a psychoanalytical formulation of the process of therapy and parental feedback sessions conducted with an adolescent diagnosed with bulimia nervosa. It also incorporates the therapist's experience of being in the room with both the patient and the patient's parents. Through exploring the concept of 'mutual recognition' and being present in the moment, it seems that therapeutic change is able to occur in both the patient and the family. Furthermore, this article explores the difficult process of negotiating feedback sessions with the patient's parents. The expression of the experiences of both the therapist and patient are brought to life by psychoanalytical theory and phenomenological experience. A phenomenological exploration of experiences allows for the transcendence of conventional investigative research settings as "interpretive phenomenological research cannot be separated from the textual practice of writing" (Fortune, 2009). This article could constitute a protocol as it captures unique data from a setting that is often not easily accessed, and provides data and insights from the perspective of the therapist, which are often not expressed.

Introduction

This article seeks to make sense of how the term 'mutual recognition' can be put into operation in the patient-therapist setting, as well as the therapist-parent setting during the process of feedback. Through 'seeing' and 'knowing' a patient both cognitively and emotionally, the patient can be 'brought to life' to her parents. This allows them to experience her differently, and thus allows for shifts in this particular patient and family to occur.

Phenomenology allows for a detailed description of conscious experience and the analysis of mental experiences rather than observed behaviour (Basson & Mawson, 2011). Phenomenology, inspired by Heidegger, focusses on the explanation, construction and interpretation of information (Basson & Mawson, 2011). This article is based on Moran's (2008)

contention that phenomenology can be understood as a radical, anti-traditional style of philosophizing used to describe phenomena (Basson & Mawson, 2011). This article seeks to theorize processes that may be at play during feedback sessions when working with an adolescent patient who has been diagnosed with bulimia nervosa.

Working with patients diagnosed with an eating disorder is a difficult task, especially when the patient is an adolescent (Fleming & Szmukler, 1992; Franko & Rolfe, 1996; Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009). Not only does the therapist have to contend with the patient trying to find and establish an identity separate to that of the parental couple, but there is also the presence of an eating disorder that must be dealt with (Franko & Rolfe, 1996). In any therapy with a young individual, the negotiation of parental feedback represents an additional

complication. These feedback sessions can be either a positive or difficult experience for the therapist and/or parents. The process is especially difficult when there is an overt sense of frustration and anger at having to deal with an eating disorder, clandestine feelings of hopelessness and helplessness, and fears of not being able to help their child. The therapist is required to strike a delicate balance between being able to hear, understand and recognize her patient's feelings, while being sensitive to the parents, as well as identifying and addressing the dynamic and structures in place that have allowed for the development of an eating disorder.

A recent experience provided a renewed sense of hope that perhaps the process of understanding, experiencing and 'knowing' a person is enough to inspire change, not only in the therapy process, but in the family as well. There is a shift in experience when a therapist knows a patient and the patient feels known by the therapist. Insights develop that perhaps seem mysterious at first but may be a product of two subjectivities both consciously and unconsciously knowing, experiencing and recognizing each other.

In attempting to examine the idea of 'seeing' and 'knowing', theories within the realm of contemporary psychoanalysis and phenomenology are outlined. This article explores the term 'mutual recognition' by drawing from its historically phenomenological influences, moving toward a more contemporary theoretical understanding of the concept and its uses in psychoanalytic psychotherapy. The way in which sense was made of this concept as part of the experience of providing feedback to parents of an adolescent patient diagnosed with bulimia nervosa is discussed. The processes involved operationalizing feedback sessions that allowed the parents to experience their daughter differently.

Mutual recognition

The concept of mutual recognition has received increased attention within contemporary psycho-analysis (Orange, 2008). The term evolved from the concept of 'recognition', which has its philosophical roots in Hegel (1807/1977) although various modified psychoanalytic usages of the term have emerged (Reis, 2008). Recognition is mentioned in the works of Lacan, through his emphasis on 'mis-recognition', self-psychology and the mirroring process; in Winnicott's developmental theory; in Benjamin's mutual recognition; as well as in the process of recognition as defined in infant research and the Boston Change Process Study Group (Orange, 2008; Reis, 2008).

According to Reis (2008), Hegel's work is important for psychoanalysis as his book operationalized the process of becoming a 'self-conscious being', that is, a person who can tell what is of themselves and what is derived from outside. Reis (2008) argued that, for Hegel, an individual's capacity to be conscious of an external other as distinct from that individual, requires some level of awareness that the self is a subject for whom something distinct, an other, is presented as 'known'. This process requires the reflexivity of self-consciousness (Reis, 2008). Hegel (1807/1977) suggested that, "self-consciousness exists in and for itself when, and only by the fact that, it so exists for another; that is, it exists only in being acknowledged" (p. 111). This hypothesis suggests that the creation of the self only comes into being (indirectly) "by virtue of being recognised by another human self" (Hegel, as cited in Reis, 2008, p. 161). Hegel further added that the individual cannot have an immediate relation to the self, but only relates to the self as mediated by the other (Muller, 1996).

The idea that being recognized and seen by another person is fueling and allows for the identification of a sense of self may be useful in trying to understand what might happen in the case of an eating disordered patient, whose self has been formed while at 'war' with the other person (parent/s). This may have a resultant effect of the patient experiencing a surrender of her sense of self as she has given up the hope of ever being recognized by her parent(s).

Giving feedback to the parents or caregivers of eating disordered individuals can be a difficult and unfulfilling process (Le Grange & Lock, 2007). The therapist is often left feeling inadequate and helpless as (s)he is unable to shift the patient's perception, and, by virtue of this, is unable to help the parents 'see' or experience the patient. It could be argued that the eating disorder has allowed the patient to be 'seen' by her parents, possibly constituting a form of misrecognition (Lacan, 1973/2006). The establishing of an eating disorder as a sense of self is perhaps the product of a distortion of the individual's relation to themselves and the injury this caused their identity (as described by Reis, 2008). If this is so, the goal of therapy could then be to create an experiential space where therapist-as-person and patient-as-person are recognized as equals in order to allow for what Fraser (2000) termed "true intersubjective relations". By virtue of the therapist knowing or experiencing the patient-as-person this could allow for the 'true self' of the eating disordered patient to emerge.

Winnicott (1971a) described and illustrated, with case examples, the interactive process that transpires between therapist and child as each alternates drawings in the game he calls 'squiggles'. Winnicott detailed the drawings by which each embellishes the squiggle of the other. Within the context of Winnicott's observation, the child becomes aware that

another is aware of what the child is aware of within, bringing both parties to a moment of shared awareness. This is a moment of 'specificity' in recognition, which Winnicott called both a 'sacred moment' and a 'moment of meeting', which involves a new coherence in the child's experiencing of both its inner and outer worlds of awareness. The consultations Winnicott described were often single diagnostic sessions, but if the 'sacred moment' of being 'known' was reached, this ensued the change in the child's self- regulatory organization, which would endure over many years, even from that single experience. Recurrence of such moments provides the conditions within which one comes to 'know' oneself as one is 'known'. Sander (1995) further suggested that such moments of recognition may result in the establishing of what Winnicott called the 'true self', the self that is spontaneous and not bound by social approval.

It seems possible that this process, described above by Sander (1995) through Winnicott's understanding of a space in which a 'sacred moment' could occur, could lead to a bulimic patient allowing the therapist to 'know' her during that 'moment of meeting'. It also seems possible that this 'moment of meeting' could result in the patient and therapist both knowing that they see and understand each other. Finally, it seems possible that this process could assist the therapist in understanding the patient's plight and feelings of oppression that are stifling the expression of her potentially true self.

Contemporary interpretations of mutual recognition

Benjamin seems to critically adopt the Hegelian paradigm by perceiving it through Winnicottian lenses in order to understand the shift in power relations (Reis, 2008). Benjamin used these theories to illustrate her argument that in order to be recognized, recognition of the other needs to occur in a simultaneous process. However, in order for this process to occur, mutual influence must exist. She asserted: "Both mother and infant must balance self-assertion with recognizing the other as separate, and each afford the other opportunity for dependence and independence". She further qualified this by saying: "The paradox is that the child not only needs to achieve independence, but he must be recognized as independent by the very people on whom he has been most dependent" (Benjamin, 1999, p. 52-53). Benjamin used the findings of infant research to argue that the developmental trajectory to self-awareness operates through recognition of the subjectivity of the parent or caregiver. This, Benjamin argued, could also exist in the therapeutic setting where the analyst (mother) is no longer just the fantasized intrapsychic other. Instead, she concluded that "the other must be

recognized as another subject in order for the self to fully experience his or her subjectivity in the other's presence" (Benjamin, 1995, p. 30). Early reciprocity and mutual influence are best conceptualized as the development of the capacity for mutual recognition (Benjamin, 1999). Adding to Hegel's claim, Benjamin suggested that, in trying to establish itself as an independent entity, the self must experience the other as a person like itself in order to be recognized by the other (Benjamin, 1999).

Based on this reading of Benjamin's argument, it may be assumed that, in therapy, there is a need for the patient to see the therapist as a person in his/her own right. The patient needs to acknowledge that there are two separate people in the room and that they need to trust that a mutual influence exists, allowing for an understanding of each other. However, as much as the patient has to experience the therapist (or mother) as the 'other', the therapist (or mother) also needs to experience the patient.

Orange (2008) argued that there may be more to the idea proposed by Benjamin, asserting that Benjamin did not clearly indicate that reciprocity and mutual influence are precursors to mutual recognition. Orange (2008) explained that what Benjamin means is that there is perhaps a reciprocal notion that exists in mutuality. The parent cannot experience the child unless the child is simultaneously experiencing the parent, thus each makes possible the other's recognition.

To illustrate the concepts put forward by the unlikely bedfellows of Benjamin and Orange, I would like to use the following case example of how change can occur in the presence of mutual influence and mutual recognition. Perhaps, through the process of mutual recognition, attunement is born, providing a platform where the therapist may be regarded as a 'tool' to carry the capacity of mutual recognition from the therapist-as-person in the patient's therapy situation to the feedback (with parents) situation. During this process, the therapist may be regarded as the 'tuning fork', assisting in allowing empathic attunement where recognition of the independence of the child's self is acknowledged and understood.

At this stage, the 'other' subject, Lilly, present in this 'moment of knowing' and being experienced as a separate independent person in her reality, is introduced. Consent for the article was obtained from Lilly and her parents, and pseudonyms have been used to protect their identities.

Case study

Lilly is a fifteen-year-old adolescent girl who was brought to therapy by her mother. Her mother,

Tarryn, thought that Lilly had an eating disorder despite Lilly's vehement denial. During our initial sessions together, Lilly was not at all interested in the process of therapy. She paid attention to neither her mother nor myself during the initial sessions. After the assessment sessions, it was clear that Lilly was bulimic, but she personally did not think that she had a problem and thought her mother was wasting money by forcing her to see me. The process of Lilly attending therapy seemed to be driven by her mother for the first four months. During this time, Lilly was distant, defiant, difficult and challenging in therapy. She seemed to feel entitled and wanted things done her way. However, after a few months, she was able to hear my reflections on her demanding nature and how she and her family were reacting to an environment they were creating.

Throughout the early part of our therapy together, I had the feeling that I did not completely understand Lilly. Although the relationship was superficial, the connection was strong enough for it to be maintained. The December break (summer holiday) proved a difficult time to negotiate with Lilly, as she did not want to engage in any discussions concerning this topic. Lilly constantly told me that she would be fine and suggested that maybe I was the one who could not deal with the break, and perhaps she was correct. We spoke about our mutual trepidation regarding the upcoming break and how we proposed to deal with this trepidation. Despite her wanting to create the impression of not caring about the process or about me, we both trusted in our relationship enough to know that, regardless of her tough act, she was listening to me.

I have always felt a sense of being a maternal caregiver and protective of Lilly. I would keep her in mind during breaks in therapy and would wonder how she was coping with the distance of 'our space'. When it was time for our first session after the break, her mother called to tell me that things had gone well during the holiday, but said that, as soon they returned home, Lilly's behaviour went back to normal. After speaking to Tarryn, it became evident that the family thrived on anger and aggression and that this was the 'language game' the family used.

When Lilly arrived for our session, she spoke of the holiday as a liberating experience and commented on the fact that she had been able to connect to a part of herself she did not know she had. Distance from her parents was something she craved but did not have because she experienced them as engulfing. This was perhaps the instance when Lilly highlighted her misrecognition by her parents and her surrendering of her self without the hope of ever being recognized.

The sessions subsequent to the holiday seemed to bring out a side of Lilly I had not seen before. There was energy in the room that I had never felt before. She seemed present in the room but was also real, and was no longer someone fighting a process that was experienced as being forced on her. We spoke about the experience of being present, involved in conversation and part of forming a meaningful relationship. Lilly seemed to understand all of this, and almost confessed that initially she had not thought that she would be able to engage in the therapy process. As the therapy progressed and we moved from thinking processes to the emotional realm, Lilly seemed to become more courageous and daring in the sessions, challenging both of us. She communicated her dreams and brought drawings to our sessions, allowing us both insights into her emotional world and 'deepest fears' (as she put it) she felt she could not voice. It seemed that Lilly started to develop trust in me, and in us, which allowed her to share her vulnerable side. Thus, the initial therapy process with Lilly painted a picture of the notion of finding an identity and getting to know oneself.

Just before the Easter vacation, twelve weeks after the summer break, Lilly seemed positive about getting through the break without binging and purging. We were to have our monthly feedback session with her parents the following week. Lilly chose not to be part of the feedback session, but was very active in providing material she thought pertinent for me to discuss with her parents.

On the day of the feedback session, Lilly arrived at my office looking terribly upset. Almost fuming, she stormed past me into the room and took her usual seat. She sat down and immediately said, "I hate them! I wish they weren't my parents. They just annoy me so much." She was angry and told me, "You would also be angry if you had to live with them". I asked if she could fill me in on what had happened during the week, as last week she was in a positive space and was now furious. She ranted, "Well, to be honest, things were fine, but that man who calls himself my father is a monster! I hate him so much! Argh, he just makes me so mad. I'm so upset that I can't think straight. He wants to make it about me, as though I am the problem."

At this point, Lilly proceeded to tell me about an argument she had with her sister about a missing t-shirt when her father involved himself in the matter. In a fit of rage, he grabbed her by the jaw and pushed her up against the wall. Lilly recalled what her father had said to her, saying, "He called me an ungrateful, spoilt brat and said that I would be the cause of their divorce, but before that happened, he said he would make sure that I knew what it was like to not have. He told me that his punishment was to take away my

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privileges and gate me from everything." Subsequent to this interaction, Lilly and her father had not spoken to one another and simply ignored one another's existence.

Lilly went on to express that she no longer wanted me to have the feedback session with her parents. The feeling in the room went from one of heightened anger to one of fear and despair. I wondered if she were afraid that they would hurt me and asked her if this was the case. She replied, with eyes welling up with tears, "He'll squash you! He's so much bigger than you." She shook her head and laughed in an attempt to hide the tears rolling down her cheek. I conveyed my thoughts to her that she seemed worried about me, and that she seemed to want to protect me from the pain her father would inflict on me, in the way that he inflicted pain on her. I suggested that she was anxious that he would silence me and hurt me in the same way he did her, and that she did not want me to experience the hurt that she was feeling. With tears in her eyes, she nodded. I wondered whether perhaps she was also afraid that I would be taken away from her, and, since she did not want to lose me, she was trying to protect me in the same way she wished there was someone there for her to protect her from him.

During the above discussion, I experienced an overwhelming sense of sadness. In that moment, I experienced myself as being a mother to Lilly, and was sad that my patient, whom I experienced as my child, was so scared that I would be taken away from her by 'this other' who had been imposed on us. I think that this was perhaps our 'moment of meeting' and recognizing each other, in which she saw me as a person who recognized her and her feelings and I saw her as an individual in her own right. She was finally able to trust that I had her best interests at heart and that perhaps I was strong enough to deal with her parents, especially her father, because I knew how she felt. She could draw from my strength, knowing that, in the feedback session, her voice would not be lost, because someone else had 'seen' and 'known' her.

At this point, Lilly looked up at me nodding her head, her big blue eyes more vivid in colour because she had been crying, and said, "I was thinking last night that he uses me as an excuse to express his anger in the same way that I use bulimia to hide my pain." I was completely surprised by what she had said, and, out of sheer amazement, blurted out, "Wow, Lilly that was an amazing thing to say. You should be sitting in this chair" (pointing to the therapist's chair). She responded, with a smile on her face, "Really? I was just saying how I feel. I don't know where that came from". Later in the session, Lilly told me that it felt good for her to hear that I thought she was making sense because she always felt as though she was babbling. She also gave me permission to use her sentence in the feedback session with her parents. As she left the room, she turned to look at me and said very confidently, "I'll tell them you are ready for them", conveying to me that she trusted me to keep her present in the room despite her absence.

When her parents entered the room, an overwhelming sense of anxiety filled my entire body. Her father was an enormous man, especially when compared with my own small stature, who could indeed squash me if he so desired. They sat down and proceeded to tell me a similar story to Lilly's about the argument during the week. Tarryn said, "I really do not like my daughter right now. I know this is me being a bad mother, but I don't want her to go to hospital. I want her to go to somewhere worse than hell. That's how mad she makes me." Charles (Lilly's father) agreed with this and added to Tarryn's experience by emphasizing how he wanted to instill a fear of him in Lilly, so that she knew who was boss. This conversation brought to life Hegel's notion of the power dynamics at play during the process of recognition.

While Lilly's parents were speaking, I felt myself identifying with Lilly's fear of her father, which allowed me to understand Lilly's feeling of paralysis in her father's presence. I could easily have fallen into the same power struggle, where her father could have exerted his influence on me and I would have surrendered. Instead, I think I was able to allow myself to feel the emotions stirred up in me by both Lilly (fear and sadness) and Charles (anxiety and fear). This rendered me attuned (a concept to be discussed later) to their separate experiences. This allowed me to convey a message that they were not the same, but different, and that this was okay.

I acknowledged Lilly's parents' frustration and anger toward their daughter because, in their eyes, she was impossible to deal with, and to them it felt as though she was the cause of all the arguments at home. Both Charles and Tarryn agreed in unison with this statement. I also highlighted the fact to Lilly's parents that it was easy for the family to engage and express feelings of aggression and anger, but that they struggled to acknowledge hurt, pain and sadness.

I spoke to them about my experience of Lilly prior to their entering the room, and how she perceived the incident, and how it saddened me that I was able to see and know a side of Lilly that they did not. I continued to tell them what insights Lilly had given me into their relationship, repeating that one small, perceptive line uttered by Lilly in the depths of her despair. Tarryn took a deep breath and with a tear in her left eye, asked, "Did those words come out of my child's mouth?"

When Charles exerted his presence, I felt like I needed to back out of his space. It also put me on the back foot, where I wanted to assume a defensive and attacking position to try and preserve myself from being destroyed by him. I confronted Charles about this experience of him, and the fact that I felt terribly intimidated by him, as though I was being punished for a crime I did not commit. He seemed surprised and said, "But, you didn't do anything wrong. Why would I intimidate you? I would never hurt you." I illustrated his actions and commented on how, when he sat forward in his chair and ferociously pointed his finger in my direction, this made me feel that I needed to cower back into my seat in order to allow his presence 'to put me in my place' as it were. He laughed and said, "I don't do that, do I?" Tarryn interjected and said, "Yes, Charles, now that I think about it, you do do that, and it is helluva intimidating". I went on to say that I wondered whether during the mid-week argument with Lilly, Charles' anger towards her was excessive and inappropriate given the situation. I suggested that it was almost exaggerated, as though his punishment for her did not fit her crime. Charles replied, "She speaks to me in such an ungrateful way, it just angers me. I have had to work hard for what I have and she just takes it for granted."

The subsequent interaction with Lilly's parents seemed almost surreal. I asked Charles, whether, in some way, there was a part of himself, which he did not like, that he saw in Lilly. I suggested that perhaps, through his exaggerated anger and punishment of Lilly, he was also being angry and punishing toward that part of himself. He agreed that they were very much alike. I went on to interpret his relationship with his parents, and inquired whether it was possible that a similar scenario was playing out with his daughter. In this new scenario his daughter was playing his role as the child, while he played the role of his father and Tarryn played the role of his mother. He laughed and said, with resentment in his voice, "Yes, but you know what? She says things to me that I could only wish I could say to my father. My mother was very strict with me, so I would never have gotten away with the things she says and does." He then took a breath and sat back in the couch and looked at me, with tears welling up in his eyes, and said, "It's my childhood repeating itself and I'm doing to Lilly what my parents did to me." Tarryn confirmed this, saying to Charles that it did seem like his upbringing. She also empathized with him, saying how difficult it was for him and that she knew he still had much resentment toward his father. The session concluded with Charles acknowledging his daughter's difference and independence from him, and the fact that he had been treating her like a part of himself for a long time. Charles managed to see his daughter as an individual

and me as a separate individual, without the transference blocking the process of recognition.

Therapist transformed

In relaying this part of the session, I am reminded of my feelings for Lilly. In the time spent with Lilly before her parents arrived, Lilly became a person for me, an individual. There was no theory in my mind that she needed to fit into in order for me to know how to behave. Instead, my listening to her and feeling her fear seemed to allow me to be emotionally available enough for our individual experiences to meet, 'see' and 'know' each other in that moment.

For a long time, I had offered interpretations to try to help Lilly understand her eating disorder and the purpose it might have been serving. However, those interpretations were perhaps unnecessary as the eating disorder was not the focus. Instead, the focus was on relating and building trust in each other to allow 'knowing' to occur. Further than 'knowing', I think that the empathic stance I was able to take, through just listening and not interpreting, allowed her to use me and transform me into what she needed me to be to convey her experience to her parents. I am reminded of Winnicott's (1971b) words when he stated: "I have become able to wait and wait for the natural evolution of the transference arising out of the patient's growing trust in the psychoanalytic technique and setting, and to avoid breaking up this natural process by making interpretations ... which only seem to highlight the limits of my understanding. The principle is that it is the patient and only the patient who has the answers" (p. 86-87).

Orange (2008) argued that as therapy continues, the trust between the patient and therapist grows and there is less reliance on clever transference interpretations. She argued that the analyst, like a good parent, should not be overly concerned with whether the patient or child experiences her as a separate person. Instead, such acknowledgement is a side-effect of the relentless treatment of the patient as a welcomed individual, surviving and refraining from retaliation. For Orange (2008), it is the analyst's actual human capacities that make all the difference, whether or not the patient notices these capacities.

Orange (2008) argued that therapists/analysts need to see their patients as individuals and avoid seeing them as cases. Seeing a patient as an individual allows the analyst to understand the experiential world of the patient, thus creating a space for better emotional attunement to emerge (Orange, 2008). Emotional attunement and progress in therapy are hampered by the analyst's need to be right and to have a firm grip on his cherished theory (Orange, 2008). For a long

time, I found myself engaging with patients in a distant manner as though they were 'cases'. However, with more experience, involvement and expression of my own emotional capacity, I was able to allow for emotional attunement to occur, which, in turn, allowed for access to a deeper level of therapeutic material. Loosening the grip (while not letting go of it completely) on theory allowed for an open space to negotiate emotional 'knowing', rather than creating a cerebral barrier between my patients and myself.

Therapy transformed through 'knowing'

Genova (1995, p. 26) wrote that "seeing-as weaves thinking and seeing together into an inextricable whole", which makes it impossible to distinguish between the therapist and patient. Orange (2008) seemed to take the concept of 'seeing', as described by Genova (1995), further by adopting the philosophical metaphor of 'the fly-bottle' as described by Wittgenstein (1984, as cited in Orange, 2008), claiming that, "The task of philosophy is to show the fly the way out of the fly-bottle" (p. 189). This raises the question of whether psychoanalytic healing is a similar process, in which analysts and therapists help clients to understand their entry into the fly-bottle, negotiate their time there and find their way out (Atwood & Orange, 2008). This is an interesting idea to me, and one to which I think I can relate with respect to therapy with Lilly.

What Atwood and Orange (2008) proposed is that therapists join their patient in their particular fly-bottle. By being in the fly-bottle, therapists are able to gain an intimate understanding of how the patient managed to get into this fly-bottle, and what it feels like inside, thus staying close to the patient's experience without identifying with the experience. Identification as a defense would result in twin lost souls being trapped in the fly-bottle. Rather than using identification, the concept of emotional attunement should be used, because attunement suggests that there are two psychological worlds each with their own distinct way of seeing and being (Orange, 2008).

This raises the question of how one gets out of the fly-bottle once one is in the bottle. The way out is not always clear, especially if identification (not as a defense) is necessary to facilitate emotional attunement. Orange (1995) postulated that therapists do so through a process of what she termed "making sense together" (p. 90). Here, the analyst gets close to the emotional world of the patient through verbal and nonverbal conversations, where together they identify the nature and rules of a language game in a particular experience/relational world (Orange, 1995). The analyst should be able to go into the fly-bottle and explore and understand the emotional world of the

patient, much like the 'sustained empathic inquiry' described by Brandchaft and Atwood (1987). With Lilly and her parents, I was able to get close enough to their emotional world to identify the nature and rules of the language game in their relational world, and by so doing I was able to relate to them in a manner in which they could feel understood.

Orange (2008) suggested that we need to be cognizant of the fact that the fly in the fly-bottle must feel trapped, frustrated and perhaps injured. The fly became trapped in the bottle through processes such as emotional violence, trauma or parental pathology. The fly has been left to struggle without being able to see a way out, resulting in repetitive collision with limitations. The trapped person is then often blamed for causing their own troubles, accused of projection and identifying with their own projections, as if the fly-bottle were not formed and maintained relationally. Analysts should not imagine that they would be exempt from feeling what it is like in the patient's emotional world. No mechanism, like projective identification, is necessary to explain this experience (Stolorow, Atwood, & Orange, 1998, as cited in Orange, 2008).

I believe that this process of 'knowing', which is a precursor to attunement, is needed to get out of the fly-bottle. Through experiencing 'knowing', and through the patient feeling 'known' and understood, in an experiential way, a potential space can be created in which attunement or understanding and change can occur. Through the sense of feeling understood, heard, 'seen' and 'known', the patient and analyst can both feel more confident and trusting in themselves and their relationship.

Orange (2008) argued that, the processes of attunement and re-attunement, which are themselves both products and producers of new ways of 'seeing', create ways out of the fly-bottles, which are created either by theories or by organizations of experience required to survive trauma. Again, understanding how one gets into the fly-bottle is, for me, an essential condition for the possibility of finding a way out. This often suggests a possible exit into a larger experiential world, a world with more possible ways of 'seeing'.

Conclusion

In writing this article, it became clearer to me how important it is to be the emotionally available therapist Winnicott described. I have come to realise that it is not necessarily the well-thought-out, clever interpretations that facilitate change as traditional psychoanalysis advocates, but rather the sense of being understood and 'known'. For when a patient feels that they are heard and respected as experts of their own world by the analyst, through their

flexibility and vulnerability, the resultant connection between patient and therapist is one that is powerful and meaningful beyond words. In the words of Orange (2008, p. 192), "… the analyst we hope can see this individual as more worthy, capable, loveable than the patient can. By treating a person as worth understanding, as worth knowing in all the pain and confusion, we create with this person new and more flexible possibilities for self-experience".

Acknowledgements

Referencing Format

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Melissa Card worked in the public health sector as a Clinical Psychologist for several years before joining the University of Johannesburg in 2011. In this regard, her academic interests are in the areas of psychoanalytic psychotherapy, developmental psychology and psychopathology.

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