Volume 2, Issue 2

The British Journal Of Psychotherapy Integration: Narrative Therapy And Integration

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Introduction

The British Journal of Psychotherapy Integration is the official journal of the United Kingdom Association for Psychotherapy Integration. It is published twice a year.

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Submissions

Future volumes of this journal will be on theme issues based in an integrative perspective. Two members of the editorial board will act as co-editors with the support of the two consulting editors. If you are interested in a particular theme, please contact the consulting editors and discuss your interest with them.

Editorial Structure

Volume 2, Issue 2

Contents Of This Issue

Editorial

Two Tall Tales Of The This 'Narrative' Issue Or 'A Tale Of Two Editors'

"Once upon a time in a small cottage on the edge of the forest of Ealing there lived a tall elegant witch who was known throughout the land for her infectious cackle and her excellent collection of herbal and magical teas. Many witches and wizards came to consult with her about their lives and their work and she would sit with them in her sunny consulting rooms where they would sip their teas and tell tales and then fly off home feeling altogether differently about things.

In virtually the same moment in time (although, of course, moments in time and space, like snow flakes, are never exactly the same) another slightly younger and much less well-turned-out witch was living and working over in the south west of the same country. This witch worked in a tall tower where there were many magnificent gargoyles and ghosts to consult about her work and where there was also much work to do. She was constantly busy whirling about the world searching out new and exotic spells and potions.

This whirling witch of the west (as she was sometimes described) would also occasionally arrive at the cottage in Ealing to talk about her adventures to her wiser (and sometimes calmer) colleague. Like many others, she was often quite exhausted when she arrived but a good gossip and a nice hot cup of rosehip and raven's claw soon perked her up and she was always very pleased to meet with her tall, wise friend.

They got on very well together, these two witches, and despite appearances (the one being tall and slim and elegant and the other being short and tubby and rather untidy) they were rather similar. They were neither of them an exact 'fit' for the land they'd settled in. They both came from tribes of origin elsewhere and this gave them a bit of a different take on things, a bit of an 'edge' even. Equally, they were both very good at thinking up scams and wheezes to sustain witches and wizards on-the-go as well as those in training (mid-flight consultations by cloud pattern, for instance). They both liked writing and they both liked discovering ways to encourage colleagues to gather together and to write down and exchange their ideas. One day they were sitting in the mid-morning Ealing sunlight, catching up with each other's latest endeavours, when the taller of the two witches started to describe a new undertaking that was to comprise both a writing and a gathering place at one and the same time. Both witches got very enthusiastic about these ideas and the witch of the west agreed to help with the new journal in any way that she could. Not long after this exchange she was sitting in her tower in the west looking through her inbox when she came across a particularly fluffy cloud formation from Ealing asking her whether she would like to help gather together a special group of stories that had not yet been told. Indeed she would, she thought, very much so". And that's one version of how this special issue came about. There are several more, perhaps you have one of your own?

Contents of Volume 2, Issue 2.

This issue explores some of the ways in which the 'narrative turn' in the human sciences has shaped integrative ways of working in both psychotherapy practice and research. The 'blurring of genres', as anthropologist Clifford Geertz (1980) described it, between arts and social science has broadened the representational styles available to psychotherapy researchers and has also contributed to a resurgence of interest in more literary approaches to therapeutic work and in the writing, as well as the talking therapies.

The most widely known therapeutic approach to have emerged from current interests in discourse, power relations and the 'storied lives' that people live is the work originally developed by White and Epston (1990) in Australia/New Zealand that has become known as 'narrative therapy'. The far-reaching influence of this approach is evident in many of the papers included in this journal, although this issue is not about narrative therapy per se, but rather, about the ways people have integrated narrative ideas into their work across a spectrum of approaches to therapeutic endeavours.

In an attempt at an integrated approach to the production of this journal and with the hope of extending the kinds of voices that get heard within the professional literatures of psychotherapy, we have incorporated a 'narrative' book review and have also included contributions from clients, as well as practitioners, trainee practitioners and researchers.

Kim Etherington, an integrative/humanistic psychotherapist, offers us an insight into the way in which she has integrated narrative ideas and practices into her work as a practitioner/researcher. She describes the production of an edited book or people's stories about trauma and transformation and of the ways in which the project moved beyond its original design into a collaborative process.

Jeannie Wright, also originally a person-centred/integrative therapist, has contributed a paper about her work using both on-line and face-to-face writing therapies and the ways in which narrative theories have supported these developments in her work.

Nelia Farmer is a school psychologist from the United States. In this journal she writes about her experiences as a client consulting with a narrative therapist. This contribution follows on rather neatly (we venture to suggest) from Jeannie Wright's paper, since Nelia was only able to meet her therapist face-to-face infrequently and therefore used a number of therapeutic writing strategies in this work.

Jane Speedy's article also includes the writing of a group of clients and falls somewhere within the fuzzy border territories between therapy and research. It consists of written fragments from the collective biography work undertaken by a group of young men who had, at some point, considered suicide in their lives. This work emerged out of some reflecting teamwork within the narrative therapy tradition: a coming together to witness the stories of each other's lives.

Amanda Jones is a clinical psychologist and the manager of an eating disorders service that has traditionally privileged cognitive behavioural approaches to therapy. Through some short stories of work with her clients, she portrays the integration of some of the ideas and practices emerging from the narrative therapies into her day-to-day work, operating within the British National Health Service.

Jason Hepple also works for the National Health Service as a psychiatrist working with an elderly client group. He describes, and gives vivid examples of, the impact of training as a cognitive analytic therapist on his work. This paper introduces Bakhtin's 'dialogical' approach to narrative and the way that this has been integrated into cognitive analytic therapy practice.

In this issue we have continued our usual practice of including a contribution by a graduate. Kasia Zalasiewicz provides an account of her approach to integration which formed part of her dissertation submission for her MSc in Integrative Psychotherapy at Metanoia Institute in West London.

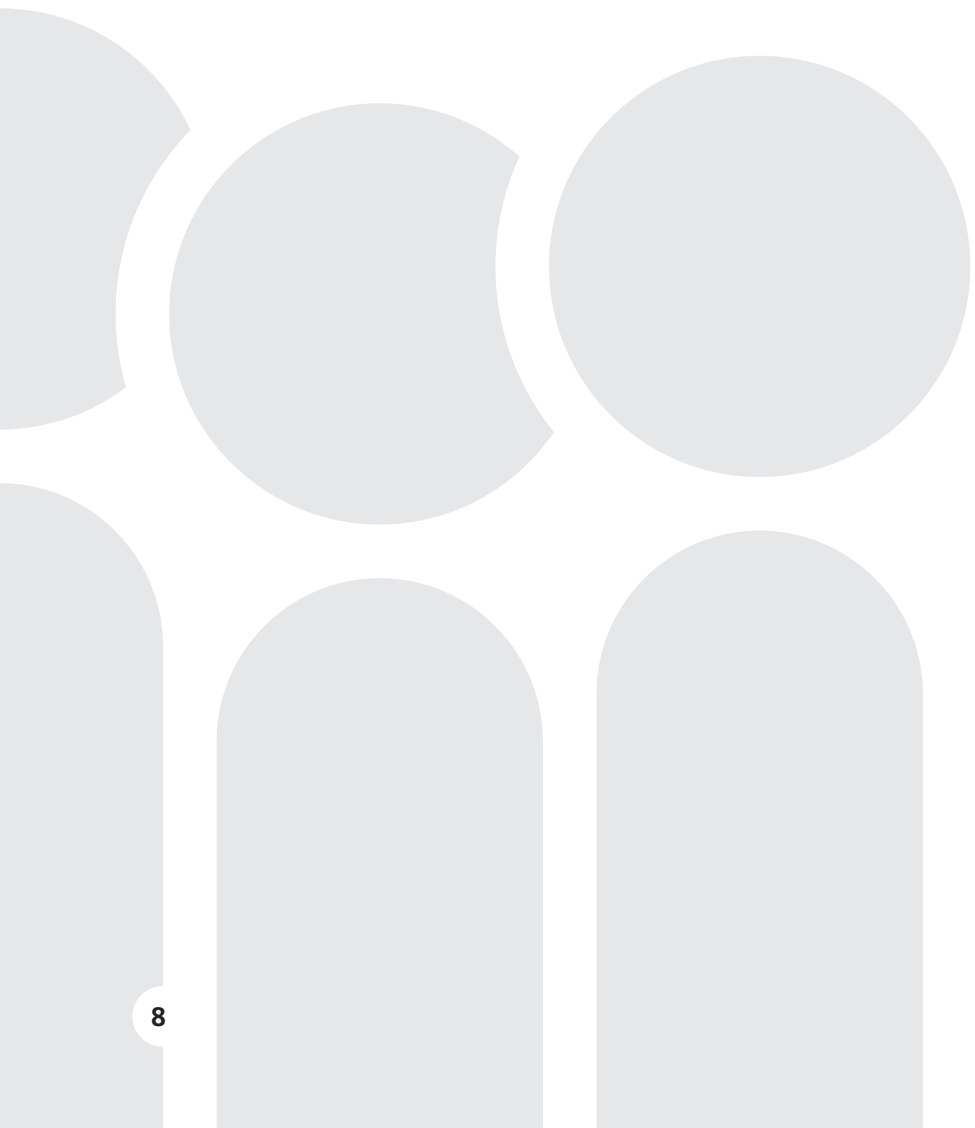
This issue also includes two book reviews, the

first, from Bernd Eiden who reviews Robert Shaw's book 'The Embodied Psychotherapist: The Therapist's Body Stroy' and the second from Jane Speedy, reviews two books from New Zealand 'The heart's narrative and 'Talk that sings', both by Johnella Bird.

Geertz, C (1980) Blurred Genres: The Refiguration of Social Thought, in: *The American Scholar, 49(2): 165–79.*

White, M. and Epston, D. (1990) *Narrative means to therapeutic ends. Norton,* New York: Norton.

Jane Speedy and Maria Gilbert
Co-editors of this issue.



Kim Etherington

Narrative Inquiry As A Vehicle For Integration: Trauma, The Body And Transformation

Abstract

This paper is based on a narrative inquiry into the stories of ten people who have experienced childhood trauma in the body, and found ways to transform those experiences, published in 2003 in a book entitled "Trauma, the body and transformation". This paper shows how, as a counsellor trained in an integrative humanistic model of counselling, who more recently has been influenced by narrative ideas in research and practice, I have integrated theories and apply them to create a new narrative that connects trauma, the body and transformation. The paper begins by describing the methodology and methods used in the original study, intertwined with related literature, and illustrates the connections between content and process through excerpts from some of the stories people told.

Introduction

This paper is based upon a narrative study of how childhood trauma can be experienced in the body, and the ways people find to heal. My interest in this topic stemmed primarily from a growing understanding about how childhood trauma had influenced my own complex relationship with my body, and the illnesses and medical and surgical interventions I had experienced over many years earlier in life, and the similar stories in the lives of many of my past and current clients.

As someone trained in an integrative humanistic model of counselling back in the late 80's, who more recently has been influenced by narrative ideas and practices, my intention in producing this paper is to bring together some of the theories that inform my current practice as a counsellor and as a researcher, and to apply that thinking to create a new narrative that connects trauma, the body and transformation (Etherington, 2003).

To do justice to these issues would require more space than is available here, but by bringing them together, and using illustrations from some of the stories written by co-authors I invite readers to seek resonance with them, and to connect with their own stories and those of the people who consult them.

Narrative Approaches To Research

Over the last decade I have been moving towards valuing reflexive ways of knowing, working collaboratively with research participants, and seeking for 'local' stories that would offer me opportunities to share in the 'lived experiences' of others that I could place alongside my own life stories in ways that would create an accessible form of new knowledge for myself and others. This has led me to develop an interest in using narrative approaches to research (Etherington, 2004).

There is a range of ways of understanding what is meant by narrative research that depend upon

the researcher's philosophical and theoretical position. My own approach is currently based on epistemologies that view reality and knowledge as constructed, and on the idea that knowledge is situated within contexts and embedded within personal, historical and cultural stories, beliefs and practices (Burr, 1995; Crossley, 2000; Gergen, 1985, 1994). These ideas challenge the accepted nature of modernist certainties and question how we know what we know, and who tells us what we know (Hertz 1995; McLeod, 1997; Polkinghorne 1988). My prior learning as an occupational therapist and counsellor was informed by modernist assumptions, medical and psychological 'grand narratives', and models of self and identity, all of which I view now as 'useful ways of thinking with stories' – and not as 'Truths'. I do not wish to discard those ways of knowing and understanding, but rather to use and integrate them along with subjective and inter-subjective ways of knowing to create rich and complex layers of meaning and understanding that can be applied to practice.

Collective Autoethnography

For the inquiry upon which this paper is based I gathered ten peoples' stories (including my own) and created a 'collective autoethnography' which was published in 2003.

Autoethnography is an autobiographical genre of writing and research that has been described as a "blend of ethnography and autobiographical writing that incorporates elements of one's own life experience when writing about others" (Scott-Hoy, 2002 p.276): a form of self-narrative that places the self within a social context (Reed-Danahay, 1997).

A 'collective autoethnography' can be described as several autoethnographic accounts arranged around the same topic that amplifies the individual voices, and has the potential to transform the reader as well as the writer, on personal and socio-cultural levels (Richardson, 1990; Sparkes, 1998).

My own intention in creating a collection of autoethnographic accounts was to construct a new overarching narrative from stories written by individuals who had begun to create a coherent story from their personal experiences, and that this narrative would provide therapists and sufferers with alternatives to the psychiatric stories of 'somatisation' described in DSM-lV (1994). I wanted to expand counsellors' and medical practitioners' knowledge of referral resources, and to challenge the idea that any one way is best, and to open their hearts and minds to the need to listen to patients whose underlying trauma was being expressed through bodily symptoms. I wanted them to think about how they might use their power/influence to create alternative services, thus challenging the restricting influence of western medical thinking.

I also wanted to create a resource that was engaging and easily accessible for professionals and those affected by trauma; to raise awareness about a little understood phenomenon; to draw attention to stories not yet told; to create the possibility of making previously unrecognized connections; and to create a sense of community, thus breaking through the isolation and alienation (for readers and writers) that is frequently experienced as an aftermath of childhood trauma.

Richardson (1990, p.26, quoted in Sparkes 1998, p.78) enlarges on this theme:

"By emotionally binding together people who have had the same experiences, whether in touch with each other or not, the collective story overcomes some of the isolation and alienation of contemporary life. It provides a sociological community, the linking of separate individual into a shared consciousness. Once linked, the possibility for social action on behalf of the collective is present, and, therewith, the possibility of social transformation".

Co-authors/participants

My co-authors were eight women (including myself) and two men between the ages of 27 and 68 at the time of writing and who had received training in therapeutic practices: they had also been in therapy themselves. My decision to select participants from this group was informed by my awareness that revisiting childhood trauma by writing about it meant reconnecting with feelings and

memories that could overwhelm or threaten to re-traumatize participants. My assumption was that therapists would have begun to deal with their childhood material, have an awareness of their own need for support and have systems in place to provide that if needed. Balancing the ethical principles of 'do no harm' and 'autonomy', meant being alert and sensitive to co-authors' needs, whilst at the same time acknowledging that they were my peers with a right to make informed choices for themselves.

The traumatic childhood experiences authors wrote about included experiences of neglect; physical, sexual and emotional abuse; witnessing the violent abuse of siblings; death of mother and personal injury in a car accident leading to adoption; and the experience of transportation from Nazi Germany at the age of four, and later, enforced repatriation.

Co-authors had experienced a wide range of bodily manifestations that they ascribed to earlier trauma, several of which had been diagnosed and treated within the medical model. These were: auto immune diseases, such as multiple sclerosis, lupus, mono-neuritis multiplex; psychosomatic disorders, such as allergies, asthma, migraine, ulcers, hay-fever, skin disorders, joint pain, back problems; somatic complaints, such as unexplained pain, illnesses, disability, sometimes leading to repeated medical and surgical interventions; dissociative experiences, such as 'out of body' experiences, sleep disorders, sensory disturbances, numbness, leading to addiction, eating disorders, self-harm and suicide attempts.

Resources co-authors named as helpful were: counselling/therapy; writing stories and poetry; psychic healing; homeopathy; nutrition; massage and other forms of body work; education; flower remedies; osteopathy; spirituality; reflexology; visualization; inner child work; loving relationships; Taoism and tai chi; self-care; kinesiology and family constellation and other group work (Etherington, 2003).

Methods

The stories were co-constructed. Authors sent drafts to me when they felt ready to do so: at this point I commented on their stories and asked curious questions concerning their meanings; taken-for-granted assumptions; how they had come to know what they knew; or to expand on metaphors and images used. In this way the stories became "a construction site of knowledge" (Kvale, 1999), and space was opened up for alternative interpretations and meanings that could facilitate new narratives (Haley, 2002). All of this had the effect of inviting "absent but implicit" (White) stories, and "thickening" existing stories, whilst remaining respectful of the author's personal meanings, and allowing for the complexity inherent in a constructionist approach.

My own stories were sent to co-authors who were invited to comment and/or ask questions in the same ways. By sharing in the process myself, co-authors were able to see how my stories were inevitably influencing my part in the co-construction of their individual stories, and the overarching narrative as presented in the book. I also gained permission from co-authors to send their stories to each other and ask for feedback, questions or comments. A fuller picture of this process and the impact on authors of engaging in this project has been submitted for publication elsewhere.

Childhood Traumatic Events

Trauma has been defined in many different ways, all of which are culturally and socially constructed and therefore limited by the socially defined stocks of knowledge available at the time. However, there is a growing recognition and acceptance of the idea that "what constitutes trauma is subjectively determined" (Miliora, 1998).

Over the last decade or so there has been a rapid growth in available literature that has enhanced our understanding of the long-term effects of childhood and the multiple effects which can shape adulthood if the traumatic experience is minimized, denied, and therefore left unprocessed and unhealed (Terr, 1988, 1993; Herman, 1992; van der Kolk, 1988, 1994. 1996; Whitfield, 1995; Goleman, 1996; Pert, 1998; Meares, 2000; Gold, 2000; Rothschild, 2000).

Trauma can result from natural catastrophes

that are outside human control and leave a trail of devastation in their wake, such as the recent tsunamis and earthquakes. Other trauma may be deliberately inflicted and can betray a person's trust in humanity: shootings in schools; bombs that explode in underground trains; physical, sexual and emotional abuse, abandonment, neglect and starvation.

Sometimes trauma can be subtle and seem, at first sight, less serious, but over a prolonged period, living in "a passively traumatic environment" can lead to chronic trauma (Meares, 2000, p.122). One-off traumatic events can produce long term and severe affects if the events surrounding the incident create additional trauma.

Heather's Story

Heather Weston, a co-author whose mother was killed in a road accident in which she herself was injured at the age of 7, felt additionally traumatized by ensuing events:

Heather lay injured for three months in an adult hospital ward, kept in the dark about her mother's death, with no attention paid to her emotional distress. Further trauma was inflicted by the way decisions about her future care were taken without consulting her. Her reluctant caretakers' apparent disregard for her personhood, distorted the ways she thought about herself as a child, and silenced her distress. Much later in life Heather's immune system began to attack her body resulting in mono-neuritis multiplex, creating disability and forcing retirement from her job in a bank.

"Trauma was compounded by trauma. The accident itself; being in a ward with a lot of much older people and seeing someone drop dead at the side of my bed; nobody talking about any of it, nobody asking about my feelings or explaining what was going on. The additional trauma of the woman in the next bed, obviously suffering from some form of mental illness or drug induced hallucination, threatening to throw her locker at me and climbing out of bed to attack me. My dreams replayed the terror of my daytime nightmare existence, crying in my sleep, only to be woken and told that I was making too much noise and waking other patients" (Weston 2003, p.102).

Michael's Story

Children who are ignored, chastised or dismissed; or trained to meet the parents' needs and ignore their own; or overly controlled and/or criticized by adults who constantly override their opinions, might experience long term and profound effects on their sense of self and identity.

Michael Len 's story described how his body shape and sense of self was determined by living in a state of "constant fear, disparagement, humiliation…". Escaping from his Hawaiian-Chinese home by enlisting in the Army at the age of 17, Michael began to educate himself and find ways of changing the stooped posture he had developed as he cowered from his parental tormentors. He described how his life's journey became one of seeking ways to overcome his early shaming experiences, ways of learning to stand proud and tall. Through Taoism he found his pathway to healing.

"You see, I was terribly weak and meek, and unable to grow stronger due to my parents' constant shaming and scolding. I was always apprehensive, anticipating the next tongue-lashing. I forever 'watched my back' and literally curled forward, slumped and hunched over" (Len, 2003 p.108).

Michael's later life was dogged by his difficulty in forming relationships based upon mutuality and respect. His craving for acceptance had left him exposed and vulnerable in relationships where he felt used and exploited.

Michael had grown up believing that being in relationship with others (notably his parents) led to pain and disappointment: a belief that might have led him to develop what Winnicott (1960) described as a "caretaker self", adopting an appearance of independence and an ability to look after others as a means by which he might vicariously experience nurture.

It is interesting to note that several studies of people traumatized in childhood have identified a high prevalence of helping professionals

among their ranks (Middleton and Butler, 1998; Follette et al, 1994; Elliot and Guy, 1993).

Gillie's Story

Gillie Bolton's poetic story leads us through her experience of transforming her experience of incest by means of creative writing. A child who is sexually abused by her father is rarely able to turn to her mother for support, so there may be no 'secure base' from which to explore her world. When those who inflict injury are the very people upon whom the child depends for their existence, the impact on the child's development of trust is severely damaged by that betrayal. Cameron (2000, p.4) suggests that the closer the relationship between betrayer and betrayed the greater the rupture in our "basic personal and societal assumptions about human bonding".

In the face of such betrayal a child may cope by unconsciously adapting or accommodating to their environment by splitting off aspects of their experience through dissociation – a concept that even now has not yet been fully explained, but is generally thought to be a mechanism that creates a split in conscious awareness that allows the traumatized person to disconnect from parts of their experience in order to reduce the impact and thereby, survive (Rothschild, 2000). This may involve forgetting the distressing experiences of childhood, disconnecting from the feelings associated with those experiences, or minimizing their effects (Whitfield, 1995).

Like many of the concepts used in the psychodynamic model, dissociation can be part of our 'normal' experience (such as daydreaming), and not necessarily a pathological condition, but when adopted frequently, it can create problems. When these 'absences' become frequent or prolonged, the ensuing disturbance in memory may create a discontinuity and fragmentation of existence (Meares, 2000).

Gillie described 'out of body' experiences, sleepwalking, and dissociation:

"I had spells when I lost control of my body: I did not lose consciousness but had to watch helplessly from somewhere up at the ceiling while my body collapsed and had to be carried to lie down; sometimes I was in bits in different parts of the ceiling. I had periods when I thought my feet weren't reaching the ground: that I was floating" (Bolton, 2003 p.127).

On leaving home for university, Gillie was able to form the close relationship which became her long-term secure base. Within that relationship she began to write her incoherent story by trusting the images forming in her mind even when she did not understand them. Eventually she was able to re-collect her truth, gather up her experiences and make sense of them through her writing:

"…the page is a silent, accepting recipient; it holds secrets trustworthily until I, as writer, could bear to become reader and develop the understanding of those secrets further" (Bolton 2003,).

The Body Responds

If a child becomes overwhelmed as a result of trauma the 'physical self' may split from the 'mental self'; the mind has little or no awareness of the body as a physical reality and emotions are not expressed directly. However the body "continues to respond to the emotion, even though the mind refuses to acknowledge it" (Dubovsky, 1997, p47, cited in Miliora, 1998).

Lenore Terr (1988) describes how trauma is imprinted via the senses and, although no conscious memory of the trauma exists, it may be experienced through bodily sensations or behaviours in response to triggered sensory memories of the trauma.

Carole's Story

Carole Mandeville was diagnosed with multiple sclerosis when she was in her forties, having previously been healthy. She told how the symptoms drew her attention to her body and, as she focused on her body, she began to reconnect with memories of a traumatic childhood. Carole began to experience terrifying flashbacks of being raped and beaten by her father, and memories of her mother's threats of abandonment. Her body bore the

physical scars of her father's violence, and body memories forced her muscles to jump and thrash about, remembering the rape: "It was astonishing to me that my body could have stored the memory and recreated it as an actual bodily experience. And as incredible as it seems not only was this recreated, but also smells and sounds from the past too. Both were as real as if they were happening in the present".

She describes a flashback:

"I sink back onto the bed; my neck stiffens, throwing my head backwards. My throat closes, there's something in my mouth – I can' t breathe, my hips start jerking up and back and up and back, faster and faster. My spine arches and drops down, then arches again. I fight for breath and my lungs suck at the air. I feel as if I'm going to suffocate, to die" (Mandeville, 2003 p.45).

Impact On Health And Care Seeking Behaviours

When a child has no language or frame of reference for their experience, or because they have been silenced by threats or refusal to 'hear', no verbal link can exist between dissociated parts so the body may speak a language of its own: perhaps through illnesses, addictions, skin disorders, gastro-intestinal problems, musculo-skeletal problems, gynaecological disorders, auto-immune diseases and endocrine problems (Levine, 1997; Northrup, 1998; Cameron, 2000; Gold, 2000).

Studies have shown that people who have experienced childhood trauma are more at risk of developing life-threatening and disabling illness and disease. A study of 9000 people in USA (Felitti, 1998) found that those who had been exposed to four or more episodes of childhood trauma had 4–12 fold increased health risk for alcoholism, drug abuse, depressions and suicide attempts. They were also more likely to smoke, to be generally ill, to have more than 50 sex partners and thus to have sexually transmitted diseases, and up to 1.6 times more likely to be obese.

A study of women who had been raped during childhood (Arnold, Rogers and Cook, 1990) noted that they had each undergone an average of eight surgical operations with a high rate (66–70%) of findings that indicated no organic disease. History of childhood sexual abuse was recognized only after the use of medical and surgical interventions.

The first port of call for many trauma survivors is often their doctor's surgery. Without an understanding of how trauma might impact upon the body some GPs do not recognize the ways that survivors present within the practice. Judith Lewis Herman (1992) says:

"All too commonly chronically traumatised people suffer in silence, but if they complain at all, their complaints are not well understood. They may collect a virtual pharmacopoeia of remedies: one for headaches, another for insomnia, another for anxiety, another for depression. None of these tend to work very well, since the underlying issues of trauma are not addressed. As caregivers tire of these chronically unhappy people who do not seem to improve, the temptations to apply pejorative diagnostic labels becomes overwhelming" (p.119).

These patients are frequently referred to as 'heartsinks' and may have spent years undergoing medical and surgical interventions as doctors attempt to satisfy themselves that no organic cause is underlying. The GP's response can mirror the feelings of helplessness, rage and confusion of the traumatized child who has not yet found a direct way of telling their story. Doctors might feel powerless to help the patient and unable to make sense of the physical symptoms they are being asked to treat. Feeling frustrated and impotent they may then blame the patient for their failure to heal and eventually withdraw in defeat.

Impact Of Cultural Messages

Stories can only be received into social and cultural contexts that acknowledge and sanction them. Physical symptoms might be related to "culturally sanctioned" ways of knowing and processing trauma (Waitzkin and Magana, 1997, p.818). Patterns of behaviour might be passed on from one generation to the next as a child observes an ill parent, dealing perhaps with their own unprocessed trauma. A mother who displaces her emotional distress into physical pain might teach her child that attention

given to an illness or physical pain will not be forthcoming in response to emotional distress. Even today in comparatively enlightened times, the stigma of 'weakness' attached to mental or emotional distress creates a situation in which physical illness is a more socially acceptable way of asking for care and rest.

Male socialization teaches boys that 'proper' men do not acknowledge distress; that to be male means to be responsible and in control (Etherington, 2000). So a traumatized male who may not be able to acknowledge, even to himself, feeling anxious, powerless or helpless, might develop ulcers, heart disease or irritable bowel syndrome as his body seeks expression of his disallowed emotions.

Foucault (1980) has drawn attention to how a person can be limited by their ability to participate in discourses that constitute what is true or possible within a society. Cultural taboos and practices arising from societal narratives about gender, race, age, economic status, ethnicity, or sexual orientation or political directives might create a 'double-bind' in which the person recognizes that their story holds destructive potential consequences for self or others if it should be told (Griffith and Griffith, 1994, p.58). Trapped in this silencing double-bind the person's body seeks its expression in 'the underground theater' of the body and its illness.

Transformation

When we use the body unconsciously as a way of avoiding direct connection with the pain of trauma, we provide ourselves with the 'credentials' to acknowledge distress and seek relief through painkillers, medical or surgical interventions. The physical disorder can consume our attention and distract from 'unsafe' underlying material (Sansone et al, 2001). Transformation is possible when we have a strong enough desire to heal, that supports us to find a safe environment in which to pay attention to the messages carried by the body that tell of our past hurts.

Transformation is a word that implies more than recovery or healing; it implies a fundamental shift at the core of our being that requires a willingness to challenge basic beliefs about ourselves and the world around us, and enough faith to accept and trust what we cannot fully understand. Transformation also requires us to have the courage to accept the flow and harmony of primitive, natural laws that can take over our experience of ourselves (Levine, 1997).

In transforming trauma we need to recognize the role of memory. Memory is not necessarily a factual, coherent or linear record of something that actually happened. Rather it is a process of bringing together parts of our experience to create a coherent and organized whole (Whitfield, 1995).

Transformation does not depend upon memories, even if remembering is possible, because this is not necessarily what will transform trauma. On the contrary, by attempting to 'delve' for memories as if they were 'truths' we risk becoming sucked back into the 'trauma vortex' again, causing further distress and re-inforcing our sense of powerlessness and inability to take control (Levine, 1997, p.204).

When we accept that memory is not necessarily something concrete but rather a 'gathering together' of different kinds of information, images, metaphors and responses, we become free to explore creatively, flexibly and spontaneously, and begin from a place of 'tacit knowing' or 'felt sense'. We might then be able to reconnect with our normal capacity to organize information in ways that help us to tell new stories about our lives and create new meanings.

As stated previously, dissociation may cause us to fragment our experiences in order to lessen their impact and help us to survive. These fragments of traumatic emotional or sensory experiences may therefore be accurate recollections of experience and each can be examined separately in order to reduce their hold on us. Emotional and sensory details and images bring the remembered fragments more under the control of the neo-cortex, the thinking brain, where reactions and behaviours can be made more understandable and therefore more manageable:

"…(the neo-cortex) contains the centres

that put together and comprehend what the senses perceive. It adds to a feeling what we think about it – and allows us to have feelings about ideas, art, symbols and imaginings" (Goleman, 1996, p.11).

Transformative Relationships

Herman (1992) suggests that memories can be transformed, both in emotional meaning and in the effects in the emotional brain if we can: a) create a safe environment in the present, b) gain some control over life, c) tell our stories in the harbour of a safe relationship, d) and mourn the losses created by the trauma.

Carole, who was diagnosed with MS, describes the kind of transformative relationship that supported her, having previously experienced therapy with someone who had terminated their relationship abruptly, unable to stay with her client's level of distress. In spite of this set-back Carole went on to find another therapist:

"She was generous and funny but more than anything she showed me the most healing thing one human being can give to another is a strong staunch vibrant love. She never pretended to know more than me, or hide behind ambivalent answers. She told me that one day I would feel a sense of peace and that one day my suffering would come to an end. Her faith in my recovery helped me to believe it… When I had been working with Sara for a year I could run again and play sport. One by one my symptoms went away and they have not returned" (Mandeville, 2003, p.51).

Listening To Our Inner Wisdom

When we acknowledge our inner and bodily wisdom we may recognize our inherent capacity for healing. We have been conditioned by society to seek a cure from doctors when we are ill, rather than accepting that our own resources and knowledge may be equally valuable. In spite of being ambivalent in our attitudes towards medicine we tend to listen to medical opinions before asking ourselves 'what is my body telling me about my life and what I need?' Sometimes we seek medical help and opinion whilst also rejecting it and feeling dismissed when we are offered unsatisfying solutions to our ills. When we listen to the messages carried by our bodies and accept those feelings without judgement, we can free up the energy trapped in denial or in endlessly searching for external cures, and use it to move us towards what we really want (Northrup, 1998). By deconstructing or re-interpreting our bodily pain we might be able to name our emotional distress and begin to explore our relationship to it and its meaning; 'what is it that I need to know about myself that my fear (or anger) is trying to tell me through my body?' 'what does this illness gives me that my body knows I need'?

Many of us are not consciously aware of the beliefs we hold that undermine our healing and well-being: beliefs laid down in our past and "lodged and buried in the cell tissue" (Northrup, 1998, p.35). Our attitudes about illness are often formed in response to events that occurred a long time ago, but the choices and decisions we currently make may still be in response to those beliefs. Intellect alone may not be enough to shift these unhelpful beliefs; we may need to acknowledge another source of wisdom, our 'spiritual' wisdom, acknowledging a greater power than intellect alone that will guide us towards achieving peace. This leap of faith may create a connection with a source of inner guidance that can accompany us throughout the most difficult times in our lives.

Those who have been brought up within a religion might already be aware of a core of faith within, even when belief in the religion upon which it was based has long since been modified or rejected. Others might seek new sources of wisdom as adults perhaps through Eastern or Western philosophies, alternative healing methods, connecting with the natural world, creativity, the arts, or by undertaking a unique spiritual journey.

Michael, who had turned away from his Confucian heritage in rejecting the family who abused him, later re-connected and found healing in Taoism:

"I redeemed my ethnicity, so as not to die within myself: I might have figuratively curled up within myself and remained a misfit… Instead I am balancing ownership of the good part

of my heritage against the disregard of my birth family and all those horrible memories. I can have a new harmonious beginning. Balance and harmony are the great hallmarks of Taoism: balance within myself – to heal myself – and harmony with others, in order to relate with others" (Len 2003, p. 118).

Finally

This paper has allowed me to reflect upon how I integrate my learning as a humanistic integrative counsellor with more recently gained ideas from narrative practices and from my personal life journey. I have brought this learning together with stories from research and shown how I use it to make sense of them. As one of the co-authors, this work has helped me experience new strength through making connections between body, mind and spirit and in finding a 'voice' with which to tell my stories.

We know that putting stories of traumatic experience into words can itself become another step towards healing and transformation and can produce physiological changes that contribute to gains in health and feelings of well-being (Herman, 1992; Pennebaker, 1988, 1993). Writing stimulates and facilitates the motor and sensory regions of the brain, and can help us recover additional fragments of the former trauma (Penn, 2001). Half known aspects of our experiences can be accessed through the metaphors we use in our writing as we "reach intuitively into some part of ourselves that is outside our notice- still unnamed but there" (Penn, 2001, p.45).

I will end with an excerpt of Ruth Barnett's feedback to me on the impact on her of being involved in the study (Barnett, 2003). Ruth had escaped the Nazi regime via the Kindertransport at the age of 4 (with her 7-year-old brother)and thus lost her home, parents, culture, and language. Her subsequent and frequent moves from foster home to foster home created trauma upon trauma in her young life. Ten years later, her enforced repatriation to her homeland and loss of her foster parents re-awakened the original trauma. Ruth carried her rage and helplessness in her body through unexplained fevers and illnesses. She had coped, until writing her story for this project, by denying that anything 'bad' had happened to her, since she was lucky to have 'escaped' Hitler. It was only through meeting and listening to the stories of several hundred other Kindertransportees during the 50th anniversary of their flight from Germany, that she faced the truth of her experience. She told me that although she had written different aspects of her life stories before, she had ignored the relationship between illness and her traumatic life experiences:

"You asked for something new, focusing on trauma expressed through the body. This was something I had neglected. Although I was aware of psychosomatic aspects in my work, I did not really apply this to myself. I had a mental image of myself as being a very healthy kid throughout my childhood. Right now I have the thought that this 'no serious illnesses happened to me' parallels my pre-story image of 'nothing happened to me because I was rescued".

Later she wrote:

"I realise how being involved in the study made connections for me – breaking through the sense of 'isolation and alienation' that was always lurking in the background for me and how I slowly moved into 'shared consciousness' and the 'social transformation' it has made possible for me. I have long known and worked [as a psychoanalytical psychotherapist] with the knowledge of the healing power of telling one's personal story – the fundamental bedrock of therapy! But my own story was different – it didn't really count!"

These stories have all touched my own, by overlapping and weaving in and out, blending or contrasting: all of them have created a response in me. In writing this paper, and placing excerpts of the stories alongside previously held theories I may be in danger of fragmenting the stories in ways that seem disrespectful to the authors' experience (Smith, 1999; Frank, 2001). This is a constant dilemma for me in disseminating research based on peoples' intimate life stories (which is one of the reasons I usually produce books!). However, I need to use my awareness of that anxiety and balance it with my intention, and the intentions of my co-authors, to use our stories to inform and educate ourselves and others, and create a richer and multi-layered understanding of complex

issues that might improve the quality of care on offer to traumatized people who want to give up using their bodies to speak for them.

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Jason Hepple

The Witness And The Judge, Cognitive Analytic Therapy In Later Life: The Case Of Maureen

Abstract

This paper briefly describes a sixteen session Cognitive Analytic Therapy with Maureen, in her early seventies, who had experienced childhood sexual abuse. One aspect of the therapeutic process is emphasised: the function of the 'Witness and the Judge'. This is a concept described by the Russian philosopher Mikhail Bakhtin, whose work has become a rich vein of ideas in the development of the dialogic, interpsychic aspects of CAT theory and practice.

Introduction

Cognitive Analytic Therapy (CAT) (Ryle and Kerr, 2003) is a brief integrative therapy developed by Dr Anthony Ryle and others over the last 25 years. More recently, CAT theory and practice has been applied to work with older people, (Hepple and Sutton, 2004). Although CAT, as its name implies, originally sought an integration of cognitive theory (particularly ideas from information processing, personal construct theory and the collaborative nature of the therapeutic relationship) and object relations theory (notably introduced by the concept of 'reciprocal roles') over the last decade much interest has arisen in the development of CAT as a dialogic therapy, incorporating ideas from the Russian philosophers Mikhail Bakhtin and Lev Vygotsky (Leiman, 1992, 1997).

While I have no room here to give a comprehensive overview of these exciting developments in contemporary CAT theory I particularly recommend the chapter by Laura Sutton and Mikael Leiman in Hepple and Sutton, 2004, as further reading. In this paper I hope to illustrate the dialogic nature of the therapeutic relationship in a CAT therapy with a woman in her early seventies and to illustrate some of the ideas coined by Mikhail Bakhtin, particularly 'The Witness and the Judge' which seem to speak so clearly to this sort of work in later life. As the long buried narrative unfolds in the sessions in dialogue, the 'responsive understanding' of the therapist allows transformation of the past abuse and the creation of a different sort of future.

A word here on reciprocal roles which will help us with Maureen's case later. Reciprocal roles describe an internalised relationship; a dance into which others are continually invited as a known and predictable way of being in the world. Maureen's core reciprocal roles turned out to be: Abusing to Abused, Critical to Striving and Rejecting to Rejected. The child, or bottom roles in diagram form, come second, the adult or top roles first. While one pole of the role-play derives primarily from the adult or child, the reciprocal role always exists as a relationship and there is always an element of both in each person as part of any future enactment. This then gives us CAT's two pronged understanding of counter-transference; empathic (identification with the child role) and reciprocal (enactment of the adult counterpart). For example, the therapist, in relation to the abuse narrative may empathically

feel sad, angry and crushed but may also fall into reciprocal responses: dismissing, overlooking or even critical and rejecting.

Some Ideas From The Work Of Mikhail Bakhtin (1895–1975)

For an excellent introduction to this intriguing thinker I can recommend Michael Holquist's 'Dialogism' (2004). Bakhtin had a remarkable life, living through both Russian revolutions, Stalinism, the German invasion in World War II and a period in exile in Kazakstan as a political prisoner, before being 'discovered' by the West in the 1970s. There are some considerable doubts around authorship of several works connected with Bakhtin, particularly as to whether his associates in the 1920's, Valentin Voloshinov and Pavel Medvedev, are really pseudonyms for Bakhtin himself, or whether he may have been guilty of some degree of plagiarism. I will here follow Holquist's lead in accepting that works attributed to these associates are likely to be written by Bakhtin himself.

His writings exist on the fascinating lemnisci of several disciplines, particularly literary theory (notably his discourse on the work of Dostoevsky), psychology, Marxist theory, philosophy and theology. Whatever field he is discussing, the reader soon realises that underlying all his work is a deeply dialogic understanding of consciousness and meaning. This provides something of a wake up call to those of us instilled with the intrapsychic understandings of Western philosophy and the psychoanalytic tradition. Bakhtin's is an interpersonal world where meaning only exists in the uncertain ground between 'I' and 'other' and is articulated via 'utterance' in the language of 'signs'. This intriguing perspective clearly has a lot to offer those interested in the exploration of the relationship between client and therapist in the psychotherapies.

In what follows I will attempt to describe my personal understanding of some of these key dialogic ideas, which will help us to explore some of the transcripted material from the case of Maureen. First some words from Bakhtin:

Consciousness As In Between

"Everything that pertains to me enters my consciousness, beginning with my name, from the external world through the mouths of others… I realize myself initially through others: from them I receive words, forms and tonalities for the formation of my initial idea of myself… Just as the body is formed initially in the mother's body (womb), a person's consciousness awakens wrapped in another's consciousness"(Notes made in 1970–1971, in Bakhtin, 1986).

Relational Reality

"The other human being I am contemplating, I shall always see and know something that he… cannot see himself: parts of his body… his head, his face, his expression, the world behind his back. As we gaze at each other, two different worlds are reflected in the pupils of our eyes…"(The Author and Hero in Aesthetic Activity, in Bakhtin, 1990).

From these snippets we begin to get a grasp of the core idea of Bakhtin's dialogical approach; that meaning only exists in between. To put it another way: what and who would we be if we had never met another being? It is only through reflection of ourselves in the response of the other that any self-reflection can evolve (what Bakhtin calls the 'I for myself'). As Anthony Ryle responds to the Cartesian "I think therefore I am': – 'We interact and communicate therefore we become" (Ryle, 2001).

This is a considerable paradigm shift for those brought up with concepts of cognitions, ego's and ids existing in the intrapsychic space of the individual 'mind'. This is a totally interpsychic theory. In his analysis of the form of the novel, Bakhtin describes utterance to be the unit of the dialogue – that which is complete in the sense that it is ready for a response from the other to which it is addressed (the addressee). An utterance can be anything from a single word to a complete body of writing. Each utterance is directed at a real or imagined other or others, always seeks to be heard and understood by the other, and is always looking to find out something more about the author (I) from the continuation of the dialogue with the other.

Responsive Understanding

"The word, which always wants to be heard, always seeks responsive understanding, and does not stop at immediate understanding but presses on further and further (indefinitely)" (The problem of the Text, In Bakhtin, 1986).

'The word' is another term often used by Bakhtin. For Bakhtin, language is the pre-eminent 'sign', signs being the conveyors of meaning in the in-between world of interpersonal reality. A sign is always two-sided; it always looks both ways simultaneously (to the author and to the addressee, to the I and to the other). Words are not the only signs. Gestures, movements, drawings, paintings etc. can continue the dialogue in the interpersonal world and in therapy. The tools used in CAT therapy are signs – the early reformulation letter addressed to the client from a position of empathic (or responsive) understanding, the 'map' where the client's world is traced out by the hand of the therapist using the 'eyes' and perceptions of the client, the goodbye letter where the time spent in dialogue together is reflected upon and appraised.

The Witness And The Judge

When I first read this little chunk of Bakhtin in his late work "Notes made in 1970–71" (Bakhtin, 1986) I could not stop thinking about its relevance to therapy. It appears among a collection of late jottings – disconnected from the text around it.

"When consciousness appeared in the world the world changed radically. A stone is still stony and the sun still sunny, but the event of existence as a whole (unfinalised) becomes completely different because a new and major character in this event appears… the witness and the judge. And the sun, while remaining physically the same, has changed because it has begun to be cognized by the witness and the judge. It has stopped simply being but started being in itself and for itself as well as for the other because it has been reflected in the consciousness of the other: this has caused it to be changed radically, to be enriched and transformed" (Notes made in 1970–1971 in Bakhtin, 1986).

This speaks to me of Clarkson's (1995) developmentally needed aspect of the therapeutic relationship and seems to describe the process of witnessing the client's narrative, particularly early trauma and abuse, which may never have been witnessed before; opening up a dialogue around that which seemed 'all said and done'. It is like going back in a time machine and entering that long closed up room where the abuse is shown to a new pair of eyes; that of the witness.

What does the witness do? I think two things:

The witness is there beside the client (often when the client is 'beside themselves'). The witness unconditionally accepts the predicament of the client, the mixture of feelings of anger, grief, guilt and self-loathing. The witness also shares these feelings, experiencing them both for himself and for the client. (The use of the empathic counter-transference or identification with the roles associated with the abused child: Abused, Overlooked, Self-loathing, in this way in CAT seems an important part of the technique, as I heard Anthony Ryle say in 2003: "How the client makes you feel in the session is the client's business"). Someone else (the other) has finally noticed what happened. In the cases of older people, like Maureen, several decades may have passed while she waited for a witness to arrive.

The witness sees the scene from a different viewpoint – that of the other. The witness will give a different account of the story to others, the witness notices things that the client gives little significance to, the witness sees the client in the context of the scene from the outside "The ever present excess of my seeing, knowing and possessing in relation to any other human being, is founded in the uniqueness and irreplaceability of my place in the world" (Bakhtin, 1990).

This second function of the witness uses aspects of the self-self relationship – only you will have your unique reaction to the story unfolding. Reciprocal counter-transference, or in CAT terms an identification with a 'top' or adult reciprocal role is a feature here. The therapist may be drawn in to enactments of the original role-play: Overlooking, Dismissing, Critical

or may establish, even at this stage, reparative top roles: Accepting, Forgiving, Protecting.

This leads us into the judge. The witness is now allowed to express a view about the story. This is difficult territory for 'non-judgmental' psychodynamic therapy. There are many boundary issues here around religious, cultural and spiritual beliefs. In my view, however, clear abuses of basic human rights are OK to make a stand against. (I would say this is perhaps more essential when working with abusers). I often say something like: "That should never happen to a child" or "All children deserve love and protection". Sometimes the function of the Judge is implicit; the client imagines that you disapprove of say, childhood abuse. In my experience, however, it often helps to voice this.

Finally in the Bakhtin description of the witness and the judge is the intriguing concept of transformation: "This has caused it to be changed radically, to be enriched and transformed". Once transformation has happened, the past, present and future world can never be the same again. This is, I think, the core component of change in psychotherapy. It is not so much internalisation of the therapist but, through the therapeutic relationship, new ways of relating to future others are now a possibility.

Bakhtin goes on briefly to clarify:

"This cannot be understood as existence (nature) beginning to be conscious of itself in man…, no, something absolutely new has appeared, a supra-existence has emerged"(Notes made in 1970–71, Bakhtin 1986).

The Case Of Maureen

Maureen came to see me for a CAT assessment and then 16 session therapy, when she was seventy-one. She had been brought up in the Second World War and its aftermath in great poverty. Her benevolent father was 'invalided' after a quarry accident. Her mother became a hard-nosed provider and protector of the family, with great self-sacrifice. Men had a dominant role in this culture and Maureen was bottom of the pecking order after her mother re-married and introduced a step-brother to the family. Maureen was sexually abused by this step-brother up to her teens when he returned from the Army, but had no 'voice' to describe her experience. She knew it made her feel terrible but could only believe that 'it must be me', my 'terrible secret'. The step-brother married and his 'petite' and expensively dressed wife were subject to covert envious attack from both Maureen's mother and herself. The result was that Maureen could admire her mother for her assertiveness and contempt (envy), hear no criticism of her, but could not own, at all, her own contempt (and rage), which got her into endless protracted disputes with her now extended family. Any attempt to name the effect she might have had by saying "Well, that's the end of Christmas then" she had already pre-emptied with a collapse into a self-blaming, rejected child, leaving me feeling helplessly abusive and critical.

The first part of the therapy was a witnessing of Maureen's abuse. As a defensive procedure against going to this desolate place she would go into a dense monologue of recounted bickering between herself and members of the family, where countless examples were used to explain how badly she has been treated. By the time she got to the end of an incident (maybe after 10 or 15 minutes) she had already sunk into self-hatred. I felt "squashed against the wall", as I said to her, to some effect. Eventually we got into the abuse narrative. My role was to keep her in the thread of the narrative (she would often divert 'beside herself' into another anecdote) and also to share the feelings. In a way I was saying: "Look, I'm here now, we must concentrate on your wounds as I know they are terrible and need attention". Here is a snippet of the Reformulation letter I wrote to her in session four to illustrate what we were doing:

"In addition to these feelings of being unwanted and less than your brothers, you told me how you were sexually abused by your step-brother between the ages of 8 and 13 years. He threatened you not to tell anyone and although you felt very uncomfortable at the time you didn't really understand what was happening to you and felt unable to tell anyone until you were about to get married. You felt angry and hurt when you saw a letter from a forces friend of his showing that he bragged about the abuse to male friends. This must have

been horrible to read… it was very sad to hear how this has made you feel that 'it must be something in me' that was to blame for the abuse. As we realised in our last session, this is a terrible feeling to be left behind in a child who was really in need of love and protection".

I was beginning to add my own position (the otherness of the witness). I had brought in the previously peripheral perspective of the army colleagues who laughed about the abuse – a vehicle for getting at some of the anger. I also judged that she needed, and deserved, love and protection. The process of transformation was beginning. In session six we were still witnessing away and I asked her to prepare a letter to her step-brother:

Session 6 transcript

J: "Again it sounds like you are struggling to know whether you can have your own opinion".
M: "Yes it is a struggle".
J: "But you know what your opinion is".
M: "Yes I do,…"

(After reading the first letter to her abuser)

J: "You said you've forgiven him?"
M: "I think you have got to forgive people".
J: "Have you really?"
M: "The thing is I believe in God and I go to Church and one of the things they tell you is to forgive…"
J: "You 'should' forgive but have you forgiven him?"
M: "They say you should forgive and forget but I can't forget so I suppose I haven't really forgiven him…"
J: "That's OK if you still feel angry with him then you do…"
M: "I wish I had written down that sort of anger…"

In the next session she brought something of quite a different order:

Session 7 transcript

"I have written one letter to you which was quite pathetic, now in this one I must tell you how disgusted I am with you, the big brother I loved… I can't find the words strong enough to describe what an unspeakable beast you were… I have gone through life with this despicable memory and only now can I talk about it, but then only sometimes…"

This is a very moving letter as it addresses me at the same time as the step-brother, with a grateful (and admiring) sideways glance. "But then only sometimes", I think, refers to the therapy. The therapy progressed well with Maureen, very pragmatically making assertive changes in her life with her current partner and her family. She experimented with expressing her 'bottom role' feelings to them and realising that embarking on 'the blame game' only ended in rejection and desolation. I include here (Figure 1, p.24) Maureen's simplified map (or Sequential Diagrammatic Reformulation – SDR – in CAT jargon). The feeling left by the abuse, 'it must be me', caused a striving, perfectionistic compensation that left Maureen feeling taken advantage of and critical of those close to her which resulted in rejection and a return to the crushed, guilty child.

To conclude the theme of the witness and the judge, I include a part of a letter Maureen sent to me almost a year after the follow-up appointment.

Post-therapy letter

"…a very big thank you, I have now got rid of my horrible feeling of guilt and my black secret – it has gone now and I feel so very different, you made me see that it was not my fault and not a guilty secret".

This is a lovely example of transformation sustained. The world is a different place from now on in the sense that new ways of relating are now possible.

Conclusion

In this short paper I have concentrated on one aspect of my therapy with Maureen to illustrate the application of the dialogic construct 'The Witness and the Judge'. While there were many other rich veins in our therapeutic encounter I hope that this theme, illustrated throughout the therapy, may help the reader to add this concept to their vocabulary. Attention to the functions of the witness seems so important in work with older people where decades may have passed before someone else arrived to

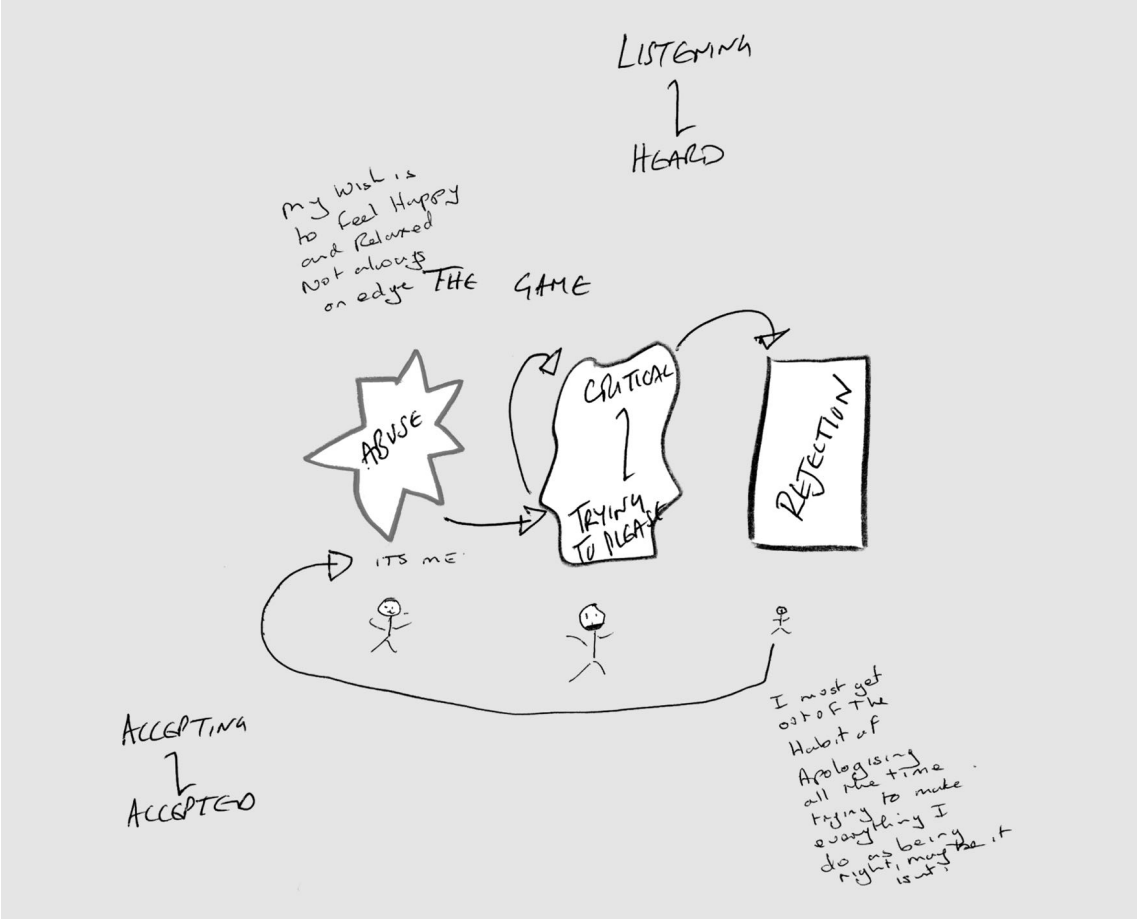

Figure 1: *Maureen's SDR – note how small Maureen draws herself after the collapse of a rejecting experience.*

take in the terrible scene and stand beside the unbearable feelings that have endured for so long. As another client, Jean (aged 86), said to me about a CAT therapy: "I thank you for giving me the chance of this costly treatment on the NHS… I hope that just because a patient is 86 they will not be turned away… I have benefited tremendously. I now feel all of one piece, and now feel I have grown up".

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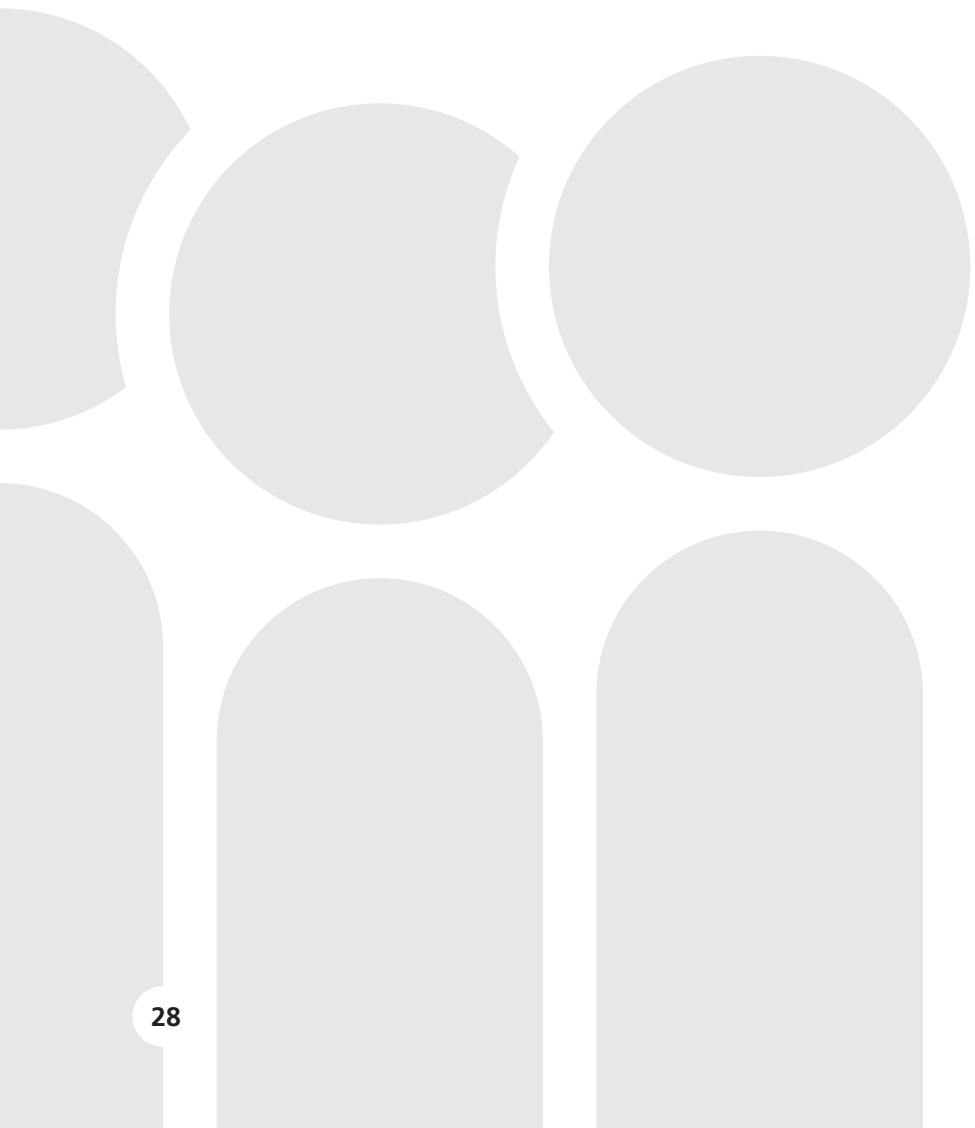

Jane Speedy And The 'Unassuming Geeks'

Collective Biography Practices: Collective Writing With The Unassuming Geeks Group

Abstract

This paper is co-authored by a middle-aged, female academic/narrative therapist and a group of young men who at the time of writing were aged between seventeen and twenty-five. The young men, who described themselves collectively as the 'unassuming geeks' had all spent some time in their lives seriously considering the possibility of and in some cases attempting suicide. The paper explores the ways in which a particular form of collective witnessing and writing practice sustained this group and its members' commitments to each other and provided them with a platform and multiple voices to speak from. The edges between therapy, research and writing and between collective and individual voices are deliberately blurred and troubled in this process and the notion of therapy as an 'individualised talking practice' is questioned. Issues of maintaining ethical know-how and of accountability to the people who consult us are also considered.

Introduction

"Learning to write and to tell stories of self against the grain of hegemonic discourses; making visible and therefore revisable the discourses through which we make meanings and selves; deconstructing the individual as existing independent of various collectives, of discourse, of history, of time and place" (Davies, et al, 2004, p.369).

One of the blurred meeting places between narrative research and narrative therapy is that between the collective biography practices used by feminist researchers and the outsider witness practices that have emerged from the narrative therapies. Feminist researchers, notably Crawford and colleagues (1992) and Davies and colleagues (Davies, 1994, 2000; Davies et al, 1997, 2001, 2004; Gannon, 2001) have recently expanded the collective memory work developed by Haug and others (1987) into a way of writing together that produces a form of collaborative research which challenges and disrupts the borders between culture and agency, so that:

"through the process of talking and listening, of writing and re-writing, the edges that mark off the texts of ourselves, one from the other, are blurred' (Davies, et al, 2001, p.169). Outsider witness practices have been developed by narrative therapists (see: White, 1995, 1997, 1999 and also Andrews. 2001; Behan, 2002; Russell and Carey, 2004) as a means of telling and re-telling the stories of people's lives to an 'audience' that privileges the process of telling and re-telling stories, rather than the expertise or person of the therapist (although both are present).

The 'unassuming geeks group' that are the co-authors of this text started in the form of a group of outsider witnesses to one young man's concerns about his life and gradually developed, slid in fact, into becoming a collective biography group, but also moved

backwards and forwards across these two ways of working. As the borders between narrative therapies and narrative research methods merged, a 'witnessed' collective biography method has emerged that has subsequently been used with other groups (Speedy, 2003, 2003a).

Perhaps it would be useful, however, before describing the particularities of how this process took place with the unassuming geeks, to outline the characteristics of outsider witness practices and collective biography work.

Outsider Witness Practices

The term "definitional ceremony" was coined by the anthropologist Barbara Myerhoff (1980, 1982, 1986) to describe the ways in which people generated visible identities by creating opportunities for the witnessing of their life's events and defining moments. Myerhoff also came up with the idea of re-membering. That is to say both accessing memories and introducing new "members" to the team available to witness and sustain the performance of lives.

> "When cultures are fragmented and in serious disarray, proper audiences may be hard to find. Natural occasions may not be offered and then they must be artificially invented. I have called such performances 'definitional ceremonies'" (Myerhoff, 1982. p.105).

Michael White, and subsequently other narrative practitioners, have used these ideas to create opportunities for the witnessing and re-telling of stories and re-membering of lives in therapeutic, workplace and community settings.

Re-tellings of significant stories to therapists and outsider witnesses offer people the opportunity to engage with others in not only richly describing, but also re-shaping life stories. Outsider witnesses are invited to the ceremony by clients (they may also be invited by the therapist, with permission, from a group of people with 'insider knowledge' of the issues). The reflections from witnesses are followed by re-retellings from the original narrator, followed by a more informal discussion of the whole process by all concerned. It is anticipated that this process will have thickened the original descriptions and/or perhaps will have taken the client to places that they had not anticipated journeying towards.

During outsider witness re-tellings people are not asked to evaluate the stories they have heard or people they have heard from (either in terms of applause and praise or any other judgement calls), but rather to identify the expressions that had most resonated with them; perhaps to describe the images that these expressions evoked, to recall stories from their own lives that these images brought to mind and possibly to articulate the ways in which the experience had somehow extended their ideas about their lives and life options. This sense of the ceremony touching the lives of the witnesses (as well as the person at the centre) is described by White (1993, p.73) as evoking:

> "Turner's (1969) 'communitas'-that unique sense of being present to each other in entering liminal circumstances, betwixt and between known worlds".

The retelling of stories without judgement by the witnesses can seem quite counter cultural to contemporary tendencies, certainly in western societies, to critique or praise the teller, rather than re-tell the stories evoked. Careful preparation and support of the witnesses is required. Well-managed ceremonies (see: White, 2002, for useful guidelines) are nonetheless frequently experienced as creative, moving, enriching and defining moments in people's lives, evoking comments such as:

> "I had no idea my life could mean so much to other people", "I had no idea what I had to say could be so useful to others" (Russell & Carey, op cit. p.85) and "I realised it was not to do with whether my story was true or not, or even to do with whether other people believed me: having it witnessed and knowing it made a difference to other people was what counted" (Midwinter, in Midwinter et al., 2005).

Collective Biography

A growing body of feminist research, spawned by the memory work of Haug (1987) and others has described itself as 'collective biography': work that draws the memories that people hold to in their lives through

a process of telling, re-telling, writing and re-writing stories "which reveal the ways in which we were (and are) collectively produced" (Davies, et al. 2001, p.169). Some of this work has been written by individuals through collective processes (see: Davies, 2000), some creatively layered and written in a collective voice by individual authors (see: Gannon, 2001) and some, as in the case of this text, has been produced through collective processes and has at times been written in individual and at times in collective voices.

Like definitional ceremony, this process of talking, writing, reading aloud, reflecting and re-writing creates a kind of resonation chamber where the echoes of similar and different stories expand the spaces between culturally familiar or appropriate explanations and assumptions and the particularities of the stories people seek to tell and the language they might uncover in so doing.

Collective biography processes have varied, but have in common their origins in Haug's (1987, p.47) memory-work with women, whereby:

"It is possible to study the process whereby we have become the person we are as a sedimentation of different levels of working over of the social. If, for example we write down and scrutinise any given memory from childhood, we find ourselves confronted with a diverse number of apparently fixed and given opinions, actions, attitudes, motives and desires, which in themselves demand explication.

Once we have begun to disentangle the knots, the process becomes endless…".

Most of these processes have included strategies for moving from conversations, to reveries, to writing, to reading aloud, to critically scrutinizing each other's writing, to re-writing and so on in a cycle. Gannon (in Davies, 2000. pp. 47–48) describes the conversational process, in ways that echo the experiences of 'witnesses' in definitional ceremonies:

"Once we start talking
Stories spill out
Lap over each other
Wash us into other stories
We give our gifts,
Memories,
to each other".

This process of discussion and re-writing can go on almost indefinitely and certainly the writings presented by the geeks, below, are considered 'work in progress' that has changed and may continue to change many times.

This kind of work sits within feminist traditions of research and seems, to have been used initially by women's groups to work therapeutically. More recent moves to describe this work as collective biography rather than memory work have brought with them a greater focus on re-searching and deconstructing meaning making processes. I would suggest, however, that this is a matter of emphasis and that much that has been considered 'therapy' can develop into published research and much that has been constructed as research can achieve therapeutic as well as scholarly outcomes. This seems particularly the case where issues of identity, marginalisation, resistance and transgression are at play.

Should I have had concerns about using ways of working that had been devised by and for groups of women with a group of young men? I think not. Equations of 'feminist' with 'about women' have long since been disrupted.

It seems equally valuable and viable to learn from and use ways of working that have usefully explored the subjectivities, sexualities and gendered embodiments of one group from the margins with those from another such group. Conversations with young men who have considered suicide lend themselves to explorations of embodiment, gendered stances, sexualities, masculinities, transgressions and resistances. Collective biography seems a particularly fruitful vehicle for such a group seeking to sustain and research itself.

Should I have concerns about blurring the edges between that which has been constructed as 'research' and that which has been constructed as 'therapy'? In many ways this is our collective purpose. The 'unassuming geeks' wanted to be published in a journal read by professional therapists. One of the geeks described 'therapists' in general as:

"Scared shitless of suicide. As soon as you say it, they panic and get you to agree to some contract that covers their agency or their arses. We need to tell them… I want to tell them. I think they must have crap training about all this".

And this is their chance. My own strong sense, also, is that as long as 'research' continues to identify itself as something esoteric and unavailable to practitioners and those consulting them, the published works emerging from the counselling and psychotherapy fields will continue to be dominated by academics and practitioners located in university settings (such as myself) rather than the voices of practitioners out in the field and the clients they are working with.

It is certainly important to be clear, blurring these edges between research, writing and therapy that I consider myself an experienced therapist and a practitioner/researcher who moves between these two fields all the time. It is also worth noticing that many narrative therapists describe their work as co-research into the lives of the people consulting them and position themselves accordingly.

Working With The Geeks

The unassuming geeks originally met as a group of 'outsider witnesses' to one young man in response to his request for a team of quiet young men or 'unassuming geeks' to listen to and sustain the stories he was telling himself. Some of this group of witnesses (including the young man at the centre of the ceremony) decided to form themselves into a support group, initially facilitated by me, somewhat in the manner described by Behan (2002) and Andrews (2001), but eventually becoming self-supporting. This group (now five men) later began writing together, partly as a result of my own practice of e-mailing them occasional poetic documents, reflecting their expressions of life after meetings, and partly because they had also begun to write to each other online between sessions.

The work we want to describe here emerged form our practice of writing 'collective biography' together, because in the end, this is what engaged everybody the most and because outsider witnessing is in some ways an extension of the reflecting teamwork used in family therapy and is so much more widely known and written about already (consult the references listed above for an introduction).

After we had been meeting for some time, both face-to-face and online and it had been decided that we might 'translate ourselves' into a collaborative writing group, I introduced the geeks to the work of collective biographers. The description 'feminist research' did not strike a chord with them, but the notion of transgressive writing practices developed by groups at the margins with an interest in telling 'stories against the grain' resonated immediately.

Ethical Issues And Accountability

As the middle-aged, female facilitator of a group of young men between the ages of seventeen and twenty – three, issues of inappropriate intrusion into the 'collective' process of biography immediately arise, as do safeguards within and dilemmas about working with and publishing the work of people contemplating suicide.

The young men in this group were not, in fact, considering suicide, or anywhere near that point in their lives at the time of taking part in this project. The one person who came along initially as a witness who was not yet ready to take up a position of drawing on memories rather than daily experience, was not included in this group. It was simply not a good point for him to join this kind of writing group and it was more appropriate for him to continue working individually with his therapist.

My work as a therapist was supervised by other professional therapists and this support continued, but the main ethical sustenance for undertaking our work together was our accountability structure as a community, borrowed heavily from the work of the 'just therapy centre' (see: Waldegrave, et al, 2004). In this way I was apprenticed to the group and accountable to them and to the friends and family members whom they had nominated to act as our team of consultants. We had many discussions in the group about moving from working together as a community of witnesses to each others' lives towards writing together about those experiences

(therapeutic, experimental, writerly and poetic not being mutually exclusive terms, but rather words that contain large trace elements of each other). My expertise as an interviewer, writing teacher and group facilitator was called upon and I was influential, although ultimately peripheral, to the group in relation to decisions about what constituted 'finished' pieces of writing, for example.

With regard to the sections published here: I wrote the introductory paragraphs you are now reading to which the unassuming geeks made very few changes. They, however, quite rightly selected the writing to be included from the work of the group without consulting me at all. As the facilitator of the process, I did have considerable influence over what was available and what was possible. My position was not neutral. It involved negotiating and navigating the landscape of power relations and relationship transitions as well as issues of gender, age and status. Much of the later talking and writing took place without me, but the group was influenced and limited by my facilitation in ways that were made transparent by one member who said:

"This is a bit the same, but different from being all men. We are all men and sometimes forget you are even in this project, but in some way we know you are in here somewhere and let's face it… you are my mum's age and that makes a difference to what I might write sometimes".

The practices of remaining accountable to the participants in this group went some way towards redressing and negotiating the complex territories between a middle aged woman therapist and a group of young male mental health system users. Redressing and negotiating, however, is not the same as negating. I also work in a University setting with all the trimmings, trappings, advantages and disadvantages of academic status that this brings. These texts, collectively owned and constructed by the geeks, remain differently constructed than they might otherwise have been. In this sense the term 'collective' remains more contested and overtly problematic than in feminist accounts of women's workshops, although the purposes: to sustain the geeks in their quest to 'occupy the language, to make it live' (Davies, 2000, p.43) remain the same.

The tensions between confidentiality, particularly for family members (hence the collective pseudonym) and pride and ownership of the writings have been, and still are, a constant theme in our discussions (see: Speedy, 2005). The collective term 'unassuming geeks' has been used in this text, for the moment, but this decision may become open to later revisions.

Constructing This Writing

Our writing sessions usually began with a conversation around a particular shared theme chosen by the group a week beforehand, such as 'suicide and selfishness' or 'thinking of others'. Sometimes one of the group brought a poem or some writing by someone they admired. The poems of R. S. Thomas were brought in by one of the group, as were newspaper articles and United Kingdom department of health (2003, 2004) reports. I brought Ntozake Shange's (1977) play: "For Colored Girls Who Have Considered Suicide When the Rainbow Is Enuf: A Choreopoem" in response to questions about plays and musicals with 'suicide' in the title and this sparked a whole new genre of scenes written as 'men in coloured shirts'. All these texts generated conversations that led into some of this writing.

A process of working together evolved. This consisted of a conversation in which a particular story or theme or piece of writing was introduced by one person. This contribution was witnessed by others in the form of re-tellings that resonated with their own lives (often in juxtaposition to dominant stories, or more frequently dominant silences in relation to suicide), followed by re-re-tellings by the original narrator. This conversation was then followed by writing, by reading aloud and then placing that writing under rigorous scrutiny within pairs or within the group. This process then moved backwards and forwards between critical scrutiny and re-writings until finished 'for the moment'. We looked for 'taken for granted' and familiar expressions, either to capture with ironic juxtapositions ('thinking of others' leading to the holding of breath to keep others at bay, for instance), or to burrow underneath 'explanations' such as 'we were looking towards the future' towards expressions like:

"A gaze that scours the landscape not only
for the lives of current others, but for
the children we might yet father…".

The 'finished' works in progress have sometimes become collectively authored works and sometimes been individually authored in collective ways. My tasks and responsibilities were to facilitate this process and provide safe online spaces and archives. None of the writing featured below is 'mine'. The extracts from the extensive collective biography work produced were all chosen by the geeks. They selected and layered together the pieces presented below out of a much larger body of writing. These pieces included some writings inspired by the works of others and some that spoke, in embodied ways, to familiar expressions within the regimes of truth surrounding suicide, youth and maleness.

Unlike some of their feminist predecessors the geeks have, quite deliberately, not stripped away all the clichés and assumptions they came out with, but rather have included, amplified and exaggerated them. Some have become themes and section titles in this paper, for instance, in order to place other ways of writing up against them. Thus familiar, everyday phrases, particularly those that had come from fathers, family doctors and other older men such as: 'on the rampage', 'just the ticket', 'you need to get out more', 'just a phase' and 'think of others' are juxtaposed with the unexpected, embodied expressions that emerged such as: 'collective curvature of the spine', 'an unassuming rampage itches gently' and 'we have considered suicide and erred in favour of breathing'.

There was much discussion about which writings should be included and when they were deemed finished. This led to further discussions about authorship, ownership and subjectivities, eliciting comments such as:

"we passed the 'who wrote what' threshold some time ago. Now the fighting is just as fierce on the 'what goes where' front, but we are still finding the words and they are still eluding us".

Extracts From The Collected Writings Of The Unassuming Geeks

The unassuming geeks are on the rampage.
Such rampages start in the belly.
They are gut twisters.
An unassuming rampage itches gently against
the skin and a modest amount of facial disquiet
and bodily dishevelment may be experienced.

We just have a few questions about
relentless forward motion. We may
not be the future and our spines may
curve unexpectedly. Is this manly?

Dishevelment may follow…

Don't say anything at school, you'll
only frighten people.
You have the right to burble on like
madmen, but we prefer you to remain silent.
'Anything you do say will be taken down'.

It came to us later, on the breeze, that it was
the silence at school that was eerie and we
now reserve the right to remain dishevelled.

Your whole life ahead of you, it's just a phase…

We have our whole lives ahead
of us. How do they know?
What if less is more? What, then,
makes a 'whole' life?

When I see ring-billed gulls picking
on the flesh of decaying
carp, I am less afraid of death.
We are no more and no less than
the life that surrounds us.
My fears surface in my isolation.
My serenity surfaces in my solitude.

(Terry Tempest Williams, 2004)

Phases are like waves, waves are also particles,
it all depends on your gaze.
Are you looking for connections
or at each of us in isolation?
Collective curvature of the spine produces
generations of hunched up men
although this could be just a phase.

Think of others for a moment…

There are many other lives to consider: soft
amphibians with razor sharp memories trying
to cross the busy roads; cormorants seeking
oil-free wings; lovers of the future with soft

downy skin and imploring olive eyes. Follow
our gaze: A gaze that scours the landscape
not only for the lives of current others, but
for the children we might yet father…

Thinking of others for a moment,
as a very small boy,
he could keep himself alive and
hopeful by thinking
that he still had the power of breath.
How did he know so much?

Thinking of others for a moment
He and no one else
had control of his breathing.
It was his body, his diaphragm,
and he could make it breathe, or not.

Thinking of others for a moment
He could hold his breath for the longest time
and keep all the others
at bay.

Heroes night: you should get out more…

Out for a drink with R. S. Thomas over
many pints. Speaking of Wales and of furies
and changing midway to Welsh. What
was said? Well, it echoed very fierce.

The furies are at home
In the mirror, it is their address.
Even the clearest water,
If deep enough can drown
Never think to surprise them.
Your face approaching ever
So friendly is the white flag
They ignore. There is no truce

With the furies.

(R. S. Thomas, 1995).

The collective medical profession prescribes
fresh air and frequent sexual activity:

"You need to get out more, mate,
sow a few oats, get laid"
"You need to get out more, mate,
you need a good shag"
What prescriptions lurk beneath
the skin for suicidal women?

All of our stuff

A performance, each one taking on a different
colour: brown, yellow, green, blue, and orange.

'somebody almost walked off wid alla our stuff'
(Shange, 1977, p.49).

We had different readings: A
rape scene. Identity theft.

Things not being what they had seemed
or how they might have ever been
imagined: somebody walking off with
every single possible expectation of how
our lives might unfurl into the wind.

Ntozake Shange has all this written on her
body. She had, in her eighteenth year, put her
head in an oven, slashed her wrists, taken an
overdose of Valium and driven her car into
the Pacific… By the time we got to read her
words, she was elsewhere, not assuming too
much. She said (of her poems, 1977, p.6):

'I am offering these to you as what I've
received from this world so far:

i am on the other side of the rainbow/
picking up the pieces of the days spent
waitin for the poem to be heard/while
you listen i have other work to do'

Performance

(a one act play for five men in
different coloured shirts)

Man in green:
It says here that the average man thinks about
sex every two minutes, what sort of sex, where
does he feel it? How often does he think
about death and where does he feel death?

Man in yellow:
Less. He fills his head with sex so that
death gets less space. The geographies
of sex are unlimited, but surely death
curdles the contents of the stomach?

Man in green:
So, in an average life, an unassuming life,
how often does a man think about death?

Man in brown:

An unassuming life is not average. It
would be extraordinary to live a whole
life without assumptions and perhaps
it would be very exhausting. Perhaps an
unassuming life would be very short.

Man in orange:
You can get a lot of sex into a short
life but only one death.

Man in blue:
You can only die once but you can think
about dying as often as you like.

Man in green:
Death by hanging.

Man in yellow:
Death by misadventure.

Man in brown:
Death by drowning.

Man in green:
Death by suffocation.

Man in blue:
You are very quiet.

Man in orange:
I am thinking about sex.

Suicide Prevention

The UK government has a strategy
So we are running our lives beneath their radar
They speak of young white men and
a lack of educational achievement
so some of us are sliding in
beneath their lasers with
darker skins and good degrees

A space like this
A year or so ago
Would have been
Just the ticket
When it was
Hard to breathe
In and out each day
Fewer thoughts flooding in, less stumbling,
Some quiet place
Like this
To get back to the future
Could have been
Just the ticket
Statistical hopefulness
We are vital statistics. A 'worrying' trend.
'suicidal thinking in young people…dramatic
increases in the suicide rates for young
black British men… young white men…
In western Australia, young men fifteen
to twenty-four… male suicide rates in
Finland, Canada and the USA…'

There is much less private panic in all this.
As part of a worrying trend, we at last have
something to grip on. Suicide rates go up and
down with unemployment figures. This all
feels more sociable. Everything has stopped
smelling of disinfectant and bedpans and
isolation. There is a whole city running
around here beneath the radar. It is really
quite cosy, back-to-back, cup of sugar?
Aspirin? Paracetemol? Codeiene? Panadol?

This is girl's stuff, boys don't swallow their
pride. We have other means of suicide:
our ropes and fumes and watery ends all
sediments of Saturday mornings huddled
together in the dark in front of cowboys,
truckdrivers and tall, tall ships in battle.
Why do more young men top
themselves than young women?
Perhaps because young women
breathe out more?
Perhaps because young women
watch different movies?
Perhaps because of all that 'action learning', all
that 'look what he made out of Lego': perhaps
its better to talk it over with 'Barbie' first?
We might be a source of sustenance
and hope for each other.
We are not keeping this inside
We are not keeping this
We are not
We are not
We'll put it on all future application forms
inside the box called 'other'
White British/White European/
Black British/Black European/
other.
The men in the box marked 'other' have
considered suicide.
Collecting statistics on those who commit
suicide is a bit of a dead end job. We
have considered suicide and erred in
favour of breathing in and out.

Could we have your attention?
We would just like to put in the
comments box of life
That we have chosen
To stick around
Although there has been much contemplation
Of a range of routes out of here
Which must not stay
Under wraps
There are strategies in place
For suicide prevention but
The contemplation of suicide is a
Frequent human event
That gets little press coverage
No red carpets
We just sidled in through the side entrance
We are stationed, breathing in
and out, at the sign of hope.
We have not yet settled, but
remain on our haunches
We are crouching in the shadows of statistics
We have not yet settled
There are dogs barking
At our heels
And loneliness threatens still
to eat away our hearts
And yet, our sweat gives off an unassuming
whiff of triumph
We are stationed, breathing in
and out, at the sign of hope.

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Jeannie Wright

A Practice Of Writing

Abstract

This article illustrates the use of 'writing therapy' both as an online form of therapeutic relationship and as the contracted, exchange of letters. Some writers, poets and novelists, have pointed out the overlap between creative writing for the exploration of our many constructed 'selves' and the process that may emerge in therapy. The article combines case studies with reflective writing about personal experiences, changes and the continuing development of an integrative narrative practice.

Introduction

"Though I write about the healing process as an individual, the insights shared are collective", (hooks, 1993, p.15).

For some people, writing is a form of therapy in itself, whether or not they work in relationship with a professional therapist (hooks, 1993). This article will focus on specific ways of using creative and reflective writing and their application in integrative writing therapy. It will explore how the narrative approach (Angus & McLeod, 2004) provides a theoretical and practice basis for using writing in therapy.

In various integrative therapeutic models, forms of writing are used as an adjunct to face-to-face counselling. In CAT (Cognitive Analytic Therapy), as in narrative therapy, letters from the therapist to the client feature and explorations of clinical supervision via written communication are developing (Ryle, 2004).

Some forms of therapy, which do not necessarily claim to be 'integrative' also, use writing. In Cognitive Behavioural Psychotherapy, apart from the more 'manualised' techniques where writing is used to list pleasurable activities or thought records, for example, more imaginative writing is emerging as part of compassionate mind training (Gilbert, 2005). What Gilbert's integration overlooks is the need for social connectedness. Narrative approaches come closest in my experience to acknowledging that therapy is essentially social and political, a more collective experience than the traditional one-to-one (Speedy, 2004).

To illustrate how writing therapy works, the 'case studies' here are practice composites. One of the attractions of the narrative approach for me is the literary metaphor underpinning terms such as 're-authoring' to describe the process of change in narrative therapy (Payne, 2000). I have deliberately chosen to focus on people (including myself) who have used writing as a stand-alone therapy, rather than as an adjunct to face-to-face therapeutic work. The lack of non-verbal communication is difficult and can feel impoverishing of the therapeutic relationship (Wright, 2002); however, there are compensations. One client grasped immediately that writing therapy would mean that she could re-read her own accounts of her thoughts and feelings, and my responses.

A careful use of language and reference to social constructionist perspectives on how language is at the very centre of creating aspects of identity and 'self' are very relevant to narrative approaches (McLeod, 1997). Markham gives

some rich examples of this representation of self in an account of online research, '…I do well when I can backspace' (Markham, 2005).

Such ideas about how we 'dwell in language' certainly inform how I work with people in writing therapy.

Using online communication in therapeutic settings came about partly through an experience of counselling and teaching counselling at the University of the South Pacific (USP), where distances between campuses were immense. Moreover, in 1997 by comparison with some colleges and universities in the UK, USP was making unimaginably sophisticated use of the internet. Students and staff could not physically access the central counselling services and would use 'virtual' written communication via email instead. Expediency therefore played a part. Languages spoken were also immensely varied, as were the cultures represented on the different campuses. To ask students and staff who e-mailed or came to the Counselling Service to write in their first language, then work therapeutically with me in English, was a necessity and led to some questioning of my hitherto 'integrative/humanistic' practice. The rapid and startling shift from an oral to an electronic culture was extraordinary to witness, as I noted in my diary at the time.

The extracts are from my diaries and other forms of creative writing. They are intended to move towards reflexivity (Etherington, 2004), opening up the personal point of view of the writer and allowing a different 'voice' to be heard.

"Evocative stories activate subjectivity and compel emotional responses. They long to be used rather than analyzed; to be told and retold rather than theorized and settled; to offer lessons for further observation rather than undebatable conclusions; and to substitute the companionship of intimate detail for the loneliness of abstracted facts", (Ellis and Bochner, 2003, p.744).

As this paragraph illustrates, some writing is beautiful to read. Aesthetics have a place in healing. Bolton(1999) points out that Apollo was god of both poetry and medicine.

Narrative approaches clearly call for evocative stories. On the other hand, there are some important 'abstracted facts' about writing therapy which will be outlined in a later section.

Yvonne – Integration In Practice

Integration in practice is not a static end-point but an on-going process. For example, most recently, with Yvonne, a person who wrote to me and asked if we could work together by letter, a narrative approach has been central. I am not able to say that I am a narrative therapist. However, the 'narrative turn' and practices that use the 'root metaphor' of narrative (Speedy, 2004) have been most influential in the 'writing therapy' that I offer. Seeking to use integrative approaches, including narrative influences, provides a way of working that seems to be the best collaboration with the person seeking help.

Owning Up

"What kind of therapist are you?"
Someone asked me the other day
in a new group of therapists.

"A talking therapist I suppose," I joked
to cover the alarm filling my stomach

"Feminist, integrative, influenced by
the narrative approach… A writing
therapist", I said and had to look down
– as in what? Doubt? Embarrassment?

"I know what I mean," I said

"But I'll have to write the answer".
Joking again to mask emotion.

So what kind of therapist am I?

The kind that doubts the whole
business/enterprise at times (Especially
the business/enterprise part of it).

I could answer as if I were being interviewed
for a job. "A writing therapist".

I ask Yvonne to describe herself and in turn, I say what I am like:

"White, middle-aged, working class up-bringing in the British Midlands, middle-class education", and so on. She, Yvonne, is African Caribbean, born in the British Midlands, in her 40's and has had little formal education beyond the age of 14, although she has worked at managerial level and is currently responsible for a team of ten.

Yvonne has recognized that she might have to go outside the family and the church, both central to her life, for some help. She first asked for some help from the GP and then from the Women's' Centre. She has had to ring a receptionist and make an appointment. She is asked to complete a questionnaire asking about her 'problems'.

"One of the key contributions of narrative therapy is the determination not to locate problems as internal to people, but instead to externalise problems and to understand that the ways in which problems are constructed and experienced are related to matters of culture and identity". (Russell and Carey, 2002, p.7)

She has also identified herself as a 'client', in need of some help. Events in her life are beginning to lead her to feeling that the problem is in her. The professional culture of 'helping and being helped' is inherently unbalanced: power in the helping relationship is engaged with at a profoundly different level in narrative approaches (White & Epston, 1990) where the term 'client' is avoided, with 'people who consult' often used instead.

Yvonne feels awkward in the first few sessions and says so, also emphasizing how disloyal it seems, talking about her family to an outsider.

Therapist Role And Style In Writing Therapy

De-centering or moving the therapist out of the spotlight in narrative approaches is another attraction for me. This is not to say that communicating warmth, empathy, authenticity and certainly respect in the writing relationship is not just as crucial as in, for example, person-centred therapy. In most humanistic orientations, the counselling relationship is at the heart of the therapeutic process. Rogers' (Rogers, 1951; Rogers, 1957) often quoted and less often practised 'core conditions' enable the client to feel 'safe' enough to express themselves openly and move towards being their 'organismic or true self'. The therapeutic role, at risk of over-simplification, is to offer the core conditions, using predominantly reflection as a way of communicating understanding of the client's frame of reference. Questions in such orientations are viewed as taking the client outside of their own thoughts and feelings and are generally viewed with some suspicion (Tolan, 2003). In contrast, according to narrative practice, questions are central (Payne, 2000). With Yvonne, in our first session (which was actually an exchange of letters) I asked a lot of questions, examples include the following:

"Friends – could you draw a kind of genogram (see enclosed example) showing where the people are that matter to you? You've said in your letter they're part of the 'important things in life'. How do you think some of these friends would see you?"

"The image I get of you is of a highly talented, energetic and generous woman who has put a lot on hold. Have you ever tried writing letters to parts of yourself that have been neglected over the last several years?"

Finding a way to express the respect and tentative curiosity – which seems to characterize narrative practice – in writing, rather than face-to-face with a person is a challenge. The therapeutic role in narrative practice is collaborative; the stance demonstrates a genuine curiosity. Anthropological metaphors are also used to describe the process of therapy in narrative approaches. Payne (2000) illustrates the rituals and stages a person might encounter using metaphors drawn from anthropology such as moving through a 'rite of passage'.

The therapist's role, to use a more literary metaphor, is also to be an audience, even an imaginary audience for the writing. I certainly held an image of my therapist, a man I had never met but wrote to in my mind whilst writing, thus reducing isolation. At times he became a coach, an editor, co-writer. He challenged me to re-author the story I was presenting by asking about alternatives, times when I had not felt so isolated, for instance. Some of the time, he began to be too directive but I felt sufficiently in control of the writing to say that

and change the focus back to where I wanted it to be. In the writing with Yvonne, I keep checking with her if we are moving in the right direction for her, or if she'd prefer another path.

According to those that espouse pantheoretical approaches to change in psychotherapy, such as Stiles et al (1990), Yvonne needed help because the feelings she had been 'warding off' when her mother died a few months previously became overwhelming when her partner left her for someone else. She had been prescribed anti-depressants by her GP and offered counselling, but preferred to write for several reasons. Her work involved frequent trips abroad and travelling was a barrier to regular face-to-face appointments. She also kept a diary and tended to confide in writing.

We agree that she'll write every week at first, and agree that in keeping a therapy diary, catching down on paper her thoughts and feelings after each session, those reflections will be private to her. I emphasize that all of this writing is for her, not for anyone else to read until Yvonne feels ready. I also stress that all the school rules of correct spelling and grammar can be forgotten in this kind of writing. Some people are not attracted to writing at all and other expressive arts, such as music, art or drama therapy might be more useful to them (Malchiodi, 2005). For others, keeping a diary has been habitual and has been about putting 'the self on the page' (Hunt & Sampson, 1998).

Bibliotherapy

I tend to suggest bibliotherapy early on (Frude, 2005) although the books I mention are often novels, poetry or cartoons, and not just the standard non-fictional 'self-help'.

Yvonne had tried several 'self-help' books and mentioned reading Ann Dickson's "A Woman in Your Own Right". It had been a revelation to Yvonne to find herself described so accurately. She writes that she has laughed a lot about shocking her daughters by describing herself as 'Dulcie Doormat' in the context of her relationship with them; she also recognizes that she can sometimes be more like 'Aggressive Agnes'. I suggest some books Yvonne might want to try, particularly novels and essays by black writers.

On finding the shelf full of Alice Walker, Toni Cade Bambara and Toni Morrison novels

1984 – dislocated
On exchange in Massachusetts
Pregnant, first child
Embarrassed, apologetic,
An English woman in small town America
Away from sisters, friends, family
Supposed to be working, learning.
June, July, August dog days in New England,
Humidity, thick and stifling.
Few students left, or staff.
I'd sit in his office
My exchange partner
(he in mine back in Notting
Ham, England)
The air-conditioning a good
reason to be indoors.
Nothing to do, indoors or out.
Then, in the library, I found the shelf.
Some English teacher,
Creative Writing, 101 or
The African American Novel,
A shelf of women writers I'd never heard of
(With my English and Related
Literature degree).
Alice Walker, Toni Morrison and all
Taught me about being female,
and being black in America,
And relieved the isolation.
I read and read
kept a diary and survived the Summer.

Personal And Political – Writing As Resistance

"Confessional writing in diaries was acceptable in our family because it was writing that was never meant to be read by anyone. Keeping a daily diary did not mean that I was seriously called to write, that I would ever write for a reading public. This was 'safe' writing. …I could be angry there with no threat of punishment. I could 'talk back'. Nothing had to be concealed. I could hold on to myself there". (hooks, 1999)

In this passage on asking for and being given a diary, bell hooks, African American

feminist, academic and writer highlights one of the most powerful benefits of writing: that on the page, we have to please nobody but ourselves. This can be a novel experience for some women, socialized into pleasing others (Russell & Carey, 2002).

hooks continues:

"The realm of diary-keeping has been a female experience that has often kept us closeted writers, away from the act of writing as authorship. It has most assuredly been a writing act that intimately connects the art of expressing one's feelings on the written page with the construction of self and identity, with the effort to be self-actualized" (hooks, 1999 pp. 4–5).

Though this is the language of humanism, conveying an essentially individualistic view, in the next sentence, hooks moves into a whole other understanding of women, writing and self:

"This precious powerful sense of writing as a healing place where our souls can speak and unfold has been crucial to women's development of a counter-hegemonic experience of creativity within patriarchal culture" (0p.cit).

Hooks (1993, 1999) connects writing with self-help, and provides detailed examples of how women who cannot afford therapy or who choose to work independently of the 'therapy industry' can work towards 'self recovery' partly by forming support groups and partly by writing about their lives and experiences. She also examines her own periods of depression and what she calls' home psychoanalysis', staying with one of her sisters ("V. who is a friend, comrade and therapist" p.106) and writing the "exercises" V. suggests.

Katie, a student at college in the USA, also keeps a diary. These sometimes intensely moving and unsettling pages are sent to an academic who is President of the International Association of Suicide Prevention, by her sister after her death. The book, "Katie's Diary: Unlocking the Mystery of a Suicide" (2004) aims to look to lessons to be learned, "to grasp the depth of her despair and to discern possible paths through and beyond it" (p.xii). Her father, who was an alcoholic, sexually abused Katie in childhood and eventually she and her sister were placed in foster care. Writing her diary, in some passages addressing herself to God, up until nine days before her death provides extraordinary insight, is almost unbearable to read in parts, and underlines the isolation she felt. It also indicates some of the limitations of therapeutic writing, which will be the focus of a later section.

For some writers, Toni Morrison for example, writing as therapy is disliked and doubted. In contrast, bell hooks considers how it has worked for her:

"I call attention to the way writing has functioned, therapeutically for me as a location where I may articulate that which may be difficult, if not impossible to speak in other locations" (hooks, 1999, p.14).

The mechanism, how and why writing can produce positive physiological and psychological results is still unexplained, but bell hooks' conclusions are similar to those of one of the major figures at the science end of research on writing, James Pennebaker pioneer of the 'writing cure'. He sums up the 'essence' of writing about emotional events nearly twenty years after his initial experiments:

"To me the essence of the writing technique is that it forces people to stop what they are doing and briefly reflect on their lives. It is one of the few times that people are given permission to see where they have been and where they are going without having to please anyone". (Pennebaker, 2002, p.283).

Research Base

Research into therapeutic writing is largely associated with cognitive and behavioural approaches (Lepore & Smyth, 2002); family therapy and health (Lange, 1996) and largely, although not totally associated with positivism and medical research settings, where language such as 'forced' and 'gives permission' is not totally inappropriate. Some of the findings from the Randomised Controlled Trials conducted in these Dutch and American universities are presented in head-line grabbing, medical comparisons, such as 'Writing Beats Pills in Asthma and Arthritis'. Various authors point out that if any new drug had produced the

results indicated for writing, its use would be widespread within a very short time.

Within qualitative research, Chase (2005) links feminism and personal narrative not from a therapeutic perspective but with a focus on women's studies and life history. She argues that the liberation movements of the 1960's and 1970's led to a renewed interest in voices that had been over-looked, silenced or deliberately drowned out. Subjective experience (Ellis & Flaherty, 1992) is now a legitimate, even celebrated basis for research (Etherington, 2003). If McLeod's view that all therapies are narrative therapies is followed through into research, narrative is a fruitful paradigm to follow.

Pennebaker (2000) indicates that,

"In our studies as in narrative therapies then, the act of constructing stories is associated with mental and physical health improvement".

Accounts and evaluations of writing therapy in a range of settings are increasing (see, for example, Bolton, 2005). Reviews of these studies (Wright, 2004) are not the focus of this article (see also Smyth, 1998) but findings can be summarized very roughly as follows:

Benefits Of Writing

Less shaming, more openness – the ability of some people to be more open on paper than in person about expressing shaming experiences and inhibited emotions.

Externalising – The focus and pace is essentially within the writer's control. As one person using writing therapy put it, 'it allows me to articulate fully without being distracted by physical surroundings or time pressure or either party's mood/mind set at that particular time'.

Availability – writing with pen and paper is available anywhere, anytime.

Clarity – some people record how writing enables them to be clearer in their communication with self and others.

Record of progress – by re-reading and reflecting on their writing, some people suggest that they gain a sustained sense of their own achievement.

Cautions Of Writing In Therapy

Isolation is a factor singled out in suicide risk (Lester, 2004). Most researchers suggest that writing without any other form of help would not be recommended for those people who have been labelled 'psychotic'. Whereas narrative approaches seek to avoid the diffusion of what Gergen (1990) refers to as the language of deficit, risks cannot be ignored and clearly writing can be a very isolating activity. Most of all, collective and communal ways of being in relationship are central to narrative therapy and it can be more difficult to work in this way in writing, although not impossible as Etherington (2003) and Meekums (2005) have shown. Lepore & Smyth's (2002) emphasis on how low mood follows writing about traumatic or emotionally upsetting experiences in the short term is a research finding I always point out to people who choose to use writing therapy.

Privacy

Privacy is a piece of paper you can fold. At the Women's Centre, where free or low cost counselling is offered by volunteers, we have just been asked to write on small slips of paper one way in which we are different. The woman leading the short training session on diversity is the only person who is visibly different in the group (and her first language is not English). We all think and write, then we're asked to fold the paper and put it in a basket. When we read from the unfolded paper at random, the writing includes:

I'm gay
I'm divorced
My dad died when I was 6
I speak Punjabi

For some it was easier to write than to speak. Later the discussion turned to how to reduce the waiting list. Most of the volunteers trained or training in humanistic orientations saw brief therapy as a possibility. It could 'empower' some

of those women who might learn 'self-help' techniques. We know that most of the women who use the Women's' Centre Counselling Service are on low incomes, have been or are in abusive relationships. I sat and considered the changes in me as a therapist who thirty years ago, active in socialist and feminist politics would have seen most of what we do in therapy as patching cracks or, at a push, 'empowering' women to enable them to fight back more effectively. These arguments lost their certainty for me at the same time as I stumbled across narrative ideas.

Note-keeping In Narrative Therapy

Speedy (2004) in a rich distillation of theory and practice says,

"The collection of ideas and practices that has become known as 'narrative therapy' might be regarded as a 'practice of writing'…" (p.25).

She explores some of the sources of these ideas and shows how therapeutic documents and ethical document keeping have been developed. Notes, usually written after the session in most therapies and then 'held confidentially' by the therapist have been another way in which narrative practice has changed my way of working. With Yvonne and Ewan, the notes I wrote in response to their writing tended to be an important part of the therapeutic process and became integrated into my written responses.

Speedy also introduces the way in which emails, faxes and/or letters and poems from witnesses and supporters can be collected in support of a current client when 'live' witnesses are not available (p.28).

Ewan – Online Therapy

Ewan, in a concise, professional manner, writes that he has requested online counselling because he is faced with a bullying colleague, who is making life in the academic department they both belong to unbearable. Ewan has been off work for several weeks. One of his colleagues has suggested the online service. Ewan is aware of his ability to intellectualise and analyse and says he could "talk around this problem for ever". I point out that he has related these very difficult events and experiences for most of our first e-mail session clearly and logically, but without any emotional content. None of the words or language he has used describes feelings at all. I suggest he might keep an "emotional diary" with a view to get "us out of our intellects and into feelings and images," (Rogers, 1993, p.64). Ewan sounds wary. On an attachment, providing some guidelines for writing therapy, I point out that this writing is for him, not for me or anyone else, and that he could try it, possibly before our next online session, in privacy and at his own pace.
For various reasons, our next e-mail counselling appointment is three weeks later. Ewan 'sounds' much less tense than before and is eager to 'talk' about the diary. "It was hard at first," he says, "felt like a chore, but it is so different from academic writing that now I find it an important part of the day".

He offers to attach some extracts about the bullying he has experienced at work. The writing is full of metaphors and images describing frustration and fear.

I am aware of how quickly we have moved from "talking from our heads" and reflect on this shift to Ewan. His sense of humour has come through in all of the e-mails.

Ewan sounds a bit uncomfortable re-reading his words. He says it's a bit embarrassing to express things like "hurt, anger and powerlessness. It's not very 'British' for men to talk about these things". He jokes about this and we explore how Ewan has used his intellect to talk his way around this cultural inhibition. We also begin to look at how his sense of humour has enabled him to distance some of the pain of these feelings. I send some cartoons.

I also ask, a few sessions later, if he has mentioned the diary to anyone close to him. He says he has, but only to his wife. I ask a lot of questions about how recent events may have been observed by a spectator, what they would have seen and heard, and how Ewan's wife might have seen it all. This is not about the "inner dynamics of the individual psyche" (Gergen, 1990) but more abut the "continuous

communicative interaction between human beings that becomes the central focus of concern" (ibid, p.10). They decide to go line-dancing, once he has returned to work on a part-time basis. Ewan stops e-mailing. Months later he sends a message to say he's found that group, the line-dancing class, most useful.

Online therapy makes it very clear to me that the therapeutic relationship is not (should not be) the centre of the client's life. Payne (2000) explains why the integration of a person-centred and a narrative approach to the relationship between the person who consults and the person who counsels is impossible.

> "Only in narrative therapy have I come across a questioning… a contrasting concept that the professional's role is more productive and ethical as a facilitator of the therapeutic actuality and potential of 'real-life' relationships, rather than as the provider of a therapeutic relationship with the counsellor herself" (Payne, 2000, p.212).

How the power that the therapist potentially holds is contradicted and challenged in the narrative approach is a complex process, influenced by Foucault's analysis (Besley, 2002). In online therapy, many assumptions about who directs and shapes the therapeutic process are fundamentally questioned, whatever the orientation the therapist brings to the relationship.

Metaphor, Tribalism And Other Therapeutic Stories…

Some therapists (and writers) would talk in terms of drawing their stories and metaphors from the subconscious, citing Freud, Jung or Winnicott, to enrich their understanding of how creativity emerges. Others would see the creative use of language as part of the self-actualizing tendency (Rogers, 1993). There is too an image of an over-full container, for example in Shakespeare's Macbeth:

> "Give sorrow words; the grief that does not speak whispers the o'er fraught heart and bids it break". (MacBeth, Act lV, 3, 209–211).

bell hooks takes a different view,

> "Like all the books I have written, it comes to me from places dark and deep within me, secret, mysterious places, where the ancestors dwell, along with countless spirits and angels" (hooks, 1993, p.7).

The particular approach I bring to therapeutic work would argue that 'giving sorrow words' is indeed key to physical and psychological health (Pennebaker, 1995), but those words need not be spoken.

In more recent stories of women's lives in China, again the image of an overfull heart:

> "Writing is a kind of repository and can help create a space for the accommodation of new thoughts and feelings. If you don't write these stories down, your heart will be filled up and broken by them" (Xin Ran, 2003, p.229)

Sometimes writing is about pouring out strong feelings, but more so that someone else can witness the experience rather than to make room for more; sometimes it is a process of listening to myself (Bolton, 2005) and at other times, there is greater clarity of thought once I re-read. Writing can, like any other form of arts based therapy, use the person's imagination and creativity. The process outlined here from a narrative perspective, and using the language of narrative therapy, can be seen as an emancipatory activity, helping to free people from their culturally dominant narratives (White & Epston, 1990) and "to apprehend experience" (Payne, 2000, p.141). With Yvonne and Ewan, I aim to work in a way that is supportive but does not enfeeble (Monk, Winslade, Crocket, & Epston, 1997). Just as I wanted in my own writing therapy, the therapist needs to be a respectful witness, there to reduce isolation rather than 'direct'. The relationship built through writing creates sufficient safety for people to 're-author' their own experiences, not just to express themselves but to transform themselves.

I also re-learn from novelists, poets and creative writing teachers the value of connection. From Mary Oliver's poem, 'Wild Geese', for example:

> "…Whoever you are, no matter how lonely,
>
> The world offers itself to your imagination,

Calls to you like the wild geese,
harsh and exciting -

Over and over announcing your place
In the family of things".

And from Jackie Kay (1998, pp. 46–47), a poet who writes in Glaswegian in her poem, "Maw Broon Visits a Therapist", I re-learn the joyous creativity of humour:

"Here – A'm quite guid
at this therapy lark eh?
Here, Maw Broon could be a therapist
Sit there like you are, glaikit,
A box o tissues and a clock,
A few wee emmms and aaas
Jings, it's money for auld rope…"

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Nelia Farmer

Writing Heart-felt Letters

Abstract

This paper, unlike most articles within professional therapy journals, is written by a client. Although the author is herself a professional therapist and school psychologist she is writing here in a different voice. This is an attempt to provide readers with some kind of insight into the experience of working with a narrative therapist. For geographical and other reasons (substantially to do with the author's own health problems) the author's face-to-face meetings with her therapist were infrequent but this was supplemented with both on and off-line therapeutic writing practices. This contribution is not intended as a justification of the narrative therapies or as a comparison with any other therapeutic approaches that might have been equally useful at the time. It is just a description of what became some life-saving and life-changing moments for the author.

Writing heartfelt letters

A few years ago, on an August afternoon, my only sister was killed in a car accident. My daughter and her husband were passengers in the car and seriously injured. This was the third of three deaths in our family within fourteen months. My brother-in-law had had a fatal cerebral aneurysm the previous summer and my sister-in-law was murdered six months later.

These losses broke my heart both physically and emotionally. I developed a cardiac arrhythmia, which resulted in multiple hospitalizations. Because of my family's concerns, perhaps especially in the area of self-care, I began seeing a narrative therapist. At one point, he questioned me about illness narratives in my family of origin. He noted that as the new matriarch in my family, who teaches self-care and nurturing to others, I was not very effective in applying these principles in my own life. The suggestion followed that it might be helpful:

"To write a letter that makes it clear it's OK to be nursed and to cry and be comforted. Maybe when you get comfortable with your own self-care, you could tell your children and they would be relieved. And who can you think of who would be standing beside you saying: 'Of course, it's OK?' Maybe you could think of all the people who can't write for themselves, and write a response for one of them."

That night, I sat down at the computer and wrote a letter to my sister. And the next night, I again sat down and wrote one from her to me. Of course, I knew that I was doing the writing of the second letter, but my experience was of her voice informing my fingers. I had a strong and loving sense of connection to Kate and her presence in my life.

These letters reflect the multiple ways identity seems to be co-constructed and how family relationships might either push us away or bring us closer to alternative, sometimes 'preferred' stories about ourselves. They also reflect the persistence of these connections after death.

Dearest Kate,

Hello, my beautiful sister. I love you. I miss you and long to be with you. It is so quiet without your laughter in my life and lonely without all your loving, generous and affirming ways. Sometimes my sorrow at not being able to touch you and call you and cook for you and meet you overwhelms me, even as it speaks to the depth of our love. I hope I communicated to you enough when you were here how much I love you and value your impact on my life. If there is anything I left out, I want to say it to you now. I love you completely, just as you are. I think I always have and know I always will.

It's amazing to me. Whether or not the tears are present now, YOU are. Your love is alive in my life in so many ways. Each day is full of reminders of you. Each gift you have left, both material and emotional, is such a comfort. Soon the ring will come, the one with the four sapphires that you always wore. Your girls have said I can have it. Wearing that will make you immediately present to me, too. All I'll have to do is look at the ring or touch it to know you are there.

And don't worry that I cry, Kate. Remember, we used to talk about this a lot, how it's good to feel. Much of my crying is because I'm selfish and want more time with you. Who wouldn't? So many times during those first hours in the hospital I tried to find evidence that life could ever be worth living for you again. I did not want to let you go. I so wanted to be able to pet your swollen body and have it reclaim its size, or to rip out those ghastly tubes and machines and just hold you and breathe life into you and dance with you and tell you it was going to be OK. You were suffering so much. So now maybe it is OK, in a different way. You are not in pain and you are not living that mockery of life the ICU offered.

Do you hear me talking to you, Kate? I talk to you so often. You know, throughout our lives together, you have been a loving and patient audience for me, and I can't do without that, so I just keep talking to you. I'm having this memory of your walking down the aisle of the church with your arm around me after Daddy's funeral. I was crying in front of all those people, which was surely abhorrent to our mother. I remember feeling ashamed, but your arm around me gave a different message of comfort and acceptance, a message I have received from you hundreds and hundreds of times. So now I need your wisdom once again. You know, I've been having these little heart problems more frequently recently. It's nothing to be afraid of, but just makes me really tired. Tim and I have been talking about self care and that it would be a gift to my children, both to relieve them of worry and to model for them, if I could walk the walk that I have tried to teach them in this regard. It's hard for me sometimes, I think because of some of the 'illness narratives' we grew up with.

Of course, our experiences were not identical. Here's some of what I remember. I remember that being sick was a bother, a disgrace really, and that somehow we were responsible for not feeling good, as if this were a way we had intentionally chosen to be difficult. It was being weak and a burden to be sick and there was no gentle love, nor kisses and rubs, nor sitting by the bedside, nor special food: just mostly being left alone until we got better.

There were also other strange things that seem related, like how bodily needs were hidden and somehow not nice or a source of embarrassment; and Gummy's absolute disgust with fat and sense of moral outrage at anyone she thought was overweight; and her discomfort with a lot of food in the house. Do you remember that? When Sandy and I and the children would visit, while she would gladly make us a meal, that was it, and it offended her if we wanted something more or different. She didn't like it that I would bring food and put it in her fridge, nor that the children and I might make something, like bread, which could get flour on the floor.

It seems to me that all of this may continue to make it difficult for us to do much of a job of self-care. Is that your sense? I know you had it much harder than I did. I will never forget Gummy's making jokes about your having failure to thrive as an infant.

You were starving because she didn't have enough breast milk but she would not feed or touch you except every four hours, because otherwise you could become spoiled. Oh, my God, Kate, I'm really sorry for this and other horrors you endured. I want to hold that baby right now and rock you and sing to you and feed you until you feel warm and snuggly and safe and full.

What is extraordinarily striking to me is what excellent care you have taken of me for my whole life. I'm wondering how you developed these skills and who may have contributed to their unfolding. And I also wonder if there is anything you might say about self-care in my life right now. I need your support and feedback and would like to ask you hundreds of questions. This is an acknowledgment of how much I value your teachings and your love, but not a pressure for any kind of response. I know you will remain in my heart and continue to give me your guidance, whether or not you can respond to this letter.

Once again, Kate, thank you.

I love you.

Nelia

Dear Nelia,

Wow! That was a very emotional letter you sent me and I have read and reread it many times. You know, sometimes it's hard for me to be serious about things that are really important to me. Instead, I make jokes, and you're so easy to tease and a joy to laugh with. I don't want to do that now, though. You have raised some issues that I want to respond to solemnly and from my heart.

A couple of things I want to say initially. First, I am so sorry about the accident and especially about Katherine's and Francesco's being injured. I would never intentionally cause them or you this pain, but to whatever degree the accident came from my driving, please forgive me. Even as I ask, I know that you did not experience anything to forgive and that your love for me has not been disrupted.

The second thing is: thank you for taking me off life supports and letting me escape from being kept alive artificially. I know you wished for a different outcome and that honouring my wishes meant giving up your own hopes for my recovery.

All of this is related to my answers to your questions. Yes, I experienced much of what you described with Gummy. And it impacted on a lot besides self-care issues. I did not feel unconditionally loved until Wally and I got together. Even in my marriage and family relationships, 'Gummy messages' took their toll. I didn't know how to express myself and was afraid to be open about what I was feeling or needing. Anger was a forbidden feeling, one I never learned to deal with, really. I would get so anxious around conflict or other strong feelings. Rather than being right out there, I would often be indirectly controlling to try to accomplish something I couldn't ask for directly. Do you remember how infuriating that quality was in Gummy?

I remember being hungry in so many ways, and having to pretend I wasn't. I remember how proficient I was at being cheerful and acting as if everything was just fine. I'm ashamed to say I also inherited some of Gummy's miserliness around money and food. As much as I suffered because of her messages, I sometimes found with dismay that I was repeating them with my children or Wally or others. And I also learned her male chauvinism: serve your man stuff. Guess that's why I was so profoundly bereft when Wally died, because most of my life centred on his well being and trying to make him happy.

You have held up a different mirror for me of someone infinitely lovable who enriches your life. I hear you and mostly believe you that this is so. I remember the countless times we have shared and the ways we have helped each other out, almost my whole life actually. So, how was this possible? Where did I learn it? I'm wondering if we didn't give this gift to each other, enhancing each other's

abilities to be compassionate and responsive, joining hands on a preferred path. I'm wondering if we taught each other about mutuality. I experience our relationship as a reflexive circle, a circle so much richer and warmer than the box we got put in by Gummy, which was tied up with criticism and judgment and disapproval. You were such a vulnerable little thing as a child. I remember how often you cried and how you would creep into my bed in the middle of the night. It made me feel good to comfort you and to take care of you. So let me speak of your gifts to me. Don't know who went first, but I remember your extraordinarily trusting and loving ways, even as a small child. You were so easy to love, because you loved so easily yourself.

Guess I was the big sister who, over the years, tried to teach you about the world and to protect you. I always wanted you to feel safe and at home in our house, and only gradually did I realize how completely you had won me over and were teaching me about the heart. We were a good pair. We complemented each other.

I want to mention a few examples of permanent gifts I have received from you which have changed my life. You told me that it is good to say what I need and to express my feelings. You received my sorrow and loved me nonetheless for not being cheerful. You taught me that I was worth taking care of, even extravagantly sometimes. You made me see that I deserved to be treated with respect and honor. And you nurtured me in many concrete ways, making me chocolate chip cookies and home made soup and vegetarian pasta dishes and huge salads.

I remember how present you were with Wally's illness and death, and in the days and weeks that followed, accepting my grief, not urging me to stop crying, and at the same time putting little pockets of joy in my life with the garden, and cooking, and our walks and shopping trips.

I know you think I helped you, too, like when you were sick when the children were little, or getting ready to move to Maine, or when Sandy was dying, or getting your finances and billing stuff in place after his death. But, Nelia, you need to know how simple that was for me, how much I wanted to be there for you, because of how loving and present you had always been for me.

So I guess we did make a circle with each other and maybe that's how each of us broke free of Gummy's legacy, at least to some degree. Is it obvious to you yet what I want to say to you about self-care? Maybe we didn't learn it very well growing up, but you have to practice it now. That's the biggest gift you could give me. The thought of your harming yourself in any way fills me with fear, not just because I love you, but also because now that I am not there in the same way, you are the only mother left in the family and one so important to my children, as well as to your own, and Dolly and Kitty and our brother.

Dearest Nelia, the phone still rings between us, it's just in a different form. Think of me with you in front of the fire this winter, or walking in the muddy rain next spring, or harvesting the first basil in June and making pesto in July, or as you are weighted down with tomatoes in September. Think of me smiling, no, more likely laughing and joyful, every time you give to yourself or eat well or rest or play. Think of me any time you reach out to someone else and know that I, too, feel the comfort of your healing touch. Think of me any way you need to, and know that I am thinking of you, too.

OK, little sister. Please remember that death cannot take your big sister from you and that love does not die. Please keep talking to me when you can. I miss you, too. Someday we will be together in the earth.

Until then, I love you always.

Love, Kate

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Amanda T. Jones

Reflecting On Narrative Practice With People With Eating Disorders

Abstract

This paper documents a few of the many ways that narrative theory and practice have enlivened the author's therapeutic work in an eating disorders service. It highlights ideas held within eating disorders services and those developed in narrative practice that can mutually enhance clinical practice. The uptake of externalising by practitioners in eating disorders services is discussed and 'externalising' is situated in a broader understanding of narrative practice. Two areas of central concern to both mainstream and narrative practice with eating disorders are then focused on. These are working with meaning and values, and working with identity and the effects of culture. Two of the 'maps' of narrative practice that can inform this work are described through examples of conversations.

Introduction

As you go about your day today, what does it mean to you? And have you any sense of what it might mean to others, how you live your day today? When you close your eyes in bed tonight, how will you think about yourself and the actions you took and the choices you made today? Do you ever think about the end of all your days and what your story will read like, this story that you are weaving your life into, during this time in history that you are living here in these places and among these people? And do you ever wonder about how the story of your life might be read by others who are from other parts of the world and from different times in future history, when ideas and knowledge have developed and assumptions about what is right and fitting have moved on?

I do not keep up as acute an awareness of the values I am expressing in the everyday and the impact of my life on others as I would like to, but have always loved an engaging, layered story. I went into clinical psychology and psychotherapy because the meanings people live by and make of themselves have consistently interested me. Are you good at your job? I became good at mine. After some years of enjoying this confidence I realized that the better I became at my job, the less intriguing people were and the more I experienced myself as a 'know all'. I really did not enjoy this. I could always come up with a hypothesis or explanation and a possible solution for the problems in living that people told me about. In my personal life, people said they found this very helpful and at work the 'outcomes' were good. But I was bored and not sure what to do about it. Then I came across narrative ideas and engaged in a detailed look at postmodern ideas for the first time. It was through this that I understood that the lacklustre was because I was using all of the professional knowledge and expertise I had developed in psychological and psychotherapeutic theories to determine the meaning of the stories people brought me. To make matters worse, these widely accepted theories were all based on ideas of people and relationships

having deficits and so the hypotheses they afforded me were predominantly critical.

As I write this, I wonder what strikes you about it, what stands out for you and what that has you thinking of? Are there similarities in your experience, or do they stand in contrast? Has it brought to mind for you what invigorates your own work and life? Or has it touched on something else? In narrative therapy terms, by reading this far you have become a 'witness' to this account of mine.

This linking of people's lives and stories is one of the many ways that narrative practice has re-energised my relationship with my working life and myself. I have been consistently enthused by the 're-authoring' narrative practices of White (2000) and Epston (White and Epston, 1990).

Two Way Traffic Of Ideas

Two years into my engagement in narrative practice, I took up a full time post in a community service with people with eating disorders. My explorations of the two fields and literatures have run in parallel. Since narrative practice is not yet main stream, my happy survival in an NHS post has been sustained by exploring and developing the links between the clinical concerns practitioners in the eating disorders field debate, and the ideas and practices of narrative therapy that can take them forward. I think that these ideas and practices are life enhancing, and are less likely to be available to people if we do not find ways to act on them and disseminate them in our national organisations.

My exposure to the eating disorders field, led me also to an appreciation of the knowledges and skills that many practitioners in it have, that do not seem to have been taken up by narrative therapists. Pre-eminent among these is the effect of semi-starvation on people's physical experience, thoughts, feelings and actions which is documented in a classic study by Keys et al (1950), and has been termed 'the starving self' (Vitousek, 2005). Related to this is how poor nutritional intake in the face of plenty can result in a physiologically driven starve-binge-purge cycle (Fairburn, 1995). Some psychotherapists in the field in England have expressed a concern that too much attention in treatment is paid to the eating itself, but I have become convinced that attention does need to be paid to the effects of inadequate nutrition and of the actions people take to counteract their nutritional intake, such as vomiting and exercising, which impact on their physical and psychological well being.

In addition, as a clinical psychologist I have always dreaded psychologising physical illness (such as hypothyroidism mistaken as a psychological depression) since people make meaning of their life experiences. So it is important for me to be able to tease out with people the causes of the things that they blame and criticize themselves for – such as carbohydrate cravings due to a drop in blood sugar but interpreted as 'lack of willpower'.

A third major area in which my practice has benefited from the thoughtful explorations of the eating disorders field is to do with the dilemmas arising from the duty of care for a person with a life threatening problem, often in the face of that person's ambivalence about recovery. These have not as far as I am aware been addressed in the literature on narrative practice beyond a mention that narrative practice is occurring in the context of a medical safety net, such as a planned hospital admission, if health becomes too compromised (Maisel et al., 2004).

So although I set out expecting a one-way traffic of narrative ideas into more mainstream eating disorders practice, I have experienced a mutual enhancement. This includes a number of areas of practice, but I want here to focus on three where narrative therapy can extend and assist with concerns formulated by practitioners in the eating disorders field.

In doing this I will not be describing in detail the therapeutic methods developed by other therapy approaches – they are well documented elsewhere. I also do not wish to obfuscate some of the important differences between theoretical approaches. One of the values of being clear about distinctions is that they can add to and extend our practice.

Externalising And Separating From The Eating Disorder

The externalising of the eating disorder is the one practice from narrative therapy that has been taken into a variety of more mainstream, modernist eating disorder treatment practices. 'Externalising' in narrative practice reflects a post modern understanding of problems, personal qualities and attributes that does not account for them, or any expressions of peoples' lives, as driven by internal psychic structures. Dropping ideas of personality, the Self and so on has a radical effect on your thinking. How would you think about people if you were not using these constructs? It also affects how you speak. These effects vary between practitioners. There is the 'radical externalising' recommended by Maisel et al (2004) where anorexia is spoken of as a separate entity, often given a name; and its motives and purposes for the person's life described as though it is a character. The purpose of radical externalising is to separate the person from a problem such as anorexia, which tends to be totalising in its effects on identity. The person may not even notice it as a problem since their identity has been reduced to a few parameters, such as equating personal value and a sense of security with weight. Some people say, "I am the anorexia". Radical externalising opens up a space for the person to begin to notice its effects in their life, to begin to have the idea that there is something else to them and in time to reclaim their own, individual sense of identity. At a different end of the spectrum is the 'relational externalising' of Bird (2005), where the therapist uses language to put thoughts, ideas and expressions in to relationship with each other by turning adjectives into nouns and then asking about the effects of them in different areas of life. "I am depressed"' becomes "This depression that you feel", leading for example to "How has the depression that you feel impacted on the relationship you have with your self?" This way of externalising has more subtle effects on language use that will be felt but not heard (Bird, 2005). This has the effect of developing reflective distance, or a meta-cognitive stance. And of course it is possible to do this, and narrative therapy, without 'externalising' at all (White, 2005).

Externalising has been taken into mainstream practice with eating disorders primarily as a technique, to describe the person as separate from the eating disorder and to enhance collaboration with treatment providers. This allows relatives and therapists to feel that they are on the same side as the person, against the eating disorder, maintaining empathy and a sense of teamship with them in the face of the eating disordered actions that the person engages in. These often seem secretive and dishonest and can now be attributed to the eating disorder. Many practitioners I work with describe this as very sustaining. However, this use holds dangers, such as the person feeling misrepresented (Vitousek, 2005). "It's not the anorexia, it's me!" is not an uncommon cry when someone feels 'ripped untimely' from their solution to living. It is also a limited, rather concrete practice that is in sharp contrast to the possibilities externalising holds in its narrative context.

Working With Meaning And Values

Working with people's values and conscious intentions is central to narrative practice. Working with higher values has also been considered especially relevant in work with people with eating disorders. This is because values are thought to guide behaviour for many people with anorexia, so that a detailed exploration of values and goals throughout therapy and the linking of goals and intentions to action over the course of time can promote a sense of personal agency and change (Vitousek and Watson, 1998). The purpose is to "explore the territory… reach a destination and recognise that they have arrived. The destination is not fixed in advance, and may only be a transit point" (p.404). Other practitioners, drawing on cognitive behavioural and motivational interviewing theories, suggest helping the person with an eating disorder to develop a non-eating disordered self with cherished values, to act as a counter-weight to the eating disordered self (Treasure, 2003). To do this they describe exploring personal values, questioning until beliefs and behavioural intentions become clear and highlighting the discrepancies between values and the eating disorder symptoms. This is to promote a sense of internal inconsistency and dissonance and a desire to change. They consider it essential that the conversation not

stay in the abstract but is linked to behaviour, using various methods such as behavioural experiments, which evoke actual episodes of living and concrete events (Fairburn, 2004).

Narrative therapy has developed conversational structures to explore the territory, to promote the person's being able to take a values-based stand and co-construct the destination (White, 2005).

To give you some background: narrative therapy holds that we make meaning by linking the events of our lives in sequence, across time and according to themes (White and Epston, 1990). The themes – in other words the stories we make – are constructed through our experiences of life and depend on the resources available to us to make sense of things. These resources include cultural and family discourses – the stories, knowledge and language that communities negotiate and engage with to make sense of their experiences. These produce a certain version of events (Burr, 2003). We are socialised into them as we grow up in a certain social and cultural context and historical time and so they seem natural, 'the way things are' and we tend not to question them. This context provides some of the 'big stories we are born into' (Carey, 2004) such as what it means to be' a daughter, or who is counted as 'family'. For example, a colleague told how he had on different occasions asked two men who were visiting his university (one from England, one from Southern Africa) if they were travelling with their family. The one replied, "No, I don't have any family, I'm single". The other had said, "No, only my wife and children were able to come with me" (Mucherera, 2002).

An important implication for narrative practice is that these stories and knowledges do not just make sense of the past, but determine our future thought and action because they include practices of the self and relationship that go along with these knowledges. For example, there is currently a discourse of 'healthism' in western culture. This is not just a way of thinking, because it has actions associated with it – such as measuring weight and ratios of body components such as fat, making certain food choices and structuring into our lives certain amounts and types of exercise that conform to current ideas of what will maximize our health. Our engagement with the discourse therefore is constitutive of our lives, including how we think about and use our bodies. It differs from the ideas around health held by previous generations in our culture – who might for example have considered their health adequate if they had no need of the doctor.

When some one comes to consult us about a problem it has never taken over their entire history and sense of self. There are always events in their lives, like the dots in dot-to-dot pictures (Morgan, 2000) that do not fit with the main picture – or problem construction – and to which the person has not attributed meaning. If you think of something you are good at – like riding a bicycle or driving – you will be able to think back over time to a number of events that support your view. If you think again for times your bike fell over or you drove into a gatepost, you will find those too. But they will not have been your dominant experience and others will not have described you as a failure in those areas, and so you will not have made much of these less successful experiences. It is often the opposite for the people who consult us – there will be events in their lives that stand in contrast to the problem story and that they will not have made meaningful. Narrative practitioners 'doubly listen' (White, 2000) both to the story being told and also to the gaps in it and life events that do not fit it and that might be an opening into a happier sense of self and identity.

So, with a person with 'anorexia nervosa' who has managed to eat her afternoon snack on two days in the previous week, I would not focus on how consistency is crucial if there is to be any benefit in increased weight (though this is the case) but on the exceptions that fit with her hopes to restore weight i.e. on the two days she did manage, and how she did that. This would include a micro-analysis of the steps she took, the thoughts she drew on and the conversations she had with herself or others that supported her in those two instances. This will give her a richer understanding of her skills and knowledge about managing snacks and make these skills more available to her to draw on in the week to come.

To give another example, Deborah had taken a step into the world outside anorexia by joining a small art class. A few weeks into it, there was

a fire alarm and the students had to vacate the building. Deborah noticed that one woman, who had a previous bad experience in a fire, was very anxious. Deborah saw a coffee shop across the road and told me, "I felt sorry for her and before I'd thought, I'd suggested we go there for a cup of coffee while we waited. I thought, okay I'll manage a black coffee. Then the others started discussing the cakes on the menu. It was awful. What a mistake". If I had only empathised with how difficult a situation it was for her, it would make it less likely that she would reach out to others in future and would entrench a negative view of herself that she could not do so. Noticing the initiative she had taken, talking with her about what had led to her making the offer, and hearing how her concern for the comfort of another was more important to her than her own, began to give us both a clearer understanding of the values she held, that did not necessarily accord with anorexia and that she could more consciously draw on to form a foundation for her sense of self and her future actions.

To help structure my conversation with Deborah, I drew on two of the 'maps' I find most useful in working with values. These 'maps' have been developed by Michael White as resources for conversations, and are not intended to be linear or prescriptive but are more of an aide memoir to the different levels of abstraction of the higher values that we can explore. This begins with characterising the problem and its effects in terms of the person's own experience of it, and then determining if this problem and its effects fit with the person's values (the statement of position map). Another person I worked with, Melanie initially called her problem 'The thinking' and knew she wanted to hold on to some it but could not say why, except that she was afraid of becoming fat. She was able to identify a number of effects it was having that she did not want, such as the conflict it was causing in her relationships with her family and the anxiety it was giving them. It was also separating her from her friends, since it was requiring a rigid adherence to meal and snack times and encouraging her to compare herself to them in terms of size and shape. In relation to herself, it was resulting in poor concentration and a 'loss of organisation'; poorer self care since it did not allow her a warm bath or new clothes; a preoccupation with numbers, checking in mirrors and calculating calories that took up much of her thinking. This was also making it hard for her to be reliable at her part time job. She evaluated these effects as not fitting with what she wanted. When asked why not, she said that these effects did not fit with how she valued treating people, which included letting people have choice and not making them feel pressured. She was also interested in being useful to others and in opening her mind up to social issues which 'the thinking' had cut her off from. She recalled that 'the thinking' had begun several years before when she had seen a television programme on a famine in Ethiopia.

The next week, Melanie mentioned that she had had most of her meals and snacks. This was an unusual initiative. In order to expand on it, I drew on a map for scaffolding identity. It gives me more options for areas to explore than the cognitive technique of draining for meaning – which I find most useful when exploring an emotional reaction. So we talked about what her intentions had been in doing this, and she described wanting to rebel against 'the thinking'. I asked about what values and beliefs about her life had informed this wish to rebel against it, and she described wanting to be more in control than 'the thinking', to have freedom and to stay out of hospital; to have time for friends and to be able keep her word without 'the thinking' scuppering her ability to do so. I asked her about what hopes and dreams for her life this expressed, and she spoke about wanting to do 'normal' things, to have a future and a job working with animals, and to be relied on by people. We then spoke about what principles she stood for that these ways of living would express, and she described that it was important to her that people act in a caring, consistent way, so she thought her principles here were reliability, caring and honesty. These were all conclusions about identity, and to bring identity back into relationship with action I asked her about whether these principles were ones she was committed to in her own life. She thought she was and that they would inform her actions by guiding her to stick to her word, acting on it in a steady way and respecting others' freedom. I also asked about how she would know if these principles needed reviewing (since eating disorders can make thinking rigid), and she described how if they were ones to stick

to, they would be making her life smoother. If they reduced her freedom or complicated her relationships, she would review them.

These initial conversations had some content that will be familiar to you if you work with people with eating disorders. Over several months our conversations have folded over, unpacked and extended on her ideas about her preferred identity and increasingly detailed the aspects of it that typify only her, and her unique ways of acting on them.

In summary, narrative practice is a values-focused approach, based in a concern with ethics and the politics of experience. Action is seen as embedded in conscious intentions, and narrative therapy works to embed future action in a value base that has a history in the person's life. In addition, there are innovative methods of delivery of narrative practice, such as inviting people in to appointments to witness the telling of preferred constructions of identity, or documenting them (Fox, 2003) that contribute to enriching the preferred sense of self and taking it out into the person's social context.

Working With Identity And The Effects Of Culture

Eating disorders have been studied in terms of their relationship to gender and culture more than have most mental health problems. Questions such as why more women than men historically have developed anorexia and why is there an increased incidence in cultures in transition such as post-communist Europe have been addressed (Nasser et al, 1997). Anorexia nervosa has long been described as symptomatic of identity difficulties. The theatre for them has been enlarged from the family to global culture; from an identity deficit and a defence against powerlessness (Bruch, 1978) to a "means of negotiating transition, disconnection and oppression… straddling two worlds, be it generational, work-family, cultural, or traditional and modern" (Katzman and Lee, 1997, in Nasser, 2003), to one form of body regulation that is engaged in as a problem solving tactic in the face of conflicting global forces that result in a confusion of identity. In this sense the body is taken as an environment that is lived in, and acted on, rather than lived through (Nasser, 2003).

Nasser (2001) has concluded that the field needs to focus more on issues of identity and the longing to belong. There has been some careful attention paid to working with families from different cultures where a member has an eating disorder (Di Nicola, 1999; McCormack et al, 2003) but ways of working in clinical practice with the research findings and ideas of the cultural theorists have not otherwise been developed.

Narrative therapy is centrally concerned with the construction and re-construction of identity and has developed ways of linking lives and relationships and working clinically with culture. These hinge on exploring how cultural prescriptions and demands are operating in someone's life. This is not done by explaining them according to common generalisations, such as 'high achieving, female'. It is primarily done by historicising and contextualising the arrival of these ideas and the circumstances of their influence on a person's life. A psychodynamic model might see a person as 'an anorexic' (Lawrence, 1984); a cognitive-behavioural one as 'having anorexia' (Fairburn, 2004); a narrative one as their 'being influenced by anorexia' (Maisel et al, 2004). To look at the influences associated with an eating disorder, we might explore when a person first came upon certain ideas about measuring up, weight and eating or fitness; what made them think these were ideas to take on in their life and why they might have been susceptible to them. This deconstruction of the ideas that support the eating disorder ranges from a cultural level ("Thin people are more in control"; "I'll be popular if I'm thin") to a personal level ("I was anxious about my dad"). As these ideas are deconstructed and seen as beliefs the person has taken on, but did not create, there are several therapeutically useful consequences. Self-blame is reduced, which in turn increases reflectiveness. It contributes to the separation of the person's sense of self from the ideas that they have taken for granted. There is the space for an increased sense of responsibility for one's relationship to the problem. Taking responsibility is often presumed by therapists to be a starting point for change, but is only fully possible when the

ramifications of a problem or idea or action on one's own and others' lives are understood.

One of the commonly operative prescriptions in western culture that I find most useful to be alert to in eating disorders is a requirement to 'measure up' to certain social norms, for example along continuums of achievement or appearance (White, 2004). We take these cultural prescriptions into our own thinking and judge ourselves against them even when others are not judging us. So we hear that a person with anorexia began dieting because she judged herself as fat, in the absence of comments from others. We judge ourselves against these norms, as having have failed or succeeded. Judging our actions against our dearly held values instead is usually more sustaining as well as more supportive of personal agency. Values-based conversations are so uncommon for most people who consult us that they find them engaging, and through them engage more with their own lives.

Conclusion

I hope this gives a flavour of how narrative practice is not to be conflated with 'externalising therapy'. It is centered on drawing out the individual's system of ethics and on getting reflective distance from our assumptions so that we can make better-informed choices and act on them. This fits with the focus in the eating disorders field on helping the person to develop a meta-cognitive stance to the eating disorder since they are seen as having acquired a worldview that colours most of their thinking (Fairburn, 2004). In narrative practice, externalising and the questions the conversational maps give rise to help the person distance from their immediate experience, reflect, make meaning and plan the next step. This is a cognitive process, followed through in action. It is only with this reflective distance that we are able to take informed responsibility for the consequences of our actions.

As one 15 year old put it when we were talking about her desire to leave the specialist unit where she had spent the previous year and was being fed by naso-gastric tube, "I thought if I was thinner I would be prettier and more popular. For the last year I've thought shit, eaten shit and done shit. I think differently now. I want to go back home, be in school for September and have a normal life". We linked her hopes for her future with the actions she would need to take, enlisted the support of her family and professionals in working towards them and she has done what she hoped for.

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Kasia Zalasiewicz

The Integrative Process: A Personal View

Editors' Note

This material constitutes the theoretical section of a dissertation submitted for the degree of MSc in Integrative Psychotherapy (Metanoia/Middlesex University). The student is required to give her own framework for integrative practice.

1. Framework

Integration: a continuous, evolving process, the weaving together of conceptual models of human functioning into a coherent whole to make a functional guiding framework for Integrative Psychotherapeutic practice. The Integrative Practitioner: open-minded, curious and questioning, able to hold more than one theoretical perspective at a time and welcoming "internal ambiguities, contradictions and paradoxes" (Shafer, 1976, pp. 50–51).

Integration is, thus, an individual endeavour, or an "odyssey" (Gilbert, pers. comm.), developmental in nature. "Integrating", to use the present continuous tense, more accurately emphasizes its dynamic quality. A "framework" implies a coherent structure that holds together different strands of theory and practice. Achieving such personal "integration" or "coming together of parts into a whole" (Lapworth et al., 2001, p. 34), of different concepts into a coherent theoretical entity, is certainly an ultimate goal. Nevertheless this "whole" is not a closed, fixed system or "Truth" but an open-ended conceptualization with the potential for creativity and change. This philosophical approach rejects the supremacy of any one school of psychotherapy over another (see Luborsky et al., 1975; Smith and Glass, 1977; Wampold, 2001), encompassing a theoretical richness and developmental potential extending across the field of psychotherapeutic theory.

Any integrative framework needs to be client-led: as Lapworth (2001, p. 34) notes, therapist-centred interventions "are likely to be counter-therapeutic". Successful integration, thus, needs to combine a personal philosophy and a broad theoretical base to fully address the unique needs of each client. With co-creation of the relationship (Joyce and Sills, 2001, p. 47) and the intersubjective dyad in the therapy room (Atwood and Stolorow, 1984), successful integration represents an interplay between client and therapist, a negotiation between the needs of the former and the attitude, temperament and training of the latter.

Integration is not a "school" but rather a philosophical attitude, with a basis in theoretical understanding. My personal theoretical framework integrates attachment theory (Bowlby, 1988), object relations (Winnicott, 1965), Gestalt (Clarkson, 1989; Joyce and Sills, 2001), intersubjectivity (Atwood and Stolorow, 1984), self psychology (Kohut, 1971, 1984), therapy of contact-in-relationship (Erskine et al., 1999) and neurobiology (Schore, 1994; Van Der Kolk et al., 1996) with a dialogic philosophy (Hycner, 1991, Buber, 1958). It thus spans the psychodynamic/humanistic divide. The bridging principle or integral in this process (Tudor, 2001) is relational: it prioritizes the therapeutic relationship and

Working Alliance (Clarkson, 1995) through dialogue (Hycner and Jacobs, 1995, p. 4) and co-creation (Joyce and Sills, 2001, p. 47). Philosophically, it rests on Buber's belief (1958, p. 18) that "In the beginning is relation".

1.1 Human Motivation

People's needs, desires, motivations evolve throughout their lives and are dependent on factors such as age, health, socio-political and family context; they are thus essentially contextual. Furthermore, we all have basic or primary needs which enable survival, in a physical sense. From infancy to old age, people need adequate food and shelter to provide a basic feeling of security. Parallel to these, people need human contact through touch and emotional responsiveness – without touch, for example, human infants fail to thrive and suffer a condition known as marasmus (Spitz, 1954). Without emotional reciprocity, infants do not develop the ability to respond emotionally and to form relationships; their development may be thwarted to the extent that "they are unable to behave and interact in ways that we would consider human" (Erskine et al., 1999, p. 3).

Thus people need psychological as much as physical security: "for a person to know that an attachment figure is available and responsive gives him a strong and pervasive feeling of security" (Bowlby, 1988, p. 27). This need persists throughout life. At times of illness or stress we need a "secure base" – not only as a source of availability and reciprocity on the part of the caretaker but as a "representation of security within the individual psyche" (Holmes, 2001, p. 7). A secure base forms not only the basis for attachment and, thus, relationship, but "without some sort of secure base, survival is impossible" (Holmes, 2001, p. 7). The need is both emotional and social: familial, societal, cultural or other systemic ties, such as religion, are important to our sense of rootedness: "People need other people. Needing people, we are, therefore, born socially and into a system" (Lapworth, 1994).

People need intimate relationships. From the earliest mother- infant bond, we carry the need for love, intimacy, companionship: "the need of relationship constitutes a primary motivating experience of human behaviour, and contact is the means by which the need is met" (Erskine and Trautmann, 1996, p. 316). Relational contact requires reciprocity, acceptance, care. It arises out of dialogue (Hycner 1991; Buber, 1958) and "appropriate affective response – genuine, spontaneous, caring – the essence of a contactful relationship" (Erskine et al., 1999, p. 123).

Further: work, play, creative pursuit, hobby – these satisfy a human need for structure, self–realization and satisfaction or pleasure: "playing the piano is like making love, it fills me completely with joy" (Arthur Rubinstein, in Zinker, 1977, p. 5). People want achievements in this realm to be recognized (Winnicot, 1965; Kohut, 1971). They – we – need to be cherished, mirrored and feel special, and carry these needs into, and throughout, adulthood.

Human beings are "meaning-seeking creatures" (Yalom, 2001, p. 133). We try to make sense of our experiences and "cannot tolerate meaninglessness" (Spinelli, 1989, p. 7). Meaning, in this context, is an élan vital, without which we may lose motivation or the will to live. So, finding "meaning in the absurdity of suffering" (Frankl, 1955) is necessary. The capacity to find such meaning in a difficult world depends in significant part on the quality of an individual's early relationships.

2. Human Development

2.1 Self In Relationship

From the moment of birth the human infant strives to form a relational bond with its mother. This bond is so essential to our survival that it led Winnicott (1965) to remark: "there is no such thing as an infant, only mother and infant together". This dyad serves not just the purpose of physical survival but is a template for our ability to form relationships in later life: "Relational competence starts from attachment patterns in childhood" (Holmes, 2001, p. 1).

The blueprint for all our social experiences thus starts in childhood. Social and psychological experiences are intrinsically linked and our intrapsychic world develops in parallel with our interpersonal world in a kind of symbiotic

process that starts from the earliest moments of the infant's life. Stern (1985, p. 5) wrote thus: "The self… is at the heart of philosophical speculation on human nature, and the sense of self and its counterpart, the sense of other, are universal phenomena that profoundly influence all our social experiences". Stern's view assumes that self develops within a relationship and acts as a developmental construct.

Self hence underlies the development of personality. It is an abstract construct responsible for cohesion, continuity and enduring self-organization, for action and affective experience (Kohut, 1977, 1984; Stolorow, et al., 1987). For a healthy self to develop – or, in Kohut's terminology – to create mature structures, a child's environment needs to foster "transmuting internalizations" (Kohut, 1971) that aid the development of the strong, cohesive self-structures essential for self-esteem. Mirroring, or being actively shown that a child is special and welcome, what Winnicott (1953) might have called "a twinkle in the mother's eye", promotes confidence, competence, self-acceptance.

Idealizing, or a need for an"idealized parental imago" – a sense of strength, potency and calm – gives a child the building blocks for a sense of security. Later, this helps us manage anxiety and overcome difficulties in life. Likewise, twinship, or the need to be like others, aids the sense of belonging.

Human beings thus clearly do not develop in isolation (Kohut, 1971; Stern, 1985) but need caretakers able to enter the subjective world of the child, who possess "attunement, sensitivity and responsiveness" (Ainsworth, 1989). If the environment meets these conditions – if it provides "good enough parenting" to paraphrase Winnicott – children feel supported: "Support is the relational ground of the environment that provides the context for all growth and development. It is the essential framework of attachment and relationship to caring and responsive others, by whose actions we learn to affirm our own existence, basic trust, and to take care for ourselves" (Kepner, 1995, p. 3). These different theoretical perspectives yield amazingly similar conclusions: our early experiences shape our development, our sense of self and of the world and of others; they need to be rooted in a responsive, supportive relationship.

3. Personality And Environment

If the environment plays such a crucial role in the development of the sense of self, then, likewise, environment must be crucial to the development of the healthy personality. Now, while a genetic component underlines certain characterological components of what is referred to as human personality, biology or "nature" likely constitutes simply a genetic potential that in itself is not the critical determinant of human development. The expression of that genetic potential is modulated by environment.

Interaction between the developing self and the immediate environment of parents or caretakers – frequently referred to as "nurture" – here contributes to the development of healthy personality: "The interaction is between the individual, with his changing but basic needs, and the changing environment's ability to meet them. Such interaction makes personality and produces psychopathology" (Johnson, 1994, p. xvii). In other words, healthy personality develops in a healthy environment that can fulfill a developing child's attachment (Bowlby, 1988), selfobject and relational needs for reciprocity and attunement (Kohut, 1971, 1984; Stern, 1984; Ainsworth, 1989; Erskine et al., 1999).

If the environment is, then, attuned, responsive: if it is "good enough" (Winnicott, 1953) – the child develops healthy attachment styles and environmental responses, which are reinforced by each positive experience. He/she learns to function physically, affectively, socially; to develop neurologically, to experience and to regulate experiences and interactions; to differentiate between self and others and to set appropriate boundaries. This leads to a healthy sense of independence without compromising the capability for intimate relationships and contact. A child learns the self functions or "tools, abilities, and qualities that we all bring to negotiating our actions and our interactions, managing the intensity of our experiences, and experiencing the sense of self in contact" (Kepner, 1995; p. 60).

Personality develops thus as a set of behaviours, interactions, adaptations around and within the environment. From a Gestalt position it is a "particular style of contacting over time"; from Johnson's characterological-developmental model it is an adaptation, an individual's response to its environment. From a Self Psychology perspective it is an attempt at a homeostatic subjective state.

4. Wider Context

The mother/primary care-taker and child dyad is crucial in forming our sense of self and our view of the world. But human development takes place in a wider socio-political context of family, friends, neighbours, society at large. How we see the world is influenced by our cultural, political, historical and geographical heritage, by the socio-economic factors of our existence. Such factors may moderate or compound the deficits of our upbringing: "It is in the family, the workplace, and the politics of humankind that we see the colossal waste and pain of our proclivity for destructive disfunctionality" (Johnson, 1994, xvi). Lewin's field theoretical perspective (1951) recognizes the all-pervasive nature of contextual influences, constantly co-created as individuals interact with each other and with their environment.

5. Psychological Problems

Given the importance of primary environmental factors in the healthy development of the self and personality, the roots of psychological problems are largely contextual, their seeds being sown early in childhood.

Mental illness, dysfunction, psychopathology, are just some of the labels given to the concept of psychological ill–health. However semantically marked they are, this terminology simply addresses a universal human problem of human suffering: suffering which, though, can be culturally modulated (Bracken, 2002) or, here, conceptualized from a Western perspective. Disorders of the self and disorders of personality, depression, anxiety, trauma, are almost universal: "Who does not sometimes suffer from official 'symptoms' of personality disorders… we all share these symptoms to greater or lesser degree" (Benjamin, 1996, p. 3; see also Kohut 1984). This statement can usefully be extended to allow a non-discrete view of mental health. For instance, Johnson (1994, p. xvii), noted that "there are several useful continua of human dysfunction from the most to the least severe, which reflect quintessential building blocks of human nature".

If a healthy environment is not available a child will adapt or, rather, maladapt, his/her behaviour for self-protection: "Children are 'learning machines' and will creatively adapt themselves to the demands and exigencies of the environment. In the process, they will develop self functions that match the demands of this kind of the environment, and they will not learn those that are not supported" (Kepner, 1995, p. 65). If the environment is particularly non-supportive or abusive, many of these adaptations will become rigid. In Gestalt terminology, such an environment thwarts normal growth and development; in Self Psychology it affects self-cohesion; in Attachment theory it creates unhealthy attachment styles.

Johnson (1994) here emphasized a child's developmental level. If environmental frustrations are encountered early in development, responses will appear as a limited array of "adjustment manoeuvres" which provide imperfect, improvised solutions to the situation, and which shape emerging character structure and psychopathology. Ware (1983) saw these adaptations as a continuum within which lay the best option the individual perceived for surviving and for meeting expectations in his/her family; they range from a healthy, functional "adaptive style" to an unhealthy, dysfunctional "personality disorder".

To Kohut (1971), mental health centres around healthy self structures which develop if our selfobject needs for mirroring, idealizing and twinning are adequately met. Failure in the environment to support these needs leads to deficits, to 'self disorders'. Kohut places these disorders on a continuum from less to most severe and suggests that the self constructs compensatory structures to adapt, defend and maintain our sense of self: "the self searches for new solutions to the frustration of its developmental needs" (Siegel, 1996, p. 156).

The self is exceptionally creative in its search for psychological cohesion, or for defensive mechanisms against fragmentation. Children will search for that person in their environment who will respond to their selfobject needs and will attempt to create more healthy relationships.

Greenberg (1989) called this "a healthy adaptation to an unhealthy home situation". But many of these adaptations have outgrown their usefulness and, when carried into adulthood and into new, non-abusive experiences, they become mal-adaptations. There is nothing 'healthy' about rigid character structures, depression, anxiety, emotional withdrawal or an inability to form and maintain relationships or to function in society. Old, once useful – more – necessary self-protective patterns, might become "…'pathology', 'symptoms' and" …the whole panoply of disorders found in the pages of the psychiatric Diagnostic and Statistical Manual" (Erskine et al, 1999, p. 12).

Pathologies and symptoms are signs of psychological distress that inhibit healthy functioning as regards work, relationships, self-concept, self-fulfillment, or life's fundamental existential dilemmas. "Life isn't working" as Joyce and Sills put it (2001, p. 59). We try to adapt to defend against the ensuing pain, and, ultimately, disintegration or fragmentation of the self for as long as we can – we fight for the homeostasis and cohesion of the self, to use the Kohutian concept. Often, we succeed, albeit at the cost of chronic low-level depression, anxiety and dissatisfaction with life. If the environmental causes intensify, however, if there is crisis or trauma, and particularly if we carry unintegrated traumatic experiences from the past, our suffering may reach a different pitch. Our old defenses or adaptations are no longer 'enough' in the face of new threats.

6. Trauma, Personality And Mental Health

Trauma has a particular place in the aetiology of mental disorders. As the brain grows in a healthy infant, it develops an adaptability necessary for its healthy functioning, through interaction with its environment: "how a brain continues to grow, develop and organize is dependent on the subsequent experiences encountered throughout the child's life" (Rothschild, 2000, p. 16).

If trauma occurs during this precarious developmental period, it can disrupt normal neurobiological functioning. Trauma is a "psychophysical experience" (Rothschild, 2000, p. 5), affecting both body and mind, and leading to complex psychobiological symptomatology (Van der Kolk, 1996, p. 217).

Trauma here can be defined as the effects of repeated physical, sexual or psychological violence. It does not per se include simple neglect or an absence of love and care, though such neglect can affect a person's ability to deal with trauma.

The effects of such trauma include disruption to attachment-forming patterns (Schore, 1994; Siegel, 1999; Van der Kolk, 1998; Holmes, 2001) with a subsequently compromised emotional ability to cope with life's vicissitudes. Early childhood trauma is linked with psychopathologies (Schore, 2001, p. 213) such as dissociative and borderline personality disorders, and different forms of traumatic adaptations such as Complex PTSD. Continuous, overwhelming trauma affects personality (Van der Kolk, 1996, p. 183; Herman, 1992) with "disturbed object relationships and attitudes towards work, the world, man and God" (Tannay in Herman, 1992).

7. Diagnosis And Psychotherapy Direction

"Psychotherapy consists of a gradual unfolding process wherein the therapist attempts to know the patient as fully as possible" (Yalom, 2001, p. 4). We can integrate the dynamic nature of the psychotherapy process, the sense in which we never fully 'know' our client, and be open to Bion's (1967) maxim of working "without memory, desire or understanding". This is possible, if diagnosis is viewed as a useful working hypothesis, a guide to understanding the client's presentation and a flexible basis for treatment planning.

'Diagnosis' tends to evoke ideas of labelling, fitting clients into narrow medical models. Prejudices are inherent in society and the medical profession is not immune to them

(Herman, 1992, p. 123). Integrative practitioners need be aware of this, yet look beyond semantic traps and political over-correctness. Diagnosis is a tool towards competence – it allows one to make sense of a client's symptoms, behaviours, beliefs; it is a step towards deciding whether we are able to undertake psychotherapeutic work with a particular person. Diagnosis can be carried out sensitively in the spirit of co-creation and dialogue, and can involve the client (see 'co-diagnosis' of Joyce and Sills, 2001, p. 60); the process can effectively enhance the Working Alliance.

Diagnosis continually evolves, is subject to modification or even complete re-assessment as we learn more about different aspects of our clients' lives, as the psychotherapeutic journey unfolds. A springboard for further inquiry rather than a final answer, an opinion rather than the only 'truth', it nevertheless aids decisions regarding the direction of psychotherapy.

Psychotherapy direction or treatment planning (we are in the realm of semantics again) is, like diagnosis, a useful, flexible overview of the potential direction of psychotherapy: not fixed, but rather a phase-appropriate anticipation of a client's needs, open to change, and taking into account both the possibilities and limitations of treatment direction. It is neither linear nor prescriptive nor some "mechanical, symptom-bound treatment" (Erskine et al., 1999, p. 81) even though it anticipates the tasks that the client and the therapist need to consider to ensure the safety of therapy (Herman, 1992; Kepner, 1995; Rothschild, 2000). It fosters "helpful prioritizations and cautions to avoid dangers, rather than prescriptions for a 'best' course of action" (Joyce and Sills, 2000, p. 72).

8. The Psychotherapeutic Process

Psychotherapy builds a unique relationship between two people via dialogue (Hycner and Jacobs, 1995, p. 4) and co-creation (Joyce and Sills, 2001, p. 47). This arises not out of the theory per se but out of a particular philosophical understanding, an attitude, a way of being with another human being (Hycner, 1991). This principle is rooted in "an attitude of genuinely feeling/sensing/experiencing the other person as a person… and a willingness to deeply 'hear' the other person's experience without prejudgment" (Hycner and Jacobs, 1995, p. xi). A dialogic attitude is the foundation for a two-way encounter that aids growth and healing (Buber, 1958; Kepner, 1995, Erskine et al., 1999). It is a slowly unravelling experience of "fellow travelers" (Yalom, 2001, p. 8) – aimed at 'meeting' another person's subjective experience. Such a process requires a special way of 'being' with another person – a 'presence' – that goes beyond "mere physical attending" (Hycner, 1999, p. 122). Presence, or "involvement", goes beyond technique: "it is not about doing so much as about being "(Erskine et al, 1999, p. 83). I see it as a way of giving of oneself or one's self to another, of making oneself available, while being fully aware of one's own emotional experience. Such a process requires the temporary suspension of one's own emotions and presuppositions so that the client's world takes centre stage (May, 1983). Presence thus entails focusing on the other person while being in contact with one's own process. Bugental (1985) considered presence as "the one essential ingredient of therapy".

Without presence or authentic involvement there can be no contact; without contact there can be no relationship, and without relationship there can be no dialogue. Without dialogue there can be no meeting and no person-to-person or I-Thou relationship (Clarkson, 1995; Buber, 1923, 1958).

The dialogic nature of the therapeutic relationship may be integrated with a view where psychotherapy is defined as "an intersubjective process involving a dialogue between two personal universes" (Atwood and Stolorow, 1984, p. 4). The interpersonal and the intrapsychic thus meet as "both approaches are concerned with the relationship – the human engagement" (Hycner and Jacobs p. 119).

Such an integration of humanistic philosophy and psychodynamic theory provides a solid foundation for a healing therapeutic relationship. By 'healing' I do not mean 'cure': rather, a process of growth, development and re-establishment of lost human connections and meanings. Through this the self, whose growth has been compromised through trauma or environmental failure, may re-establish "the

natural cycle of growth and development in relation to those developmental issues that have been most affected" (Kepner, 1995, p. 2). The self can reintegrate and strengthen (Kohut1977, 1984; Erskine et al., 1999) and develop healthier attachment styles (Bowlby, 1969; Winnicot 1960, 1980; Holmes, 2001); it can strive towards its full potential as it becomes cohesive and functional (Kohut, op. cit.; Johnson, 1994).

9. Psychotherapeutic Change

Psychotherapeutic change arises out of and within the therapeutic relationship, consistently viewed as the main factor determining the effectiveness of psychotherapy (Luborsky et al., 1983; Hill, 1989; Norcross and Goldfried, 1992) irrespective of the therapist's theoretical orientation. Psychotherapy is not linear; rather the relationship evolves fluctuates, often starts hesitantly, with the client's mistrust of psychotherapy or, indeed, of the psychotherapist. There may be reservations on the part of the therapist too, involving questions of appropriate client-therapist match, competence, therapeutic style or a client's suitability for the process. A "good enough" relationship needs to allow time to establish the working alliance, the secure base, the rapport that will aid interpersonal contact. These elements will provide the "holding environment" (Winnicot, 1960, 1988) or the safety and support (Herman, 1992; Kepner, 1995) that will act as "the container wherein growth and healing can take place" (Kepner, op. cit., p. 22).

Such "a co-creation that involves both the therapist and the client" (Kepner, 1995, p. 21) needs to rest on a Working Alliance or what Clarkson (1995, p. 31) calls "a client-psychotherapist relationship that enables the client and therapist to work together even when the patient or the client experiences some desires to the contrary". Thus, it requires a sense of "a shared enterprise" (Gelso and Carter, 1985, p. 163) that will aid a client's motivation and commitment, and their belief that psychotherapy can help (Holmes, 2001, p. 17). The essence of a successful working alliance may lie simply in a "good human relationship' (Lapworth et al., p. 15), based on contact (Erskine et al., 1999, p. 13).

A contactful, attuned relationship fosters a relatedness typically missing in the client's past experience. In this way, the therapeutic relationship provides a reparative context (Kohut, 1971, 1984; Erskine et al., 1999) in which a client's needs can be met, new ways of behaviour can be practised and old patterns and hurts explored. This reparative aspect can actively model healthier ways of relating and help a client to moderate overwhelming affect, so the new learning experience can be internalized and a person can move towards equilibrium and transition. It cannot erase an unhappy past, but helps acquire new perspectives on past experiences and finds new ways of managing them.

A therapist does not provide a 'cure' through reparative psychotherapy, but rather offers "the capacity… to contain the conflicts of the patient, that is to say to contain them and to wait for their resolution in the patient instead of anxiously looking round for a cure" (Winnicott, 1972, p. 2). A therapist's role is to aid emotional expression, regulate affect (Kohut, 1984; Stern, 1985; Schore, 1994) and normalize experience; to "care" (Winnicott, op. cit) without imposing one's own agenda; to stay close and aid "emotional proximity" (Holmes, 2001, p. 17) while retaining "otherness" (Hycner and Jacobs, 1995, p. 223).

The psychotherapeutic frame aids the creation of the secure base and thus contributes to effective psychotherapeutic process. By therapeutic frame I mean clear boundaries, a consistent and continuous relationship, and a consistent environment. Establishing clear procedures for cancellations, breaks, availability, or not, of the therapist, clarifies the therapeutic contract and creates a sense of safety (Kepner, 1995; Lapworth et al., 2001).

As regards the personal qualities of the psychotherapist, a sine qua non is interest in another human being, an "active curiosity" (Joyce and Sills, 2001, p. 21), and ability "to be fascinated with the patient" (Polster, 1985, p. 9). The process need not be relentlessly serious: humour "can be a vehicle for insight, an affirmation of the working alliance, a true moment of meeting in the person-to-person relationship or a gentle means of confrontation" (Lapworth et al., 2001, p. 24).

Regarding therapist and client matching, research is inconclusive regarding such variables as personality (Garfield, 1986, p. 142), suggesting that instead of matching per se, a process of selection based on the therapist's ability to help is applied. This is really a question of mutual assessment based on professional competence and good practice (Lapworth et al., 2001; Joyce and Sills, 2001). Psychotherapy, however, is a relationship with both the personal and social world of the client. Issues of difference – race, gender, sexuality, social class, disability, religion – are important power variables. Matching across difference may not always be possible. Rather, the therapist can offer what Kareem and Littlewood (1992, p. 16) see as the aim of the work at Nafsyiat: "The object is to create a form of therapeutic relationship between the therapist and patient where both can explore each other's transference and assumptions. This process attempts to dilute the power relationship that inevitably exists between the 'help giver' and the 'help receiver'".

10. A Personal Integrative Framework In Practice

As integrative philosophy informs practice, so the priority is on work with different aspects of the client/psychotherapist relationship. "The deciding reality is the therapist not the methods. Without methods one is a dilettante. I am for methods, but just in order to use them not believe in them" (Buber, 1967, p. 164). The principle of engagement arises out of "inquiry, attunement, and involvement… the essence of the successful therapeutic relationship" (Erskine et al., p. 17).

With so much emphasis placed on contact and meeting in a relationship, prioritization of certain aspects of the therapeutic relationship over others is inevitable. I focus on the building of the Working Alliance and aim towards developing 'real' or person-to-person relationship based on contact, openness and both the client's and the therapist's being ordinarily 'human'. I thus use both I-Thou and I-It dialogue to foster "healing through meeting" (Friedman, 1976) and to enter their subjective world. As regards my feelings, thoughts, phenomenological experiences, I share them with my client if they serve the therapeutic purpose and are appropriate to the situation: for example, I may share my sadness or opinion about an event in a client's life. The same principle applies to self-disclosure, if used, and always sparingly and cautiously; it is guided by timing, by phase of therapeutic process, by the strength of working alliance, but most of all by Yalom's 'test' (2001, p. 87) "Is this disclosure in the best interest of the patient?"

Transference and countertransference, too, may potentially aid understanding of the client's and therapist's response within the "intersubjective context" (Atwood and Stolorow, 1994, p. 64). Casement (1990, p. 7) considered that transference, especially "difficult transference", can be seen as a signal of distress or conflict needing attention "an expression of unconscious hope" rather than a disruption to the process. It is, of course, up to the therapist not to place responsibility on the client should difficulties to the working alliance arise.

Working with difficulty in a relationship is essential; a reparative potential exists here through the provision of a 'healthier' response that avoids repeating traumatic responses evoked by the original carer – "a corrective emotional experience" (Alexander and French, 1946). Similarly, working non-defensively and owning one's mistakes can be equally therapeutic, providing we take into account the impact on the client (Casement, 2002, p. 32).

There is the delicate question of touch, which may be a healing element in therapy, despite the frequently defensive attitude to it amongst psychotherapists. It use, however, needs to rest on an ethical framework (Smith et al., 1998) and solid working alliance to avoid potential re-traumatization.

I work with what the client brings, whether focusing on the present, the past or the future. In this sense, psychotherapy is client-led. In an increasingly time-limited context, however, the most practical therapeutic judgment may be to concentrate on the here-and-now. Nevertheless, it is important to hold some sense of the future in terms of goals and potential transition in psychotherapy "future-in-view" (Elton Wilson, 1999). However, many aspects of the psychotherapeutic journey do not

necessarily yield easy answers. Marcel's words (1951) seem a fitting epitaph to this existential dilemma: "Life is a mystery to be lived, not a problem to be solved".

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Book Review By Jane Speedy

'The Heart's Narrative: Therapy And Navigating Life's Contradictions' And 'Talk That Sings: Therapy In A New Linguistic Key By Johnella Bird'

A post-modern understanding of the localised nature of knowledge, alongside some debate between discursive/essentialist versions of what it means to be human, has seeped into the theoretical discussions available within most therapeutic approaches. Nonetheless the majority of therapeutic practice takes place 'as if' human beings were individual islands in the stream of life.

When I first came across the narrative/discursive therapies my heart leapt at the possibilities of working therapeutically with people in ways that practiced (rather than merely theorised) a more social, discursive and relational sense of human agency in the world.

My excitement and eagerness to travel the world seeking out education and training in these approaches and bring them back to the UK was only slightly diminished by the discovery that although these post-psychological (as in post-individualistic psychological) approaches owed much of their genesis to feminist, critical and postcolonial activity and theory, all the leading proponents and founders of these approaches seemed to be men of European origin. I would not wish to diminish the remarkable contribution of these men in any way, but, well, shall we just say that it all felt a little bit familiar? Having come across this phenomenon before many times in my working life, I began to wonder whether similar discourses were at work. I began to wonder whether there might also be people of other cultures and genders who were busy developing and teaching this practice somewhere in the world, as well as the men who were writing about it.

And then I came across Johnella Bird who has been developing a very original approach to therapeutic endeavours over the last 20 years, in her native New Zealand, and has only recently, somewhat reluctantly, published her work. This reluctance is, in part, an expression of a resistance to the creation of further orthodoxies within therapeutic discourse and strong hopes for the development of more fluid, living engagements with people. To this end these books eschew descriptions of any fixed, 'one size fits all', therapy models and provide readers with a rich, multi-storied exploration of ways of working within 'a relational paradigm'.

These two books are both densely written, the second book 'Talk that sings' much easier to read than the first, but both are very carefully written and thought provoking contributions. Both provide myriad stories from practice and many opportunities and exercises for readers to engage with by themselves.

The first volume'The Heart's Narrative' is both the story of how this practice took shape, situated in the landscape and culture of New Zealand and also an introduction to the author's current practice. At the heart of the book lies the author's invitation to engage

with therapy as a 'relational externalising conversational process'. By attending to how we position ourselves as therapists and 'clients' and the language we use to create meaning, we are invited into a process of continually constructing and reconstructing ourselves in a relational 'I', position rather than as the fixed, autonomous "I' of traditional western discourse.

A strong commitment to finding ways to move people beyond binary positions (such as trust/mistrust) and to opening up richer spaces for people to inhabit in their lives is articulated throughout the book as a 'feeling for words' or for 'talk that sings', which the author likens to Miss Smilla's (Hoeg, 1983) 'feeling for snow'.

'a knowledge of snow that moves beyond the binary of snow/not snow, towards descriptions that incorporate the qualities, consistencies, colour ranges, smell and shapes that support a feeling for snow'. (Bird, 2000:16)

Ms Smilla found herself 'resourced' to read the weather and engage differently with the seasons through a 'feeling for snow' and Johnella Bird suggests that by listening to 'talk that sings', to talk that provides a sense of movement and talk that discovers, contextualises and extends the meanings people give to words, people consulting therapists may find themselves similarly 'resourced' to engage differently with their lives.

The Heart's Narrative explores these ideas and encourages their practice at some length and then moves on in the later chapters to relate them, to the concepts of trust and fear, disconnection, gender relations, ethics, power and therapeutic practice through the use of stories from practice and through training exercises.

One of the ways that this book is both a 'difficult' and at the same time compelling read, is that one of the binary positions it challenges or avoids, is the either/or division between theory and practice that has so dominated the literatures of counselling and psychotherapy in the past. Thus the book is interspersed with references to complex poststructuralist ideas, works of fiction and so forth, (albeit not in a 'shopping list of references' tradition), as and when they come up in the practice narratives

This mirrors the author's descriptions of 'moving though' theory so that it sits alongside a therapist in her archive, rather than dominates the way she situates and thinks about her work. In this way, the book gives readers a very vivid experience of the author walking her own talk, but it is sometimes quite densely written. This reader, at least, would have preferred to have had an index to take herself back and forth more easily on her own journey through the text.

The second book 'Talk that sings' is no less complex and no less compelling, but somehow forms a more coherent whole. This text extends and enriches the explorations of relational language –making strategies undertaken in the previous work. The author states very clearly: 'I propose it is possible to make change by languaging into existence the resources people have or could have'.

And goes on to richly describe this proposal. The book is divided into three sections; the first 'relational consciousness is the difference' outlines the ideas informing the author's thinking, largely through stories from her own therapeutic practice. Her explorations and illustrations of the use of the 'continuous present tense' to open up spaces for movement in people's lives has been particularly valuable to this reader. The second part, 'relationally speaking', excavates the author's practice more extensively and demonstrates this for readers with further examples and numerous exercises for them to engage with. The last section 'illustrating the therapeutic practice', does just that by showing us how the author works with individuals, couples and families and children.

This is perhaps a more conventionally constructed book that nonetheless continues to maintain the author's strongly held commitments towards not privileging textual knowledge over clinical practice. It does so through using language with great care and by continuing to weave and pleat stories of practice and the ideas that sustained, or were generated by them in and out of the whole body of the text.

The author talks extensively in this text about the commodification of therapy and eloquently illustrates her concerns with reference to Janet Frame's (1983) short story about

human attempts to possess the blackbird's song, which ended with the consequence:

"They stopped singing. It was dark outside although the sun was shining. It was dark and there was no more singing".

I see two these books as companion volumes, the one leading into the other and would recommend them both, although if I was only able to buy one of them 'Talk that sings' would have to be it. Johnella Bird's own hope for her work is that it provides a temporary platform from which therapists and the people consulting them can make their own clinical and theoretical discoveries and in this, I believe, she more than succeeds.

NB: These books are published in New Zealand and are quite hard to come by in the UK. In this regard, I recommend the UK-based online narrative bookshop: http://www.narrativebooks.co.uk/

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Book Review By Bernd Eiden

'The Embodied Psychotherapist: The Therapist's Body Story' By Robert Shaw

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Robert Shaw's new research in the area of embodiment is of an interest to me as I have been working as a body psychotherapist with clients and groups for over twenty years now. His attempt to bring the relevance of embodiment to the attention of colleagues from the wider field of counselling and psychotherapy is very timely and necessary. The book contributes to the debate on the body/mind split and attempts to offer a holistic model for viewing the therapeutic relationship.

Part 1 'The body in psychotherapy' starts with a brief outline of the origins and development of the body/mind dualism, illustrating also rightly how body therapists have perpetuated the body/mind split. Somatisation is clearly one of the means whereby the body is brought into the realm of psychotherapy. However, in the way somatisation is used, it still contributes to the body/mind separation by acknowledging the client's body only.

The use of language also plays a significant part in maintaining the body/mind split as psychotherapy borrows terms from medicine and science.

When looking at psychotherapeutic techniques, where the body becomes part of the therapeutic exploration, Shaw discusses in more detail the problematic issue of touch.

Shaw suggests the concepts of 'embodiment', intersubjectivity and the narrative as a way out of the body/mind dilemma. He develops his argument by saying that our bodily sense arises from how we perceive the world and that our embodied sense necessarily incorporates our biographical experience. Thus embodiment is also related to how we relate to others and language is embodied. Thus therapeutic relationship is an embodied encounter. Feelings are somatic as well as cognitive processes. Empathy is a bodily phenomenon, 'the feeling of being led by another's experience' (p. 48), occurring in an intersubjective relationship.

Shaw proposes a framework whereby therapy is seen as a meeting of two 'lived-bodies' (p. 45) and as such provides the basis for a therapeutic narrative by acknowledging the phenomena arising from the lived-bodies of those involved rather than a means of interpreting another body's behaviour.

This theoretical model enables going beyond the mind/body dualism and enables to avoid concepts like countertransference according to Shaw. He believes that traditional psychotherapy doesn't have sufficient concepts to understand embodied phenomena. He suggests a therapy that is a co-constructed narrative, a story telling, including bodily feelings, shared by both lived-bodies with their own biographical situations. This concept challenges the notion of the therapist as the expert and acknowledges client's experiences as paramount and they're not to be interpreted.

My own understanding of the narrative movement is that it is located in social constructionism and post modernism. The narrative approach privileges subjective experiences over objective/expert knowledge and believes in no fixed or ultimate truth/realities and in no essences/truth, but only discourses. Narratives are stories by which people give meaning to their experiences, and they are a means to structure lives. In this approach therapy is about bringing forward the more hidden stories we have about ourselves.

In part 2 'Psychotherapists' body narratives' Shaw summarises his research about therapists' various involuntary bodily reactions occurring while working with clients, e.g. nausea, sweaty palms, asthma, revulsion, smell, muscular/skeletal pain, cold/hot. These bodily responses are held as knowledge, possibly shared as part of the narrative, but not given as an interpretation to the client. The body of the therapist is seen as a receiving device tuning in to the need of the client. Shaw's research values the subjective experiences of the participants.

The passion of the writer becomes more evident in part 3 'The embodied psychotherapist' when he formulates his main thesis which is that the therapist's bodily experience and feelings are an essential ingredient for the therapeutic encounter to become embodied.

The therapist advocates a deeper exploration of these embodied states through 'body empathy' (p. 133). Shaw is very explicit that such use of the therapist's bodily reactions in a co-constructed narrative goes beyond the traditional therapeutic discourse, as the therapist's bodily reactions are not the client's feelings. This somatic resonance provides an embodied experience and establishes an empathic bond which suggests that a connection at a profound level had been made.

'The therapist's body can be seen as a vehicle for conveying something of the intersubjective nature of the therapeutic relationship'. (p. 143). Shaw emphasises the exploration of subjectivity as the main aim of psychotherapy and highlights its intersubjective nature.

I would now like to share my thoughts and personal responses stimulated by the book. I fully support Robert Shaw in challenging the issue of professional power in psychotherapeutic models. Due to the historic development of psychotherapy and the body/mind dualism, most psychotherapeutic models depend on expert knowledge and power located in professionals. Expertise is demonstrated through language. Professional power is maintained in defining problems and preferred solutions, in determining treatment and controlling access to resources.

Shaw's plea to value the body as highly important in the therapeutic encounter is a welcome contribution and yet it leaves me, as a body psychotherapist, left out and puzzled why contemporary body psychotherapy is not represented. I consider Shaw's view of body psychotherapy to be outdated and his perspective on body psychotherapy remains limited by looking only through the lenses of his own training as an integrative psychotherapist. His critical observations about the general lack of knowledge on the body in psychotherapy trainings are valid. In the body psychotherapy taught at Chiron the basic premise is that the sense of self is rooted in the body and catalysed in the relationship. Relationality means seeing the intersubjective field as a primary context for therapeutic work, where the therapist is not the expert, yet is instrumental in enabling change. We struggle to resolve disembodiment and objectification. In order to move away from the medical model Chiron's approach to body psychotherapy is based on the notion of the wounded healer. We bring relational commitment to the pain of the client rather than expertise or techniques or cures. We let our own wounds be touched and activated and help to understand the connection between the client's and our own inner world.

Somatic resonance, the ability of the therapist to empathise at a somatic level, is an essential ingredient in our work. Our body psychotherapists are trained to become closely connected to their body/mind and access it as a therapeutic tool and to pay detailed attention to the energetic, non-verbal, right brain to right brain interaction.

In the wider field of psychotherapy we witness a ground breaking paradigm shift regarding our understanding of the relationship between

body and mind through recent developments in neuroscience and attachment theories. We know that emotionally attuned interaction affects the physiology of the body which has the potential to transform the dualistic nature of mind and body to an understanding of the body/mind being interrelated and co-created and part of one system. Relational psychoanalysis now recognises that immediacy, emotional availability and mutuality are essential to the therapeutic task, which also asks for an inclusion of the body in the consulting room. These are exciting and fundamental changes in the field of psychotherapy. So I believe that it is not the right time to dismiss such important concepts as countertransference as not useful any more and favour a synthesis of 'embodiment' of the narrative as a holistic model, as Shaw suggests in his thesis. The concept of countertransference has undergone revolutionary changes over the years, e.g. in the 1950s, and will continue to be developed and embrace 'embodiment', if the profession demands it. In our training at Chiron the therapist's use of his/her body is taught thoroughly experientially, as well as theoretically. The therapeutic relationship is accessed and deepened through the somatic countertransference and may be translated into therapeutic interventions. We consider countertransference as embodied in contrast to the historically developed notion of countertransference. 'Embodied countertransference' can be a cornerstone of a holistic relational framework which sees the therapeutic relationship as intersubjective system of complex, parallel body/mind processes. I need to say all this to illustrate that Shaw's approach is not entirely new and radical as he claims it to be.

Another critical observation of mine concerns R. Shaw's reflections on the use of touch in psychotherapy. He has not found a fully integrated position on this issue and remains rather ambivalent and fearful. He talks about the use of touch mainly as comforting, i.e. creating an experience of gratification, and doesn't differentiate further. Touch, in our work as body psychotherapists, is used as a way of accessing unconscious material rather than soothing. It is a way to deepen the connection with feelings, sensations, images, memories and thoughts. It is a challenge to know when it is therapeutic to gratify the desire for touch and when it is more valuable not to do so and facilitate a process of necessary disappointment.

I hope that my review of the book has been helpful and leads to further discussion as my body psychotherapy stance naturally colours my view.

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Chiron web site: www.chiron.org (including articles by Shoshi Asheri, Roz Carroll, Bernd Eiden and Michael Soth).

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Letter To The Editors

A Note On The Exotic By Ray Holland

I found Andrew Samuels' piece in the previous edition of this journal (Vol. 2, No. 1) interesting, and one could not disagree with some of his assertions. However, I was left questioning Samuels' take on his Muscovite, 'Winnicottian-NLP' supervisee. It reminded me of a talk given earlier in the year by the psychoanalyst, Ronald Britton.

During his talk Britton told an amusing story about how, after the demise of the Communist regime, the Russian President became enthused by all-things psychoanalytic. The Russian population appeared to follow their President's lead and became similarly excited by psychoanalysis. Britton was invited to Moscow and after a number of visits one might say that he was also struck by the 'exotic' He found a plethora of advertised psychoanalytic practices that included, 'psychoanalytic tarot card reading' and even 'psychoanalytic massage'. Britton's observations echo the Russian psychoanalyst Igor M. Kadyrov's recent commentary on the development and current status of psychoanalysis in Russia. At one point Kadyrov hypothesises a complex process in which 'a reaction formation against a 'totalitarian object'' has produced 'widespread variations of 'jolly' (Sebek, 1998) psychoanalysis, that is, 'as if' psychoanalysis, which is characterised by a flippant or even perverse attitude towards psychoanalytic boundaries and professional ethics' (Kadyrov 2005, p. 474; original emphasis).

Casting an eye on the domestic scene, Britton and Kadyrov's observations reminded me of how some contemporary Reichians have also attempted to meld various working practices into an exotic mix. The most ambitious being working in the 'transference relationship' with whole-body 'biodynamic massage' Psychoanalytic massage, London style. Herein is my broad concern. By promoting the foreign or exotic in the domestic, to use Samuels language, one can easily undermine the 'foundation' (Grondin 2003, p.18) upon which a therapeutic orientation rests and support an 'anything goes' policy. Essentially, one risks becoming an advocate of what the philosopher Roger Scruton describes as 'vulgar relativism' (Scruton 2004, p.33; original emphasis), in which deconstruction reigns and, 'no opinion has authority apart from the point of view which adopts it' (Ibid. p.32).

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