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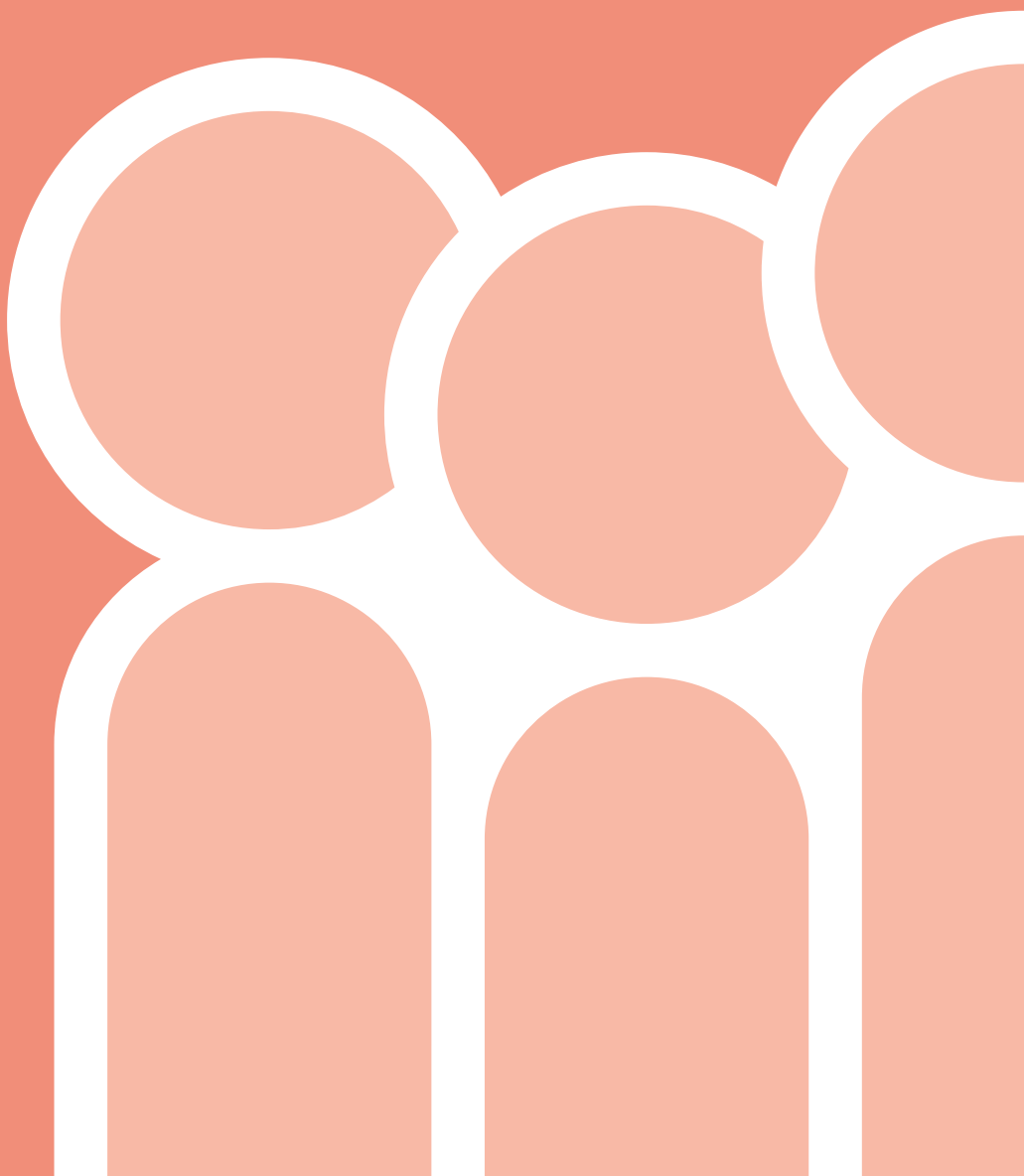
Various Facets of the Integrative Endeavour



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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 and the Editorial Process

Articles for this journal are subject to an anonymous peer review by two members of the editorial board. If you are interested in joining the board, please contact us by email or call Maria Gilbert on 020 8997 6062. If you are interested in submitting please visit our web site (www.ukapi.com/journal/) and download a copy of the submission guidelines.

Consulting Editors

Maria Gilbert and Katherine Murphy

Editorial Board Members

Volume 10, Issue 1 (2013)

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Editorial

Various Facets of the Integrative Endeavour

The journal offers a place where integrative psychotherapists of very different persuasions can articulate their own individual understanding of the integrative endeavour and its application to practice. We have always supported the idea that there is no one integrative paradigm or school of integrative practice . This edition of the journal once again exemplifies the differences and the richness that exist in the field of integrative practice. We welcome contributions from related fields and diverse practice contexts and this is again reflected in the following articles. We appreciate how all the authors have enriched their scholarly theoretical conversations with personal and clinical material.

In the first article Richard Newbury brings right in to the forefront of our attention material that can easily remain hidden and unspoken. He lucidly explores and shares his research into the history of sexual fantasies within the world of psychotherapy. His reflections on the various clinical understandings and uses of sexual fantasies invite the reader to consider seriously this are of human experience. He conveys well the contentious nature of some of the viewpoints whilst holding these with respect to all.

Sue Wright's submission comes in two parts, the first is a thorough and accessible exploration of hope and despair particularly for traumatised people with rich reference to literature in the field. She offers a way of thinking about the hopelessness that therapists may be caught up in and act out in the face of the presented hopelessness and despair of their clients. She combines well an experience-near style of conveying her reflections and bringing her theoretical discussion to life in this way. The second part represents the theory in action in an expanded case vignette that illustrates well the complexities and the paradox of working with these dynamics. Overall Sue makes a case for grounded mature hope in the context of this challenging work.

Charles Pickles addresses the dynamic tension between the subjectivity of the therapist as person and the objectivity of impartial scientific enquiry and the possible place for both positions in any clinical enquiry. In these heady days of this kind of debate Charles maintains an even-handed attitude and appreciation of the values of both ways of learning about the therapeutic process and therapeutic effectiveness. He offers the clinician a way of holding both polarities in the service of their work.

As is our practice, we have included the theoretical section of Stuart Baker's clinical dissertation that forms part of his Doctorate in Integrative Counselling Psychology and Psychotherapy at the Metanoia Institute.

We also include one book review.

Peer Review

Articles for this issue of the journal have been peer reviewed using a formal peer review structure that we have drawn up from our experience as co-editors and we will be continuing with this process in future issues. We have a list of peer reviewers who have agreed to

undertake this task and we would be interested in hearing from other psychotherapists who might be interested in joining this group.

We will continue having themed editions with a guest editor and then issues more generally on themes of integration. We again invite readers to contribute articles and we will also continue to invite contributions on particular themes.

Maria Gilbert and **Katherine Murphy**,
Co-editors of this issue.

Richard Newbury

Sexual Fantasies; Some Ways They Have Been Clinically Used and Understood

Abstract

Sexual fantasies have been variously understood according to the theoretical commitments, and dogmas, of the different psychotherapy traditions. This article attempts to show these divergences but also highlights theoretical correspondences that might tend towards an integrated view. The clinical situation is hypothetically invoked to lend a practical aspect to the theoretical discussions. The author's Jungian commitments emerge with regard to the phenomenology of fantasising during partner sex.

Introduction

Among the schools of psychodynamic psychotherapy there are different views about what sexual fantasies mean and therefore what they might be doing for us when we entertain them. These different opinions about the possible intra-psychic meanings and functions of sexual fantasies comprise, however, only part of the clinical picture. The wider therapeutic context includes approaches adopted in sex therapy, informed by behaviourist and social constructionist inter-psychic perspectives. These may give attention to the activity of fantasising while avoiding a focus on the content, meaning or intra-psychic function of fantasies. As a psychosexual therapist partly using a cognitive-behavioural model, as well as a psychodynamically informed psychotherapist, my own clinical integration involves a situational application of all the above approaches to varying degrees. My own recent research focussed on the clinical use of sexual fantasies in sex therapy, with particular regard to how 'partner-replacement' fantasies might disturb couple intimacy should they be disclosed in couple sex therapy (Newbury et al, 2012). Fostered by some observations of Schnarch (Schnarch, 1997) I also became interested in how restraining 'partner-replacement' fantasies during couple sex might promote intimacy and what he calls 'differentiation'.

I intend that this article should provide a (necessarily) brief overview of the clinical understandings and uses of sexual fantasies. My own philosophical values will be visible in this enterprise, as well as in the later presentation of my own research and ideas. While it is now routine for researchers to declare their intellectual commitments in the name of transparency and honesty, it is also the case that to a considerable extent 'postmodernism has become synonymous with enquiry itself' (Rosenau, 1992, 12). To the extent that this is the case, authorial philosophical confessions that are not postmodern assert their claims to truth (without parentheses) in the 'ready-relativized' context of the postmodern meta-orientation. It should be noted that this meta-orientation entails relativist assumptions that professional philosophers have not stopped arguing about (e.g. Boghossian, 2006), in spite of insouciant claims to finality from all sides; neither has dissent abated in our own field (e.g. Flaskas, 2002; Held, 2005; Mills, 2012). Consequently,

I occupy a position where postmodernism can operate as a critique of modernism, and vice versa. Pocock (1995, p.169) writes that postmodernism 'should make those with knowledge claims nervous…but it should not require us to dump what we have agreed to call knowledge…' Each orientation may exercise a mutual restraint on the potential excesses of the other, yielding what he calls 'a better story position' (Pocock, 1995). Holmes (2010, 74) invokes Popper to the effect that 'the truth can never fully be apprehended, but untruths can be identified through falsification… The patient says "No, that's not quite it…" '. This leaves me in the company of some critical realists, two of whom (Lopez & Potter, 2001, p 9) declare that 'knowledge cannot be reduced to its sociological determinants of production. Truth is relative to be sure but there is still both truth and error (as well as lies!)'. The importance of this personal disclosure will become apparent in certain strictures I place upon strong social constructionist accounts in favour of what they themselves would call an 'essentialist' leaning; also, in my willingness to suggest a provisional, non-socially contingent teleology of self-development in pursuit of what Schnarch calls 'differentiation' (Schnarch, 1997, passim) and Jung individuation. Conversely, certain psychoanalytic notions strike me as lacking regard for environmental and social contingencies. These matters can be taken-up in context.

I will start with a look at sexual fantasies as understood in the clinical situation by psychoanalysis, object relations, self-psychology, attachment theory, and the work of Michel Bader, which might be called 'cognitive psychoanalytic'. I will then briefly refer to what sex therapists do with fantasies under a behavioural regime as well as the influence of social construction on the field. I will finish with some reflections arising from my research that can be illuminated by Jungian concepts. I hope it will become evident that any of the models may have something useful to offer the clinician and client, depending on the client's issues. Unswerving loyalty to either conflict or deficiency models is not helpful; as Holmes notes, 'In reality both are probably right' (Holmes, 1995, 55).

Two Kinds of Orgasm

Were you to have visited a psychiatrist or psychoanalyst even as late as 1970, as, let us say, a married woman, and disclosed that you usually used sexual fantasies during intercourse with your husband, you may have been told that you were emotionally immature, deriving your gratification from regressive masturbatory (clitoral) fantasies (Hollender, 1970, 70). Unless your partner was obviously insensitive or poorly related to you (say, alcoholic), your persistent recourse to fantasies might have suggested that your capacity to relate to him was poor due to unconscious rage, fear of rejection, guilt (ibid), - you were neurotic. Your fantasies were masturbatory and therefore clitoral. Freud had in 1925 supplied the rationale for this in his explanation of the guilty avoidance of masturbation by girls:

> *It cannot be anything else than her narcissistic sense of humiliation which is bound up with penis envy, the reminder that after all this is a point on which she cannot compete with boys…recognition of this anatomical distinction forces her away from masculinity and masculine masturbation [of the clitoris] on to new lines which lead to the development of femininity. (Freud, 1925, emphases added, cited Gay, 1995, p. 676).*

Your pathological situation, as a hypothetical client, may have been further underlined by Freud's comment that 'a happy person never fantasises, only an unsatisfied one' (Freud, 1908, cited Gay, 1995, p. 439). Incapable of fulfilling the developmental demands of mature femininity through your marriage, your erotic clitoral fantasies suggest a form of compensatory regression. The pioneer sex therapists Heiman and LoPiccolo noted that, 'For the woman in or out of therapy who took these messages seriously, the possible consequences appear rather dire: guilt, shame, fear, self-hate, and denial seem to be likely outcomes' (Heiman & LoPiccolo, 1978, p. 53). From a social constructionist perspective, they offer the interesting suggestion that 'fixation or immaturity replaced earlier concepts of sin and physical harm as the reason for controlling sexual expression' (Ibid, p.55).

I derived this hypothetical clinical sketch from the research of Hollander, a psychoanalyst and psychiatrist, published in the form of an article

entitled Women's Coital Fantasies (1970). Many of Hollander's observations are perceptive, sensitive and in accord with some current thinking about, for example, rape fantasies (Ibid, p 68). However, the distinction between vaginal and clitoral orgasms and the supposed immaturity and inferiority of masturbation and associated fantasies, the sexual politics implied by these notions, the idea that sexual dysfunctions indicated developmental psychopathology, these and other beliefs were considerably discredited by the contemporary work of Masters and Johnson. Their emphasis on sexual difficulties as often acquired rather than endogenous, and susceptible to being unlearned, as well as their physiological researches, began to dismantle the notion that sex must shoulder the burden of psychopathology. I notice that one of Hollander's participants, a 'Mrs F', was emboldened to declare in her interview that the vaginal orgasm was a "myth", 'stating,' says Hollander, 'that it was perpetuated because if it is the only type of orgasm worth having, it makes women dependent on men'. This, fortunately, was the shape of things to come. Even so, for reasons connected with aspirations toward couple intimacy and also what Jungians would call 'individuation', and definitely not for Hollander's reasons, I have some sympathy with Hollander's assertion that, if excessively engaged in, 'Coital fantasies essentially serve to convert a two-person situation into a solo performance (or masturbation) in an emotional sense' (Hollander, 1970, p.70). I will discuss this personal view later.

I think it important to say before going further that, in my view, because psychoanalytic truths regarding some aspects of sexuality were oppressive and misguided, damagingly so for some, prior to the revisions compelled by Masters and Johnson and the corrective developments of the sexual revolution, I do not therefore suppose, along with radical social constructionists, that truth itself is now a suspect category. Such a position leads to what Boghossian calls a 'fear of knowledge' (Boghossian, 2001, 2006), rather than a just anxiety about it (see also, Kitching, 2008, p126-8). Whilst it is true that objectivity and truth have been used oppressively, it does not follow that they must be scrapped as concepts; Boghossian asks, 'Are we to be suspicious of the concept of freedom because the Nazis inscribed "Arbeit Macht Frei" on the gate of Auschwitz?' (Boghossian, 2001). A right-thinking zeal for celebrating difference should not be at the price of jettisoning potentially universal themes or other meaningful conceptualisations about our common humanity (Mills, 2012, p 62). It has not escaped anyone's notice that in order to make their case postmodernists use many modernist assumptions (Hansen, 2007, p112), including imperatives to historicize that are as absolute as some essentialist's assertions of ahistorical truths. For example, Dimen (2001), in the course of de-pathologising perversions, furiously scolds Kernberg for erecting a model of 'mature' object relating which she regards as a tyrannical norm based on a 'family values' ideology. Her intolerance of his proposed innate trajectory of development (essentialism) suggests instead a preference for displacing the sources of motivation into what Mills calls the 'social-linguistic' sphere, a pomocentric decentring of the subject, as he notes, that 'deplete[s] the notion of individuation, autonomy, choice, freedom, and teleological (purposeful) action because we are constituted, hence caused, by extrinsic factors that determine who we are' (Mills, 2012, p 39). One aspect of human experience is magnified at the expense of another. As in due course I intend to outline a Jungian, archetypally motivated teleology of greater self-integration, or individuation (Huskinson, 2004, p. 81), when it comes to our use of coital fantasies, it is important that I restate my position now as one where constructionism and objectivism are in a dialectic of mutual critique; this recognises that 'subjectivity is simultaneously grounded in experiences of passive perception of objective [innate and external] truth and the creation of new realities' (Hansen, 2007, p 115).

A Return to the Psychoanalyst

A number of years have passed and you, the client, return to the psychoanalyst for some help. 'Interminable and disappointing psychoanalyses aimed at the mythical goal of eradicating clitoral eroticism' (Kaplan, 1974, p 3) are now hopefully the exception. The years that have passed have been characterised by an altered view of authority and its pathologising pronouncements, as shown by the redoubtable 'Mrs F' above, as well as much research into fantasies, including, for example, Zimmer et al (1983), showing,

contra Freud, that unsatisfied people did not fantasise more that satisfied people, although, supporting the dissatisfaction thesis in a different sense, 58% of the sample used fantasies to defend against dysphoric feelings. Back in the clinic, your analyst may have read Robert Stoller, whose initial interest in the role of hostility in so-called perversions eventually extended to the proposition that rage, revenge and fear derived from ordinary childhood traumas and humiliations form the mainspring of sexual excitement (Stoller, 1979). Your fantasies understood under this conception might script the reversal of humiliations and the enactment of revenge. However, the distinguished psychoanalyst Ethel Person critiques this idea by noting that hostility is often the cause of loss of desire, and that were hostility always implicated, then working through it in analysis should lead to a loss of desire, which does not happen (Person, 1999, p 218-229). Even so, Stoller's phrase, 'erotic fantasy turns childhood trauma into triumph' often does, in my experience, capture the dynamics of compulsive or fetishistic behaviours (Stoller, 1975). Supposing your mother was violent and frequently hit and spanked you, and you brought to analysis your tendency to entertain fantasies of spanking and perhaps sexual behaviours around spanking, one way to interpret your fantasies and behaviours might be to see that by eroticising the trauma, the threat that it represents to your psychological integrity is reduced. Eroticised, the trauma can at least be borne, if not integrated. The voluntary re-enactments with partners may mitigate feelings of childhood helplessness, thus reclaiming a component of efficacy. I suppose that this creative solution might be described as a defence, as might conceptualising it as an 'identification with the aggressor' were the spanking role to be adopted. I should say that such fantasies or behaviours need not emerge from a physically violent childhood, but could arise from unconscious anger and disappointment with caregivers, or other possibilities, as we shall see. For Kohut, whom we will discuss shortly, the defence of eroticisation (or sexualisation), deployed to fill in a structural deficit perhaps created by childhood trauma or selfobject failures, provides enormous relief via 'the sudden reorganisation or reconstitution of the self that may accompany sexual activity' (cited Tolpin, 1997, p.185).

Ethel Person agrees with Mitchell that fantasies are a primary 'arena in which relational struggles and issues are played out' (Mitchell, 1988, p. 102, cited Person, 1999, p. 221). In answering the question as to how it is that sexual pleasure can incorporate into itself solutions to conflicts and traumas while simultaneously gratifying us through fantasies, wishes and needs, she embraces Mitchell's proposals. These are, in condensed form, that early sensations and processes, along with defences, internalisations and projections of the mother-child dynamic, become organising paradigms for subsequent psychological events; that penetration and interpenetration of bodies set the stage for fantasies of longing, hostility and merger; that sexual excitement provides the language for expressing dramatic dynamics around conflict, anxiety, escape; that exclusion from parental sexuality will lend sex and fantasies a quality of struggling to overcome exclusion or transgressing norms. Person adds narcissistic gratification to Mitchell's list, meaning being chosen, or desired, as conferring power. That these factors shape and recruit sexual fantasies as solutions to relational struggles underscores the thought that early and adult relationships are psychophysical phenomena (Holmes, 2010, 103). Apart from exclusion from parental sexuality, these proposals do not invoke infantile sexuality, a thesis that needs rethinking according to Holmes (Ibid 104-5), with whom I am in complete agreement here. Person, however, is not herself exclusively relational, and maintains the importance of drives and their expression through infantile sexuality. Given this, I wish to suppose a heterosexual male client arriving at our hypothetical psychoanalytic clinic with lesbian fantasies.

Now Kahr notes that, along with marital partners, therapist may be the last to know about their client's most private masturbatory fantasies 'unless patients take the plunge and risk sharing a deeply embarrassing and potentially humiliating fantasy in the early stages of therapy' (Kahr, 2008, p 40). Let us suppose that our client does not embrace this 'trial by fire' challenge, but, where safety seems to warrant it, divulges the theme of his fantasies. For Person, and the classical school, there are important Oedipal factors involved with this very common fantasy. Firstly, there is no

Oedipal rival to stir castration anxieties, just two women; the fantasiser may submerge his incestuous impulses through an unconscious identification with one of the women, thereby avoiding castration fears (Person, 1999, p.340-340). Such identification also reverses supposed exclusion from parental sexuality. Person offers a second tier of explanation along the lines that men begin with insecurities and anxieties about being able to please their mothers stemming from the preoedipal abandoning mother, the intrusive anal mother and so on (ibid. p. 329). Two women satisfying each other remove this doubt (as presumably a male presence would provoke an identification) while erotic success is maintained. We will see in due course with Michael Bader's work that feelings of an inability to please the mother, not necessarily based on Oedipal or preoedipal factors, provide an analogous explanation for these fantasies.

Two further psychoanalytic schools have their own emphases, - object relations and self-psychology. One object relations view is espoused by Arnold Cooper (Cooper, 1991), who takes narcissistic restitution (restoration of one's sense of omnipotence) as the motivation for perversions, which in his view are in varying degrees universal, - fetishes, masturbation in relation to stress, use of pornography, any 'rigid routine not subject to emotional influence'. Behind these activities are three unconscious fantasies designed to deny preoedipal helplessness in the face of an all-powerful, dangerously malignant mother. These unconscious fantasies determine the scripts of our conscious fantasies (ibid. p. 24). The first unconscious fantasy involves dehumanising the object; "the mother is really dead or mechanical and I am in complete control". Do we see this in ruthless objectifications where real people are rendered in two-dimensions for the purposes of fantasy control? The second unconscious organising fantasy dehumanises oneself; "I need have no fear because I am beyond being controlled by my malicious mother, because I am non-human, unable to feel pain, a slave who cannot act but only be acted upon". Do we see this in the internet post ``Looking for Girls to Take a Walk on My Body', by Doormat-Girl? The third denial of passive helplessness is to secure masochistic pleasure: "I triumph and am in control because no matter what castrating monster-mother visits upon me I can get pleasure from it, so she (it) is doing my bidding". Do we see this in the internet post, 'Women Kicking Men in the Balls', by John? Presumably milder versions of these fantasies reflect less acute experiences of maternal unresponsiveness, leaving fewer feelings of helplessness. Cooper thought Stoller was right about hostility, but as and aid to dehumanisation rather than the mainspring of excitement.[1]

Kohut presented the case of 'Mr A', for whom preoedipal empathic misattunements led to failure to internalise self-soothing, tension-regulating capacities. When, during latency, Mr A's father became depressed, a traumatic de-idealisation occurred and compensation for preoedipal losses became unavailable. Vulnerable in later life, failures of affirmation from idealised men led Mr A into sexual fantasies of masturbating muscular men (not enacted) aimed at restoring lost vitality (Siegel, 1996, p. 72-75). Tied up in fantasy, the helpless man was masturbated by Mr A. I will let Kohut speak for the meaning of this fantasy in his 1972 Chicago Institute Lecture:

> *What Mr. A was symbolically doing, of course, was the following: the husky man, the object of …his fantasies, was a stand-in for the idealised omnipotent, archaic father imago, and Mr A was draining the father imago of that strength and internalising it by masturbating him… (Kohut, 1996, p. 9).*

Thus for Kohut, Mr. A's lack of self-structure caused him to use this fantasy to restore an important self-selfobject tie both to counteract self-fragmentation and as a source of vitality.

I feel that I might draw upon any of these conceptualisations depending on the clinical situation. My reservations concerning infant sexuality leave me with some attachment theorists and Kohut's later view to the effect that Oedipal difficulties may be the product of developmental deficits rather than a universal source of intra-psychic conflict (Eagle, 2007, p. 38, in eds. Diamond, Blatt & Lichtenberg). Given that, for me the classical Freudian view may have application for certain

1. These examples of internet posts are taken from Bader's book Arousal, see References.

clients, although I cannot give it the priority bestowed by some psychoanalysts. This is also in line with Jung, who felt that Freud 'had mistaken the "disintegration products" of developed sexuality, found in neurotic individuals, for the raw material of the mind' (Kalsched, 1992, p 71). Astonishingly, and very controversially, the maturity of vaginal orgasms is attempting a comeback (Brody et al, 2012), although few will be convinced and the methodology of its proponents is the focus of serious criticism. Clinically moribund, perhaps it thrives on political objections.

An Attachment Theory View

The self-psychology/ attachment view of the Oedipus complex as a pathological rather than normal development may be unpacked in terms of sexual fantasies. For self-psychologists the supposition is that if the parents respond to the child's intensified affection in overstimulating ways, or respond to its intensified assertiveness with a hostile-competitive attitude, these misattunements weaken the child's self, and its non-sexual affection and non-hostile assertiveness break down into later sexual drivenness and destructive hostility (Siegel, 1996, p.160-161). Sexual fantasies might then act to ameliorate the dysphoric affects of structural deficits (Tolpin, 1997, p. 179). Mikulincer & Shaver speculate that the Oedipal triangle, if constellated, might impact the avoidant attached child, whose model of the other is already negative, by exacerbating their pre-oedipal hostility and increasing their defensive stance in relationships. The anxiously attached child might experience an even greater frustration in its attempt to merge with and control the caregiver (Mikulincer & Shaver, 2007, p. 71).

The attachment system shapes the sexual system and its fantasies, '…the fantasies reflect[ing] the relational goals associated with different orientations, rather than compensate[ing] for attachment-related concerns' (Birnbaum, 2007, p. 340). Research shows that anxiously attached individuals are likely to have romantic fantasies in which they are affectionate, passionate and pleasing; they are also likely to report submission themes (Birnbaum, 2007). Birnbaum postulates that submission fantasies might affirm sexual irresistibility to others, and certainly this wish is often clinically supported. Attachment avoidance is associated with limited expression of affection and intimacy in fantasies (ibid. p. 338). Avoidant people not in relationships are especially likely to see the objects of their fantasies as aggressive and alienated as well as to represent themselves as humiliated. Birnbaum postulates extreme deactivation here, presumably validating distancing, but these fantasies put me in mind of Cooper's dehumanising strategies to deny preoedipal helplessness and, as Cooper notes, 'protect against the vulnerability of loving' (Cooper, 1991, p.24).

Michael Bader

Michael Bader's work on sexual fantasies is built upon the clinical and theoretical work of Joseph Weiss (Weiss, 1993). Weiss allies himself with Stern (1985), maintaining that infants have no wish fulfilling fantasies and neither do they distort reality for defensive purposes (Weiss, 1993, p. 27). Instead, for Weiss, the authority and virtue of parents must be maintained at all costs; if this were not the case then children would be faced with intolerable insecurity and helplessness. The child, ever mindful of the parental tie, acquires 'pathogenic beliefs' about itself when that tie is disrupted in the pursuit of normal, desirable goals. For example, the child might infer that he burdens his parents with his dependency, or hurts them with his independence. These unconsciously held pathogenic beliefs create feelings of guilt and responsibility that block sexual excitement and handicap us in our pursuit of our own interests more generally. Survivor guilt is the pathogenic belief that being happier and more fulfilled than those we love will harm them and be disloyal, leading us to set our happiness defaults to the level of our parents or family. Sexual fantasies work to disconfirm pathogenic beliefs, turning the 'no' of guilt into the 'yes' of pleasure. Propelled to adapt to reality rather than maintain gratifications and pathology, our fantasies work to overcome the pathogenic beliefs and allow enjoyment. Unlike preoedipal or Oedipal material, pathogenic beliefs are relatively experience-near; the intrapsychic conflict is essentially between feelings of guilt or shame or worry, and normal developmental objectives. Bader offers the lesbian fantasies of

Lloyd in a case vignette. Little that Lloyd did as he grew up made his mother happy, and he acquired the belief that women were either threatened or disappointed by men. He inferred that he lacked what it must take to please women. His lesbian fantasies discharged him of the besetting doubt, guilt, and responsibility of his pathogenic belief (Bader, 2009, p. 17). He could identify with either party without pressure to please or endure ambivalent feelings. This has something in common with Person's view (above) that men begin with anxieties and insecurities about being able to please their mothers, but for Person this is about preoedipal abandonment, the intrusive anal mother and then the whole apparatus of Oedipal conflicts. For Bader, sexual fantasies are not a disguised representation of universal conflicts but are antidotes for acquired guilt, worry, shame and feelings of rejection, and involve material usually recallable by the client. This enables the therapist and client to negotiate the meaning of the client's fantasies, recognising that the client's psyche is already searching for a solution, rather than resisting or blindly repeating its neurotic conflicts.

Bader reminds us that, '…we cannot determine the precise meaning of a fantasy without knowing a lot about the fantasiser' (Bader, 2003, p. 102). Even so, let us take a hypothetical avoidantly-attached male with fantasies of consensual anal sex with a woman. Psychoanalytic theories of so-called perversion would no doubt seek to contribute an interpretation. A classical conceptualisation might, I suppose, see the fantasy as achieving a furtive, non-vaginal, incestuous coupling. Many of us might perhaps think that a retributive anger (for unresponsive caregiving) subordinates her anal experience to his genital pleasure, while her consent and enjoyment defensively denies his anger and her unavailability. We might note that the sex it is not face-to-face and therefore maintains comfortable emotional distance for an avoidantly attached person. However, using Bader's approach, our client's fantasies might reverse the client's experience of his austere, depressed and unhappy mother, extrapolated via a pathogenic belief to all women, converting her instead into a sexy and hedonistic figure, while his anal enjoyment of her completely absolves him of feelings of responsibility for her sexual stimulation (her personal contentment).

The Author's Research and Proposals

Person notes that sex therapists tend to use fantasies with their clients as a pilot light (a stimulant to excitement) and analysts as a Rosetta stone (a clue to the patient's psychological life) (Person, 1996, p. 229). The 'pilot light' approach of sex therapists to fantasies tends to be very behavioural, especially where sexual functioning is the objective ("If your fantasies promote the desired behaviour, have them!"). Combined with the influence of social constructionism on sex therapy, where analysis of the personal meaning of fantasies might carry the aura of 'essentialist' patholgising, the consequence has been that fantasies are, as Person observes, left to analysts. My own research partly focussed on how the disclosure or encouragement of fantasies in a clinical couples setting might impact couple security and intimacy (Newbury et al, 2012). One theme of the research looked at what partner-replacement fantasies might do with regard to couple intimacy. The view of a number of participating clinicians was that far from subtracting from couple intimacy, fantasies might regulate it! After all, a life where such fantasies were seriously feared might suggest an unhealthy enmeshment, or perhaps a 'preoccupied' form of insecure attachment where the fantasising partner's availability was doubted. The idea that fantasies might then mediate tensions between self and other, autonomy and union, engages with Schnarch's (1997) ideas of differentiation / enmeshment:

> *Differentiation allows us to set ourselves apart from others and determines how far apart we sit; it also opens the space for true togetherness. It's about getting closer and more distinct – rather than distant (p. 74)*

As a Jungian, more 'distinct' sounds to me like more individuated. Poor differentiation during partner sex, for Schnarch, is responsible for fantasising to "tune out", to escape "togetherness pressure" and the boredom of emotional fusion (ibid, p. 243). Higher differentiation leads to including the partner in the content of fantasies, or maintaining a partner focus by reducing

fantasising and increasing the intimacy and potency of sex (ibid. p. 244). Research attempting to coordinate differentiation (a concept developed by Bowen's family systems, 1978) and attachment comes together with the statement that successful differentiation entails self-regulation, which involves an ability to 'be thoughtful about the facts [experiences] that stimulate feelings and …think through actions, despite powerful feelings' (Meyer, 1998, cited Skowron & Dendy, 2004, p. 353). This seems analogous to secure attachment, characterised by a capacity for reflective functioning. The point is that, like differentiation, this kind of secure attachment might need to be 'earned' through effortful self-control. However, we are not entirely alone, for inherent in Jung's broader conception of libido, unlike Freud's, is not only the desire for pleasure but also an urge towards a transformation of desire through limits (Kalsched, 1992 pp. 70-73). The processes of Jung's unconscious Self have a teleology towards higher functioning.

From a Jungian perspective, Samuels (2009) notes that sex outside of relationship – promiscuity - is largely un-theorised, but is pathologised as 'fear of intimacy, problems in attachment and relationship, perversion and so on' (ibid. p. 14). Instead, he argues, promiscuity might function as an archetypal structure for lifelong relational individuation (ibid. p. 15). Invoking the Jungian notion of pairs of opposites balanced and held in tension by the psyche, he notes that promiscuity and monogamy are the shadows of each other, 'They are linked by their defensiveness against the other: monogamy defending a weak ego and low self-esteem, promiscuity a defence against the dangers of intimacy' (ibid. p. 6). This brings us back to my participant's assertion of the regulatory role of fantasies. Indeed, Samuels observes:

> *Promiscuous traces and shadows may be present in constant sexual relationships via the operation of fantasy; and there is a constant element in apparently promiscuous behaviour, if the image of the sexual Other remains psychically constant…. Sexual imagery is not only a desire for physical enactment [a Freudian view]. It is also a symbolic expression of an emotional longing for some kind of personal regeneration through contact with the body of an Other (ibid. p. 13).*

However, as Jung writes, 'The ego keeps its integrity only if it does not identify with one of the opposites…', but holds the tension between them (Jung, 1946, CW 8, Para. 425, emphases added). In the process of depathologising promiscuity, Samuels omits to remind us that monogamy, too, must function as an archetypal structure for individuation, and forms a pair with promiscuity. Schnarch's differentiated person (I would say 'individuated') must hold the tension between monogamy and promiscuity and, if necessary, self-limit the play of coital partner-replacement fantasies and 'tune-in' to the possibilities of here-and-now intimacy. Jung goes on to say that social and religious leaders make holding the tension difficult by wanting the individual to favour one or the other (some social constructionists valorising polyamory, for example Barker, 2004, and religious leaders preaching monogamy); but, 'Individuation does not shut one out from the world, but gathers the world to oneself' (ibid. Para. 432).

Our client's sexual fantasies might be informative, should they choose to share them with us, but, like dreams, we should not be straining to reduce them to a definitive meaning, for their meaning might simply elude us if they are mediating factors that remain outside consciousness. Like dreams, too, their interpretation will be collaborative, with the client recognising the 'better story'. The stability of their content might, of course, reflect their organising function, but it might also reflect their reinforcement through thousands of orgasms. Connected with this is that they may not change as a result of therapy, for as Bader notes, 'Pleasure is a powerful reinforcer' and we have no investment in altering successful arousal mechanisms (Bader, 2003, p. 191). But restraining them is, in my view, another matter.

> *Note to the reader. If you have clients troubled by erotic rape fantasies, wishing perhaps to understand, change or modify these, I recommend Critelli & Bivona's article appearing in the References below, as well as Maltz & Boss's book.*

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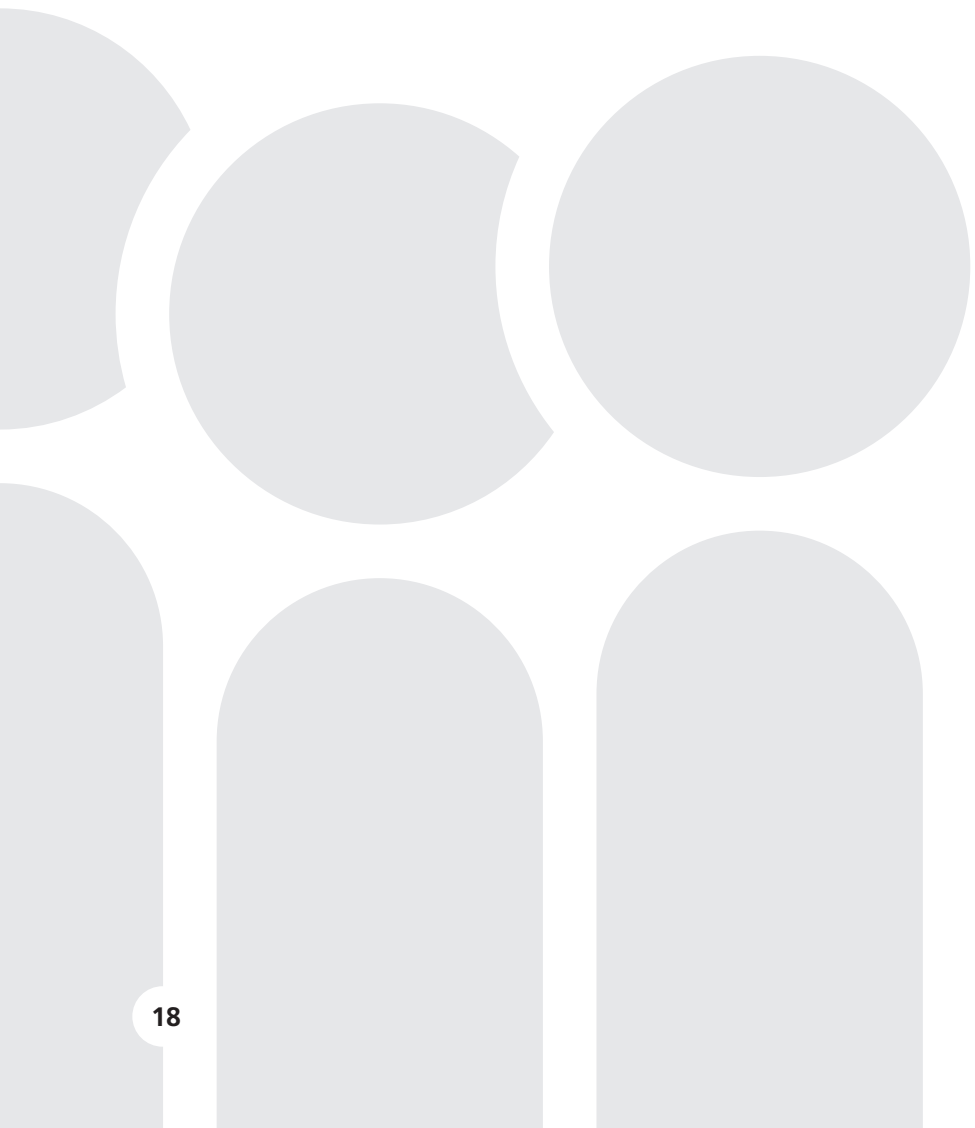

Sue Wright

"As Long as You Have Hope": A Study of Hope and Despair in the Therapeutic Encounter Part One: Our Need to Hope

"You can overcome anything as long as you have hope".

Abstract

In this two part article I intend to use the concept of hope as a lens for working with complex clients; to consider the impact of trauma on the individual's relationship to hope and to give examples of working with repeated cycles of hope and despair using a Sensorimotor, body oriented approach which integrates ideas drawn from mentalisation theory, psychodynamic thinking and neuroscience. In Part One I shall outline what contributes to states of chronic hopelessness, including a history of attachment failures and childhood and adult trauma. Using an extended case example I will then discuss the relationship between hope and illusion, trying to tease out how we can tell what is genuine and realistic as opposed to a more illusory type of hope entailing a dependency on "magical solutions" and idealised, omnipotent saviours. In Part Two I shall present two further cases, which like the first are heavily disguised in order to protect client confidentiality, in which I encountered the hope/despair cycle at first hand. I shall illustrate how we can be pulled into working too hard to foster hope and what can happen if we are able to shift away from the impulse to rescue and "do something" to an attitude of curiosity and acceptance. The study will end with an attempt to define what I call the "dimensions of hope", namely certain factors that, if present, contribute to a more realistic and sustainable message of hope. Throughout my intention is to encourage us all to keep questioning our part in a client's "system" and to get to know the "traps" which might pull us into non-mentalising responses to a client's urgent seeking for or vehement dismissal of hope.

Introduction

What keeps people going when there seems no hope? When everything they try is blocked? When they experience endless frustration, feel unheard and end up exhausted because of meeting the same negative responses again and again? What can pull people up again when for the 100th time in life's game of snakes and ladders they have slipped down a snake? What gives them the energy and motivation to begin the ascent of yet another ladder? And why is it that some people seem so hopeless – unable to trust that things can change, scared to try something new and so caught in despair that they withdraw from contact with others and sometimes from life itself? Or that others endlessly switch between hope and excitement followed by disappointment and frustration because the wished for solution failed to materialise?

I became interested in the subject when working with cases that, at times, pulled me to my limits – when there seemed no end to the person's suffering and any change seemed hard to sustain – people who had often endured horrific traumas and were still haunted by the after effects of their ordeals. In tandem with this was a growing curiosity about my own relationship to hope and about the things that either inspired or dashed hope. I began to notice when I, or a client, slipped into a dependency on false, illusory hopes and how this differed from hoping for something more realistic and attainable. From this I began to appreciate that hope is both an individual and an intersubjective phenomenon and to consider not only what destroys or fosters hope internally, but also the ways in which individuals and systems can get locked into cycles of hope and despair and, linked with this, into dynamics where blame and responsibility are common. Reading about how people have managed to survive horrendous experiences fuelled my interest. I also began to question how different schools of psychotherapy conceptualise hope and advocate working with states of hopelessness.

The Characteristics of Hope and of Despair

How do we define hope? Is it an emotion? A state of mind? A blend of emotions? An existential position? We use the word in different ways, sometimes saying "hope" when we mean "wish", which could be a wish that rationally we know will not be fulfilled, and sometimes implying faith or trust in the possibility, even if it is only tiny, that something will occur. One way of looking at hope is to think in terms of linked emotional states such as optimism, excitement and interest or, alternatively, as a quieter, more serene state of acceptance and trusting that "all will be well". The former all involve a level of high physiological arousal – a "buzz"; the latter state - reminiscent of the Buddhist idea of "taking refuge", a resting of one's trust in something outside the self, leads to calm states of both body and mind, in other words to parasympathetic nervous system functioning (Hanson, 2009). When these emotional states are around we generally feel good about ourselves and are more likely to reach out to others. Because hope about one aspect of our lives can feed others, we are also more likely to try new things. We have more sense of mastery and of control over our lives.

The foundations of a hopeful outlook lie in early childhood. People with a secure/resolved attachment style (Ainsworth et al, 1978; Feeney & Noller, 1996) are more likely to be optimistic by nature, confident about trying things and trust that others are there to help if necessary. For someone with an avoidant/dismissing style we might expect a tendency to take a sceptical position, certainly not relying on others and generally resolutely self-reliant. Meanwhile those classified as anxious-ambivalent will be endlessly preoccupied about the future, full of self-doubt and unable to stay hopeful without the support and encouragement of others. People in the final attachment category of disorganised/unresolved may flip between extremes of too much hope and giving up. For them an early history of trauma and attachment failure will have a significant bearing on their relationship to hope.

In addition to holding in mind the four attachment categories, the Circle of Security model (Marvin et al, 2002) offers a richer, more nuanced explanation of why some people may have a more positive outlook than others. In this model, based on Ainsworth's concepts of a Safe Haven and a Secure Base, the interest is in the dyadic dance between a parent and child's attachment systems and in what leads to smooth interactions and repairs after interactional failures. It is argued that because of individual attachment styles a parent who is warm, loving, there for the child when distressed and good at attuning to his or her affective states may not always be so good at supporting his exploration and thus promoting resilience through mastery building experiences. Meanwhile a parent who actively encourages the child to explore the world, even to be "tough", may feel less comfortable about providing a Safe Haven and welcoming him when he falters and needs help to manage distress. I would argue that an optimistic, hopeful perspective is more likely if the child's parents offered both a Safe Haven and a Secure Base from which to step out into the world than for someone whose parents mis-attuned to either his attachment or his exploratory needs, and in cases of minimal provision of either, then the child would have

to find alternative auto-regulatory strategies to create any sense of safety and hope.

Hopelessness is linked with the emotional states of despair, disappointment, defeat, numbness, shame and sometimes cynicism and anger, and physiologically with hypoarousal, in other words low energy and physical exhaustion. It is a state characterised by disruptions to our sense of efficacy, time and meaning. People without hope often tell us how everything they have tried so far has failed and how whenever they seek help they only meet with blocks. Their despair is made worse because of a tendency to make comparisons – between self and others, how things are and how they used to be or how they would like them to be, and the let downs and attempts that get nowhere, when compounded with "discrepancy mode" thinking (Segal et al, 2002), lead to people feeling useless and powerless. The chronically hopeless often speak of feeling trapped, especially if all their perceived options have potentially negative consequences, for instance the dilemma of not feeling safe with a current partner, but being terrified of living alone. Their sense of time is disrupted because there seems to be nothing to reach towards that offers a better future. They are facing something that feels endless and unendurable. Over time their sense of meaning and purpose erodes. There is little to live for. Albie Sachs (1966: 254) captures this in the account of his imprisonment in solitary confinement in apartheid South Africa. He wrote,

> *"The worst symptom of all … I am losing the will to resist. Nothing seems to matter anymore. I feel flat and lonely, and I do not seem to care about anything. 'So what' sums up my attitude. Life is purposeless. To continue to live like this is purposeless. …. I feel powerless to achieve anything. Time and isolation have dissipated my emotional energy."*

What Destroys Hope?

There seem to be a number of factors that take people into the place of despair. Some people learn very early in life not to hope for too much – children living in chaotic homes, facing neglect and abuse or witnessing terrible things. But trauma experienced at any age can be a hope killer. The event or events shatter the sense of ongoingness and of basic trust in others and the world. Indeed one of the criteria of Complex PTSD as defined by Judith Herman (1992: 121) is that it entails an alteration in systems of meaning and more specifically, a "loss of sustaining faith" and a "sense of hopelessness and despair". Often it is not just the awfulness of the event/s themselves but the after effects, what I call "trauma's tsunamis", which contribute to a sense of being out of control, a loss of sustaining beliefs and states of despair. Van der Hart et al (1993: 23) write: "survivors often speak of the helplessness and hopelessness they feel as they perceive a 'random and chaotic' world, where nothing is predictable or safe". These after effects include the very debilitating symptoms of a nervous system that is "out of kilter" because of repeated shifts between being on red alert and varying degrees of numbness and shutting down; intrusive memories; the need to avoid any reminders of the trauma; the loss of trust in others and a sense of self as bad and worthless. Over time this can build up into a profound state of aloneness, helplessness and despair.

One situation I have often encountered is when people have worked, been effective parents, managed daily life and then because of a traumatic event or an event which served to bring to the foreground repressed memories or emotions about previous traumas, they suddenly crashed into illness. They found themselves subject to intrusive thoughts and flashbacks which kept them in a state of fear and alertness and made it hard to be with people and to go out. They had to stop work and began to avoid social events. Such dramatic changes left them confused and frightened about what was going on, even fearing that they were going mad. They compared life now and before falling ill and struggled with guilt about no longer being the person they used to be. Typically these people present with a combination of depression and anxiety, and sometimes with additional somatic problems. What they and others do not realise is that their "symptoms" are not shameful or mad, but may in fact owe their presence to the way that evolution has shaped our physiological responses to danger. I am going to explain this as I believe we can respond more effectively to the chronically hopeless if we consider this and linked states of mind from an evolutionary, neurobiological perspective.

Immobilisation as a Defensive System

Evolution has primed the brain to mobilise the body in readiness for fight or flight in response to danger or, if these strategies are not possible, to go into freeze or to down regulate into a state of shut down or feigned death. The latter is of particular relevance to our subject. "Shut down" is characterised by a loss of energy and muscle tone, whilst heart rate, blood pressure and breathing rate all go down. This is accompanied by emotional numbing and a slowing or shutting down of cognitive processing, in other words a dissociative state.

Whereas the hyperaroused states of fight, flight and freeze are all associated with the sympathetic nervous system, shut down or feigned death is mediated by the dorsal vagal branch of the parasympathetic autonomic nervous system (Porges, 2012; Corrigan et al 2011). The dorsal vagus puts a "brake" on functioning. This down regulation of the mind and body is highly adaptive in situations where it would not be safe or possible to fight or to flee. Porges (2012: 8) describes how "shut down" helps people survive horrendous things by raising pain thresholds and thus reducing the physical pain actually experienced. It also facilitates survival by energy conservation, for instance by cutting down on metabolic demands for oxygen and food until resuming activity is safe. In the face of a violent aggressor it can be a crucial way to minimise harm and thus, in some situations, to stay alive. Yet many people see it as a shameful "giving in" rather than as an important strategy to preserve both the mind and the body.

As a "normal" part of a cycle dorsal vagal braking is also linked with recuperation, the resting and healing which our bodies need after enduring illness or some form of danger. Then, after a period of recuperation, there should be a return of energy, interest, motivation and pleasure in being with people. However, trauma survivors often get stuck in this hypoaroused state and with it there can be a significant lowering of mood. Sometimes there is a "collapse" into persistent exhaustion and depression if the individual had been on red alert for a long time in response to actual or perceived danger and unable to make use of instinctive fight or flight responses – what Levine (1997) calls a truncated trauma response. Sometimes more dissociative, shutting down responses to threat or emotional overwhelm can become a habit which is adopted increasingly under stress. Thus "a mental state that is biologically determined for a brief and immediate response to attack can become chronic" (Corrigan et al, 2011: 22).

The subjective experience of what Shapiro (2009: 13) calls "hunkering down", especially if prolonged, includes feelings of hopelessness and helplessness and beliefs about being worthless, useless and about the impossibility of change. Such beliefs can unfortunately be reinforced over time by hurtful comments from others. The other common subjective experience is a withdrawal from people. Siegel (2010: 23) reflects how helplessness can pervade our whole system and limit our response and thinking. "It shuts down our sense of possibility as we isolate ourselves from involvement with others and even ourselves".

Again what people do not appreciate is that in terms of interpersonal safety there can be a survival logic to giving up hope and to hanging onto beliefs about personal defectiveness. Janina Fisher (2012) described hopelessness as an ingenious way to avoid disappointment and argues that all the hypoaroused states that our clients present with – despair, depression, shame, numbness, lethargy - have a protective element and it is our job to be curious about what this might be. Such states, she explains, keep people "below the radar" and in dangerous homes and violent relationships this is highly adaptive. It keeps you a little safer. Beliefs organised around hopelessness keep us from venturing out of our comfort zone. If you don't expect much and your nervous system is predominantly hypoaroused you don't risk. As a child you don't risk moments of excitement being cruelly squashed; of playfulness earning a slap; of being ridiculed for natural childish showing off or inquisitiveness. Meanwhile, as an adult depressed states combined with the shame based beliefs which frequently go hand in hand with a pessimistic outlook, reinforce submissive responses and keep the individual in what may be a safer position of avoiding and hiding rather than risking being hurt even more because of complaining or fighting (Corrigan et al, 2011).

We therefore have three elements – physical immobilisation marked by lethargy, loss of energy and motivation; emotional numbing marked by states of depression and hopelessness, and entrenched beliefs about personal defectiveness and futility, all of which contribute to a withdrawal from people. Another way of thinking about this is that the chronically hopeless stop using their social engagement system. Like fight, flight and freeze, social engagement is one of our instinctive responses to danger. As Porges (2012: 5) puts it, "the human nervous system is on a quest, and the quest is for safety and we use others to help us feel safe". Our attachment system primes us to reach for a trusted other when we are in danger and in more ordinary contexts at a neurological level we use right-brain to right-brain connections in order to calm and be calmed by another person's nervous system. Hopelessness reduces our capacity to socially engage. Anything that thwarts or compromises social engagement is likely to contribute to despair and with it, over time, to a state of profound aloneness as well, frequently, of shame.

Time and Hope

It is interesting that, from a place of optimism, our relationship to time is very different to that when stuck in hopelessness and despair. A fundamental characteristic of hope is that is enables us to have a future in mind. We need to be able to hope, to dream, to envisage future scenarios. Indeed one feature of our sophisticated "homo sapiens" brain is that we can run simulations of the future (Hanson, 2009). At an evolutionary level the capacity to envisage possible outcomes if we do X or Y and make predictions based on what we observe of the world around us has undoubtedly helped mankind as a species to survive. Meanwhile at an individual, psychological level being able to anticipate how other people might behave, to have internal blue prints of what to expect in certain social situations, helps us to steer a course through relationships.

As Victor Frankl (2004: 81) wrote, "it is a peculiarity of man that he can only live by looking to the future … and this is his salvation in the most difficult moments of his existence". In his moving account of life in a concentration camp he described the distorted sense of time that living what he called "a provisional existence of unknown limit" can create. He noted how without a future to envisage some prisoners occupied themselves with retrospective thoughts. They looked to the past to make the horrific present less real. But he argued, "in robbing the present of its reality there lay a certain danger. It became easy to overlook the opportunities to make something positive of camp life … it left people losing their hold on life" so that everything became pointless (2004: 80). Psychologically the lack of a future in mind, coupled with the limitlessness of their imprisonment meant that many gave up. Appreciating this, Frankl tried to encourage his comrades by pointing out future goals which could give their restricted lives some meaning.

There are many parallels here with people we see who have experienced very traumatic events as children and adults. However, I am struck how, whilst some of those men and women in the concentration camps may have been able to ruminate on a past full of good memories and loving relationships, the past is not a mental refuge for many of our clients, but is itself a reminder of horrors. The past haunts them; the present feels unendurable and the future looks uninviting or there is no sense of a future at all. Thus we could see hopelessness as a time expanded state accompanied always by the wish for something to end.

Beginnings

Sometimes we learn about a client's relationship to hope in the first meeting. This was certainly the case with Mae, a woman whose history was one of neglect, abandonment and physical and sexual abuse from early childhood. Mae arrived for that meeting weighed down with two heavy shopping bags which she dumped on the floor with a weary sigh and then, wincing with pain, carefully straightened her back. She told me that she was due for a cortisone injection and could not wait for it to be done as it always gave immediate relief. She added, "I wish one day they would find a permanent cure – something that would get rid of this back problem once and for all". I speculated whether she may have a wish for a similar emotional cure? Mae agreed. She said she is someone who expects

instant results. She wants a miracle cure. I acknowledged the wish, especially as I knew that she suffered from debilitating anxiety and depression and had seen numerous professionals over the years, but suggested, maybe what was really needed was to be able to face and tolerate the pain first. And so began a long journey together in which we worked on many intensely moving, tragic stories from her childhood and made sense of how traumatic experiences coloured her relationships and her self-beliefs.

This beginning illustrates what we might call a dependent relationship to hope – the ongoing quest for the miracle - an investment in illusory hopes when there is a reification of the capacities of others or the potential effects of objects and substances. Other clients tell us about a lack of hope, perhaps by listing all the things they have tried and people they have contacted which have not "worked", or they might quickly minimise their problems – like one young man who arrived with a carefully written list of all his problems, then as we began to study them suddenly said they did not seem that serious and wondered if he would just be wasting my time. Alternately we might catch ambivalence – a switching between hope and no hope in how the client describes what he is facing and what help he is seeking.

False Hope and Mentalisation

"In psychiatry there is a certain condition known as delusion of reprieve. The condemned man, immediately before his execution, gets the illusion that he might be reprieved at the very last minute. We too, clung to shreds of hope and believed to the last moment that it would not be so bad." So wrote Victor Frankl (2004: 23) about his arrival in concentration camp. He then went onto describe some of his initial experiences. He said that it was not long before "the illusions that some of us still held were destroyed one by one, and then quite unexpectedly were overtaken by a grim sense of humour. We knew that we had nothing to lose except our ridiculously naked lives" (2004: 29).

For a moment read the following and notice your responses: "Nothing is working. Things are getting worse. I don't see the point in carrying on with therapy". Then study your response to the words: "I've had enough … I can't keep going like this." "I don't feel safe any more." "I might as well be dead". Do you notice anxiety? Despair? Guilt? Do you find yourself detaching and not wanting to think about the person who might be saying these words or a pull to do more? I am sure that most readers will have heard similar statements on many occasions and have caught the all too contagious sense of helplessness. One of the traps we can be pulled into as therapists is being induced into the "quest for the miracle" and trying to provide shreds of hope in non-mentalising ways. We can get sucked in by the wishes of the client and the expectations of family members and other professionals. This might include colluding with the illusion some people have about us not failing or abandoning them – because of course, as human beings and as part of a Transference - Countertransference drama, we do inevitably let our clients down in small and sometimes big ways. We can take on the mantle of the only person who could possible help – what Frawley and Davies (1994) call the role of the "omnipotent rescuer". When a client is dealing with something unbearable or in a state of uncontained anxiety, if unthought about this overwhelming affect often becomes the hot potato that gets passed around, along with an urgent appeal to do something. Like other people in his or her system, we are likely to catch the hopelessness and the anxiety driven impulse to act.

As an example of a system being pulled into the hope/despair paradigm let us consider a team working in an addiction treatment unit. For their clients – all of whom had experiences of multiple trauma, loss, and dashed hopes - the addictive substance had an obvious appeal to provide false hope or to numb despair. For the workers, whose days were characterised by chaos, "fire fighting" and endless demands on their time and resources, it was all too easy to slip into exhaustion and despondency. One very skilled counsellor said despairingly, "no matter how hard I try, I can't save them from relapse" and like her colleagues she frequently used words like "relentless" and "never ending" – which we could argue as resonating with the time perspective of the hope-deprived noted above.

What the counsellor was needing at that point was to know that someone was doing well and to see that her interventions had some impact. We all have a human need for such "rewards". These moments of positive feedback, even if small, help retain our hope. But if, after lots of effort on our part, a client does indeed relapse or becomes dismissive or attacking of the therapy, then we are quite likely to feel frustrated, angry, doubtful of our skills and tempted to give up. Or it might be that the clinician himself will turn to illusory hope. "Things will get better when we have more staff, if she leaves; when we have a different manager or a new office." The snakes of relapse plus the demands of a system monitoring "outcomes" can be the hardest to endure.

As I write I realise that "if this … then" thinking is a useful cue to step back and ask what is going on. When is it important to keep hope alive by going the extra mile and when is it a collusion - a denial of pain or of the client's own capacities? Are we responding from a well thought out position or have we slipped into a non-mentalising state where only action will do? "Only action will do" is one of three proto mentalising states which, in developmental terms, precede the more mature and flexible ability to reflect and make sense of the contents of our own minds and the minds of others, in other words to mentalise. In "teleological mode", as this state is known, positions become polarised – for instance, between good and bad or between absolute certainty and absolute doubt (Bateman et al, 2004).

When this mode is operational the messages from our clients might include: "If only … you did this for me; they stopped that; someone listened; someone cared; I could go back home; I could do this … it would all be OK". The "if only" might also include a change of treatment or personnel: "If only I could see someone else; be sent to that expert or they would change my medication". For people in the client's world the script might be: "If only ….. someone else took over; he or she grew up; he got off his backside; he stopped moaning" and so on. For therapists meanwhile, the "If … then" list might include: "If only I knew how to or was trained in ….; other people in the system did their bit; she attended regularly; he was more motivated and did his homework" or "I was allowed to work with him for two years rather than 20 sessions". Interestingly, in all these examples there is some form of discount (Schiff et al., 1975). Each member of the system will either discount his or her capacity to do anything (personal inadequacy); or the ability or willingness of others to make a difference or, at worse, the solvability of the problem. And unchecked discounting rapidly leads to futility.

Another strategy to deal with hopelessness is to intellectualise away the real issues, using theory to locate the blame somewhere else –"she's borderline"; "he's passive aggressive"; "of course it's his parent's fault"; "it's a faulty neurological circuit"; "how can he use therapy if he is drinking so much?"; "he/she is non compliant" and so on. It is all too easy to fall into the trap of labelling rather than staying curious about the meaning behind what someone says or does, and in this way we effectively shift the responsibility elsewhere and hence feel less helpless and guilty. And so in addition to the hope/no hope paradigm we have a closely linked paradigm of blame and responsibility. Someone has to take the blame; someone should be taking more responsibility and is not and so everyone, in Thich Nhat Hanh's terms, ends up "blaming the lettuce" for failing to thrive (1991). At the same time our own over exalted sense of responsibility can lead to getting pulled into ever more frantic activity in an attempt to find the "magic solution".

One thing we should always be curious about is whether the client's idealised hopes might actually be a form of procedural or implicit memory and whether what we are encountering is really an echo of the child's experience of longing and waiting for someone to step in and make things better. In the same way we should bear in mind when pulled into trying too hard to assist the client out of despair, that in some cases states of hopelessness and depression are also a manifestation of implicit memory – in other words they are state dependent. The body is effectively telling us of something that has already happened. It is not just getting caught in a sense of time being endless, it is a slipping back into an earlier time – an echo of the past. So rather than panicking about this, to simply ask the client "could this be telling us how you used to feel?" can open up a rich dialogue and help shift the client and the therapy out of stuckness.

When Hope Preserves the Self and Keeps People Alive

I am going to return to the case of Mae in order to illustrate how earlier experiences of hoping and of hopelessness can be re-enacted in the present; how hanging onto hope, even if false hope, can keep someone going and then how it can also be adaptive not to hope. For the purposes of the theme of illusory hopes one of the stories Mae told me has particular relevance and it has stayed with me as a graphic illustration of how, for a child, the need to hope for something different can be crucial. When you are little and cannot change or escape the situation unaided, fantasies of "rescue" help you to get through the day. Such fantasising is adaptive not regressive, which I appreciate is a different perspective from that of traditional psychoanalysis where fantasies are thought of in terms of unconscious infantile wishes. Indeed, we could go so far as to say that illusory, magical hoping can keep people alive.

Mae's story is of a young girl standing at a gate waiting for her Mum to turn up. Her mother had psychotic episodes, drank heavily, had an evil temper and abandoned her four children when Mae was 5. The children were put into care "just until Mum comes back". But "just until" took 7 years and for all that time Mae stayed hopeful, always waiting. Her last image of Mum was of her walking down the drive in the rain. To cope with the loss she held onto the comforting fantasy of Mum returning with bags in hand as if she had just popped to the shops. No one ever explained anything to Mae. They simply told her to be patient.

Mae ended up in a boarding school run by a harridan who labelled her as "the social services brat" and kept telling her that she would "come to nothing". At weekends, when many of the children went home, Mae was one of the few left behind. But each Friday afternoon she went to the gate to watch and wait. She would stand there for hours and when teachers tried to call her in she argued that she didn't want to miss her mother if she turned up unexpectedly. "I had to hope", she explained. "I had to believe that I would get away from that place. I had to believe that Mum was OK."

When Mae's mother finally did turn up it was not the happy reunion she had dreamed of. Her mother offered no explanation or apology, no expression of delight at seeing her daughter again. She had a new partner and baby in tow and was preoccupied with them. It was as if she had not been away and was simply collecting Mae at the end of the day. When I asked how that young girl had felt Mae admitted to fury at being displaced by Mum's new family. She did not understand why her mother had bothered to come and find her. But she was aware that she could not let anyone see her anger. "If I lost that relationship", she explained, "it would have meant that all I had been through for seven years was wasted".

Significantly the theme of hanging onto hope and waiting was re-enacted in a current relationship with a man who took advantage of Mae's tendency to rescue people. Clive would show up when he was struggling, convince Mae that he really cared about her, but before long would be off again. Mae both knew that he would never make a commitment, yet kept hoping that one day he would change. As we processed the memories about her mother Mae suddenly realised the parallels. "I am doing what I did with her. I can't let him go. I hang on, just like I did with Mum. I keep putting up with things – but really I am furious."

We can see how hanging onto hope, even whilst a part of her knew that some of these hopes were unrealistic, provided Mae with a source of comfort as a child and also in the present. She was also one of the clients who helped me to understand the double edged nature of hope and why not hoping can also protect the self. According to Napier (1993), with highly traumatised clients we can anticipate a sudden backlash after moments of progress and hope. Such backlashes might include a dramatic dip in mood, an escalation of self-harm or suicidal feelings or some other form of self-sabotage or attack on the therapy. To the clinician, perhaps heartened by signs of improvement, this can lead to frustration, weariness and puzzlement unless we understand the reasons why parts of the self might guard against hope. As Napier explains, for some people hope can be a signal that bad things are about to happen or a reminder of being tricked or being badly let down, like the neglected

child who was given some lovely presents on Christmas morning, only to have them taken away that night and never see again, or the little girl who was so excited when the kind man down the road invited her to a party until she discovered that at this party little children got abused. If being noticed, doing well, relaxing, getting close to someone or having positive emotions got you into trouble in the past, it makes absolute sense to avoid them and to never risk hoping for too much.

In Mae's case one of the ways that backlashes emerged was in the form of a highly critical inner voice which stepped in after any hint of change. In a mocking way the voice kept putting her down and reminding her of things from the past that she regretted. Mae said that this voice never went away and that it took away all her confidence and hope. On one occasion I asked how she thought it helped to have a critical part always there ready to step in and put her down. Even though I guessed it was protective in some way I was surprised by her immediate, insightful response. "It reminds me – 'don't ever risk hoping that things could go well or that you could succeed!' It keeps me indoors. It stops me applying for jobs. It stops me joining things and getting to know people." As we explored the survival logic of such an undermining ego state it became clear that Mae had learned at school to suppress any ambition or hope of praise because of the headmistress's repeated injunctions "not to get above your station". If she got good marks or triumphed at sport her success was immediately dismissed with such remarks as "you'll never amount to much" or complaints about not trying harder or insinuations that she had cheated. There was something tragic about this annihilation of any belief in her own capacities or hope of future successes.

A more realistic form of hope, which was neither rooted in magical thinking nor dismissive of her capacities and the genuine attributes of others, began to emerge slowly during the therapy. This meant gently challenging the critical and despairing parts of self when they emerged and repeatedly validating all the small achievements Mae did make so that slowly over time she could risk doing more and, crucially, replace self denigration with the thought that she was doing her best. From this place Mae started to assert herself and set boundaries with Clive. She became more thoughtful about whether she wanted to respond or not; she risked saying no to him and to others, and she developed the capacity to challenge her own preoccupied ruminations about this man. By the time we ended our work Mae had decided that she was comfortable living alone. She had her children and grandchildren. They were enough. And crucially she now knew how to take care of the younger self inside who had for so long been in a state of "loyal waiting" (Danelian et al, 2012), for the missing experience of unconditional love and care.

Hope and Despair in the Transference

Some of the most important shifts occurred when the theme of hope and disappointment entered the therapy itself and rocked our normally positive relationship. Sometimes we had to negotiate telephone appointments because back pain prevented Mae driving. On one occasion there was a muddle about timing and my attempts to make contact did not work. The next week Mae arrived announcing that she had had a terrible week. An appointment with an orthopaedic surgeon had been cancelled because her GP had not sent the necessary paperwork. Mae was angry and tearful. "I thought this was my chance to find out what is really wrong and that someone would work out what will stop the pain. I was pinning my hopes on the appointment. And now I feel so let down. No one cares. I can't go on like this. I don't want to be here any more." She stormed for several minutes, then quietened when I said that maybe the fact that I did not call her also felt like a "not caring" and that this was hooking in lots of old feelings about being let down when you really depend on others for help. She admitted that when our telephone session did not take place she thought I did not care either and so she angrily decided not to contact me as she would normally do.

I reflected how hoping that the meeting with the surgeon would provide a solution had kept her going for several months, and now that hope seemed to have been cruelly dashed. Mae agreed. She had slipped back into despair and since learning about the cancelled consultation had stayed in bed for much of the time. "If no one

cares and I can't get what I want, I'll stay in bed", she announced. Everything, including therapy, felt pointless. But Mae was prepared to engage in a discussion about how unbearable it felt to wait and wait and feel hope draining away. We noted that she had waited for me to call, then got fed up and went out. She had already endured a very long wait for treatment for her back problems. She had spent months waiting for Clive each time he went travelling with vague promises about coming back when work permitted. And there were the countless hours as a child when she waited in vain for Mum to walk back up the path and greet her with the love she craved. When I noted how waiting hooks lots of emotion Mae agreed. "I can cope if I know what's at the end of the wait", she said, "and if I can understand what is going on". But as a child there was no clear end in sight, nor anyone who could tell her what had happened nor why her mother had treated her with such cruel neglect.

As the session evolved Mae kept shifting states, one minute hopeless and giving up, the next into the blame/responsibility paradigm and complaining about all the non-caring professionals and like a sulky child claiming she "didn't care". But gradually she allowed me to see and share the sadness that lay hidden behind these familiar coping strategies and as we explored Mae's feelings, especially about the perceived let down on my part, she returned to a more thoughtful, adult place – sad, but no longer seeming so resourceless and dependent on others.

Working With Hopelessness: The Need to Grieve

What conclusions can be drawn from this case about how to respond to the inevitable dance between hope and despair that we encounter when working with people with complex problems and traumatic life stories? One of Mae's strengths was that once I had found a way to calm whatever state she was in on arrival, whether it be panic or fury, she was willing to step back and reflect on what had triggered her and why she had responded so strongly - in other words, she regained the capacity to mentalise. A number of points made by Jeremy Holmes are relevant here (2010: 96, my italics). He writes "a held child/ patient can use mentalising to overcome despair and thus himself hold hope in mind". His meaning here is that through putting things into words, which he argues could be through poetry as much as via therapeutic conversation, we can find a way out of unendurable stuckness. Holmes continues: "To mentalise is to construct a reparative bridge over the chasm of loss" – it helps us to cope with and survive the separations, losses, failures, disruptions and "potential traumata of every day life" (2010: 95). We can have and be aware of our feelings rather than drowning in them.

Two of the words Holmes uses - "held" and "bridge" - merit discussion. Being held or contained implies a degree of safety and, as he points out, "for mentalising to operate there has to be a safe space, both literally in the therapist's room and also an internal space in his or her mind" (2010: 90). We have already noted that being trapped, whether in reality or within the grip of memories that render the present unsafe, is a common cause of despair and we should not underestimate what we provide both practically in order to create a climate of safety and interactively as a neurobiological regulator (Schore, 1993) in order to steer a client through the worst moments of despair. This is not about "doing" anything – the busier, "find a solution" stance – but a way of being with the client that enables him to feel deeply accepted and, returning to the idea of social engagement, helps to calm his nervous system (Porges, 2012).

The relational aspect of the work, when viewed not just as the meeting of two minds, but of two nervous systems, is crucial and that is why the word "bridge" is also salient. The "reparative bridge" is both intersubjective and intrapsychic. It is a bridge between self and other; between past and present and between the formless, fragmentary stuff of procedural memory and the more linear, digested material of narrative memory. Returning to Holmes - mentalising can overcome despair and enable the client to "himself hold hope in mind". This suggests a more mature capacity for reflection and emotional regulation, rather than a dependency on idealised others. A traditional psychoanalyst would view this as a shift from primary process thinking where hopes are based on infantile sexual and aggressive impulses, and secondary process thinking which involves a renunciation

of fantasy in favour of the reality principle. Interestingly, whereas for Freud hope was based on illusion, contemporary analysts, as Mitchell (1993: 206) points out, would view it as "seeking a psychological space in which a genuine desire may become possible, in which the self can find a "new beginning". The cases to be presented in Part Two illustrate the movement towards new beginnings and also how, from an integrative perspective, we can hold in mind the interplay between illusory hope with its particular relational impact and real hope which enables, rather than limits connectedness.

Finding true hope often entails a "letting go" and grieving the things that were lost or could not happen in the past. Grieving can also be considered as a bridge – a bridge between past, present and future (Van der Hart et al, 2006); a process that is adaptive because "it feels like a relief – it resolves and leads to acceptance" (McCullough et al, 2003: 23). If clients can be supported to endure their feelings - and in Mae's case the challenge was to help her face the anger she felt with her mother and then the sadness that came from contemplating so many missing experiences - it becomes possible to move into a more hopeful future.

As therapists we cannot magic away the terrible past. We can never be the longed for loving other and so we need to be constantly vigilant about becoming the sole resource in a client's life at the expense of fostering his or her capacities for self-care. Yet there are times when we are the only person who keeps hope alive – a bridge between the endlessness of their despair and the possibility, even if only tiny, of something new - and for very desperate clients, as one of the cases presented in Part Two illustrates, this matters. Sometimes we have to be willing to journey with a client into the abyss and face the despair with them - to be in a place of having no clever answers, no solutions to suggest, no tools at our disposal. Just to sit with someone in the dark and feel and acknowledge how bleak it feels. "You can overcome anything as long as you have hope", a client said to me on one occasion, and I believe that hope is more sustainable if we feel accepted and do not have to travel alone. As Holmes (2010: 85) says: "if sorrow can be given words, feelings shared and objectified, their power to distress or overwhelm is mitigated. Poetry and psychotherapy are both concerned with repair of the endlessly rent human experiential and communicative fabric". This is a very different place from getting stuck in non-thinking despair.

Sue Wright

"As Long as You Have Hope": A Study of Hope and Despair in the Therapeutic Encounter Part Two: New Meanings and New Experiences

"Every client is an experience that wants to happen not a problem to be solved". (Kurtz, 1989: 146).

Abstract

In the first part of this article I wrote about the logic of shutting down physiologically and mentally as a short-term survival strategy. However, when stuck in states of low mood and energy, as is often the case with survivors of severe trauma, the continual effort to get through the day steadily erodes any sense of self-worth, efficacy and hope and they often shift into states of suicidal despair. It can be a challenge for those working with such clients to resist the contagion of hopelessness, the urge to act or, alternatively to avoid and give up. In Part Two I shall present two further cases in which I was pulled into the hope/despair cycle and thus became part of the client's "system" and will use these cases to discuss what can help us shift out of stuck cycles and hence offer a more genuine message of hope. One of the clients in question had a trauma history and struggled with debilitating episodes of depression. The other presented with a complex mix of mental health problems including self-harm, depression and severe anxiety. I shall return to the idea of resisting "doing" and trying to "find a solution" which I touched on in Part One, and consider how we might find a different way of being with the client. I will then explore certain factors, which I call the "dimensions of hope" that, together or in isolation, are necessary to sustain hope.

The Endless Rain Story

Before turning to these cases let me describe a personal story of hopelessness. I suspect that we all encounter brief moments of hopelessness which punctuate our day and colour it in a way that affects what we do and how we view ourselves and others, and sometimes we may go through prolonged periods of despair and stuckness when we question the very purpose of our life. We could term these "small d" and "big D" lows in the same way that Shapiro (2001) referred to "small t" and "big T" traumas – and for people who have experienced "big T" traumas or who struggle with an enduring health problem, the latter state is very common. The example in question was certainly not one of the "big D" moments in my life, yet it is interesting because of what it told me about my own relationship to hope. I call it the "endless rain story", a personal response to the weeks of uncharacteristic, relentless and sometimes destructive rain that the UK endured in 2012. I moved through a range of different responses as week after week there seemed no let up in the weather, no shift into the sun and warmth that I longed for. The messages that my hope-seeking self came up with progressed from: "it will be better tomorrow" to "by the weekend" to "surely next month will be different!" Like my

client Mae I felt that I could cope if I knew that there would be an end to my waiting and, like her, when hoped for ends failed to materialise I slipped into less mentalising states of mind. Because being outside and in touch with nature is such a resource for me, the repeated experience of getting soaked, the lack of sun plus damp penetrating cracks in the fabric of my house, began to impact my mood. I remember a frustrated moment when I learned that things were unlikely to improve for weeks because the Jet Stream was stuck. In an unmentalising way I protested vehemently "well move it!" I wanted someone to take responsibility, to do something and was ready to blame anything I could.

However, in calmer, more mentalising moments I reminded myself that protesting and trying to change what was would not help. I needed to find a place of acceptance. For me this included capitalising on good moments and reminding myself that the inconveniences that the rain caused me were trivial compared to how others suffered – both in this country and in countries subject to far worst climatic disasters. As Frankl (2004: 116) said, "when we are no longer able to change a situation, we are challenged to change ourselves", and what I needed to do on the gloomiest days was change my perspective. Whilst this sounds simple and obvious, changing our attitude, which Frankl (2004: 75) described as "the last of human freedoms", is not necessarily easy and certainly not for people who have been fighting to survive for years. However, I believe that some of the most important and moving change moments that occur in therapy are when something enables a shift in perspective. It can be something small or a big moment, but it is something that opens the door to hope. The shift might, as in the case of the young woman I will discuss next, be because of learning the reasons why we do what we do. For the victims of early trauma it might be learning, and really taking in, that the haunting past is truly over - an experience that one client called "being given the gold ticket in the chocolate factory" (Dahl, 1964).

Lara

Lara was a highly intelligent young woman and a gifted pianist who had been involved in mental health services since her teens because of severe and at times life threatening self-harm. Lara felt that her problems started when her Italian parents moved to this country when she was 13 and shortly afterwards her elder sister was diagnosed with leukaemia. She described a sudden loss of all the familiar routines that made her life feel safe, how anxious she felt to be in a place where people did things so differently and how worried she became about everyone she was close to. She began to worry obsessively about playing the piano and could only perform if she first worked through a series of rituals. She did not integrate into her new school and became increasingly isolated, managing anxiety with a range of rituals which included becoming very obsessive about how and what she ate. My first speculation was that the obsessions and self-harming behaviours were not so much the problem as a desperate solution to deal with anxiety, but later I came to appreciate that they were attempts to solve problems that had been around long before the family moved.

Like Mae, Lara communicated her ambivalence about hope on our first encounter when she said, "I'd really like things to change, but I'm scared it will end and nothing will have happened". Later she asked sadly, "am I too broken or just a nuisance and need to pull myself together?" When I enquired what Lara meant by "too broken" she explained, "things haven't changed even with lots of input … I've never been able to use help and everyone just loses patience with me".

For a period in what was a long therapy either Lara or members of her family communicated, both explicitly and implicitly, such desperation that in addition to extra time spent on telephone contacts, I often found myself trying hard to involve other professionals with my own urgent requests and arguments for additional support. I usually began with a hope: "If this was available, then ….", but generally received the response that nothing could be provided or only after a long wait. I then shifted into either frustration or despair, plus an element of guilt at yet again having to be the messenger for bad news. When reflecting on my responses I became curious how often someone – me, Lara, her family, another professional - was expected to take responsibility and how blame got passed around in this system – and I noticed that blame and responsibility were

around most when Lara's "symptoms" got worse and something undermined hope.

There were certainly periods when I was induced into Lara's system and into more teleological responses. However, there were also times when for weeks, I had to face the fact that there was nothing to offer but my presence. Like Lara, like her parents, I had tried all the avenues I could think of and nothing had worked. I could see how hard it was for her to get through an hour, let alone a whole day. I heard the weariness in her voice as she told me that there was no fight left in her. I had seen how her confidence and faith had been shattered after several hope inducing attempts to obtain a much more intensive form of therapy than I could offer, something we all thought might help her to break the addictive cycle that entrapped her, but were told could not be funded. I had to encounter at a personal level the despair side of the cycle and to deal with my own fears, sadness and anger too about Lara's possible death, the tragic waste of a young life full of so much potential. During those sessions we just sat and talked, sometimes both with tears in our eyes. And somehow she got through it. The day Lara said to me, "I don't think I would have got through the last few months if you hadn't been there" felt a moving acknowledgement of something far more important than responding to the pull to act.

In the concluding sections I will speak of the importance of having something that gives meaning or purpose to our lives. For Lara the "meaning" came when she realised that what she had struggled with so long could be explained in terms of Asperger's Syndrome. She read widely on autistic spectrum disorders, and as we matched her reading with looking back at her childhood and at her current ways of responding to things, it became increasingly clear that this diagnosis was far more appropriate than the different diagnostic labels Lara had "collected" over the years – and especially what was for her the inherently blaming diagnosis of Borderline Personality Disorder. Whilst still struggling with a sense of being different and very lonely, a loneliness that had not been so apparent until the shock of moving to live in a very different culture, Lara could now identify with a group of other people in the "Aspie" world. She could make sense of the at times "anti social" and odd ways in which since early childhood she had responded to sensory hyperarousal, to difficulties in understanding other minds and to obsessive fears about change. But what made sense to us had to be communicated to others and a long process of waiting for a psychiatric assessment and then for more appropriate forms of support took Lara again and again through the hope/despair cycle.

However, these oscillating states were more manageable now that Lara had her meaning and the knowledge that this was a condition she shared with other people. As a result of her understanding Lara began to explore new ways to manage sensory and emotional overload and this gave her more sense of control. She blamed herself less for who she was and slowly began to grieve the loss of the future she and her parents had anticipated for her – realising that what was possible now would always be conditioned by the particular fears and ways of being that Asperger's brings with it. But "living well" with an autistic spectrum disorder became a possibility. With a different context for understanding her self-harm Lara also began to courageously tackle these addictive strategies. She realised that only by confronting what she most feared would she ever have real control of her life and the inspiration of a different future with choice and freedom kept her going. In a recent session I reminded Lara of what she had said at our first meeting about the therapy ending with nothing having happened. "Has nothing happened?" I asked. I felt moved when she replied, "no, I have found myself".

Anna

My next case, again illustrating how therapists can get pulled into trying to provide hope, concerns a woman who descended into despair after a terrifying sexual assault. "Anna" had been a successful business woman but after the assault had to give up her career because of the debilitating symptoms of PTSD. She was particularly troubled by an acute and exhausting hypervigilance which formed a backdrop to her days. She found it very hard to relax or to fully concentrate on anything because of always "being on edge" - listening intently to distant sounds, jumpy if the phone or door bell rang and aware that she was

always looking over her shoulder when out. Physically this manifested as chronic tension and restlessness and, because of difficulties sleeping, a permanent state of exhaustion and low mood. Anna said that she used a lot of energy to keep memories of the assault out of her mind. But she felt that they were always there waiting to leap out, especially when least expecting it. She was desperate for respite but could not allow herself to relax for fear of what might happen if she was not on guard. Her attention was so outward focussed that Anna missed noticing things about herself such as if she was hungry or had hurt herself. Not only had Anna lost her job and a rich social life but, worse, she had lost confidence in her judgement.

Thinking about her life before the assault evoked intense sadness because of all that she had lost. On one occasion Anna described looking at old photos and said sadly, "it is as if all the colour has gone out of the pictures. I don't seem to be able to access happy memories anymore". The future looked bleak because of the constant anxiety that something terrible would happen again and because the trauma had left her effectively unable to differentiate past and present, it was so hard to be in and enjoy the present moment.

Using a Sensorimotor approach (Ogden et al, 2006) my first aim was to develop strategies to help Anna manage the flashbacks and the anxiety which troubled her when going out or at night. She was willing to learn and to put things into practice, but still had days when she was highjacked by overwhelming anxiety, followed by feeling angry with herself or very flat. As the therapy moved between moments of a little more hope and then back into despair, I became aware of a pull for both of us to work too hard. I was aware of wanting to give some tangible hope that things could change – perhaps coloured by knowing that I was Anna's third therapist since the assault and aware of an internal voice saying "surely you can make a difference!" I knew how desperate Anna was to get rid of her hypervigilant symptoms, which she said neither medication nor therapy had ever touched, and was aware that character traits she had always viewed as strengths, such as being very self-reliant, preferring not to ask for help and caring for others rather than attending to her own needs, kept getting in the way of healing because she repeatedly ignored her body when it flagged up the need to rest.

In retrospect I realise that change could only come as a result of Anna learning that she could tolerate her memories and the emotions they evoked and for this to happen I had to manage the tension between offering hope and being able to sit with her when things felt hopeless. As a first step towards tolerating knowing her vulnerable self we had to both become curious about her familiar survival strategies – about the "on guard" part of self and the "self-reliant" part. For instance, could she start to accept, rather than fight the hypervigilance? Could she also notice when rejecting help or being very busy was masking feeling sad or vulnerable? I remembered Janina Fisher's beautiful idea of "dancing with the resistance" (2012), a version of what in DBT is called "radical acceptance", which entails being curious about the purpose of entrenched patterns and limiting behaviours and reframing them as adaptive rather than trying hard to change them or to make something happen. From a place of compassionate acceptance that she had been vulnerable and still could be, I knew it would be easier for Anna to come to terms with living a life that could never be quite the same.

There were many steps on this journey towards acceptance of which I can only give a couple of examples. On one occasion Anna arrived saying how fed up and frustrated with herself she felt. Whilst away for a few days she had not felt frightened and had allowed herself to rest and let other people take over. But once back home she felt jumpy. She realised that she was frightened of feeling frightened and so fell into the trap of racing round doing as much as she could before the fear took over, ignoring tiredness and the wish to stay in the warm and trying hard to avoid thinking and feeling. I noted that a tough part of her was back in "soldiering on mode" declaring "I shouldn't need help", and that there was also a protector part around, namely her busy mind, always assessing things and on the look out just in case anything dangerous emerged. Anna laughed at the thought of her mind as a protector. She said it gave her a warm feeling inside. It was then possible to share my thoughts about the dilemma facing us. We both wanted things to change and this led to an urgent attempt to find something

to "fix" the problems and in particular, to get rid of the "hypervigilant protector". Along with this Anna's tough, self-reliant part kept trying to avoid any hint of feeling sad, lonely or vulnerable. But it was important not to neglect the vulnerable self and to treat it more kindly. Anna was interested in the Buddhist notion of "pain plus our thoughts about it leading to suffering" and in the idea of trying to change our thoughts by mindfully noticing them (Kabat-Zinn, 1991). It reminded her of how inspired she was by a disabled friend who seemed able to accept and live in the moment.

During another moving session, simply noticing and "tracking" her body, a process that is integral to Sensorimotor Psychotherapy (Ogden, 2006), enabled Anna to manage the intense arousal which had emerged as she touched on a traumatic memory. As she calmed down Anna used the words "I can" and repeated them as if testing them out. It felt good to be able to say those words and I repeated them back to her. Her first response was to say, "but I don't believe it", so I modified my statement: "most of the time you can do things". That led to a visible shift. It was bite-sized enough for Anna to take in and her body relaxed. It reminded her of past achievements and more recently of the successful outcome to a campaign she and friends had run to save their local library. We stayed with the memory of working together, noticing how she sat and how she might move from a place of mastery. I invited Anna to practice sitting in this confident way and to keep remembering small achievements as a reminder of "I can".

Later discussing the session in supervision helped me to appreciate the importance for the hope-deprived of experiences of mastery and shared activity. Even more important, my supervisor's translation of those tentative words "I can" into "I can bear the part of me that suffered and was so hopeless" made emotional sense. I realised that this was what we were working on all the time – building up tolerance of the memories. It was not that we needed to talk about them – and I never discovered exactly what had happened to Anna – nor to process them in depth in the way that one might using EMDR. More important was to deal with Anna's phobia of the memories and of emotions and sensations so that she could tolerate remembering without such overwhelming fear.

In our final session Anna said that what she had most appreciated was that therapy had provided her with a safety net in which to explore. She shared how previously it felt as if she had been left out on a hill to die, feeling very lonely and scared. Now she realised that safety nets did exist which could hold her through the worst moments and with this knowledge it was easier to enjoy daily life. "I am not scared any more", she announced. "I am not powerless. I can do things I want and I know that it's OK to take time for myself". These were amazing changes for someone so deeply traumatised and so stuck in old ways of surviving.

The Dimensions of Hope

The quotation with which Part Two opens is one I find inspiring and need to remind myself of now and then when I feel the pull to make things happen. If we can let go of the idea of needing to do or solve something and hold the idea of providing the client with a new experience and engaging in a more "being" approach, then our clients will be more likely to access what they need for transformation and healing. Porges (2012: 19) says something similar from a neurobiological perspective: "As soon as we attempt to modify a person's behavior, we tend to overwhelm the client with so much negative feedback emphasizing that the behaviour or feelings should be changed, that the client responds defensively as if they did something wrong …. This changes their physiological state and makes the circuit for social engagement behaviors unavailable ….. If we want individuals to feel safe, we should not accuse them of doing something wrong or bad." A "being" approach includes a compassionate and curious stance and a willingness to stay alongside the client as well as to make use of what we notice about his responses and our own. It also demands finding a way to hold the tension between bearing something that feels overwhelming and keeping the candle of hope alight. We cannot hold this tension unless we keep reflecting on both our client's and our own relationship to hope and noticing how the latter shifts, sometimes ebbing in tune with a client's descent into despair,

sometimes strong and steady as we connect with things that resource and inspire us.

One thing that has aided my reflections is to think of hope in terms of certain "dimensions" and I shall end this study by discussing each and how they apply to the material presented. The list of dimensions includes:

1. Something that gives meaning to our experiences
2. A sense of mastery and strategies to feel in control of ourselves, our emotions and our world
3. A sense of a future with good things to look forward to
4. Trust in others and the capacity for meaningful relationships
5. Faith in something larger than the self and things that give purpose to our lives

Finding Meaning

> *"Man is ready and willing to shoulder any suffering as soon and as long as he can see a meaning in it" (Frankl, 2004: 117).*

If we return to the idea of an "experience that wants to happen", I would argue that through entering a "transitional space" where there are possibilities for "safe surprises" (Bromberg, 2006: 12) and opportunities to reflect on them our clients can gain a much greater sense of mastery and control over their lives. But it is not merely the experiencing per se – it is the new meanings they can bring (hence highlighting the word "reflect"). This was very much in Kurtz's mind in the work he did as a Hakomi psychotherapist (Kurtz, 1989). It is an important element in the approach of Ogden and those who have expanded his work in the Sensorimotor tradition (Ogden, 2006; Fisher and Ogden, 2009) and also has connections with mentalisation theorists and the approach of relational analysts like Steven Mitchell and Philip Bromberg.

Kurtz (1989: 139) also wrote, "the goal of therapy is not any particular experience: it is a change which organises all experiences differently, a change in the way of experiencing. To make that kind of change we must deal with meanings and not just experiences. We must bring out the meaning of the way we organise experience, the way we do things, the way we put our world together, perceive it and think about it". Although the circumstances leading to despair were very different for the three women discussed in Parts One and Two, what they had in common was that through encountering and weathering what was most painful in therapy, they slowly developed a new sense of meaning to their lives. In Lara's case change came when she began to appreciate how she had always organised experiences from an Asperger mindset. This enabled her to drop familiar blaming beliefs, such as that she was naughty, anti social or selfish, and for the first time she started to like herself. In Anna's case, the assault had called into question all that had previously given meaning and purpose to her life and so, like other survivors, she was left "without ontological, psychological or spiritual meaning structures that offer safety, hope, control, trust and esteem" (Van der Hart et al, 1993: 23). Although therapy did not "get rid of" her hypervigilance and anxiety, it enabled her to appreciate how since the assault she – or rather her survival brain – had organised experiences around the premise that "it might happen again" and that "nowhere was safe". Once Anna realised this things felt less random and chaotic. She began to regain confidence in her own judgement and to "get out of her own way" when old character strategies, such as putting others before herself and working hard and not listening to her body, reared their heads. She began to accept having needs and, as noted earlier, allowed herself to do the things she wanted without slipping into guilt.

A Sense of Future Possibilities

> *"If I accept you as you are (or have been defined), I will make you worse. If I treat you as though you already are what you are capable of, I will help you become that".*
>
> *(Johann Wolfgang von Goethe, 1749 – 1832. My words in parentheses).*

Another common thread for Lara, Anna and Mae was that therapy helped them to establish a new relationship to time. Rather than the endlessness of despair and fear, something so hard to bear that at times each of them

contemplated suicide, they found new ways to manage difficult days. They began to mourn and let go of past hurts, losses and regrets. For Lara and Mae this included the shame and regrets about the self-harming strategies they had used in order to manage overwhelming states of mind. For Anna and Mae it included encountering state dependent memories, but as a result of being able to stay in the present and observe their experience - what we call dual awareness, these memories could now be reflected on, rather than continually highjacking them. In this way they achieved what Van der Hart et al (1993, 2006) call "presentification", namely being able to acknowledge that certain events happened, they happened to the self and, whilst awful, they are over. Anna's feedback indicated that she really got this after a session in which we experimented with alternately glancing at a list of words that captured an aspect of the trauma and then throwing a ball between us – a technique used in EMDR with complex clients. "To realise that by putting bits of it into the present rather than it ripping me into the past", she said, "it will be just words on paper – I might have feelings about it, but it won't have such impact." She had been able to keep one foot in the past and one firmly in the present and said that this felt empowering and gave her hope after many months battling disturbing flashbacks. The past had haunted her present for too long. Now she could begin to envisage a future with good things to look forward to.

Mastery and Control

"Magic is believing in yourself, if you can do that, you can make anything happen."

(Johann Wolfgang von Goethe, 1749 – 1832)

We all need experiences of success and of feeling "in charge" – moments when, like Anna, we say: "I can"; moments to look back on with pride and to build on in the future. But trauma robs people of agency and empowerment and leaves them fearful of many seemingly ordinary things, troubled by an inner world that feels chaotic and wracked with beliefs about being a failure and with shame and self-loathing. It cannot be underestimated how exhausting and undermining it is to be constantly fighting flashbacks and intrusive thoughts and ruled by an out of kilter nervous system. I want to stress that this also applies to someone like Lara whose ongoing struggles with sensory hypersensitivity, obsessional anxieties and mind-blindness (Baron-Cohen, 1997), which whilst not a consequence of trauma, were traumatising in their own way and evoked a similar sense of chaos and loss of control.

Being able to appreciate at a bodily as well as at an intellectual level that the traumatic past is truly over brings a much greater sense of control. Empowerment also comes as a result of learning new strategies to manage emotional and physical arousal and to feel in control when something triggers strong responses, something which applies not just to people with a trauma history, but to those with different reasons for feeling hopeless and helpless. For some people regaining control and developing the confidence to go out and interact with others are major achievements. It can be a slow process with its own snakes and ladders of despair and hope. Yet each new experience of mastery can be built upon. It was a positive day when Anna said, "I am just starting to put my head above the parapet … I am finding my voice again", and I could cite many other examples of clients taking small steps towards a more hopeful future. The small steps occur both inside and outside therapy- and one of the values of an "experience near therapy" such as Sensorimotor Psychotherapy is that it emphasises small experiments and discovering and building upon the client's innate strengths and resources. The new experiences might include finding a way to tolerate an emotion; to be in more in contact with another person; to stand and walk with greater confidence or to ask for what one wants and say no to things one doesn't - and the more those "experiences that want to happen" emerge, the more able people become to engage with the demands and joys of daily life rather than being so dominated by survival responses.

Trust in Others and the Capacity for Meaningful Relationships

"The only time I felt hope was when you told me you could see no hope, and you continued with the analysis" (Winnicott citing a patient, 1960: 152).

"I don't think I would have got through the last few months if you hadn't been there" (Lara).

I believe that hope is fundamentally a relational phenomenon and, as Mae's story illustrates, it can be both destroyed and fostered within relationships. For anyone who lacked a secure base as a child and who has been badly let down by others, trust does not come easily. It has to be earned. Not only does trauma erode trust, but the shame and confusion of its after effects tend to remain a private, secret experience – something that can feel impossible to put into words and share with another person. My clients have often asked: "How can I tell my family that every day I am just hanging on? That even when I am with them I feel so anxious? That I am often tempted to hurt myself? That I want to die?" "How can I explain to my doctor or CPN that I keep switching off? That sometimes I don't feel like an adult? That I don't understand people?" That I keep seeing things that make me feel crazy?" In the context of such struggles it is not surprising that despair and helplessness are typified by a withdrawal from social engagement.

Van der Hart et al comment that, "once new meanings, cognitions and expectations (which may include beliefs about the future and expectations about one's abilities or how others will treat you) have been established, the possibility of improving relationships with others (and with oneself) becomes more plausible" (1993: 24). (My words in parentheses). As therapists our part in the creation of new meanings and expectations or, in Bowlby's terminology, new internal working models - is crucial. If, and this is expanding upon Kurtz's idea, we see our clients as people to be with rather than as problems to be fixed, then improving relationships with self and others becomes more of a possibility.

"Being with" can entail a more conversational approach (Hobson, 1985); allowing a "real relationship" (Clarkson, 1993); risking self-disclosure and exploring what is going on between us. Our interest – if genuine and compassionate - can help bridge the gulf created by shame and self-doubt and, as the stories of Anna, Lara and Mae illustrate, help people to slowly accept themselves. Sometimes I have wondered, "am I being a therapist?" after a session in which Lara and I discussed books and debated subjects of interest. The pull to "do something" and show results is so endemic in our culture and when Lara said, "I never thought that I might end up liking a therapist and enjoying talking about things with her", a part of me wondered "is that OK – for us both to genuinely enjoy our shared discussions?" But I knew, because of observing what this led to, that it was. It was about allowing a genuine meeting in order to help Lara discover more about herself and about being with others. It tapped into the quest to find and nurture what was meaningful for her and, notwithstanding her difficulties understanding people, to develop more meaningful relationships. I observed too, that our intellectual sharing regulated Lara's mood. She could begin a session angry or despondent. Having played with ideas and explained her thoughts, she became more energised and, hence, more hopeful.

"Being with" also includes a willingness to stay alongside someone in order to help them through the bleakest moments of despair and grief. When Lara kept communicating that she was "tired of fighting and getting nowhere …. tired of endlessly failing and people being cross and disappointed with her", I thought of Sisyphus, the mythical King who was condemned to pushing a huge rock uphill which always rolled down again however hard he tried. But what, I thought, if two or three or twenty people had joined him? What if they all pushed? People would often say to Lara, "only you can do it", and whilst at one level perhaps they were right, sometimes we can not do things entirely on our own, things that might be possible with support and encouragement. Whilst it is certainly important to keep monitoring the pull to rescue – the territory of illusory hope - I believe that now and then we need to lend our weight to pushing the rock.

Faith and Purpose

"He who has a why to live can bear with almost any how".

(Neitzsche, cited in Frankl, 2004: 109)

Throughout history, when there is literally no one else to turn to, a belief in something greater

than the self has kept people going through unimaginable ordeals. I once asked a client if he could draw something to represent the "ups and downs" he was complaining about and which seemed to undermine small moments of progress and hope. Bill drew a mountain path, full of twists and turns and unexpected hazards. When finished he said sadly, "but I can't see the top. It's covered in mist". This image powerfully captured the endlessness of his depression. But then, with a look of deep calm, he said "but I'm not alone on the path. I know that God is with me". For Bill his faith gave him the hope and courage to keep persevering.

None of the women mentioned in the article were people of faith – indeed I recall Mae in one of her angrier moments proclaiming "and what has God ever done? He just left me to it as well!" But in her own way each woman found or regained a sense of purpose, something to sustain her when the going was tough. For Lara, her purpose lost and then regained was her music and even though I suspect that she may still face some very bleak, desperate phases, it was heartening to learn that with a new-found sense of meaning she began to tentatively play again and contemplate studying music. For Mae and Anna a new sense of purpose could only be found after letting go of the "shoulds" and "oughts" surrounding the idea of returning to work. But having stopped worrying about what people thought and reached a more accepting place Mae began to feel comfortable in her role as a carer for her grandchildren, knowing how much that helped her children and how impossible it would be to combine the role with paid employment. Meanwhile after a process of grieving her former roles, Anna allowed herself to enjoy a slower paced life in which she could garden, read and fulfil a long-standing ambition to learn to weave. These things provided reasons to get up in the morning and, crucially, to stay alive.

There are many different ways that people gain a sense of purpose. For some a loved one keeps them going – "I need to be there for the children". For others it is a new challenge – perhaps literally climbing a mountain, running a marathon, learning a new skill, supporting a charity, training to be a therapist or a creative project. Equally we might find our personal refuge in nature or in music or art. Sometimes these "refuges" or "resources" – and we can use different terms to describe them – are enduring ones. Sometimes we adopt a purpose for a period of time - for instance writing this article gave me a sense of purpose and helped me get through some very cold, dreary winter days - and then we move onto another. It does not matter what it is that inspires us, but as Frankl knew so well, it matters that it is there.

Concluding Thoughts

> *"Adults must grow up and live their own lives and not perpetuate old fairytales, especially if doing so makes life a long spell of misery".*
>
> *(Feldenkrais, 1985: 240).*

Hopelessness is so often the consequence of being objectified in some way – a body to be used; a child implicitly or explicitly expected to perform certain roles in the family system such as the "good girl"; the "peace keeper", the "gifted pianist" or "the joker" and later in life, a problem or a diagnostic label to be fixed. It follows experiences when one's subjectivity is shattered, when personal reality is distorted and denied, when personal strivings are squashed or ridiculed. With this in mind I am interested in what relational psychoanalysts have to say about the creation of personal meaning and the development of subjectivity. For instance – and this accords with the dimensions of hope - Mitchell (1993: 37) argues that in contrast to the Freudian project, the goal of contemporary analysis is "not the establishment of a rational normality but the capacity to generate a sense of self and relationships felt as important, meaningful and deeply one's own." It honours how subjectivity can emerge in the interactions between therapist and client and appreciates the need for a "safe domain" in which the client "can pursue an authentic personal experience" (Mitchell, 1993: 39). In this article we have seen how, with a new sense of meaning and of possibility in the future, all of the women discussed slowly began to relate to themselves and to others in different ways. For each the sources of inspiration and hope were different, but once found they enabled them to pursue a far more authentic personal experience.

Looking back on these cases has enabled me to clarify and refine what I mean by "dimensions of hope" and to appreciate how interlinked they are. Change might begin in one dimension but can then spread to others. "Presentification" provides a greater sense of control and mastery. With meaning and purpose our future expands and we can more truly "live our own lives". A faith in something beyond the self or trust in others can help someone to endure periods of despair and encourage him on the first steps towards change. I am also struck by the interconnectedness of hope and relationship. Something new and unexpected within a relationship may be the catalyst for hope.

A belief in the importance of the therapeutic relationship and the conviction that ultimately how we are with our clients is more important than what we do, has always been a key premise behind how I work. More recently, another source of hope for me has been learning about neuroplasticity and appreciating that to mindfully observe our experience, to be curious, to reframe things and experiment in small ways with doing things differently all offer opportunities for the mind to change the brain. In terms of the client's relationship to him or herself, this I believe, is what occurs during the course of an experience-near therapy in which we encourage a non-judgemental, observing stance in our clients (Doidge, 2007; 2012). Through our curiosity and willingness to "dance with the resistance" we can help people to become more self-compassionate and to appreciate the "survival logic" of old, and sometimes harmful, ways of being, and by not struggling to change them, the door opens onto something new. Having said this, and as the quotation from Goethe highlights, we don't have to passively accept the client as he is, nor the apparent hopelessness of a situation. We can be an advocate for future possibilities and challenge the withdrawal from social engagement as well as the dependency on illusory hopes and reliance on external solutions that so often goes with helplessness. Again this is about holding tensions and being ever mindful about how we position ourselves in order to avoid getting sucked into a client's "system" and taking roles such as the "longed for rescuer" or the "useless, helpless other", and to flexibly shift between sitting with the client's despair and keeping the candle of hope alive.

In this article I have discussed the challenge of identifying and letting go of illusory hopes and the importance of grieving the hurts, traumas and missing experiences of the past. I pointed out that grief can be a bridge between a painful past, a bleak present and a more hopeful future, but that for people who have experienced trauma and been hurt as children it is important to find a way to acknowledge that the past is truly over – to escape old fairytales and nightmares - before it becomes possible to grieve. Through the lens of three long-term clients I have also endeavoured to show how the route from despair and from being stuck in old habits and protective patterns demands new experiences and the creation of new meanings and how as therapists we can be an active participant in the "experience that wants to happen".

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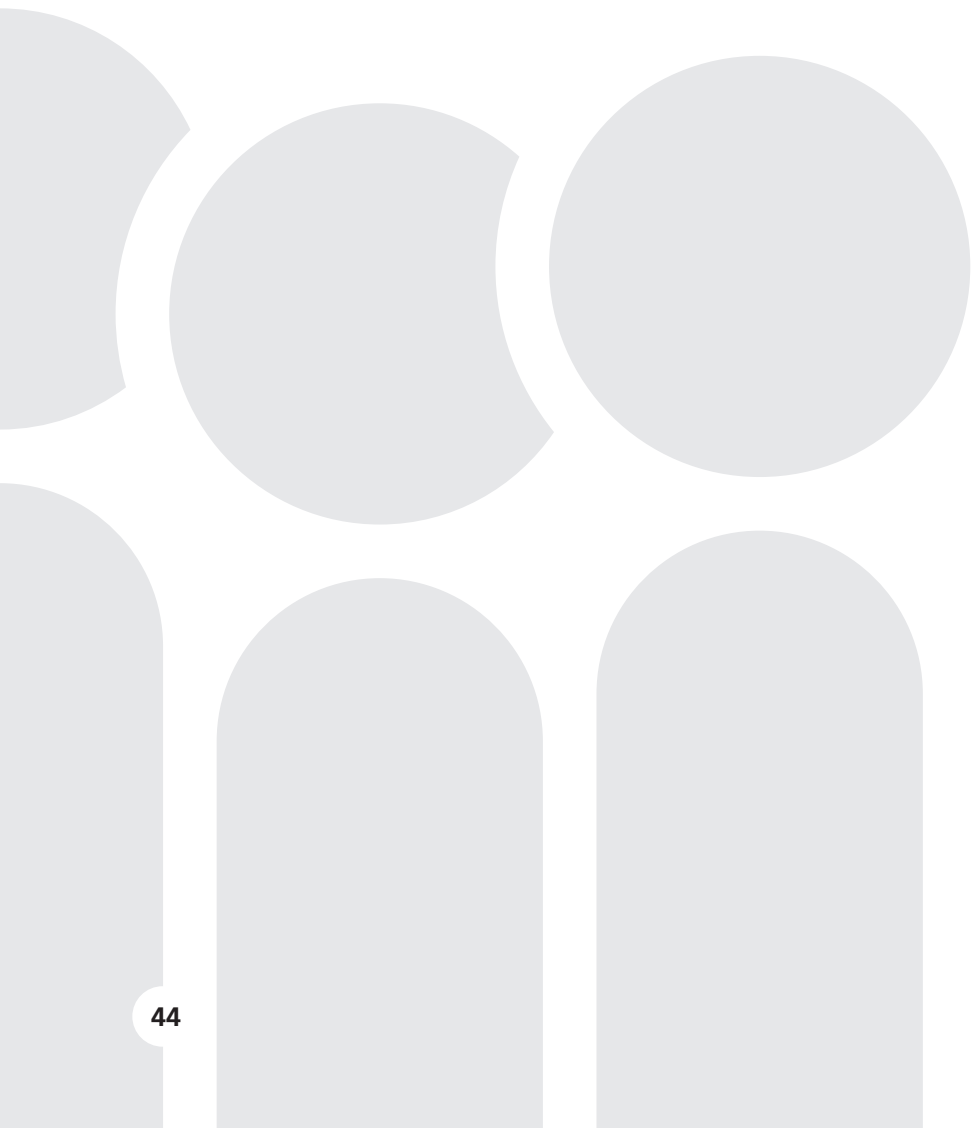

Charles Pickles

On Being a Therapist and a Person: Self-reflection, Science and Impartiality

Abstract

Therapeutic relationships are a special form of interpersonal interaction, eliciting affective and empathic responses from the therapist that can participate in her quest to come to some understanding of the person and their problems. The scientific method, and/ or commitment to some guiding psychotherapeutic orientation on the other hand, requires that a practitioner not be influenced by her 'subjective 'responses in conducting, evaluating, and applying clinically relevant research. How these two requirements are brought together in the therapeutic engagement is examined. Both forms of knowledge and understanding share the principled need for impartiality hence the requirement that the therapist have some capacity for self-reflection. The relation between the neutrality required for science and impartial self examination is discussed.

Preliminaries

To be reflective in clinical practice the therapist must be prepared to critically examine not only her knowledge of the theory and practice of a therapy, but also aspects of herself and her behaviour. To be critical in this sense the therapist must be self-aware and have a capacity for self-critique; what might be called self-reflexivity. This principle covers a wide range of relevant factors that can affect her work; her age, gender, socio-economic status, background beliefs and emotional responses to individual clients and client groups, her own personality and vulnerabilities and her current mental health.

She also needs to respect and be familiar with the pertinent research and empirical work emerging from her own school of therapy and other relevant areas. Perhaps the essence of this is captured by the following principle; that the therapist be influenced in her work by the theory and evidence acquired via the quantitative and qualitative methodologies that define her discipline. The point of this it is argued, being that they are independent methods for determining what is going to count as clinical and theoretical knowledge independent of her pre-theoretically informed 'subjective' prejudices and 'intuitions'. They also provide a coherent framework for the psychological material with which she has to engage. In these respects they provide, or hope to, guidance for the progress of therapy and the establishment of therapeutic efficacy.

Both 'self-reflexivity' and the demand to respect scientific /theoretical findings involve taking up a position of 'neutrality' or 'impartiality. In essence this is a requirement to distance oneself from oneself in the former case, and, in the latter, examine the arguments and evidence as dispassionately and objectively as possible. Assessment and therapy however occur within highly emotive, subjective and personal contexts, aspects of which can be therapeutically revealing and productive. This paper is concerned with examining some

of the issues surrounding the requirement of impartiality that is a pre-condition of self-examination and the appropriate use of theory and evidence , and its relation to the intricate interpersonal contexts within which psychological interventions occur.

Introduction

The assessment and formulation of a client's presentation requires the development of a good therapeutic relationship, and the interpersonal skill, self-reflectiveness and empathy necessary to accomplish and maintain the former. It is these interpersonal and self-reflexive factors, as well as the scientific and theoretical findings pertinent to her client, that the therapist has to take into consideration when reflecting on the clinical situation: She has to build a picture of the person facing her, how they are presenting to her, how the way she is behaving both verbally and non-verbally might be affecting the way this client presents and what clinical information she discloses. All therapies accept the influence of the interpersonal on the therapeutic process. Even those which do not regard personal relations as the primary agent through which change is negotiated, such as Cognitive-Behavioural Therapy, acknowledge that therapeutic progress entails the establishment of an empathic and collaborative union.

Despite, then, the meeting between client and therapist occurring within a particular social setting which partially specifies the roles each is to adopt, including the cognitive mindset of the practitioner , aspects of the personalities, behaviour, social skills and background of each participant enter ineluctably not only into the presentation and understanding of the difficulties of the client, but also affect the formation of an effective therapeutic and professional relationship. It is inescapably interpersonal.

There are obvious senses in which interpersonal relationships are defined by becoming emotionally engaged with other persons; being spontaneously affected by how they feel and react to oneself, caring (or not caring) about the state of their 'inner worlds' and what is happening to them, forming a unique relation defined by the intertwining and interpenetration of the world and experiences of each other, and the central importance they come to occupy in one's identity and life.

Scientific investigation and theoretical debate, on the other hand, deliberately attempts to exclude such emotive-affective reactions and concerns from its methods: attachment responses, being emotionally affected , having immediate and intuitive thoughts are not considered to play a role in the establishment of scientific facts and the veracity or otherwise of a theory. The value of science in answering certain sorts of questions is predicated precisely on not allowing such personal-affective responses and associated cognitions to influence decisions about an area of research or the methodology appropriate to its domain. Put simply, someone who relies on the judgement 'It just doesn't appeal to me' to justify their dismissal of a psychological theory or psychotherapeutic approach, on these grounds alone and in the absence of any supporting arguments or evidence for the dismissal would not only fail to persuade someone otherwise convinced, but generate concern about the nature of their clinical practice. Psychotherapies of all sorts whether or not they are committed to establishing of efficacy or theoretical potency via scientific methods that are supposed to guarantee neutrality of judgement based on impersonal reason, must have distanced ways of reflecting on such issues to some degree independent of emotive-intuitive responses alone.

Whilst the essence of science and theory thus commits the researcher to examining the domain of interest through an impartial rational prism governed by the appropriate research, in the therapeutic situation she is involved with another person and so cannot prevent the reactive thoughts and feelings about a client that she might experience in day-to- day interpersonal interactions. The client, of course, also has spontaneous thoughts and feelings about the therapist.

We cannot of course take up the entirely distanced rationality to others that we can take up to non-sentient objects. One might put this by drawing attention to the observation that we cannot fail to see not only a human face when we see it, but a human life in it. Neither can a

therapist fail to see and respond to the human face presented to her. Our emotive, reflective, and intuitive behaviours are drawn out and patterned in relations with others, and these intricate dances form the networks within which our identities, personalities and emotions are expressed. They form a shaping background whose structures are often hard to discern. This perhaps emphasizes, rather than detracts from the need for the therapist's self-reflexivity; the need to try and ensure that her primary task is not being influenced by factors not properly related to the client and her struggles. The therapist role is partly defined by her distancing herself from the person , not qua person, but as person-seeking –help, and to do this she must take up some internal distance from her responses as person-qua-person. As we shall see in the next section however, this is a delicate judgement; trying to prescind entirely from the humanity of her responses might obscure her gaining an important understanding of the other; self-reflexivity should be properly aimed at guiding and evaluating her natural responses.

As a person she cannot then help but bring to her encounter with another person those aspects of herself and her history that are elicited in the presence of others. It is perhaps this that underlies the widespread acknowledgement that interpersonal variables (eg those related to attachment), play a fundamental therapeutic role. So, the therapist must reflect on herself qua client, reflect on herself as self, and maintain a distance that allows her to think about the client through the organising prism of her theoretical orientation. Amongst all this she must maintain a relationship with the client that acknowledges her personhood, respects the ultimate autonomy of the other to which that position commits her, and acknowledge the limitations of perspective and attachment of her own agency as a therapist.

Personhood, Science and Therapeutic Relationships

The expression of personhood in day to day life and ordinary social interaction, perhaps otiose to mention, is not a scientific activity. When I am gossiping, sharing, feeling rejected, falling in love, feeling jealous, and being angry, these emotions and their associated behaviours occur in the context of patterned relationships with others. How my identity and subjective experience is expressed in these social or individual contexts is the outcome of a complex narrative involving predisposing factors such as attachment history (including loss), biological endowment, social, cultural, and personal variables. The outcome of all these influences is the particular subjective experience of what the philosopher Thomas Nagel (1999) has called 'What it is like' to be myself. The same, of course, is true of the other with whom I interact, and the product of this interaction of two worlds is a unique relationship constituted by the understandings, misunderstandings, biases, other- directed behaviour, social skills and empathy or lack thereof of each individual.

A therapeutic relationship, despite those features that distinguish it from social and attachment relationships with family, friends, and partners, brings inescapable elements of the personality and character of therapist into the therapy; she can no-more entirely escape this than she can entirely escape what the movements of her face and body often truthfully convey to others. What partly distinguishes a therapeutic relationship is the coming together of two individuals for a mutually understood (or misunderstood) purpose; the well-being of the client.

To attain this end, or whatever the appropriate goal of the therapy is conceived to be under this broad rubric, what she offers will be oriented via her theoretical position. However, whatever theoretical position the therapist takes up in relation to the client, and whatever position of neutrality is required or assumed by a particular therapy, the therapist cannot prevent the occurrence of spontaneous thoughts, emotive and empathic (or non-empathic)responses, and other feelings about or aroused by the client. Neither, of course, can the client about the therapist.

To treat the client entirely neutrally like an 'object' of investigation in a scientific category, or object of confirmation or information of a psychotherapeutic theory and be unresponsive to her individuality, is in part, to adopt the position of the medical model in psychiatry. One criticism of the latter is precisely that that it treats without the empathy necessary to guide the humane responses that result from grasping

the life of another person. The client, who remains a person, experiences this situation as if she is being treated like an unfeeling object, which is exactly how she is being treated.

Emotive and cognitive unresponsiveness to the individuality and personhood of a client, and his treatment as one data point identical to any other in some diagnostic or other psychological category quickly leads not only to lack of empathy, but a failure to accurately discern, formulate, and interpret his difficulty. The need for formulation of a client's problem as distinct from just diagnosis is, in part, recognition of this fact. Formulation is the construction of a unique story which attempts to account for the presentation of the client's problems by placing the various proximal and distal causal and related factors abstracted from theory and research into an individualised narrative. The attainment of this goal occurs within the interpersonal relationship which can affect how information is revealed, the way it is revealed, what is revealed, and how the cognitive significance of it is to be understood.

The achievement of therapeutic change is not just one which is imparted instructively to the client but is a task of mutual construction; one which has as a condition of its emergence the coming together of two persons, out of the mutuality of which experience can emerge a shift of understanding by the client; a new understanding of their world. It should be quite apparent that the conditions of this shift, and the self-knowledge which comes slowly to consciousness (or; a change in consciousness), and behaviour change are a partial function of the mutual intertwinement of persons and not a relation between one person and another abstractly conceived as an object of distanced study.

Every psychotherapeutic tradition recognises that the relationship between therapist and client is an important feature of therapeutic change however this is conceived, and whatever is postulated to be the primary motivator or process of change. In the cognitive behaviour therapies a recent series of papers on this issue was published in 2007 edited by Paul Gilbert, whilst in the same tradition but incorporating rational-emotive therapy a new book is due to be published in 2014 by the well known author Windy Dryden. Within the broader psychotherapeutic context the centrality of the relationship ensures that the literature on the subject is vast. Two recent examples of books which have concentrated on the role of attachment and its developmental precursors are David T. Wallin's Attachment in Psychotherapy (2007) and Jeremy Homes' The Search for the Secure Base: Attachment Therapy and Psychotherapy (2001). Petruska Clarkson's The Therapeutic Relationship (2003) tries to identify and explicate different kinds of relationships within the therapeutic context. This literature is mentioned, not with respect to any particular merit, but to indicate the scope and importance of the issue.

Trust, Empathy, Other Minds and Knowledge

One of the bounds that hold the therapeutic relationship is trust, an important component of any therapy. This complex ethical-emotional state is partly dependent on the attachment that has formed between client and therapist. Trust can only emerge within a developing relationship out of an interplay between client and therapist during which the empathic, ethical , and subjective responses to the client help form her judgement and confidence that the therapist respects her integrity. This confidence may be seen by some as itself an important agent in the attainment and maturity of the client's psychological integrity, but even those who do not assign it a central healing position, recognise trust and empathy as a necessary condition of therapy.

The client's sense that her integrity is so respected is a consequence of the therapist's ability to respond appropriately to the distress of others, which is itself dependent on the implicit grasp exercised in everyday human relations that the other has a first person perspective from which their life is experienced and understood. This capacity involves psychological abilities which do not originate from adopting the scientist practitioner approach, mastering a theory and its associated practice, and learning a series of technical procedures, but emerge in the early lifespan from interpersonal attachments. Undoubtedly such abilities are honed, developed, sophisticated and partly shaped in development and maturation (or

not) and, professionally, in adulthood, via exposure to schools and practice of therapy.

The essence of grasping and engaging with the life and world of another rests in part on a developed ability to imagine, implicitly or explicitly, 'what it is like' to be them. Much research in developmental psychology and 'Theory of Mind' is aimed at understanding the maturation of how we learn to take up the perspective of another person and the cognitive skills it entails. The work of such developmental researchers as the psychoanalyst and psychiatrist ,Peter Hobson (2000), have shown that sensitivity to the emotional world of others and attunement to their emotional states is fundamental to the emergence of language and interpersonal psychological language.

The early emergence of a sense of self is irretrievably linked via the interlinked emergence of these abilities to the dawning of awareness that other minds with their own perspectives surround the post -infant child, with a developing correlated need to be able to understand and predict what the contents of those minds might be and how the other, whose mind it is, sees and acts in the world. The acquisition of the distinction between the first-person (oneself), the second –person (the other) and the accompanying abilities to discern, describe, and become attuned to the internal worlds of others is to come to be able to know and understand (or misunderstand) another- a form of knowledge that can only be acquired in interpersonal interaction. This knowledge is incorporated into the psychological terms that the growing person becomes competent (or not) to describe and make sense of the behaviour and worlds of others and themselves. Within this development , where it is properly nurtured, also grow the important components of respect, compassion and care for others that provide the fundaments of any co-operative social activity, including, of course, psychotherapy.

Interaction with others is thus a necessary social condition of the possibility of any human identity, and is enmeshed with coming to understand, explain, and be able to offer the kind of day to day explanations (often successfully!) of the lives of the others that surround us. Successful and healthy development of the person in respect to these factors contributes substantially to successful relationships, underpins intuition, and is an ineliminable source of potential knowledge and understanding about the cognitive-affective life of another. Knowing another in this way is thus embedded in how we learn and come to use the common psychological words of our language and our ease and familiarity in their use. Some have argued further that understandings of this kind cannot be incorporated into the scientific world-view because they involve an ineliminable reference to how the world is seen by individuals; precisely the subjectivity science tries to escape by developing generalised and objective explanations of phenomena from 'no point-of –view'.

Whatever the resolution of this dispute about science and knowledge of each other, the importance of attuned subjective responses to another as a source of clinical valuable information and hypothesis generation is thus not only fundamental to any form of counselling and psychotherapy, and an essential part of any training, but also to the establishment of a productive therapeutic relationship.

The nature of scientific activity and knowledge, on the other hand, is differentiated by non-personal forms of engagement with the data of its domain: most particularly a non-affective, non-subjective and rational evaluation of the data in the light of the principles of reason and statistics. Empathic –intuitive idiosyncratic understanding of the kind adumbrated in the paragraph above on the other hand, rests on the exercise of emotive and intuitive skills which the scientific method excludes from its procedures precisely because it is at home and partly developed to underpin empathic engagement with individual persons.

In the psychological sciences whilst the data might be the behaviour, cognitive-emotional and sensory life of others, decisions about data are quite explicitly not governed by inter-individual, empathic , personal, or emotive responses, but by the need to exclude these characteristics from decision making processes to ensure that methods for testing hypotheses and developing explanatory theories are not influenced by subjective responses, hence the much vaunted phrase 'intersubjective validity'.

These two approaches are not mutually exclusive when reflecting on how they might be brought to bear on the process of psychotherapy: As the scientific method recognises, empathic and intuitive responses which are natural (to varying degrees) to interpersonal relationships, can however be unduly influenced or distorted by factors both internal and external to the therapist generating beliefs, thoughts and feelings which are unsustainable in the face of the evidence and dominated by personal prejudice. It is these concerns that motivate an important pre-condition of the scientific approach i.e. that the investigator adopts a standpoint towards the phenomena of interest from which they prescind from their own prejudices, beliefs, and intuitions and allow judgements to evolve from scientific methods that attempt to provide answers to questions independent of any such inclinations.

It is the recognition that there is a need for the impartiality and neutrality embedded in the idea of being guided by theory and/or scientific method, that is also reflected in the concept of self-reflexivity; the therapist's attempt to examine her intuitive thoughts and feelings from as impartial a perspective as she is able. This latter caveat points to the impossibility that she can ever be entirely neutral about herself and the relationship; the place from which she examines herself is always from some perspective that is hers, and the place from which she examines the relationship is always from some perspective that is within the relationship. Nevertheless the requirement for reflexivity is a recognition of the limitations of subjectivity, empathy and intuition, and inherits the principle of impartiality as an attempt to find as neutral a stance as possible from which to examine the motives, feelings, desires and beliefs that she has in relation to the client.

Impartiality is not just a principle restricted to the scientific method; it is also a requirement for the non-scientific disciplines, such as Law and History, which acknowledge the need for impartial and rational thought. It is to some degree an idealised principle and reflection on personal and interpersonal matters has an inescapable emotional import; to reflect the therapist has to recall interpersonal events, and as cognitive psychology studies of memory, neuroscience, and psycho-analysis teach us what we recall is not free from cognitive bias and emotive colouring.

This is where the requirement of impartiality comes in that can work comfortably in harness with empathy, intuition, subjective thought and feelings, and the scientist practitioner model. What it demands in the therapeutic context is not that the therapist ignores her (changing) feelings and thoughts, but that she tries to maintain a perspective from which they do not intrude or obscure, but at best, are informative about the client. In other words she tries to be as impartial as she can about herself, her own views and behaviour and how these are affecting the multiplicity of variables active in an assessment or therapy, because these factors affect formulation, therapeutic process, the relationship and outcome. Self-reflection is also a narrative process; the relationship and therapy is constantly evolving and changing shape, and the therapist, to the best of her abilities has to try and track her location in this psychological space. That therapists recognise how essential supervision is to their activities is a partial reflection of these facts.

Conclusion

What unites the scientist practitioner model and self –reflection is that both of these concepts have as a pre-condition of their exercise that the therapist learn to 'stand back' from their own internal cognitive and emotional life in the clinical interests of their clients. The use that is made of impartiality has differences in each of these cases as this paper has illustrated. In the former, neutrality takes no account of the feelings and thoughts of this particular interaction or these particular participants, although the information that can be gathered from it might be used by the therapist to inform them about the problem and subsequent options. In the latter, the therapist's subjective responses and those of the client participate in creating the inter-personal relationship. In this context impartiality requires the therapist's self-reflection in an unique human interaction as part of an attempt to understand her own contribution to the developing therapeutic narrative and how it might inform her about her client's presentation. In this sense, the need for an engaged neutrality derives not only from

consideration of what is to count as effective therapy, and how to conduct it, but is also an ethical condition underpinning assessment and therapy; the injunction to act and think in the best interests of the client and not oneself.

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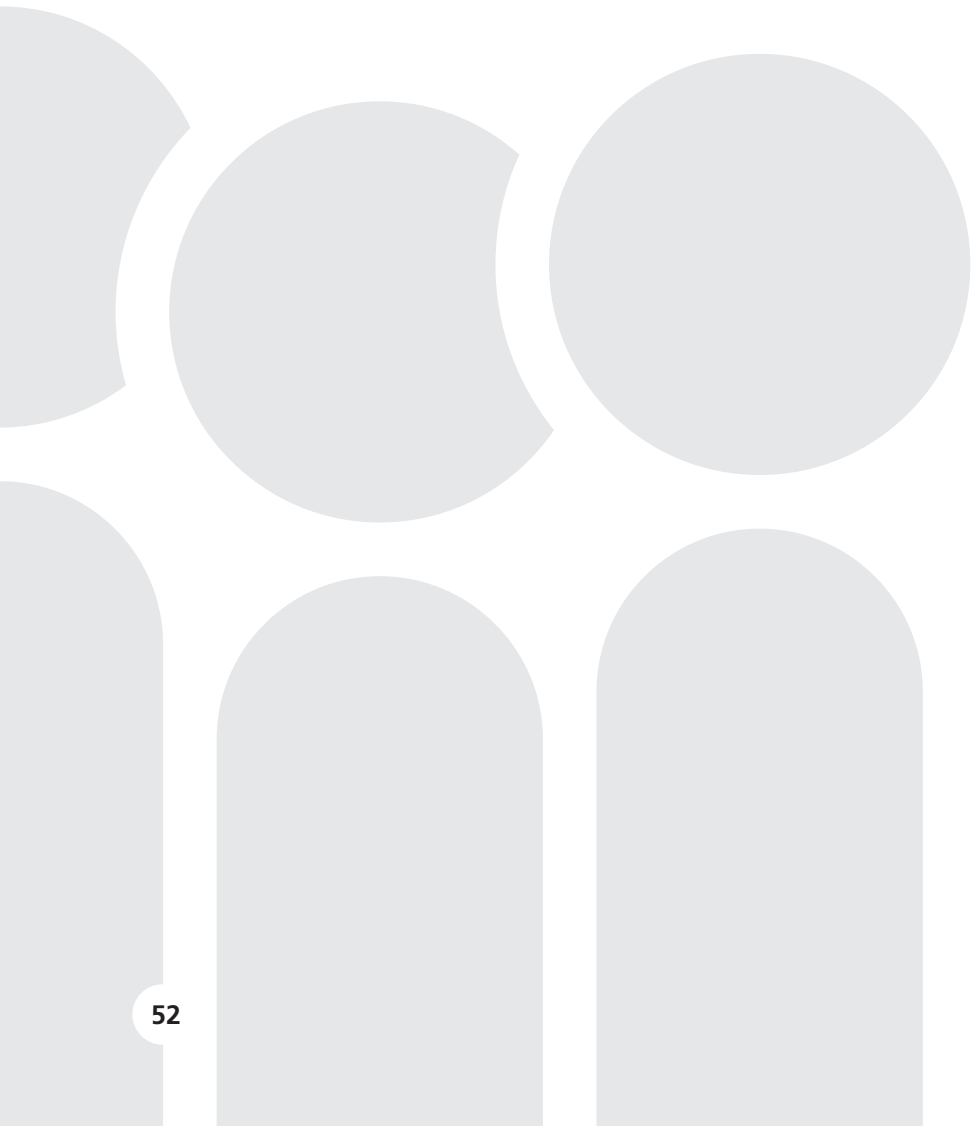

Stuart Baker

How I See Myself as a Practicing Integrative Psychological Therapist

1. Overarching Framework of Integration

At the core of my framework for integration is relationship and the centrality of the co-created therapeutic-relationship. My approach is relational-developmental based on a multi-dimensional framework, which understands the 'developing-self' as 'self-in-relationship' with our environment (Evans and Gilbert, 2005). This includes our relationship to body, self, others, our contextual field and environment, and the transcendental. I aim to understand my clients' self-relatedness at these levels over the course of their lifespan, with particular attention to early developmental experience and its impact on subsequent development.

Within this my model highlights a two-person-psychology unfolding in a co-created process (Stolorow & Atwood, 1992). It is in this intersubjective-space where healing and growth takes place facilitating the client to experience greater relational flexibility, spontaneity and immediacy in the present through 'different self-with-other-experience' (De Young, 2003).

My integrative frame has two perspectives: the here and now and the there and then (Lapworth & Sills, 2010). Primarily in the room I am using concepts that inform me of the here and now contact to maximise the meeting between therapist and client, particularly the authentic relationship in the existential encounter and the recognition of the dialogical 'healing through meeting' (Hycner & Jacobs,1995; Buber, 2004). However, at times, what I notice in my work while focussing in the here and now, is the emergence of unconscious developmental issues from the there and then. In this regard my integrative model has a strong developmental orientation drawing from the psychoanalytic schools of attachment, object-relations, and self psychology which help inform me about what might be happening and to work in that space. I find Schore's neurobiological affect-regulation-theory (1994) helps me integrate these concepts at both theoretical and clinical levels, and I find it important to pay attention to my clients' ability to self-regulate as well as our interactive affect-regulation (Beebe & Lachmann, 1998)

As a Buddhist influenced psychotherapist I aim to take-up a position of being 'experience-near' with my clients, open to my client's phenomenological and subjective experiencing. I aspire to hold a mindful-stance to enable me extending a dialogical invitation to my clients, aiming for empathic connection, attunement, inclusion and confirmation so as to enter into their subjective world without judgement. My mindfulness practice helps me be aware of and present to my own experience and that of my clients in the room, especially in the relationship of self to body (Kabat Zinn 1990, Siegel 2007, Bien, 2006). I pay attention to my own and my clients' somatic communications and bodily felt-sense (Gendlin, 1981), particularly my own countertransference, which can be a 'therapeutic resource' (Evans and Gilbert p.68, 2005), helping me understand my clients' unconscious communications about what they

need me to know and feel (Bollas, 1987) as well as what's going on in the room between us.

In this way I hope to include all domains of my client's self-relatedness and subjective experience in the room to provide 'a container for change' (Evans & Gilbert p.2, 2005) within the context of the therapeutic relationship.

2. Personal Philosophy and Values

My philosophy is deeply informed by Buddhist principles and values, focusing on how to alleviate and transform suffering, facilitate growth and connectedness to self, others and the world. I have chosen the path of Vipassana or Insight-Meditation (as described by e.g. Kornfield 2002, Nhat-Hanh 1994) as my personal spiritual path. I aspire to live this path through the practice of mindfulness - awareness of present moment experience with acceptance and non-judgment–which I see this as key to the healing process. However, I find it challenging to fully integrate this eastern philosophy into my life, and am aware of tensions and incompatibilities between my western and Buddhist philosophies / 'selves' - especially when my 'corporate-self' is in the foreground.

A central part of Buddhist philosophy for me is around the nature of suffering and how we often add to our emotional and physical pain, whether caused by internal factors or external events, through resistance and unwillingness to accept things as they are but wanting them to be different. I believe that by bringing awareness and acceptance to the suffering we create for ourselves and others we can transform it. Thus a key part of my work is helping clients become aware of and understand their subjective experience, differentiating things that can be changed from those that perhaps cannot and helping change their relationship to those that cannot through a process of disidentifying, acknowledging, allowing and possibly acceptance.

Within a Buddhist framework we are all mutually interdependent and deeply interconnected. All processes in life co-arise on a vast scale in a non-linear web of causality in which no event can be separated from any other (congruent with field-theory, Lewin-1952 and modern quantum-physics). The human personality and self are one expression of this moment-to-moment interdependent multiply-determined causality (Sills 2009 p.104). I adopt the Buddhist view of intrinsic health, which may become obscured and that a spiritual underpinning comes into play in all the deepest healing processes.

I see this Buddhist notion of interdependence and co-construction as compatible with dialectical constructivism, where there is no one truth but multiple perspectives. I believe people's sense of themselves and their world emerges out of dynamic processes and interactions where the world and self is jointly constructed from multiple aspects or voices, and that people are meaning-creating beings who are motivated to symbolize experience in awareness (Greenberg, 2002). Thus our truth is defined by subjective experience and co-constructed in relationship with others. Within this dialectic we also find our search for mutuality and individuality, uniqueness and connection, which lie at the heart of the human struggle.

I believe that the western phenomenological-existential approach is compatible with Buddhist notions of how we are conditioned, mindful awareness of subjective experience, inter-being / inter-connection and acceptance of our existential conditions. Within the phenomenological-existential approach I value the acknowledgement of uncertainty, angst, man's search for meaning, our situated freedom and our inherent relatedness: how man is in the world and not separate from it: 'The world and I are within one another' (Merleau-Ponty 1962). I aim to be aware of my clients' existential experience through the use of the phenomenological method of enquiry which parallels mindful enquiry.

The values that I find core to practicing as a psychological therapist arise from the interplay of these philosophies and my life experience. The key Buddhist attitudes that I aspire to hold in the room with my clients are: a commitment to awareness, presence, acceptance, compassion, letting-go and non-judging. I also hold the existential-humanistic-person-centered principles of: agency and self-responsibility, growth tendency, wholeness and integration,

pluralism, equality and authenticity as central values in my view of the person.

I believe that the approaches outlined have large areas of compatibility focused on the inter-relatedness and co-construction of all relationships through 'reciprocal mutual influence' (Stolorow & Atwood 1992, p.18) and experience the meeting between therapist and client as the central healing mode (Hycner, 1993).

3. View of Person

3.1 Multi-dimensional Motivational Forces

My primary view of human motivation is that humans are inherently relationship seeking (Fairbairn 1952) and that this is at the heart of all other human motivations. I believe human motivation is essentially intersubjective and that humans are 'embedded in an interactive matrix with others as his or her natural state' (Mitchell 2000, p.105).

Within the primary motivation of relationship I adopt a multi-system approach and find Lichtenberg's (1991) theory of structured motivation useful as an overall integrating frame of different domains of motivation across the lifespan:

(1) psychic regulation of physiological requirements. Within this system I would integrate Stern's (2003) emphasis on affect-attunement and the 'self-regulating-other' and Schore's neuropsychobiology of affect-regulation (1994).

(2) attachment and affiliation – in this area I use are Bowlby's attachment theory (Bowlby 1969), intersubjectivity (Stolorow & Atwood 1992), and Kohut's self-object transferences (1984).

(3) exploration and assertion – including motivation around mastery and self-efficacy. Here I find Bandura's theories of self-efficacy and modelling important (1977) and research on separation/ individuation (Mahler, 1975).

(4) aversion or withdrawal – I find it particularly important to address this in client work using mindful-awareness of our tendencies to move toward or away from certain internal and external stimuli (Bien, 2006)

(5) sensual enjoyment and sexual excitement – in my work I use mindfulness to develop awareness of the sensual (Germer, 2006).

Lichtenberg's model of motivation does not sufficiently address motivations arising from existential concerns. In particular I believe it important to recognise and work with my client's needs to make or search for meaning (Yalom, 1980) and to construct meaningful narratives of their experiences (Fonaghy, 2002). I also find it critical to acknowledge that human motivation is not always conscious and is influenced and conditioned by implicit processes (BCPSG 2008), whether this is conceived as: Freud's dynamic unconscious (1915),'internal working models' (Bowlby, 1969) or RIGS (Stern, 2003).

3.2 Structure of the Person

I favour an epigenetic model of human development where an individual results from the interaction between a unique genetic endowment and a particular social-relational-environment (Bowlby 1969, Schore 2002). In this context I hold a multi-dimensional view of the person developing via an interactive reciprocal-system from infancy (Stern, 2003) which unfolds in the context of intersubjectivity across the lifespan (Mitchell, 2000). I aim to develop awareness and work with the whole of the person of my clients, addressing aspects of their self-experience at the levels of the biological, intraspsychic, interpersonal, intercultural, ecological and transcendental (Evans & Gilbert 2005, p.47). Across these multidimensional view of self-functions I pay attention to explicit and implicit processes and the consonance and flow between these (Fosshage, 2005).

I believe that we are 'relationally-generated' (Fairbairn, 1952) with the 'self' taking shape from relational encounters between infants and primary caregivers from birth. Infant observational research supports the formation of self as arising from interactions between infant and primary caregivers (inter-alia: Beebe & Lachmann 1998, Stern 2003, Trevarthen 1992) and neuropsychyobiological research links this

to influencing the developing structure of the brain (Schore, 1994). At a theoretical level I find that object-relations theories help support me in my conceptualization of my clients, particularly Fairbairn's notion of endopsychic structure (1952) and Bowlby's attachment theory (1969).

I am aware of the tensions around the construct of 'self' and in particular to what extent 'self' is structure or enacted as process from moment to moment. I take a Buddhist and constructivist view of this self-as-process: 'the solidity and coherence of the self is only apparent, emerging from innumerable instants of self-building, just as the apparent reality of a movie emerges from the illusion of continuity generated by numerous individual frames of film' (Germer 2005, p.251). My experience of mindfulness-meditation has led me to experience that what we commonly take to be a sense of continual personal self is the arising and passing away of the interplay of five co-arising processes or skandhas (Brazier, p.84): consciousness, perception, feeling tone, volitional impulses and body processes. This Buddhist psychology perspective parallels Stern's work on self-constellations (2003) in which self, including the sense of 'who-I-am' and 'how-am-I-in-relationship', is constructed in a dynamic process rather than being a structure or entity (Sills 2009; Stern 1995).

Given an understanding of self as arising and co-created in relation with others, allows for the possibility of a multiplicity of self-constellations to arise depending on our internal and external conditions. I aim to help clients become aware of these in the room as they seem to find it to useful to become aware of these and name them. To this end I use Berne's ego-state model (1986) and Assagioli's (1971) sub-personalities which are phenomenologically close to clients' experience of different aspects of the self.

To truly relate to and understand my clients I aim to develop an appreciation of their contextual self: cultural, social, economic and political factors: 'Every client can only be understood from their own frame of reference, and from within their own cultural milieu' (Evans and Gilbert 2005, p.59). Thus in my work I aim to hold an awareness of my client's context, difference and otherness, whilst maintaining an appreciation that we are inimitably in relationship, part of the same field, connected to the same 'source'.

3.3 Concepts of Optimal Development, Derailments and Relational Trauma

For me optimal-development provides the capacity to develop and sustain meaningful relationships, to negotiate the processes of: separation and connection, individuation and dependency and uniqueness and mutuality. I am aware of the tensions between stage approaches to development like Mahler (1975) vs. those that take a multi-level approach like Stern (2003). I prefer to take a continuous or lifespan view of development and find a multi-level approach less rigid, as a process view seems closer to phenomenological experience.

I understand optimal-development from the perspectives of infant observational research which supports the formation of self as arising from interactions between infant and primary caregivers (inter-alia: Beebe & Lachmann 1998, Stern 2003, Trevarthen 1992) and neuropsychyobiological research links this to influencing the developing structure of the brain (Schore, 1994). I find Schore's neuropsychobiological model of social, emotional and brain development (1994) the most integrative lens through which to view development and pathology, particularly in its view of healthy development and derailments / trauma as opposite sides of the same coin.

Attachment

The research suggests that a good-enough attachment experience is likely to lead to optimal development whereas its absence may lead to sub-optimal development, deficit, derailment or psychopathology (e.g. Bowlby 1969, Ainsworth 1978, Main 1996). A secure attachment is co-created through reciprocal mutual affective interactions between caregiver and infant (Bowlby, 1969) and seen to confer a measure of resilience in later life and the capability to form intimate relationships. Developmental derailment may occur with any of the four insecure attachment styles, depending on the impact of the negative attachment experience; however, it is the

disorganised category where children are most at risk from derailment and trauma.

Given this strong research base I pay attention to my clients' insecure child attachment categories (Bowlby, 1969) with corresponding adult states of mind with respect to attachment (Main, 1995) in order to develop an understanding of how what happened back then shows up in the here and now.

Affect Regulation and Dysregulation

Research and clinical experience also show how affect dysregulation can form the basis of developmental deficit and psychopathology (Schore, 1994). I find the subsequent work of Stern (2003) on affect attunement and Schore (1994) on interactive-affect-regulation extends Bowlby's work by demonstrating how affect is central and how learning to communicate emotional states is an essential developmental process. I find it crucial to note that from this perspective psychopathology and trauma does not just arise from abuse or major traumatic events but can simply arise from the non-availability or insensitivity of caregivers: what Khan referred to as "cumulative-trauma" (1963 p.286) and Erskine describes as 'the little missed attunements, discounts, punishments, and rejections—like grains of sand that pile up until they form a dune' (1999).

Attunement is vital to healthy development as it mediates 'the creation of an attachment bond of emotional communication with the primary caregiver and the development of self-regulation' (Schore 2005, p.206). Such attunement is achieved through the dyadic regulation of emotion through processes of interactive-affect-regulation between infant and caregiver (Schore, 2002), mediated by the two key processes of 'affect-synchrony' and 'interactive-repair' (Beebe and Lachmann, 1994). Interactive patterns of 'disruption and repair' occurs as part of normal development (Beebe and Lachmann, 1994) and the process of the caregiver re-attuning to the infant following a misattunement is 'essential to the internalisation of a structural system that can regulate stressful negative affect' (Schore 2002, p.442).

Where such a growth-facilitating emotional environment is not provided the infant will not be able to adaptively regulate arousal and psychobiological states, resulting in dysregulation which may have significant consequences without interactive repair (Lachmann and Beebe, 1997).

3.4 Continuity of Early Relational Trauma into Psychopathology

Schore argues that early experiences of chronic dysregulation impacts the developing self-system through expression in right-brain structuralisation which may help explain the formation of internal working models (Bowlby, 1969) and RIGS (Stern, 2003) which become blueprints for future relationships. This would mean that the caregiver is not just a short-term regulator of the infant's emotional state but influences right-brain development and the long-term capacity of the child to cope adaptively in its social-environment (1994). In this way chronic dysregulation 'lay(s) the groundwork for an insecure attachment, right brain dysfunction, limbic-autonomic deficits, and the development of a predisposition to later psychiatric and psychosomatic disorders' (Schore 2005, p.210).

The most significant consequence of early relational trauma is the loss of the ability to self-regulate, with limited capacity to tolerate and modulate the intensity and duration of affect, especially biologically primitive affects like shame, rage, anger, despair, panic-terror and positive affect such as excitement or elation (Schore, 2002). Such maladaptive deficits in affect-regulation may be expressed in a spectrum of severe psychopathologies (Kernberg, 1988). However, I also believe it important to keep in mind that early relational trauma/dysregulation does not inevitably lead to psychopathology and depends on subsequent experience and a person's resilience.

Given such evidence I believe it critical to appreciate the impact of dysregulation in my clinical thinking and attend to my clients' patterns of regulation in the therapeutic relationship. I track how such relational experience from the 'there and

then' may show-up phenomenologically in the room in the 'here and now'.

3.5 Diagnosis & Problem Formulation

As well as a developmental-relational view of my clients' problems I benefit from using diagnostic systems such as DSM-IV-TR (2000) to conceptualise my client's issues, inform my treatment planning approach and give me a common language with colleagues; though I acknowledge its limitations, particularly in not addressing etiology.

I also consult Benjamin's 'Interpersonal Diagnosis and Treatment of Personality Disorders' (1996) as it integrates DSM-IV-TR Axis-1 terminology with an interpersonal perspective, which is more aligned with my integrative stance, and provides useful treatment planning frameworks. Additionally I also like to conceptualise my clients in terms of character structure or personality type, referring to Johnson and find his idea of a 'structural development continuum' of psychopathology, from a 'character style' through to 'character neurosis' a more flexible way of applying diagnostic thinking (1994). Where relevant I use Johnson's character styles to help me recognize patterns in clients and appreciate how these are often organized around basic life-issues in early development and how these different styles may require specific cognitive, affective and behavioral intervention.

Though I aim not to pigeon-hole or objectify my clients such systems can provide a useful framework to test and expand my thinking.

4. The Process of Psychological Therapy

I believe that the process of psychotherapy needs to be centred on the therapeutic relationship rather than techniques or tools (though the latter may have their place at times within the context of the relationship) and believe that most change arises from this relational stance. I will outline some key elements of the process of psychological therapy that are important to me, including: the co-created nature of the process, working with the implicit and explicit, phenomenological enquiry, my relational methodology and my take on the nature of the therapeutic relationship.

4.1 The Co-created Psychotherapeutic Process

At the heart of my view of the process of therapy is intersubjectivity whereby the client and therapist, the two subjectivities in the room, co-create a relational field through 'reciprocal mutual influence' (Stolorow & Attwood, 1992) at conscious and unconscious levels. As therapist, I am not a neutral entity or blank screen but inevitably a fully engaged participant in a mutual process (Aron, 1996), both influencing and influenced. I welcome a deep emotional engagement and acknowledge that my feelings are inevitably part of the process, often usefully so.

4.2 Working with the Implicit and Explicit

Within the intersubjective field I take a multi-systems view and work with both implicit and explicit processes. I am mindful of the ongoing debate in the literature, particularly between the BCPSG (2008) and Fosshage et al (2005) around the relative importance of implicit and explicit processes (cf. the relational experience vs interpretation/insight debate), and whether these are parallel systems or more closely inter-connected. In the meantime my priority is to work with both in the room depending on my client's needs, aiming for integration. My experience in the room with clients is that both domains of interaction happen simultaneously, although one process may be more in the foreground at one moment and that there is a 'dance' (Fosshage, 2005) between them, as the implicit is made explicit and the explicit evokes the implicit.

4.3 Attuned Phenomenological/ Mindful Enquiry

I use the method of phenomenological enquiry to focus on my client's worldview (Spinelli 2005; Erskine 1996, 1997) and to understand the subjective meaning of the various aspects of my client's self-experience (Sills, 2009) and their multi-dimensional self-functions (Evans & Gilbert, 2005). In this process I pay attention to

both implicit and explicit processes, particularly clients' affective experience, bodily felt-sense (Gendlin, 1981), and somatic communications - aiming to bridge the body-mind gap.

The process by which I undertake the enquiry is key, probably more so than the content, and needs to be undertaken relationally and mindfully. I find Erskine's relational methodology (1996) of empathic attunement, respectful enquiry, validation and psychological involvement fits well with my integrative framework. The use of this relational methodology with phenomenological enquiry and mindful attitudes of curiosity, presence and compassion enables me to extend a dialogical invitation to my clients, aiming for connection, attunement, 'inclusion and confirmation' (Hycner & Jacobs, 1995).

Through this process I hope to attune to my client, in turn helping the client regulate their own affect; seek to understand and help them make sense of their experience and developmental pathway; to offer provisional and tentative understandings to the client for consideration with empathic understanding so as to co-create meaning and new narratives with the client, and to positively affirm their uniqueness and essential worth (Mearns & Cooper, 2005).

I hope to engage deeply with my clients, demonstrate my willingness to be impacted by them and facilitate their move toward integration through greater awareness and acceptance, 'being with' my client rather than 'doing to' (Baker, 2012).

4.4 The Nature of the Therapeutic Relationship

In the same way that I take a multi-dimensional view of the self (Evans & Gilbert, 2005) I find it useful to view the therapeutic relationship as made up of a range of complementary relational processes or domains (c.f. Clarkson's five facets, 2003). In practice I find it useful to be aware of which relational domain is foreground at any time, and pay attention to how different relational processes may arise and then pass into the background during a particular session and over time across the therapy process. I do not favour any one of the relationship domains, believing all are present in the room, serving different needs and functions and therefore equally important in the work. I consider the different relational domains a useful 'scaffolding' to facilitate my awareness of the overall relationship, in the moment and in post-session reflection, rather than with the intention of deconstructing the relationship. I will outline how I work with these relational modalities, and how these overlap and interact, to form the co-created therapeutic alliance.

I am aware how these relationship labels can be problematic and carry a range of meanings; thus I hold these lightly and will situate myself in relation to them.

Forming a Working-alliance

I still see the first task of the therapeutic-process as establishing a working-alliance (Greenson, 1967) to create a basis to work together, despite challenges that it may have run its course (Safran & Muran, 2006). I aim to create a 'holding environment' (Winnicott, 1989) in which my client can begin to feel safe enough to trust me with their story and instil an appropriate degree of hope in the therapeutic process (Yalom, 1995). My way of being with the client is critical at the early stages of the relationship, particularly with respect to demonstrating empathy and providing support.

As our relationship develops I pay particular attention to ruptures to the alliance (Safran & Muran, 1996) which provide vital moments of potential for learning and growth. Where ruptures occur I try to face them with an open and non-defensive attitude, encouraging my client to acknowledge and explore these and be curious about our respective roles in this and our impacts on each other.

Facilitating 'the developmentally-needed or reparative relationship' (Clarkson, 2003).

I am mindful that this area of relationship can be interpreted in many ways and some understandings of this, like Alexander and French's 'corrective emotional experience', (1946) are subject to criticism for appearing manipulative and technique driven or leading to gratification. I do not subscribe to such explicit

use of the relationship in this way but work with developmental-needs at a more implicit level, aiming to provide my clients with a 'reparative or replenishing relationship or action where the original parenting was deficient, abusive or over-protective' (Clarkson 2003, p.113). However, at the explicit level I do pay careful attention to my client's non-verbal communications and 'vitality affects' (Stern 1985, p.54).

In this regard I aim to provide a level of 'optimal frustration' (Kohut, 1996) and function as a self-regulating-other (Schore 1994; Stern 1985) to provide my client with a different-self-with-other-experience (De Young, 2003).

Through our co-created relationship I hope to invite and support my clients' need for affect-regulation (Schore, 1994) and interactive repair (Beebe & Lachmann, 1998). Schore's 'model of clinical expertise' (2007) refers to the need for therapist's: clinical sensitivity, empathy, intuition, affect regulation, the ability to take the transference, and facilitate interactive-repair of ruptures. He believes that it is through these non-conscious functions of the right-brain, rather than the ability to generate interpretations from the left-brain, 'that facilitate change in the patient's unconscious' (2007-p.13).

The challenge is how does one come by such 'expertise' in implicit process? For me I aim to develop and attune to such implicit processes, my own and my client's, through my mindfulness-meditation practice, which may prepare the ground for such receptivity to occur. There is a growing body of evidence suggesting how mindfulness practice may support the development of such therapeutic qualities e.g. Baker (2012), Grepmair et al (2007), Hick & Bien (2008), Wexler (2006), Wang (2006) and Aiken (2006). There is a convergence in the field between psychology, neuroscience and mindfulness, with research suggesting that the part of the brain that is developed in the process of emotional-attunement is the same part of the brain that is developed during mindfulness-practice (Siegel 2007, Hanson 2009 and Davidson et-al, 2003).

Aiming for a Dialogic Relationship

This domain of relationship has also been referred to as the 'real' or 'person to person' relationship which can be problematic in terms of definition and connotation. My subjective experience in the room is that all relational modalities have a felt-sense of existing in that moment and being 'real' – so who is to say what is real and what isn't? So for me 'real' is about a way of meeting that involves authentic interaction between me and my client. As a relational therapist at the heart of what I offer my client is 'a real person, willing to be in relationship with them' (De Young 2003, p.160) and genuinely engaged.

I believe holding a dialogical attitude maximises the meeting between therapist and client and facilitates intersubjectivity in the therapeutic encounter by drawing my attention to the 'invisible intangible dimension "between" us… out of which our separateness and uniqueness emerge' (Hycner & Jacobs 1995, p.3). I sense that it is this 'between' at the contact boundary of therapist and client that is the source of healing. I aspire to fully enter into a here and now existential encounter with my clients to prepare the way for Buber's 'I-thou' way of being, Hycner's 'healing through meeting' (Hycner & Jacobs 1995, p.5) or Stern's 'moments of meeting' (2004, p.168). Although I cannot force 'I-Thou' moments I prepare the 'ground' (Hycner & Jacobs, 1995 p.10) for these to occur by being as present as possible in the moment.

Mindfulness-meditation practice helps me prepare this 'ground', enabling me to hold the paradoxical position of wanting these moments to occur yet not attempting to force them, and developing an attitudinal-stance and therapeutic qualities which support genuine contact. By bringing mindful-awareness into the therapeutic encounter itself I am more able to be present, open and available to my clients.

I believe that 'being with' my client rather than 'doing to' through techniques and strategies allows me to be more empathic, present, spontaneous and responsive to our here and now experience in the room and facilitates us moving beyond a relationship at the working-alliance level to greater relational-depth (Mearns & Cooper, 2005).

Harnessing Transference-countertransference & Implicit Relational Processes

Often in the room with clients I find that developmental-issues or archaic patterns of relating from there and then arise in the here and now relationship and that much of this is out of awareness and unconsciously motivated. Thus I believe it is important to encourage transferential and implicit relational processes to unfold, seeing them as a critical communication channel and manifestation of the co-created relationship.

I aim to use the relationship to provide a critical-scene for the reworking of a client's transference or 'organizing-principles' (Stolorow and Atwood, 1992) that organise their relational experience. I do not favour implicit or explicit process but view them as equally important in the work with the focus on being to integrate these two flows of experience.

I find it important to track 'implicit relational knowing' (BCPSG 2008): non-language and non-conscious processing outside of focal attention, which may emerge at the boundary of conscious-awareness and includes our knowing how to be with others. I find such implicit communication in the co-created therapeutic process emerges as: transference-countertransference, projective-identification and enactments. I aim to encourage my clients' early implicit experiences into the room in the present moment (Stern, 2004) and symbolise such split-off experience in verbal-form (Stolorow and Atwood, 1992) so it can be owned and re-integrated. Similarly I find Stern's (1989) concept of 'unformulated-experience' and Bollas' notion of the 'unthought-known' (1987) complement my appreciation of unconscious process.

The object-relations concept of object-usage is also key to my approach: listening out for who is speaking right now in terms of internal-objects and also checking who am I right now for this client in the transference, understanding the need to appropriately frustrate and challenge the client to face themselves, and at other times as the analytic-parent to the analytic-child, to offer moments of repair for their deficits and traumas. I would extend this concept to how I understand myself to be embedded in the here and now transference-countertransference mix, co-created (Racker, 1968) by our two unconscious minds or subjectivities communicating together (c.f. Gerson's 'relational-unconscious', 2004) where I bring my own implicit relational principles to the encounter as does my client.

I find it useful to look out for when my clients may be experiencing 'repetitive-transference' (Stolorow and Atwood, 1992) where they relive the past as a here and now relational struggle (De Young, 2003) and how this plays out in the room between us. I will work with my clients to help them understand these moments, develop awareness of how they show up in our relationship and out-there with others and aim to facilitate them with a different self-with-other-experience (De Young, 2003).

At times I may aim to provide clients with a different self-object experience to counter developmental deficits in self-structure and allow for repair and building of self-regulatory capacity (Kohut's 1977, Schore 2003 p.92) whilst guarding against their 'expectations and fears of a transference repetition of the original trauma' (Stolorow and Atwood, 1992). I am mindful of working with Tolpin's 'forward-edge' transferences in order to facilitate the emergence and growth of clients' 'future development potential' in juxtaposition to their 'the trailing edge of pathology' (2002 p.186).

Countertransference

Like transference I regard countertransference as an implicit form of communication which I can harness as a resource in my work, to tap into the emotional and relational 'undercurrents' in the room and my clients' 'unverbalized or unverbalizable' experience (Wallin 2007, p.115). I look-out for my own countertransference and how my client's transference may hook into my own historical material creating a particular and unique connection or disconnection (Maroda 1991, 1998).

Paying attention to my countertransference allows me to connect with my clients on a non-verbal/right-brain to right-brain level, opening a different window on to my clients' experience, complementing our left-brain/ verbal / explicit process. Through the 'use

of self' in the countertransference I look for the opportunity to uncover my clients' communications about their 'unthought-known' and to bring this with any disavowed experience into the room to work on together, which when disclosed, might potentially open to a 'transformational experience' (Bollas, 1987).

For me countertransference is primarily a somatic experience and I am mindful of and present to the impact of my clients on my own bodily and inner-experience: '…much of what we pick up from our patients, we may first feel in our bodies and perhaps most immediately in our breathing' (Aron & Anderson 1998, p.28). I aim to adopt a stance of 'inclusion' (Hycner, 1993) where I am able to move between my subjective experience of the countertransference and an observer position. Through in the moment reflection and outside the room (using reflective function, therapy and supervision) I try to differentiate my arising process from my clients', distinguishing whether my countertransference is reactive or proactive (Racker, 1968).

I believe that the appropriate use of countertransference disclosure (particularly as discussed by Maroda 2002, 2010) can help meet the patient's need to experience the analyst's emotional involvement and feel recognised: 'it is the therapist's willingness to be forthcoming and to show emotion that is curative and stimulates emotional honesty in the patient' (2002 p.103). I find it can often be useful for my clients when I disclose my here and now felt-sense when I do not believe it is my own but an unconscious/ implicit communication from them.

The Underlying Transpersonal

I draw on the Buddhist philosophy and practice of mindfulness as my personal spiritual path. Mindfulness is 'simply being aware of what is going on, as it is arising, connecting deeply and directly with this and relating to it with acceptance' (Crane 2004, p. 2). I use mindfulness to keep me present to my experience in the here and now and enhance my awareness, while holding the mindful attitudes of acceptance, non-judging, patience, trust, non-striving, beginners' mind and compassion (Kabat-Zinn 1990). This is how I aim to bring my transpersonal-self and being into the room to forge a 'being to being' inter-connection with the other (Sills, 2009).

5. The Process of Change

As a psychological therapist my goal is stimulating the client's own organismic self-regulation and healing processes. It is the quality of the co-created therapeutic relationship that prepares the ground for such healing to occur. I place intersubjectivity at the core of psychological therapy and the process of change: 'The intersubjective engagement between patient and analyst has become increasingly understood as the very fulcrum of and vehicle for the deep characterological change psychoanalysis facilitates' (Mitchell 2000, p.125).

I believe that therapy provides an intersubjective-space, which enables change at a number of levels (cognitive, affective, behavioural) and across different self-functions, both interpersonally and internally through integrating old experiences and generating new experiences (Lyons-Ruth, 1999) and iterating between the implicit and explicit domains (Fosshage, 2005).

I recognise the research into the relative contribution of a range of therapist and client factors that may hinder or facilitate this relationship and the change process, particularly that the client's participation is the most important determinant of outcome (Hubble, 1999). I try to understand my impact on these therapist-factors through my own reflection, supervision and therapy and maintain awareness of client-factors throughout the therapy process.

5.1 Healing Through Relationship and the Implicit

Research points to the intentional use of the therapeutic relationship as being central to client outcome (e.g. Luborsky et al 1975, Bergin and Lambert 1978, Hubble, Duncan and Scott 2000) with Lambert (1992) proposing that it accounts for 30% of successful outcome variance. Thus I regard the co-constructed therapeutic relationship as

the fundamental vehicle for change through creating new self-with-other experience.

I view psychotherapy as a process that might potentially recreate the attachment-matrix in which the self can potentially be healed, where what was not provided by a sensitively attuned parent back-then may be provided by an empathically attuned therapist in a developmentally reparative relationship in the here and now. Fonaghy et al's (2002) proposition that the intersubjective therapeutic relationship aims to generate a secure-attachment relationship within which the client's mentalizing (reflective-function) and affect-regulating capacities can develop, and where the client comes to know himself through the process of being known by another. The BCPSG supports the view that change occurs with the therapeutic relationship at both implicit levels through reworking old relationships and co-creating new ones (2008).

Schore's regulation model is at the heart of my understanding of change: 'implicit interactive-affect-regulation…is the central organising principle of development at all points of the lifespan, including the change process of therapy' (2007 p.11). The critical role of affect regulation was shown in a study by Diener et al (2007 p.939): 'The more therapists facilitate the affective experience/expression of patients in psychodynamic therapy, the more patients exhibit positive changes.'.'

Another key dimension of repair in the relationship I work with is the intentional provision of self-object experiences for clients, mirroring, twin-ship and idealisation, which creates change through the process of 'transmuting internalisation' (Kohut, 1971).

I would also include the importance of the therapist's modelling of process and behaviours in the room as an additional change mechanism, rooted in Bandura's social-learning (1977). However, at times I will draw attention to this process to make it explicit to maximise my clients' development opportunities.

I hope that in facilitating new experiences for my client I may challenge the beliefs embedded in their 'core interpersonal schema' (Beitman, 1992), loosening them and allowing new schema to emerge.

5.2 The Role of Explicit Communication

Though I understand the crucial role of implicit right-brain to right-brain healing processes for working at a pre-reflective level, I also believe there needs to be an appropriate balance with using explicit communications to facilitate change. This I also incorporate the use of interpretations to develop client insight, capacity for reflective function and mentalization, work to co-construct coherent autobiographical narratives (Fonaghy, 2002) and make meaning of existential issues (Yalom, 1980).

I believe that a critical change factor is self-awareness and that 'awareness itself is curative' (Perls, 1951). I use feedback and mindfulness-awareness exercises to bring my clients' patterns and defences into the room, to allow them to realize new things about themselves, see old situations in a new light and look differently at significant-others. In this way I hope to facilitate my clients' awareness of the possibility of choice and the necessity of responsibility. I combine facilitating my clients' self-awareness with development of their embodied observer or witness-conscious (Deikman, 1982).

At times, particularly in short-term NHS work, I believe that psycho-education (Anderson et al, 1980) can play a critical role, providing clients with fundamental background information about their condition, enhancing coping competence and the acquisition of treatment knowledge (Bäuml et al, 2006), extending their potential for informed self-help outside of sessions.

5.3 Changing One's Relationship to One's Experience

My empirical experience (particularly in my personal meditation practice) supports Beisser's 'paradoxical theory of change', which proposes that 'change can occur when the patient abandons, at least for the moment, what he would like to become and attempts to be what he is' (1970 p.1). In order to help the client abandon explicit change efforts

of experiential control or avoidance efforts Hayes et al propose that the therapist actively foster a sense of 'creative-hopelessness' (1999 p.87) to validate the clients' experience of the futility of struggling with internal experience. If this strategy is used sensitively I believe it opens the door to dialogue around acceptance and letting-go, which paradoxically open up possibilities of transforming how one relates to one's experience. Using a mindfulness approach I help my clients to experience and stay with their stuckness and struggle in the room and learn how to be present to their own experience (Kabatt-Zinn 1990, Siegel et al 2007, Germer-2005, Bien 2006). When clients are ready I may help them cultivate and practice self-acceptance (Hayes 2007, Fulton in Germer 2005) and self-compassion, which are increasingly being associated by clinicians and research in the change process (e.g. Gilbert, 2009).

6. Conclusion

I believe the most important thing I can offer my clients is my true presence and availability: 'To be fully present and fully human with another is healing of itself' (Shepherd et al 1972 in Geller 2002). When in a state of presence I may open up the possibility of relational-depth: 'a feeling of profound contact and engagement with another' (Mearns & Cooper 2005, p.4).

To offer my presence I need to find a way to be clear, centred and available. I aim to achieve this through being mindful in the room with my clients but also by preparing the ground through my own meditative and contemplative practice. I aspire to meet Bien's challenge to therapists: 'Therapy is a calling, a way of life. If mindful therapy is not part of our way of life we run the risk of becoming only technicians, not healers' (2006 p.22).

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Book Review by Brad McLean

Therapist and Client: A Relational Approach to Psychotherapy

Author: Patrick Nolan

Publisher: Wiley-Blackwell, UK

MANY of us who have undergone relational psychotherapy training find it hard to put the therapeutic relationship anywhere but centre stage in the therapeutic endeavor but for those not familiar with the relational sensibility, Irish Psychotherapist Patrick Nolan's book Therapist and Client: A Relational Approach to Psychotherapy is a good place to begin the exploration.

Nolan, who is the Director of the Irish Institute for Integrative Psychotherapy appears to have taken up a challenge that has not wholly been explored successfully in the literature to date - bringing together the evidence to support this currently prevailing relational paradigm and showing how it works in practice. He achieves the synthesis needed and clearly answers the questions: how does it all fit together and, more importantly, how could I use it in my work?

The book's introduction paints a picture of the author's professional and personal experiences including references to early memories and diverse clinical experiences and how these have shaped both his character and professional life in a way that provides a framework for the book's complex subject matter.

He explains how through his humanistic training he learned about the importance of congruence and the recognition of feelings, while later in his career his psychoanalytic training offered insights into the role of the participant observer and the value of clear boundaries. But through these references to difference, he returns to the common factor of these therapeutic styles.

For example, Nolan's tale about his mother's 'neighborly counselling' offered him the first glimpses of some of the 'qualities, spaces, interactions and dynamics' that he writes about in the book.

"Not until years later did I even hear words like 'empathic stance,' 'mirroring' and 'intersubjectivity', but I saw them all captured in my mother's interactions with customers at our local store," he writes.

The arc of Nolan's professional career is vast, from training as a social worker to his exposure to the human potential movement, his training in a host of different modalities including gestalt, reality therapy, body-orientated, humanistic and psychoanalytic approaches. Despite these explorations, therapy, he says, finds its roots in ordinary human contact, how this contact occurs and the processes inherent in it.

Writing in the book's foreword Emeritus Professor of Family studies at the University of Leeds, Peter Stratton, mentions that the plethora of ideas in Nolan's book could be considered daunting, and, should the author wish to be grandiose, he could claim that

the book is a "universal conceptualization of all interpersonal theories."

I agree, both that the book is packed full of complexity and detail (and deceptively slim) and it manages to cover just about every aspect of the relational, interpersonal and intersubjective aspects of psychotherapy.

The first chapter explores infant research and its link to the development of the self, attachment, affect regulation, reciprocity and many other developmental/relational insights that inform our understanding of the adult self in relationship with 'other' in the therapy room.

In these pages, the author skillfully draws the reader into the complex but fascinating world of affective attunement, reciprocity, rhythmic coupling, turn taking and matching. Further, the intricacies of vitality affects, attuning and switching modes of expression are explored in terms of the way they are used to navigate the relationship between therapist and client.

Three chapters explore the role of the interpersonal relationship, the intersubjective aspects of relational work and, importantly, the vital role of a 'potential space' for creativity and play.

Having worked as a body therapies, Nolan pays tribute to the important area of the relational mind-body connection in the next chapter and in this section he outlines five modes of experience, function and expression in the therapeutic encounter: body sensation, emotions, cognition, imagination and motor activity.

The final chapters of the book are devoted to the practicalities and complexities of working relationally with a focus on areas such as 'fragile' and traumatised clients, the role of assessment from a relational perspective and adapting the relational approach to the client. In this section Nolan focuses on valuable considerations including contracting, tailoring the therapeutic stance, adaptability and arriving at an individual relational style.

I very much like the metaphor Nolan uses to illustrate how after 30 years as a therapist he appreciates, no matter what approach a therapist takes, that the effectiveness and potency of the psychotherapeutic dyad hinges on how "alive the interpersonal relationship is in the present moment."

"The various schools of psychotherapy may sail under different flags, but all are carried by the same winds and the same currents, and they can all flounder on the same rocks…the setting, the approach, the intervention, these of course, are influential but it is the therapeutic alliance that makes the essential difference."

As several reviews have already noted, the book deserves wide readership among both students and advanced practitioners but I also believe the book should attract an important readership that I think sometimes gets forgotten – the relatively new relational therapist.

This group is particularly hungry for texts that effectively bridge theory to practice in an elegant, accessible way. A common criticism about relational training is that it is both hard to teach and even harder to learn and Nolan has struck the right balance here by exploring the core theory, particulars and skills of everyday relational psychotherapy practice, illustrating this with truly meaningful case vignettes and practical advice.

New therapists want to develop a personal style and unite their clinical experience, supervision, therapy and reading in a way that helps to formulate the therapist they want to become. I believe for this group, Nolan's book is perfectly pitched.

While new practitioners will benefit from reading this book, therapists of all levels of experience, especially those who are focusing on the relational aspect of their work, will find this book a useful place to visit and revisit; to think, to reflect and to play with the ideas.

Brad McLean is a psychotherapist based in Sydney, Australia. He studied at the Australian Centre for Integrative Studies and sits on the board of the Australian Transactional Analysis Association. He can be contacted at *www.bmctherapy.com*.

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