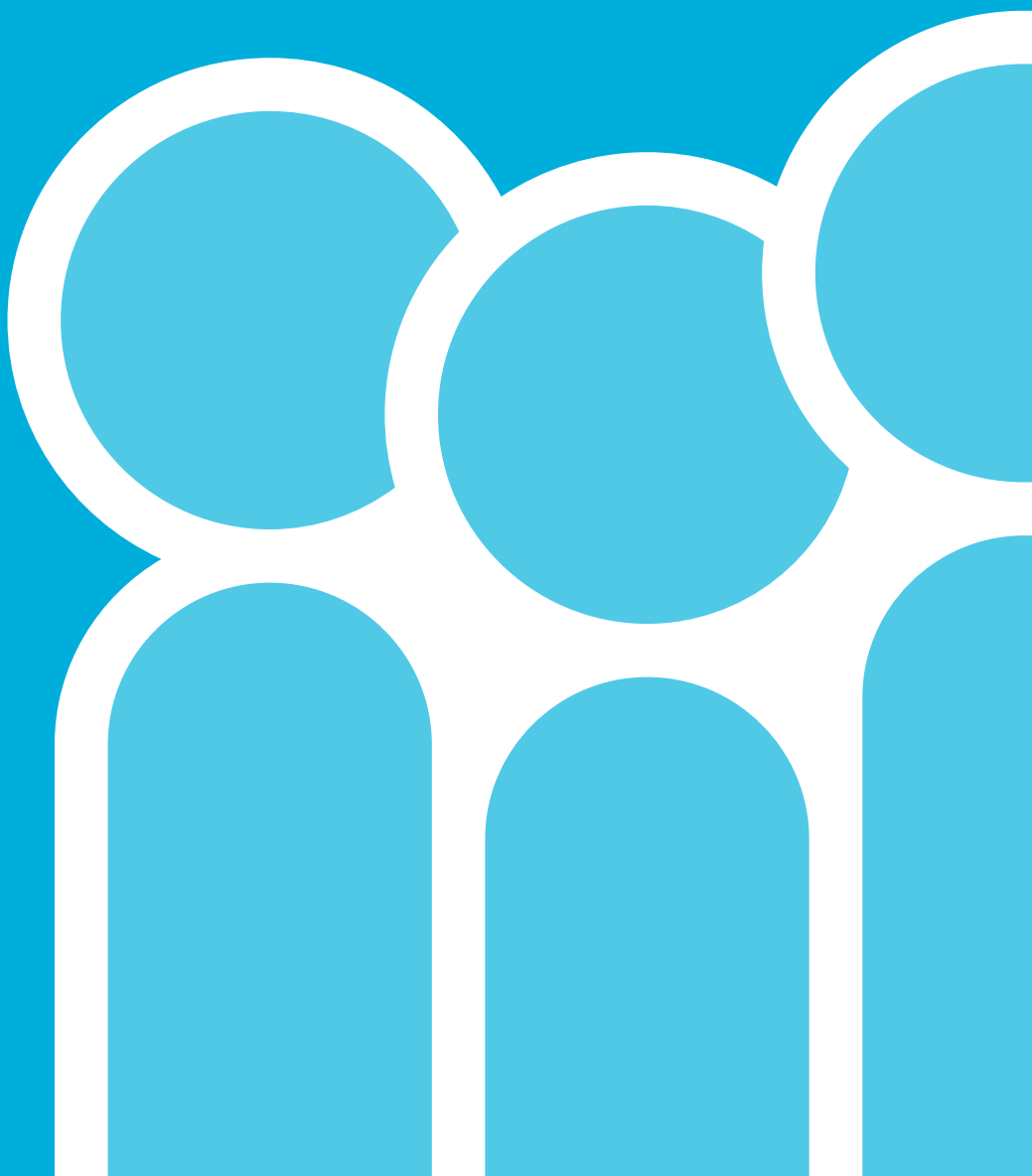
Volume 3, Issue 2

Integrating The Personal And The Professional



Volume 3, Issue 2

The British Journal Of Psychotherapy Integration

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 submitting please visit our web site (www.ukapi.com/journal/) and download a copy of the submission guidelines.

Editorial Structure

Volume 3, Issue 2

Contents Of This Issue

Editorial

Integrating The Personal And The Professional

We have an interesting range of articles in this sixth edition of the journal. Although some of the authors would not formally identify themselves as integrative psychotherapists, each writer explores themes that could be incorporated into an integrative framework. Several authors have touched on the interface between the personal and professional as this impacts on our clinical work. All have been willing to share their own personal experiences in their reflections on the process of being a psychotherapist. Perhaps what links all these authors in some way is the acknowledgement of the inextricable connection between the personal and the professional.

Contents Of This Issue

Karen Maroda provides a vivid sense of the human capacities for love and hate in all relationships, with particular reference to the therapeutic relationship. Discussions of these themes in the literature tend to focus either on the client or the psychotherapist but seldom on the co-created relationship between them as Karen does here. She challenges practitioners to be alive to their own experiences of these intense emotions in the therapy room and to distinguish between what is a healthy exchange to be embraced and what might be a disruptive enactment to be worked through in the intersubjective space. We particularly appreciate the courage and honesty of Karen's account of her work.

We are grateful to Routledge, the publishers of Patrick Casement's forthcoming book "Learning from life: Becoming a Psychoanalyst", for permission for the advance publication of the second chapter of this book. It is refreshing to read Patrick's candid self reflection on his early experience, and the links he makes between his personal story and his later choice to become a psychoanalyst. This chapter is a testament to the quotation from Nietzche used by Carole Archer in her piece on integration: ' A philosopher's system arises from his autobiography'. In his story of his struggles and his transformation through them, Patrick provides a moving example of courage to us all.

Damian Gardner brings the process of supervision to life in his account of his research into shame in supervision. He reminds the reader of the inevitability of the parallel process arising in the supervisory relationship, reflecting the intense affects of the clinical relationship. Damian writes of the process of shame and of being shamed, in a compassionate and deeply reflective manner. He reminds us that our personal vulnerability is always close to the surface as we practice as psychotherapists and supervisors in his reflections on his personal learning from his research project.

Jocelyne Samuels continues the theme of the transpersonal in the psychotherapeutic endeavour, which was the theme issue of our last journal. Jocelyne pays particular attention to Jungian and Post-Jungian perspectives on the transpersonal and makes a passionate plea for exploration of the shadow in our individual and collective activities.

She also gives a graphic account of how working with the arts offers a possibility for reaching areas of experience which may otherwise be missed, particularly in work with children. Jocelyne's article is a comprehensive exploration of a range of interesting themes for integrative psychotherapists which she views as central to the processes of psychotherapy.

Rex Bradley reminds us of the importance of sibling relationships in identity development. He puts the case that these relationships are often as influential in the child's development as relationships with primary caretakers. Rex's case examples in the context of family work bring the issues of sibling rivalry to life for the reader. He makes his point well that the psychotherapist working with these issues needs to acknowledge with humility that long-lasting change may not be easily achieved. We appreciated the candour of his clinical accounts in bringing this under-recognized dynamic to our awareness.

Sue Wright gives a clear and accessible synthesis of some of the current writing on the impact of trauma on human functioning. What Sue adds to the discourse is the poignant recognition that both psychotherapist and client have to enter the realms of the 'unbearable' in order that something new can emerge. We particularly appreciated the clarity and humanity of Sue's account of her work in this area and the moving clinical examples that illustrate the challenges to both practitioner and client.

We have now established a tradition of publishing a example of a student's final written submission for their qualification. In this issue we include an account by Carole Archer of her integrative approach to psychotherapy.

Maria Gilbert and **Katherine Murphy**.
Consulting editors and co-editors of this issue.

Karen J. Maroda

Desire, Love And Power In The Therapeutic Relationship

Abstract

Desire, love and power are all interconnected within the therapeutic relationship, alternating in importance and emphasis. This paper takes on the rather large task of individually examining and integrating the various manifestations of these emotional events. The chief focus of the paper is the therapeutic value or detriment, as the case may be, of erotic transference and countertransference. Clinicians are encouraged to experience both their client's and their own erotic and loving feelings without judgment and learn to manage these affective events as they would any other.

Introduction

Psychoanalysis has a long history of both sexualizing and de-sexualizing the therapeutic relationship, often guided by the therapist's need to be seen sexually or to defensively ward off the client's erotic interest. The ascendance of the two-person approach invites a more detailed look at how sexual and loving feelings can be utilized by both therapist and client. The prevailing question has been, and remains: What is the underlying meaning of expressed erotic or loving interest? This question used to be answered solely in terms of the client's motivations, without regard to any provocation by the therapist, and was most often regarded as defensive. Now we are more willing to consider that erotic and/or loving interest has as much potential for being a healthy expression of the client's adult capacity for attachment as it does for being defensive or pathological. And the therapist's participation in creating a loving and/or sexual bond cannot be denied, for better or worse.

Searles (1979) spoke candidly of his erotic and loving interest in all his clients, but because he worked primarily with hospitalized borderline and schizophrenic clients, most of what he wrote was not considered applicable to psychoanalysis. More recently Cooper (2003) has argued persuasively that oedipal conflicts are never resolved, rather they are similar to other issues that are stimulated and re-worked throughout the lifespan. And Davies (1994, 1998, 2003) has been at the forefront in emphasizing the healthy, positive aspects of the erotic transference-countertransference.

I recommend Mann's (1997) extensive review of the literature on erotic transference-countertransference, with an emphasis on its positive contributions to the overall therapeutic experience. For more elaborated discussions of love in the therapeutic relationship see Coen (1994, 1996) and Bridges (1995).

Gabbard (1996) has said that the old attempt to distinguish between transference love and love outside the treatment is essentially a waste of time. I agree with Gabbard that it is gratuitous to question the validity of the client's feelings when they "sue for love", and as equally gratuitous and defensive for therapists to negate their love and sexual desire for their clients.

Person (1985) has noted the parallels between the therapeutic relationship and that of lovers. Rather than denying these similarities, we tell our clients as gently, but firmly, as possible that acting on these feelings is impossible. Instead we will seize the opportunity to explore some of the deepest and most profound emotional experiences that human beings can have with each other. Zuckerberg (1995) poetically states that "falling in love, being in love, loving, being loved, represents a powerful and fundamental human need and in itself a reparative theme in psychotherapeutic treatment" (p. 235).

As much as I admire Zuckerberg's eloquence, the notion of love and being in love in the therapeutic relationship can equally represent the aforementioned defensive maneuvers that are attempts to gain power and control. How do we know the difference? As with most subjects of analysis, we are not as concerned about the erotic transference-countertransference when things are going smoothly. If the loving, erotic transference is clearly facilitating a deeper emotional experience that leads to insight and grieving what cannot be, we are not concerned. But if the client keeps upping the ante, demanding to know more about the therapist's life and sexual feelings, demanding intimate physical contact and/or sex, or if we are beginning to feel out of control, then the therapist becomes legitimately concerned. How did we get here? Why is the client defending so wildly against being vulnerable in the treatment? And what, if anything, is the therapist doing to stimulate these feelings and behaviours? And how are these issues resolved, particularly when the client is reluctant to discuss them?

Many clients resist the idea of talking about feelings that can never be acted on. They often say, "What is the point?" which is just another way of saying that they feel embarrassed or even humiliated by this suppression of desire in the therapeutic relationship and wonder what the therapist's motivation is for encouraging it. The client wonders, "Do you wish to make a fool of me? Or Do you take sadistic pleasure in my being so exposed and vulnerable? Or Do you enjoy the admiration or sexual arousal that you feel when I speak of my feelings for you?" The client says, "Okay, I understand why we can't have a sexual relationship, but then let's drop it and go on to other things. Why should we keep talking about it"?

It is at this point that the therapist discusses with the client the need to express any and all feelings for the sake of self-awareness, acceptance of feelings, affect-management, the acquisition of insight and the opportunity to grieve what cannot be. Exploring the client's fears of humiliation, objectification, rejection and over-stimulation can help her to understand why it is necessary to express whatever strong feelings she is having. Not surprisingly, many clients who resist the expression of their romantic feelings for the therapist harbour a secret fear that they will succeed in seducing the therapist and destroying the treatment. Others consciously or unconsciously know that they have been seduced and are resisting this power move on the therapist's part.

Love Or Power?

To this point, I have been discussing clients who disclose a loving, erotic transference to their therapists. But we all know that some clients are aggressively sexual, combining a demanding hunger for power and control with their sexual desire. These clients are the ones who have great difficulty accepting the asymmetry of the therapeutic relationship. They fear helplessness, rejection, dependency and, ultimately, psychic annihilation. Wry and Welles describe this as 'erotic terror,' and Kumin (1985), as 'erotic horror.' Often having been physically and/or sexually abused as children, these clients essentially protect themselves in the therapeutic relationship through the zealous seduction and courtship of the therapist.

This type of aggressive erotic approach is almost pure power, typically begins very early in the relationship, and is not the constructive, healthy burgeoning of loving and sexual feelings that most authors are referring to when they speak of a healthy erotic transference. In accordance with mutuality, it is fair to note that some therapists have similar fears of intimacy and vulnerability and need to sexually seduce their clients for their own protection. But I believe these clinicians are in the minority, often end up as

sexual predators, and there is little to be said about them that would change this situation.

In his classic paper Blum (1973) attempted to distinguish between the more expectable loving, erotic transference and the sexually aggressive, power-driven one. He created a different category for these difficult clients and did so by coining the term "erotized transference" versus erotic transference. Blum cites Gitelson when he describes those with erotized transferences as people who demand to be loved in the absence of a capacity for love. (P. 62). Elaborating on the nature of their attachment, he says:

"These are not ordinary reactions of transference love, and these clients can resemble intractable love addicts. Their erotized transference is passionate, insistent, and urgent. While conscious discomfort and guilt may be present, the guilt may be isolated and unconscious. The conscious fear is not of regression or retribution, but of disappointment and the bitter anguish of unreciprocated love. Through projection and denial they can assume their therapist indeed loves them. For the borderline clients manifesting this reaction, transference and reality may be dangerously confused. There is the threat of regressive loss of reality testing" (p. 64).

When Blum says they defensively imagine that the therapist reciprocates, the implication is that the therapist clearly does not. The therapist experiences the client as aggressive and assaultive. Making the distinction between loving and aggressive erotic transferences may seem simple at first glance. But many people appear at first to be gentle and loving, only becoming aggressive well into the treatment, when the threat of emotional annihilation surfaces. Or when the therapist becomes too seductive and overstimulating.

Distinguishing between an intense but essentially positive erotic transference and a defensive or aggressive one can be especially difficult if the client fluctuates from one to the other. I think a key variable in making this discrimination is the countertransference. When I treat a client with the aggressive sexual transference described by Blum, my reactions range from curiosity and interest to irritation and frustration, and eventually to helplessness and rage. Even during more peaceful or enjoyable moments with the same client, I rarely reciprocate the feelings of love and sexual desire. (Although I may occasionally feel simultaneously aroused and disgusted by my arousal if the client is especially seductive.)

I can know something about the client's motivations through my own internal emotional responses. Something is wrong when a client persists in declaring undying love for me and I do not feel loved at all. As Blum points out, those who demand love are usually incapable of it. Instead of feeling loved, I usually feel assaulted, and work overtime to maintain the boundaries in the face of all manner of intrusions on my privacy and attempts by the client to control any and all aspects of the treatment.

With a client who seeks love more than power, my countertransference is different. I feel a warm expectation of seeing the client whose love is not essentially defensive and who inspires a reciprocal deep affection or love in me. If I feel any anxiety or apprehension, it is born out of a sense that I might lose my emotional equilibrium. When the client looks at me with a longing that is both loving and sexual, I am slightly afraid of being aroused. When she speaks of her desire to make love to me, sometimes I am aroused. More times than I care to admit to, I have changed the subject at this point. Why have I done this?

Instinctively, I felt the pull to act on my desire, just as the client does, because we are both human. Rather than being comfortable with this feeling and acknowledging the naturalness of it, I felt guilty, ashamed and anxious. As a young therapist, I'm not sure I knew the difference between feeling the pull to act on my feelings and actually acting on them. So I had to cut them off. Without really thinking it through, it seems that I felt that having my sexual and loving feelings toward a client might lead to abusing a client-something I could never accept doing.

Early in my career I did not realize that gratification for the therapist is not necessarily unseemly. I believe I would have been less disturbed by my erotic and loving feelings toward my clients had I realized that without

some gratification (Maroda, 2005), there is no relationship. The delicate balance in the therapeutic relationship is one of enough gratification to keep therapist and client invested, yet frustrating both therapist and client in their deepest desires, which often centre on filling voids from the past. So part of our dilemma centres on identifying when the romantic, loving and/or erotic moments in the therapy are defences against further movement and when they are part of a deepening relational experience.

Accepting And Managing The Erotic Countertransference

Much remains to be explored regarding the productive use of sexual feelings in the therapeutic endeavour. When a client expresses love or sexual desire toward me, as with everything else, there is a part of me that rightly asks, "Why now?" And this is not inconsistent with being emotionally available. There is plenty of room to receive the client's feelings, accept my own feelings, and still ask, "why now?" Within the relational paradigm, the answer to "why now" may or may not have as much to do with the therapist as the client. Unfortunately, the literature is replete with examples of therapists who, in examining there own sexual feelings toward their clients; inevitably attribute the origin of their feelings to the client's conscious or unconscious seductions. Traditionally, the therapeutic attitude was, "If I am sexually aroused, then the client is seducing me." While this may be true at times, it certainly cannot always be true. Often, the reality is that the seduction is mutual, as it is in most human relationships. At other times it is the therapist who is the seducer.

Now that love and desire are accepted in the therapeutic relationship, curiosity, rather than guilt or shame, has become the order of the day. We can examine the potential contributions of both therapist and client, clearly aware of the issues and underlying vulnerabilities, yet still assign some responsibility. For example, we know that persons who have been sexually molested are more likely to be seductive with everyone, including their therapists, because this is the relational pattern they know (Mitchell, 1988). And these individuals are much more likely to have sex with their therapists than those who have not been sexually abused (Pope & Holroyd, 1993). A less well-known reality is that therapists who have been sexually molested are also much more likely to have sex with their clients than those who have not (Margolis, 1994, Kernberg, 1994). And they are more likely to have sex with a client who is also a therapist. Keeping in mind the vulnerabilities of both therapist and client can help to prevent boundary violations and failed treatments.

Although the aggressively sexual clients described by Blum may present the most difficult situation of erotic transference, this type of client is the exception rather than the rule in most practices. Lester (1985), Goldberger and Evans (1985), Altman (1995), and Gabbard (1994) have stated previously, and I concur (Maroda, 1991), that the therapist who has sex with this type of client often does so as much out of rage and a desire to punish the client as anything else. It is when the countertransference frustration and rage go unexpressed and unresolved that aggressive sexual events occur. So this type of case might be better discussed under the rubric of countertransference aggression.

Whether dominated primarily by love or aggression, Person (1985) reminds us, sex is power. So when the therapist asks herself, is this client trying to influence me through his or her erotic feelings, the answer is inevitably "yes, of course." The literature on affect tells us that one of the purposes of any emotion is to influence the receiver. Therefore, a more constructive question is "What does this client want from me at this moment in time?" Or, if the countertransference is being examined, "What do I want from this client at this moment in time?" In what direction is each of us attempting to move the relationship?

Gabbard (1995) points out that the more mature, reciprocal feelings of sexual attraction and love often come as the client is approaching termination. In the throes of separation anxiety and anticipated loss, both parties may find themselves filled with longing and sexual desire. But this does not preclude such feelings from occurring at any point in the therapeutic relationship. I have personally found that I am more likely to be sexually attracted to clients

during the early 'honeymoon' period. Later, as the inevitable conflicts arise, I find the litany of my faults or deficiencies serves as a cold shower.

Are erotic feelings part of the natural flow of the relationship, moving it along toward greater depth and understanding? Or is this an interruption? Is it an attempt to block any meaningful emotional connection? Is it a defence against anger or grief? Is it an attempt to feel powerful rather than weak and dependent or afraid? Has either party slipped into the gray zone of a fantasized sexual healing taking place if only they could become lovers? These are all appropriate questions for the clinician to ponder when a strong erotic and/or loving relationship develops in treatment.

Gender And Sexual Orientation

Person (1985) was the first to note the differences in expression of erotic transference on the basis of gender. We are all familiar with her report that "women in general appear to experience more intense and fully developed erotic transferences (p.166)," regardless of the sex of the therapist. She says that heterosexual men are less likely to have an openly erotic transference, even with a female therapist, ostensibly due to the power dynamics involved—a social concept seconded by Wry and Welles (1994) and by most clinicians in their daily experience. Gabbard (1994) notes another apparent gender difference. He says that male therapists often respond to their female clients' tears with sexual arousal. You might say that this is a power response if there ever was one. Perhaps. A deep show of vulnerability and surrender often elicits sexual feelings in men, but apparently not in women.

Again, I think this has more to do with social roles and expectations than simply the desire to dominate and be aroused by domination. Granted, some male therapists may take sadistic pleasure to the point of arousal in their female clients' suffering. But some may also be simply responding out of the intimacy and tender feelings of the moment.

The fact that female therapists are not as likely to feel aroused under the same conditions may have more to do with the fact that the man who is crying is often embarrassed or ashamed, and quite uncomfortable in this position. This self-rejection, combined with the female therapist's own social conditioning regarding what is sexually desirable in a male, may result in the female therapist's tendency not to find this situation arousing.

Pope & Holroyd (1993) have reported that male therapists are more likely to be sexually aroused by a client who is physically attractive, female therapists by male clients who are 'successful.' So a female therapist may feel great empathy for a man or a woman who is crying, but due to social conditioning, is not likely to be sexually aroused. Speaking as a lesbian, I have noticed that while I do not typically feel any arousal while a female client is crying, especially if she is crying hard or sobbing, it is not unusual for me to feel very tender feelings, sometimes accompanied by some sexual feelings, in the quiet, emotionally intimate moments that follow.

Heterosexual Romance As A Defence Against Homosexuality

Blum (1985) and Person (1985) note that the intense heterosexual romance within the therapeutic dyad is not always what it appears to be. They say that sometimes the passionate mutual heterosexual romance is actually a defence against underlying homosexuality. In these cases both client and therapist harbour rescue fantasies, conscious or unconscious, that they will finally be able to truly be in love and aroused by someone of the opposite sex-something that has eluded them in spite of their marital status or heterosexual history. The unavailability of the other helps fuel these unrealistic fantasies, often culminating in open declarations of love that destroy the treatment.

Regarding same-sex pairings, Tyson (1985), Kernberg (1994), Gabbard (1994), and Mann (1997), suggest that social homophobia expectably recreates itself within the therapeutic situation. Frequently both therapist and client defend against homosexual feelings and fantasies. Male-client, male therapist dyads are particularly reluctant to experience homosexual longings. As mentioned previously Person (1985) and Wry and Welles (1994),

note the ease with which women can feel and express erotic feelings toward each other.

Although I agree that women are much more comfortable with homoerotic feelings than are men, I want to take this opportunity to state what many gay and lesbian therapists believe to be true—that when there is an intense and long-lasting homoerotic transference-countertransference, it is likely that one or both of the dyad actually has a homosexual preference-even when both are women. At times when I read accounts of same-sex dyads of either sex, I am astounded at the lengths that some therapists go to, creating elaborate defensive explanations for why they are intensely sexually attracted to their same-sex clients, or why those clients are attracted to them. I have stated elsewhere (Maroda, 1998) that not only do these therapists refuse to consider that they might be gay, they typically refuse to consider that their beloved clients might be gay either.

I emphasize the homosexual elements in the erotic transference-countertransference because, due to the social unacceptability of homosexuality for both therapist and client, this issue accounts for many of the sexual acting out episodes or truncated treatments. This includes the pseudo-heterosexual romance mentioned previously. Gabbard & Lester (1995) admit that some therapists appear to use their clients to explore their own sexual conflicts and confusion. Citing a study by Benowitz (1995), of therapist-client sex when both are female, they reported that only forty percent of the female therapists identified themselves as lesbian. The rest identified themselves as heterosexual, bisexual, or confused. Twenty percent had never had sex with a woman before. They also note that Gonsiorek (1989) reported a similar pattern in male therapist-male client dyads. These statistics are remarkable and clearly demonstrate that the therapist who has unresolved issues regarding his or her sexuality is more likely to sexually abuse a same-sex client than a therapist who has self-identified as gay or lesbian.

That which is denied and repressed is most likely to be acted out. In the gay community it is understood that "straight" therapists can be potentially dangerous on two grounds. One, that they will reject the love and erotic feelings of the gay client. Or two, that they will repress their own homosexual impulses, while seducing and teasing the gay client, generating unbearable levels of frustration.

Disclosure Of Erotic Countertransference

Historically, we have wrestled with how to manage the erotic transference and countertransference, both internally and in the relationship. Kumin says, "Both client and therapist suffer from being objects of frustrated desire (p.15)." We know that interpreting the client's frustrated love and sexual desire as transference is disrespectful, defensive and non-therapeutic. I believe that encouraging graphic sex talk, disclosing aspects of the therapist's sex life or sexual fantasies, failing to comment on sexually provocative clothing or postures are also non-therapeutic and can serve as a substitute for sex between therapist and client. The challenge remaining is how to allow both client and therapist some room for feeling sexual, neither squelching these feelings nor being unduly seductive.

Most people writing on the subject of erotic countertransference agree that disclosing it is generally not a good idea (Gorkin, 1985, 1987, Mann, 1997). Mann incorrectly identified both Searles and myself as clinicians who favour disclosure of the erotic countertransference. This is not an accurate representation of my view. I am generally against disclosure of erotic countertransference, with only rare exceptions. The verbalization of mutual sexual attraction almost always contains the threat of destroying the therapy relationship. When it comes to sex, in most people's minds, saying leads to doing. But the client who is the exception must still be taken seriously. Clara Thompson (1964) said,

"Should the therapist admit stronger erotic effects when they are present? I believe there are occasions when this is necessary if the analysis is to continue. Failure to admit that one is sexually attracted to a client, when this occurs, means to the client that the therapist is afraid of the situation and that he feels guilty. The childhood situation is repeated—the client suffers from the parent-therapist's guilt" (p.69).

In The Power of Countertransference I cited a case report by Atwood, et. al. (1989) where the client of a supervisee needed her therapist to verbally acknowledge that he found her attractive, having been denied acknowledgment of her burgeoning womanhood by her father during adolescence. She told him repeatedly that she was not seeking any type of sexual encounter with him. She simply wanted her reality validated. (And she was right, by the way. He was attracted to her.) I cited this as one of the rare instances where I would answer the client's repeated, rational and well-thought out request for information of a sexual nature. In line with my guidelines for any disclosure, the client asked for the information. The therapist did not volunteer it. I continue to believe that the client who asks the therapist to reveal her sexual feelings toward the client for reality-testing purposes, with no expectations or fears of sex occurring, is the exception rather than the rule.

When I consider any type of self-disclosure I always ask myself, "If I am inclined to disclose a certain feeling or attitude toward the client, would I be just as inclined to disclose an opposing feeling or attitude?" For example, if I find it acceptable to state that I love a client, do I find it equally acceptable to say that I hate a client, under the right circumstances? If not, my desire to disclose has not passed my litmus test. Clients often wonder aloud whether or not we love them or find them sexually attractive. This does not mean they necessarily need an answer. Would the therapist who is willing to admit to being sexually attracted to a client also be willing to admit to not finding the client attractive? Again, I believe that either disclosure is rarely therapeutic.

Accepting The Erotic And Loving Countertransference

I have stated previously (Maroda, 2002) that the client always knows what we are really feeling, and often it is enough for us not to deny these feelings, or show discomfort when the client accurately identifies our feelings, or expresses her own strong feelings. As Kohut (1979) suggested, sometimes it takes great effort to simply sit quietly, fine-tuning our narcissistic equilibrium, as we are told that we are loved beyond words, or found to be beautiful or handsome beyond compare, particularly if we do not feel worthy of such admiration and devotion. Acceptance of the client's feelings lies in our ability to stay with the client, and to stay with our own feelings without undue discomfort. If we feel aroused and feel guilty, then we will truncate our emotional experience. And in the process of distancing from our own feelings, we necessarily distance from the client in that moment.

I think it is not a coincidence that the longer I practice the easier it is for me to deal with erotic feelings from my clients, and within myself. And it has been a relief to both my clients and me that I long ago lost the need to interpret their affection or sexual attraction as some type of transference. As I have stated elsewhere (Maroda, 1991, 1999) the client will typically make her own interpretation regarding the transferential nature of the relationship.

One young woman I treated noticed that she was preoccupied with me and found me sexually attractive. She was married and pregnant with her first child, so she found this experience a bit confusing. She knew that I was a lesbian and wondered out loud if this made it more likely for her to make some kind of erotic connection to me, regardless of her own sexual orientation – a thought that I have pondered many times and find interesting. What bothered her more than anything else was her subsequent realization that I am close to her mother's age. "Does this mean that there were sexual overtones to my relationship with my mother?" she asked. Given that her mother has always been extremely possessive of her and that during her pregnancy her mother announced to a group of friends that her daughter was having "my baby" this hypothesis has more potential than you might think.

I find the whole notion of the erotic transference-countertransference to be a fascinating one to explore, having been relieved of my guilt and shame for being attracted to my clients, as well as understanding that I need not fear that I will act on those feelings. Even though I agree with Gabbard (1998) when he says, "Never say never," the possibility of my acting on any sexual feelings with a client seems more remote after twenty-five years of practising

without having done so. I feel certain that I could have done a much better job with erotic transference-countertransference had it been part of my early training. Feeling guilty about my erotic countertransference, and having no introduction to responding constructively to erotic transference-countertransference, made this aspect of therapeutic treatment much harder than it had to be.

Ultimately, each clinician must assess his or her own vulnerability in this arena, as well as strengths. When a client falls in love with the therapist, what does that mean about the therapist's conscious or unconscious wishes? Are some clients, and some therapists, essentially more focused on sexual issues and feelings than others? If so, where does this originate? And what constitutes a good match?

Given the emphasis on mutuality, is it possible for a client to be in love with a therapist who is not at least a little in love with her? Is the therapist's claim of non-participation believable, especially in extreme circumstances, such as being stalked, kissed, or finding her client in a state of partial nudity? Are untoward developments in the erotic transference-countertransference more about power than sexual longing or love? And what is the difference between the therapist encouraging the client to freely express his or her loving and sexual feelings versus establishing an ongoing scenario of sex talk that is sexually gratifying for both therapist and client?

I realize that I have asked more questions here than I could possibly answer, given the extent of our current knowledge. But I think they are all worth exploring and represent issues we need to be mindful of as we work in the erotic transference-countertransference.

As a great believer in mutuality, I think that the clients who love me and/or feel sexually attracted to me always sense that these feelings are shared to some extent. The exception I make is the sexually aggressive clients noted by Blum, who typically have a sexualised psychotic transference that includes a defensive illusion that I share their feelings. These clients fear being destroyed by the therapist and seek to protect themselves through sexual conquest.

The client I described throughout Seduction, Surrender and Transformation (1999), Susan, was this type of client. She was extremely seductive, winking and smiling at me every time I walked into the waiting room to get her. She had sex with her previous therapist, who she then abandoned. Susan did not overtly feel abused by this therapist, because she was in the power position over her therapist. She and I engaged in frequent power struggles over her desire to call me constantly, her rage when I ended the session on time, and her reluctance to pay me. She also demanded physical contact with me that I refused.

My feelings toward her were often sympathetic and understanding, because of her traumatic history. But sometimes I became so frustrated and angry that I hated her. I cared about her, but I did not love her, nor was I attracted to her. Her failure to seduce me seemed to negate her and make her feel too vulnerable. In retrospect, I think she might have done better with a therapist who did find her sexually attractive, but who held the line nonetheless.

Her subsequent rage, demands, and breaches with reality made it very difficult for me to treat her. Everything I thought was reasonable, she didn't. And she really believed that if I would only hold and caress her, she would be healed. My attempts to break the power struggles and move into real communication were only sporadically successful. At one point I insisted that she take a small dose of anti-psychotic medication when she could not move past her psychotic transference and she suddenly became reasonable and progressed quite well for the next year. Unfortunately, she hated the side effects from the medication, particularly the weight gain. She had always prided herself on being quite thin and could not accept this change in her body image.

One day she announced that she was going off her medication. I told her my fears that she would return to her aggressive demands and emotional storms, but she assured me that this would not happen. But it did. Her demand to be held and stroked re-surfaced with a vengeance and the treatment finally ended in stalemate. She found another psychologist who agreed to do body work with her, and we terminated.

Clients who do not have traumatic histories, who have not been sexually abused, and who do not show any signs of a psychotic transference, typically display feelings of affection or love or attraction that are in line with my feelings toward them. This is not to say that their feelings are typically reciprocated in kind. The client's emotional experience is supposed to be more intense, more primitive, less controlled, than the therapist's, and this is usually the case. When a client says she is deeply in love with me, I typically feel a more subtle, sensual caring or love that is not disconcerting, with or without some moments of sexual attraction. I am more likely to think of this client outside of sessions, but not obsess about her as she does with me. I am usually touched and flattered by my client's expression of love and sometimes become nostalgic remembering the bittersweet experience of being in love with my own analyst.

Facilitating The Client's Expression

Regarding the expression of sexual feelings, fantasies, and dreams, I encourage my clients to disclose this information, if they allude to it or bring it up directly. If we accept that both therapist and client can and do experience loving and erotic feelings towards each other, not always as a defence against experiencing weakness, dependency or some other unwanted emotion, then how do we treat these healthy expressions? What do we say to clients who ask if we love them or find them attractive? How much expression of eroticism in the therapeutic session is healthy, given that the normal culmination of mutual attraction is not allowed? When are we encouraging our clients' expression of adult, sexual relatedness and when are we teasing them or having 'virtual' sex in the sessions? Facilitating their self-expression is one thing, engaging in mutual, ongoing seduction is another.

A few years ago (Maroda, 2000) I was asked to discuss the papers of three therapists who wrestled with these issues in their sessions and reported on them. I particularly and strongly disagreed with Rosiello (2000) who appeared to promote ongoing graphic sex talk with a client. She also permitted another client who was attracted to her to breast feed her infant in the session. Other therapists have reported cases where clients partially disrobed or repeatedly wore revealing clothing to sessions and were not told that these behaviours were unacceptable.

If the client becomes too graphic when discussing sexual matters, I usually try to refocus on what she is feeling. I have never found endless details about a fantasized sexual act to be anything other than a substitute for sex itself. As Bollas (1994) says, "reporting an erotic fantasy is in some respects an erotic event in its own right (p. 573)." Yet there is no doubt that the tolerance for eroticism can be a highly idiosyncratic trait, depending on the client's and therapist's views about sex and the body. So how far do you let a client go? And how much do you encourage further expression from a client who is prudish and reluctant? I think the level of comfort of both persons is extremely important. If either client or therapist is feeling embarrassment, violated, or sexually overstimulated, this is reason enough to curtail the conversation. I think we can safely say that attitudes about sexuality are one area that is vital to a good therapist-client match.

The Therapist As Seducer

I am disturbed by therapists who report that many of their clients have followed them, kissed them, left sexual messages repeatedly on their answering machines, or have disrobed to some degree during a session. Bollas reported a case where a therapist even allowed the client to masturbate during a session. To my mind these are overt sexual events that the therapist is colluding to produce.

More disguised collusions in a covert sexual relationship may exist when therapists allow their clients to call them in the middle of the night, call them when they are on vacation with their spouses or partners, or see their clients late into the evening with the excuse that this is the only time they can meet. Sexual energy, like any other energy, must go somewhere. As I stated in the beginning of this paper, the natural outcome of a prolonged sexual attraction is the sex act. Since this desire must be sublimated in the therapeutic relationship, it is often perverted into thinly-disguised sex talk, mutual obsession, or seduction followed by abandonment.

A poignant example of this latter point can be seen in Carter Heywood's (1995) *When Boundaries Betray Us*, which documents the mutual seduction by Heywood and her therapist, ending in traumatic rejection for Heywood. Following many sessions with both of them sitting on cushions on the floor with a room filled with lit candles, Heywood proclaims her love for her therapist, and wants the promise of a friendship after termination. The therapist responds by panicking and distancing from Heywood, never returning to the blissfully sensual state in which they had functioned previously. Heywood's sense of betrayal is palpable and understandable. Her therapist seduced and abandoned her. Heywood argues that her therapist should have agreed to a friendship after termination, but I disagree. Her therapist shouldn't have established the romantic relationship between them. Once created, it served as a huge obstacle to Heywood giving her therapist up and doing the requisite grieving over this loss.

The phenomenon of the therapist who engages in mutual seduction with a client, then dumps her when things get out of control, is not uncommon. Nor is it uncommon for a client to seduce and abandon her therapist. I find that few therapists are prepared for this scenario and have significant difficulty when they realize what has happened. The lack of closure in the relationship produced by abandonment can be equally troubling to the therapist who has been abandoned. How often does sex between therapist and client result from the fear of being left? I think we need to discuss these complicated interpersonal issues in more depth than we have.

Dealing With Eroticism In The Transference-countertransference

And we can deal with eroticism better than we have in the past. Interpreting the desire to have sex as nothing more than the child's need to fuse with the mother, can be replaced with a more honest and direct acknowledgment of the client's desire to know the therapist physically, and have his or her adult sexuality affirmed. And therapists can become more comfortable with their own sexuality, understanding that they will be attracted to their clients, allowing themselves to have these natural feelings without guilt or shame. Therapists also need to be realistic about their own potential for stimulating sexual feelings in their clients. Those who seem to stimulate their clients too little or too much may choose to examine this further in their own treatment.

But in the end the issue of erotic transference-countertransference will always be challenging, because of the necessary inhibition of sexual behaviour. Responding to the client's erotic feelings is no easy task, as Elise (1991) has pointed out previously. We can be attracted. We can be in love. But we cannot make love. So what we do instead may be destined to contain a degree of unnaturalness or stiffness that we would do better without. Yet we have no choice.

The normal social discourse during such moments must be denied in analysis. We speak neither of our mutual love or attraction for the client, nor do we reject the client's expressions of unrequited love. So what do we say? I have found that relaxed and easy exploration on my part puts the client at ease, yet is not seductive. I will ask the client to describe his or her feelings, but never ask for specific sexual details. After all, it is the emotional meaning that is important. As I stated previously, if the client volunteers too much graphic material, I steer her toward feelings instead. I find that the verbalization of this material is very sensitive and I am careful to follow the client's lead regarding when, how much, and in what way we talk about it.

When a client asks how I feel about his or her expressions of love or attraction, I usually say that I am moved, or flattered, or both. I find that most often my clients simply want to know that their feelings are received with understanding and warmth. They want to know that I am neither unreceptive nor overwhelmed.

I recall another client I treated a number of years ago who periodically proclaimed her love for me in a very heartfelt and tender way. I felt touched and saddened when she said how much she wished she could be with me. I just looked at her empathically and said nothing. I literally could not think of one thing to say in that moment that would not diminish the power of her feelings for me, or mine for her. After looking at her for a long time, I finally said, "I

don't know what to say right now." She replied, "Just say, I know." And from that time forward we had an understanding that all I needed to say to her during those moments was — "I know."

Summary

The presence of erotic feelings, often accompanied by love, can serve to open up both therapist and client to an intense, transforming, positive experience. Yet the old warnings about eroticism and proclamations of love as potentially defensive – used to control rather than reveal – must be taken seriously as well. The two-person approach acknowledges that the client, however, is not the only person in the dyad who can use eroticism to derail the treatment rather than deepen it.

Both therapist and client may feel love and attraction for each other for all the best and all the worst reasons. And the therapist benefits from examining his or her own behaviour and needs, as well as the client's, when the erotic transference-countertransference seems out of control.

Accepting that being loved and desired is gratifying and is often present at some point in a successful treatment, can help therapists to be more comfortable with sexual feelings in the relationship. I disagree with my colleagues who believe that heightened states of fear or sexual arousal as a result of an intervention can be therapeutic. As with all issues in analysis, the key to knowing what is working and what is not is the client's asymptomatic response to our interventions and ability to move deeper and gain insight.

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Patrick Casement

Chapter 2: An Emerging Sense Of Direction

Two roads diverged in a wood, and I—
I took the one less traveled by,
And that has made all the difference.
(Robert Frost 1920).

Note: This is a chapter from Patrick Casement's latest book *Learning from Life: Becoming a Psychoanalyst* (published by Routledge in September), we have received permission from the publishers to print chapter two in our journal to give you a flavour of this interesting new book.

Introduction

Some further vignettes from my childhood and early life help to illustrate the strange progression that led me eventually into the world of psychoanalysis. They not only show how a sense of direction can emerge even out of the tangled web of a life, but may also prompt others to wonder about their own roots and the ways by which each arrived at where they are in their life's journey so far.

Family Setting

I was the second of four children. My brother is two and a half years older than me, my two sisters being seven years and nine years younger.

I was born into a family that had its own strong traditions and family expectations. On my father's side all the males before me, for three generations, had been in the Royal Navy. My grandfather was an admiral, my father became a captain, his two brothers were also senior naval officers; and then my brother joined the navy, later becoming a commander. Although I was very different from my father and brother there seemed to be an unspoken wish in the family that I might eventually come round to seeing things in the same kind of way, perhaps even to join the navy as well. In the end I was "the one that got away."

There is a photograph of me with my brother, both of us in sailor suits. He was six and a half and I was about four at the time. My brother is standing very straight, giving a proud salute to our father and looking very correct. I, by contrast, can be seen saluting with the wrong hand. I have enjoyed thinking of this as a prophetic sign of my different way ahead, even though it probably only shows that I hadn't yet learned to conform.

"…me with my brother, both of us in sailor suits…"

Being Difficult And/or Different

Throughout my early years I was often seen as 'difficult', and I have no doubt that I was. But I have since wondered whether some of that being difficult may also have been an attempt to stand up for myself against pressures to be different from myself.

I can clearly remember a time when I was five or six years old and a war refugee who came to live with an uncle and aunt, where we were also living at the time, insisted on changing how my hair was parted. Until that day it had been parted on what used to be regarded as the girl's side. When my mother protested about this interference, the woman replied: "You are trying to make a girl of this boy. He should not have his hair parted on that side."[1] My mother claimed it was only because my hair grew that way, which this woman said was "nonsense." She then demonstrated that my hair grew naturally for a parting on the boy's side, where it has remained to this day.

Making Sense Of The Past

Many years later, my analyst formed the impression that my mother may have had a miscarriage when I was between four and five. His reconstruction had been prompted by hearing I had an uncanny awareness of early pregnancy in those around me. Once I even sensed this in someone whose pregnancy had only just been confirmed.[2] Another element in this reconstruction was found in the fact that I had developed colitis when I was five which, interestingly, did not subside until my sister was a year old. By then I was aged eight. So it seemed I may have experienced my earlier wish to get rid of my mother's next pregnancy as if that wish had been dangerously powerful, perhaps feeling that I had killed her baby. Therefore, when my sister was born, it would have been very important for me to see that this next baby was surviving. I may then have begun to feel less of a need to be punishing myself internally, my colitis seeming to combine some pain in myself with a frequent getting rid of whatever seemed to be bad, even lethal, inside myself.

This reconstruction made sense of a lot that had otherwise been difficult to understand, and my hypersensitivity to pregnancy disappeared soon after my analyst had made sense of it in the way that he did. I became increasingly convinced by his hypothesis, to the point where I finally asked my mother straight out: "Why did you never tell me you had a miscarriage?" She was clearly very shocked that I had heard about this, saying: "Who told you? Nobody in the family was ever meant to know about this." I proudly replied: "My analyst told me."

I then learned that there had been a miscarriage shortly after I was four, but what I did not like to ask was the gender of this lost baby. I suspect it may have been a baby girl. Perhaps my mother had later been trying to turn me into a kind of substitute daughter. She had also taught me, around the same age, such feminine arts as crochet and knitting. Compounded by the absence of my father during the war years, this left me to identify more readily with the women around me than with the few men in our lives at that time. This may later have helped me, in some ways, to work with patients who were reliving early times with their mothers. But it became important that I also find male role models in order to achieve a better balance in my gender identity.

Looking back to that time, my mother would have conceived just before or just after the beginning of the war, amidst all the uncertainties about the future. In addition, my father was subsequently away for long periods at a time because of the war. So I can imagine that her pregnancy just then may well have carried a huge emotional investment for the future, possibly also heightened by an anxious awareness that people in the services did sometimes get killed during a war. This pregnancy could therefore have felt like a last chance for my mother to have another baby — perhaps also carrying a hope that the baby would be a daughter as she already had two sons.

1. In those days, at least in the world my parents lived in, it was assumed that boys would usually have their hair parted on the left side and girls on the right.
2. I return to this in chapter 10.

Where Do Babies Come From?

One family memory, recounted to me by an amused aunt, comes from when I was about five. We had been sent out to a tea party on a hot summer's day. When we got back I told my mother that we had all been swimming. As I had gone out to tea without my bathing costume,[3] my mother showed some surprise at this. She enquired: "Were you all little boys, or were you little boys and girls together?" I am told that I replied: "I don't know. We were not wearing any clothes." I clearly had no idea about gender, even at that age. In fact I didn't work out the gender thing until my second sister was born, by which time I was nine. Only then did I realize it hadn't been that my first sister had something wrong with her. She and my other sister were different from me because they were both girls. Well, better late than never to find out about these things. I was clearly a late developer.

My father was away for most of the war years. Although he came back from time to time, for short periods of leave, I remember him as mostly absent. In relation to that, when I was seven, I was travelling by train with my mother who was holding my baby sister. In the railway carriage we met a friendly lady who, as a way of making conversation, asked me if this was my sister. I am told I had proudly replied that she was, whereupon this lady asked (as it was wartime) if my father had seen my sister yet. My mother remembered, with embarrassment, that I replied: "Oh, no. He's been away for years and years and years." I had clearly not yet worked out how babies were made, or I had repressed any sense of that.

Being Impossible

From the age of four my brother and I were taught at home by someone known as our "governess." She also found me very difficult, but stayed on for nearly seven years despite this. She was the first person who stayed. All my nannies had left after a very short time, so it was with this governess that I had my first remembered experience of someone who was prepared to "see it through." This she did until well after I had been sent to boarding school. I went there when I was aged eight and our governess didn't leave until almost three years later.

When this governess finally announced she was going, I remember crying myself to sleep every night for the first few weeks of that term, convinced she was leaving because I had been so bad. When my mother heard of this she quickly reassured me that it was not to do with me. It was allegedly because our governess didn't want to have to look after small babies, my second sister being then about one year old. However, years later I met this governess again and told her I had once imagined she left because I was so difficult. "But that is exactly why I did leave", she said. "You were just impossible."

Another memory of my time with that governess, also reported to me by an aunt, was that I used to infuriate her with my readiness to make a nonsense out of what she was asking me to do. For instance, she would try getting me to concentrate and would say: "Patrick, put your mind behind it." I am told that I would feign ignorance as to what she meant, replying: "Put my mind behind it? Where do I put it? Do I put it here, or do I put it there?" I can readily see why she often found me impossible.

That is a clear example of how infuriating I could be, but it can also be seen as an early expression of my not wanting anyone trying to control my mind, or telling me what to do with my mind. Interestingly, we can also see this as demonstrating a child's concrete thinking.

Children are often slow to understand metaphor and even more slow to understand sarcasm. I vividly recall a time when I was at boarding school, aged nine and being taught by the headmaster, when I was called up to his desk to have my Latin sentences corrected. Trying to complete just one more sentence before going up, I half stood while continuing to work out the verb to complete the sentence. He said: "Don't hurry", so I sat down to finish it properly. He then yelled at me for being insolent. I suspect that I was often insolent but on this occasion I was simply taking him at his word.

3. In those days a boy's bathing costume included a front, with straps, rather like an overall. It was the fashion then for males as well as females, even children, to keep their nipples always covered when in public.

Schools

We lived a very sheltered life, surrounded mostly by other members of the family: aunts, uncles, cousins, and people who were "out of the same drawer" as the family. I also recall being told off, as a teenager, for wearing my shirt collar outside my sweater. My mother said I must never do that as I "might be mistaken for a grammar school boy", a degree of snobbery that appals me when I think of it.

Steps to reach out to people not like us were discouraged. I was stopped from going on cycle rides with a boy I met in our neighbourhood because he was "a village boy." While still at boarding school, with no one from there living anywhere near, I remember school holidays as being very isolated and lonely, especially after my brother had joined the Royal Navy when I was 15. This led to my becoming introverted and defensively self-sufficient. I also found it difficult adjusting to being back home after having been in the communal rush and tumble of school. I recall an occasion, at the beginning of one school holiday, when I was trying to get my mother's attention, as when trying to get a master's attention in class, and saying to her: "Sir, Sir, please Sir," not realizing what I was saying. My sister has also reminded me of an occasion when I had expostulated at my mother with the words "My dear man", an expression of emphatic disagreement often used by boys at Winchester.

I have already written about how my prep school headmaster had the imaginative insight to see beyond my difficult behaviour, making me a school prefect. For the remaining time at that school I became a model of virtue, but this did not mean I had become a radically different person. Instead I had discovered how to present a compliant surface, which worked with people in authority because that was encouraged and praised. This surface way of being, even if hiding much of what I really felt, seemed to be what was most required in order to be accepted.

At my next school, Winchester College, I had no reason to play the prefect as I was years away from that possibility. So the awkward and problematic child which I naturally was surfaced again. This was largely how I came to be known until the seductive pull of authority again began to be felt, as I came to be in line for promotion to house prefect and later school prefect.

I took my "O" levels during the first year of that changed form of examination. In those days no grades were given; they only gave a "pass" or a "fail." For some reason, I was so little worried by exams that I didn't even notice that I hadn't received the results-letter, which the housemaster had promised to send to each of us during the holiday. Nor did I remember to ask him about this when I returned for the next term. The exams had slipped entirely from my mind until I found other boys comparing their results. I seemed to have had very little sense of competition with others, at least in relation to the exams, with one significant exception.

In one maths class I found the work very easy and got 100 per cent for my first week's "out of school work" (the boarding school equivalent of homework). Another boy, who has remained a lasting friend from those days, also got 100 per cent. So for every week of that term I competed with him, afraid to get anything less than full marks, which during that term I never did. I was placed top of the class for the term's work, but when I took the end of term exams I came bottom. I had become so reliant upon checking the textbooks, finding similar examples so that I could check the methods to be used, I had failed to internalize what I was meant to be learning. So the polished surface of success, with my perfect results throughout the term, had been disguising a hidden failure to learn. All my homework of that term had been based on copying the textbook methods rather than finding solutions from within myself. My failure in that exam was a most salutary experience.

Those exam results had been a much more true assessment of my ability. Regrettably, however, the school rationalized these away as some aberrant performance on my part and I was prematurely promoted to a scholarship class. There I totally failed to come up to the teacher's expectations and had to be moved down to a lower class where I still needed to learn what I had been failing to learn before.

Attachments

In my final year at school my parents were in Germany, my father being stationed there as part of the British military forces posted there after the war. During my final Easter holidays I had a chance to take part in a Royal School of Church Music course, when senior choristers from cathedral choirs throughout Britain would join together, under the auspices of the RSCM, to sing for two weeks in a selected cathedral. It was to be in Winchester Cathedral that year and I was fortunate enough to be allowed to join the RSCM choir for their fortnight of training and cathedral singing. This meant that I remained in Winchester for the beginning of my holidays, staying with the master of music and his wife, who had become substitute parents during my last years at the school while my parents were abroad.

For the remaining two weeks of that holiday I was left to fend for myself amongst my extended family, my parents having decided that "it wasn't worth paying" for me to travel to join them for only two weeks. So, after wandering between various aunts and uncles, I ended up with my father's elderly mother. Although I was fond of her I also found her exhausting to be with. I therefore decided to go back to my school house three days early. I excused myself from my grandmother, claiming that the holiday had ended, and made my way back to Winchester. There the house matron agreed to make up a bed for me until the term started. I was clearly showing a major attachment to my school.

Like my preparatory school, Winchester had become the most stable part of my life. My parents had lived in 17 different homes in about the same number of years. I can remember how frequently I would wake up in my bed finding that it took me quite some time before I could make out where I was. But at each of these schools the place always stayed the same, in contrast to my homes that kept on changing.

My attachment to the school itself became very evident when the time came for me to leave after my last term. In my final hours there I could see just how attached I had become to the bricks and mortar of the place. When everyone else had packed up and left, with barely a second thought about not seeing them again, I spent a long time walking round, weeping my "goodbye" to the buildings, the chapel, the music school where I had spent so many hours, and all the places that had been significant to me. I was showing an attachment to places rather than to people. I had too often experienced people as unreliable. They had kept on leaving, and we had kept on leaving people as we moved from one home to another. The school buildings, however, remained the same.

A Flirtation With Certainty

During my last year I came under the influence of a group of evangelical Christians who drew me into a different kind of conforming. I think this may have appealed to me because it seemed like a kind of non-conforming, not going along with religion as taught at home or at school.

With a large number of other boys, I was lured to a "holiday camp" where a group of enthusiastic evangelicals were able to find an opportunity for playing upon impressionable young minds. We were offered "sure and certain salvation", and no stone was left unturned to convert the boys to an evangelical view of how to be a Christian. I remember (with great unease) the last few days when, during evening prayers, we were asked to "pray for the two boys who have still not received Jesus into their hearts."[4] I knew that I was clearly one of those.

After discovering I was in a minority of two, not having yet been through the process of being converted, I hesitantly accepted initiation from the person allocated to be my guide. He then took me through the steps of admitting my "sinfulness" and accepting the blessings of salvation being offered. Although I had to admit (to myself) that I didn't feel any different after this than before, there was definitely something that got into me then that I was not able to outgrow until quite a few years later.

With embarrassment, I remember going home from that camp and challenging my parents to see that they had apparently not yet become true

4. I can respect some people who believe in this kind of Christianity, but I still have a problem about the pressure that is put on others to accept the same way of seeing things.

Christians. They were quietly devoted members of their local church, accepting the rituals of matins and communion without question. And there was I arrogantly demanding that they face what I had been told to regard as "the error of their ways", in order to have them join me in the same evangelical state of mind I had been persuaded into. But for me, an adolescent who was feeling pretty much at sea and without any real sense of purpose, this new thinking seemed to provide what was lacking. It was appealingly definite. For a while I seemed to have found a sense of direction, even a mission in life.

From this grew the idea that I might have a vocation to become a priest, an idea that stayed with me — on and off — for several years. However, as could be imagined, this was not greeted with much enthusiasm in my family. "What career prospects are there in that?" asked a concerned uncle, who then half answered his own question: "I suppose you could go on to become a bishop." But I don't imagine it would have worked very well if I had approached an ordination panel claiming that I felt called to become a bishop! I never got beyond the idea of taking the first steps of that journey.

National Service

After Winchester I went almost straight into national service, which was then still obligatory.

Rather inevitably, I applied to go into the navy, having been encouraged to do so by my father. To be more precise, those of us who chose the navy were required first to join the Royal Naval Voluntary Reserve (RNVR). I had to go through a period of intake training in what was known as Victoria Barracks, in Portsmouth, an establishment which I later heard was condemned as "unsuitable for human habitation." My task for six weeks was to clean the toilets. I did this with great vigour, singing in my head the hymn by George Herbert with the lines:

Teach me, my God and King,
In all things thee to see,
And what I do in any thing
To do it as for thee.

A servant with this clause
Makes drudgery divine:
Who sweeps a room as for Thy sake
Makes that and the action fine.

I eventually made the toilets so pristine that I was tempted to bar the way to anyone who tried to use them.

After this my training was to prepare me for becoming a supply officer if I managed to make the grade. This took place at a naval shore establishment in Yorkshire called HMS Ceres. This involved doing everything at the double, when not marching on the parade ground, and generally having to demonstrate that I had what it takes to become an officer. We were meant to demonstrate what were known as "OLQ's" (officer-like qualities) or what national servicemen called "oily q's", suggesting that we would be judged on how well we were fitting into everything expected of us.

Of course, this dovetailed all too well with that side of me which had become ready (yet again) to push aside my true feelings about life in order to win acceptance from those in authority. In due course, I was commissioned and sent off to be a midshipman in HMS Glasgow, the flagship of the Mediterranean fleet, under the command of Admiral of the Fleet Lord Louis Mountbatten.

Meeting Real People

In my next ship, HMS Aisne, I had an opportunity to explore Rome for three days as part of a scheme initiated by Mountbatten. He wanted sailors to have a chance to explore the sights and cities around them while they were serving in the Mediterranean. In Rome I met up with six sailors from my ship and we spent three days seeing the city together, during which I time I got to know them more closely than I had yet been able to know any people like sailors. This opportunity was only possible because we were all in plain clothes.

I was later required to write up an account of those three days. In my summary of that experience I said that, as well as the obvious benefits of having had the opportunity to see around Rome, one of the most significant gains for me had been the chance this had

provided me for getting to know the sailors. Through being with them in this full-time way I had come to realize that, when not separated by our different uniforms, we could be joined by having much in common. Out of uniform we were all ordinary men.

I was reprimanded for this report, being told I had clearly misunderstood the reason why I had been given permission to go to Rome on this excursion. I should either have seen the city on my own, away from the sailors, or I should have taken charge of them and, as it were, marched them round Rome — with them following my orders. I was told that I could have had a valuable experience of leading the men. Instead, I had "shown a disrespect for the uniform" and I might even have to be disciplined for this.

My report was duly submitted to the fleet officer responsible for overseeing such excursions, who then forwarded it to Mountbatten. When it was returned to me I found that my summarizing paragraph had been marked with approval in the margin. It had been selected by Mountbatten himself to be quoted in the fleet report as an example of what could be achieved by those who took advantage of the scheme he had initiated.

This experience became a kind of beacon for later on. I had met real people, seemingly for the first time in my life, meeting them without the protection of uniform or status. I had begun to meet life beyond the cloistered world of my family or boarding school, and most recently in the wardroom on board ship. It was partly because of those memorable three days that I would continue to seek chances to be with real people, for that is how I came to think of those who, unlike me, seemed to have escaped the pressures to conform to the expectations of others.

University

I had applied to Trinity College, Cambridge, while I was still at Winchester. It seems strange, looking back, to realize that I had been accepted simply on the basis of an interview. It was taken for granted that I would pass my 'A' levels, no grades being given at that time. I had chosen physics, which was a natural choice as I had won a school prize in that subject.

My father later found out that I could have all my university fees paid for by the Royal Navy if I joined to become an "electrical officer." I would also be paid a salary throughout my time at Cambridge. It seemed as if I had laid myself open to the danger of being drawn into the "family business" after all, in spite of myself. I could not bear the thought of this, so I wrote to Trinity withdrawing my choice of physics and suggesting economics. I have no idea why I chose that, as I soon discovered that I would probably never understand any of it.

Nevertheless, I left it on record that I was going to read economics until I arrived for my first week in Cambridge. There I met my tutor who said that I could change again if I insisted, but to what? I admitted I didn't know so he went through the list of possibilities. At the end he was puzzled as I had given him reasons why I could not imagine studying any of the subjects from the list, and there were no others. He therefore offered me a suggestion. "The weakest excuse you have given me was with regard to Anthropology. You said you didn't know what that is. It might be useful if you attend lectures at the Faculty for Anthropology for two weeks and come back to see me." I immediately made further enquires into the meaning of Anthropology, and discovered it had been defined as "a study of Man — embracing women." That sounded promising!

After the recommended fortnight I was completely sold on the idea of Anthropology and, in many ways, I regret not staying with it for the full three years. During that first year's study I came to learn about the essential discipline of maintaining an open mind, especially when trying to understand how others live their lives and how societies different from our own are structured and maintained. I had never had to engage with such an idea. It inspired me to learn more of this open-minded approach and what we could then learn about "the otherness of others." This was to become a central issue in my approach to psychoanalysis.

During that first year I had settled into a decision to read Part II Theology for the remaining two years. This was to test out my earlier notion that I might become a priest, but it was also in order to have a

chance to be taught by Harry Williams,[5] who was then Dean of Chapel in my college. He was one of the most inspiring minds around in Cambridge at the time.

One of the things I learned from Harry was his notion of breakdown as breakthrough, he having had his own quite serious breakdown, for which he had received some years of psychotherapy. He saw this as having provided him with an opportunity to break free of old ideas, old ways of being, old dogma and ideas of certainty, to find beyond these a chance to discover life afresh and a new meaning in life. This fired my imagination, but I never realized how it might eventually come to be my own experience.

While at Cambridge I came to realize how our assumptions about people can profoundly affect how we relate to them. I had been attending sermons preached by Mervyn Stockwood (later to become Bishop of Southwark) in the university church of St Mary's, which he used to fill to "standing room only" when he was preaching. I was very impressed by his sermons but I hated the way he delivered them.

Whenever Mervyn Stockwood was addressing the congregation he used to speak out of the side of his mouth and I quickly developed an intense dislike of him because of this, as I was assuming this to be an affectation. Why, I thought, did he have to spoil such excellent sermons with this most unattractive manner of delivery? However, I later learned that he had suffered a serious stroke. Since then he had only been able to continue preaching by taking no notice of what he might look like. He could only make himself heard if he worked the muscles on one side of his face to compensate for the other side where he had lost all movement. I was shocked. I had totally misjudged this man through seeing him only in terms of my assumptions about him. It was a most useful lesson. It was the first time I had come to realize that we all relate to others in terms of the image we have of them in our own minds. Only later did I learn that this is what psychoanalysts mean by "object relationships."

5. The Reverend H. A. Williams.

What to do?

I left Cambridge with my degree but with no plans. I only knew that I probably would not become a priest.

Having no idea what to do with my life I was looking for some way to spend a year out. I was then fortunate to hear of a training programme in Sheffield which had been set up specifically for ordinands, those in the process of training to become priests, allowing them a chance to work and study in the context of an industrial community before taking their final steps towards being ordained. There I joined several others, all of whom were halfway through their theological college training before offering themselves for ordination. Although I was not so clear about my own future I had a link with them through my degree in theology.

During my year in Sheffield I spent the first six months working in a factory that made steel and steel magnets. I was employed as a bricklayer's mate which involved me in hod-carrying, when that was required, and just about every other rough task that was needed when not actually working with the bricklayer. I had to muck in with what was known as "the building gang" in this factory. They were building onto the premises, so there was plenty to do: digging foundations, digging a tunnel for a new weighbridge, shovelling wet concrete into a chain of barrows (at the rate of five tons per hour for each man with a shovel, and I was one of them), and learning to throw bricks up 30 feet (without them spinning) where they would be caught and stacked on the scaffolding for the bricklayer to use.

When underground, digging the weighbridge-tunnel, I was working closely with an Irishman who liked to call me Pat (which I tolerated even though I usually don't like to be called that). He once looked up from our tunnelling, both of us on our stomachs, black in the face from dirt, and said to me: "Your father should see you now, Pat!" It would certainly have been a shock for him to see his son alongside this hard-drinking Irishman, down a hole and shoveling earth back along the tunnel using his hands like a mole.

The second six months in Sheffield was spent "in community" with five ordinands

and the charismatic Canon Roland Walls as our spiritual leader and pastor. During this time I became somewhat clearer that I would not become a priest. Instead, I applied for an interview with ICI for training in personnel management, mis-spelling "personnel" in my letter of application. I was not accepted. Later I applied to the Home Office for training as a probation officer. I then had to acquire a diploma in social studies, for which I studied at Barnet House, Oxford.

Breakdown

While doing the Barnet House course my life began to fall apart and I became almost unable to sleep. (When first writing this, I had not intended to give details here but I have since been persuaded that some explanation might help to limit speculation.) Two things had thrown me. The person around whom I had been building my life, and whom I had set my heart on marrying, had contracted an illness from which she would die. Some time later she had decided to marry a friend of mine. Not only had I lost her, I felt I had also lost the only way I could imagine for coping with her dying: being with her to the end.

That was why I could not sleep. After a week of this I sought help from my GP who referred me to the local mental hospital where, he said, they could offer me assisted sleep. I had ten days in which to find my feet again before going to my first fieldwork placement in a probation office. The medical director of the hospital offered me a week on a private ward where I could be given all the sleep I needed and this should be sufficient to set me back on my feet. It seemed an ideal solution.

I arrived as arranged on the Friday evening to find that no one was expecting me. The medical director who had told me to arrive then was away for the weekend. I was at my last gasp, still having had next to no sleep. I felt hugely let down and was in no state to cope with this new crisis when I was already feeling so close to collapse. For want of any other option I agreed to be admitted, for the time being, in the acute admissions ward of the hospital. I was given only ten minutes with the admitting doctor.

Subsequent reflection

I'm sure I would have had more time with the psychiatrist who admitted me had it not been that I just could not go through my story again in the context of feeling so utterly let down. I had told as much as I could to the medical director two days before.

This further let-down, on top of what I had been going through already, was just one let-down too many. What was happening in this hospital was itself a further trauma. Later, in my clinical work, this experience was to become a powerful stimulus for being alert to the risk of repeating a patient's trauma.

I have since come to regard trauma as "that which cannot be managed alone". I was unbearably alone in that hospital, with no one at all to turn to. With our patients we can at least hope to be with them as they begin to face and to work through the experience of early trauma as this comes to be re-experienced in the course of their analytic work with us. But they do need to be sufficiently held, by an effective (and affective) relationship with us, for that to be possible. Also, they need to have begun to trust our analytic holding of them if they are going to be able to work through those experiences of trauma in the course of their work with us, as I have described with my burned patient (Mrs B).[6]

I was very angry with the medical director for having forgotten to make the arrangements he had offered. In fact, I felt too angry to speak to anyone until I had a chance to speak to him. However, despite my remaining totally silent on that Friday evening and all of Saturday, by the Sunday I had sufficiently recovered from the initial shock to be interested in the other patients on my ward, some of whom illustrated the diagnoses I had been learning about on my course. At least one patient was psychotic, one a manic-depressive, one an alcoholic who

6. *On Learning from the Patient* (1985, chapter 7; 1991, chapter 7) and further discussed in *Learning from Our Mistakes* (2002, chapter 7). Although I shall not be describing my work with Mrs B in this book, I refer to it because that is the clinical work for which I have become most widely known.

was having repeated epileptic fits while being dried out, and a severely depressed person having narcosis treatment. This last person was being kept asleep for all but a few hours out of every 24, to give him a prolonged break from experiencing his most recent trauma.

On the Monday morning I met the medical director doing his ward round and asked him about the room he had promised. He simply announced I was not going to be allowed the private ward. He said: "You are far too ill for that". I had no idea what was the basis for this decision until a nurse later told me it was because I had remained not-speaking for the whole of Saturday. Even so, while not understanding why I was being kept in the acute admissions ward, I settled down to have my week's rest. The strange life on the ward was extraordinary but also enlightening, though often noisy and sometimes quite shocking.

At the end of my first week, when I was making preparations to leave in order to be available for my fieldwork placement on the Monday, I knew I would need some time to clear my system of medication so that I could drive safely. But when I said this to the nursing staff I was told that I was not going to be allowed to leave. Only then did I learn that my Home Office training had been suspended; this without a single word being said to me about it, let alone any discussion with me about whether I thought this might be a good thing or not.

What nobody at the hospital had taken trouble to find out about, or allowed me time to speak about, was the fact that I was in a state of shock from the cumulative trauma in my personal life. I needed time to process these experiences. I also needed a chance to be talking these through with somebody who could help me to come to terms with them, and maybe also help me to understand why I had been so thrown by these experiences.

Strangely, even though the medical director knew (from the initial consultation) something of what I had been through, his treatment of me never reflected any knowledge of that. Instead I was treated as if I were suffering from endogenous depression, apparently requiring nothing more than medication. For much of the time I was so drugged I could barely walk, kept throughout as the only "bed patient" on the ward.

On top of this I found that I was allergic to the medication, with the result that I swelled up all over with a body-rash that began to drive me crazy. I even had to tie my hands to the top of the bed to prevent me scratching myself in my sleep, because I had sometimes woken to find that my nails had made me bleed. I was eventually given some antidote cream for this, which was fine until it ran out during a weekend. I was then told that no more could be prescribed until the Monday and no notice was taken of my pleas for a duty doctor to be called to attend to this unbearable allergic reaction.

Foolishly, but in desperation, I turned to a supply of Piriton I had brought into the hospital with me. This had been previously prescribed for a hay fever allergy, so it occurred to me that it just might help to alleviate the rash.

I was already feeling quite suicidal, my life having anyway fallen apart. As well as what had been happening to me before, which had caused me to have such serious insomnia, now my Home Office training had been suspended. In addition, I was being treated as if I had no rights and no mind of my own. On top of that, I had this uncontrollable itching which was making me feel quite demented.

During that night I continued to take the Piriton, with increasing doses, hoping that it might eventually do something to allay the irritation. Suddenly, nothing else seemed to matter. Finally, I felt it would serve the hospital right if I died. So I took the whole bottle which had been almost full.

This was my mistake. From that moment the medical director was able to use my attempt at suicide to justify keeping me in the hospital, whatever the original reasons for keeping me there might have been. I found myself trapped, unaware of my rights. Nobody inside or outside the hospital was fighting for me or troubling to find out what my rights might be. My life seemed to have come to a virtual end.

It was during this prolonged period of despair that I wrote to my former tutor, Harry Williams, knowing that he too had been through a

time of breakdown. I still remember his reply. In his letter he said: "The Good Friday experience can go on for a long time and it can feel as if it will go on for ever. But believe me, Patrick, in time you will come through this to your own Easter Day. And things will not be the same as before." How right he was.

It was only towards the end of my time in hospital that I learned why I had not been allowed to have the private ward which had initially been offered to me. A Spanish nurse took me to one side when there was no one else around so that he could speak to me in private, saying there was something he had to tell me. He said that he knew I should never have been on that ward. He then explained that the medical director was well known for not being able to admit any mistake. He had forgotten that the private ward he had offered me was being decorated, but he could not admit this to me.

The medical director could have apologized. He could have offered me the choice of not coming into the hospital, perhaps with medication to help me sleep, or the option to stay on a more appropriate ward. Instead he had used my angry silence in order to justify treating me as "too ill to be allowed to be in a private ward". Continuing to conceal his mistake, he had informed the Home Office that I was apparently too ill to continue with their training. From that simple failure to admit a mistake everything else had escalated. It is not surprising that, following this, I came to be interested in mistakes; the need to acknowledge them and learn from them.

What the nurse had told me about the medical director was later validated by other observations. For instance, at some stage towards the end of my time as a bed patient the other patients brought me a letter they had written to the matron, which all the patients were being asked to sign. They were asking for the dayroom of this ward to be redecorated so that it could be made lighter. It was decorated in such a dark shade of grey-green that nearly all the light from the windows was absorbed, even when there was clear sun outside, so that it was not possible even to read in that room without artificial light. The other patients had ended this letter saying: "It is hard to see how anybody could be anything but depressed in an environment such as this."

Feeling more cheerful since the nurse had spoken to me, I too signed this letter. But as there was no room at the bottom of the page I put my name in the only space left, which was at the top of the list of signatures, adding: "Yours all very depressed, Patrick Casement", followed by the other names.

The result was startling. The medical director came storming into the ward, initially to me as he thought I had started all this (my name being the first on the list), saying: "I will not tolerate my choice of decor being questioned." He then turned to the whole ward and said: "I am ordering every patient on this ward to have compulsory occupational therapy, so that you will not have time on your hands to be writing critical notes like this."

The only experience of occupational therapy on the ward I had personally witnessed was seeing the master of an Oxford college (then also a patient on this ward) sitting in a corner, with his thick fingers like two bunches of bananas, struggling to make a basket out of reeds. This task had been prescribed as apparently suitable OT for him! At that time we did not hear anything of the much more imaginative work that occupational therapists do elsewhere.

The patients' response to this new order was to state unanimously that under no circumstances were they going to be sent to do basket-weaving. I don't know how the patients actually dealt with this as I was still a bed-patient, but I heard that they had all "gone on strike" until the medical director took back this order.

The last that I heard about this medical director was some time after I had been discharged. I returned with a friend to show where I had been and, on meeting one of the staff I had got to know, I learned that the medical director had gone off sick with some kind of breakdown shortly after I had left, from which he had not returned. I was not surprised at this news.

Another bizarre aspect of my time in this hospital was that I came to be used in somebody's research project. They seemed to be wanting to show that mood might be changed if the body-type is changed. I had been reading about body-types on my course, so I knew I would initially have been classified as

an ectomorph, those regarded as "the lean and hungry type." The hospital therefore insisted on making me eat extra food throughout my time there, as well as giving me medication that kept me as a bed patient for over three months. When I eventually left the hospital I was seriously overweight, with a quite different body-type called endomorph, the kind that is thought of as being "fat and jolly". But this body-change had done nothing whatsoever to stop me being depressed and brooding about the value of life. I had certainly not become jolly.

After I was discharged I was offered psychotherapy — my first experience of this. I had already learned about the silent technique, which used to be rationalized around an idea that the first things said by a patient would be the most significant. As by a robot, I was treated to that kind of silence. (I later discovered this therapist was a psychoanalyst; that kind of psychoanalyst.) I refused to play the game. My situation felt too dire to be playing games.

I was still extremely angry with the hospital, feeling they had almost destroyed my life. This therapist was part of the hospital staff, so my anger was being expressed at her through my silence. Finally, after three completely silent sessions, during which neither of us had said a single word, I told her that I regarded this as a complete waste of time. By "this" I meant the stalemate between her and me, which was getting us nowhere. She just took me at my word, agreed with me and discharged me. She did nothing to enquire further about whether I still wished to receive some help, or even why I thought it a waste of time. She never even asked me why I had come into the hospital or why I had agreed to see her.

I left that hospital feeling that a successful suicide would be what they all deserved. What had they done except to make my life almost unbearable? But I also began to think that there must be better ways of treating patients.

In the 17 weeks I had been an in-patient I had been allowed a total of 15 minutes alone with a doctor: ten minutes when I arrived and five at my discharge. For the rest of the time I was spoken to by the medical director only when he came on his ward rounds, always in the company of his junior doctors. The notion that somebody desperate enough to attempt suicide could be discharged without any further discussion or enquiry seemed extraordinary. I became determined to find something better than that.

After this I was required to see the late Dr Stewart Prince, then a Home Office consultant and Jungian analyst, to see if I was fit enough to resume my training. At the end of the consultation he told me that he preferred to believe my account of what had happened rather than the account he had received from the hospital. He saw no reason why I should not resume my Home Office training.

The Otherness Of The Other

While still studying for the Home Office qualification, I had a chance to learn something important about the "otherness" of the other. I had come to know a family strikingly different from my own and I had come to envy the children of this family for the freedom they had, from an early age, to make their own life-decisions without their parents interfering or trying to control. This seemed to be how I wished my own family had been. But to my surprise one of the daughters had a breakdown and was admitted to a mental hospital.

As I had some experience of life in a mental hospital I was encouraged to visit her. There I was invited to meet the art therapist who had been treating this girl. "Would I like to see some of her paintings?" I then saw that each painting had a muddled mess in the middle, from which — on every single painting — there were two parallel lines reaching out to the very edge. The art therapist suggested that the patient had been prematurely separated from her mother, made to be self-reliant before she was emotionally ready, as a result of which it seemed she was now reaching out to refind the lost umbilical cord.

Whether that was so or not I don't know. But the very idea was a revelation to me. Until then I had naively imagined that we all had to fight our way out of the clinging embrace of an umbilical cord if we were ever to achieve separation from our mothers. But here, it seemed, was somebody who had a completely opposite problem. Far from having to fight for her separateness she

seemed to be trying to re-join with her mother, to re-negotiate her separation from her.

From this, I began to see the importance of realizing we cannot simply "put ourselves in the shoes" of another person, for we are then likely to get some things very wrong. We may read others, in whatever situation, as it might have been for us had we been in their shoes. But each person has his or her own history, his or her own sensitivities, most of which will be quite different from how we ourselves have been or might have been. It was from this that I began to develop the notion of trial identification with the patient, whereby we can try to imagine how that person might experience whatever; not how we might. These are two very different experiences and represent a key issue in our attempts at understanding our patients. We are always confronted with the otherness of the other, though we may quite often fail to realize this as fully as we need to.

I also had the good fortune to marry someone from a family very different from my own. The members of her family were all real people, none of them having been caught in keeping up appearances, which had been such a feature in my own background. This chance to be with someone who was so truly herself helped me to continue my journey towards finding whatever was more real in myself. For so long this had been largely lost to me. And yet, all along, I had been trying to kick against the traces, trying to emerge, trying to find a way to be authentic, even amongst those who often seemed to be more concerned with fitting in and being accepted by others. No wonder I had been considered difficult.

So, by this strange and circuitous route, I became a probation officer. After three years of working in probation I changed to work as a family caseworker for the London Family Welfare Association (known as the FWA), in an office that covered the East End of London.

During my time there I trained to become a psychotherapist. In subsequent chapters I shall be describing some of that social work, from which I began to find further pointers to my subsequent understanding of psychoanalysis.

Psychoanalytic Training

I have always felt it was a bonus not to have gone into therapy, or later into analysis, for any training purpose. I went into therapy because I needed it. My life was still in a confused and fragile state. Later, I went into analysis to deal with feeling a fraud as a therapist.

When I eventually applied to the London Institute of Psycho-Analysis for training, I was interviewed by Dr Clifford York and by Isobel Menzies (later Isobel Menzies Lyth). I made a point of telling each of them that my interest in psychoanalysis had originally grown out of my experience in the mental hospital. I needed them to know what I regarded as the worst about me. If I was accepted for the training, I wanted them to know that nothing had been concealed. I wanted to be accepted as me, and not for any attempt at being what they might have been looking for.

Later, when I had qualified as a psychoanalyst, I wrote to Dr Stewart Prince to thank him for his help in extricating me from the tangle I had got into with the mental hospital, and to say I had since trained as a psychotherapist and then as a psychoanalyst. He wrote back saying that he was delighted and he wished to celebrate all of that by asking me out to dinner. He then raised a glass to my past, my present and my future. Some years later, when he died of a heart attack, I wrote to his widow who told me that, at the time of his death, he had my first book in his car. He had been reading this with the intention of writing a review of it for a Jungian journal.

Some Reflections Upon The Journey So Far

The progression of my life had certainly not been in the kind of straight line that my family might have preferred. It could look as if I had taken many detours, getting caught in a cul de sac or two on the way. But, looking back, I feel that every step of the journey came to play a significant part in leading me to where eventually I began to arrive.

I had experienced many pressures to become like other people. As well as being often rebellious I had also tried conforming. But I had never completely lost touch with

the rebel in myself, which had helped me not to get totally lost in compliance.

In the course of this journey I had begun to find my own voice. I had also found that I was strongly attracted to an open-minded approach to life, sensing and coming to value the otherness of the other, rather than still being caught into the constricting world of "received truth" and dogma.

In parallel with this finding of my voice I also became able to speak in public. Up to that time I had been paralysed by stage-fright so that I had been unable to speak in front of any large group. I had not even been able to ask a question at a lecture during my five years at university. I think this constriction was largely because until I had begun to find a mind of my own I could not yet speak with my own voice.

My way on, beyond training as a psychoanalyst, would lead me into exploring many of these matters further, especially in my clinical work. Whatever I had been discovering throughout that journey I have tried to share with others, in my teaching and my writing. But along the way I had to let go of much of my old thinking. This is surely what Harry Williams had meant when he spoke of an Easter Day that can lie beyond what (for me) I came to see as a necessary Good Friday. I now believe we cannot discover what lies beyond the brittle security of certainty until we can recognize how this is failing us. Perhaps only then can we become free to explore what lies beyond the known and the familiar.

Postscript

Throughout the time that I was being treated as a bed patient (over three months) I was so deeply medicated that I was barely able to register or remember any of the visits from my family, which fed further into my sense of isolation and abandonment at that time. Unfortunately, as my parents had grown up to believe that it was best not to speak of difficult things, my stay in that hospital was subsequently treated (as my mother"s miscarriage had been) as if it had never happened, so I did not even know until many years afterwards that they had actually been regularly visiting me. It was later, in psychotherapy and psychoanalysis, that I began to find the freedom I needed to be fully open with someone and to face whatever needed to be faced.

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Damian Gardner

Beneficial Episodes Of Shame In Integrative Psychotherapy Group Supervision: Supervisee And Supervisor Perspectives

Abstract

This paper describes a small-scale qualitative research project carried out as part of the author's Integrative Psychotherapy Training. The research involved an analysis of interviews with three supervisors and their supervisees that focused upon a "beneficial" experience of shame in a group supervision session. The paper describes the background context to the research before briefly describing the methodology and the participants in the study. There follows a summary of the findings and a discussion of some of the key themes including: the factors that influence shame in group supervision; the issue of emotional containment in supervision; the links between projective identification and affect theory; and how supervisors work beneficially with shame in supervision. The paper concludes with a personal reflection of how the research has impacted on the author's practice.

Opening Comments And Overview

In the following paper I describe a qualitative research project that was conducted in 1999 for the dissertation component of my Integrative Psychotherapy Training M.A. In addition to describing the project, the findings and the original conclusions, I have also included a more personal note about the background to the project and some reflections on how this work has impacted on my professional practice. The narrative account provided in the original research report is thus contextualised into the wider story of my development and practice both as an Integrative Therapist and Clinical Psychologist and also as a Supervisor and Supervisee. The original dissertation report (Gardner, 1999) is available on request by email and contains much more detail on the background literature, the methodology and the research findings (including participants' quotes).

Background To The Research

When I began my training as an Integrative Psychotherapist at the Sherwood Psychotherapy Training Institute in 1998 I was already qualified and practising as a Clinical Psychologist and had several years of NHS experience. The course at the Sherwood offered a developmental-relational model of therapy that was compatible with the other therapeutic models I was familiar with as well as providing an overall framework for theoretical integration (Shmukler, Evans & Hutchby, 1998).

By the time I began the course I had a range of supervisee experience that had nearly always been good enough, had often been outstanding but had, at times been difficult and unsatisfactory. Particularly painful had been two episodes of what I could describe

as "active shaming" by supervisors though the negative impact of these waned through the beneficial and reparative supervision I received subsequently. I had also started to supervise both Clinical Psychologists in Training and the therapy of colleagues from other professions.

On the Integrative Psychotherapy training course I had been powerfully impacted by a module entitled "Shame: The Master Emotion". The module used both didactic and experiential approaches to explore an integrative understanding of shame which combined Affect Theory (Tomkins, 1987; Nathanson, 1987); Psychodynamic theory and especially Self Psychology (Kohut, 1971); as well as approaches from the experiential tradition (Evans, 1994). The training module left me acutely aware of how shame "policed the borders" of unacceptable territories of the self, colonising and placing out of bounds areas of memory, need expression and the free and healthy expression of emotion in particular. I became excited by the observation of usually unnamed shame processes occurring in all sorts of diverse areas of life, be it clinical work, literature (especially Jane Austen's work), or global politics. Best of all, knowledge of the psychology of shame and how to work with this emotion therapeutically offered a process for liberation from shame (Kaufman, 1989), a "key" which could be used in the context of a therapeutic relationship to "unlock what was trapped or hidden inside".

One of the domains where I saw shame as a powerful determinant of behaviour was in the context of supervision. I myself had experienced unhelpful shaming in supervision and I also knew of supervisees on training courses who had systematically mis-portrayed their clinical work because of the real or imaginary shaming responses they anticipated from their supervisors. And, as a new supervisor myself, I was freshly aware of the potential narcissistic drives to preserve one's esteem as a senior of higher "status" (Gilbert, 1997) in front of the bright, talented and perceptive trainees who I was starting to supervise early in my career.

Initially, I was interested in finding out more about unhelpful shaming experiences in supervision until I was jolted out of this plan by the realization that negative and deterministic narratives of abuse were becoming pervasive in out culture. For example, crime writing had become saturated with accounts of serial killers abused in childhood. In the supervision literature there were some excellent papers mostly theoretical and/or including anecdotes from practice about shame and supervision (Alonso & Rutan, 1988; Talbot, 1995; Brightman, 1984/5; Mollon, 1989). It was notable that there was, however, very little systematic research on the topic of shame and supervision and no readily identifiable studies on the potentially beneficial experiences of acknowledging and exploring shame in supervision. With the support of my research supervisors, the task then became one of identifying an appropriate paradigm for exploring this topic.

An Approach To Studying Shame In Supervision

I vacillated over whether to focus the study on supervisors or supervisees until it became clear that the interpersonal nature of shame was such that it would be most useful to include both groups in the study. Interpretative phenomenology offered an approach to gathering qualitative information that could be respectful of the participants and enable a deep and supportive exploration of their experiences. As participants I recruited three pairs of very experienced supervisors along with three supervisees who could identify an occasion where an episode of shame had been experienced by the supervisee in a supervision group but where this had been a "constructive" experience. Supervisee/supervisor pairs were interviewed separately, the interviews being recorded and transcribed. In each of the three cases the episode of shame had occurred in the context of an Integrative Psychotherapy Supervision Group. Transcripts were coded into themes and sub-themes using a procedure adapted from Giorgi (1979) (quoted in Moustakis, 1994, 13–14). For details on the recruitment process, ethical safeguards and approach to analysis see Gardner 1999.

For reasons of confidentiality, demographic background details were kept to a minimum in the study. However, the following brief comments give some context. The first pair interviewed comprised a female supervisor and a female supervisee who had several years'

post-qualification experience. The supervision episode concerned a very challenging client whose material interacted with the supervisee's personal history. The second pair comprised a male supervisor and male supervisee, also with several years' experience as a qualified practitioner. In their supervision episode, material from two clients interacted closely with personal history for the supervisee and the session was intensified by a significant suicidal threat by one of the clients. Finally, the third pair comprised a male supervisor and a female supervisee who was still in training and relatively inexperienced. The shame felt by supervisee three was less directly linked to a specific client issue and more closely associated with a sudden but intense sense of incompetence in her work.

What Emerged From The Interview Transcripts

Several core findings emerged from the study. First and foremost, it provided a vivid account of the three supervisees' episodes of shame in supervision. The experience of doing so was intensely distressing and involved feeling unacceptable, incompetent, and small, vulnerable and unsafe. Not least, this experience was acutely felt as a public experience in the context of group supervision with group safety/unsafety a clear theme for all three supervisees. Despite this, these same supervisees identified no negative effects of the session and cited positive impacts on themselves, their clients and the supervisory relationship.

The supervisors and supervisees identified being given space to acknowledge and feel what was happening and a respectful, non-shaming therapy like enquiry as a central feature in the supervisory process. Safety and trust in the supervisor was critical. The supervisors were aware of the role of personal issues for the supervisee but differentiated their work from therapy and took care to explore the client/supervision issues. As the supervision progressed, supervisors and supervisees became aware of a recovery of shame and return of thinking. One supervisor and two of the supervisees placed great emphasis on eliciting feedback from the rest of the supervision group.

Two main differences emerged between the supervisees and the supervisors. First, supervisees made more frequent and more salient references to "horizontal shaming issues" than the supervisors (i.e. a sense of shame in relation to their peers in the group rather than the "vertical shame" felt to the higher status supervisor). Second, supervisee accounts exhibited more references to confusion of memory and their internal experience predominated more over objective external description.

The supervisors' approach was informed primarily by knowledge of shame theory and personal work on their own shame issues. They had readily accessible memories of their own supervision including a range of both positive and negative experiences. Like the supervisees, the supervisors rated the outcome of the supervision as positive for clients, supervisees and the supervisee relationship.

Factors That Influence Shame In Group Supervision

A simplified schematic outline of the factors influencing shame in supervision suggested by the findings of the study is given in Figure 1. Shame experiences are seen as deriving from an interaction of pre-session factors and in-session factors. The occurrence or not of a shame experience and its phenomenology is seen as deriving from a complex interplay of these basic components. For example, Supervisee 1 was impacted primarily by client factors, proactive countertransference, contextual factors and supervisory relationship factors. Supervisee 3 was clearly impacted by pro-active countertransference, the training context and horizontal shame factors in the group.

These factors need to be understood in the context of a background understanding of shame theory. For example, as noted in the introduction, defences against shame are very strong and a significant degree of safety and trust in the supervision group appears to be a prerequisite to supervisees being open to experience and explore shame in a beneficial manner. It is also worth noting that, since supervision is defined as an ongoing relationship, there will be quite

complex interactions between the in-session and pre-session factors. Primary among such interactions might be a range of factors that have not been a focus of the current study such as self-transferences, initial contracting processes, the strength of the "supervisory alliance" and longer term group dynamics.

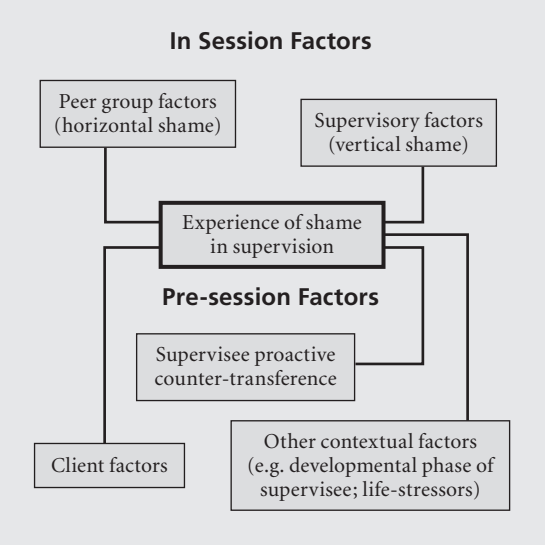

Figure 1: *Factors identified in the study as inflencing shame in Integrative Psychotherapy supervision.*

Containment And The Supervision/ therapy Boundary

An interesting feature of the findings of this project is the illustration of the distinction between supervision and therapy. Although supervisors and supervisees agreed on the importance of a safe, therapy-like process, the supervisors were clear that the task was supervision and not therapy. Thus Supervisors 1 and 2 continued to sensitively explore in detail the clients' material, while Supervisor 3 addressed a common but sensitive personal development issue (acknowledging competency) without being drawn into an exploration of the personal history of the supervisee. At the same time, there were no hidden rules "forbidding" the supervisees intense affective experience, which could have kept the material out of the supervision

Although derived from a study on shame, it is probable that a similar picture would have emerged from any strong affective process such as rage or despair. A primary function of beneficial supervision is thus to provide emotional containment that offers a safe and boundaried reflective relational space. In doing so, understanding and emotional stability is secured by the supervisee, which in turn fosters growth in the client.

Projective Identification And Affect Theory

While recognising shame as just one of several important affects, it is also useful to consider its unique aspects, as illustrated in the findings of this study, especially in relation to projective identification. Space limitations preclude a full treatment of this complex topic (Cashdan 1988; Ogden, 1982/1992) so the focus here is limited to the role of affective processes in projective identification.

As apparently experienced by Supervisees 1 and 2, projective identification involves powerful disavowed emotion by the client and its reception by the therapist who is pressured into either over identification or an unhelpful re-enactment of the past. Affect Theory (Tomkins, 1987; Nathanson, 1987) describes shame as a mechanism by which affective and other key need expressions are regulated in the infant which can lead to the disavowal of the original need expression. This is an adaptive process that accommodates the infant to what is interpersonally permissible to important caretakers (such as inhibiting the expression of sadness if it is unattended to by care-givers). It follows, therefore, that whenever a client is involved in projective identification then shame would be involved in the client's original historical repression or denial of emotion. The client's developmental-relational issues are then paralleled by the supervisee who is pressured by the combined intensity of their own pro-active counter-transference and the client's disavowed affect. Supervisee 2 illustrated this with a complex matrix of shame that both echoed a male client's shame about "coming out" as well as being related to anger, helplessness and responsibility associated with the threat of suicide, a very passive-aggressive female client's behaviour and aspects of the supervisees' own personal history.

As a general rule, the integration of Affect Theory and theories about projective-identification suggest that whenever a major

projection is the focus of supervision the supervisee is particularly vulnerable to shame. Alertness to this may further protect the supervisory space from unhelpful acting out through shaming, avoidance or other processes.

How Supervisors Work Beneficially With Shame

It would be neither possible nor desirable to turn the complex phenomena described by the participants of this study into a "how to recipe" for working with shame in supervision. To do so would be to ignore the complexity of the phenomena and the uniqueness of the supervisory relationships experienced. Nevertheless, some general guides emerge from the findings that complement the comments of Talbot (1994) and other authors cited earlier.

First, it is clearly acceptable to name what is happening and to stay with the process. It is possible for the supervisor to do so through disclosing supervisor countertransference or by sensitively acknowledging the supervisee's distress. At this point it might be helpful to make an explicit contract around the shame issue(s). Second, the client material and the supervisee's experience can be explored in an attuned, therapy-like process. This may take time and may need a sophisticated awareness of the different shame factors outlined above. Third, with clarification of the supervisory issue, the supervisor may be aware of a re-emergence of thinking and recovery from shame in the supervisee. Finally, the supervisor can bring in the rest of the group for feedback after the supervisee has begun to emerge from shame. Throughout these stages the supervisor adopts a supportive stance both in terms of "presence" and possible explicit statements of support. To manage this successfully the supervisor apparently benefits from both a firm knowledge of shame theory and comfort with their own shame. There will, naturally, be many other supervision skills and competencies involved as well, depending on the supervision content.

Supervisor- Supervisee Differences

Two noticeable differences can be identified between the supervisor and supervisee accounts. The first is the repeated references to a lack of explicit memory for external events in the supervisee accounts and instead a vivid "felt" memory for the internal experience of the shaming episode. The second is the degree of emphasis placed by supervisees on the group context prior to the episode of shame and, for two of the supervisees, the positive feedback form other members of the group subsequently.

The lack of clear memory could, in theory, partly result from the slightly different interview schedule used for the supervisee accounts. However, it is hard not to believe that the experience of shame and associated disturbance of cognition also played a role. In support of this view, it is significant that supervisors noted a return to thinking in the supervisees as an important sign of recovery from shame. When strong feelings of shame have been felt by a supervisee it may therefore be helpful to have a debrief/resume at the end of the session or at the start of a subsequent session to explicitly establish a shared understanding of what has occurred and any key implications for the clinical work.

The role of group factors and group feedback is clearly a complex topic. From the point of view of supervisors working with a shamed supervisee in a group, it is important to be aware of (and possibly on occasions to actively explore) potential feelings of not-belonging or not feeling safe and valued in the group. Subsequent to an episode of intense shame, it is may be very important for the supervisee to get feedback from members of the group. At the same time, boundaries between group supervision and group therapy need to be maintained with the priority being containment and the support of the supervisee-client relationship.

Limitations Of Study

The limitations of this study primarily derive from the small scale qualitative methodology employed. First, the sample of three supervisory pairs may not be reflective of the breadth of "beneficial" experiences of shame in Integrative Psychotherapy supervision. Second, the methodology employed is reliant to a degree on memory. This is less of a problem for the

more phenomenological descriptions given by the supervisees than for the supervisor accounts of their interventions. For example, the absence of any reference to group feedback from Supervisee 1 and Supervisor 1 cannot be taken as strong evidence that it did not occur — just that it was not spontaneously mentioned in the interview. A feedback and verification process with participants, as used in grounded theory, would have added clarity (Stiles 1993; Strauss & Corbin, 1990).

Reflections Since Completing The Project

Carrying out this project has undoubtedly had a major impact on my professional work. Most obviously it has influenced my work as a supervisor. I always mention the possibility of shame as part of initial contracting for supervision — though instances of very intense shame remain relatively rare. However, this may be somewhat misleading: the developmental relational issues that constitute part of the frame for a growthful supervisory relationship suggest that in some sense supervisors are always working with background shame (or pride). Put simply, this research has further encouraged me to try to really attend to and value the supervisees I work with and to foster an atmosphere of safety — especially in terms of contacting and expressing emotion.

As a supervisee, I am still aware of the process of self-supervision I sometimes need in order to get myself to "take the plunge" and voice what may seem bad, unhelpful or even dangerous about my clinical work. I cannot quite greet that familiar, hot, skin-feeling as a friend but at least it is a much less feared enemy. And, given my current safe and supportive supervisors, it is always worth taking the risks of vulnerability and self-exposure in order to reach a more surprising and useful understanding of myself and the relevant clinical material.

Conducting research does make you familiar with a topic and I sometimes forget that the concepts presented here are new to some people, perhaps more so to my colleagues in Clinical Psychology than Integrative Psychotherapy. It has been heartening, however, that the research has been well received and I have had opportunities to present thoughts about shame, supervision and boundaries in supervisor training workshops organised by the local clinical psychology training course.

Finally, this project has convinced me of the power of small-scale qualitative research. With six participants and no budget, this project has influenced my development and clinical practice more than any random-control trial has ever done — or is ever likely to do. I now hope that with this publication others may also find the research useful in stimulating fresh understandings and possibilities in their supervision, be it as supervisee or supervisor.

Acknowledgements

I would like to thank the participants for their time and their trust and the great supervisors and trainers who have helped me so much over the years. Also, to Rai Turton, Research Tutor at the Sherwood Psychotherapy Training Institute, who demonstrated that it is possible to teach research without it being either dull or anxiety provoking.

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Jocelyne Samuels

Reflections On The Transpersonal Dimension In Integrative Psychotherapy: Art, Imagination And The Creative Process

Abstract

This paper will explore the relationship between the collective unconscious as defined by Jungian and Post-Jungian models of the psyche, and the social, historical, cultural and political contexts of our clinical experience today. I will provide some reflections on the nature of the transpersonal, and consider how these might translate into psychotherapeutic practice, with specific reference to the arts, imagination and the creative process. At the post-modern interface where spiritual idealism meets cultural materialism, I am seeking to encourage a deeper engagement with Jung's concept of the shadow: personal, cultural and archetypal. This paper aims to stimulate the imagination, promote critical discourse and inspire further reading. It intends to highlight the limitations of standardised psychotherapeutic technique and, through a re-evaluation of our relationship to the psyche, remember the art of the physician. I am recommending greater humility, less certainty and more imagination in the consulting room.

Introduction

The structure and form of this paper does not always follow a linear narrative, taking each idea through to its logical conclusion in turn. Instead it spirals cumulatively around the subjects towards its conclusions with the intention of following the 'logos of the psyche.' Therefore the image I would use to describe this process is dropping pebbles into water in the hope that they will ripple out in very different directions for each reader to develop in their own way. I am not offering answers but rather sharing my thoughts. The first of these is that the article is dedicated to Hermes, described by Lopez-Pedraza as the God of the arts, alchemy and psychotherapy, and the presence that makes it possible for "the therapist to love his practice in the way an artist loves his art." (1977: 9)

Lapworth, Sills and Fish (2001) provide an excellent multidimensional framework suggesting the significance of behavioural, affective, physiological, cognitive and spiritual elements in an integrative approach. For the purpose of this paper I am concentrating on following a trajectory along transpersonal lines. This in no way implies that the others are not equally significant for psychotherapy.

Pluralism And Integration

Having worked as a drama and movement therapist and integrative arts psychotherapist in London over the past eighteen years I have encountered clients from a vast range of psychosocial backgrounds. I integrate and apply theory very differently according to the needs of the individual, and do not privilege any particular idea or method in

any generalised sense. In adapting creative and psychotherapeutic approaches, I find that essentially the age, gender, disability, sexuality, religion, race and culture of the client is paramount. I have come to realise that each person requires a unique therapeutic response, depending on their character, current life circumstances, developmental concerns, personal history, political history and presenting issues. I am informed by all the arts therapies, attachment theory, neuroscience, psychoanalysis, analytical psychology, body psychotherapy, cognitive, behavioural, systemic, humanistic and integrative perspectives. My clinical work in particular combines developmental, relational, archetypal and contextual perspectives, constructing and deconstructing these as they are reconstituted in the discourse during each individual clinical case.

Jung claimed he was "unsystematic very much by intention… we need a different language for every patient. In one analysis I can be heard talking the Adlerian dialect, in another the Freudian" (Jung 1961: 153). Perhaps this is evidence enough to suggest Jung was a humanistic and integrative practitioner.

The Transpersonal And The Impossibility Of Definition.

The term transpersonal will mean something different to everyone. There is not now, and I hope there never will be, a universally accepted definition of the nature of the transpersonal dimension in Psychotherapy. Uniformity in this area could be extremely restrictive for clients if it were to be imposed. It does suggest that whatever it is that is informing or influencing the clinical work, it is beyond what is human or personal. It may, therefore, include spiritual, religious, social, economic, moral, political, biological or other factors which infect or affect the therapeutic encounter and dialogue. As the transpersonal is often associated with spiritual matters, I would like to emphasise contextual issues as having a transpersonal significance to explore the material end of the spectrum. This is in keeping with the alchemists' dictum to spiritualise matter and materialise spirit.

The upsurge of literature on Buddhism and psychotherapy (Eptsein 2001, Safran 2003, Welwood 2002, Young-Eisendrath and Muramoto 2002) and the transpersonal per se (Peck: 1978, 1983, 1993, Rowan 1993, Miller and Young- Eisendrath: 2000, Clarkson: 2002, Wellings and McCormick: 2000, 2005, Schreurs: 2002, Paloutsian and Park: 2005) suggests that it is possibly becoming more significant in clinical work. I wonder how prepared we are for this possibility, particularly if a school of thought or method is contemptuous of spirituality in principle? The humanistic tradition was born out of disillusionment with the limits of analytic and behavioural perspectives which is how it came to be known as the 'third force'. This phrase has symbolic resonance for the rest of the paper, in which the arts emerge as a third force in clinical work. Jung suggested the God image is always projected somewhere, whether we know it or not, or like it or not. Jung would suggest that the archetype of the Self will be evidenced by whatever the governing principles or ideas are 'acting as God' in the work. Financial concerns are all too often the ultimately determining factor, and there is considerable disaffection amongst personnel in public services for this reason.

Both the power of and problem with the so-called transpersonal dimension is, I believe, that it provides infinite scope for the projection of our imagination. I am suspicious of diagrammatic pictures, especially when they espouse hierarchies or seek to promote a standardised or universally applicable set of ideas. Jung suggests that theories are the very devil and that every psychology is a subjective confession on behalf of the innovator. Therefore whilst our integrity within the medical model that has appropriated psychotherapy depends on the careful and rigorous study of theory to enable effective assessment, treatment and possible outcome, it is foolish to identify entirely with any of them. Our intense search for and construction of theory could also be understood as a defence against the terror of the unknown, and it seems important to remember the speculative nature of all working hypotheses. Models of the psyche and our fantasies about intervention are acts of imagination (Stevens 1990: 27). Due to cultural and historical specificity they are also continually subject to change.

As Jung suggests the assumptions of today will be different from those of tomorrow (Jung: 1961: 153). For example a woman who came into psychotherapy in old age was still traumatised by the experience of being prescribed LSD in the NHS for a mental breakdown many years before. The real issue underpinning the psychological collapse in middle age had been undisclosed sexual abuse in her childhood. This remained invisible to the mental health system she engaged with, which did not refer her to psychotherapy. We can see how the prescription repeated the pattern of violation by facilitating another form of psychic intrusion that could not be integrated.

Health As The Capacity To Adapt To Change

Gareth James defines health within the context of homeopathy as: "The ability to constantly adjust to changes within ourselves and our environment" (1995: 10–13). Supporting people in managing the change process works for me as a simple aim for psychotherapy in general. The pace of change is rapid today and therefore adaptation has to be fast moving in order for people to cope. Individuals, families and organisations have to be very dynamic to survive. Change brings with it the transference of all our personal histories with their abandonments, bereavements and betrayals, as well as the anxiety attached to uncertainty in our anticipation of the future. Not surprisingly it can be very scary.

The Absence Of Containment In Religion: Meaning And Purpose.

Post-modern people are perhaps less likely to be contained by a 'grand narrative' (Lyotard, 1984) based in absolute truth. The comfort, security and discipline of formalised religion is foreign to many. Edward Edinger has described in depth the psychological significance of the religious function in the psyche, (1972) claiming that it is the loss of containing myths in the Jungian sense "that is the root cause of our current individual and social distress." He has suggested that: "with the loss of awareness of transpersonal reality (God) the inner and outer anarchies of competing personal desires take over" (1984: 9–11. It is not difficult to imagine how consumerism provides a perfect breeding ground for this condition. Advertising has always understood the power of images to affect behaviour, and many of today's artists make their living that way. Images are utilised without conscience to manipulate collective desires, urges and anxieties very effectively.

Edinger's thesis was that human consciousness had shifted throughout religious history from a basis in law to faith, and was now moving into the realms of direct experience. He claimed that people are now forced into the position of experiencing "relation to God in the individuals' relation to the unconscious" (1984: 90). What he problematically described as the "new dispensation" (which has a somewhat missionary feel to it) was in fact Edinger suggesting that psychotherapy is a vessel for the emergence of spirituality in our culture.

What Jung was proposing was that the task of psychotherapy was to bring a conscious attitude to the contents of the unconscious. He was interested in the dialectical tension which was constellated here between the ego and the Self in this process. He thought that "the fight with the shadow" was a matter of ethical responsibility (Jung: 1947). Therefore I would suggest he was less concerned with 'seeing the light' than 'knowing the dark', and confronting this from within.

The Transpersonal In The Context Of The Shadow And The Unconscious

Jung is cited as the first person to use the term transpersonal (Rowan 1993: 30). He distinguished between a personal and a transpersonal unconscious (CW, Vol 7, para 103). Since then post-Jungians have added another layer which has been inserted between the personal and the collective unconscious described as the cultural unconscious. (Henderson 1990: 103–113). This is important in ensuring archetypal psychology is not applied in a simplistic, reductive or prescriptive way with a notion of universality that does not do justice to the originality of the personality or the social context.

There are very different traditions within Jungian psychology which have a tendency to

polarise. At one pole there are developmental schools of thought, which have been heavily influenced by psychoanalysis and work primarily within the field of transference and counter-transference dynamics. At the other pole the classical Jungians pay more attention to the archetypal material and in particular the symbolic nature of dreams (Samuels 1985). As an Integrative practitioner both the in-depth work with the image and the psychodynamics of the therapeutic relationship have equal importance. It is possible to witness again how such group dynamics and institutional politics — personal, cultural, archetypal and collective shadow — can detrimentally influence the evolution of theory and practice. Contextual perspectives have linked Jungians from across this divide. For example Michael Vannoy-Adams (1996/2001) and Christopher Hauke (2000) who, originate from classical and developmental traditions collaborate in introducing cultural and historical perspectives in their overall critique.

The shadow as defined by Jung will be "the thing one has no wish to be" (Jung: CW16, Para 470) so whatever the aspirations of the personality or the society, they will be constellated in reverse when it comes to shadow. These can be positive attributes which remain unexplored, 'in shadow,' sometimes referred to as the gold in the shadow (Johnson 1991: 42–47). They can be all the so called negative aspects of the personality, often culturally and historically determined which are denied, repressed or split-off. Archetypal shadow has an explicitly negative connotation and has an autonomous quality which Jung equated with evil (Stein: 1995). Excellent work has been done on definitions of shadow by a range of voices from different traditions (Zweig and Abrams 1991).

In both image and concept, the term shadow, like the transpersonal, also suffers and succeeds from being both vague and specific at once. It can also simply describe all that is within which cannot be directly known (Von Franz 1974: 3). All too often the unconscious can become colonised by a few rather bleak theories, which can be applied with religious conviction and eliminate any possible presence of real 'otherness.' Perhaps the colonial history of the British Empire leaves its trace in such relational patterns which can be informing applied technique. Outside of the mind, outside of our control and outside of our conscious knowledge and understanding, the transpersonal is certainly a force to be reckoned with in clinical practice.

Jung initially used the term; the objective psyche to describe the archetypal level and depths of the collective unconscious (Whitmont 1969: 41–56). He positioned here an autonomous functioning which literally drives and possesses the individual and the collective, for better and worse. His concern was that no-one took the problem of evil seriously enough. Stephen Batchelor's book, *On Living with the Devil* (2004) explores *Meditations on Good and Evil* tracing the concepts through a variety of religious traditions in a way that might interest psychotherapists. For Jung absolute evil did exist and it was a transpersonal phenomenon.

A danger therefore is that we might wish to comfort and delude ourselves with positive projections on to divinity, which could, in effect, increase the possibility of us being blindly driven or unknowingly possessed by the counterpart to idealisation. According to classical Jungians the only immunisation against 'acting out' cultural and archetypal shadow is to 'own' personal shadow. I would suggest that both individual psychotherapists and the profession as a whole have more work to do in becoming conscious and more self critical in challenging themselves from within. This is vital if we are to protect our clients from our potential to cause harm. According to Jung the apprenticeship to becoming a psychotherapist is the integration of the shadow, which is a process that is suffered. Suffering is not a marketable concept these days on any level and psychotherapists can get caught in the same consumerist trap as skin care specialists in trying to prevent it.

Contemporary post-modern perspectives have taken a view that the microcosm of the individual human consciousness is formed and constituted by the collective culture that it is situated within. Neither the client nor the therapist can be divorced from the reality of the society they inhabit. Whilst the persona of our society is committed to equality and our organisations now operate anti-discriminatory procedures, these exist precisely because

everyone has internalised racist, homophobic, ageist and sexist attitudes which have been prevalent in our culture throughout history to the detriment of our vision. With reference to personal cultural and archetypal shadow these areas do, in my view, require careful investigation, analysis and deconstruction in the context of psychotherapy training.

Jung claims: "All opposites are of God, therefore man must bend to this burden; and in doing so he finds that God, in his oppositeness has taken possession of him, incarnated himself in him. He becomes a vessel filled with divine conflict" (Jung CW 11: Para 659). Jung suggests that in becoming this vessel we perform a divine service for God. A remarkable study of this 'alchemical' process can be discovered in Monika Wilkman, *This Pregnant Darkness* (2004). Similarly the significance of alchemy in analytic and relational methods has also been explored by Nathan Schwartz-Salant (1995/1998). Finally Jung suggests that: "In so far as analytical treatment makes the 'shadow' conscious it causes a cleavage and a tension of opposites which in their turn seek compensation in unity. The adjustment is achieved through symbols." (Jung 1961: 367).

Anima-mundi — World Soul

Further blurring the boundaries between 'inner' psychological reality and the 'outer' social world from a completely different angle, the 'anima mundi' or 'soul of the world' is an idea developed by post-Jungians like James Hillman, (1982: 71–93) and Thomas Moore (1992, 1989, 2004). The idea of the 'unus-mundus'- one world, has been significant across many spiritual and religious traditions from Chief Seattle (1977) to the Dalai Lama (1999). The psychological impact on the individual of global, social, economic and political factors and inequalities has been explored by Andrew Samuels (1993). The emotional impact of environmental threats has been discussed by Joanna Macey (1994) and Mary Jane Rust (2004: 50–63). The concept of the collective unconscious which refers to the "meaningful spiritual aspect of experience" (Whitmont 1969: 41) links all these perspectives as the source of the interconnectedness of all things. Each of these writers have emphasised the significance of grief and human self destructiveness concerning the problems of the planet as a whole today which we can see enacted on the international political stage and in the presenting issues of the people that we treat.

As the human ego and our society become increasingly defeated by the creativity and innovation in psychopathology today, Jung's psychological approach based in depth and the search for meaning rather than cure could become very valuable. As global capitalism and the market force economy gain ever further momentum, environmental concerns become ever more threatening, and religion's power to contain either diminishes or falls prey to fundamentalism, our spiritual malaise will perhaps become a serious presenting issue in itself. This may already account for the significant increase in numbers of people entering into psychotherapy and psychotherapy trainings at this time.

Transpersonal Forces And The Limits Of Conscious Choice.

The transpersonal dimension forces itself on to the agenda for psychotherapists because whether it is the result of natural disaster, hormones or being made redundant from a job in car manufacturing, whether it is a common cold or cancer, whether it is the aging process or the catastrophe of asylum seeking, whether it is divorce, bereavement, depression or addiction, we have to suffer the effects of forces that are greater, more powerful and dominant than our intellect or will. We are all subjected to pressures from outside and from within that reiterate we are not in control of our lives or our world.

The autonomous quality of the shadow which can exercise control over the personality has been understood all too well by people who have suffered with addiction, and likewise: A teenager tells me she has no idea why she is slicing up her arms. Another young woman cannot explain why she is killing herself through starvation. A little boy of eight tells me he doesn't know why he is washing his hands until they bleed. The paedophile can find his actions truly abhorrent and horrendous and yet not be able to stop

enacting them. People often do not want to 'act out' the urges and compulsions that afflict them to the detriment of self and others. They feel powerless as to how to stop being made a victim of an unknown force which emerges from within and means that they are in no way 'master of their own house.'

Interestingly, the first of the twelve steps is to own powerlessness and this came out of the encounter between Jung and the founder of AA. These espouse a higher power conceptualised differently for everyone, which undoubtedly has a marked effect in the treatment of compulsive conditions. In my experience psychotherapists can be a little contemptuous of the twelve step fellowships. For example a client complained to me recently that a psychotherapist had asked: "when will you no longer need to attend these meetings?" I would suggest that there is much more to learn from the success of a completely free self help network that has proven success rates in managing addictive and compulsive behaviours of all kinds and from considering the psychological effects of conceiving of a transpersonal dimension in the recovery process.

Jung states: "We are still as much possessed by autonomous psychic contents as if they were Olympians. Today they are called phobias, obsessions and so forth; in a word neurotic symptoms". He continues: "The Gods have become diseases" (Jung CW13 para 54). This complex idea has been considered in depth by many post-Jungians, but perhaps it needs a far more extensive inquiry to comprehend what he was really getting at (Zeigler: 1985, Kiddel and Rowe-Leete: 1988 Whitmont: 1993). Hillman suggests: "To study the complex only personally or to examine only personally the psychodynamics and history of a case is not enough, since the other half of pathology belongs to the Gods" (Hillman 1975: 105).

The Arts In Psychotherapy

When I ask myself, what can do justice to the freedom and dignity of the human soul or attune to the reality of this perilous journey we must each make in a lifetime? The answers for me have always been found in the arts, which underpins my passion and commitment to them in the therapeutic context. A man who had been in the East End during the last war, lost his faith when a bomb dropped on his orphanage, and he was the only child to survive. Whilst he was a committed atheist, he claimed that there was only one way to describe classical music, and that was — Divine! Like dreams, (Mattoon 1978) the arts bring in a third element which is the transpersonal dimension. Classical Jungians might describe this as the objective psyche, whose presence can be made manifest and intentions known through active imagination.

The arts can enable non-verbal client groups to access psychotherapy, and can facilitate contact with those parts of the self that are beyond words or precede language. As an integrative arts psychotherapist the human imagination is central to my practice, through dreams, active imagination, and the creative process. All the arts including; drama, music, dance/ movement, painting, clay, sandplay, puppetry and poetry are employed in the interests of the principle of "hospitality" to the psyche and its manifestations (McNiff: 1992). This proposes art as medicine, the vehicle through which some possible self knowledge and self mastery might be gained if it were possible to get into right relationship to the unconscious, and 'all the Gods are welcome, because they are coming bidden or not' (inscribed in Latin above the door of Jung's practice).

The arts and the creative process can catalyse regression into the personal and collective unconscious and therefore need to be handled with care. For the purpose of this paper I am concentrating on how the arts might support people in engagement with destructive elements in the shadow. It is important to have experiential understanding of the creative/destructive process in psychotherapy training before simply applying techniques.

The Transcendent Function

The current president of the Jung Club in the UK writes: "In essence Jungian therapy aims at bringing psychic transformation through the 'transcendent function'- in other words a Jungian approach, whether through analysis or a life lived reflectively, consists in a slow process of growing self awareness whereby a number of polarities (expressed unconsciously

by the conflicts that tear us apart) become conscious, are painfully suffered, and by the grace of God are reconciled in a 'third' which transcends them; that is, by the healing symbol" (Tuby. Ed Pearson 1996: 34). The transcendent function is a Jungian concept that has been little explored outside the arena of analytical psychology (Miller, 2004). The field of the arts therapies has become increasingly influenced by psychoanalysis in recent years, and has perhaps missed the spiritual significance of this concept for their clinical work. Jung was the first practitioner within a western psychotherapeutic paradigm to value the creative process as therapeutic in itself and not merely a springboard into further analysis. His own art work and that of his patients held in Zurich testifies to his respect for the animated image in therapy.

Metaphor, image and symbol can serve as psychological protection when approaching intensely difficult psychological material. They can act like the gifts, given to Perseus when he set off on his quest to slay the Gorgon. Athene gave him a shield and Hermes provided the cap of invisibility and winged sandals. Just as it was impossible to stare Medusa in the face without being turned to stone, so it can be just too terrifying to look at some aspects of psychopathology in a direct way. Clients can become literally frozen or petrified. Natural defences like resistance, deflection or avoidance may be appropriate coping mechanisms, but symbol, metaphor and image can allow profound engagement with psychological processes to occur in a manageable way. This is what the Sesame approach to drama and movement therapy would define as an "oblique approach" (Pearson: 1996; Lindkvist 1998).

An example of the transformative nature of the creative process in an oblique approach is illustrated in art by an elderly man in a hospice facing death in the knowledge of a lifetime's untreated alcoholism behind him. He sets out to paint a killer shark in a vast sea, which he feels is now destined to devour him in the water. As the image unfolds, out of the depths a dolphin emerges and an association from him to salvation. He knows it is the dolphin that saves the shipwrecked sailor, and has been described as the 'mind of God in the sea.' His attitude towards his own imminent death begins to alter as a result of this transformation in the creative process. He is calmer and less terrified about what he may be approaching.

Violence In The Arts: Mediums And Vehicles For Transference And Transformation.

The arts are in themselves impersonal and therefore can receive the force of transpersonal energy and affect in full where the interpersonal nature of the therapeutic relationship may be inadequate in withstanding its force. For example a pile of clay can receive the full impact of a punch in a way that allows embodied expression where words may be futile. Whilst it may be a cliché to bang cushions, there is no doubt that the physical enactment of aggressive impulses can be vital for undoing what Gestalt therapy would describe as retroflection (Zinker: 1978, Clarkson: 1989, Mackewn: 1997). It may be very necessary to shred, to hit, to thump, to cut, to slash, to tear, to rip to smash and to burn in order to fully convey and communicate the impact and harm that has been caused to individuals. Examples include; a child who has seen both parents killed in front of him in Rwanda, a man who grew up with a gun in his hand in a refugee camp in Lebanon, a gay man beaten up in his own street in a homophobic attack, a teenager who has been gang raped having stepped into a taxi, a woman subjected to regular beating from her alcoholic husband, a visitor to this country who on arrival had her luggage thrown off the train in a racist attack, a woman whose hair was burnt off by her psychotic mother in childhood, a young boy with disabilities who has been seriously bullied and tormented by his peers. These are clients who have experienced inhumane treatment and have required an equally inhuman transpersonal medium to transform their personal tragedy into their human potential.

I have witnessed murders in the sand play, enormous monsters created, confronted and destroyed through art and drama, the terrifying atmosphere of nightmares played out in music, retaliatory stabbings enacted through knives and clay, violent fighting crafted into dance, drama and ritual. I would suggest that the vehicle through which the transpersonal can be made manifest in terms of the homeopathic ideal where 'like cures

like' needs to be similarly inhuman. The art media are resilient and robust. You can safely kill in art reflecting on and expressing the murderous impulse safely. Joy Schaverien's work on the transactional object is worthy of serious consideration here (Schaverien: 1995). Irene Champernowne, a founder of the arts in Psychotherapy who created a Jungian oriented artistic community for people with mental health problems called Withymead, (Stevens: 1993) is quoted via oral tradition as saying; "For the love of God and your neighbour find a vessel for your evil," intuiting the place of art in expressing and containing archetypal shadow.

Therefore I would suggest that the arts can 'contain the uncontainable,' in keeping with what anti-exclusion policies in schools are attempting to do. This is why it is part of the mission of IATE along with the NSPCC to ensure a child therapist is allotted to every school in the country. For example, a boy aged eight who had seen his mother beaten up by his father who then left, never to be seen again, was perhaps not surprisingly smashing windows in every school he went to and was subsequently excluded from. When he was finally able to access an integrative child psychotherapist the history of his experience emerged in the sandplay. He told the story with miniatures in the safety and containment of the box of sand. He wouldn't have told anyone literally what had happened if he hadn't had this medium to play out and thereby convey his experience. Having an art form to articulate and enact the violence he had been exposed to, prevented him from continuing to act this out in the school context to the detriment of self, others and property. It also afforded him the opportunity to experience his affective explosions with an emotional literacy specialist away from the classroom. This enabled him to begin to grieve and to mourn. In our culture there are now so many children with emotional and behavioural difficulties, who are labelled, excluded and even prescribed drugs, without ever having had the chance to communicate what may be really going on for them.

The gun and knife crime amongst teenagers is growing exponentially and I would suggest that it is vital we discover creative ways for violent and destructive energy and affect to be engaged and expressed safely in psychotherapy. A group of adolescents in a substance abuse clinic used modern technology to make powerful and dramatic music together which certainly articulated their aggression successfully. This was a psychotherapy group which began with clients simply bringing and playing their own pre-recorded music, and developed into quite extraordinary collective improvisations with titles like: *The End of the World*. I would suggest that we need to accept more responsibility for what young people may be expressing on behalf of the collective, listen more carefully to what they are communicating and resource them with 'languages' they relate to and can relate through. The arts in psychotherapy provide the scope for exactly this to happen. I am therefore arguing as strongly as possible that the problems our society is facing now and will have to contend with in the future leave absolutely no room for professional politics that could weaken the force of what psychotherapy has to offer in any way.

The arts have the capacity to literally 'get things out of the system' like the biological functions of sickness, defecation, screaming and crying. They can also enable an engagement with transcendence, contemplation and act like a form of prayer. Therefore they can naturally articulate both the sacred and the profane. Cathartic and regressive techniques could be inappropriate for many clients. What is medicine in one situation will be poison in another.

Access To All: Art As Compassion Our Collective Human Inheritance.

I would suggest that as well as being indiscriminate about what issues art will accept, receive, express and communicate on behalf of us all, the artistic experience belongs to everyone from every culture and religion as their own natural birthright. Arts education has often quite deliberately promoted the myth of the artist as elite and separate from the rest, (Boal: 1974) and therefore clients often need support with discovering their innate creative potential. Even some arts therapists believe that the therapist has to show evidence of a high level of expertise within the medium to be able to achieve clinical efficacy. I would argue this principle can be employed

in a pretentious way that perpetuates these myths, rather than promoting access to all.

Art is not a product of European or American theory imported across the globe. In the immortal words of a participant at a psychoanalytic conference in Johannesburg; "these theories are like trying to feed the starving people in Africa frozen turkeys". Art has always channelled the manifestation of a community's conflicts and tensions in the spiritual and material world, and it is always there ready to rework our afflictions if we can create conditions that are conducive. Art facilitated in the right hands can be the most profound and compassionate response to circumstances for both the individual and the collective. It can quite simply be honesty itself. Käthe Kollwitz's drawings and sculptures of German children starving in the 1930's are a perfect example of this degree of emotional truth.

Pathology, The Gods And The Revelations Of The Psyche

It is the art of the physician within a classical Jungian frame to support the client with a possible discovery that in their symptom is their soul. Like the grit in the oyster the symptom, if worked with effectively in psychotherapy can result in the pearl (Hillman: 1979). This is in no way a simple or formulaic task, but I am suggesting that both active imagination and the creative process can be of assistance (Johnson: 1986, Schaverien: 1992, Mc Niff: 1992, Chodorow: 1997, Stewart 2000, Malchiodi: 2002). I have witnessed many clients' claims that in their curse they found their blessing.

Hillman has suggested throughout his fifty years of writing in this field that the most serious disease symptom of our time is literalism. He has been constantly investigating the relationship between psychology and religion as they both have a shared focus which is the life of the soul (Hillman: 1979). Whilst according to Hillman, all "pathologising is a way of mythologizing" (Hillman 1975: 99) the thinking given to our diagnostic categories, assessment and treatment paradigms can be very limited in terms of imagination (Hillman 1997: 10, McConeghey: 2001: 44). Hillman suggests: "Whilst in the throes of pathologising the psyche is going through a reversion into a mythical style of consciousness… reminding the soul of its' mythical existence." (Hillman 1975: 99–100). Therefore he is arguing that the telos or purpose of the symptom is to lead us back into relationship with the symbolic realm, to point the way back into relationship with a poetic basis of mind and thereby the divine origins of our nature. If art is allowed to be the vehicle through which the animation of pathology becomes possible, the individual may then discern its meaning and purpose. In this process they may also discover a far deeper experience of Self and with that a feeling of greater wholeness.

This paradigm, as with all holistic medicine, affords suffering a dignity and a purpose with a spiritual meaning and value (Ziegler: 1983, Whitmont: 1980). If, as Hillman suggests, "within the affliction is a complex, within the complex an archetype, which in turn refers to a God" the process of animating the symptoms in paint, clay, sand play, dance, drama, poetry or music, honours the dishonoured God in itself, re-integrating those denied repressed or neglected aspects of the Self that are seeking recognition. To symbolise the problem or to bring the pathology to life through metaphor is a paying homage in itself which can enable a psychological change: "The affliction reflects a pathos, a movement taking place in the psyche… we owe our symptoms an immense debt… symptoms not therapists led this century to soul" (Hillman 1975: 71). In his book *Emotion*, Hillman suggests that incorporating art into therapy is an opportunity to ask the emotional condition what it wants, and how this divine influx can best be served (1992: xii).

Suicide As A Vital And Necessary Psychological Image

Hillman suggests that to actually kill oneself is a form of 'literalised catastrophe,' and that the suicidal impulse has symbolic significance in the image of a desired rite of passage for the soul. It is a call for a symbolic death and rebirth (Hillman 1964). For example a suicidal male client in mid life crisis enacts the suicide he yearns for in art. He uses clay, paint, mental imagery and drama to enter the experience of his fantasy. Step by step he constructs,

communicates and lives out symbolically his tremendous desire for death. The relief and the release this brings is both tangible and evident. The next session he is brighter, more alive with new thoughts and feelings about living. Jung states: "The personification enables us to see the relative reality of the autonomous system, and not only makes its assimilation possible but also depotentiates the daemonic forces of life" (Jung CW13, Para 55). To enact suicide via a creative medium, can allow the image to be lived out to the full, which allows for a ritual in which the psychological transition can be deeply experienced. (James Roose-Evans: 1994). Suicidal imagery can also lead to an understanding of the symbolic and spiritual significance of self sacrifice. This approach to working with suicidal ideation may be suitable for some clients and definitely not others.

Identification With The Gods

Whilst the transference of the healer archetype can be constructive in treatment, there is a danger that psychotherapists who experience the transference of the Self, or the God image as defined by Jung, can become like Guru figures, inadvertently identifying with the governing principle in the psyche, and behaving like a spiritual teacher who knows the way and can initiate and guide others along it.

Psychotherapists are often wounded people who have experienced powerlessness in their own lives for different reasons. Whilst I subscribe to the archetype of the 'wounded healer' being operative in psychotherapy to the benefit of many clients, I am also curious as to what the effects on a profession might be, which is composed of a group of people whose involvement in the field has arisen from psychological distress in their own personal histories. It is clear that those who have suffered personally make empathic insightful and effective practitioners. I would propose that suffering is a pre-requisite to becoming a good therapist, but what are the implications of this for a profession made up of 'wounded' people?

One danger might be that psychotherapists who have been hurt or harmed by abuses of power in the past could find it tempting to identify with archetypes, parental or God-like as this gives them the sensation of being powerful. The 'power complex' as defined by Jung can lead to all kinds of ego inflations on behalf of the psychotherapist and somehow we all know intuitively that the transpersonal lends itself in particular to problems in this area. Therefore we need our critical faculties Self-directed to immunise against the psychological and political consequences of ego inflation and over-identification with archetypal material.

You will recall Jung's dream where he is walking through a vast darkness with a candle. He is stepping tentatively forward protecting the tiny flame with his hands from the huge shadows all around him (Jung 1961; 107–109). This he suggests is the light of human consciousness where hope resides. As in the moment when he finds himself playing like a child with stones by the lake (Jung 1961: 194–225) we see his admissions of powerlessness and the necessary humility required for something genuinely new to emerge. All our psychotherapy sessions are a form of action-research into the phenomenology of the psyche and if we could allow for more inter-subjective play, spontaneity and improvisation, as well as observation and analysis, we might be educated by the authority of the imagination and the remarkable innovations of the human soul in response to adversity.

Aesthetics And Psychological Health.

The aesthetic is a realm for eternal debate and I am just going to touch on one aspect of its personal and psychological significance in the modern world. In our increasingly urban lives, perhaps there is a thirst and yearning for an experience of beauty in nature that has transcendent depth. I am talking about the spellbinding quality of a bluebell wood, a wild animal in a dream or the stars in the night sky. A passionate garden designer living long term with an AIDS diagnosis explained to me after some years of psychotherapy: 'it is the quest for beauty in my gardens that keeps me here.' It is clear that his attachment to this world was inspired by the beauty in nature and he tended the life force like a devotee would the altar, as comfort and remedy for his condition. Perhaps the significance of aesthetics might become the subject for more

in depth research into the psychological health of individuals and our society.

In Temporary Conclusion

The significance of the transpersonal dimension in our work is complex, diverse and multitudinous in its manifestations and forms. Jung's term for the aim and the process of psychotherapy was individuation and this is a worthwhile concept when considering the client in treatment, the practitioner who is 'treating' the client and indeed the method itself. Perhaps optimum performance occurs when all three are aligned in perpetual motion.

Van Morrison's track from the album Enlightenment espouses: "Just you and me and nature in the garden." I would suggest we look more to story and song, spend more time in parks and in the countryside, at art galleries and theatres, concerts, dance more, play more, with children if possible. This is more likely to refine our skills, sentiments and aesthetic sensibilities in a way that will make us truly 'fit for purpose.' This is the kind of continuing professional development that psychotherapists could do with more of.

Our lives are maimed and ruptured by transpersonal forces all the time and there are no safe havens where you can build a wall against the brutality of the changing world. The pathos of the psyche, 'the suffering of the soul' is everywhere, and the clients who cross the thresholds into our consulting rooms are often feeling horribly defeated, desperately seeking refuge and the resources to survive, to manage, to cope. Jung suggests that every defeat for the ego is an accomplishment for the Self, which requires a certain shift or turning upside down in our perspective to recognise the real significance and worth of our suffering.

In a 'person centred' way (Rogers: 1965) the individual can determine their own difficulties through the creative dramatisation of them. In giving aesthetic form to their own psychological process it may be possible to contend with their problems and move forward out of the ingenuity of their own creativity and imagination. In this method the medicine lies in the heart of the wound, 'divined' through the artistic endeavour of the suffering person.

Jung writes: "The artist is not a person endowed with free will who seeks his own ends, but one who allows art to realise its purpose through him…. What the physician does is not his work: he is the means by which nature is put to work" (Jung 1966: 101).

In summary

I am arguing that:

1) The transpersonal dimension is indefinable and psychotherapists should not operate with a fixed model that can be applied in any standardised way within the context of our diverse culture and society.

2) There are many transpersonal factors which catalyse change that can be natural, environmental, social, political, economic or spiritual and are completely outside of the control of the individual.

3) Navigating the change process in the internal and external world is central to the task of psychotherapy, and the symbolic language of the psyche as experienced through dreams, active imagination and the creative process may assist in the way change is approached and managed.

4) The imagination can be a key to unlock vital and necessary resources to recover from trauma, manage transitions, thrive and fulfil human relationships and human potential.

5) Listening to dreams and engaging with symbol, image and metaphor in the clinical context may provide a source of profound wisdom to support the process of recovery.

6) The psychotherapists' attitudes and values, including internalised beliefs, prejudice and assumptions that have been prevalent in our culture and history concerning: age, gender, sexuality, disability, 'race' culture and religion are influential in the outcome of the work. These require careful attention and analysis during training, as a matter of ethical principle.

7) Any identification on behalf of the psychotherapist with knowledge, power or archetype can be detrimental to the clients' process of Self discovery.

8) The psychotherapist's imagination, or lack of it, will enable or restrict the conditions in which the client can create and engage with psychotherapy and life. Therefore stimulating the imagination through artistic engagement of all kinds can be a rich resource for continuing professional development.

9) When addressing the transpersonal dimension in clinical practice it is vital to be consciously aware of the shadow, (personal, cultural and archetypal) to avoid unconsciously contradicting the intention of the work in practice.

10) Art and the creative process can be of immense value in objectifying emotions so that they can be recognised, encountered, reflected upon, confronted, owned and even integrated rather than 'acted out' in ways that could be harmful to self and others.

11) With respect for the psyche and psychological life, in these times of considerable uncertainty and change, it might be of value to investigate in more detail what Jung was suggesting when he proposed that we consider the meaning of symptoms at least as much as their cure, and advised: 'let nature be the guide'

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Rex Bradley

The "Transference" Of Sibling Relationships

Siblings: One of two or more individuals having one or both parents in common; a brother or sister, a person's relatives considered as a group; kinfolk.

Abstract

In this paper, I show some examples of an awareness that has grown for me over the years in my work, of the damage resulting from families where there has been poor or non-existent boundary setting and weakness from parental sources. In the worst cases the effects have been to make it impossible for the most affected survivors to find a way of having enough form to make their own way in the world without constant fear of failure and self-loathing, a corrosive legacy of the sarcasm, fear and physical and emotional abuse that result from the lack of family boundaries and guidance.

Introduction

I recognise that we spend masses of our time as therapists, working with clients whose belief systems and behaviours are naturally carried forward based on their life experiences.

We feel we must recognise too that: "Everything happens in a context and everything is affected by the context it happens in" (attrib. Wittgenstein). And so we must fully acknowledge this fact in our work with clients or risk being less helpful in our work with them.

All our experiences and circumstances can shape our way of interacting with the world. Along with our gender, size, colour, power, strength and physical stature, along too with a multitude of other factors, for example, environment, health, poverty, wealth, education etc., all play their part to in how we are "ourselves" in the world. i.e. the "person" that we and our friends and colleagues recognise as "us".

I have increasingly acknowledged that a major part of the history that we all carry forward is formed directly or indirectly by our relational history with our siblings, as well as the relational input from our parents. The transferences that we carry forward from parents, their shaping of our life, the parents' interests and preoccupations, seem to become ours despite our sometimes violent efforts not to be like them.

In the family, siblings too must make their own efforts to accommodate or disguise their fears and fragilities, as the dynamics in the family require continual adjustment in order to maintain their position in any family where contact is not open and clear. As an example, in a family where there is a regime that includes unclear communications, or violence, blaming or shaming, open sharing is less and less possible, and a hierarchical system is formed. I think of these families as being like a slippery pole, where you have only to slacken your grip for a moment and you are down at the bottom again. This becomes tiring and frightening.

Here in the stress of such a family, the strongest, cleverest, most cunning and

manipulative, the meanest, strongest, brightest may triumph over the timid, fearful, honest, or sometimes the smallest, or the youngest. Though not always; the collective we call a family is capricious, sometimes the smallest or weakest can be the family favourites.

We must bear in mind that each individual in the family may have a very different "wish list" in terms of their position. Some may want to be at what they perceive as the top position in the family, others, often the ones who have suffered most from the family dynamics, may wish to go unseen, unrecognised and therefore be "safe".

As therapists it can help if we recognise that this often unremarked dynamic is something we work with as a background every day. It can occur directly as a presenting issue or problem within the family; or as something we see as a background of emotional colour and form, a way of being in the world that informs the rest of our clients' lives. This fundamental, historical and often unconscious blueprint requires that we to have a picture of the family dynamics and how they shape our and our clients' lives.

Exploring and uncovering this blueprint or map together with our clients helps our work be more thorough. The immediacy and relevance of our work is greatly improved if we include looking at relationships and dynamics with siblings as well as those with parents and grandparents. I see the dynamics of the family as an interactive system that is always in progress, which often involves especially competitive or conflictual forces in the family.

Recognising the powerful effects of these dynamics and looking for their effects on our clients can be rewarded in most cases by a fuller sense of the context that the family provided for our clients. That awareness can quickly lead client and therapist to a larger understanding of the specific impact of that environment, and its resultant effects on the client.

I need to make it clear that I am writing of what we do as therapist in a one to one situation, as well as with all or part of a family. I believe even when we sit and work with an individual the influence of the family of origin remains there in the room. We can gain by recognising too that what one family member means is often, perhaps even usually, at best only partly understood by the other family members. All of those family members may have their own differing understandings, what is meant by one person in the family may be completely misunderstood for years.

I have heard the somewhat surprised snippet "but I always thought you…" so many times that it seems to be a key phase in working with all or part of a family. At this point it's a sign to me that the family process and tacit understandings are beginning to be re-examined and challenged and a little more acknowledged. Then the powerful shaping of the family structure can be acknowledged and better understood at last, and the influences examined and welcomed or fought against and rejected.

Family Dynamics

Let us look first of all at some of the extraordinarily powerful dynamics that can influence the family. As human nature can at any point in life be relied upon to be in some state of flux, so there may be a kind of tidal flow in the relationship between siblings, and possibly therefore a continual variation in the individual's status in family relationships.

In the full breadth and depth of our personality we are pretty consistent, and can be relied upon to be "familiar". We are angry in this way; sad in that; etc. In the dynamics of a relationship, whether the person is a sibling, teacher, mother, father, or Traffic Warden! We will choose and show the same strands of our behaviour in our bonding with "another". i.e., we will ingratiate, cower, fight, shut up, bully, seduce, be bullied, or whatever way we think and feel we can manage to do for the best. Perhaps we do whatever we feel we can get away with at any moment in any particular relationship. Even a twosome can have a pretty powerful dynamic running through it!

I think it is important not to be tempted as therapist to think that there is any common pattern to Sibling relationships; some rules of thumb. For example, "the younger the sib the tougher the ride they get". I firmly believe that any temptation to generalise or make up such rules in this way should be avoided.

Each sibling relationship has elements that are unique to itself and the relationship may or may not correspond very much with other sibling and parental relationships in the family.

As we look at our patients, friends, colleagues, we can see patterns of behaviour. These patterns make them "familiar" to us and because we keep their image in some special way we know them immediately when we turn the corner and we unexpectedly see them in the street. The delighted "I knew it was you, what are you doing here?" moment.

It is interesting as a therapist to consider the needs a person may have to change or to keep their differing behaviours. However, as therapists we must be careful to see a pattern and watch it, without coming too quickly to a conclusion that some other action or remedy is needed on the client's part. At the appropriate time we need to be ready to endorse and support, or to question the client's view of the family.

My understanding is that sibling relationships have the same uniqueness as all human relationships, and that any random house-to-house survey would reveal that generality.The dynamics of every family are different to every other family; indeed in its detail the family is unique. The dynamics of the family also vary as the aging, number and gender quotients of the family members change. Interestingly, the introduction of a new family member, either by birth or adoption, or simply because there is a need for long term house sharing, must lead to some accommodation by the whole family to the new circumstances.

A Therapist's Perspective

As therapist we must approach family issues prepared for surprise, shock and a process of learning; bearing in mind that we must be completely open in our approach to the family. We need to be very open when taking the case. whether we are dealing with the whole family or a single family member who is retelling their experiences and consequences of being in their family of origin. Being open to what any client is presenting, and remaining open to their experience without interpreting it is vital. Ideally they should not have to correct their story, nor feel forced to explain again how it was for them. Nor should they have to insist that it was not in fact how you thought it was for them.

All the above advice comes from my own mistakes of being over confident in my understanding over the years.

Another element of "working with families" is of course that we are all working with the product of families, even if we never see another member of a client's family in our consulting room. This is why it is so important to question, at least in our own mind, where the disabling patterns arise that we may see in our clients in our work.

Also, we need to acknowledge the long-term nature of sibling relationships. As friendships often come and go, sibling relationships are permanent; they often have the longest duration of all our relationships. Our siblings often share our lifetime and in this they are quite unique. This is worth remembering in terms of the changes that may happen in sibling relationships over many years.

I found this snippet from the work of Mach (1905). It seems to give support to the sense of how deep and long lasting in ego terms the relationships grown in the family are:

"The apparent permanency of the ego consists chiefly in the single fact of its continuity, in the slowness of its changes. The many thoughts and plans of yesterday that are continued today, and of which our environment in waking hours incessantly reminds us (whereas in dreams the ego can be very indistinct, doubled, or entirely wanting), and the little habits that are unconsciously and involuntarily kept up for long periods of time, constitute the groundwork of the ego".

Ernst Mach "The Analysis Of Sensations" (1886, Revised To 1905).

The family responds to internal and external pressures in its own ways; each individual's responses to the pressures will be typical for them, and the family too will have it's overall character. Like planets and suns within a system, each family member goes about their own course in the family in their own way. However,

the system may seem very strange to outsiders; it could have two or three suns and two or three planets, or many suns and one lonely planet!

Illustrative Case Examples

Let us look at work that reflects the importance of sibling relationships in families and individuals that I have worked with, either alone or with colleagues, either as a whole family, or part of a family, perhaps with a colleague in the case of large families. I will also look at cases where in working with individuals there has been a clear need to uncover and interpret the effects of family dynamics.

Though all these pieces of work are real, gender and other realities have been changed in order to preserve the confidentiality of both the families and the individuals concerned.

First a family, Father, Mother, and seven siblings, four boys and three girls, the presenting person was the Father, the issue was that the family was always in turmoil, and Father presented with a good deal of distress, fearing that he would have to end the marriage and break up the family. Though he came to work on his own issues, it quickly became clear that due to the behaviour of his wife and the powerful effect that she had on the family, it would be very useful to see the family as a whole.

Fortunately there was a unanimous vote in favour from the siblings, three aggressively for meeting, the other four acquiescing. We duly met as family, my co-worker and myself.

The first session was almost entirely taken up with logistics, arranging suitable times to meet and agreeing to a batch of 6 sessions, with either one or two week breaks between them, partly in order to accommodate individual work contracts that had to be met. We tried to ensure that everyone was there, which was not easy as some of the siblings had left home and were living in various parts. The only people to miss any sessions were Mother, (reported in ill once) and one of the siblings who was stuck at work. With administration at an end, we asked Father to introduce the issues that he felt needed to be addressed, as he was the author of the situation. The issues, seeming to stem from the problems in the parents' relationship, were largely agreed by the meeting, except that mother disagreed with the agenda.

The Mother immediately stated that she was leaving the family. She admitted she had been having an affair for several months (it turned out to have been much longer than that) and that as far as she was concerned the relationship with the father was over.

After the initial shock had died away a little, it was clear that some of the siblings were not as surprised as others. This quickly became an enquiry into who knew this was going on, which I thought came from the eternal human question of "why wasn't I told". In fact, to the Father's anger and discomfort, three siblings reported as either having been told by Mother, or having "discovered by accident".

At this point an interesting view emerged of the dynamics in the family, both in terms of who knew, why and how, but also how clearly the three of the siblings who knew, two female and one male, were also the most powerful players in the dynamics of the family, though they were not the oldest.

Although voices were raised, there was a surprisingly swift acceptance of the fact of mother's affair, though Father angrily demanded time with mother alone to discuss their relationship. As we were at the end of the 1-½ hours set aside for the meeting, all agreed to stop there and meet again the next week. In the course of the next session we were to discover more family secrets.

The next session opened with an update for my colleague and I, all were present. Mother had moved out to live with her new partner and his two children. Father was grieving, alternating between anger and tears. The siblings were displaying a mixture of feelings that reflected the split, confidence on one hand and rage, tears and fear on the other.

The parents were quiet at first, whereas the children, especially the older ones, were restive and obviously a lot of feelings between siblings were going unexpressed. So we began to ask siblings to open up with how they felt. The response was fairly immediate and we needed

to keep the interactions to a reasonable level as siblings aired their angry positions.

The dynamic quickly began to come from, "the ones who didn't know": There was again much rage and hurt over not knowing; feeling left out, and betrayal, first at Mother, who looked fixedly at the floor, perhaps feeling ashamed. Then onto "those who knew", this was a rage which grew as the inhibitions of the quieter group melted and they began to pour out their rage in what they seemed to experience was a safe place. After a while it emerged that Mother, who had private means, had distributed secret favours and gifts among some family members, including, but not only, the knowledgeable three.

Once again mother looked uncomfortable, and this time the family members who had been favoured looked ashamed too. But, as the rage subsided, so the hurt at being left out, the divisive "contracts" that had been negotiated, and the sense of having been seen as "second class" or "less than" came to the surface. This was a phase full of hurt and pain, increasingly followed by remorse on the part of the perpetrators. Everyone was in tears, it was one of the most poignant meetings of humanity that I had witnessed and felt to be a true catharsis. We revisited this over the course of the next four sessions, which led us all to a satisfactory ending.

The Father and Mother reached an accommodation that meant that although they went their separate ways, they would join in with appropriate family celebrations.

However, I later learned from one of the siblings, who I met in a completely different therapeutic setting, that in fact those rifts caused by the hidden approval of some family members had never completely gone away, though as far as she could tell, Mother was no longer being partial in her dealings with family members.

This sibling made it clear to me that the work was never finished. She reported that despite the work, some siblings had never given up their exalted positions, and refused to be challenged. The parents were never involved to this depth again as they in turn were more split off from the family as time went by.

That meant that there could be no realistic resolution of the conflict. I was further convinced by this revelation that sibling relationships can be left set in stone for life, unless situations such as this can be completely worked through, so that a point is reached where there is at least some sense of a level playing field, and equality and mutual respect can be achieved.

I am particularly concerned in my private practice by the number of situations in families where siblings are neglected, especially when left to their own devices with one another. In my experience this can be particularly pernicious.

In the final example of my concern, we address the issue of transference into our everyday relationships from our relationships with siblings, I present the personal experiences of a long established psychotherapist, now in his sixties, who we shall call Peter. He looks back to a therapeutic regime much less defined than most of us practice now:

"As many of us did in the Seventies, I first came to learn about Psychotherapy as a client. I went to therapy as I was anxious and very unhappy. As I look back on that time, I recognise that I was depressed. My therapy was largely about recognition of what was right for me as an individual and looking at how I affected the people around me. The goal was to be aware and know what I wanted, and to be able to stand up for myself and negotiate "properly" for it with my family, peers and colleagues. I did not look in any detail at the relationships I had with my family of origin. We had not been close for many years; I left home as soon as I could, in order to "be out there in the big wild world". I only recognised much later that there was much more to my not getting along with my family, and my urgent need to get away.

As I moved around the world I sent cards to my family for holidays and festivals, but made no attempt at dialogue, and skirted neatly around anything that meant actual contact. Then came a disastrous family holiday break, which was designed to celebrate an important anniversary for my parents. Father was seriously ill and so it seemed impossible to say no. After just 12 hours of my arrival,

as I tried to find my way in the family, I realised why I had stayed away for so long.

I had a major problem with my family, and I was not alone. My younger sister and my brother seemed as ill at ease as I did in the family, and my father too seemed very unhappy as well as being unwell. I saw more clearly than ever that I could never, ever 'get it right' for my sister. (And I still can't!)

I saw the family dynamics clearly for the first time over the course of the next day. I saw how our family had always been so misshapen and so stultifying, as a result of our eldest sister having the unwavering support of our Mother at every turn, asking all the time if there was anything she wanted.

I was shocked to realise that my elder sister had always been at the very centre of the family in this and other ways, and that she had our mother's attention in a peculiar way. For our Mother, even my Father, despite his illness, was a distant second, and my brother, younger sister and I were 'also rans' in the scheme of things. There was a huge rift in the structure of the family and for me on that day, also a maddening sense of the impossibility of any mobility in this family dynamic.

I attempted to raise the issue three times over the next few days, my younger brother and sister would not even consider raising it, and my Father simply waved me away, a little tipsy as usual.

I went to my mother and elder sister and raised the issue, which resulted in the usual fury from my sister and mother's angry defence of her eldest. The holiday break staggered to an end, and our fragmented family retired to its geographically disparate safe havens.

As I've looked at what drove our family apart, I understand there was a rift between our father and mother from the beginning, and my eldest sister became mother's help meet and confidant, creating a Gordian knot which could never be undone. Over the years the family set itself in stone; no one was able to shift it, to the cost of all concerned." Peter.

I have seen many families like Peter's where there is no chance of change; the family itself is unable to move; as he says, it is set in stone. It is very difficult indeed to shift the architecture of such a family, the consequences are only very slowly recognised, and of course they differ for each family member. Every member is affected negatively by the dynamics of such a terribly closed system. From my work with child survivors of sexual and physical abuse, I know there is only very limited contact with the outside world, and very few visitors, who either know nothing of what is going on in the system, or condone it. Healthy links to a healthy society would seem to be vital for a healthy family system.

In Conclusion

Humans have worked with one another for millennia and we have bettered both the family and the tribe, collaboration certainly works! We have come from our naked origin in the Great Rift Valley and populated the world. We have moved from cleverly using stones as hammers and sticks as levers and supports, to micro medicine and all the astonishing achievements of our race.

At our root, we are habitually committed collaborators. As our world changes, some of this drops away, but the family unit can still make good and helpful use of the old skills of caring and minding, for the benefit of others as well as of ourselves.

In 'The Blank Slate' Steven Pinker writes: "In traditional foraging societies, genetic relatives are more likely to live together, work in each others gardens, protect each other, adopt each others needy or orphaned children and are less likely to attack, feud with, and kill each other" (2003).

In our work with our clients, the model of open communication and collaboration is a good one and fosters the strength of healthy relationships that enable all of us to grow wiser and stronger.

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Sue Wright

Bearing The Unbearable: An Integrative Approach To Working With Tauma

Introduction

It is interesting that on mentioning the title of this article to a colleague it was construed as "baring", in the sense of revealing what cannot be revealed, rather than "bearing", meaning "enduring" something that is overwhelming. Actually, both meanings are apt when we work with people whose experiences lie at the extremes of human suffering. Such experiences were unbearable to live through, and would have caused overwhelming physiological and emotional arousal, and are unbearable for the survivor to think or speak of in the present as this often rekindles identical feelings and sensations.

All traumatic events, whether natural disasters, accidents, interpersonal violence or the results of war and terrorism, are embedded in a social context. The most damaging in their impact on self-beliefs, relationships and functioning and the most likely to lead to post traumatic stress are what are variously called relationship trauma, attachment trauma or betrayal trauma (Allen, 2001; Freyd, 1996 cited in Allen). Relationship traumas are very hard to "bare" and speak about. The survivor knows that the people it should be possible to turn to for support would be unable to "bear" (contain) knowing the truth or, worse, are a cause of the events. He is left alone to make sense of what occurred and to manage the emotional after effects (trauma's "tsunami's").

This is the "self-with-other" world that we step into when we work with survivors of relationship trauma. It is a world where we are repeatedly challenged to bear the unbearable and think about the unthinkable. A few years ago I would have also added "speak the unspeakable". Now, however, I am more aware just how overwhelming the narrative process can be for a client and of the complex judgements needed to determine when "speaking the unspeakable" might be bearable and what needs to be done in advance to make the process more manageable. This work also involves a lot of self-study (both internal and external supervision) and self-supports to ensure that, as clinicians, we are robust and grounded enough to weather hearing about the unthinkable and witnessing its re-enactments in the present.

In what follows I intend to discuss how the past can be relived in the present; how this impacts on the therapist and the therapeutic alliance and to consider what can help client and therapist to survive. I draw on a range of theories to make sense of these processes including psychodynamic concepts, attachment theory and the growing psychoneurobiologicial research on trauma and in practice I integrate a relational perspective with body-oriented approaches.[1]

1. I am informed by my trainings in Integrative Psychotherapy, Dance Movement Therapy and, more

The Reliving Of The Past In The Present

One of the unbearable aspects of trauma is the way the past intrudes on the present, for instance in the form of flashbacks and behavioural, interpersonal, emotional and somatic re-enactments. An understanding of the nature of memory and of different levels of cognitive processing helps to explain such intrusive phenomena. Memories do more than store the factual details of an event. The details are encoded along with how the event was directly experienced, that is with associated feelings and body sensations and with representations of salient interpersonal dynamics. From this it follows that, once one element of a trauma is evoked, there is a tendency for all the elements to be reactivated — what is known as a "state dependent memory" (Van der Kolk, 1989). In some cases the triggering element might be a word or thought and instead of being understood as a symbol of that event, the individual experiences it as if the past were happening right now. This is known as 'psychic equivalence mode' (Krueger, 2002; Holmes, 2003; Bateman and Fonagy, 2004).

The re-experiencing of bodily states associated with the original trauma includes states of hyperarousal, numbing or both. Van der Kolk (1987) called the alternation between these states the "bi-phasic response to trauma". We all have an optimal range of arousal, the "optimum arousal zone" or "window of tolerance", within which we can maintain normal functioning and information processing (Ogden and Minton, 2000; Siegel, 1999). Under stress or faced with reminders of the trauma, survivors can rapidly be pulled out of the "window of tolerance". They may become highly activated (fight/flight responses) or hypo-aroused (freeze/submit responses); they may fail to discriminate between 'now' and 'then' ('psychic equivalence mode') and turn to old behavioural responses in a desperate attempt at self-protection. Repeated behaviours can also include acting in ways that echo what was done to them (identifying with the abuser) and re-entering abusive relationships. Added to all these 'relivings', many victims of childhood trauma still have contact with those who perpetrated or colluded with the original abuse. They are repeatedly sucked into the harmful family dynamics that they are desperate to escape and the rapid triggering of state-dependent emotional responses means that again and again they find themselves putting up with things, saying "yes" and failing to assert their needs.

To Give Some Case Examples:[2]

1) Naomi was abused by her step-father and accused of "asking for it" by her hostile, rejecting mother. She learned that to survive she had to pretend to be OK, never complain and rely entirely on herself. But it is a brittle self-reliance because a part of her still desperately craves some indication that her mother loves her. In the present, the impact of still seeing her step-father and the ongoing anxiety that her mother might abandon her is becoming unendurable. The effort of saying "yes" to any demand from the extended family and constantly overriding her own needs is exhausting Naomi and, I believe, is the cause of recurrent health problems.

In recent therapy sessions Naomi has been extremely agitated and terrified that she might not be able to cope any more or sustain the pretence of being OK. On one occasion I sensed that she felt completely trapped — unable to think of a way out of the situation because each option was potentially as frightening as another. For instance, to share her desperation with anyone else feels impossible. She is scared that, if the abuse were spoken about, others would find out and this would blow apart the family to which she is so anxiously attached. On reflection, I imagine that, as a child, Naomi often felt trapped like this. There was nowhere for the little girl to escape to; it was impossible to talk to anyone about what was going on and her efforts to resist the abuse or elicit some warmth from her mother were to no avail.

2) Dawn is a woman in her 30s who presents with features of Dissociative Identity Disorder. She was abandoned by her alcoholic mother

recently, Sensorimotor Psychotherapy. Some examples of works that I have found helpful are given in the bibliography.

2. To protect client confidentiality all examples use fictitious names and details.

and ritually abused when in foster care. Later carers were physically abusive. I have been with Dawn on many occasions when a small trigger — a word, look, idea — has led to a rapid switch into a state of "being" the 5-year-old child, crouching terrified in a corner, shaking and speaking with childlike language. In this state the abusers are still here and very threatening.[3] She worries that they will get into the building, attack her and also harm me. For the "adult" Dawn this process is also unbearable. She cannot understand why it is happening. It feels as if she is going mad. It runs counter to all the strategies she has evolved over the years to avoid anything to do with the past and to discount, suppress or use alcohol to numb her emotions.

3) Marcus: My third example is of a man who endured severe trauma when held as a political prisoner in his home country. As a result of these experiences Marcus developed a hypervigilant orienting response. He was acutely observant of anything different in his surroundings — in my room for example, he would immediately notice if a small object had been moved and want to know why. He was exquisitely sensitive to other people's body language, scanning gestures and expressions in order to gauge someone's mood. He demanded explanations — to know why I said and did things, demands that I found challenging and put me on the spot (me as the interrogated victim), until I was able to make sense of the protective function of his actions. Marcus could also switch into a frozen state — his voice failing him, his limbs feeling weak as he struggled with the urge to curl up small.

Marcus entered therapy because at work he kept, in his words, "collapsing" in this "humiliating" way. It alarmed him because it was becoming increasingly difficult to hide and ran so counter to his efficient, trouble-shooting self. Slowly we were able to identify a connection between the freeze response and Marcus's interactions with a new and very demanding manager. There was something about the latter's intimidating manner and looks that reminded Marcus of one of his interrogators.

3. This is an example of someone caught in a "state dependent memory" and functioning in "psychic equivalence mode".

What made it unbearable was not that the manager was like him, to Marcus's sensitised nervous system he became the interrogator and in response he froze and dissociated as, I suspect, he did at the time of the trauma.

With clients like Naomi, Dawn and Marcus what is communicated again and again, and by impact rather than with words, is a flavour of how, in the past, they were subjected to repeated shocks — to awful events that must have seemed crazy as well as terrifying. And like a mother with a very sensitive baby, I have to be exquisitely careful in order not to 'trigger' or over arouse them and to attune to tiny changes in expression or energy which indicate a need to change the focus and slow things down. It is a process that can feel exhausting.

Our Responses To The Unbearable

At this point it seems appropriate to consider how, as individuals, we respond to the unbearable. It can be disturbing enough to hear or read about extreme human suffering, but the most unbearable aspect of trauma therapy is when the past enters the room in very tangible ways and we become witness to or indeed part of the reliving. Firstly, it can be immensely disturbing to witness a client's intense arousal as he or she relives a trauma memory. Here I have in mind sitting with Dawn when she has a flashback and regresses to being the 5 year old. It is as if I was there at the time watching the terrified child and feeling helpless — not knowing what to do or say that might make a difference nor when she might regain adult functioning. It is also hard to stay hopeful when the influence of the past repeatedly jeopardises our relationship. For instance, Dawn expects to be rejected and so is highly alert to anything in my expression or words that might indicate that I am angry with her. We can also be disturbed by evidence of the relived past in what clients tell us about their lives outside. For example, to hear how Naomi is criticised and humiliated when she visits her mother and, in response, is momentarily unable to speak or act.

When overwhelmed by something that shocks us, whether what we hear or witness, there is a risk that we will unwittingly communicate that we can't bear to listen to the client's story

or be with her when she is like this. A shift in gaze or posture; forgetting something or glazing over — the "rejecting" messages are very subtle, but quickly picked up by people who have learned to be immensely sensitive to non-verbal cues. Equally, in benignly trying to reframe a cognitive distortion; change a behaviour; reduce a "symptom" or normalise a coping strategy we may be experienced as saying, "this is too much for me". "You are not acceptable as you are".

Returning to Naomi, I began to notice small rifts in our alliance whenever I tried to challenge her entrenched belief that she is bad and that the abuse was her fault. I needed to step back and identify that for me, one of the awful consequences of abuse is that it leads to intense self-hatred and blame. I want my clients to know that they were not the wrong doers, that I don't see them as bad. However, more important ultimately is to convey our willingness to be with someone who is so "bad" and our willingness to understand what it is like to live with such beliefs, rather than perpetuating a denial of the client's reality. In a similar way I believe that it is important to convey our understanding as to why people develop certain coping strategies (whether this be to self harm, dissociate or isolate from others) and why they need to maintain these strategies, however harmful they may be in the present.

'Trauma Specific Transference'

Especially challenging and hard to bear are those times when the trauma is re-enacted within the therapeutic relationship and we are induced into roles related to the trauma such as that of the "helpless victim", the "neglecting bystander" or worse, the "persecutor" (Davies & Frawley, 1994, pp 167–185). When a client denigrates us, rubbishes what we offer and accuses us of being uncaring this hurts us because we want to help, to make a difference. When we feel completely helpless it undermines our confidence and sense of ourselves as "OK". When we experience moments of intense fury with a client it shocks us that we could entertain such thoughts.

Wilson and Lindy (1994) call these "trauma specific transferences". TSTs can be roles that we "inherit". They can also be related to the environment and therapeutic frame — for instance something about the room that triggers arousal or about a silence, about being questioned, about cancelling an appointment — often seemingly innocuous occurrences, but which have symbolic meaning for the survivor. It can be hard to think straight when in the grip of TSTs, but thinking is what we need to do, to stay mindful so that we do not over react and can use these experiences as information about what the client's life is like and how he may have been treated.

A model that I find helpful to make sense of my countertransference responses and refer to in order to guard against unwittingly acting something out is shown below. Wilson and Lindy argue that our responses to the unbearable can be normative or subjective and that from either position we can be pulled into rescuing or avoiding. For example, if repeatedly 'attacked' we will feel like withdrawing — a normative response, but potentially heightened if the client's story has personal resonance. If we have been pulled into the role of "persecutor" or "bystander", even in a small way — for instance by feeling relieved if the client misses an appointment, then we are likely to move to the rescue side in order to compensate. These positions are not fixed. We can oscillate between them. Hence the importance of finding a middle ground where we stay mindful and attuned.

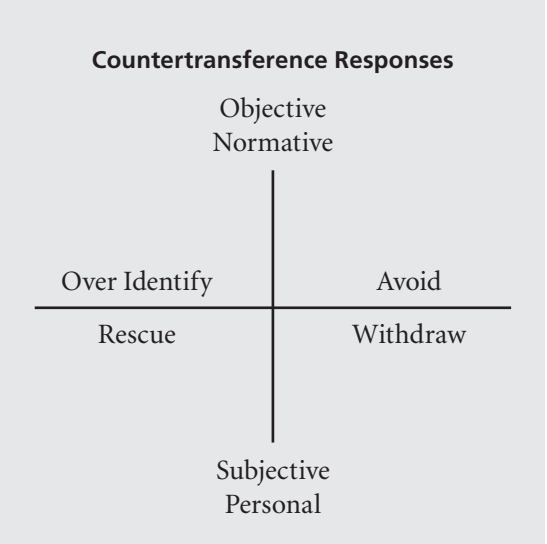

Diagram 1 *(adapted from Wilson and Lindy,1994)*

An example of how the model informs my thinking about both individual cases and team

dynamics, can be drawn from a supervision case. Bel, the supervisee, had contracted to work for 24 sessions with a chaotic young woman who had been multiply abused. As they approached the final session Simone was increasingly anxious and demanding. Sometimes she became panic stricken, communicating in various ways a fear of falling to bits without Bel's support. On other occasions she angrily accused Bel of "opening her up" and "leaving her hanging" and insisted that Bel should arrange something to help her once the therapy ended.

In one of our final sessions Bel arrived and, with some embarrassment, asked if I would schedule in another appointment because she had decided to offer Simone four more sessions. She thought there had been insufficient time to do all that she had intended and asked my advice about which of a long list of exercises she should try in the time remaining. When I asked what would happen if we thought about how to manage the ending not what to do, Bel realised that she had been sucked into rescuing. "Normatively" anyone could have felt helpless in the face of Simone's repeated acting out, whilst "subjectively" I knew that Bel was also dealing with her own sense of loss at ending her placement in this setting. In parallel I realised that I too had feelings of hopelessness about Simone's future. But, in my case I had defended against this by moving to the avoidant pole. For instance, I registered impatience as I contemplated when I could meet Bel for an extra session and I caught my mind wandering to other things in the first part of our discussion. Interestingly these dynamics were repeated amongst others in the team. Some leaped into planning what should happen next. Others scathingly commented on the "time wasted" on the client.

As part of the "rescue/doing too much" response, I know that when I start wishing: "if only I knew how to use EMDR"; "had a technique for …"; "had been on that course or read that book", then I am finding something hard to bear. Wondering if anything that I do is of use is a repeated thought when I am with Naomi and Dawn. My knowledge of how, as children their efforts to stop the abuse and elicit the love they craved had no effect and how, in the present, they frequently complain of failing at everything, has helped me to understand these feelings. Nonetheless there are still times when I find myself longing for something that might make a difference. But the important thing is to be able to sit with the despair, reflect on it and believe that my own ability to manage unbearable emotions will provide sufficient containment for them to gradually internalise this function for themselves.

Writing about work with severely deprived children Hoxter comments, "it is the raw pain that requires our attention; it cannot be explained away; it has to be attended to and encountered in ourselves". If we can bear what we imagine the client is experiencing or has experienced and what happens inside us in response, then there is a chance that the raw pain can slowly be transformed (Hoxter, 1983, p. 131 & Bion, 1967). But surviving the rawness can have its costs. Another concept from the work of Wilson, Lindy and colleagues (1994, 2001, 2004) is that of "empathic strain". The concept is used to describe when we are stretched to our limits by exposure to traumatic stories and re-enactments. Empathic strain may be in response to a particular story or individual or cumulative (one shock too many in a day) and can be experienced in various ways. Emotionally this may be by feeling demoralised, and doubting our ability to do this work or feeling very angry or sad or scared. It can also be experienced somatically. For example, we may feel sick, exhausted, in pain or we may have headaches and problems sleeping. It can lead to behavioural responses on the "avoid/rescue spectrum" and to psychological reactions such as detachment. In order to help us to bear the unbearable and minimise the potential for empathic strain we need our own supports — good supervision, contact with peers, a range of self-soothing activities — and, because trauma has such an impact at a somatic level, we need to pay attention to our physical as well as to our emotional and intellectual needs.

What Do Clients Need To Help Them To Bear The Unbearable?

Returning to our clients, how can we help them to bear the unbearable? Looking back at the history of trauma work there have been significant changes over time. In Freud's day

traumatic sequelae were viewed as hysterical fantasies and the cure was to "get it out", to "make the unconscious conscious". In the 1960s and 70s the emphasis was on expressing feelings, that is on "abreacting". Now, however, there is increasing stress on helping the trauma survivor to manage the arousal — the dysregulation to his system caused by exposure to overwhelming events or their memories. We know that 'baring' (thinking and speaking about) the unbearable is only possible if a client can regulate emotional arousal. It needs to occur, if at all, in a carefully timed, phased approach.

In all phase oriented approaches — and the first to propose such a model was Janet in the 1890s (van der Hart & Steel, 1997) — the first stage is always to build safety and stabilise the client. Even a decade ago phase one was thought of as a 'warm up' for the real work of telling the story. Now we know that healing can occur without 'baring' all and that, contrary to 'old' wisdom, it doesn't have to get worse before it gets better. Indeed, we have a crucial and immensely hard task in trying to ensure that things don't get worse.

To explain the reasoning behind this we need to think developmentally. If a child is brought up in a climate of violence and abuse with no one to help him to manage and make sense of overwhelming experiences, often because his carers were "frightening" or "frightened", then he will grow up lacking certain crucial skills and "self-capacities" (Deiter; Nicholls & Pearlman, 2000).

These include:

a) Firstly, the capacity for self-reflection, emotional regulation (being able to tolerate intense emotions and self soothe) and mentalisation (the ability to think about the contents of the mind — thoughts, feelings, and desires — and appreciate that others can think and feel differently) (Fonagy, 2001: Bateman & Fonagy, 2004). In a secure environment these three functions are slowly internalised as a result of repeated experiences with 'self-regulating others' (Stern, 1985).

b) Secondly, the ability to maintain a sense of one's self as ongoing, integrated and worthy.

c) Thirdly, the ability to form positive relationships in which it is possible to feel comfortable being close to others and alone.

What we are dealing with then is, on the one hand a highly sensitised nervous system — the client has a very small "window of tolerance" for emotional arousal (Ogden and Minton, 2000; Siegel, 1999) — coupled with fundamental deficits in the key capacities that should, given a good enough start in life, help the individual to manage high arousal. These deficits can manifest in certain basic and highly entrenched fears (Steele et al, 2001; Nijenhuis et al, 2004).

They include not just a "phobia" of traumatic memories but also:

a) A phobia of mental contents. Often it is not just the memories themselves that become unbearable but any feelings, so that splitting off affect becomes a common strategy.

b) A phobia of attachment and dependency. The survivor of relationship trauma has learned that it is safer not to trust or get close to others.

c) A phobia of change and normal life. Even if it is severely limiting, the survivor will prefer to stay with the familiar.

d) And lastly, because it stimulates thoughts about the other fears, a phobia of the therapist and the therapy.

From this follow four key guidelines:[4]

a) Overcoming fear of the memories, in the early stages of the work at least, is more important than narrating them. One aspect of this is helping clients to differentiate between past and present. It is also more important to focus on the effects of remembering than on the content of the memory. Here the technique of metatalking, namely "talking about talking", is important. When we adopt a metacognitive position we are not only empathising with and demonstrating that we understand the fear; we are distancing from

4. Here I owe much of my evolving understanding to the work of Pat Ogden and Janina Fischer of the Sensorimotor Psychotherapy Institute.

the experience and the risk of 'equivalence mode' functioning and so helping to lower arousal. Furthermore we are developing the possibility of shared meaning (Holmes, 2003).

b) Overcoming fear of feelings is more important than encouraging cathartic experiences. This is not to deny that expressing emotions can be healing and can foster integration, but only when the client feels safe and in control rather than at the mercy of further hyperarousal. Again talking about feelings in a metacognitive way is important.

c) Helping clients to slowly expand their "window of tolerance" is more important than focussing on changing behaviours or thoughts. As Rothschild's work (2000) emphasises, we need to help clients to "put the brakes on", and this entails being very alert to signs of acceleration. We also need to respect the survival value of old, often maladaptive, coping strategies whilst helping the client to develop new resources.

d) Lastly underpinning all this, is appreciating how fundamental the therapeutic relationship can be. Van der Hart et al (1993, pp 162–180) speak of "shifting the trauma from an autistic re-experiencing, to a relational sharing". Whatever procedures we learn and apply, it is what goes on between therapist and client whilst working with these techniques that is important. Whatever our theoretical background, it is how we are with our clients that matters.

There are a number of aspects to this. Firstly are conditions that we hopefully offer to any client, but which are crucial for people who have learned not to trust others, such as consistency, firm boundaries and responses that are attuned, accepting and non-retaliatory. A second requirement is our capacity to offer containment. This is particularly important for anyone whose carers were unable to contain their own or the infant's distress. By carefully tracking the client's arousal and titrating the amount of the trauma story being discussed, we offer something developmentally needed. We serve as "self-regulating others" (Stern, 1985) or "psychobiological regulators" (Schore, 2003) and in this way can help the client to develop his own self-regulatory functions. Here, it should be stressed, we are doing much more than 'teaching' skills in distress tolerance. As we engage in a process of shared attention and attune to the client's shifting states of mind using verbal and non-verbal interventions to either 'up or down regulate' emotion, we are communicating at a subtle level that his mind — his subjectivity — has been grasped by the mind of another person and deeply understood. Crucial too is the fact that we are not trying to 'change' him. To be able to share one's subjective world and have that accepted as it is with no judgements or pressure to do anything different can be a uniquely healing experience.

Finally, and the deepest and most challenging aspect of the "relational sharing", is our capacity to enter into the client's story and stay steady. Whilst we may try hard to keep a positive alliance; be nothing like the abusive or neglectful figures from the past; make the environment as safe as possible in order to avoid triggers and put the brakes on given any signs of arousal, there is an inevitability about being pulled into re-enactments of the original trauma.

"To be truly understood", said Peterfreund, "one must evoke similar experiences in the receiver" (1975, cited in Lindy, 1988, p. 244). By feeling some of the helplessness, rage, self-doubt and shame that the survivor has felt and maintaining our capacity to stay mindful, we offer something developmentally needed — the experience of being with a "self-regulating other" who can help to make sense of what is going on. These live experiences contribute to real healing.

The Unbearable Core

There is another aspect to weathering unbearable moments during the course of therapy — whether these entail being pulled into trauma specific roles or facing phases when the therapeutic relationship seems unlikely to survive or worse, when the client's life is at risk. Only then do we learn the unique language of what is unbearable for that client. The situations that take the trauma survivor out of the "window of tolerance" will be uniquely calibrated for each individual and will be related to the particular constellation of interpersonal dynamics that characterised the original trauma. What I am calling the

"unbearable core" of the trauma will impact at every level of the survivor's functioning. It effects how he sees himself and others; his relationship with his body; his thoughts and behaviours and strategies for survival. It will frequently emerge in symbolic, metaphorical ways and in repeated patterns of behaviour and involuntary responses or what Panksepp (1988) has termed "emotional operating systems".

I will end with some examples of the "unbearable core": For Naomi, the core issue concerned making the "wrong" choices. At the re-enactment level she regularly described things that had gone wrong at work or in her marriage. From my perspective, the fault often lay elsewhere, but Naomi inevitably took the blame upon herself. "I loused it up". "If I hadn't chosen X, Y wouldn't have happened". Only gradually did a connection emerge between these familiar remarks and the past, for one of Naomi's enduring beliefs is that she "chose" to be abused and that this choice irretrievably damns her. In reality there was no choice. The child was trapped between two impossible situations — "Say yes or I'll start on your sister"; "Let me do it or I'll kill the kitten" — between their suffering or her own. And in our relationship I often found myself stuck in a "damned if I do and damned if I don't" impasse. Making sense of my feelings helped me to appreciate that the hardest thing for Naomi to accept is the lack of any choice, for without the illusion of some control she is left to face the enormity of her helplessness.

In Dawn's case it was unbearable that nothing she did to protect herself had worked. The little girl tried desperately hard to 'be good' in the hope that her abusers might then be 'nice' to her. She repeatedly said 'sorry' thinking that this might stop such horrific 'punishments'. In the therapy this was re-enacted in various ways. When the five-year-old self emerged she repeatedly muttered the words "be good" and "me sorry". As her adult self Dawn was endlessly apologising and berating herself for not trying hard enough and occasionally she became angry with me about the therapy not working. And, with a sinking feeling in my stomach, I frequently thought, "this is not working" — for instance, when I adopted different strategies to help Dawn regain adult functioning before leaving or tried to convince her that I was not angry. Eventually a significant shift occurred when, after an agitated stream of "sorry"s, the "child-self" added sadly, "it didn't work". We could then begin to acknowledge how frightening it must have been that, however hard she tried, she was never able to stop the abuse.

Finally, with Marcus the most unbearable aspect of his traumatic experiences was to be treated like an object and worse, a useless object. With this dynamic in mind, it made sense why he became so incensed each time his new manager undermined his decisions, by-passed him in favour of younger colleagues or called him to task for speaking out about bad practices. It reminded Marcus of all the occasions when he had been subjected to the will of others and when he had been 'silenced' as a political risk in his home country. And I could only understand these dynamics by becoming victim to ruthless attacks on the therapy — labelled as useless, treated as an object and silenced when I tried to offer something helpful.

Conclusions:

Just as there will be something uniquely unbearable for each client, so we as therapists will find particular events or experiences unbearable to witness. We will have our own "unbearable core". I have already mentioned that I find it hard hearing how victims of abuse blame themselves. At times I also find it unbearable not to be able to help, to realise that nothing I am doing is making any difference. It can be hard to think straight when in the grip of TSTs and when we are pulled into role re-enactments. It can be hard to stay consistent and not react when we find ourselves at the core of what is unbearable for the client or for ourselves. But staying mindful is what is needed — so that we do not step out of role; so that we can help to contain the client's affect and so that we can use these experiences as information about how the client may have been treated. When something is unbearable, when we come face to face with the raw pain, it creates imperatives — an urgent need to change things, to escape, to discharge emotions. However, our ability to "respond without urgency to the client's urgent needs" (Rothschild, 2000) will, paradoxically, have an immediate effect on making the unbearable easier to bear.

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Carole Archer

Personal Integrative Framework

Editors' Note

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

1. Introduction To My Model Of Psychotherapy Integration

The fundamental core of my model of psychotherapy integration is the client and psychotherapist in a relationship paradigm, grounded in the psychotherapeutic alliance, supported by supervision. The conscious and unconscious interactions of the psychotherapeutic relationship enhance the experience of self for the client, facilitating understanding to enable change, and resolve or alleviate suffering.

My psychotherapy integration is work in progress. I feel secure in what I present and offer to clients but do not regard this as absolute. I agree with Schore (2000) that the psychotherapist must be freed from identification with theories, thereby remaining open to the spontaneous images and feelings of the neurological unconscious. How I experience clients, how I understand the structural development of the self, derives from my life experience, culture, values and training. These, with continual self reflection and awareness of knowledge, will continue to evolve (Prall, 2004).

Nietzsche claimed a philosopher's system of thought arises from his autobiography (Yalom, 1991). The philosophical base that emerges from my experience and belief system supports a post modern perspective, i.e. there is no universal comprehension but multiple realities, where people subjectively cocreate meaning (Denzin & Lincoln, 2000, in Evans & Gilbert, 2005). This relates to holism, systems and field theory where the physical, mental and social environment of a person has meaning and relevance. These perspectives embrace phenomenology, i.e. that reality consists of objects and events as they are perceived in human consciousness (Spinelli, 2000). Thereby I am drawn to leave the security of theory and encounter the existential unknowns, i.e. death, meaninglessness, isolation and freedom (Yalom, 1991).

The above philosophical principles underpin the following values of my psychotherapy integration. Fundamentally a person has meaning in relation to an other, and only has control over the present moment. A person's subjective experience, impacted by contextual, cultural and environmental factors, is their reality and determines behaviour. Through relationship a person can acknowledge and express feelings, be heard, nurtured and loved, have fun and explore the world.

These principles and values emphasise the significance of the nurturing, reparative and sustaining relationship in psychotherapy as fundamental to the client's process of development and integration. This is substantiated by research which states that the relationship between psychotherapist

and client is the most important factor for successful outcomes in psychotherapy (e.g. Bergin and Lambert, 1978, in Lapworth et al, 2001). This position has developed from a theory of contact by Perls, to Fairbairn's premise that people are relationship-seeking, and Guntrip's and Winnicott's relationship theories. Berne's theories of ego states, Rogers' focus on client-centred therapy, and Kohut and others' application of sustained empathic inquiry further endorse this (Erskine & Trautman, 1997).

My psychotherapy integration incorporates developmental theories chronologically. I draw on object relations theory which addresses our intrapsychic history, and attachment theory which focuses on how a person becomes a self in relation with others. Developing the focus on the psychotherapeutic relationship, self psychology asserts the self requires the presence of others. This focuses on the individual's experience as determined by the responsiveness of the other, emphasising the role of empathy. Further to this the premise of intersubjectivity, a theoretical concept describing an interpersonal process, emphasises the finding of the self in recognition by and of the other, i.e. in relationship (Mollon, 2001). Expanding from these, I focus on the relational dialogical perspective where psychotherapist and client cocreate the relationship from their unique subjective experience consciously and unconsciously.

1.1 Overview Of My Model Of Psychotherapy Integration

1.1.1 A View Of The Self

The self in relationship is central to my psychotherapy integration. Both psychotherapist and client are impacted by affective, behavioural, cognitive, physical and spiritual aspects of the self. These aspects are influenced by the motivation and structure of the developing self (function and dysfunction) within the context and culture of the environment. The relationship of self to self and self to others can be defined on several interacting levels i.e. the biological, intrapsychic, interpersonal, intercultural, ecological and transpersonal. These concepts inform my problem formulation.

1.1.2 The Process Of Integrative Psychotherapy

The process of psychotherapy integrates the client and psychotherapist in a therapeutic relationship to enable change influenced by relational modalities and techniques over time. This process affects other relationships for all participants. For example the client's relationships with family and the psychotherapist's relationship in supervision are impacted by, and will feed back to, the client/psychotherapist relationship.

I will now expand and discuss this overview.

2. A View Of The Self

2.1 A Definition Of The Self

Phenomenology proposes that each of us has a unique, intentionally derived conscious experience of the world and ourselves (Spinelli, 2000). Our sense of self includes our whole environment, our being (conscious and unconscious), and life context (past, present and future). Our awareness of our self emerges from a series of interactions in relationship. We classify ourselves in relation to our experience in the world with our bodily and psychological experience (Kepner, 1996). Fonaghy et al, 2002 (in Evans & Gilbert, 2005) further define the relationship of self as subject and self as object. The self as subject refers to the "I" who observes, categorises and defines experience, and forms the "me" as self concept, a personal representation of how I function in the world, a view of myself as object among other objects.

2.2 Motivation

Motivation can be defined as the biological, emotional, cognitive and social forces that activate and direct behaviour. For me, motivation derives from a fundamental drive for survival and relationship with others. This is supported by Fairbairn (1994) who asserts our basic striving is for relationship.

Stern (2003) states that the child organises experience around motives which include object relatedness. Kohut's self psychology derives from attachment as the central motivation of the self to establish cohesiveness (Shane et al, 1997). According to Mitchell (1988, in Fonagy, 2001) we are motivated to create and express ourselves within relationship. Thereby we create meaning and opportunity to cope with life's existential anxieties (Yalom, 1991).

2.3 Structure Of The Developing Self — Function And Dysfunction

The relational theories I draw on concur with the philosophical base, values and motivation of my framework for psychotherapy integration. The theories are presented progressively reflecting their development from object relations, attachment theory, neuroscience, and self psychology, moving to a relational paradigm. This parallels my personal development from a need for relationship and attachment to an ability to function in the dialogical between, and is congruent with my theoretical development as evidenced in my psychotherapy practice.

2.3.1 Object Relations Theory

The individual's conscious and unconscious interpretation of intrapsychic and interpersonal relationships, beginning with the mother-infant dyad, lays the foundation for the development of identity, and the basis for future relationships. I feel a child, from conception, has some form of personality/identity. It is thought provoking to consider the impact of the intrauterine, interpersonal relationship of mother and foetus.

I draw from the object relations theorists Fairbairn, Winnicott, Guntrip and Balint who regard the self as derived from internal relationships between different aspects of the person, each affecting the other. A person is object seeking, motivated to innately seek relatedness with an other, which can be an aspect of a person. The self reflects our social nature, neither developing nor long surviving outside a relational context (Gomez, 1997).

Object relations theory regards psychological dysfunction as an expression of fixation at a developmental stage. For example Balint's (1992) 'basic fault' describes such a lack of attunement. The basic fault results from a distorted relationship between the child and a person in their environment which leads to intense and overwhelming anxiety. Aims to live above this anxiety involve acting out traumatic self object internalisations from childhood in current relationships by using defensive strategies, emotional withdrawal and disintegration to protect the traumatised self from the consequences of unmet needs. Such dysfunctional behaviours are immature efforts to resolve early traumas. These attempts typically fail since we use immature manipulations to get others, who are engaged in similar manipulations, to meet our needs.

2.3.2 Attachment Theory

Moving from object relations theory's largely intrapsychic perspective, attachment theory offers explanations of how the developing self becomes a self with others. This defines an interpersonal relationship to develop a sense of security from an attachment between the child and an emotionally attuned other (Holmes, 1994).

Attachment influences and organises motivational, emotional and memory processes in relationship to significant care givers. The emotional transactions of secure attachment involve a caregiver's sensitive responses to the child, promoting positive emotional states and modulating negative states. Repeated experiences become encoded in implicit memory as expectations, and thereby models of attachment, which develop a secure base in the world, promoting emotional resilience (Siegel, 1999).

This is supported by Stern (2003). He hypothesises several developmental tasks in the evolving sense of self to the age of 3 to 4 which emphasize the importance of an appropriate attachment relationship. These phases include the sense of agency, without which the self experiences loss of control; the sense of cohesion, without which the self may experience fragmentation; the sense

of continuity and affectivity without which there can be disassociation; the sense of a subjective self able to attain intersubjectivity with another, without which there is loneliness; the sense of creating organisation, without which there can be mental turmoil; the sense of communicating meaning, without which there can be exclusion from socialisation, environment and culture (Stern 2003, pp7–8).

Neuroscience substantiates attachment theory. The process of interaction between child and caregiver creates neural connections that form attachment patterns, a relationship process internalised by the child as affect regulation (Siegel, 2001). The disruption of attachment bonds in infancy leads to regulatory failure, with the good enough caregiver provoking reattunement. This enables the internalisation of a system to regulate stressful negative affects. Such communication of emotional states psychobiologically underpins empathy (Schore, 2002).

There is a shift to the understanding, more compatible with Fairbairn's attachment to bad objects, that children become attached to whatever is available. So those attached to maltreating or insensitive figures are presumed no less attached (Mitchell, 2000). An insecurely attached person may experience differing feelings towards their attachment figure, from love to fear or rejection. Such attachments are insecure compromises to maintain contact with the object. A child with an insecure ambivalent attachment style views self as unlovable, with an unpredictable other who has to be manipulated into caring. The insecure avoidant child feels unworthy of care and experiences an other who does not nurture, forcing repression of longing and anger in order not to drive the other further away. The disorganised/disoriented child is abused or neglected. S/he has no strategy for responding to the caregivers avoiding or resisting approaches, and so appears confused or frightened and immobilised (Holmes, 1993).

The caregiver who rejects or reacts inappropriately to the child's expressions of emotions and stress induces traumatic states of enduring negative affect with extreme levels of stimulation and arousal. There is no interactive repair, so dysregulated states are incorporated as a pathological internal object relation, a representation of a dysregulated self in interaction with a misattuning object. This results in severe alterations in the biochemistry of the immature brain, particularly areas associated with the development of coping strategies. As attachment is weak there is little protection against other potential abusers (Schore, 2001; 2002).

Attachment theory proposes how a person becomes a self with others across the lifespan. This can be obscured by our cultural myth which denies adult interdependence with others (Kepner, 1996).

2.3.3 Self Psychology

In self psychology Kohut regards attachment as motivation for the self to develop and maintain cohesiveness. Focusing on relationship, Kohut states the self requires the presence of others (Fonagy, 2001). Kohut suggested care giving individuals serve special functions as self objects in the healthy development of narcissism. The mechanisms of the self/self object transactions in the infant/caregiver (and client/psychotherapist) dyad facilitate an environment for experiencing dependent maturation (Schore, 2002). Kohut recognized that fragmentation arises in the child whose mental and physiological state is not regulated adequately by the care giving environment.

The first self object experience is mirroring, where the caregiver's affirmations develop self esteem. The child further acquires cohesion, the ability to self soothe and a capacity for ideals through experiences of merging with the perceived greatness and calm of an idealised self object, which can be the father. The child acquires a sense of belonging and continuity in space and time through twinship self objects, experiencing a sense of alikeness.

However, depending on the quality of interactions between self and self objects, the developing self will emerge in degrees of cohesion to fragmentation (Kohut & Wolf, 1978). Kohut (in Mollon, 2001) states attachments may be to those who traumatise, functioning as anti self objects. This results in disturbance of physical and psychological stability with a tendency to withdrawal and

rage. Such interactions become internalised as representations or expectations of relationships. The child will fail to self soothe and may resort to pathology e.g. dissociation, self harm, substance misuse. Kohut refers to two types of such disintegration, differentiating a fragmented self from a depleted self. Fragmentation arises in the child whose mental and physiological state is not regulated adequately by the caregivers. Schore (2002) suggests that throughout life a fragmented self describes a self system that is in intense, dysregulated sympathetic hyperarousal, a paralysis of the right brain core self. Kohut's depleted self characterises dysregulated parasympathetic hypoarousal, a dissociation experienced as an implosion of the self. There is insufficient energy to form the interconnections responsible for coherence, and a loss of interactive and auto-regulation, so the self experiences hopelessness and helplessness.

For Kohut empathy is sensing what a situation feels like for the other to enable self soothing, a feeling of connectedness and introspection. Kohut's focus was on understanding the individual's experience as determined by the responsiveness of the other (Mollon, 2001), and not primarily on the therapeutic relationship

2.3.4 Trauma, Abuse And Shame

The experience of trauma is often intergenerational and repressed. Succeeding generations sense something awful, and so experience unaccountable anxiety. Such presymbolic dread is normally unconscious manifesting later in life where the illusion of safety is fragmented, exposing terror and death anxiety.

Additionally abuse occurs within, and severely impacts, the relational context. Abuse by a caregiver halts the self object conditions necessary to establish a coherent sense of self, possibly back to the fragmented self. The child's perceptions are dissociated with severe anxiety, turning rage onto the self, giving rise to depression, self hatred and impulses to self harm (Mollon, 2001). The repression of emotions often manifests in the body (Hycner, 1993) linking psyche to somatic expressions of repressed feelings.

As a result of lack of early empathic attunement, especially from trauma or abuse, a person often suffers shame, an inner repulsion against one's own existence. Defensive patterns against feeling shame include withdrawal, attacking the self and/or others, self righteousness, avoidance of relationship and use of neurosis to preserve our existence (Hycner, 1993). The antidote to fragmentation, shame and rage is the experience of empathy from an other (Mollon, 2001) i.e. in relationship.

The above discussion of the developing self elaborates how, depending on early experiences, we make lasting assumptions (somatic, emotional and cognitive) about ourselves, others and our role in the world which lead to habitual patterns that are productive, or limiting and dysfunctional, all of which informs my work with clients.

2.4 Context/Culture

I consider my model of psychotherapy integration within the context and culture of the person and society. This holistic philosophy, within a field and systems theoretical framework, considers an individual's beliefs and practices within their social, political, historical, economic, and ecological environment. Erikson (in Fonagy, 2001) emphasised that the culturally conditioned experiences of the caregivers' environment influences the developing self. Additionally the relationship of self to the physical environment probably impacts the ecological dimension of being (Evans & Gilbert, 2005).

I acknowledge that the theories I draw on are mainly from white, middle class, male, Judeo Christian 20th century western cultures. This reflects my background and experience as a white female born in 1957. However in our multicultural society my approach must consider those from other backgrounds and cultures. I accept my subjective, cultural and contextual self, utilising phenomenology to open myself to the experience of others. With an holistic and systemic focus I aim to understand the client in the totality of their life situation (Evans & Gilbert, 2005).

2.5 Problem Formulation

To inform my hypothesis I maintain a phenomenological, relational focus, and attend to the client's physical, affect, cognition and behaviour states, and developmental dysfunctions. To develop a working alliance, the foundation of the psychotherapeutic relationship, I consider the client's motivation to relate, trust, and form attachments (Gelso & Carter, 1985), an essential base to develop the tasks and goals of psychotherapy (Bordin, 1979). I attend to conscious and unconscious relational patterns which emerge in the psychotherapeutic relationship as resistance, often in the transference and counter transference. I reconsider and readjust my conceptualisations, as appropriate throughout psychotherapy.

The above corresponds to Smith Benjamin's (2003) interpersonal diagnostic procedure which assesses relationship in terms of the client's perceived input (i.e. behaviour and affect), their responses and subsequent internalisations. This reflects the client's internalised perception of psychosocial situations impacting their self concept. Distortions may lie in any domain of the client's perceptions, responses and internalisations. Such issues mainly arise through continuation of, or identification with, relationships/ behaviours developed in the past. Considering this, and reflecting on a client's personality style, I do refer to the Diagnostic Statistical Manual of the American Psychological Society (DSM IV). The outline of symptoms of psychological distress, personality factors, physiological health, psychosocial and environmental stressors of Axis II categorises personality as:

1) Odd or eccentric behaviours:
paranoid, schizoid and schizotypal

2) Dramatic, emotional behaviours: histrionic, narcissistic, antisocial and borderline

3) Anxious, fearful behaviours: avoidant, dependent, compulsive and passive aggressive

(Elton Wilson, 1996).

I do not use DSM IV to diagnose or guide treatment in the literal sense, but the behavioural emphasis of these groupings can point to developmental and personality traits, and possible self disorders, which often informs me regarding a client's way of being, helping me to further understand their potential needs. However DSM IV is a product of its time and culture, and I am aware of the issues of labelling the client, and thereby losing their individuality. To formulate an adequate problem formulation I require considerably more information about the client's holistic world.

I support the client to adopt more adaptive ways of being by enabling contextually appropriate understanding of the origin and function of their interpersonal and intrapsychic patterns. To facilitate this I reflect on developmental theories, and the possibility of trauma and shame. Utilising object relations and attachment theories I address intrapsychic functions that manifest interpersonally through transference phenomena enabling the client to understand and resolve unconscious destructive patterns of relating. Self psychology enables me to focus on the client's subjective experience utilising the empathic relationship to facilitate the client to heal past deficits.

3. The Process Of Integrative Psychotherapy

Underpinning the discussions of my view of the structure and development of the self, I now outline an integrative view of change followed by reflection on the process of therapy over time, including relational modalities, strategies, techniques and interventions.

3.1 Change

In my framework for integrative psychotherapy change occurs primarily as new relational patterns are interpersonally co-created and internalised within the psychotherapeutic relationship, generating awareness, insight, catharsis, new experiences and action (Mitchell, 2000). Research supports the effectiveness of the psychotherapeutic relationship as the central agent for change. Hubble et al, 2000, (in Evans & Gilbert, 2005) state that hope for the future, including expectations of psychotherapy, is essential for change. Yalom (2001) believes it is only when the relationship in psychotherapy enlists deep emotions that it becomes a

powerful force for change. This supports Evans & Gilbert (2005) who maintain that change occurs just beyond one's comfort zone. The task is to cocreate a relationship to enable change which transfers to the client's wider world.

Schore (2002) contends that the system underlying psychotherapeutic change is the right hemisphere of the brain, the biological substrate of the human unconscious and emotional self. Right hemisphere to right hemisphere communication may be a healing factor where the process in the psychotherapeutic relationship restores the deficient relationships of childhood (Schore, 1994). This parallels self psychology which states change and development occur in the progressive differentiation and maturation of self object relationships. Conveying empathy at this nonverbal level corrects dysregulations in an atmosphere of mutuality. This leads to increased ability in the client to verbalise, broaden insight and achieve greater autonomy (Wallerstein, 1995). Consequently therapeutic change occurs by transforming methods of processing and regulating affect relied on by the client for psychological survival. It is important to be aware of the subtle, small changes that occur reflecting and celebrating these with the client, thus consolidating cognitive awareness and meaning making.

3.2 Relationship Modalities

Because of the relational density between a client and myself, there are complex considerations that influence the process of effective relational psychotherapy. I aim to be adaptable and versatile, sensitively attuned and contextually aware. I attend to the client's developing sense of a coherent self within a relational/dialogical perspective, considering transference and countertransference, various strategies, techniques and interventions, and the ending of psychotherapy, within the support and learning of supervision.

With reference to the developmental theories discussed, I focus on the developing self in relationship drawing on Kepner's (1996) healing tasks model. This outlines interacting stages of healing to develop emotional support and manage feelings. The psychotherapeutic relationship provides a context to affirm trust and enable growth, and thereby develops support. Developing self functions enables the capacity to integrate experience and interactions with self, others, and the environment. Undoing, redoing and mourning reconsolidates the client's perceptions and behaviour to enable meaning making for self and the world, i.e. a contextual reorganisation of past, present and future.

The following relationship modalities are applicable throughout the healing tasks model.

3.2.1 Relational/Dialogical Perspective

Object relations, attachment and self psychology theories are oriented to the subjectivity of the client or psychotherapist with some emphasis on the relational area between. Developing from this, I concur with dialogical psychotherapy (from existential thinking), and relational psychoanalysis (from the interpersonal tradition and object relations) both of which accentuate the psychotherapeutic relationship as a co-creation between client and therapist contributing from their subjective experiences (Mitchell, 2000). The dialogical perspective created occurs between two polarities; an I thou relationship — recognising the uniqueness and separateness of the other; and an I it relationship — where the other is an object (Hycner, 1993).

Focusing on the dialogical infers meeting the client at their psychological developmental level to enable a healthier relational stance through intrapsychic and interpersonal understanding. Early in therapy the psychotherapist is often objectified, essentially an I — it relationship. The client oscillates between I — thou and I — it relating with the psychotherapist experienced as a real person and a surrogate for the world (Hycner, 1993). Often until the major intrapsychic difficulties are integrated the client cannot explore interpersonal aspects. To this effect, understanding the client's self object transferences develops an intersubjective rather than an intrapsychic process (Mollon, 2001).

In the psychotherapeutic relationship there is mutual contact and trust between client and therapist, but not mutual inclusion. Inclusion is the role of the psychotherapist. This requires

me to be centred in my existence, maintaining my cognitive, emotional and experiential awareness whilst attempting to sense the client's experience. This is more than empathy, which Hycner (1993) states is a feeling that resides in the individual. For the client such inclusion, and recall of a lack of attunement in significant relationships, induces memories of unmet needs. Clients may deflect these emotional memories by anger, withdrawal, or even dissociation. In an unconscious attempt to elicit attunement and understanding, clients may express unconscious conflicts or feelings by acting out through overt behaviour, e.g. by coming late to sessions. Such resistance is an intrapsychic, protective manifestation of the client's vulnerability as they relate to the psychotherapeutic situation with the fears and expectations experienced in other relationships. Resistance is part of our existence and being in the world, but when explored creates opportunities for contact (Hycner, 1993). I remain aware that my resistance, i.e. the expectations and fears that prevent me encompassing the client's behaviour, can exacerbate client resistance.

I recognise the difficulty clients often have in the contrast between the contact offered in psychotherapy with the awareness that needs for relationship were previously unfulfilled. This may result in a defensive reaction from the client which could signal that I am proceeding more rapidly than the client can assimilate (Kahn, 1997). My misjudgment in understanding, inaccurate interpretations, or repetition of the client's past could result in the client reverting to an archaic self object relationship. Here I could become the unreliable parent. Mollon (2001) suggests non-defensively acknowledging the error, deferring from a transference interpretation. The power is that something real has occurred with an opportunity for the client to re-experience the past with a different outcome, i.e. with the psychotherapist who can manage the anger, distress or disappointment.

Elements of the relational/dialogical perspective can evoke the real relationship. This interpersonal genuine meeting in the present acknowledges the common experience of the participants, and can enable insight (Lapworth et al, 2001), e.g. sharing humour. Expanding from this the transpersonal relationship, a connection between participants approaching mystical/spiritual encounters, may encapsulate experiences beyond rationalisation. This may spontaneously be an aspect of an I-thou moment.

Within the dialogical/relational realm, the contextual/representational relationship encompasses cultural and socio-political perceptions of client and psychotherapist. This holistic concept attends to the relevance, and context, of my, and the client's, individuality. Personal history, gender, age, ethnicity, race, personality etc, all shape perception of, and contribution to, the psychotherapeutic relationship.

Consequently the dialogical, developmentally needed psychotherapeutic relationship is reparative, nourishing deficits in the client's experience. Because of my background I am aware I crave a dialogical relationship. I aim to use this positively as a psychotherapist, and not attempt to have my needs met via my clients. Clients do pay me attention, often idealise me but, with relevant use of supervision, I remain aware of these inherent pitfalls.

3.2.2 Transference And Countertransference

Transference occurs when the client transfers aspects of experiences of past relationships onto the psychotherapist (Lapworth et al, 2001). Countertransference is the conscious or unconscious response of the psychotherapist, derived from the relationship, which can aid the resolution of interpersonal issues. Countertransference may be determined by the psychotherapist's needs, rather than the client's, which, if not acknowledged, may reinforce the client's history.

The client and I enter the psychotherapeutic relationship with respective subjectivities from our individual archaic perception of self and others. These organise how we interactively construct experience, and thereby codetermine the transference. I continually reflect on the interaction and consider who is contributing what to the experience, remaining aware of my projective needs for a good enough parent.

In self psychology, Kohut outlined differing areas of transference which derive from the

self object experiences previously discussed. A need for confirmation evidences as a mirror transference where the psychotherapist serves as a mirror in which the client recognises or creates himself. An idealising transference demonstrates a need for merger with an idealised strength (Kohut & Wolf, 1978). A twinship transference attempts to fulfill the need for contact with an other experienced as similar. Within these transferences the childhood frustrations of developmental needs are re-experienced but with a deeper experience of empathy which facilitates self empathy. For Kohut this results from optimal frustration, a lapse in the provision of one's needs by a self object, but a failure small enough to enable the client to adopt the provision of self needs. This occurs through transmuting internalisation where characteristics of self objects are integrated into the personality (Mollon, 2001).

The intersubjective theorists delineate interacting elements of transference; the self object experience-seeking, and repetitive relational dimensions (Stolorow & Atwood, 1992). In the self object transference the client yearns for the psychotherapist to meet developmental needs. The repetitive dimension refers to the client's fears and expectations that the experience in psychotherapy will repeat past developmental failures. Both self object and repetitive aspects of the transference can oscillate as a parallel process, the phenomenon where relationships and interactions which appear in one setting are reflected in another (Evans & Gilbert, 2005).

Tolpin (2002) extends the concept of self object and repetitive transference. She suggests we retain the frustrated remains of healthy childhood development, proposing an unconscious ability to enable positive self object, forward edge transferences. In the presence of an other who is responsive enough, these dormant healthy aspects of the self, the remaining elements of forward edge strivings, can be accessed and integrated. They can be revived from the defences and/or idealisations that protect the self but restrict healthy development. Focusing on the needs of the relational self in psychotherapy encourages the emergence of healthy needs for self object functions. Thus there is a change from the trailing edge, repetitive experience, of the past to the forward edge, new experience, enabling developmental potential. The psychotherapist is therefore a necessary transference object and a person, until a pattern of I–thou mutuality is established (Evans & Gilbert, 2005).

The above goes some way to illuminating an ever changing unconsciously co-created interpersonal, relational field between subjectivity and intersubjectivity which forms part of the client/psychotherapist relationship. Ogden (1994) refers to this as the analytic third. This unconscious process of experiencing one another as subjects creates a specific framework for reflecting how client and psychotherapist create a third object. The task is to create conditions where the unconscious intersubjective, multi-faceted analytic third might be experienced and transmuted into awareness of self and other that can be preconsciously and consciously reflected on, verbalised and incorporated into a client's sense of self.

The issue of ending of psychotherapy will emerge after a fairly sound and mutual I–thou relationship has developed (Evans & Gilbert, 2005). Consideration, reflection and planning for this with the client is essential.

4. Conclusion

Supervision and reflexive practice provide opportunity for me to reflect on the nature of the psychotherapeutic relationship. In my model of psychotherapy integration client and psychotherapist influence each other in an ongoing cycle. This also integrates and affects other relationships, e.g. interpersonal — with the client to family etc; and the psychotherapist to the supervisory relationship. Thus the client, psychotherapist and supervisor all impact the contextual field, past, present and future.

The development of the self in relationship with others is a unique relational process and the central organising principle of my framework for psychotherapy integration. I have discussed this as a constantly evolving process philosophically, theoretically and in practice to indicate my understanding and experience with a client, the interplay between these, and how I work with this process.

The core of the paradox of integrative psychotherapy is that in the human must be integrated an array of seemingly conflicting characteristics. It is the ongoing essence, and struggle, of the practice of integrative psychotherapy to elicit the tension of such opposing polarities.

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Book Review by Naomi Anderson

An Introduction To Integrative Psychotherapy By K. R. Evans And M. C. Gilbert.

Palgrave Macmillan, 2005

Integrative Psychotherapy can take many different forms depending on what is being integrated and how it is integrated. In the opening pages this book locates itself in the Relational paradigm of psychology and psychotherapy, meaning that the "what" of this approach are ideas around the nature of therapy being understood as a relational process. The self of the client and the therapist and the process between them is understood in the context of their relationship together. Integration, the "how", is seen as a dynamic process of professional development whereby a psychotherapist moves from pragmatic eclecticism — in the service of the different needs of the client — through to an integrated, theoretical flexibility which is still committed to theoretical and philosophical coherence.

Having established what the authors mean by integrative psychotherapy this book then goes on to do what is says on the cover — it integrates theories, practices and even ideas from other paradigms, into a working model of psychotherapy. The opening chapter sets out the philosophical basis for their model — this appears to be a pragmatic post modernism, where plurality and scepticism is balanced with the practical need to make assumptions about "truth" in order to do the work, whilst holding these assumptions with "modesty" and "flexibility" (P12). They briefly outline the development of these philosophies in a readable and appealing way that prompts the interested reader to further study. The chapter ends with a brief outline of the epistemological basis of their theory i.e. the way in which this approach to psychotherapy understands and gains knowledge about the relationship. They describe the theories of Phenomenology, Field theory, Holism, Dialogue and the two person view of psychotherapy. This whets the appetite rather than providing enough information, but this is in line with the aim of the book and numerous references direct the reader to further investigation. The chapter ends with a very useful summary in 15 points.

The authors then go on to consider the history of integration which apparently dates back as far as the 1930's. It paints an optimistic and positive view of the maturity of the profession as it moves into an integrated position. Has the road been as smooth as they suggest? Has integration progressed as far as they suggest? What ever the answer to these questions, the chapter makes for good reading and again contains a useful summary.

A wonderful review of the research into the effectiveness of psychotherapy follows. Having waded through boring and lengthy articles on the subject this chapter was very different and came over as refreshing and clear. The view here is little less optimistic and cites the many research bodies who appear obsessed with professional and academic competition, comparing one modality of psychotherapy with another, rather than looking for common factors within all psychotherapies.

The authors then move on to consider the practice of psychotherapy that emerges from the philosophy and theory, stating clearly again that this is a developmental and relational model. Therapy is seen as a "constantly evolving co-constructed relational process to which client and therapist alike contribute" (P65). The chapter defines their understanding of self and as it is a relational model this is inevitably "self" in relation to the other … i.e. self to body, self with self, self to others, self to culture, self to environment, and self to the transcendent. This is a useful way of drawing together many different contemporary ideas from the schools of Psychoanalytic Inter-subjectivity (Stolorow and Atwood 1992), Dialogic approaches within Gestalt Therapy (Hycner 1993) and Relational Psychoanalysis (Aron 1999). Again what is offered is a well referenced overview as an introduction and guide to further reading.

Having presented the philosophy and theory that underpins their approach the authors then present a detailed and extended case study to illustrate their ideas. From a reader's perspective this is nearly always a good way to add flesh to the otherwise dry bones of philosophy and theory, and this case study is no exception. It is presented with much detail in a satisfying story form with a beginning, middle and end. It implies many of the core ideas of relationship mentioned earlier and we see some of the person of the therapist as well as the person of the client.

A very detailed and structured diagnosis is presented integrating diagnostic procedures for the Humanistic, Psychoanalytic and Medical schools of thought. This is no mean feat and illustrates the pragmatic and flexible approach to integrating clashing paradigms! The case study is littered with references to many different psychotherapeutic models which have been integrated, Gestalt, Transactional Analysis, Dialogic Psychotherapy, Inter-subjective Psychoanalysis, Object Relations ideas, and the developmental ideas in the Attachment school of thought. Again ideas are well referenced for further study for the interested reader.

In criticism of the case study, the therapist's views were presented with an assurance of the accuracy of assessment which the authors earlier theories would have suggested were more speculative and a co-creation of the therapist and client. A greater emphasis on awareness of the plurality of "truth" in the therapy relationship and within the thinking of the therapist would have been more in line with the earlier writing. Referring back to P12, the authors write "The assumption on the part of the therapist that his/her judgement is superior and will in the end govern the 'storyline' may become a form of oppression".

The chapter on the therapist's use of supervision provides a useful reflection on the therapist's process and does redress some of the above criticism.

The book ends with a look at challenges and concerns for psychotherapy. This starts with a look at training and a very long list of training outcomes. Whilst possibly interesting for trainers it is tedious to read and does not really add anything to the book — it does not feel an appropriate place to publish such a list.

The final chapter looks at Integrative psychotherapy in the wider field of UK practice. The professional issues which are briefly addressed are dogma and power in the National Health Service, oppressive practice in cultural issues, and a call to carry out more research. These are clearly all very important issues and it is encouraging to see these issues addressed in the context of this book which is likely to be read by those new to the profession. In addition it could have been of value to address these issues within the therapy relationship i.e. internally as well as psychotherapy in relation to the wider world. This would be a consideration of the potential for the abuse of power, dogma and oppressive practice between any therapist and client. In essence this would be a chapter on the ethics of the author's proposed approach to Integrative psychotherapy.

However, in spite of these few criticisms, this is an intelligent thoughtful book and covers a breadth of ideas. It is a great starter for those considering entering a training in Integrative Psychotherapy and wanting to know more about this approach. It would also be very useful for those who have embarked on training in Integrative Psychotherapy and are looking for an initial grounding. It is an excellent resource book for references to further reading and could be valuable for experienced clinicians

of other disciplines who may find it useful to gain an understanding of this model.

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Book review by Diana Shmukler

Learning From Life: Becoming A Psychoanalyst By Patrick Casement

Readers of Patrick Casement's previous and extremely well known works, starting with *On Learning from the Patient* (1985), will be delighted to know that his latest work, *Learning from Life*, and subtitled *Becoming a Psychoanalyst* has just been released. It is an extraordinary book and also a very brave one.

Mr. Casement sustains his distinctive voice in this highly original, unique and yet very accessible and readable work. Readers can feel privileged by his sharing personal and autobiographical details in order to describe his journey from a confused — although clearly gifted and brilliant — adolescent to the widely read, well known, highly respected and eminent psychoanalyst that he has become. Herein lies the courage and the interest in this work. It is unusual for a psychoanalyst to reveal or disclose personal details. Yet, these very autobiographical aspects bring alive and make real the points of understanding that emerge in this work and illustrate the insight and the wisdom that he brings to bear both in psychoanalytic situations and beyond.

The central question in this book — what makes a psychoanalyst? — is of interest to those in the fields of psychoanalysis, psychotherapy and counselling as well as to many others whose lives have been touched and affected by the understanding that these areas throw on our internal worlds. In some way this could be seen as an exploration into that area where the inner world finds expression in the outer world, and where the influences of life shape our internal experience.

Mr. Casement's commitment to learning — learning from life as well as others (and in particular, his patients and the supervisees who have come to learn from him) — is emphasized throughout.

Part 1, called *Development*, starts with a chapter headed "Learning from Life" in which Mr. Casement shares vignettes from childhood that all readers can readily identify with. The skilfully drawn sketches capture the child's conflict between want and desire — and the parental rules and prohibitions. Although he describes himself as being a "difficult" child, it is clear from the stories that he was normally curious, active and opportunistic in the way that children are. He, from this early age, preserved and fought for his independence rather than conforming. It is this independence of mind that laid the ground for his subsequent creativity and originality, so clearly a hallmark of his contribution. There is also a highly charged, poignant example of how early emotional experience deeply affects subsequent adult life and the sensitivity and self-awareness that it takes to make the links between the two. This chapter is followed by "An Emerging Sense of Direction", which continues the story of his development and growth. Here too, we get a situation that many people can identify with, which is finishing school with no idea or sense of what to do next. And, something about the

struggle many young adults go through in order to find meaningful work and a vocation in life.

Perhaps the bravest section in the book is Mr. Casement's description of his breakdown in early adulthood, an experience that we know many creative, gifted and talented people have had. Reading his life story up to that point shows that he needed some respite in order to find his own path and voice. Very often, and this has been well documented, it takes something like a frightening and risky breakdown experience to point out the way. It also takes unusual ability and good support to be able to emerge from such an experience and then use it productively.

The book goes on to discuss Mr. Casement's interesting and unusual way of relating to theory. Freeing himself from the need to fit the patient into the theory — and using it only when it is substantiated by the clinical work — is of course what underlies the originality of his work. There are numerous examples in "Finding a Place for Theory" which show how the patient's behaviour reveals and communicates to the analyst/therapist what needs to be attended to and where the help is needed. Many examples from Mr. Casement's experience as a social worker are given in this chapter, making it rich with practical, everyday situations and problems.

The next chapter, "Learning to Say No" is key to much of Mr. Casement's work and his way of thinking. Embedded in this discussion is the shift in understanding, particularly pertinent to those who have been trained in a humanistic tradition, of the need to hold boundaries firmly and respond to what patients need rather than what they feel they want. Often, what they need is someone who will say "no" — and risk, and take, the anger that results.

Mr. Casement's contribution lies closest theoretically to D.W. Winnicott's unique and brilliant expansion of psychoanalytic thinking. In particular, Winnicott's notion of the "use of an object" and the way in which Patrick Casement has described and elucidated it to make it even more clinically relevant and accessible, which brings about a significant and important change to many people's clinical practice. This is captured for me by the idea "Would you rather be effective or nice?"

Sometimes it is critical for the therapist/analyst to bear becoming the "bad object", as one patient once said to me, "the same as them only slightly nicer", in order to be used. In other words, allowing the patient the experience of being with rather than an interpretation of someone who can bear being perceived as the bad one, without collapsing, retaliating or disappearing. In so doing, the analyst/therapist frees the patient from the need to "self hold" and enables them to internalise and manage what seems to be unmanageable affect in a completely different way. These ideas, and the importance of understanding, dealing with, and managing aggression, are further elaborated in a chapter entitled "Hate and Containment".

Chapter 6 follows with a very interesting analysis of Samuel Beckett's relationship to his mother tongue. He first wrote in French and only after his mother died was he able to write in English, her language and his first. This chapter follows a well known psychoanalytic tradition in which psychoanalytic thinking is applied to biography and literature.

The chapter "Mourning" which follows, movingly discusses the consequences of failing to mourn, and the help that a therapist/analyst can give a patient needing to mourn significant loss.

One of Mr. Casement's earlier and well-known contributions is the notion of "internal supervision". Here he presents a detailed description of a workshop that he has given over a number of years, in which he illustrates this idea. By stepping metaphorically into the patient's shoes, he works to understand what impact he, the analyst, is having and how much of the patient's reactions can be understood as a reaction to the analyst rather than to their own internal responses. This is followed by a chapter called "Developing Clinical Antennae", amply sprinkled with clinical examples, which expands on the need for self-awareness and sensitivity to self and other in analysts and therapists and a clear exposition of the "use of the object".

The second part of the book, *Reflections*, is more philosophical and comprises three chapters, "Some Things Difficult to Explain", "Certainty and Non-certainty" and "Looking Back". If I have one criticism with this book it lies in Mr. Casement's lack of clarity in expressing his own spiritual beliefs. Although this is an important area to think about and address in these final chapters, I was left with a sense of not only the ineffability of the topic but also the uncertainty about Mr. Casement's own views. Perhaps this is just too difficult to put into words, and it contrasts sharply with his clarity on other issues.

In this tone of reflection, he sums up by asking some important questions — such as what is it that brings about change in patients? — and making some valuable observations. For example, in talking about traumatised patients, where he sees trauma as "that which cannot be managed alone", he recognises the analyst/therapist's opportunity to be there for what seems unbearable to the traumatised patient.

The final chapter concludes with Mr. Casement's admission that he felt challenged by a review of his first book that read in part "Patrick Casement's book…seemed to come from nowhere, to be met with critical acclaim and the status of a modern classic." (Review in Changes, July 1986.).This work, then, is an attempt — and a successful one at that — to describe where the books, and his insights and ideas, have come from.

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