The British Journal of Psychotherapy Integration

Volume 10, Issue 2 (2013)

Integrating the Personal and the Professional

ISSN 1759-0000

Volume 10, Issue 2 (2013)

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.

ISSN 1759-0000

Contacting Us

Please address all correspondence to:

Ukapi
Flat 1
13a Alexandria Road
London W13 0NP

Alternatively you can email us at:
journal@ukapi.com

For general information regarding UKAPI please visit our web site:
www.ukapi.com

Copyright

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 2 (2013)

Contents of this Issue

Editorial

Integrating the Personal and the Professional

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 continue to support the idea that there is no one integrative paradigm or school of integrative practice. As we often note in the editorial we sometimes establish a themed journal and seek articles accordingly. Sometimes, we collect a melange of articles which may or may not coalesce around a theme. All our contributions are from practitioners who have an allegiance to an explicit integrative sensibility though they understand this differently.

For this edition of the journal we had the unusual pleasure of both a range and a diversity of suitable contributions. On the one hand, this edition is a melange. On the other hand, there is a shared echo of thoughtful exploration, richly referenced on specific personal and professional aspects of practice. There is a sense of standing back from the immediacy of therapeutic engagement and reflecting on our philosophical and theoretical underpinnings whilst still grounding this in practice.

Avril Hollings has written a very sensitive, thoughtful and clear account of the challenges that are particular to working with lesbian, gay, bisexual and trans couples. Drawing on years of experience in this field, she highlights what could be seen as common in any couples system and what may be unique to these groups. We appreciated Avril's drawing close attention to what is similar and what is different with clear links to her practice.

Lesley McGown presents the findings from her Doctoral Research into 'Spontaneous Mental Imagery' as it arises within the therapist in the therapeutic setting. Lesley explores this phenomenon as 'a form of uncanny intersubjectivity' and 'developed insight' about the world of the client. She also talks about how the therapist might use this and raises questions of explicit self disclosure. She invites each of us to be alive to this process and to welcome it as part of the implicit communication between therapist and client.

Philippa Perry offers a very personal and idiosyncratic account of her experiences both as a client and then as a therapist revisiting issues of therapist self-disclosure from a seemingly humorous, yet thoughtful perspective. Philippa illustrates the inevitable link between the personal and the professional in our work.

Michael Tophoff explores the interface between some eastern and western traditions. particularly in relation to a separate sense of self, the privileging of autonomy, independence and separateness rather than the inextricably interdependent nature of all people, creatures, and the cosmos. This is essentially a philosophical conversation which might raise questions about our underlying assumptive systems in psychotherapy.

David Zigmond, with the agreement from the writer of the first letter, presents us with a heartfelt communication, decades after the event that attests to the power of the human to human relationship in the work we do, which endures over time. As someone who chooses to

stay working within the NHS, David questions the effects of some of the current evidence-based arguments and inevitable (perhaps) restrictions due to lack of resources of all kinds.

As is our practice we have included the theoretical section of Michelle Bearman's MSc Dissertation that forms part of her final submission for this degree at Metanoia Institute/Middlesex University.

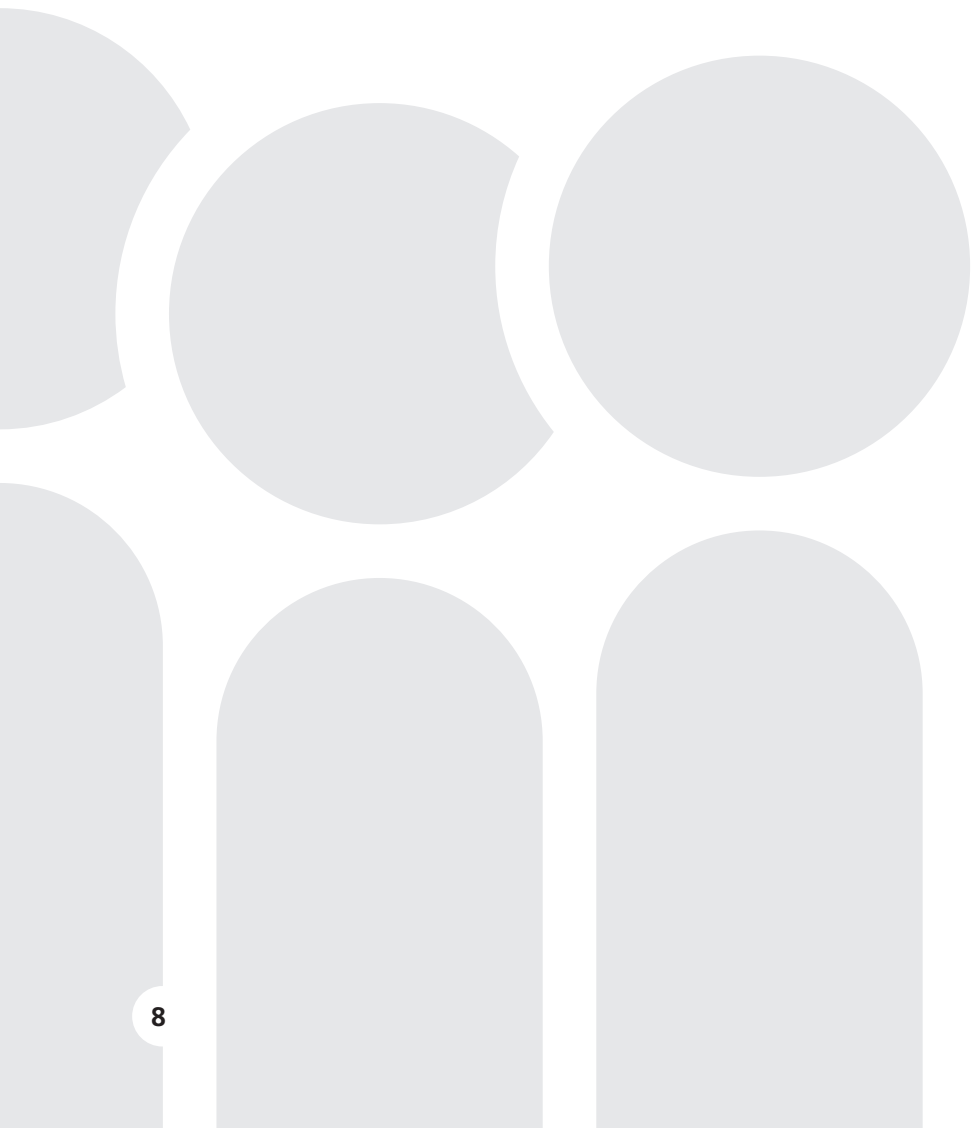
We also include one book review.

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.



Avril Hollings

Therapy and Counselling with Lesbian, Gay, Bisexual and Trans Couples

Abstract

In this paper I write about my experience of working with LGBT couples and relationships and offer some reflections and some recommendations for those working with, or considering working with lesbian, gay, bisexual and trans clients in relationships and couples. I set the scene by giving a historical, social and legal context to LGBT relationships, and naming what I see as some of the key issues for therapists working with LGBT clients to hold in mind. I illustrate my experience and thinking about the work by using clinical vignettes which draw on combined clinical experience.

Introduction

This article is based on my experience working with lesbian, gay, bisexual, trans and heterosexual couples over 20 years in both private practice and the voluntary sector. For seven of those years I worked in a LGBT organisation with couples and those in relationships of various configurations, where gender identity or sexual orientation was relevant. This work has been both time limited (6-12 sessions) and longer term.

I am an Integrative psychotherapist. Relational in my approach, I use humanistic, psychodynamic and systemic thinking, psycho-educational input, and ideas from gay affirmative therapy (Maylon, 1982; Davies and Neal, 1996) to inform my work.

The lesbian, gay, bisexual and trans communities are diverse and varied and there are important differences in the experiences of particular groups within them, which is beyond the scope of this paper to discuss in depth. We live in a society where heterosexual, dyadic relationships are the dominant model of relationship. LGBT people all, in various ways, experience oppression, invisibility and the internal legacy of their embodied sexual and/or gender experience/ identity and relationships often not being recognised, or of these being perceived as wrong by others. All are impacted by heteronormative assumptions, ' assumptions that heterosexuality is normal and that anything other than heterosexuality is abnormal' (Barker et al, 2012).

Most of the clinical examples in this paper are of lesbian and gay couples. Regrettably this mirrors the lower visibility of the couple relationships of both bisexual and trans people in society and in clinical writing to date. The increased presence of support and campaign groups speaking out for trans and bisexual people is helping to address this. I will use the term 'therapy' as inclusive and applying to both couples therapy and counselling, and 'therapist' to apply to 'therapists and counsellors'.

Different Models of Relationships

Being in a couple is important for many people; it is something they hope for, and when in a couple, this relationship is a significant part of

their identity and something they want to last. This is true for many people, of whatever sexual orientation or gender identity. How people define what being in a couple means varies enormously and there is more diversity and openness about different models of relationship in the LGBT communities than in the 'straight world'. For example, it is not unusual for LGBT couples, and in particular for gay men (Bell and Weinberg, 1978) and those who identify as bisexual (Barker and Langdridge, 2010), to negotiate boundaries which include having sex with others. I have worked with polyamorous couples where one of the couple had two long term partners at the same time and with couples who share a lover with each other. Some people of all orientations do not want dyadic relationships, or live within this framework.

It is helpful for all therapists to have a flexible view of what being a couple may look like and to be open to understanding how any two (or more) people describe their relationships to themselves and others. For those working with LGBT couples this is particularly important.

As therapists we need to educate ourselves about the broader contexts and norms of our clients' lives, in terms of race, culture, religious belief, disability, sexual or gender identity and other crucial aspects of their identity. Through dialogue and exploration with them we can come to understand each couple's particular context. We also need to be aware of and reflect on our own context(s) and values, our relationship to these and how this may be perceived by clients and impact on the work.

Therapists working with LGBT couples need to know about the range and different models and ideas about families within the LGBT communities. Who one person considers as their family may differ considerably from another. For some, 'family' may not be made up of people with whom they have a biological connection, but of friends, ex-lovers, or other combinations of choice (Laird, 1998). One LGBT family may comprise entirely of adults, another may be a gay male couple and the children they adopted and raise together, or a bisexual woman who lives with her girlfriend and for part of the week with her girlfriend's daughter, who is co-parented by them and by the child's father, who is a gay man in a relationship with his partner.

Couples Therapy: Distress, Vulnerability and Containment

In my experience couples often seek therapy when they have exhausted their own resources to deal with an issue or difficulty between them. Many come when they have a sense of things going wrong and they are hurting. It is often a brave step. Intimate and sexual relationships tend to evoke the dependent relationships of childhood in which needs for love, care, fun stimulus and safety may, or may not, have been met. Central as they are, to many people's identity and sense of well-being, when relationships are floundering, or at risk, this can be painful and disturbing.

All couples, whatever their sexual orientation, gender identity or presenting issue, need to feel safe enough, and well enough understood and contained by the therapist to address issues which may be deeply personal and difficult to talk about: issues like sex, intimacy, failures of intimacy, rage, anger, shame and hurt.

Historical, Legal and Cultural Context of LGBT Relationships and Couples

Homosexuality was only declassified as a mental illness in the UK in 1992 (ICD 1992) and until 1967 homosexual sex was illegal. The age of consent for homosexual sex was made the same as that for heterosexual sex as recently as 2001 in England, Wales and Scotland and 2009 in Northern Ireland. Changes in Britain and elsewhere over the last two decades have improved the legal status and visibility of LGBT people and couples. In UK these include the introduction of the Civil Partnerships Act (UK 2004), granting legal recognition of same sex partnerships, Gender Recognition Act of 2004, introducing Gender Recognition Certificates and protecting the privacy rights of trans people, Equalities Acts (Sexual Orientation) 2007 and 2010 and Criminal Justice Act 2003, legislating against and granting enhanced sentencing for hate crime on grounds of sexual orientation and trans identity (Legal Aid, Sentencing and Punishment of Offences Act 2012). Culturally there is more coverage in the media and mainstream cinema of trans people, gay relationships, same sex families and celebrity lesbian and gay couples and families. However,

heterosexism, (Blumenfeld and Raymond 1988), homophobia (Herek,1996), biphobia (Barker et al, 2012), transphobia (Hill and Willoughy, 2005), discrimination and hate crime continue. Home Office Statistics for 2011-12 record 4,252 reported hate crimes on grounds of sexual orientation and 315 on grounds of transgender. The under-reporting of hate crime by those who identify as LGBT is well documented (Stonewall, Dick, 2008; Turner, Whittle and Combs, 2009; Whittle et al., 2007; Barker et al, 2012).

LGBT Couples: Safety, Recognition and Mirroring

Many LGBT couples experience homophobia, biphobia and/or transphobia from within their family, from neighbours, at work or from strangers in the street. Some experience unprovoked attacks and hate crime. Therefore, many make choices to conceal their relationship, or conceal it in some situations, or do not feel safe to demonstrate affection in public.

Most lesbian, gay, bisexual and trans people will have grown up without being accurately mirrored in respect of their sexual orientation and/or gender identity. They will have often been, or be, mirrored 'as if' they were heterosexual and/or 'as if' they were male or female, even if this does not reflect their felt gender identity. As therapists we need to both understand this and offer good enough mirroring to the clients we work with.

For many LGBT people in relationships issues of: Is it safe? Will you accept me/us? Will you 'get' me/us? How much of myself/ ourselves can I/we show? are multi layered and ever present. These questions are important to couples seeking therapy. In her research with LGBT couples and therapy/counselling Grove (2003) states 'the need to feel accepted is demonstrated by the repeated comments from the men and women interviewed that they could only talk to someone who would really understand and value the deep love that they felt for their partners.'

Understandably, LGBT couples do not want to see a therapist who will pathologise them, have negative attitudes about their identities, or apply heteronormative assumptions to them. They want their therapist to 'get' their relationship, and understand the cultural norms of LGBT cultures and relationships. Knowledge of issues relating to non-heterosexuals is essential and therapists cannot rely on their clients to educate them (Davies, 1996; King et al., 2007).

Understanding and Working with the Impact of Oppression and Internalised Shame on LGBT Couples

Heteronormative assumptions exist within most of us, as do negative thoughts and feelings about gender variance and same sex desires and behaviour. They are a consequence of growing up in a society which privileges heterosexuality, and which has a long history of discriminating against, or not recognising, other sexualities. They are a legacy of growing up in a society with a fixed, binary view of both gender identity and sexual orientation, where the dominant societal options are that we are male or female, gay or straight. In fact, human beings are diverse and there are many ways in which individuals experience and express gender and sexuality, describe their identities and relate with others. One or more of these may change over a lifetime either subtly or sometimes more profoundly (Neal, 2005).

When individuals 'transgress' society's norms with regard to sexual or gender identity their embodied experience conflicts with the negative attitudes they have internalised and creates a sense of needing to hide, feelings of shame, and self-loathing commonly referred to as internalised homophobia (Maylon,1982; Gair,1995), internalised transphobia and internalised biphobia (Ochs, 1996). Therapists need to understand, recognise and be able to work with the impact of internalised shame on couple relationships. This may include conscious and unconscious negativity towards the couple relationship from one or both partners, or towards one partner, a couple's withdrawal, isolation, perfectionism, or what Hertzmann (2011) refers to as interfering with a couple's creativity.

Importance of Therapists Addressing Their own Feelings Regarding Gender and Sexuality

All therapists, and particularly those working with LGBT clients and couples, need to explore their own feelings of same and other gender attraction, their places of flexibility and rigidity regarding gender identity and their own heterosexism, oppressive thoughts and behaviours and internalised shame. They need to be aware of how these may play out in the systems they co create with couples they work with. Hertzmann (2011) states "As therapists we can probably only work effectively with these processes in our clients in so far as we have worked on our own feelings about our sexuality, gender and our own internalised homophobia, regardless of our sexual orientation, ….and this is always a work in progress".

Multiple Oppressions

Many couples experience multiple oppressions (Dhillon 1997; Dhillon-Stevens 2001) for example, race, age, religion, disability, class and education as well as those of gender and sexuality. The impact of these on the couple and how the different oppressions may interlock needs to be held in mind by the therapist. Often, in my experience, they go foreground and background in the work.

LGBT Couples: Choosing a Therapist

Some couples seek out an LGBT therapist, others prefer to work with someone they know is not LGBT, sometimes there are other factors which effect who they see. Therapist attitude, knowledge and practice are more important than their sexual orientation (King et al 2007).

Social context, the historical legacy of oppression, invisibility and individual experience contribute to LGBT couples watching for signs to indicate whether a therapist, or particular setting, is going to be open to working with them and understanding their relationship. These may include attempting to read how comfortable a therapist seems with them by noticing the therapist's body language, spoken language or what they do not mention. 'Hypervigilance is one of many normal responses to oppression, heterosexism and growing up feeling different' Davies (2007). In their research into Clients' Perspective of Same Sex Couples Counselling', Grove and Blasby (2009) found the underlying perceived discomfort of the therapist/counsellor will have an impact on the client's ability to engage with the therapeutic process (O'Neill, 2002), the sense of the therapist not valuing the relationship (Pixton, 2003) and the capacity to address issues of importance to the couple relationship.

Couples may ask whether a therapist has experience of working with other LGBT couples. Questions around professional experience should, in my experience, be answered factually. There are different schools of thought as to how best to address a client's questions about the therapist's sexual orientation or gender identity. While it is up to the discretion of the practitioner how to respond to questions of disclosure, it is important to consider the context and meaning of the question for the client(s) and the potential impact of possible responses (Davies, 1996; King et al,2007).

Common Issues for all Couples and Particular Issues for LGBT Couples

In my experience many issues which couples bring to therapy are shared by heterosexual, lesbian, gay, bisexual and trans couples, such as conflict, dissatisfaction with sex or intimacy, affairs and betrayal, a change in circumstances or the relationship, negotiating differences, or one or both parties thinking about, fearing or wanting to end the relationship. There are also some issues which are specific to LGBT couples.

In order to maintain confidentiality I will illustrate this with vignettes of fictional couples, whose situations and issues are based on those brought to therapy by many. Other vignettes similarly use fictional couples to illustrate common issues.

Ahmet and Geoff have been together for 9 months. Ahmet, who is 30, is from the Indian Sub-Continent and has lived in Britain for two years. He is Muslim and both his family and religion are very important to him, he also loves Geoff. This is his first same sex relationship and he is not out about his sexual orientation

to anyone, let alone about this relationship. He is still making sense of it himself. Geoff is a white British man of 45 who has been out for years, and active on the gay scene. He wants to be open about his relationship with Ahmet, whom he loves. He has fought hard for his rights to be out and sexually active and for his pride in his identity as a gay man.

These are very different places to be coming from personally and in terms of the experience and expectations each has of relationships. For this couple, as for many, this presented tension between what each felt was at the heart of their personal identities and their feelings towards and desire to be in a relationship with one another.

The issues of who knows about their relationship, how they talk about it with others and deal with their feelings about this with each other, were keenly linked to their individual sexual identities, cultural contexts, the issues of being 'out' and 'not out' and the differing significance each placed on this.

For some couples seeking therapy LGBT issues are central, for others LGBT issues and the fact that they are an LGBT couple is background. They simply want the therapist to be ok with them being an LGBT couple and then get on with talking about arguing more, or not having much sex, or that one has just found out their partner is having internet sex.

Kristoff and Jay have been together for ten years, and Civil Partners for five. They come because Jay has found out Kristoff has been having a relationship with another man. They had an understanding that their relationship was monogamous and are in crisis. Together we look at what has happened, how it has happened, what was not being addressed within the relationship and what the way forward is for them. Kristoff and Jay decide they want to stay together and explore what needs to change and what they are willing to do to change their relationship. We work with their feelings of betrayal, anger and guilt and they revisit their understanding of the basis of their partnership, its boundaries, and whether to renegotiate these.

Issues of gender identity and/or sexual orientation often go background and foreground in the work. As therapists we need to be able to hold the LGBT lens in mind but to not hold it too tightly, and not to force everything through it. Research into the therapy experiences of 393 American lesbian and gay men identifies the importance to clients of the counsellor not making an issue of their sexual orientation when it was not relevant, and of not being afraid to raise it when it was (Liddle, 1996).

My Model for Working with LGBT Couples

This diagram shows how I think about working with LGBT couples (see Figure 1).

At the centre sits the presenting issue(s) and agreed focus, framed by the timeframe available and the context in which we meet. Generally this will include a process issue for the couple. Informing this are multiple lenses through which I view the couple relationship; its context and history, intrapersonal and interpersonal dynamics of the couple, the co-created relationship I have with them, and how we are all located within the wider and multiple fields in which we live.

This is another fictional example. Martha and Jade, a lesbian couple, who have been together for five years, are considering having children. They want help to talk about and explore how they feel about becoming parents and about being gay parents. They want to consider their options about who will carry the child, how it will be conceived and how they will deal with their families' responses. They have tried talking about these issues with each other but both feel so strongly that they end up arguing, withdrawing, feeling hurt and desperate. They are afraid this issue might tear them apart as a couple.

The process issue we agree to focus on is to explore and understand what happens when Martha and Jade try to talk with one another about having children, what is touched for each of them individually and how they hear and impact each other. This includes understanding their escalation, withdrawal and desperation and exploring if there may be choice points for each of them during a conversation that would allow different possibilities to emerge.

As a therapist it is helpful to have knowledge and understanding of the practical issues the couple bring, as well as the context for lesbian parenting in this country. This includes information about how other lesbian couples create families, legal implications for lesbian couples who become parents both in and outside of civil partnerships and knowledge of support networks and resources.

By establishing a safe space in therapy, Martha and Jade can be supported to discuss the various issues round becoming parents and get a clearer sense of whether or not they can find a way forward with parenting as a couple. This will also allow them to build skills and confidence to address difficult issues together.

Exploring with them what made talking about parenting together so difficult and how to unstick this touched on their personal, family and relational histories, their cultural contexts and differences, their attachment styles, internalised homophobia, grief about not being able to make a baby together without assistance, Jade's history of rejection within her family and the differing emphasis and importance each gave to 'family' in their lives.

The points at which each felt not heard by the other were carefully examined so they could say what hadn't been said, repeat what had been missed and each could hear and let the other know what they had heard. They began to notice where there was an escalation or when they felt an impulse to withdraw. It was important to address the support they had individually and as a couple and how they might build on this.

Martha and Jade began to have conversations about parenting which didn't end in a fight and then felt more able and willing to raise issues with one another outside the therapy room. Sometimes this worked well, sometimes things escalated. What changed over time was their confidence that they could talk about parenting without it putting their relationship at risk. They moved away from despair and felt equipped to continue talking and to explore their practical options together when the therapy ended.

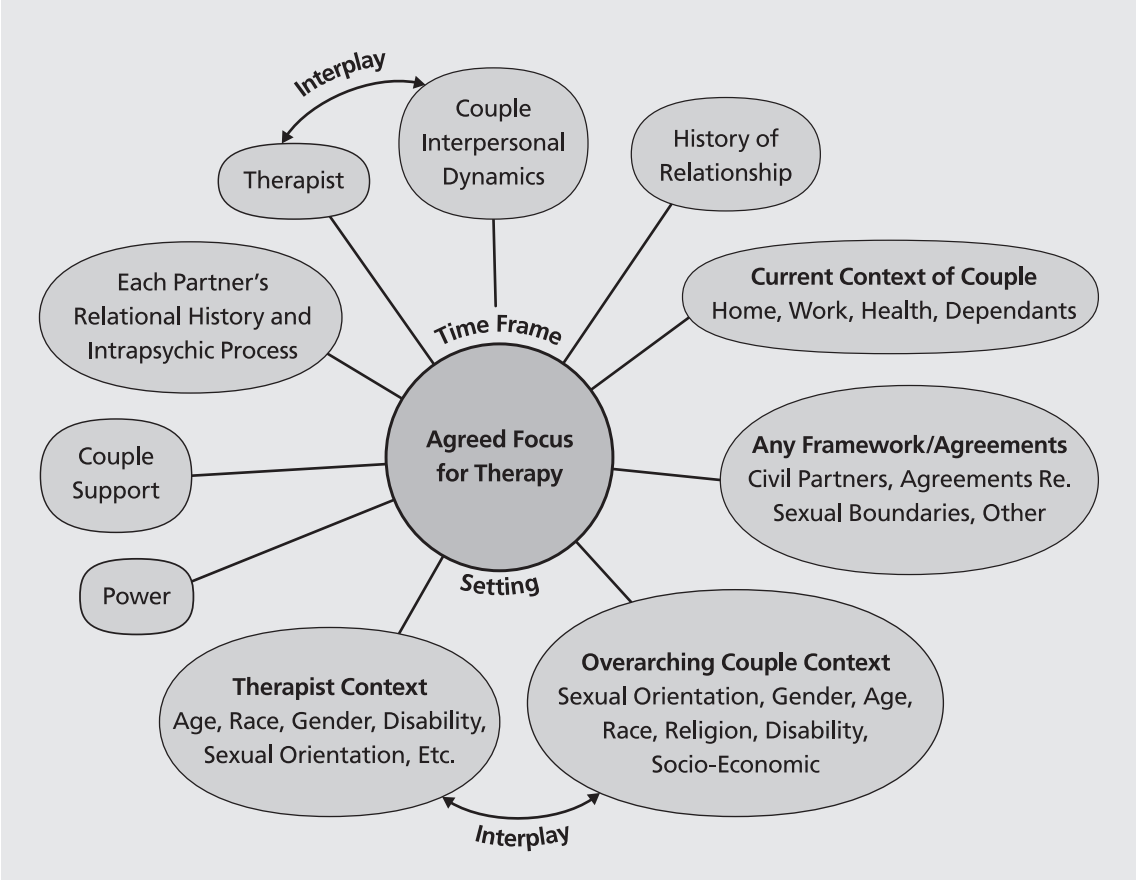


Figure 1: How I think about working with LGBT couples

As for many couples considering becoming same sex parents, this decision touched many issues including those of identity, existential questions, internalised homophobia, support, family systems, grief, their own experiences of having been parented and the question of whether each partner wants to parent at all and/or with this partner.

Importance of Context and Issues of Power in Working with LGBT Couples

No relationship exists in a vacuum and having an understanding of the context of the particular couple is something I begin to map in my head while considering the couple, their issues and what we might usefully do together. Holding in mind the various contexts of the couple, my context, the context in which we meet, the wider social, cultural, religious, historical and political contexts is particularly relevant when working with LGBT couples and with any couple who may experience oppression and discrimination because of who they are and the relationships they have. Issues of power within the couple and between the couple and therapist need to be held in mind and in my experience it is important to be willing to address these.

Support and Isolation

I ask all couples what support they have as a couple. This question can be particularly relevant to many LGBT couples, for whom issues of invisibility and lack of support can be very real. The answers it elicits can be revealing. Some do not understand the question, others are surprised anyone would have thought of relationships needing or deserving support. For some it highlights their isolation and pain around this.

While many LGBT couples I work with have a robust support network of friends, other couples, family and sometimes other professionals, are quite isolated. Some same sex couples, including those with children receive less support from their family of origin than most heterosexual couples (Oswald, 2002). Some are isolated because they withdraw to protect their relationship from actual or feared homophobia, transphobia, biphobia or abuse, because one or both partners may not be 'out' to their family, to anyone or even to themselves, or because of internalised shame. Some couples retreat into the couple relationship because it is new and all they want to do is be together, or because they are trying to protect the relationship from what they perceive as the sexually predatory gay scene. Isolation puts pressure on relationships.

For very isolated couples it is a big step to seek therapy and invite a therapist to witness their relationship. In my experience being an OK first other to talk to about their relationship is important, as is supporting the couple to build a support network for themselves and their relationship beyond therapy. If the couple leaves therapy with a sense that their relationship matters, having difficulties in relationships is normal, seeking support is important, receiving it is possible and that they don't need to hide their relationship and/ or love from everyone, then something significant has been achieved.

Drive to be Perfect

Oppression, heterosexism, fear of others negative responses and internalised shame all play a part in the pressure felt by many LGBT couples to be seen as a 'good couple' or 'good parents' and prove their OK-ness to themselves and others. This can lead couples to conceal their relationship difficulties and miss out on the chance to normalise these and get support.

Of course there are also many "straight " couples who feel pressure to be perfect, because of family pressures or internalised messages or sometimes because their relationship challenges cultural or societal norms and there is pressure to do better than ok as a couple or family to prove a point and defend against actual or feared criticism.

Difference and Belonging

In my experience it is important to hold in mind issues of difference and belonging and be able to address these explicitly with couples. Being and growing up LGBT in a straight world can make feeling different very real. Being an LGBT couple in a heteronormative society evokes feelings of difference. There

will also be differences within the couple and between me and them individually and as a couple. These may be differences of sexual orientation or gender identity or of age, race, economic status, background, religion and so on. The particulars of each of these will have an impact on the couple and on the way in which their context(s) (family, culture, religious group etc.) views their relationship and how they themselves feel about it.

The couple may see themselves as belonging to several groups or communities or none, for example, racial, family, religious, work based, neighbourhood, clubs or online. They may feel in conflict with, ambivalent towards, rejected by or rejecting of some contexts. They may feel they belong to the LGBT community or a sub section of it, or one or both of them may feel outside or different to it. Each partner may feel differently about this.

Some LGBT couples go out on the commercial LGBT scene and many do not. Sometimes those that don't, or once did but not anymore, feel that in some way they are not being "properly gay." Sexual and/or gender identity can become entangled with a certain kind of lifestyle. I find it helpful to normalise experience and normalise a range of experience and to mention that many LGBT people live or feel similarly, or have spoken of grappling with similar issues as the couple I am working with.

Each partner may also feel differently about their sexual orientation or gender identity, as with Geoff and Ahmet earlier, one may have had many same sex relationships the other may not be out and this may be their first gay relationship. The way internalised shame manifests for each partner and their awareness of it may be different. This may affect how they feel about their relationship and towards one another.

Missing Role Models and Freedom to be a Pioneer

For LGBT couples and families there can be more room for creating a way of being and configuring relationship(s) that works for them, than for 'straight' heterosexual couples, as they are stepping outside the heteronormative model and often going beyond the family model they grew up with. Couples may have, or need to find, other role models, or to create their own. 'The lack of rigid role delineation often leaves room for creativity' (Carl, 1990). Individuals and couples may experience this as exciting and pioneering (Decker, 1984; Simons, 1991) or scary, or they may fluctuate between the two. However, as with any sub culture, there can be rules about how to be as an LGBT couple which also exert pressure.

Couples Affected by Changes in Sexual Orientation or Gender Identity

Sexual orientation and/or gender identity sometimes changes for one or both partners in the life time of a relationship. This can evoke intense feelings for both partners and often a sense of crisis for the couple. It can feel as if the very the foundation on which the relationship was founded has been uprooted and challenge the identities of both partners. Feelings of shock, betrayal, guilt, loss, shame, powerlessness and anger are common. While some couples have people in their lives they can talk with and get support from about these changes, many do not.

Lilly and Dave, a married couple in their late 50's with two grown up sons, felt very isolated when Lilly told Dave she thought she was a lesbian. They did not know any other couples in this situation and felt alone, afraid and at a loss as to what to do with their strong feelings. It was unclear what the way forward was for them, and whether this could be as a couple. Couples therapy helped them voice and explore their feelings safely and begin to think through how they could access further support individually and as a couple, including possibly finding other couples who had similar experiences.

Jason and Stella are a married couple with two young children. Jason recently began exploring his trans identity. He and Stella have been talking with each other about this, but these conversations are difficult because of the intensity of feeling it evokes and because neither wants to hurt the other. Both feel stressed and unhappy. They come to therapy seeking help with having these difficult conversations.

Concluding Thoughts

For those whose loving, sexual or intimate relationship are not sanctioned by society, or are condemned or not seen by it, having a space where it is possible to be a couple and have their relationship seen and valued can be particularly important. This is true for many whose relationships straddle cultural or religious fault lines, and spoken and unspoken rules of class, age or disability as well as those of gender and sexuality. In my experience for some couples it is profoundly healing to have a place where their relationship (s) is at the heart and where their love, pain, desire, frustrations, limitations and joys can be seen and spoken of, alongside what is encountered from others in the having of the relationship.

In order to work with LGBT couples therapists need to understand the historical and social context of LGBT people and their relationships, get to know the particular context of each couple and be open to understanding how they describe their relationship to themselves and others. A degree of creativity and flexibility in conceptualising relationships is essential.

Heterosexism, oppression and discrimination impact on the daily lives and internal worlds of lesbian, gay, bisexual and trans people and on their relationships. Understanding and being able to address the impact of this on the couple, on ourselves as therapists and on the systems created between the couple and therapist is important.

Issues of safety, visibility, power, difference, belonging and isolation are significant in the lives of many LGBT couples, within the couple and in their experience of seeking and having therapy. Resilience, creativity, freedom from fixed roles and heteronormative ways of configuring and structuring relationships are also often part of the territory. Therapists need to hold in mind the couple's LGBT identity/ies and be able to address this explicitly, while also allowing it to be figural and ground in the process.

Finally, therapists working with LGBT couples and relationships must investigate their own heterosexism, oppressive thoughts and behaviours and their own internalised shame. Our willingness to explore and challenge our own feelings of same and other gender attraction, and our places of flexibility and rigidity regarding gender identity are crucial, on-going aspects of the work.

References

Barker, M. & Langdridge, D. (2010). Whatever happened to non-monogamies?: Critical reflections on recent research and theory. *Sexualities 13(6), 748-772*

Barker, M., Richards, C., Jones, R., Bowes-Catton, H., Plowman,T., Yockney, J. & Morgan, M. (2012). *The bisexuality report: Bisexual inclusion in LGBT equality and diversity.* Milton Keynes: The Open University Centre for Citizenship, Identities and Governance.

Bell, A. & Weinberg, M. (1978). Homosexualities: *A study of diversity among women and men.* New York: Simon and Schuster.

Blumenfeld, W. & Raymond, D. (1988). *Looking at Gay and Lesbian Life.* Boston: Beacon Press.

Carl, D. (1990). *Counselling Same-Sex Couples.* New York: Norton.

Davies, D. (1996). *Towards a Model of Gay Affirmative Therapy* in D. Davies and C. Neal (eds) Pink Therapy: A Guide for Counsellors and Therapists Working with Lesbian, Gay and Bisexual Clients. Buckingham: Open University Press.

Davies, D. (2007). Not in Front of the Students. *Therapy Today, 18(1), 18-21*

Decker, B. (1984). Counselling Gay and Lesbian Couples. *Journal of Social Work and Human Sexuality, 2: 39-52*

Dick, S. (2008). *Homophobic Hate Crime. The Gay British Crime Survey.* London. Stonewall

Dhillon, H. (1997). *Integrative Psychotherapy Dissertation, MSc in Integrative Psychotherapy.* Middlesex University

Dhillon Stevens, H. (2001). *Anti-Oppressive Practice in the Supervisory Relationship.*

In M. Carroll & M. Tholstrup (eds) Integrative Approaches to Supervision. London: Jessica Kingsley.

Gair, S.R. (1995). *The false self, shame, and the challenge of self-cohesion,* in J. Glassgold and S. Iasenza (eds) Lesbians and Psychoanalysis: Revolutions in Theory and Practice. New York: The Free Press

Grove, J. (2003). Can heterosexual counsellors or generic agencies help same-sex couple? An Exploratory Study, *Counselling and Psychotherpy Research: Linking research with Practice. 3:2, 129-137.*

Grove, J. & Blasby, S. (2009). The therapeutic encounter in same-sex couple counselling – the client's perspective, *Counselling and Psychotherapy Research: Linking research with practice, 9:4, 257-265.*

Hate Crime, England and Wales 2011-2012, Home Office 13 September 2012

Herek, G. (1996). *Heterosexism and homophobia*. In R. Cabaj & T. Stein (Eds.), Textbook of homosexuality and mental health (pp.101-113). Washington, DC: American Psychiatric Press

Hertzmann, L. (2011). Lesbian and Gay Couple Relationships: When Internalized homophobia gets in the way of Couple Creativity. *Psychoanalytic Psychotherapy. Vol.25, No.4, December 2011, 346-360*

Hill, D. and Willoughby, B. (2005). The Development and Validation of the Genderism and Transphobia Scale. *Sex Roles, 53 (7-8), pp 531-544.*

King, M., Semlyn, J., Killaspy, H., Nazareth, I., and Osborn, D. (2007). *A Systematic Review of Research on Counselling and Psychotherapy of Lesbian, Gay, Bisexual and Transgendered People.* Lutterworth: British Association for Counselling and Psychotherapy.

Turner, L., Whittle, S., Combs, R. (2009). *Transphobic Hate Crime in the European Union.* A research project sponsored by ILGA Europe and Press for Change.

Laird, J. (1998). *Invisible ties: Lesbians and their families of origin.* In C.Patterson & A. D'Augelli (eds.), Lesbian, gay, and bisexual identities in families: Psychological perspectives (pp. 197-228). New York: Oxford University Press.

Liddle, B. (1996). Therapist sexual orientation, gender and counselling practices as they relate to ratings of helpfulness by gay and lesbian clients. *Journal of Counselling Psychology, 43 (4), 394-401*

Maylon, A. (1982). *Psychotherapeutic implications of internalised homophobia in gay men,* in J. Gonsiorek (ed) Homosexuality and Psychotherapy. NewYork: Haworth Press

Neal, C. (2005). Transformations. *The Journal for Psychotherapists and Counsellors for Social Responsibility. Autumn 2005*

Ochs, R. (1996). *Biphobia: It goes more than two ways.* In B. Firestein (ed.), Bisexuality: The Psychology and Politics of an invisible Minority. London: Sage

O'Neill, B. (2002). 'We didn't connect at all': The experiences of a gay client. *Journal of Gay and Lesbian Social Services, 14 (4), 75-91.*

Oswald, R. (2002). Resilience within the family networks of lesbians and gay men: Intentionality and redefinition. *Journal of Marriage and the Family, 2002.64 (2): pp. 374-383*

Pixton, S. (2003). Experiencing gay affirmative therapy: An exploration of client's views of what is helpful. *Counselling and Psychotherapy Research, 3 (3), 211-215*

Platzer, H. (2003). *The Pace Family Therapy Service; An Independent Evaluation*

Simon, G. (1991). *Working with people in relationships,* in D. Davies & C. Neal (eds.) Pink Therapy. Buckingham: Open University Press

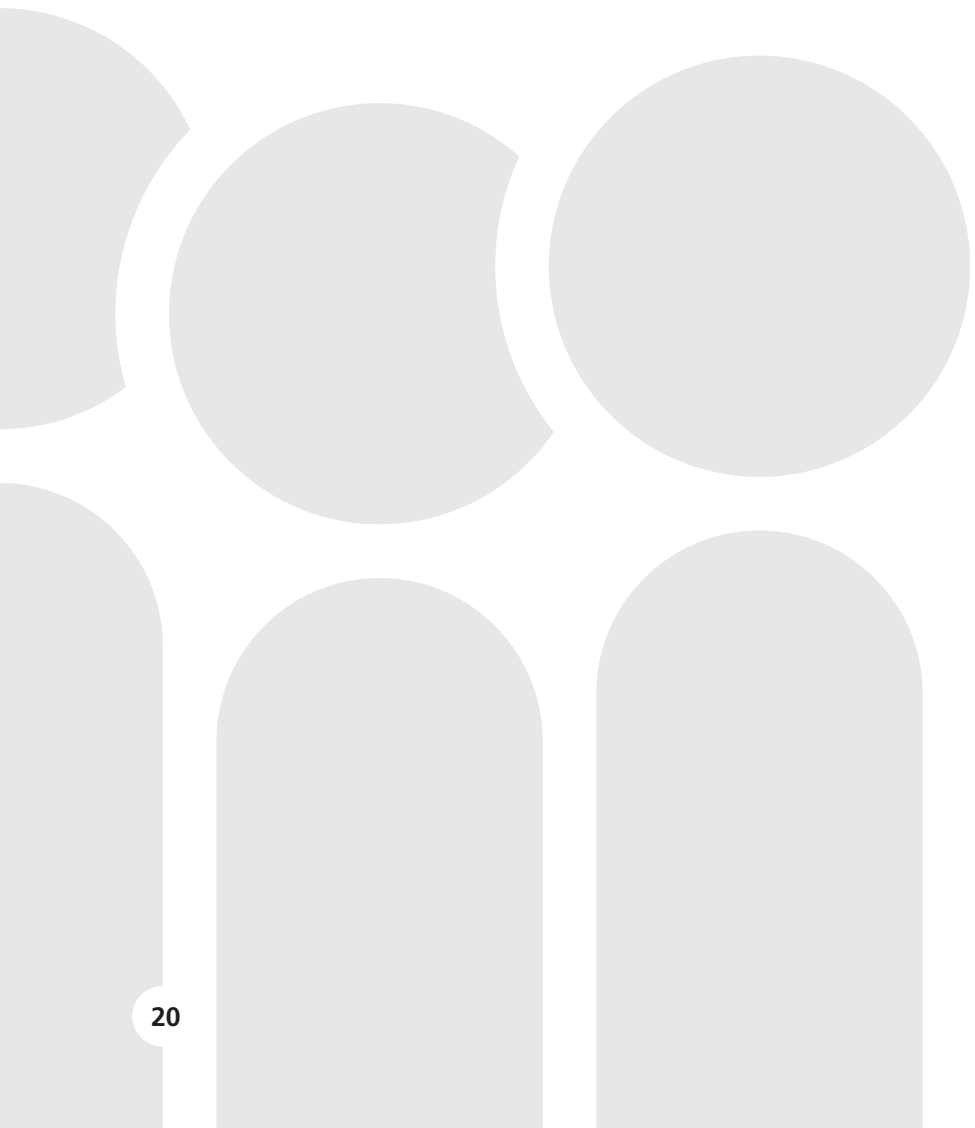
Simons, S. (1991). *Couple Therapy with Lesbians.* In Hooper, D. & Dryden W. (eds) Couple Therapy. Buckingham: Open University Press

Whittle S., Turner L & Al-Amami M. (2007). *Engendered Penalties. Transgender and*

transsexual people's experiences of inequality and discrimination. London: Equalities Review

Avril Hollings (UKCP Reg.) is an Integrative Psychotherapist and a clinical supervisor (UKAHPP Accredited). She has over twenty years clinical experience of private practice in North London and for many years also worked in the voluntary sector. She works with both individuals and couples and has extensive experience of working with clients in both LGBT and heterosexual relationships.

Avril set up and ran a fee paying Counselling and Psychotherapy Service for an LGBT charity. She supervises both accredited and trainee therapists and counselling psychologists and is a Primary Supervisor for students at Metanoia Institute. She has been a member of UKAHPP Board of Ethics for five years and an examiner for two UKCP training organisations.



Lesley McGown

Reaching into the Relational Unconscious: Integrating Spontaneous Mental Imagery into Clinical Practice

Abstract

This paper draws on my doctoral research which seeks to inquire into the therapist's experience of spontaneous mental imagery (SMI) in the clinical situation. Specifically, I endeavour to address four questions which relate to the integration of SMI into clinical practice. These are: i) Is working with SMI 'allowed'? ii) What is it like to experience SMI? iii) What concepts can we use to make sense of SMI? and iv) How might SMI impact on the therapeutic process? In developing a response to this last question, a model of understanding is presented which aims to illustrate how SMI, as a function of the unconscious relational field, becomes what I refer to as a Transformational Third.

It is hoped that this paper will offer other clinicians a platform from which to consider their personal experience of SMI and to assess its potential impact on their own practice.

Introduction

Imagine you are with a client and suddenly, from out of the blue, an image drops into your mind as if from nowhere which seems to bear no relation to what your client is saying. Maybe you see a picture or alternatively a word, or even several, which stare back from your internal screen. What sense can you make of them? Are they familiar: a snippet from a film or line of poetry? Or, is it a scene from a fairy tale? Perhaps the images are so bizarre that they seem to make no sense at all; in fact maybe they feel somewhat intrusive and you struggle to re-focus on what your client is saying. At other times you may experience auditory images: a fragment of a song or a familiar strain on the piano. Are bodily sensations also involved? Whatever the form of imagery, how do you respond? Do you simply sit with your experience, perhaps become mildly curious but thereafter let it go? Or do you attend and reflect upon it wondering about its relevance and whether it is something to be shared with your client or kept to yourself? If shared, how effective has your intervention been? Has it facilitated or hindered the therapeutic process? How confident have you felt that working with what I am calling spontaneous mental imagery (SMI) was clinically legitimate?

These are some of the issues that were at the heart of my doctoral research into the therapist's experience of spontaneous mental imagery, a term that refers to images which occur, as Bucci (2002) proposes, in all sensory modalities. Here is an example of SMI emphasising the visual. It is provided by one of my research participants whom I shall call Sandra. In this extract she is discussing her spontaneous imagery of a bear who is tentatively emerging from captivity and how she makes sense of this imagery in relation to the work with her client 'A'. She describes how she holds in

mind the image of the bear as though it is an "animated essence" of her client's being:

> *"…and in my mind it's like as I'm working with 'A' I'm visualising whereabouts this bear is in its process to integration into the wild again and into being free and and […] it's almost as if I am seeing where the bear is in its integration and seeing where 'A' is in his integration of allowing another to join with him in the process and at the moment he is able to stand sort of with two paws on the grass but is frozen there, he's just watching and observing, can't go further. That's how it feels with this client."*

This vivid account of SMI works on many levels. Immediately striking is the picture of the bear which is not only visually compelling but also highly emotive. The power of the imagery is felt in the way that Sandra uses it to connect with her client's emotional core or, as she poetically puts it, with an "animated essence" of his being. It is as if she has reached into the heart of the image and felt its pulse. The image acts as a window not only into the client's psyche but also into his heart. The bear has moved from his place of captivity to a grassy space, but his watchful self remains frozen. Sandra does not share the image with her client but uses this scene as a guide to the client's sense of safety within the therapeutic relationship which is governing his emotional readiness to engage. Perhaps another way of putting this is that the image becomes a metaphor for the therapeutic relationship, a notion to which I return below.

Having set the scene, I will now take a brief look at the literature on mental imagery and thereafter provide an outline of the research project. The remaining discussion will be devoted to addressing the four questions introduced earlier in this article.

Overview of the Literature

Whilst mental imagery, predominately visual, has a long tradition in psychoanalysis, the focus has traditionally been on the patient's imagery which has been largely viewed as a form of resistance (Freud, 1899; Kanzer, 1958; Warren, 1961). However, the emergence of the Relational School towards the latter part of the twentieth century and its emphasis on the interpersonal nature of the therapeutic relationship, has seen a gradual awakening to the significance of the therapist's experience of imagery phenomena. The psychoanalytic literature in this regard remains relatively modest and thus the purpose in undertaking my research was to build on this as yet emergent body of work and so contribute to expanding and enriching our understanding of SMI and its potential impact on the therapeutic process.

In terms of contemporary literature, I begin with Schaverien (2007), a Jungian analyst, who developed Jung's approach of active imagination to include the perspective of the analyst. She suggests that her new formulation of active imagination offers a way of understanding certain forms of counter-transference. An understanding of imagery in terms of the analyst's countertransference is also found in the psychoanalytic literature (eg Ross and Kapp, 1962; Kern, 1978; Doucet, 1992; Bollas, 1995; Ogden, 2002).

One contemporary author, Mark (2009), offers a number of case studies each distinguished by different ways of working with and understanding SMI. His observations include a view of imagery as a metaphor for the therapeutic relationship which, in illuminating the underlying dynamics in a way that makes them available for discussion, fosters connection and a deepening of the therapeutic relationship. This process potentiates a shift from dissociative states to the associative, thereby suggesting imagery's vital role in affect regulation. Mark also proposes that meaning emerged through the interlinkage of the analyst's embodied SMI to its symbolic expression (imagery) of the patient. The significance of interconnection between different modes of processing is examined by Bucci (2002, 2009) whose multi-disciplinary model of the mind suggests that SMI plays an important part in therapeutic integration.

Authors such as Ogden (eg 1999, 2002) and Birksted-Breen (2012) focus on the importance of the analyst's state of reverie as conducive to the emergence of imagery. Bollas (1995) considers the importance of evenly hovering attentiveness (and by implication 'reverie') in facilitating the emergence of imagery and also emphasises the potential role of the analyst's

intuition. He refers to imagery phenomena as a kind of counter-transference dreaming.

Other ways of understanding SMI have emerged through research into mirror neurons (eg Gallese et al, 2007; Meissner, 2009; Bromberg, 2006) which in turn has typically been linked to the capacity to empathise.

Finally, whilst arguing that images are critical to the process of relating empathically to the patient, Arizmendi (2011) refers to ways in which they can potentially also compromise the therapeutic process. This cautionary note is echoed by a number of other authors. These include Ogden (2002) who highlights the elusive nature of imagery as well as its potential to feel intrusive. Yalom (1991) draws attention to the pitfalls of attempting to translate imagery into language (also see Sarraute quoted by Shattuck, 1984). This connects to the complex issue of disclosure of SMI, a concern also raised in my study. The challenges of working with SMI are further discussed later on.

The Research Project

This was a qualitative study using a semi-structured questionnaire to guide interviews with five psychotherapists, chosen because of their interest and experience in SMI. All participants were qualified to Masters level or equivalent at time of interview, with post qualification experience ranging from 24 years to two years. Theoretical backgrounds included drama therapy, transactional analysis and integrative approaches with varying emphases on humanistic (person-centred) and psychodynamic traditions, Jungian psychology, psychoanalytic thinking and influences from attachment theory. Participants were united in their relational stance with its emphasis on the interpersonal.

Interpretative Phenomenological Analysis (IPA) (Smith et al, 2009) was used to shape the analysis and to identify major themes. Working within this flexible framework, I introduced an adaptation involving the use of my own SMI as a way into the text and to access another level of consciousness. An example of this method, which was informed by psychoanalytic epistemology (Hollway et al, 2012), is given below in the section: What is it like to experience SMI? Full details of the research methodology are discussed elsewhere (McGown, under review). My own visual imagery was also influential in helping me to develop a novel model of understanding (see 'Re-conceptualising SMI').

I now turn to the first of the principal questions under consideration. This concerns a fundamental issue which arose spontaneously from the research, namely:

Is Working with SMI 'allowed'?

The response to this appeared to be largely influenced by the therapist's training background and in some cases gave rise to a tension between a personal affinity with mental imagery and its integration into clinical practice.

On a personal level, most of the participants strongly identified with their capacity for imagery as a vital and integral part of the self. This capacity was variously described as 'innate'; as a coping strategy arising in response to difficult childhood experiences; as so important that without this experience the person would be 'lost'; and as an integral part of life: 'it's just what happens to me'.

With regard to the view of one participant that her capacity for imagery was 'innate' -seemingly linking this to her use of it as a form of containment or way of coping with a difficult childhood - we might wonder if, without this (unconscious?) motivation, her 'innate' capacity would be equally manifest. This raises the question as to whether it might be possible for therapists to actively develop their capacity for SMI to inform the therapeutic process, a matter to which I return below.

From a clinical standpoint, my study highlighted how one participant's effective use of imagery (primarily from a person-centred perspective) was overshadowed by her concerns around professional validation. Troubled thus about the validity of her approach in the eyes of an authoritative body such as the NHS, she would suffer lapses in self confidence which gave rise to shame. Ways of coping, perhaps as a form of protection, would include a highly vigilant

and cautious way of working. Whilst the need to be careful in working with imagery was shared by all of the participants, arguably the highly guarded approach in this particular case went beyond typical good practice. It suggests an additional theme relating to a sense of isolation, perhaps shared by a further participant who felt that her colleagues had little understanding of, or were unable to connect with, her approach.

These reports, especially with reference to the first case, provide a graphic illustration of the tension between practice and theory in some orientations. Both participants clearly used SMI in an effective and beneficial way for their clients, although both, in varying degrees, were impacted by how they perceived their work might be critically viewed by others.

In contrast to these experiences, another participant described his way of working with SMI with ease and confidence. He attributed this relaxed and exploratory attitude mainly to his training as a drama therapist, adding that his second training in TA emphasised imagery in the theoretical material. In sum, this strongly suggested that his professional background gave legitimacy to his use of SMI.

These findings indicate that a personal affinity and capacity for imagery is not always easily transposed to the professional, ie clinical setting, which suggests a need to foster the integration of SMI across a wider range of trainings. Aspects of such training might usefully include a raising of awareness of SMI by encouraging clinicians to examine their experience of such phenomena, together with developing their own understanding and approach to working effectively with this important dimension of the relational unconscious. These topics are addressed within the context of the questions that follow and seek to provide a basis for the development of such training.

What is it like to Experience SMI?

The adoption of IPA in this study elicited rich, insightful accounts of the participants' phenomenological experience of SMI. For example, one participant described her experience immediately prior to the emergence

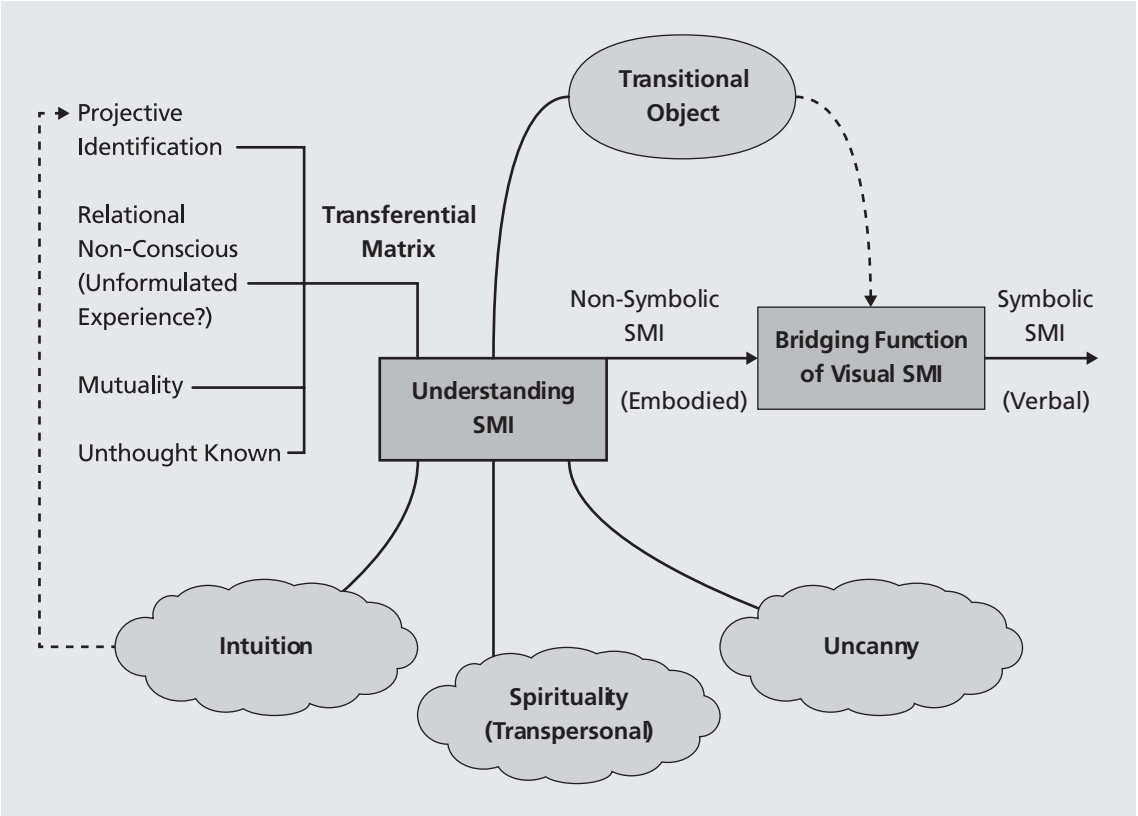


Figure 1: Multiple Understandings of SMI

of SMI as similar to tuning into an 'old style radio' which demanded patience and fine adjustments to hit the spot; another explained that 'something' arose within from her 'healing place'. A 'something' that flowed into her senses, which she described thus: 'it might come into my ears sometimes, so it could be auditory but I think it's kinaesthetic first .. and tactile, then visual'. In both cases, for the image to crystallise something else had to happen. For one, imagery formed as she gave words to it and engaged in mutual gaze; for the other it was the arrival of an Aha! moment which triggered the image. For both, the experience was strongly relational.

These accounts provide some indication as to how participants experienced SMI on a multi-sensory level. The finding that images occur in all sensory modalities is consistent with some models of imagery phenomena in the existing literature (eg Bucci, 2002; Ogden, 2002; Mark, 2009; Fosshage, 2011). In my study, whilst such experiences typically included visual imagery, for one participant this was not so straight forward. His primary connection was at a kinaesthetic level and it was only after reflection that he realised he had been taking the visual aspect for granted. It appears that his imagery, to borrow a phrase from Donnel Stern (2003) had become part of the 'unformulated background of the sessions' (p245). The tendency for visual imagery to be taken for granted was further emphasised by another participant, giving rise to speculation that visual spontaneous imagery may well be a rich source of clinical material that is undervalued or frequently not fully used.

Other accounts of SMI emphasised its complex and elusive nature, specifically, that it was 'very very hard to pin down' and carried a sense of the uncanny. This experience of SMI as being mysterious or slippery to grasp is exemplified in the following extract where a participant explains that although his imagery is linked to fairy tales, it is nonetheless 'slightly one removed'. Thus although the character is 'a bit like' Little Red Riding Hood she 'wasn't actually Little Red Riding Hood', and this was also the case with his imagery of Alice in Wonderland. 'They were like them, he says, 'but they ... didn't evoke that story directly'. What are we to make of this?

This participant's account suggests an experience which was somewhat disorienting and in the event it gave rise to my own experience of SMI, which in turn perhaps facilitated my capacity to make sense of what he was seeking to convey. The picture that came to mind was of two images, one superimposed upon another. There appeared to be some similarities but the two did not quite match. The top image - the fairy story - hovered over the other which mimicked the feel of the fairy tale but had its own story. It was as if the metaphor of the fairy story accommodates a second metaphor. Or put another way, one metaphor nests inside another. These words, uttered by Christopher Bollas (2003:48), seem to resonate with this idea:

> *'…images constitute another mode of self expression, each an intense condensation of many ideas thought simultaneously.'*

What Concepts can we Use to Make Sense of SMI?

Participants in my study offered a rich and complex matrix of understanding (See Figure 1) that ranged from more familiar theoretical constructs to notions far more difficult to articulate residing in the transpersonal realm.

As far as theoretical constructs were concerned, SMI was typically understood in terms of transference or counter-transference, a notion which, as we have seen, is consistent with existing literature. However, in two of the cases projective identification was implicated as an aspect of the transference, with one participant speculating on the role of intuition as a kind of antenna for the development of projective identification. Moreover, in some cases, in fact for more than half of the participants, although transference was given as an initial explanation for SMI, this developed into a far more complicated set of ideas. These reflected the intersubjective nature of SMI and included concepts such as mutuality (Aron, 1996; Bromberg, 2011); the 'unthought known' (Bollas, 1987); and the relational non-conscious (understood to be experience that had never been conscious compared to Freud's notion of the repressed unconscious).

An additional finding related to theories of models of the mind. I referred earlier to the experience of one participant who realised that he had been taking the visual aspect of SMI for granted. Reflecting on this experience led him to understand that an intermediary process had facilitated his translation of embodied SMI into words. That is to say, his visual imagery had served as a kind of bridge between the non-verbal (embodied SMI) and the verbal. This finding resonates with models of the mind proposed, for example, by Panagiotou et al (1977); Bucci (2002;2009) who writes about a referential process which links the subsymbolic to the symbolic mode; and by Schaverien (2007) in her development of Jung's notion of active imagination.

Evidence of visual mental imagery viewed as some form of intermediary was revealed in a somewhat different way by its perception by another participant as a transitional object. This was not used in the classical sense (Winnicott, 1971/2005) but adapted whereby the imagery nonetheless had a transformative effect in facilitating the client's experience, or 'transition', from one psychic space to another.

Whilst the concept of attunement was implicated in the emergence of SMI, we might wonder what underlies the capacity to 'tune in' to such experiences. Is it something to do with the particular therapeutic dyad? Or, is it more to do with the therapist's receptivity, for instance, their attitude of openness to the client's unconscious processes? As mentioned above, the analytic literature suggests that such an attitude is facilitated by a state of reverie. Birksted-Breen (2012) however, goes further in suggesting that this state enhances the therapist's openness to an intuitive modality, a viewpoint echoed, as we have seen, by Bollas (1995).

These preliminary references in the literature sparked with the findings in my study where the role of intuition was suggested both implicitly and, in the case of two participants, explicitly. Further support for an intuitive sense underpinning the emergence of SMI is provided by Berne (1977) in accounts of his own intuitive impressions referred to as 'ego images'. Moreover Heinl (2001) argues that his intuitive approach gave rise to mental imagery which led to remarkable insights. These involved the discovery of core traumatic issues in patients that were far superior to any result obtained via logical thinking. Heinl's intuitive approach involved the development of a phase model, a concept which is also taken up by Welling (2005) who proposes that intuition should not be viewed as a single phenomenon, but as a process. In his 5-phase model, the amount of information contained in the intuition increases from one phase to another, with the emergence of mental imagery eventually occurring in the fourth phase which he calls the 'metaphorical solution phase'. Such models involving the meticulous exploration of the intuitive process, may well be helpfully included in training programmes to cultivate the capacity for SMI and its integration into clinical practice.

Other ways of understanding SMI involved the transpersonal realm, with two of the participants making sense of SMI within a spiritual context. One participant, who believed that the images were given to her by God, also implicated the schizoid aspect of her personality. Recent research reported by Carson (2011) has confirmed a link between schizotypal personality and creativity and it is interesting to speculate the extent to which such factors might be implicated where the capacity for SMI is particularly prevalent within certain therapeutic dyads.

This topic concerning the emergence of SMI within a particular dyad arose spontaneously during the course of interviews. The majority of participants suggested that its occurrence may be due to some form of archaic relational resonance, or in one case, to the matching of an avoidant attachment style. The modest attention in the literature to the notion of matching seems to centre mainly on explanations related to the mysterious or transpersonal (Bass, 2001; Ferenczi in Dupont 1988), whilst Symington (1983) refers to the deep and abiding patient-analyst interconnection as the 'x-factor'.

Among the sample as a whole it was widely felt that there was something 'surreal' or 'uncanny' about imagery phenomena. In this respect Boyle (2010) offers an interesting examination of neglected parapsychological origins that may underlie a range of non-verbal forms of intersubjective communication (including by implication SMI), which

he refers to as 'uncanny intersubjectivity' (see also Bollas, 1995; Bass, 2001).

In his review, Boyle draws attention to the work of Grotstein (2007) on projective transidentification, that is, a particular form of communicative projective identification (based on the work of Bion) that may be partly dependent upon 'extra-sensory perception'. With regard to the existence or otherwise of telepathy in this context, Boyle notes that Grotstein comes to the view that some analysts demonstrate telepathic capacities. Drawing on Allik (2003), Boyle adds that from this perspective 'it may even constitute a form of clinical wisdom to mindfully cultivate a capacity to experience the uncanny so that new things might be discovered...' (Boyle 2010:27). It can be argued that this somewhat tantalising remark is suggestive of a possible further avenue to be addressed in training in terms of fostering the therapist's receptivity to SMI.

I now turn to the fourth and final question, namely:

How might SMI Impact on the Therapeutic Process?

SMI was primarily viewed as playing a vital and beneficial role within the therapeutic process. Three major themes emerged encapsulating how SMI was found to facilitate the therapeutic process. These related to functions of guidance, holding and connection. Each emerged from the analysis in terms of what appeared to be the prevailing principle function in any one case, although in practice there will be some overlap.

Guidance: SMI was widely found to be source of guidance or form of 'developed insight' into what was happening within the therapeutic relationship, shedding light on to the nature of the relatedness between patient and therapist. Such images (whether disclosed or not) were thus viewed as a metaphor for the therapeutic relationship (as illustrated earlier), a finding which was consistent with the extant literature (eg Ogden, 2002; Mark, 2009; Bucci, 2009; Arizmendi, 2011; Birksted-Breen, 2012). In my study this applied to various modalities of imagery phenomena, including embodied SMI, which were helpful in informing the therapist's stance in terms of their way of 'being with' the client.

Holding: The capacity for images to 'anticipate and hold' as expressed by one participant, took on a different nuance for each interviewee. Sometimes it was the way in which an image was able to hold complexity, to support the therapist's capacity to remain in uncertainty until, 'over time ... you'll make more sense of it'. On other occasions it served as a form of 'anchoring' in terms of a kind of regulatory object for both therapist and client. A further aspect of the holding or containing function of imagery, emphasised its effect in terms of facilitating therapeutic change, specifically with the client's process of integration. In this case the imagery became a way for the client to share aspects of himself which hitherto had felt too frightening. Recall above that this particular function of SMI, suggesting its transformative potential, was also cited by Mark (2009).

Connection: The potentially transformative nature of SMI was also widely demonstrated in the way that it provided 'another way of meeting'. This way of meeting was invariably thought of as something special or extra-ordinary, born of a coming together within a shared intimate space. This in-between space, named as a 'privileged place', was one pregnant with the potential for something different to happen. It was a place co-created by, and unique to, the therapeutic pair, a kind of shared imprint which intensified the sense of intimacy and deepened the dyadic bond.

Sometimes the intimate feel of the connection arose from sharing the imagery, for instance when it became a sort of third object which could be shared and used in a playful way. At other times, it seems that words were not necessary in order to experience a sense of internal shift. This is exemplified in one account where a meeting via SMI was experienced as transcending the personal and reaching into the spiritual realm. It involved an intensely fine attunement, maybe suggesting a different state of consciousness, culminating in a highly emotionally charged moment where the connection made in this in-between space was palpable. It is as if in that moment the space became a 'transitional space', in which a silent internal transformation took place.

One way of thinking about such a moment is through the lens of Stern's (2004; BCPSG 2010) moment of meeting. However, whilst this may prove a useful stepping stone, my intent was to explore a wider picture. I wanted to try and get inside the psychotherapeutic process, specifically to present some ideas, based on the findings of my study, which might provide a framework for conceptualising SMI and its role in the process of change.

Re-conceptualizing SMI

Central to my proposed model of understanding is the concept of an in-between space, or 'privileged place', specifically, a unique meeting place for the therapeutic pair in which the phenomenon of SMI is co-created: a place of extra-ordinary sensibility, of in-betweenness, belonging to neither and yet to both. But how can we make sense of this: a space that belongs to neither and yet to both? The image that comes spontaneously to my mind is one of the seashore. At the point where the sea meets the land, a kind of conversation takes place between the unfurling wave and the shore to which it temporarily lays claims. And yet what has happened in this moment of mix-up, or as Balint (1992) might say, of this harmonious interpenetrating mix-up? He uses this term in reference to the interpenetrating mix-up of foetus and environment-mother and exemplifies this duality of separateness and togetherness by using the analogy of a fish in the sea. The question arises: Is the water in the gills (or in the mouth), part of the sea or of the fish? Likewise, in terms of the seashore, in that moment where water meets land, what has become of the occupied space? Is it land or is it sea? Surely both elements retain their unique qualities but in coming together they create a third, coined by the word: sea-shore. In transposing this idea to the therapeutic domain, the meeting of two subjectivities creates a third object or analytic third in the form of imagery phenomena.

The concept of an analytic third is well documented in the analytic literature. However, as Gerson (2004) observes, thirdness has no singular, agreed-upon definition, being generally thought of as 'a realm that transcends [my italics] the subjectivities of the two participants' (p74). Ogden (1999) elaborates on this stating: 'the analytic third is not a single event experienced identically by two people; rather it is a jointly, but asymmetrically constructed and experienced set of conscious and unconscious intersubjective experiences in which analyst and analysand participate' (p110). Similar to Winnicott's (1971/2005) potential space, also referred to as a transitional space or play space, the analytic third or third analytic space, is a space of creativity where something new can be discovered and experienced; where personal knowledge and thoughts can be transcended (Knafo, 2012). This implied transformative effect if taken up by Bromberg (1998) who, in his discussion on the opening up of therapeutic space, describes the notion of thirdness, or in-between space as 'a space belonging to neither person alone, and yet, belonging to both and to each; a twilight space in which 'the impossible' becomes possible' (p278).

These last few words whereby 'the impossible' becomes possible, evoke the potentially transformative effect of imagery phenomena described in my study and exemplified above. Overall, whether providing guidance, a holding environment or facilitating connection, its mutative effect emerged as a significant finding. It thus seems fitting that any development of a conceptual understanding of SMI emphasises this quality. As such, and drawing on Bollas's (1987) concept of the transformative object, I should like to elaborate on the notion of thirdness in the context of SMI by proposing its delineation as a Transformational Third.

In sum, this model highlights a Winnicottian frame in which mutual unconscious influences within the therapeutic relationship potentially create a rich transitional space – or 'privileged place' – in which the client's experience can be transformed through engagement with SMI, conceptualised as a Transformational Third. This concept is encapsulated in Figure 2.

A Cautionary Note

Notwithstanding the potentially facilitative role of SMI, my study also highlighted some of the challenges which arose in working with such phenomena. These included the potential for SMI to trouble or confuse the therapist, an effect summed-up by one of the participants as

'discombobulating'. Although it can be argued that such experiences might be thought about and usefully worked with after the event, it nonetheless highlights the potency of SMI to both perturb as well as to enable. Its disturbing impact was further evidenced by accounts of untimely disclosure leading to rupture in the therapeutic relationship. The risk of intrusiveness was emphasised, suggesting the need for an especially cautious, sensitive and respectful approach in working with SMI.

Concluding Remarks

Drawing on my doctoral research, I have sought to address four key issues pertinent to the integration of SMI into clinical practice. The first point of inquiry identified tensions between a personal affinity with mental imagery and its application as part of therapeutic technique. This gave rise to concerns about the validity of using SMI, although these varied according to the training background of participants. A second line of inquiry concerned the multi-sensory ways in which participants experienced SMI. This exploration also led to the suggestion that despite the potential value of spontaneous visual imagery, it may well be undervalued or possibly not fully used. A third question addressed ways of understanding SMI with participants offering a complex matrix of explanations ranging from aspects of transferential phenomena to the uncanny. The fourth and last line of inquiry which concerned the impact of SMI on therapeutic process, led to the identification of related key functions. Based on the potential for transformation inherent in these key functions, a model was developed to illustrate the potential potency of SMI as a Transformational Third. Difficulties in working with SMI were also considered and the need for a cautious and sensitive approach was emphasised.

Implications for practice arising from this study, suggest the need for training programmes, across a wide range of theoretical orientations, to include a greater awareness and understanding of the many aspects of SMI and its potential value to the therapeutic enterprise. This would include the exploration of optimal ways of working with SMI, thus supporting its integration into clinical practice. Clearly this also has implications for supervisory practice and continuing professional development. Furthermore, and in the light of the above discussion on intuition and its potential role

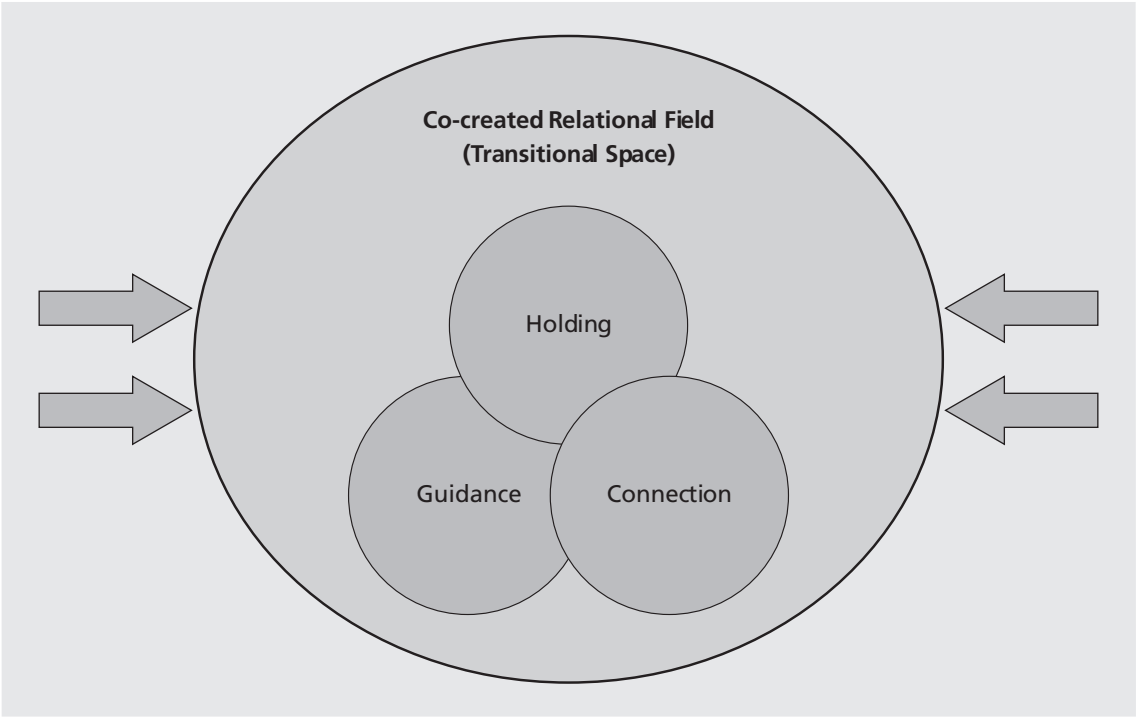


Figure 2: SMI as a Transformational Third

in mediating SMI, it may well be fruitful for training programmes to consider this and other ways in which therapists might actively develop their capacity for SMI to ultimately inform and enrich the therapeutic process.

Acknowledgements

I am most grateful to the psychotherapists who took part in my study and to my academic consultant, Dr Nick Midgley, for his invaluable support and guidance throughout the course of my doctoral research on which this article is based. My thanks also to Dr Alistair McBeath of Metanoia Institute/Middlesex University.

References

Allik, T. (2003). Psychoanalysis and the uncanny: Take two OR When disillusionment turns out to be an illusion. In J Boyle (2010). From telepathy to projective transidentification: Casting a beam of intense darkness upon the role of uncanny intersubjectivity in psychotherapy. *The British Journal of Psychotherapy Integration, 7 (1), 17-31.*

Aron, L. (1996). *A meeting of minds: Mutuality in psychoanalysis.* Hillsdale, NJ: Analytic Press.

Arizmendi, T. G. (2011). Linking mechanisms: Emotional contagion, empathy, and imagery, *Psychoanalytic Psychology, 28 (3), 405-419.*

Balint, M. (1992). *The basic fault: Therapeutic aspects of regression,* Illinois: Northwestern University Press.

Bass, A. (2001). It takes one to know one: or, Whose unconscious is it anyway? *Psychoanalytic Dialogues, 11 (5), 683-702.*

Berne, E. (1977). *Intuition and ego states.* In P. Clarkson, Transactional Analysis psychotherapy, An integrated approach, London: Routledge.

Birksted-Breen, D. (2012). Taking time: The tempo of psychoanalysis. *The International Journal of Psychoanalysis, 93, 819-835.*

Bollas, C. (1987). *The shadow of the object: Psychoanalysis of the unthought known.* London: Free Association Books.

Bollas, C. (1995). *Cracking up: The work of unconscious experience.* London: Routledge.

Bollas, C. (2003). *Being a character: Psychoanalysis and Self Experience.* London: Routledge.

Boston Change Process Study Group, (2010). *Change in psychotherapy – A unifying paradigm.* New York: Norton.

Boyle, J. (2010). From telepathy to projective transidentification: Casting a beam of intense darkness upon the role of uncanny intersubjectivity in psychotherapy. *The British Journal of Psychotherapy Integration, 7 (1), 17-31.*

Bromberg, P. M. (1998). *Standing in the spaces: Essays on clinical process, trauma & dissociation.* Hillsdale, NJ: Analytic Press.

Bromberg, P. M. (2006). *Awakening the dreamer: Clinical journeys.* Mahwah, NJ: Analytic Press.

Bromberg, P. M. (2011). *The shadow of the tsunami and the growth of the relational mind.* East Sussex: Routledge.

Bucci, W. (2002). The referential process, consciousness, and the sense of self. *Psychoanalytic Inquiry, 22, 766-93.*

Bucci, W. (2009). The sleeping analyst, the waking dreams: Commentary on papers by Richard A. Chefetz and David G. Mark. *Psychoanalytic Dialogues, 19 (4), 415-425.*

Carson, S. (2011). The unleashed mind. *Scientific American Mind, May/June, 22-29.*

Doucet, P. (1992). The analyst's counter-transference and/or transference imagery. *International Journal of Psycho-Analysis, 73, 647-659.*

Dupont, J. (1988). The clinical dairy of Sandor Ferenczi. In A. Bass, (2001). It takes one to know one: or, Whose unconscious is it anyway? *Psychoanalytic Dialogues, 11 (5), 683-702.*

Fosshage, J. L. (2011). How do we 'know' what we 'know'? And change what we 'know'? *Psychoanalytic Dialogues, 21 (1), 55-74.*

Freud, S. (1899). Screen Memories. In J. W. Kern, (1978). Counter-transference and spontaneous screens: An analyst studies his own visual images. *Journal of the American Psychoanalytic Association, 26, 22-47.*

Gallese, V., Eagle, M.N., & Migone, P. (2007). Intentional attunement: Mirror neurons and the neural underpinnings of interpersonal relations. *Journal of the American Psychoanalytic Association, 55, 131-176.*

Gerson, S. (2004). The relational unconscious: A core element of intersubjectivity, thirdness, and clinical process. *Psychoanalytic Quarterly, LXXIII, 63-98.*

Grotstein, J. S. (2007). A beam of intense darkness. In J. Boyle, (2010). From telepathy to projective transidentification: Casting a beam of intense darkness upon the role of uncanny intersubjectivity in psychotherapy. *The British journal of Psychotherapy Integration, 7 (1), 17-3.*

Heinl, P. (2001). *Splintered innocence: An intuitive approach to treating war trauma.* East Sussex: Routledge.

Hollway, W. & Froggett, L. (2012). *Researching in-between subjective experience and reality* [45 paragraphs] Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 13(3), Art. 13. Retrieved from http://nbn-resolving.de/urn:nbn:de:0114-fqs1203132

Kanzer, M. (1958.) Image formation during free association. *Psychoanalytic Quarterly, 28, 465-484.*

Kern, J.W. (1978). Counter-transference and spontaneous screens: An analyst studies his own visual images. *Journal of the American Psychoanalytic Association, 26, 21-47.*

Knafo, D. (2012). Alone Together: Solitude and the Creative Encounter in Art and Psychoanalysis, *Psychoanalytic Dialogues, 22 (1) 54-71.*

McGown, L. (under review). A Qualitative Study of the Therapist's Spontaneous Mental Imagery and its Impact on Therapeutic Process. *Counselling & Psychotherapy Research.*

Mark, D.G. (2009). Waking Dreams. *Psychoanalytic Dialogues, 19 (4), 405-414.*

Meissner, W.W. (2009). Towards a neuropsychological reconstruction of projective identification. *Journal of the American Psychoanalytic Association, 57, 95-129.*

Ogden, T. H. (1999). *Reverie and interpretation: Sensing something human.* London: Karnac.

Ogden, T. H. (2002). *Conversations at the frontier of dreaming.* London: Karnac.

Panagiotou, N.C. & Sheikh, A.A. (1977). The image and the unconscious. *International Journal of Social Psychiatry, 23, 169-186.*

Ross, W. & Kapp, F. (1962.) A technique for self-analysis of countertransference: Use of the psychoanalyst's visual images in response to patient's dreams. *Journal of the American Psychoanalytic Association, 10, 643-657.*

Schaverien, J. (2007). Counter-transference as active imagination: Imaginative experiences of the analyst. *Journal of Analytical Psychology, 52, 413-431.*

Shattuck, R. (1984). *Life before language.* In D B Stern, Unformulated Experience: From Dissociation to Imagination in Psychoanalysis, Hillsdale: Analytic Press.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, method and research.* London: Sage.

Stern, D. B. (2003). *Unformulated Experience: From Dissociation to Imagination in Psychoanalysis.* Hillsdale: Analytic Press.

Stern, D. N. (2004). *The Present Moment in Psychotherapy and Everyday Life.* New York: Norton.

Symington, N. (1983.) The analyst's act of freedom as agent of therapeutic change. In A. Bass, (2001). It takes one to know one: or, Whose unconscious is it anyway? *Psychoanalytic Dialogues, 11 (5), 683-702.*

Warren, M. (1961.) The significance of visual images during the analytic

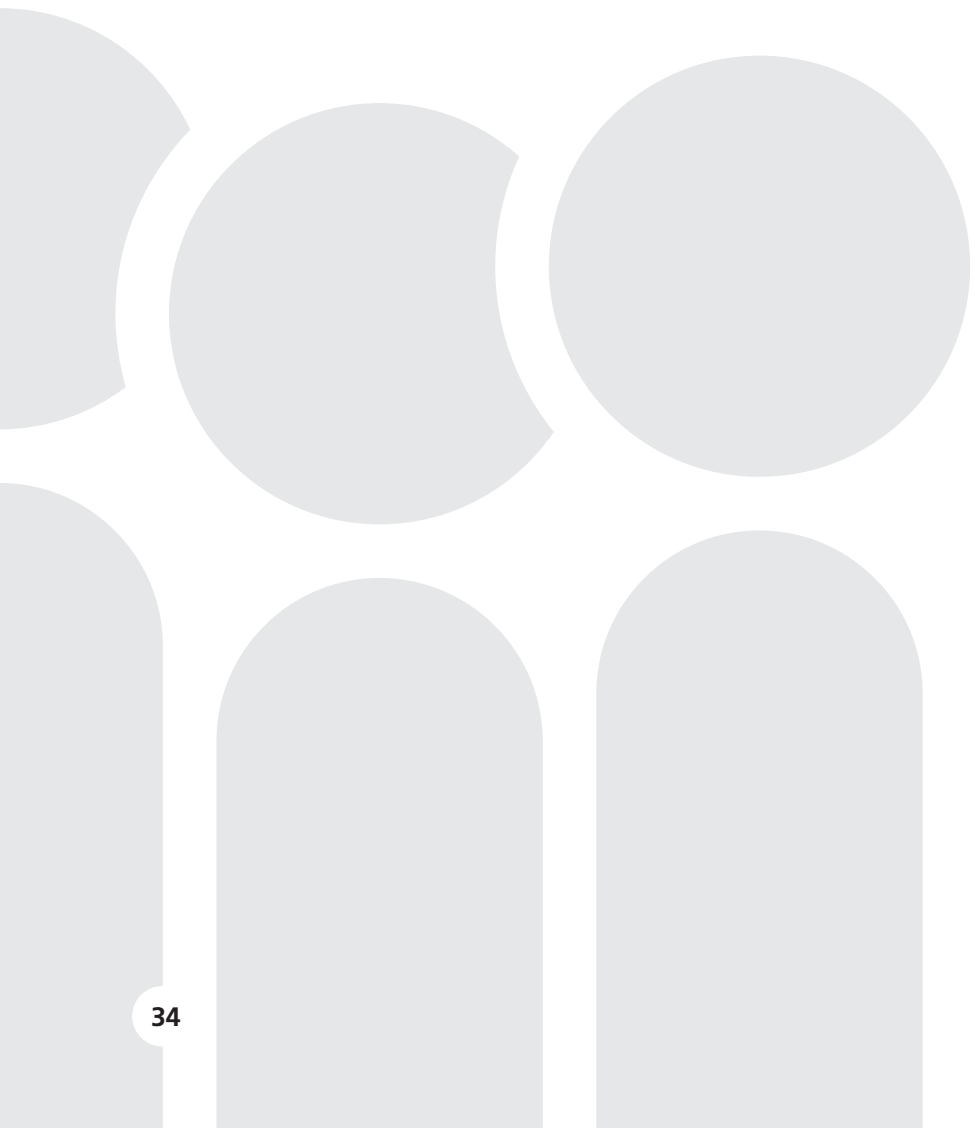
session. *Journal of the American Psychoanalytic Association, 9, 504-518.*

Welling, H. (2005). The Intuitive Process: The Case of Psychotherapy. *Journal of Psychotherapy Integration, 15 (1), 19-47.*

Winnicott, D.W. (1971/2005). *Playing and reality.* Oxon: Routledge Classics.

Yalom, I. D. (1991.) *Love's executioner and other tales of psychotherapy.* London: Penguin Books.

Lesley McGown is a UKCP registered psychotherapist and clinical supervisor in private practice. She also works with the London based Clinic for Dissociative Studies as a Consultant Specialist Psychotherapist. This paper is based on research undertaken as part of her Doctorate in Psychotherapy by Professional Studies at Metanoia Institute/ Middlesex University. She can be contacted at: lesleymcgown@blueyonder.co.uk



Philippa Perry

How Should a Therapist Be?

Musings and examples of the impact of different styles of therapist's self-disclosure covering: 'The Blank Screen', 'Self-Disclosure Lite', 'Affective Authenticity' and 'Self-indulgent Leakage'.

The publication of 'The Examined Life' by Stephen Grosz took me back to other books of case studies I devoured decades ago, such as 'Love's Executioner' by Irvin Yalom and 'The Road Less Travelled' by M. Scott Peck. These books were pivotal for me. It was through reading them I saw my future. I thought if all these people have been transformed by therapy then I could be too. I was so excited that such a science or art form, whichever therapy was, existed and I knew that one day I would experience it for myself.

To find a therapist I used the Yellow Pages and soon I found myself in an upstairs back room in a house in Kilburn, lying on the couch. Which was not a couch but a single bed next to the wall. There was a small table next to the bed with a bright lamp on it, behind the dazzle of which the therapist sat. It was difficult to see her. The light of the window was also behind her. There was a desk in the room, upon which there was a typewriter (this was in the days before the personal computer). I assumed all therapists wrote wonderful case studies and perhaps I might feature in one.

So I lay on this bed. This was a bit annoying as I was not tired and it felt awkward lying down in the presence of someone I did not know and could not even see. I just sensed her there. She felt to me, more of an indifferent ghost, rather than a caring presence. The positivity I had brought to this experience from my case study reading began to recede.

I tried to voice my current concerns: things that were foreground for me in my life at that time. I was recently divorced. I had a new boyfriend. And even though I was happy with my boyfriend and was enjoying myself at art school during the day, every morning I would wake up as though weighted by sadness. I lay on the therapist's bed trying to go into as much detail as I could about all this. I cannot remember her saying anything except for 'Times up', after fifty minutes. At the end of the month I received a bill for an enormous amount of money, I wrote a cheque and brought it to the next session. She indicated to me I was to leave it on the desk and did not mention it or thank me. The whole experience was a bit of a let down after 'The Road Less Travelled.' I began to ask questions, "What sort of therapy is this?" To which she replied, "Vy do you vant to know?" The foreign accent was reassuring, I assumed it was Austrian. "Because I want to know what I'm supposed to do and what is supposed to happen." "Ah" She'd reply and then say nothing further. In the next session I tried again, "Why am I speaking to a ceiling, why can't I see you?" If I was lucky she might make a sound a bit like "Mmm."

As time went on I found it increasingly hard to talk under these conditions and I took to writing a journal during the week and reading it to her during my sessions. I sat up to do this. She did not appear to be happy about this turn of events. At least, I felt this was the case. It was hard to tell. "You can just talk, you

don't have to read." I took this as a directive and I chose to ignore it. I was getting more from writing my thoughts and feelings down that I was trying to remember them or share them as they happened with her in the sessions. So I continued to write them down and read them to her. It made me feel on slightly firmer ground than when I just talked to the glare of the lamp and the surrounding darkness.

One of the episodes I read from my diary was this:

"I was walking on Hampstead Heath by myself and I came to Kenwood House where a concert was due to take place. So I sat on the grass and watched what was going on and thought I would stay for the music. I noticed a little girl of about four wandering about and crying and no-one was taking any notice of her. So I went up to her and asked her what was wrong. She was lost. She could not find her mummy. I took her hand and suggested we look for mummy together. We did not have much luck, so we slowly made our way to the organisers' hut. The little girl asked me to promise that I would not leave her and she squeezed my hand. I made the promise that I would not. There were two lovely young women in the hut who were as concerned as I was about the little girl and they immediately made a loud speaker announcement and we all reassured the little girl that mummy would be here soon. She seemed fine with the two women and so I said I would leave her in their capable hands. The little girl's eyes opened very wide as I left and I knew I was breaking a promise and I told myself this did not matter. I felt sure her mother would turn up soon. I went to sit down again. Ten minutes later, the announcement about the lost child was repeated. Adrenaline shot through me, tears started to stream down my face and I had to get out of there, and I ran away. Although I was concerned for the little girl, it was my feelings for myself that I was finding intolerable."

I looked up and tried to see my therapist through the glare of her lamp. She spoke, "Did you ever lose your mother?"

"No, I never lost my mother."

"Who did you lose?"

"I didn't lose anyone." And then I started to cry. And cry. The snot was running down my face. I felt alone. I saw some tissues on the table below the lamp. I had to assume I could use them although she had not even pushed them towards me. I took one and continued to cry.

She said it again in quite a hard, accusing way as if I was being naughty and trying to hide something, "Who did you lose?"

I knew that from birth until school I had a nanny. A round the clock baby sitter and wiper and feeder of me. My mother did not work, but the 24/7 demands of a toddler are tough and my mother liked to go out and see friends and go shopping unencumbered by a child. I cannot remember minding this as I was comfortable with nanny. All I know is that I had nanny and now I do not have nanny. So nanny must be the one I lost. I have no memory of losing her but even as I type this again now, decades after that particular therapy session I feel the possibility of crying building up behind my eyes. I told the therapist about nanny and the only reason I knew I was telling the truth was because I was crying. There was a spot in me that was covered up most of the time but the little lost girl on Hampstead Heath had found it and I had found it again in that session.

I told myself that this was why I felt sad in the mornings. I even worked out a theory that it was because I had someone precious in my life again, my new boyfriend whom I did not want to lose. I worked this out myself. My therapist went back to her usual stance of saying nothing.

I kept up my diary and it was from re-reading this that I made connections between the nanny incident and things happening in the present. If my boyfriend was late, I would imagine he had met with an accident and had died, or worse, had found someone else (this was in the days before mobile phones). I then would feel the feelings as though either or both of those imagined calamities had actually happened and the relief I felt when he turned up with grease on his fingers because his motorbike had broken down, almost made my suffering worth it. But I began to know that I expected any good relationship to turn out like my relationship with Nanny. When familiar feelings of fear of abandonment occurred I could say to myself,

this is not Nanny, this is different and gradually I became a little more secure which made life slightly less excruciating and I probably became easier to live with. I had been in therapy for eight months. The only way therapy seemed to work was by my keeping a diary. So I resolved to continue with the diary and drop the therapy. My therapist seemed surprised that I intended to stop therapy. She thought instead I should double the number of times I visited her each week. I pointed out that in eight months she had said but one thing that moved my self-discovery along and she even said that in a way I found cold and interrogative. She said in that same manner: Was that not my experience of how she said it, rather than how she said it? I said she was right but if I experienced her like that, why would I continue to submit myself to it? She offered me no answer and so I stopped. The next time I saw her was sometime later on the local news. She was wreathed in smiles and clutching the arm of an Iraqi national who had been imprisoned in the UK during the start of the Iraq war and had later been released. Her accent was not Austrian it was Iraqi, and I had been telling her stuff about my comfy middle class life while her country was being invaded, her relations probably in danger, and her man had been wrongfully imprisoned. In retrospect my attitude towards her has softened. She might not have been the most brilliant of therapists. She was an ordinary psychotherapist and most psychotherapists, including me are ordinary.

She had facilitated me in finding a narrative for how I felt. Sure, her style was somewhat minimalist but I began to feel more grateful.

Now with further reading, a psychotherapy training and years of practicing as a psychotherapist myself, I think I understand my Iraqi therapist even better. I think she was trying to get it right. She was practicing an old fashioned kind of psychoanalytic psychotherapy that placed importance on neutrality. I have googled her all these years later to try to find her, but could not. Maybe its just as well. If I asked her about the theories that underpinned her work she might still reply with a 'Mmm.'

Psychology is a science. Psychotherapy is an art. In its earliest days I think it was unsure about this. Neutrality may be a left over when the analyst was trying to act scientifically, with an almost surgical detachment. It was also thought that if the therapist acted as a blank screen, whatever the patients thought of the therapist would be the patient's own projection onto that screen and so could learn about themselves using the therapist as a sort of mirror. Perhaps this is what my therapist was trying to do, although as she did not share this information with me, I am not sure how I was supposed to work that out.

If I think about the word 'neutrality', what comes to mind is a country which does not take sides in a war, having no part in it and taking no action. Inactivity may be possible politically but in my experience it is impossible personally. How can any person's behaviour be viewed as being merely blank and inactive? In a functioning relationship I think the idea is that we mutually impact upon each other? (Slavin, M.O. & Kriegman, D. 2005). I heard an anecdote once of a psychoanalysis student who had waited for years to undergo analysis with a famous, uber-analyst. She was enthusiastic on first meeting the analyst, and held out her hand to her saying how much she had been looking forward to that moment. The analyst did not return her smile nor her hand, she nodded towards the couch and took her chair at the head of it without meeting the analysand's eye. I think if you try too hard to be a blank screen, you just come across as rude.

There is a line between not acting impulsively towards clients, not imposing beliefs and values onto them and behaving as though they are barely there. Maybe this is about the gap between theory and actual practice? (Greenberg, JR 1983). A theory may state: "Neutrality is the technical manifestation of respect for the essential otherness of the patient" (Chused, J.,1982) or "a nonjudgmental willingness to listen and learn" (Poland, W., 1984) but a clinician could interpret such theories into taking a non-responsive position towards their clients.

An element of what makes us go crazy in the first place, is I believe, when we are lied to by someone in a position of trust. Being lied to, either innocently or knowingly, or having information that effects us withheld from us means that in order to fit in with the world as it is presented to us we have to make compromises

to our outlook, we have to learn to blinker what we can see, we suppress our intuition as it does not fit with what we are told and in such ways we sew the seeds of our neuroses. My belief is that if the therapist holds back too much of themselves they are in danger of compounding this original injury rather than uncovering it.

From the humanistic tradition Carl Rogers purported that in order for therapy to succeed, what was needed on behalf of the therapist was congruency and unconditional positive regard. He believed in openness and self-disclosure. Listening and understanding only go so far, you need to show that you empathise with the patient. He said, "To withhold one's self as a person and to deal with the other person as an object does not have a high probability of being helpful" (Rogers, C. 1967). But how does this theory of not withholding the self translate into practice? I have heard clients complain of their former therapists that they shared too much of their personal lives. Indeed, I remember one newspaper editor who was in therapy with me, interrupt me to tell me it was of no interest to her how she impacted upon me, it was, she said, besides the point. And yet, what is too much disclosure for one client, will not be enough for another.

This is why therapy is an art and not a science. How much you disclose has to be down to being sensitive to what is in any particular client's best interests.

There are people who think honesty means telling the person you are with everything that is passing through your mind however offensive or irrelevant the other may find it, and they think this is a good thing because it is honest. However, I think that therapist's self disclosure is necessary if the work is to advance but all disclosures need to be for the benefit of the client and not solely the therapist. Of course it may be hard to know until you try what will deepen a bond and what will hinder it, what will be useful feedback and what might turn out to be self-indulgent leakage. There will be times when any mental health practitioner gets this wrong and that is okay. Its not a precise art and a functioning relationship is not about the lack of rupture. It is about how those ruptures are repaired.

Here is a story about self-disclosure which happened in my fourth course of therapy, which happened to be with an analyst.

I had been struggling with whether I could go against my conditioning and buy myself a new car, brand new, not second hand. The analyst was a benign presence through all of this, asking the right questions that revealed to me what belief systems I had been operating under. And I questioned those old belief systems and bought myself a car. I was rather chuffed and reported it to him. He gave out a sigh. This worried me. My father would have disapproved of such proflicacy, I could still interpret others to mean the same as my father meant but I wanted to stop this habit so I needed to know the meaning of that sigh. My analyst hesitated and then disclosed what the sight meant:

"Why has a girl got a better car than me?"

This is an honest disclosure. I am sure the therapist did not relish sharing his jealousy, his sexism, his attachment to things material. And without analysing why, I felt far more trusting of him after this. My whole body was willing to go down to a deeper level in the analytic work. Perhaps it was because if he was willing to share who he actually was with me, not who he thought he ought to be, but who he actually was, sharing traits he may not have been proud of but more to the point his humanness I could learn to accept who I really am too, not who I thought I should be, but who I am, and have the courage to be it. Obviously I am still a work in progress but you get my point. He made himself vulnerable in saying that, he took a risk because it could have all gone horribly wrong. I could have thought something along the lines of I cannot work with a jealous misogynist and instead of the disclosure allowing me to trust him, it might have had the reverse effect. But in that example he managed the art of psychotherapy just right because if he had replied differently to me, had he forsaken congruency for the typical therapist style of asking me why I needed to know and gone on to interpret my question correctly as transference of my father onto him, he would be withholding information from me that would prevent me from moving beyond that transference. I would have felt it in my body that I still could not trust him had he taken this line,

even if I might not yet know it in words. The other thing that strikes me about this example is that I had requested to know what the sigh meant - I had asked for feedback. I am hesitant to say there is a rule that self-disclosure should only happen when it is asked for, my position is that the art of attunement requires flexibility rather than rules. But I also notice that when I misattuned to my client, the newspaper editor, she had not asked me to share what impact her material had upon me, nor given any other indicator that she might be ready to hear it.

We cannot be harsh on my first therapist on her lack of self-disclosure, she may have been reticent but I did experience her as authentic, if unsympathetic. She had not the benefit of our contemporary literature on the necessity of therapist self-disclosure. She could not have read, for example, Karen Maroda's The Power of Countertransference, 1991, as it was published after my initial experience of therapy. In this book, Karen Maroda talks about the need for mutual emotional exchanges, including the analyst's own self-disclosure. The review of Maroda's book on the Routledge website quotes the psychiatrist and psychoanalyst Harold Searles who said about it: "If we follow the example set by Maroda, we shall be minimally likely to 'act in' our emotions in our sessions with our patients. They will benefit greatly as a result; we practitioners shall benefit; and the profession of psychoanalysis and psychoanalytic therapy will become healthier and stronger than it is at present." Thinking about what Harold Searles called 'acting in' and I more usually call 'acting out' - had my analyst not shared how my new car made him feel, no harm would have been done, although it might have slowed down the progress of our work together. However, had he not even been aware of his countertransference, how would it have leaked into the therapy? My theory is that had he been unaware of the feelings my behaviour brought up in him, is that he may have been in danger of acting out in punitive ways towards me. I also think that had he not been in the habit of sharing how he was affected by me I would not have had the experience in therapy of real authentic communication. Indeed, Karen J. Maroda posits that therapists must build on Stern's notions of affective attunement by expressing their own emotions in order to make affective responses as they are critical for completing the cycle of affective communication. (Maroda K.J., 1999). I have had plenty of therapy where the practitioner has tried to express their own emotion in response to me as a client. For example, both my second and third therapists might remark that they were 'sad' that I had, say, a critical inner voice, but these interventions did not have an authentic ring, it felt more like something that had been said to them and that they were repeating. It did not feel as though it was actual self-disclosure, more like going through the motions of self-disclosure, what I could label: "self-disclosure lite". Looking back now I realise I was unable to surrender to the therapy process with these two therapists as, on a somatic level, I felt unable to fully trust them. I did not see this at the time and I admit now I am forming a narrative in the present around feelings as I remember them but for now this is a belief I can hold.

As a client, if a therapist is to attune to me, I need a sort of open, risky communication, where the therapist shares their affect without being able to be sure of its impact, even at the risk of mis-attunement and rupture but each therapeutic dyad must work at finding its own way. What is affective, effective therapy for one client though, will not necessarily suit another. So a therapeutic style may differ from client to client. Unlike a social relationship, the therapeutic relationship is purportedly for the client's sake. So although authenticity is vital and sharing affect is key, the way the therapist attunes to the client will mean that the practitioner's style will vary between clients, and as people are organic, not static, a style will vary between sessions and between moments within the same session.

For some clients my first therapist will be a better therapist for them than she was for me and for others, had my latter therapist attuned to them in the style he attuned to me it might have had unfortunate consequences. Perhaps authentic sharing of affect is not the way forward for every client, perhaps even the style of the blank screen might suit certain clients. I was a different person when I first started therapy and perhaps the self-disclosure of my analyst would have been too much for the person I was when I was an inexperienced client. Authenticity, attunement and affect are difficult qualities to measure,

so a scientifically proven answer is unlikely to be in our grasp. This will not hinder our endeavours to continue to practice, experiment and improve the art of psychotherapy.

As any Cognitive Behavioral therapist will tell you, extremes are rarely desirable, so a leaky therapist who does not know how to bracket what would not help the client, and a practitioner who hides themselves so far behind the metaphorical screen that they are not offering a relationship are probably the least helpful therapist styles. Practitioners, with the help of their clients, can find their own middle ground.

And I am going to finish by going back to where I started, with M. Scott Peck: "…it is the willingness of the therapist to extend himself or herself for the purpose of nurturing the patient's growth – willingness to go out on a limb, to truly involve oneself at an emotional level in the relationship, to actually struggle with the patient and with oneself. In short, the essential ingredient of successful deep and meaningful psychotherapy is love" (Scott Peck, M. 1978).

References

Chused, J (1982) The role of analytic neutrality in the use of the child analyst as a new object. *Journal of The American Psychoanalytic Association Vol. 30 pp3-28.*

Greenberg, JR (1983) The problem of analytic neutrality. *Contemporary Psychoanalysis Vol. 17 pp239-257*

Maroda, K.J., *Surrender, and Transformation: Emotional Engagement in the Analytic Process.* 1999 The Analytic Press, Inc. p65.

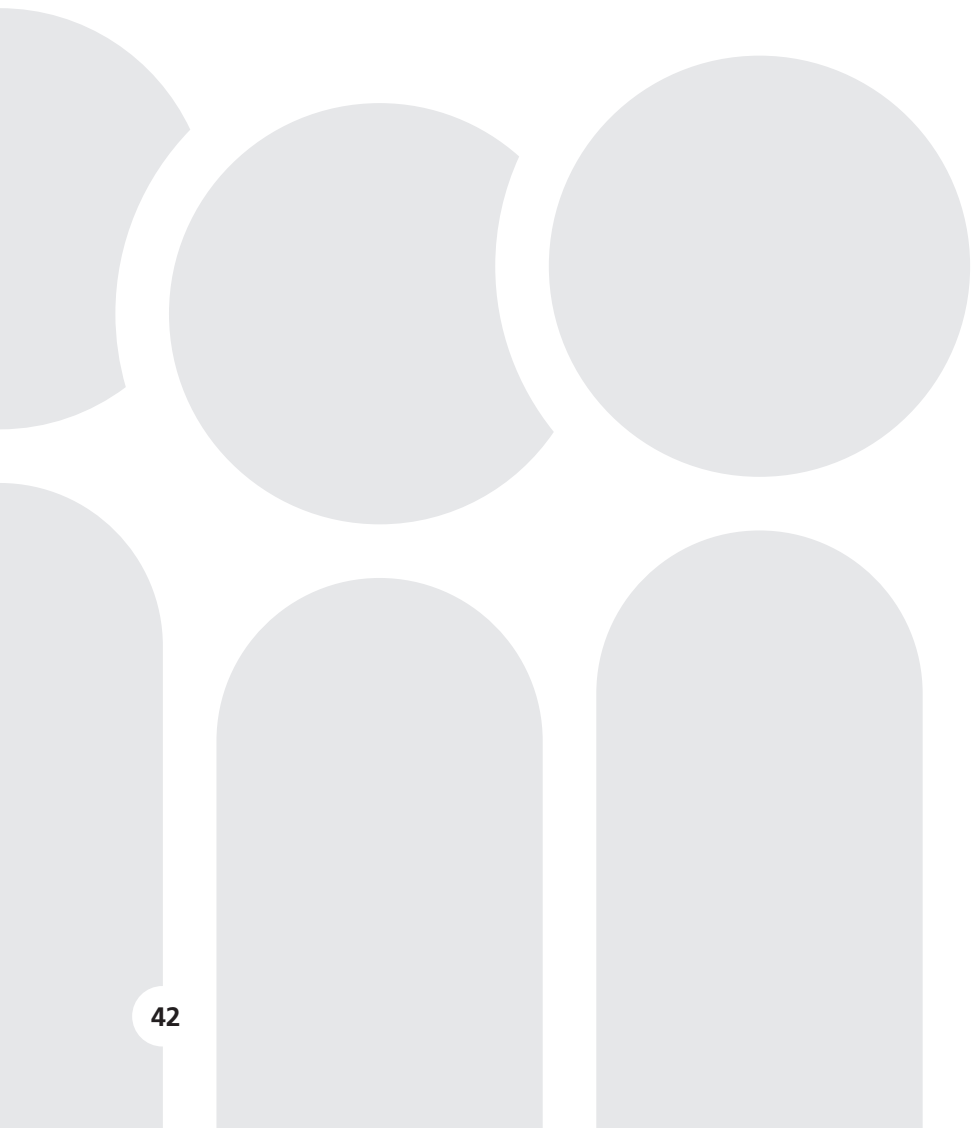
Poland, W. (1984) On the analyst's neutrality. *Journal of the American Psychoanalytic Association Vol. 32 pp283-299.*

Rogers, C.R., (1967) *On Becoming a Person.* Constable, London p47

Scott Peck, M *The Road Less Travelled.* Simon and Shuster, New York 1978, 2008 edition pub by Rider, London p161.

Slavin, MO & Kriegman, D (2005): *Why the Analyst Needs to Change: Toward a Theory of Conflict, Negotiation, and Mutual Influence in the Therapeutic Process.* Relational Psychoanalysis Vol 2 Innovation and Expansion, The Analytic Press

Philippa Perry UKCP is an integrative psychotherapist, currently not practising in order to concentrate on writing and speaking. She has written two books, Couch Fiction, a graphic novel published in 2010 by Palgrave Macmillan, that attempts to show how psychotherapy works, and How To Stay Sane, a self help book written for The School of Life and published by Pan Macmillan in 2012. She has given talks about psychotherapy at many events in the UK and abroad including The Hay Festival, Latitude Festival, The School of Life Live Tour, 5 x 15, and Intelligence2. She is a regular contributor to The Culture Show on BBC2, Psychologies Magazine, Psychology Today and The Guardian, examples of her articles can be found here: http://www.guardian.co.uk/profile/philippa-perry and here: http://www.psychologytoday.com/blog/how-stay-sane. She is also a faculty member of The School of Life. Philippa is often to be found on Twitter taking self-disclosure to new depths on subjects such as cats, gardening, the telly, culture, etc., as well as psychology and psychotherapy, Twitter: @philippa_perry



Michael M. Tophoff

Daoist and Chan Buddhist Dimensions of Self and No-self in Integrative Psychotherapy

Abstract

Eastern philosophies and religions, such as Buddhism and Daoism, offer different insights into the existence – or non-existence – of the self. In Buddhism, the self is deconstructed, in Daoism, the self is cultivated. The author discusses how the dialectics of both approaches offer pragmatic ways of bringing these insights towards tangible, personal experiencing in the therapy room, both in the client and in the therapist. He addresses the relevance of these concepts for the integrative psychotherapist.

Introduction

In Western psychotherapies, from an anthropocentric world view – the existence of a distinct and separate self vis-à-vis an outside world – is a fundamental tenet. In the psychotherapeutic *process of becoming a person* (Rogers, 1961, my italics), the client actualizes, develops and strengthens his self. According to Rogers (Evans, 1975, 16), the self 'includes all of the individual's perceptions of his organism (…) and of the way in which those perceptions are related (…) to the whole exterior world.'

Purkey and Stanley (2002), focus on the self as a major player in psychotherapy. They define the self 'as a totality of a complex, dynamic and organized system of learned beliefs that an individual holds true to regarding his or her personal existence. It is this self that provides consistency to the human personality (Purkey&Stanley, 2002, 474).

Austin (1968) tries to find an neuro-anatomical substrate for the self.

In the Eastern traditions as Daoism and Chan Buddhism, however, the existence of a separate self is fundamentally questioned. Is there such a thing as an autonomous and independent self? Or is, on the contrary, the self basically connected and interdependent? The answers to these questions have fundamental consequences pertinent to the practice of integrative psychotherapy. They are the focus of this paper.

First, the self will be discussed as it manifests experientially in the introspective self-reflection of therapist as well as of the client, and in the dialogical self-other dimension in their relationship. We will then tap into Buddhist and Daoist traditions to widen our anthropocentric viewpoints and make sense of the dialectics of self versus no-self as exemplified in the discussions of concepts such as the Buddhist deconstruction of self, versus the Daoist cultivation of self.

Finally, the implications and consequences of these viewpoints for an integrative psychotherapy practice will be discussed. Here, we will focus on issues such as self-care for both therapist and client, working with grief and loss in the therapy room, as well as on ethical and ecological consequences for an integrative psychotherapy

The Experienced Self

In Carl Rogers' classical statement from 1957, he points out that, for constructive personality change to occur, 'two persons are in psychological contact (...) the client is in a state of incongruence (…), the therapist is congruent' (Rogers, 1957). Both persons experience their very distinctness and their individual separateness versus the other. Meanwhile, however, this seemingly clear distinction may be obscured. Psychotherapist as well as client may project parts of him/herself onto the other, so that they appear to belong to the other and are not experienced as part of one's self. Furthermore, each of these two, client as well as therapist, may be in a position to avoid certain, and maybe quite essential, parts of his self, which Depestele (2009) calls the other self. So the experienced self – in Depestele's terms 'our usual self' (op.cit.96) – may be only, so to speak, one side of the coin.

Rogers never left his basic assumption of experiencing a distinct and separate self. The notion of a separate self in recent psychotherapeutic approaches, however, has gradually been challenged by some researchers (Markus&Kitayama, 1991; Holdstok, 2011; Cooper&McLeod, 2011; Cooper&Ikemi, 2012). Without referring specifically or in detail to Eastern philosophy, these authors place the concept of self in a cultural context. The independent self is often assumed to be universal, but it may be quite specific to our Western, anthropocentric culture. As such, it determines the very nature of individual experience, including cognition, emotion and motivation (Markus&Kitayama, 1991).

Holdstock (2011) challenges the generalized validity of a Western world view which is embedded in a majority of psychotherapeutic approaches. Though Holdstock does not negate the self as an independent entity, he balances this concept with the self that is interdependent. Based on his studies of African cultures, and of their mutual interdependent social systems, he formulates as a contrast to the Cartesian dictum ('I am because I think'), the African notion of 'I am because I belong' (op.cit., 291). Psychotherapeutic interventions facilitating the individual expression of emotion, may – in a different cultural context – not be therapeutic at all. Holdstock (op.cit., 289) even states, that 'propagation of the individualized notion of the self as the unit of the social system at the expense of interpersonal relatedness can be iatrogenically damaging'.

In a captivating dialogue, Cooper and Ikemi (2012) discuss cultural aspects of the continuum separateness versus togetherness in psychotherapy, where Cooper reflects on a relational stance, and Ikemi offers elements of Japanese culture which foster this attitude. Ikemi describes the impact of culture in this continuum, when he states that "in English, people are separate and identifiable entities. In Japanese, there is always this 'togetherness' in a sense that there are many ways of saying 'I' or 'you'" (Cooper & Ikemi, op.cit.,127).

Eastern philosophies and religions, such as Buddhism and Daoism, offer different insights into the existence – or non-existence – of the self. In Buddhism, the self is deconstructed, in Daoism, the self is cultivated. The dialectics of both approaches offer pragmatic ways to bring these insights towards a tangible, personal experiencing in the therapy room, both in the client and in the therapist.

Buddhism: The Deconstruction of the Self

Historically, the self (Sanskrit: atman) is a reality in Indian, Hinduist thought. It is the 'inner core of things' (Murti, 174,16). It is against this concept of the self that Siddhartha Gautama, the historical Buddha, revolted. His central Buddhist teaching revolves around anatman, no-self. With the exception of very few Buddhist schools, like the Vatsiputriya, and, to a lesser degree, Chinese Buddhist schools such as Ch'an, anatman remains one of the focal Buddhist teachings: sentient beings, persons as well as objects, are devoid of any independent, autonomous and unchanging self.

It is important to note, that anatman is not solely a philosophical but also a psychological concept, highly relevant for psychotherapy practice, because it touches on the fundamentals of our clients' suffering: the affirmation of a self implies the distinction between 'I' and 'other'. Phenomenologically, the 'I' is close to the client, the 'other' more or less distant. In

creating the distinction between self and other, a Pandora's box eventually opens in front of the client. As he/she becomes attached to his own self, the other person(s) is perceived as different, as less familiar, sometimes even as hostile. It is exactly here, that suffering starts.

The Third Zen Patriarch Seng-ts'an (d. 606) (Austin, 1998, p. 700) expresses this poignantly when he discusses the bliss of the 'Great Way' versus the suffering which is enhanced by holding on to a preferred and separate self:

'The Great Way is not difficult for those who have no preferences. When love and hate are both absent, everything becomes clear and undisguised. Make the smallest distinction, however, and heaven and earth are set infinitely apart. (…) If there is even a trace of this and that, of right and wrong, the Mind-essence will be lost in confusion'.

In making a distinction between oneself and the other, the potential groundwork for personal suffering is laid. The 'Great Way', or bliss, opens up to the one who is able to transcend this difference. As will be shown further on, psychotherapy may be of help in this process.

Devoid of essence, the self is, in Buddhist terms, impermanent - what we behold as stable is, in fact, an illusion. Within the practice of psychotherapy, the suffering of loss, death of a loved one, or divorce, are all instances of change and impermanence. The reason for suffering in the client is his attachment to a notion of a stable and distinct self, which is permanent. It is only along a therapeutic path of deconstruction of the self, of awakening to the 'Great Way' through the letting go of the illusion of permanence, that we may reach nirvana. Nirvana means: destruction, in this case: destruction of the self.

Deeply understanding the illusion of permanence may offer our clients new ways of dealing with personal catastrophes. This may be illustrated by the Buddhist psychology concept of the five skandhas.

Here, man is described as consisting of the five skandhas (skt. heap or group): body, feelings, perceptions, impulses and emotions, acts of consciousness. All these are empty and without permanent substance. During our lifetime we are no more than a passing and momentary collection of these skandhas, and as these change, so does their composition. Death does not fundamentally alter this process. Death means a change and dissociation of these skandhas, which will combine into ever different aggregates. The modern Buddhist teacher Thich Nath Hanh (oral communication) uses a beautiful metaphor as an illustration of 'death', which may well be used within the therapy room: the therapist strikes a match, a flame appears. Then he blows out the flame and then lights a new one. He asks the client where the first flame has gone. Is the first one different from the second flame?

Another of Hanh's metaphors is a cloud. If the circumstances are favorable, the cloud appears. If the circumstances change, the cloud disappears…only to appear, when the moment is right, as being transformed into water, mist, or ice.

Unlike the anthropocentric West, where man forms hierarchically the head of a pyramid, in the East, and certainly in the Mahayana Buddhist Schools, phenomena are not conceived as distinct and in a hierarchical order, but as arising in a mutually interdependent web of cause and effect, a dynamic which is called 'dependent origination'. The self is causally dependent, as part of a causal and conceptual flow (Williams, 2009, p.69). In fact, all phenomena are interdependent, in other words, ultimately there is no demarcation between an 'individual' and the 'environment'. Each of our acts impinges on all beings in a fundamental non-separateness. Clinging to the idea of a separate self, which includes clinging to one's body, leads to suffering of oneself and of other beings.

Daoism: The Cultivation of Self

The dialectics of deconstruction and of cultivation of self offer a constructive perspective for psychotherapeutic practice. In contrast to early Buddhism, Daoism is more focused on the cultivation of self. This practice, relevant to our psychotherapeutic work, is based on the following considerations.

Historically, Daoism precedes Buddhism by about 3000 years. With Buddhism's advent from India to mainland China, Daoism, next to the Chinese philosophy of Kung Zi (552-474 BCE), greatly influenced the imported religion, which became known as Ch'an (lit. contemplation, Japanese: Zen) Buddhism. Both Daoism and Buddhism share a unifying world view, where anthropocentrism does not belong. In Daoism everything is part of the Dao – the self is overflowing (Kohn, 2011), it is everywhere. The Dao (lit. way) is seen as the all-embracing first principle, from which all appearances arise (Schuhmacher & Woerner, 1989). In Daoism, the self is not deconstructed – in Daoism it is cultivated. What does this mean?

As in Buddhism, the self in Daoism is not an independent and separate entity. It does not exist, like all phenomena, as distinct. Instead, the overflowing self (Kohn, 2011) is part and parcel of the universal Dao. Considering the serious linguistic difficulties in translating ancient Chinese abstract concepts into Western terminology, it seems warranted to state that in Daoism the experiential sense of self – as a universal human embodied experience – is affirmed. While essentially interwoven and interdependent, nonetheless the self is individually experienced as an embodied self and as such it does have its unique boundaries. Within a clear and reflected awareness, dynamic patterns of change, of transformation and of interdependence are realized. This embodied or incorporated self deserves to be cultivated. In a macroscopic perspective, the human body is likened to the country: the government has to take care of the country like one has to take care of one's body. The fundamental role of the human body is indeed the very heart of Daoist thought (Schipper, 1993). Keeping the body healthy and preserving its harmonious functions (Engelhard, 2004, 74) is a focal Daoist concern.

In psychotherapy too, this should be a focal concern. A healthy lifestyle is a relevant theme both for client and therapist. Self-cultivation or self-management by the psychotherapist helps him to avoid the pitfalls of mental and physical burn-out. Cultivating the embodied self is instrumental in the prevention of illness (Tophoff, 2013). The same holds true for the client. Frequently, he presents symptoms of stress-related conditions. Learning to cultivate his embodied self – self-care or self management – will enable him to better cope with stressful life events.

Implications for an Integrative Psychotherapy

The dialectic integration of cultivation as well as deconstruction of self as reflected in Daoist and Buddhist teaching, can have profound implications for the practice of integrative psychotherapy. This will be illustrated by focusing (1) on self-care or self-management for both psychotherapist and client, (2) on working with grief and loss in the therapy room, and (3) on interpersonal and ecological consequences for an integrative psychotherapist.

(1) Caring for the client must be preceded by caring for oneself. It is not only the client who has to learn how to cope with tension, stress and anxieties, the therapist, too, has to deal positively with these issues in order to stay healthy, mentally as well as physically. The cultivation of the embodied self is, self-management, and is of equal importance to the psychotherapist, as fostering ways of self cultivation in his clients.

To enhance healthy functioning of the embodied self, methods originating from Daoist traditions, deserve a legitimate place within the repertoire of integrative psychotherapy. These methods primarily include the training of mindfulness. Mindfulness is the prerequisite for a conscious and receptive openness to one's day-to-day experiences. Thus it is the essential core of self-management. Clients may be trained in mindfulness through methods as developed by Kabat-Zinn and co-workers (Kabat-Zinn, 1996). Another way of mindfulness training is Sensory Awareness, as developed by Charlotte Selver (Tophoff, 2006). Both methods can be well integrated within a psychotherapeutic treatment. The method of Sensory Awareness fosters, within the client, an attitude of truly sensing what is needed by his organism. Only from this perspective can the client begin to acquire possibilities to understand and,possibly, to fulfill these needs.

Exercises in natural breathing may also be part of the integrative psychotherapist's repertoire.

Sensory Awareness offers many of those breathing exercises. These consist of teaching the client to allow breathing as it wants to be, instead of forcing or trying to regulate it. In this way, focus on breathing helps the client to stay in the here-and-now (or to return to it), instead of fantasizing about past or future.

Self-management in therapist and client within the process of an integrated psychotherapy may also be greatly enhanced by the practice of meditation (Tophoff, 2013), which is rooted in Buddhism and in Daoism. The beneficial effects of meditation have been widely demonstrated (e.g. Delmonte, 1884; Speca et al.2000; Hölzel et al.2011). The therapist may teach the client the simple practicalities of sitting, walking or standing meditation. Therapist and client may meditate together, or incorporate a twenty-minute timespan of meditation into their daily routines.

Self-management for therapist and client implies also (the teaching of) a healthy lifestyle, functional in the prevention of illness, such as healthy eating habits.

2) Loss of a beloved person and grief are themes often encountered in the therapy room. An integration of Buddhist and Daoist concepts on loss and on dying offer relevant support for the integrative psychotherapist. Leijssen (2008, p.220) shows how encountering sacred aspects of human life is one of the critical elements of good psychotherapy. One of these aspects of human life is death. Death and death related events are themes which are frequently actualized in integrative psychotherapy. In working with the integrative psychotherapist, the client - and may be even the terminal client facing death - may be assisted in reaching the phase that 'when (he) own(s) what is really felt, (his/her) body connects to a Larger Body and it shifts into a new space' (Leijssen, op.cit. 222). In other words, the self is transcended towards a unison of self and cosmos. This implies two things.

First, a readiness to let go of the concept of an independent, separate and permanent self, as in Buddhism. Second it implies the competence of the person in approaching death as a healthy person: the cultivation of self, as the Daoists say, is done, as Schipper (1993, 214) succinctly describes, 'in order to remaining alert, master of oneself, upright and lucid – to enter life with a firm step, and leave it with an equally firm step '(My italics).

The therapist will assist the client on the journey of gradually letting go of the concept of a stable and permanent self, in order to come to appreciate his self as fluid and impermanent, ever changing, ever transforming, like the cloud or the flame. At the same time, the client's awareness of what is in the here-and-now will help him to enjoy the qualities of the moment. Within the context of self-management and insight into the impermanence of one's self, eventually a healthy dying becomes an option.

(3) Interpersonal and ecological implications for an integrative psychotherapist are also contained in the self versus no-self dialectics. Buddhist and Daoist teachings emphasize interdependency, connectivity and the transcendence of the independent 'I' – (independent) 'Thou' paradigm. In interdependent origination, as we have seen, the self is essentially and fundamentally connected not only with all sentient beings, as in Buddhism, but with all of our environment, all of nature, all of the cosmos, as in Daoism. This has profound consequences. First, interdependent connectedness precedes individual difference, the 'we' precedes the 'I'. In marriage counselling, to give but one example, it is more helpful to first look for similarities and commonalities between partners, than to start off with differences.

Second, interdependent connectedness has ethical and ecological consequences, relevant to the integrative psychotherapist. In Daoism caring for the embodied self is equated with caring for the people. In Buddhism, no separate self exists, which implies deep solidarity with other beings which are not seen as separate from us. Caring for the environment thus is not just an external obligation, but the natural result of a deep understanding. Thus, in working with a client, the integrative therapist is aware of the context of his interventions, and he is conscious about their social and ecological consequences. Virtuous behavior in the Daoist sense, is not based on external rules, but on deeply and mindfully seeing, hearing and understanding the nature of interconnectedness. In striving purposefully toward realizing Virtue, man

and Virtue are separated (Tophoff, 2003; 2007). Thus the Daoist philosopher Lao Zi states: 'The more laws are promulgated, the more thieves and bandits there will be' (Waley, tr., 1958, p.211). In this sense, the integrative psychotherapist has a responsibility that transcends the intimacy of the therapy room.

Conclusion

Contrary to an anthropocentric world view in psychotherapy, the dialectic integration of the Buddhist deconstruction of self and the Daoist cultivation of self within integrative psychotherapy, leads toward emphasis on self care and self management of both therapist and client in order to be able to cope with stress and stress related diseases. Furthermore, the dialectic integration of self and no-self offers support to the integrative therapist when he has to deal with loss and grief in the therapy room. Finally, it helps him understand the social and ecological context of his interventions.

References

Austin, J.H. (1998). *Zen and the Brain.* Cambridge: M.I.T.Press.

Cooper,M.&Ikemi, A.(2012) Dialogue: A dialogue between focusing and relational perspectives. *Person-Centered & Exp. Psychotherapies, 11:2, 124-136.*

Cooper, M. & McLeod, J. (2011). Person-centered therapy: A pluralistic perspective. *Person-centered & Experiential Psychotherapies, 10:3,210-223.*

Delmonte, M. 1984. "Physiological Responses during Meditation and Rest." B*io-Feedback & Self-Regulation, 9. 2: 181-200.*

Depestele, F.(2009). From Symptom to Self in Experiential Psychotherapy. *Person-Centered & Experiential Psychotherapies, 8:2, 94-108.*

Engelhart, U.(2004). *Longevity Techniques and Chinese Medicine.* In: Livia Kohn (Ed.) Daoism Handbook, 2004, Boston-Leiden: Brill.

Evans, R.L.(1975). *Carl Rogers, the Man and his Ideas.* New York: Dutton.

Holdstock, T.L.(2011) Towards a paradigm shift in the person-centered approach. *Person-centered & Experiential Psychotherapy, 10:4, 286-298.*

Hölzel, B.K.et al. 2011. How does Mindfulness Meditation work? Proposing Mechanisms of Action from a Conceptual and Neural Perspective. *Perspectives on Psychological Science, 6.6:537-59.*

Kabat-Zinn, J. 1996. *"Mindfulness Meditation: What It Is, What It Isn't, and Its Role in Health Care and Medicine."* In Comparative and Psychological Study on Meditation, ed. by Y. Haruki et. al., 161-70) Delft: Eburon.

Kohn, L. (2011). *Living Authentically, Daoist contribnutions to Modern Psychology.* Dunedin (Fl): Three Pines Press.

Leijssen, M. 2008. Encountering the Sacred: Person-centered therapy as a spriritual practice. *Person-Centered & Experiential Psychotherapies, 7:3, 218 – 225.*

Markus, H.R. et.al. 1991. Culture and the self: Implications for cognition, Emotion and motivation. *Psychological Review, 98(2), 224-253.*

Murti, T.R.V. 1974. *The Central Philosophy of Buddhism.* London: George Allen and Unwin.

Purkey, W. W. & Stanley,P.H. 2002. *The Self in Psychotherapy.* In: Cain, D. J. & Seeman, J. 2002. Humanistic Psychotherapies: Handbook of Research and Practice. American Psychological Association.

Rogers, C.R.1957. The Necessary and Sufficient Conditions of a Therapeutic Personality Change. *Journal of Consulting Psychology, 21, 95-103.*

Rogers, C. R.1961. *On Becoming a Person.* Boston: Houghton Mifflin.

Schuhmacher, S. et al. 1989. *The Rider Encyclopedia of Eastern Philosophy and Religion.* London: Rider Books.

Schipper, K. 1993. *The Taoist Body.* Berkeley: University of California Press.

Speca, Michael et al. 2000. "A Randomized, Wait-List Controlled Clinical Trial: The Effect of a Mindfulness Meditation-Based Stress Reduction Program on Mood and Symptoms of Stress in Cancer Outpatients." *Psychosomatic Medicine 62:613-22.*

Tophoff, M. 2003. *Chan Buddhism: Implication of Awareness and Training for Managerial Functioning.* Destelbergen: Cartim.

Tophoff, M. 2006. Sensory Awareness as a Method of Mindfulness-Training within the perspective of Person-centered Psychotherapy. *Person-centered & Experioential Psychotherapies. 5:2.*

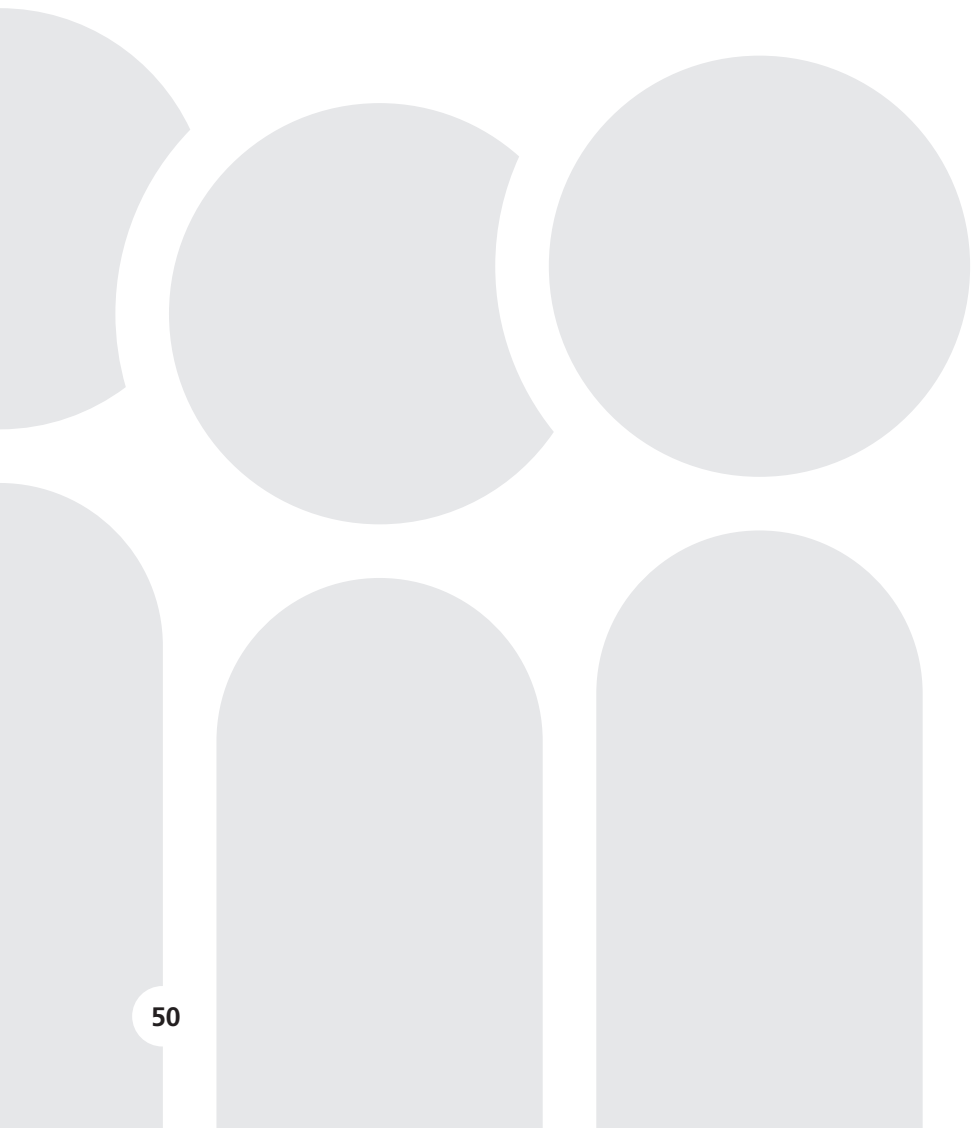
Tophoff, M. 2007. The Ethics of Knowledge and Action in Postmodern Organizations. *Journal of Buddhist Ethics, 14.*

Tophoff, M. 2013. Daoist Principles in the Martial Arts: their Relevance for Illness Prevention. *Journal of Daoist Studies, 6, 161-175.*

Waley, A.(tr.) 1958. *The Way and its Power.* New York: Grove Press.

Williams, P.2009. *Mahayana Buddhism: the Doctrinal Foundations.* London/New York: Routledge.

Dr.Michael M.Tophoff, clinical psychologist and a State licensed psychotherapist, received his Ph.D. at the University of Utrecht. He undertook postdoctoral training in psychotherapy and group processes in the USA and in Japan. He heads the Center for Psychotherapy N.Holland. Dr.Tophoff teaches Conflict Management at the Business School of the University of Amsterdam. He has published internationally in the fields of Psychotherapy, Mindfulness, Buddhism and Daoism, Health Care and the Martial Arts.



David Zigmond

Physis: Healing, Growth and the Hub of Personal Continuity of Care

A thirty-nine (39) year delayed follow-up correspondence with Sally

Explanatory Introduction

Occasionally benign coincidence far exceeds mere serendipity, as if the cosmos has somehow read and responded to our intent. Receiving the letter was one of those occasions: its primally evocative and illustrative power far exceeds its apparent brevity and plain speaking. This needs some explanation.

First the Stage

For several years I have been increasingly resolute in pursuing qualitative research into the nature and significance of personal continuity of healthcare. I have been led to this by witnessing and enduring the consequences of its progressive loss, especially in the latter third of my professional lifetime. From this has come some understanding. For example, much of this involution derives from the fact that relationships are more difficult to code, manufacture, manage, quantify and research than, say, drugs or physical procedures. This is a conundrum. Rather than acknowledging its difficulty we have instead worsened it by creating something of an academic (then economic and administrative) oligarchy from the 'safer' confines of more easily codifiable and quantifiable research and knowledge – the Shibboleths of 'Evidence Basis', a kind of nouveau riche Ruling Class. This newer and narrower culture then often wreaks blind damage because subtle, and thus less measurable, aspects of care then become liable to indifferent neglect or, worse, rationalised hostility and exclusion. In this arena of collateral damage the loss of personal continuity of care is one of the most important and egregious examples. When I was a young practitioner I was encouraged to develop and nurture this earlier longer-term and personal approach. I did not then perceive the probability of its extinction.

Now, the Events

I am perusing a letter, one of many: there are always more. My eyes scan for the sender, semi-consciously, to decide on priority and degree of attention. The name galvanises my distant memory. I then search for other details, to confirm my guess: it is correct.

I have not heard from Sally for thirty-nine years. My visual memory quickly yields her face, its expressions, thence to her mien and spirit; I remember a very sensitive, melancholic and intelligent young woman struggling with her own shadows, intensity and complexity. I cannot remember anything more precise about her symptom-constellation, or her life or family history. I suppose she would be called 'Chronic severe depressive dysthymia': a more adventurous psychiatrist might also risk 'underlying conflicts and struggles with identity formation'.

As I write this I have not refreshed, checked or garnered more details: the account is thus fresh but unrefined. My recollection is that my encounters with Sally spanned about three years and were located in three consecutive Greater London hospitals. I was then a young trainee psychiatrist, very interested in unproceduralised influences of healing. I was certainly receptive to psychotherapeutic ideas but had not (yet) any training. I was only marginally older than Sally and not that differently endowed with resources and problems. I knew this but was able – with care – to sequestrate 'it' but not myself: our roles were then clearly different – our selves and existential predicaments were not. Her letter, after four decades, indicates a further convergence of our common humanity.

Sally's letter is a pithy personal testament of great power and – I believe – importance to all healthcare professionals. Her clear and candid account is suffused with many themes, all of which merit long thought and discussion. I certainly will not attempt to designate these all for the reader, but instead here briefly highlight themes from the cultures of care that include yet transcend we two individuals.

For me, most remarkable is the evidence of how, in those previous decades, we were able to create imaginative, sensitive, flexible services. The best of these could, and did, then deliver a much more substantial person-centred continuity of care. For several years I worked with such services: they are now very rare. I remember my supervisory consultants being accommodating and encouraging to provide the flexibility of arrangements, space and time for this therapeutic relationship (and others) to run its course and bear its fruit. This was possible because there were, then, far fewer diktats, rules and bureaucratic obelisks stymying autonomous, responsible judgements of wisdom and experience. In those days coded and hegemonic psychiatric diagnosis was far less important than personal connection and understanding; care often proceeded down unmade tracks rather than prescribed tarmacked, generic Care Pathways; care was often a delicate dance improvised between individuals rather than an institutional march decreed by academic or administrative committees.

Sally today would be most unlikely to find such continuity of personal containment and accompaniment in any NHS Psychiatric (not Psychotherapy, remember) Services. What she then received may now seem extraordinary, but it was not uncommon then. I am saddened not just for patients, but also for the working welfare of current doctors: few, if any, will have the licence or latitude for such broad, deep or long contact with individuals, or garner the humanly profound and lasting satisfactions.

Some will say that we cannot now economically afford such bespoke services. I do not agree: such care is much cheaper than the kind of anomic, multi-disciplined, multi-teamed approaches that flounder with great expense and poor personal connection in the current NHS. I see this regularly and spend much of my professional time trying to repair the damage. If we do not make good human sense to one another, economic and human costs are much higher.

Sally's letter was a kind of dramatic oxymoron – a shock from the anciently familiar: amidst my current healthcare concerns it rapidly crystallised into a welcome and edifying sense. For the outside reader its private significance for us both is easily imagined. This will produce many individual resonances. Many may identify Agape: non-erotic, unpossessive, unidealised love that is probably essential to Physis. The institutional and cultural themes invite opportunities for reflection that should not be missed: hence this invitation to greater readership. After contact and discussion with Sally she agrees. This is thus a documentary presentation, and to anchor authenticity real names are used.

I have attached my reply to her largely for human interest.

The correspondence is unedited, apart from the omission of addresses. Claybury refers to Claybury Hospital, then a large psychiatric hospital in suburban East London. It closed about twenty years ago

Letter 1

3 June 2013

Dear David Zigmond

Back in the 1970s I was a patient of yours. At first an outpatient at North Middlesex Hospital and then I became an inpatient in Claybury.

I met John at Claybury and although at the time many people advised against us getting together, we went on to have a happy 30 years. Like everyone we had our ups and downs, had three great kids, Rachel, Paul and Natalie, and now three lovely grandchildren too.

He died 3 days after that anniversary in 2006. I continued my long career in nursing which has changed so much from those early years and in the last decade I focused on palliative care which was more in tune with my own values and beliefs on patient centred care. I retired last year as all the NHS changes finally wore me down!

I'm writing not to just tell you all this information but to let you know what a difference you have made to my life. You really cared, you made me feel like I was important, not just another NHS patient. You listened and believed in me. I don't often talk about that time to many people, but when I do I say how you made me feel safe and I believed that you wouldn't leave me – and you didn't. I left and never told you what a big impact you had on my life and that I knew I would never sink into those dark depths of depression again, I felt healed. That experience influenced every area of my life and work and the person I became.

Radical changes have taken place in mental care over the years but it wasn't just about the system, I was so fortunate to have had you as my Doctor. I don't know how difficult it was in those days to keep me as a patient when you moved hospitals, but you did and it made all the difference. I've never forgotten, it's just taken me a long time and before any more time passes, I just want to say a heartfelt 'Thank you, you saved my life'.

Best wishes

Sally Baynes (Davies)

Letter 2

15 June 2013

Dear Sally

Thank you so much for your candid and unsentimentally heartfelt letter.

I very quickly recalled your face and your spirit though, interestingly, I cannot remember your 'clinical' details, your 'history'. It is instructive, what we retain of one another.

I find your letter remarkable for the span of time you recall and the unaffected clarity and veracity of your account. I am deeply gratified and moved that the 'cuttings' I offered you so long ago were cherished, planted and nurtured by you and have steadily borne fruit, over a lifetime. In parallel it has been my conviction, over my working lifetime, that this kind of activity should often lie at the heart of what we do for one another. In these realms most damage and most healing is human.

It sounds to me as if your 'recovery' has gone far beyond the medically mapped realms of 'symptom relief' and 'good clinical outcome'. You indicate that most wondrous and humbling transformation: you have turned your painful burden into a compassionate and healing gift, for yourself and others. It seems that this has cascaded through your marriage to two generations of family, and beyond that to your many recipients of palliative care nursing. All of this is heartening for me, too: our healing and nourishment of one another is often unobvious.

But there are shadows, too, where I also wish to join you. You refer to your 'patient-centred values and beliefs … being worn down', leading to your retirement (from the NHS). Likewise, your reference to 'radical changes in mental healthcare' making your own previous healing experiences most unlikely now. I resonate with this: such concerns are at the centre of my vocational life.

We are here different in our adjustment: you have expediently retired to your more accessible gratifications of family and grandchildren; I remain contentiously engaged with heroic obstinacy, possibly because I do not yet have grandchildren (though the social and biological machinery looks promising).

It seems that as we get older we find solace and peace in a few simple and timeless maxims: 'Counting our Blessings … Seeing

what is there, not what is not …'. Simple to say, yet often so difficult to live by. It sounds as if you have managed a great deal.

Your letter has particular and intense value for you and I. But I think it has messages that are universally important, especially for healthcare workers. What you talk of lies before, behind and beyond all trainings, texts, systems, manuals, data and codes which now weary and alienate so many.

With suitable safeguards, could we publish these letters?

Whatever your reply I have found it deeply satisfying to have heard from you in this way: such communications give great difficulties even deeper meaning.

With warmest wishes

David Zigmond

Interested? Many articles exploring similar themes are available via David Zigmond's home page on www.marco-learningsystems.com

David Zigmond would be pleased to receive your feedback.

Michelle Bearman

Practising as an Integrative Psychotherapist

Editor's Note

This material constitutes the theoretical section of a dissertation submitted to meet part of the requirements of the MSc in Integrative Psychotherapy at Metanoia Institute/Middlesex University. The student is required to give her own framework for integrative practice.

A.1: An Introduction to my Integrative Model

"Human beings relate to each other not simply externally, like two billiard balls, but by the relations of the two worlds of experience that come into play when two people meet" (Laing, 1967, p.53)

I quote Laing as his view informs my practice as a relational psychotherapist. I see the relationship as co-created between client and therapist. My integrative model is a living organism, not a fixed structure. It is flexible and open to new learning, including that of clinical experience, related research and experiences of continued professional development. The shift over time is subtle. What I present here is my current way of being as an integrative therapist.

At the centre of my integrative framework is a relational core from which my integrative model flows. I hold in mind that past experiences influence the present and integrate developmental theories such as Bowlby (1969) and Stern (1985) that emphasise the early interactions with significant others that impact the development of self across the life span. I am influenced by Schore's (2003a) neuroscience research that emphasises the importance of attachment on the developing infant thus determining the capacity to regulate emotional states.

I believe my way of being with the client enables me to be open to the uniqueness of each individual, not only as the person presented in the room, but also within their multi relationships within society, including their cultural identity. I view the therapeutic relationship as an inter-subjective dialogue, two live organisms in the room – client and therapist – two subjectivities who, by meeting and conferring, can co-create meaning that can lead to an expansion of understanding and personal growth (Stolorow and Atwood, 1992). These theoretical concepts are held in my integrative model and are united by the contact between them, which encourages an open dialogue that stems from my curiosity. I view the healing component of therapy as fundamentally embedded in the relationship.

A.2: Philosophical Assumptions and Values Informing My Practice.

My philosophical assumptions are influenced by humanistic and existential values. Human beings live in a relational world. Yes we are individual, but we need others in order to develop across our life span. This in turn helps shape and defines our identity, thus giving meaning to our existence (Laing, 1967; Yalom, 1980). The therapeutic relationship echoes this social dynamic. The therapist and the client are mutually influenced by each other and therefore

both are participants in the co-creation of the relationship that occurs between them (Stolorow and Atwood, 1992; Laing, 1967).

This concept of co-creation complements my humanistic values of respect and the need for a non-judgemental approach. These beliefs arise from my personal experiences of being of mixed race origin and culturally different from the majority. Equality is a passion that is rooted deeply in my integrative framework. Each client deserves respect and dignity for their difference and diversity. I do not know their world or their experience yet I can be aware of the impact of their culture that in turn can shape thoughts, behaviours and belief systems and their interpersonal relationships (Lago and Thompson, 1996; Kareem, 1992). I attempt to look beyond my own assumptions and the prejudice of others by expanding my vision.

I am aware that humans can be cruel and destructive to self and others, as well as being tender and loving. I understand disruptive behaviour can be a form of communication that cannot always be spoken. In my opinion behaviour is acted out in various forms and is often judged negatively by society. The negative response, like the behaviour, often widens the gap and the opportunity for effective communication is lost.

I see people as doing the best they can to survive life. A client's world is not entirely foreign to mine, as I too am human; imperfect, living in an imperfect world. I understand the struggles of mankind as universal, and I believe anxiety is a widespread phenomenon. It is not sympathy I embody in my philosophical values, it is a compassion for humanity (Gilbert, 2005).

A3: A Personal View of Human Beings

A.3.1: Human Motivation

I regard the core of human motivation as a collection of relational strands whose overall aim is to increase the chances of survival, for the individual and for the species as a whole. For me there is a shared need, which is to be in relation with others as well as a need to be true to one's selfhood. This thinking complements my view that human beings are complex social mammals, individually unique and biological in nature. I see each of these aspects as being influenced by the multiplicity of relationships in life, self to self, interpersonal, societal and cultural. I share Barrett-Lennard's view that relationship is "the primary medium of human life" (2005, p.xi). I agree with Bowlby (1969) that it is in our biological nature to seek proximity to others for added security and safety. However, I also bear in mind that attachment does not necessarily mean a safe base. I concur with Main and Solomon (1986) that the desire to attach to another is so strong that human beings will attach to others even though they may be cruel and destructive to their well-being.

I believe that human beings are motivated to grow even in the bleakest of conditions (Rogers, 1961). People will do their best to survive and cope by adapting to the surrounding environment. I agree with Rogers (1961) that this "actualising tendency" is biological in nature. I feel that alongside this need to adapt is an internal longing to be authentic. This, for me, relates to Stern's concept of human beings as having the "desire to be known and share what it is like to be them" (Stern, 2004, p.97). I also believe that as human beings we are motivated by a desire to make sense of our experiences especially in a "world devoid of intrinsic meaning" (Yalom, 2001, p.133). When meaning is vague or absence we can lapse into ontological insecurity (Laing, 1967) that if prolonged can lead to psychological and physiological distress. (Stolorow, 2007).

To summarise briefly my integrative model consist of a collection of motivational forces that are primarily relationship seeking, a desire to be authentically known by others and self, alongside a search for meaning of life experiences. I believe that these strands interweave and exist throughout a person's life span.

A.4: Developmental Considerations

In my integrative framework a sense of self is not developed in isolation but rather through the relational matrix of connection and disconnection with significant others especially in the primary years. I concur with Stern (1985)

that an emergent self is present from birth. I view the emergent self as being determined by genetic history, personal temperament and will further unfold and develop in response to the conditions of the environment, by this I mean primarily the responsiveness of the care givers in relation to meeting the infants needs and mental states. As Stern (1985) emphasises, this early phase of life for the infant is a world without an understanding of words, leaving the infant to be reliant on sensory motors for the communication exchange.

This early relationship between adult and infant is a dance of self-discovery for the infant. It is though the reciprocal interaction of early relationship that the infant can begin to know a sense of self. This is often communicated through a variety of actions such as touch, handling, tone of voice and the mutual gaze between mother and infant. For optimal development these "vitality affects" (Stern, 1985), need to be cued by the infant and the mother needs to be able to pick up and respond timely to the cue. This is how the mother attunes to her infant sensing the infant's need often in an intuitive way.

Affective attunement provides a regulating other that encourages the infant in time to develop the capacity to self soothe emotional states which in turn I believe is "the essence of self-organization" (Siegel, 1999, p.279). However, attunement does not mean never making mistakes. The mother needs to be able to manage ruptures and repairs (Beebe and Lachmann, 1998). These researchers remind me that rupture and repair are necessary for the full potential of development. It is in these moments when disconnection happens and is repaired that the infant in time builds an internalised sense of safety. These repetitive moments become templates for "representations of interactions that have been generalized" (RIGS) (Stern, 1985). I view RIGS as similar to Bowlby's "internal working models" (1969), which in turn become the building blocks of "knowing" or "implicit relational knowing" (Lyons-Ruth, 1998), an unconscious reference map on how to gauge being in relationship with others, self and the world.

An environment that can be trusted by the infant encourages a sense of inner security in which one's full potential can be developed (Bowlby, 1988; Erickson, 1985; Stern, 1985). The interpersonal connection, as Schore (2003a) and Siegel (1999) have highlighted, influences the developing brain in infancy, in turn affecting the capacity for physical, social and psychological life.

I believe that resilience is strengthened in the early years of life through the provision of interpersonal relationships that foster a secure sense of self. Bowlby's concept of "the secure base" (1988) or "the good enough mother" (Winnicott 1958) encourages resilience and enables the development of "mentalization" (Fonagy et al, 2004). Mentalization is a reflective process that implicitly and explicitly interprets self-actions and that of others to become "a key determinant of self-organization and affect regulation" (ibid, p 23). The more that one is able to engage in this function of self and other reflection the more one can reduce the risk of creating maladaptive coping strategies, such as an alternative style of attachment as a way of managing the discordance in the relationship. As well as the secure attachment Ainsworth et al (1978) identified the anxious-avoidant, and anxious ambivalent attachment styles. A fourth category identified by Main (1981) as disorganized-disoriented attachment that is often associated with a history of profound trauma. These attachment styles are discussed in more detail in section A.5.2.

A.5: Concepts that Inform My Integrative Problem Formulation

A.5.1: Dysfunction

This being human is a guest-house.

Every morning a new arrival.
A joy, a depression, a meaness,
Some momentary awareness comes
As an unexpected visitor.
Welcome and entertain them all!

Rumi (2005, p 19)

Rumi's words remind me that human beings are emotional beings. If all goes well in our primary relationships we develop, as I discussed earlier, a secure sense of self and have the capacity to

manage the emotional states that are part of our human biology. Dysfunction in my view impairs our ability to self regulate emotional and mental states, and if prolonged can lead to dysregulation (Schore, 2003a). I am influenced by Masterson (2005) that dysfunction arises from a combination of "nature, nurture, and fate" (p.15), which I understand as personal temperament, early mis-attunement leading to dysregulation and experiences of loss or separation such as death or divorce. I believe that in distressing moments "affect states can be grasped only in terms of the relational systems in which they are felt… affect becomes traumatic when the attunement that the child needs to assist in its tolerance, containment and integration is profoundly absent" (Stolorow, 2007, pp.3-4). The infant is left to manage emotional states that are outside their maturity to do so or in Siegel's terms his "window of tolerance" (1999, p.253). For me the core of dysfunction arises from repeated failure in the early attachment system to provide a regulatory other (Schore, 2003b). In response the infant develops an insecure attachment towards the caretakers in his primary environment.

A.5.2: Developmental Derailments

Insecure attachment styles reflect the nature of parenting. The anxious-avoidant child develops in response to an unresponsive caretaker. In a barren world of love and affection the child learns to limit expression of emotional needs as a way of maintaining distance attachment. (Holmes, 1993; Siegel, 1999).

A child with an anxious ambivalent style grows out of relationship with a caretaker who over time has demonstrated an inconsistency in his parenting. The child adapts away of being that shows itself in clinginess, an inability to tolerate separation and therefore impeded capacity to engage in exploration due to a preoccupation with the caretaker. (Ainsworth et al, 1978).

The disorganised-disorientated attachment style experiences the caretaker both as a safe and as a fearful base. This reminds me of being "caught between a rock and a hard place". Main and Hesse describe the child experiencing "fright without solution" (1992).

When caretaking in the early years is consistently unreliable in meeting the needs of the developing child I believe the child engages in processes such as splitting, or as Laing (1969) says divisions of the self. The child is pulled to adapt to ways of being which are acceptable to others and the world (Rogers, 1961), yet in doing so becomes divorced from the original self (Moore, 2000) or as Winnicott (1965) terms develops a false self. However I do not like the use of "false" which for me carries judgemental overtones. I prefer to see the self that is presented as the "permissible self" the parts of self that were viewed as acceptable by others in early relationships and have now become dominant in presentation. That is no less false than the self that is hidden.

A.5.3: Effects of Trauma

I believe that no human being is immune to trauma it is "an essential part of being human" (Van der Kolk et al, 1996, p.3). However not all trauma becomes traumatic. The provision of a supportive enviroment fosters a secure sense of self that provides a buffer for managing these stressful events. The effects of trauma impact psychologically, physically, and interpersonally. The various degrees of individual responses to traumatic events depend on the person, their history, present circumstances and the quality of support available in the environment around them following the event (Herman 1997; Stolorow, 2007; Siegel 1999).

A.5.4 Childhood Trauma

In childhood cumulative traumatic experiences contributes to the developing personality in negative and positive ways (Herman, 1997). The constant struggle with attempting to manage an environment that is neglectful or abusive to a child leads to an imbalance in her emotional states. The preoccupation with survival affects the capacity to simply 'be' with others. It is difficult to respond to others in an empathic way or even to receive empathy (Van der Kolk et al, 1996). Attention span is often short lived which makes it increasingly difficult to take in new information. A child that lives in a frightening world resorts to a shut down operation – "a severe constriction

and narrowing of the horizons of emotional experiencing" (Stolorow et al, 2002 cited in Stolorow, 2007 p.4). I believe that when the unbearable affect is unmanaged it can lead to what Schore (2003a) describes as "affect dysregulation". In early trauma this will have an impact on the developing infants capacity to be able to mentalize (Fonagy et al, 2004).

I believe in its severe form the effects of trauma present on a continuum from personality traits to disorders, in its severest form psychosis. The origins can be traced back to failures in the empathic responses within the early attachment system. When I was in my psychiatric placement I witnessed many patients experiencing psychosis. A large majority had a history of addictions to substances. I concur with Flores (2004) and view addictions as an attachment disorder. In my clinical stance I am mindful that the drug of choice is a significant relationship that will involve feelings similar to protest, separation anxiety, related to Bowlby's (1969) considerations on attachment and loss.

I believe psychosis is an attempt to retreat from an actual interpersonal world that has failed empathically (Stolorow and Atwood, 1992). Whilst psychosis creates a barrier to contact, I am interested in Laing's view that a form of communication remains if only we are willing to listen and engage with it (Laing, 1967). I believe when the immediate environment fails to attend to a person, wider society in the form of institutions such as psychiatric hospitals and prisons generally will do so. I believe insanity is feared in the same way as murder, and other misunderstood behaviours. At a deep level I feel it touches within us all a deep knowing that given particular circumstances any of us could be capable of enacting these ways of being (Kearns, 2005) that are "universally human" (Benjamin 1996, p.3). I view these ways of being as the best or the only solution that one could find to survive in environmental conditions that were far from favourable.

A.5.5 Diagnostic Considerations

When I am considering a diagnosis I am mindful of Gilbert and Orlan's view that "any 'diagnosis' [is] a 'tentative hypothesis' open to regular revision, and not a 'label for life' that categorizes a person forever after" (2011, p.102). Which chimes with my humanistic value base.

I draw on Johnson's (1994) model of character styles, as it is complementary to my integrative framework. Johnson demonstrates how early development and life experiences influence developing character styles. He also shows how persistent environmental frustrations can lead to the formation of personality disorders. For me his concept humanises people's experiences and encourages me to look beyond a label, reducing the possibility of judgemental acting out on my part.

An empathic approach is also emphasised in the Masterson approach (2005), which is an integration of object relations, attachment and neuroscience. I am drawn especially to his writings on the "borderline" presentation and his ideas on 'abandonment depression', which is when clients fall into a depressive state following either actual or perceived threat. The client can become reliant on satisfying the needs of others as a way to avoid the agony of abandonment. His approach gives me useful information that in turn encourages me to empathise and hold the necessary boundaries in the therapeutic frame that he deems as crucial for effective therapy. He stresses the need to empathise with the hidden self, because to empathise with the "permissible self" alone would stunt growth and change.

I am also influenced by Benjamin's model (1996) of interpersonal diagnosis and treatment, which again serves as a map for diagnosis and implications for therapy. I do struggle with aspects of the medical model such as the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition Text Revision) (APA, 2000), which to me appears as judgemental and misses the idiosyncrasies of being human. However it can be valuable as a reference to help identify criteria especially for Axis I and Axis II, which I utilise to provide a tentative signpost to treatment planning.

A.6: My Practice as an Integrative Psychotherapist.

This section focuses on the different relationships within the therapeutic relationship. Although separated out here to allow for

discussion, I view them as interweaving although at times one will be more figural than the others, depending on the need of the client.

A6.1: The Process of Change

I hold the view that the process of change begins with the client's awareness that something is out of line with their sense of being in the world. This may be something specific and known to them, for instance substance use, anxiety, depression, a pattern of failed relationships, or a general dissatisfaction with life. I agree with Bohart and Tallman (1999) and view the client as an active self-healer whose contributions in the therapy dyad are as worthy as my own. In my experience clients often enter therapy when their self-healer is in some way stuck in the healing process. I believe the therapeutic relationship that incorporates an "atmosphere of interest, warmth and tolerance" (Cooper, 2008, p.99) is the foundation for a client in time to feel safe enough to reveal and explore aspects of his personality and way of being in the world. I am guided by Beisser's paradoxical theory of change that "Change occurs when one becomes what he is, not when he tries to become what he is not" (1970). My invitational stance as therapist that it's okay to be who you are, I believe creates an opportunity for the client in time to work at "relational depth" (Mearns and Cooper, 2005). This I believe needs to be experienced within an intersubjective dialogue that considers "the individual's world of inner experience and its embeddedness with other such worlds in a continual flow of reciprocal mutual influence," (Stolorow and Atwood, 1992, p.18). I believe this approach also "deemphasises the power imbalance and in which both therapist and client are working together" (Glass and Arnkoff, 2000, p.1469). This complements the research of Miller et al's (2005) that stresses the importance of a collaborative style that is significant in the outcome of change. However, I do not see growth and change as linear. I concur with Chaplin (1988) who suggests it is a process that weaves forward and back on itself repetitively.

A.6.2: The Working Alliance

For me the working alliance is the secure base of the therapeutic relationship. Research indicates that establishing a working alliance early favours a positive outcome (Horvath and Bedi, 2002). I begin by being attentive both to the verbal and non-verbal dialogue in which the client and myself engage. My respect for the client's autonomy communicates to the client that I view her as an active participant in the contractual agreement (Bordin, 1994; Wilson, 1996). This has also been evidenced by research as a contributing factor for effective change (Horvath and Bedi, 2002). Building the emotional bond that Bordin (1994) views, as a necessary ingredient in a strong working alliance can be a slow process that increases with time. I feel the working alliance is co-created by the two people that are engaged in the process, as Clarkson (1995) says . "It is the part of the client-psychotherapist relationship that enables the client and therapist to work together even when the patient or client experiences some desires to the contrary" (p. 30).

A.6.3: Ruptures and Repair

DeYoung describes rupture as "that's just life in relationship... the organizing principles of two people can be so different as to miss each other, scare each other, and set each other off in all kinds of unpredictable ways" (2003, p.151) yet they are also "a tension or breakdown in the collaborative relationship between patient and therapist" (Safran et al, 2002, p.236) and can be a threat to the effectiveness of the therapeutic relationship. I see it as my role to stay alert to fractures in the alliance and initiate repair if the client appears unaware. If the client is the one to bring it to my attention, I will hear his voice in a respectful manner and be open to entering a dialogue concerning his experience with me. I believe that this approach can both be healing and reparative, "only in the context of an object found, lost and refound can a patient begin to develop autonomy – a sense of self to which he can return in times of stress" (Holmes, 2001, p.33). The repair of ruptures, as Safran et al (2002) suggest, also helps develop the capacity to manage breakdowns and tensions in relationships both in and outside the therapeutic frame.

A.6.4: Transference and Countertransference

I view transference and countertransference as an ordinary form of co-created communication. The client may respond to me as if I am a significant other from the past, expecting experiences to be repeated. I hold in mind self-psychology and the self-object needs of mirroring, idealisation and twinship that (Kohut, 1984) saw as developmental needs across the life span. I respond to these needs by attuning to them as they arise in the process with respect and care.

Casement (2002) uses the term "communication by impact" for those countertransferential feelings that the therapist receives from the client that currently have no narrative. However I am aware that feeling states can also be my own material. I make significant use of supervision to explore and reflect on these experiences. My clinical experience informs me that countertransference comes in a variety of forms such as images and body felt sensations. I am learning that communication through projective identification entails feeling states that the client is unable to hold and is therefore transferred to the therapist to hold and give back to the client in manageable parts (Casement 2002). How I choose to respond to my countertransference depends on the need of the client and the strength of the working alliance. With regards to self-disclosure I am influenced by Maroda's (1998) view that "it is the therapist's willingness to be forthcoming and to show emotion that is curative and stimulates emotional honesty in the patient" (p.103) and therefore reparative in nature.

A.6.5: Enactments

Enactments are co-created unconscious processes of both client and therapist that lead to "an interaction that has unconscious meaning for both" (Chused, 2003, p.678), I agree with (Maroda, 1998) that either the client or the therapist can be the initiator of these events. In my experience enactments are difficult to note in the immediacy of the event. However, I view it as my role to be curious about these moments as what lies within them is a wealth of information for understanding and growth.

A.6.6: The Reparative Relationship

From my relational stance I view all effective therapy as the opportunity to be reparative in nature. The co-created relationship that grows within a respectful arena of responsive care (Cooper, 2008) can become the secure base from which a client in time can engage in the exploration of "knowing what you are not supposed to know and feeling what you are not supposed to feel" (Bowlby, 1988, p.99). I use the tone and rhythm of my voice as well as the movement of my body, to respond sensitively to the clients way of being, these "vitality affects" (Stern, 1985) are the rhythms of affect attunement. "The therapist listens to the patient's explicit verbalizations but at the same time is also listening at another level, an experience-near subjective level that implicitly processes dynamic moment by moment affective communications at levels beneath awareness." (Schore cited in Gilbert and Orlans, 2011, p.139). I believe that over time this empathic attunement regulates emotional affects and is reparative in nature by facilitating the revision and updating of the client's RIGS (Stern, 1985) and internal working models (Bowlby, 1969).

A.6.7: The Person to Person

I know that I myself like human contact, and although not always easy, I like to be authentic. I am aware that for many clients this can be overwhelming or fearful. I ask myself the question, is it my need that I am meeting or that of the client? I often wonder what it is like to be on the receiving end of me. Casement (2002) terms this "trial by identification". I carry an invitational stance that I am willing to meet the person and am not fearful of myself being seen. In revealing myself in appropriately timed self disclosure, I believe I model a way of being which the client can not only identify with (Clarkson, 1992) but also experiment with in his own time (Maroda 1998). I believe that within the personal is a transpersonal realm. It involves the willingness of both therapist and client to put faith in their intuition and trust the 'unknown' (Clarkson, 1995; Peck, 1990). For me it is moments of contact where barriers on both the side of client and therapist are temporarily suspended and a fullness of contact is made. As Field (1996) explains, "I have in

mind those moments where two people feel profoundly united with one another yet each retains a singularly enriched sense of themselves. We are not lost in the other, as in fusion, but found" (p.71). As therapist I attempt to see and greet the whole client, not in parts in isolation yet interested in the complexity of the person's wholeness. I come with a willingness to move from what Buber (1958) terms an I-It position to be open to the possibility of an I-Thou meeting.

A.6.8: Strategies and Techniques

I integrate techniques of phenomenological inquiry within "an intersubjective matrix in which processes of self healing, self articulation and self consolidation can be resumed and realigned" (Stolorow et al, 1994, p. 93). I engage in a shared conversation that consists of "testing and checking each other's talk, by them questioning and challenging it, reformulating and elaborating it, and so on" (Shotter, 2008, p.1). However I view "talk" as consisting of several forms of communication not only speech. Therefore as a therapist I am interested in the non verbal dialogue in the room paying special attention to body language images and dreams. I creatively use metaphors and art materials to help aid expression or dilute impasses. However I am mindful that the introduction of these tools may reflect mine or the client's impatience in wanting a quick solution, or a steering away from uncomfortable feelings. I am also aware of the potential for shame in the using of creative strategies that often have the capacity to elicit unconscious material into awareness. Therefore I pace creative interventions to attune with the client's needs. My clinical experience has also informed me that as the client's "self healer" is reactivated clients often embark on spontaneous acts such as drawing, poetry or writing a journal and bringing it into the session for exploration.

A.7: Conclusion

My Integrative framework has at the centre a relational core based on humanistic and existential values. My model is informed by the assumption that human beings are relationship seeking from birth. Early relationships between caretakers and the infant provide the nutriments for ultimate growth and psychological health. It is not surprising then that I hold the hypothesis that it is a lack of empathic attunement that causes dysfunction in the development of selfhood and in turn impairs capacity to relate to self and to others.

Clients often engage in psychotherapy due to being stuck in their own ability to self heal. Unsure of how to move forward and with a realisation that something is amiss, they seek another in the form of a therapist. From the moment of contact co-creation is in motion. It is no longer a single journey, but rather each party bringing their person into a shared enterprise. It can be a challenging process and at times there can also be moments of joyful contact, such as shared humour and the ordinariness of living. I believe that entering therapy is a search for authentic contact with self and self with other. Or in Moore's view "care of the soul" (1992). In therapy we open ourselves to the possibility of contact to closed parts of ourselves, perhaps to parts that we never even knew were lost. Clients have a choice how to use the therapy to the best of their advantage. I believe the client has a deep knowing of what he needs (Rogers, 1961), although it is not always known in words. I believe therapy can be a healing process for those that are willing and able to embark on the journey.

References

Ainsworth, M., Waters, M. and Wall, S. (1978). *Patterns of Attachment: Assessed in a Strange Situation and at Home.* Hillsdale, NJ: Lawrence Earlbaum.

American Psychiatric Association (2000). *DSM-IV-TR: Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition, Text Revision).* Washington, DC: Author.

Barrett-Lennard, G. T. (2005). *Relationship at the Centre: Healing in a Troubled World.* London: Whurr Publishers Ltd.

Beebe, B. and Lachmann, F. M. (1998). 'Co-Constructing Inner and Relational Processes: Self- and Mutual Regulation in Infant Research and Adult Treatment.' *Psychoanalytic Psychology, Vol. 15, No. 4, pp.480-516.*

Beisser, A. R. (1970). *'The Paradoxical Theory of Change'.* In Fagan, J. and Shepherd, I. L. Gestalt Therapy Now. New York: Harper Colophon Books.

Benjamin, L. S. (1996). *Interpersonal Diagnosis and Treatment of Personality Disorders.* New York: The Guilford Press.

Bohart, A. C. and Tallman, K. (1999). *How Clients Make Therapy Work: the Process of Active Self-Healing.* Washington, DC: American Psychological Association.

Bordin, E. (1994). *'Theory and research in the therapeutic working alliance: New directions'.* In A. O. Horvath and L. S. Greenberg (eds.), The working alliance: Theory, research, and practice (pp. 13-37). New York: Wiley.

Bowlby, J. (1969). *Attachment and Loss,* Volume 1: Attachment. London: Pimlico.

Bowlby, J. (1988). *A Secure Base. Clinical applications of attachment theory.* London: Routledge.

Brandschaft, B. and Stolorow, R. D. (1994) *'The Difficult Patient'.* In The Intersubjective Perspective. Lanham: Rowman & Littlefield Publishers Inc.

Buber, M. (1958). *I and Thou.* London: Continuum.

Casement, P. (2002). *Learning from our Mistakes.* Hove: Brunner-Routledge.

Chaplin, J. (1988). *'Feminist Therapy.'* In Rowan, J. and Dryden, W. (eds.), Innovative therapy in Britain. Buckingham: Open University Press.

Chused, J.F. (2003). 'The Role of Enactments,' *Psychoanalytic Dialogues, Vol. 13, pp.667-687.*

Clarkson, P. (1992). *Transactional Analysis Psychotherapy: An Integrated Approach.* London: Routledge.

Clarkson, P. (1995). *The Therapeutic Relationship.* London: Whurr Publishers Ltd.

Cooper, M. (2008). *Essential Research Findings in Counselling and Psychotherapy.* London: Sage Publications Ltd.

De Young, P. A. (2003). *Relational Psychotherapy: A Primer.* Hove: Brunner-Routledge.

Erikson, E. H. (1985). *Childhood and Society.* New York: W. W. Norton & Company Inc.

Field, N. (1996). *Breakdown and Breakthrough: Psychotherapy in a New Dimension.* London: Routledge.

Flores, P. J. (2004). *Addiction as an Attachment Disorder.* Lanham, Maryland: Jason Aronson.

Fonagy, P., Gergely, G., Jurist, E. L. and Target, M. (2004). *Affect Regulation, Mentallization, and the Development of the Self.* New York: Other Press.

Gilbert, P. (2005). *'Compassion and Cruelty. A biopsychosocial approach.'* In author (ed.) Compassion. Conceptualisations, Research and Use in Psychotherapy. Hove: Routledge.

Gilbert, M. and Orlans, V. (2011). *Integrative Therapy: 100 Key Points and Techniques.* Hove: Routledge.

Glass, C. R. and Arnkoff, D. B. (2000). 'Consumers' perspectives on helpful and hindering factors in mental health treatment', *Journal of Clinical Psychology, Vol. 56, No. 11, pp.1147-80.*

Herman, J. L. (1997). *Trauma and Recovery.* London: Pandora.

Holmes J. (1993). *John Bowlby and Attachment Theory.* Hove: Brunner-Routledge.

Holmes J. (2001). *The search for the secure base.* Philadelphia: Taylor & Francis.

Horvath, A. O. and Bedi, R. P. (2002). *'The alliance',* in J. C. Norcross (ed.), Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients. New York: Oxford University Press, pp. 37-69.

Johnson, S. M. (1994). *Character Styles.* New York: W. W. Norton & Company.

Kareem, J. (1992). *'The Nafsiyat Intercultural Therapy Centre: Ideas and Experiences in Intercultural Therapy',* in Kareem, J. and Littlewood, R. (eds). Intercultural Therapy. Oxford: Blackwell Science Ltd.

Kearns, A. (2005). *The Seven Deadly Sins? Issues in Clinical Practice and Supervision for Humanistic and Integrative Practitioners.* London: H Karnac (Books) Ltd.

Kohut, H. (1984). *How Does Analysis Cure?* London: The University of Chigago Press.

Lago, C. and Thompson, J. (1996). *Race, Culture and Counselling.* Buckingham and Philadelphia: Open University Press.

Laing, R. D. (1967). *The Politics of Experience and The Bird of Paradise.* London: Penguin Books Ltd.

Laing, R. D. (1969). *The Divided Self.* London: Penguin Books Ltd.

Lyons-Ruth, K. (1998). 'Implicit Relational Knowing: Its Role in Development and Psychoanalytic Treatment'. *Infant Mental Health Journal, Vol. 19, No. 3, pp.282-289.*

Main, M. (1981). *'Avoidance in the Service of Attachment: A Working Paper'.* In Immelman, K., Barlow, G., Petrinovitch, L. and author (eds.) Behavioural development, pp.651-693. New York: Cambridge University Press.

Main, M. and Hesse, E. (1992). In M. Ammaniti and Stern, D. (eds.) *Attachment and psychoanalysis (pp.86-140).* Rome: Gius, Laterza & Figli.

Main, M. and Solomon, J. (1986). *'Discovery of a New, Insecure-Disorganized Disoriented Attachment Pattern'.* In Brazelton, T. and Yogman, M. (eds.) Affective Development in Infancy, pp. 39-51. Norwood, NJ: Ablex.

Maroda, K. J. (1998). *Seduction, Surrender, and Transformation: Emotional Engagement in the Analytic Process.* Hillsdale: The Analytic Press.

Masterson, J. F. (2005). *'Integrating Attachment and Object Relations Theories and the Neurobiologic Development of the Self'.* In author (ed.) The Personality Disorders Through the Lens of Attachment Theory and the Neurobiologic Development of the Self: A Clinical Integration. Phoenix, AZ: Zeig, Tucker & Theisen, Inc.

Mearns, D. and Cooper, M. (2005). *Working at Relational Depth in Counselling and Psychotherapy.* London: Sage.

Miller, S. D., Duncan, B. L., Sorrell, R. and Brown, G. S. (2005). 'The partners for change outcome management system'. *Journal of Clinical Psychology, Vol. 61, No. 2, pp.199-208.*

Moore, T. (1992). *Care of the Soul: How to Add Depth and Meaning to Your Everyday Life.* London: Piatkus Books.

Moore, T. (2000). *Original Self: Living with Paradox and Originality.* New York: Harper Collins Publishers Inc.

Peck, M. S. (1990). *The Road Less Travelled. The New Psychology of Love, Traditional Values and Spiritual Growth.* London, Sydney, Auckland, Parktown: Random House

Rogers, C. R. (1961). *On Becoming A Person: A Therapist's View of Psychotherapy.* London: Constable & Company Ltd.

Rumi, J. D. (2005). *Rumi: The Book Of Love – Poems Of Ecstasy And Longing.* Translated by Coleman Barks. New York: Harper Collins.

Safran, J. D. (2002). "Brief relational psychoanalytic treatment", *Psychoanalytic Dialogues, Vol. 12, No. 2, pp.171-95.*

Schore, A. N. (2003a). *Affect Disregulation and Disorders of The Self.* New York: W. W. Norton & Company Inc.

Schore, A. N. (2003b). *Affect Regulation and the Repair of The Self.* New York: W. W. Norton & Company Inc.

Shotter, J. (2008). *Conversational Realities Revisited: Life, Language, Body and World.* Chagrin Falls: Taos Institute Publications.

Siegel, D. J. (1999). *The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are.* New York: The Guilford Press.

Stern, D. N. (1985). *The Interpersonal World of The Infant: A View from Psychoanalysis and Developmental Psychology.* London: Karnac Books.

Stern, D. N. (2004). *The Present Moment in Psychotherapy and Everyday Life.* New York: W. W. Norton & Company Inc.

Stolorow, R. D. (2007). *Trauma and Human Existence: Autobiographical, Psychoanalytic and Philosophical Reflections.* New York: Routledge.

Stolorow, R., Atwood, G (1992). *Contexts of being: The Intersubjective Foundations of Psychological Life.* Hillsdale, NJ: The Analytic Press.

Stolorow, R., Atwood, G. and Brandchaft, B. eds. (1994). *The Intersubjective Perspective.* Lanham: Rowman & Littlefield Publishers Inc.

Van der Kolk, B. A., McFarlane, A. C. and Weisaeth, L. eds. (1996). *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society.* New York: The Guilford Press.

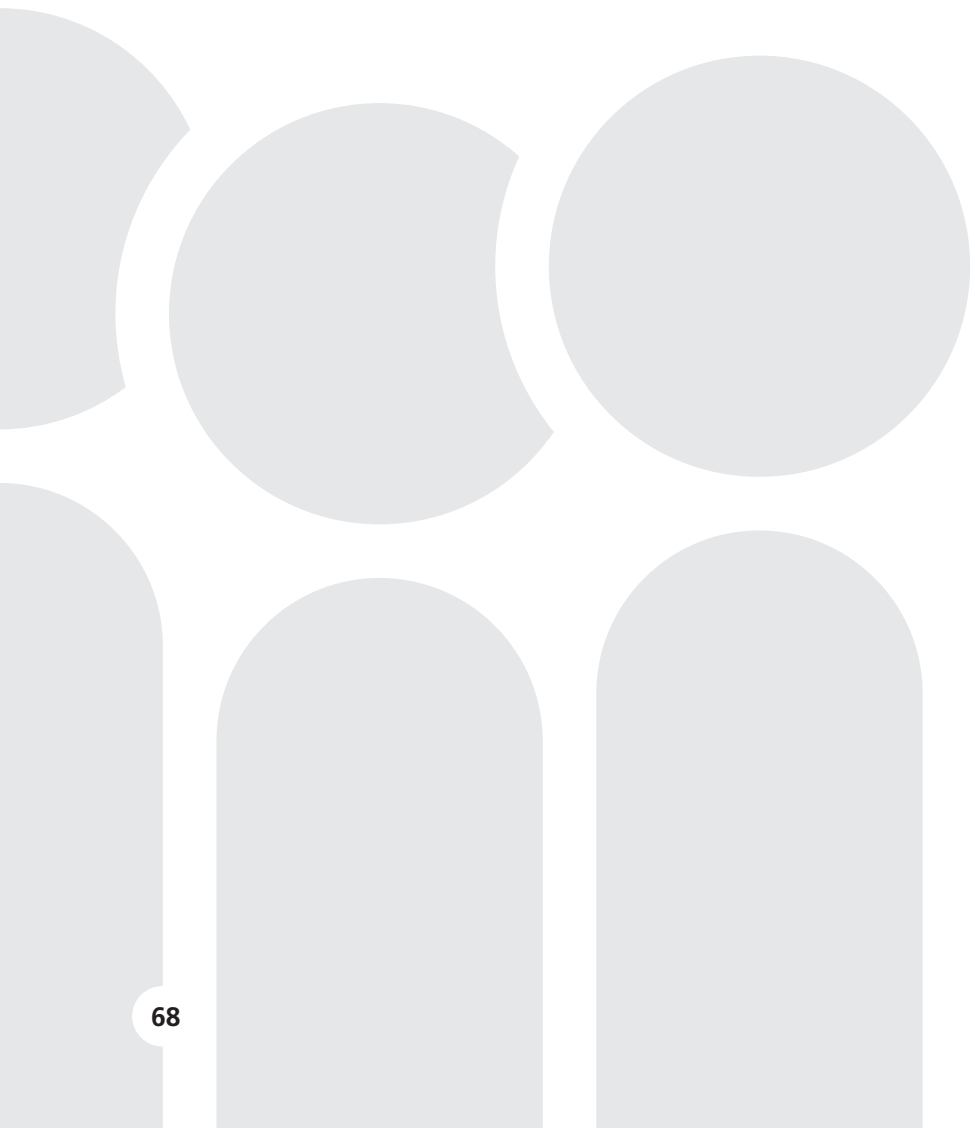
Wilson, J. E. (1996). *Time-conscious Psychological Therapy: A life stage to go through.* London: Routledge.

Winnicott, D.W. (1958). *'Transitional Objects and Transitional Phenomena [1951]'.* Through Paediatrics to Psychoanalysis. Collected Papers. London: Karnac Books.

Winnicott, D.W. (1965). *The Maturational Process and the Facilitating Environment.* London: Hogarth Press.

Yalom, I. (1980), *Existential Psychotherapy.* USA: Basic Books.

Yalom, I. D. (2001). *The Gift of Therapy.* Reflections on being a therapist. London: Piatkus Books.



Book review by Maria Gilbert

'Integrative Counselling and Psychotherapy: A Relational Approach'

by Ariana Faris and Els van Ooijen, (2012) London: Sage

In this book the authors present their Relational Integrative Model (RIM) of psychotherapy. However, they make clear throughout the book that they view 'integrating' as an ongoing process, not a fixed state at which you arrive for once and all, but an ongoing process of personal and professional development. This position comes across very clearly both in their theoretical discussions and through their case examples.

They describe theirs as a 'model with a relational heart' focused on the co-construction of meaning between therapist and client. In this sense integration is an ongoing process for both therapist and client. I appreciated their highlighting of the three questions that they see as central to practice:

Why do we do what we do?

How do we do what we do?

What do we do?

These questions serve as the focus in the chapters on: Approach; Method; and Technique.

In the chapter on 'Approach' they summarize the basic presuppositions and assumptions underlying their trans-theoretical framework. They focus on the co-construction of meaning within an contextual lens, drawing on an intersubjective perspective. The authors are transparent and open about their own particular theoretical interests which inform their Relational Integrative Model. They do not pretend to be all inclusive but prioritise those approaches that they are grounded in, namely Psychodynamic therapies, Cognitive behavioural therapies and Humanistic therapies. These three approaches overlap in their model and at the same time retain their individual identity. They also include an emphasis on a 'contemplative' mode from their interest in mindfulness practice, which is embedded in their practice. They convey a sense of a creative dialogue amongst these different approaches that enriches psychotherapeutic practice.

What stood out for me in particular in the section on Method is the excellent diagrammatic representation of 'The Therapeutic Journey' that they provide on page 64. They stress the importance of the relational frame which facilitates the unfolding of stories and narratives over time in the therapeutic context.

The chapter on Techniques is comprehensive in providing a sense of the variety of interventions that are part of the RIM in practice. Their focus is on what is therapeutically most useful to the client. They use the term 'relational dynamics' to capture the non linear, non causal focus that allows for new stories/narratives to emerge. I appreciated their emphasis on the importance of 'curiosity', their emphasis on the importance of the client's (and therapist's) relationship with her inner world and her

relationship with others, and the use of mindfulness practice to support the therapist in 'shuttling in an out of the client's experience'.

The final section on professional issues is interesting, although I did have the sense that it was rather 'tacked on' and would have warranted a more comprehensive discussion and elaboration of the ideas presented , especially in terms of their interesting approach to ethical and reflexive thinking.

Overall, my only reservation is the manner in which the model is confined to the writers' interests in the three approaches that they elaborate upon, without mention of how they may in future incorporate other perspectives. However, this is also a strength of the book as it is so clearly and honestly related to their own experience and background.

I consider that this book will prove of interest to trainee therapists and practising therapists alike in its provision of an interesting Relational Integrative Model. The questions for the reader to consider at the end of each chapter are well focused and will make for good discussion points for students. Throughout the book the authors provide useful and interesting client examples that illustrate the authors' points very well and bring the concepts under discussion to life for the reader. As I read these examples, in particular the example of long-term therapy with the client named Andrew, I was impressed with the sensitivity to process and by the humility demonstrated by the therapist/s.

Overall, this is an interesting and very engaging book in which the writers commitment to their project enlivens the material and conveys the sense of how the elaboration and illustration of their model has emerged from years of practice, discussion and reflection.

I would commend it to therapists and trainee therapists.

Volume 10, Issue 2 (2013)

Production Information

Made in London by Matthew Gilbert

Printed in the United Kingdom.

Visit our web site for the latest
information about Ukapi.

www.ukapi.com