The British Journal of Psychotherapy Integration

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Integrative Practice With An Emphasis On Working With Trauma

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Introduction

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

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Editorial Structure

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Editorial

Integrative Practice With An Emphasis On Working With Trauma

In this edition of the journal most of the contributions are related to working with different aspects of trauma primarily with individuals but also from a more systemic perspective. We have also chosen to include an exploration of the development of an integrative framework by a training organisation over their organisational lifetime. In all cases the authors are exploring their values and philosophy of practice as integrationists and how they have integrated different bodies of knowledge and experience over time. The authors illustrate for us the basic tenet of integration: that there is no one and only integrative approach: there is a great and creative variety of effective ways of working that all share a commitment to a coherent and systematic blending together of different modalities.

Contents Of This Issue

Rainer Schiedel has generously shared his practice experience with foster children and their carers. His theoretical reflections on the challenges facing both these groups as well as the people who work with them, are grounded in moving practice examples. He particularly reminds us that foster carers are being asked to provide a corrective emotional experience through a form of 'therapeutic' parenting. He places emphasis on the support that such a task requires of the foster carers and illustrates this through his vivid examples. He also demonstrates how the Adult Attachment Interview could be used in the selection of carers for such a complex and demanding task.

Zoe Lodrick provides an interesting and accessible review of neurobiological thinking concerning human response to threat and trauma and associated survival strategies. Zoe introduces the five F's, a useful summary of basic survival responses to traumatic experiences. She then goes on to describe principles of recovery to trauma that reference the neurobiological underpinning in approaches to the treatment of survivors of trauma. Zoe's article is a very useful overview of what can sometimes appear a very complex subject yet her article is an excellent introduction for people wanting to integrate neurobiological thinking into their current working practice.

In similar fashion, Philippa Perry provides a survey of some recent clinical writing on the techniques and management for working with people manifesting with dissociation and dissociative identity disorder. In the course of this discussion, she brings to life through the case material the difference between dissociation, dissociative identity disorder and repression and reminds us that all these processes are along a continuum of severity. Philippa writes in an experience-near style which engages the reader and invites you to consider your own practice from these perspectives.

By way of a contrast, we present to the readers Sue Jones' account of her findings

from her doctoral research into the shadow side and the potential abuses within psychotherapy training organisations.

After interviewing people from many different organisations she reflects on the conscious and unconscious dynamics that may be particular to the complex task of educating psychotherapists and relates this to findings reflected in the literature in the field. Sue offers a way of working in training organisations that might allow for greater transparency and freedom from fear in the development of psychotherapists.

By way of a further contrast, Michael Soth's article explores how a training organisation has faced the challenges within their own modality and the field of psychotherapy and psychology in general to evolve their own paradigm of 'Integral-relational body Psychotherapy'. Michael Soth reminds us that the 'integrative project' is relevant to an approach to thinking about individual clinical practice and to the development of a training organisation's model of education over time. This dense account illustrated with 'maps', requires the reader to carefully navigate complex ideas to arrive at a full appreciation of the richness of the emerging framework that is at the heart of this endeavour.

As is our tradition we have included an example of a student's theoretical discussion taken from her final dissertation for the MA in Humanistic and Integrative Psychotherapy. We have also included two book reviews.

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

Rainer Schiedel

Caring For Traumatised Children In Foster Care – The Challenge Of Therapeutic Parenting

Abstract

This paper explores the experiences and specific developmental needs of traumatised and abused children who have been placed in foster care. Using an introductory case example, an overview of the impact of child abuse on the developmental pathways of children is given, particularly in relation to developmental attachment and affect regulation. Foster carers need to be able to provide therapeutic parenting to these children to provide them with the necessary corrective emotional experiences to recover from their abusive experiences. Giving further brief case examples, the paper focuses on the challenges and complexities involved in maintaining a positive relationship with foster children with often very oppositional and extreme behaviour and explores the motivational factors and qualities that carers need to bring. The relevance of the Adult Attachment Interview is explored for assessing prospective carers for their suitability for this difficult job.

Introduction: Case Example[1]

Ten-year-old Justin had been in this foster placement for two months. Four previous placements had broken down over the last two years. Towards the end of the third joint therapy session with Justin and his foster carer, Justin had become somewhat restless. I suggested that we should finish playing the therapeutic board game, which Justin had initially been keen to try out. There was enough negativity in my suggestion for Justin to feel shamed, creating an impulsive response and sudden change of mood. He sent the board game flying into the air and responded to my useless question of what was going on (I knew what was going on) with well aimed spitting in my face. The sand of the therapeutic sand tray soon followed. Jim, the foster carer, received similar treatment when he intervened. Justin then pulled a couple of pins out of a pin board, left the room very quickly and headed for Jim's car, scratching across the bonnet with the pins. He continued to spit and kick anyone who tried to approach him. Eventually a colleague held him, with her arms firmly around him from behind, for a short while and he calmed down almost immediately as she talked to him calmly. Justin then quickly apologised for his behaviour, before demanding a treat for having been good.

Even before the above incident Jim had acknowledged that he found it difficult to cope with caring for Justin. For a couple of weeks Jim had been experiencing mild panic attacks and felt a constant lump in his throat, a familiar symptom he recognised from a depressive episode, some ten years earlier. The strain of caring for Justin had taken its toll on the whole family. Jim's teenage daughter had moved out to

1. All case examples in this article are based on real life situations experienced by the author but the details of events and names have been changed to preserve confidentiality and anonymity.

stay with friends and Jim's wife was despairing, dreading to come home after her shift work.

Initially, when first placed with his carers, Justin hid faeces in places all over the house, although this behaviour had largely reduced, following therapeutic intervention and careful behaviour management. However the house still smelled due to occasional relapses. Justin's oppositional behaviour and his constant controlling demand for attention was the most difficult challenge for Jim. Due to concerns about previous incidents of sexually inappropriate and harmful behaviours towards other children, there was a need for constant supervision. This did not allow for any periods of respite for Jim. Nevertheless, he was determined not to let Justin down and wanted to continue caring for him, in spite of his family's resistance. Jim's parents had rejected Jim when he was 16 and he had lived rough for a couple of years. He was now determined not to reject Justin. However, a few weeks later, the foster care provider decided to end the placement to allow for a planned move to another placement, rather than risking a likely crisis break down, which would have been even more difficult for Justin.

Justin, like many other children who come into the care system, had been through years of traumatic experiences. This started before birth, through episodes of domestic violence during his mother's pregnancy. It continued during infancy, leading to the first child protection conference being called by the local authority when he was two years old, following a physical assault and injury by his mother's partner. It took another six years of physical, sexual and emotional abuse and neglect until the local authority eventually obtained care orders for Justin and his younger siblings who were adopted and consequently separated from Justin.

In spite of his abusive life experiences, Justin was intensely loyal towards his stepfather who had been more or less his primary carer. He said that he liked being hit by his stepfather, as it helped him to be hard, so that he could take a punch as an adult. He excitedly described how he would deliberately hurt his younger brother, including breaking his leg by hitting him with an iron bar if he "grassed" on him and how he had been involved in many fights, including fights involving knives. Justin was on a final warning in relation to these offences and had been referred to the Youth Offending Team. Justin's subjective experience was that he had looked after himself since he was aged three years. When exploring the needs that a baby might have, he said that he did not like babies, particularly when they cried and he would want to tape their mouths shut. This seemed symbolic of how Justin had to learn to negate his needs, i.e. blocking the expression of need and blocking the response to that need as a self preserving reaction to avoid the pain of the need not being met (Johnson, 1994). His way of coping and emotional survival was to align himself closely to his abusive stepfather whose attitudes and values he had internalised.

The Effects Of Trauma And Its Interaction With Development

It is important to understand the contextual background of traumatic events when assessing and planning interventions with children like Justin. The developmental level at which trauma occurs, as well as the frequency and the intensity of traumatic events, have a major impact on the capacity of the victim to adapt (Van der Kolk, 1996). Trauma in the form of abuse from a primary caregiver during periods of the victim's personality formation has a particular quality, due to its inter-relational and chronic nature. Herman (1992) sums it up: "Repeated Trauma in adult life erodes the structure of the personality already formed, but repeated trauma in childhood forms and deforms the personality" (p. 98).

Neurodevelopmental Effects Of Trauma On Affect Regulation

Neurodevelopmental aspects are important when trying to appreciate the effects of childhood trauma. This is not to pathologise children but helps us to appreciate how impulsive behavioural responses may be beyond children's control as opposed to them just deliberately trying to be difficult. The brain develops in a hierarchical fashion. With increasing development the higher more complex areas begin to control and modulate the more reactive, primitive functioning of the lower parts of the brain. Consequently the

person becomes less reactive, less impulsive and more thoughtful (Perry, 2001). All areas of the brain store information related to the function they mediate (Perry, 1999). The Cortex stores cognitive information, e.g. names, faces, facts. The limbic system can store emotional information, e.g. fear, pleasure, sadness. In the brainstem, the anxiety or arousal states associated with a traumatic event are stored. Re-exposure to cues associated with the trauma can elicit these traumatic memories and the connected feelings.

The brain develops in a 'use-dependent' fashion (Perry, 2001; Stien, 2004)), which means that particular parts of the brain will develop depending on the level of activation. Consequently persistent states of fear in childhood will significantly alter the developing brain and lead to persistent states of hyper-arousal or dissociation. In adulthood this can lead to violent behaviour and/or emotional numbness and extreme forms of dissociation. However this also gives a message of hope in that it appears to suggest the possibility of changes in the 're-wiring' of the brain depending on stimulation of particular parts of the brain through correcting and healing experiences.

> *During a joint session with 14-year-old Carl and his foster carer, Carl described his problems with his arms, which seemed to have their own life and were frequently raised sideways during arguments with his foster carer, when his oppositional behaviour in placement was challenged. The carer had, at times, felt physically threatened by Carl waving his arms in this way. I talked to Carl about the different parts of the brain, the reflective, thoughtful one and the more impulsive one, dealing with flight and fight responses, which are designed to keep one safe in the face of dangerous situations. We talked about which part of the brain Carl used if a bus was just about to hit him when crossing the road. I referred to my knowledge of Carl's experiences of serious domestic violence and his volatile relationship with his mother. I wondered if the impulsive parts of the brain had been over-exercised in Carl's life by such experiences, allowing this part of his brain to be too strong. Now his challenge was to allow the reflective part of his brain to be exercised by different kinds of experiences with his foster carers. When I asked Carl if this made any sense to him, he said that it made a lot of sense. The carer and Carl were then able to reflect on strategies to exercise and strengthen the reflective muscles in Carl's brain. This allowed Carl to talk about how he had perceived the carer as fed up (with him) as soon as he had to be reminded of any chores and he had felt like a failure again, this triggering the shame related response.*

In my experience, these kinds of discussions can achieve immense relief for children, who get confused and frightened by the force of their emotional responses in spite of their best intentions to behave differently. Addressing this jointly with the carers in therapy sessions provides the children and their carers with insights in relation to actual experienced incidents and helps to create a shared motivation for change, whilst recognising the difficulty in achieving this.

Long-term Effects Of Trauma On Victims Of Abuse And Implications For Clinical Practice

Mollon (1996) helpfully clarifies the relational/developmental aspect of trauma by referring to Kohut's (1971) self-psychology. The organisation of the self is seen as dependent upon the responsiveness of empathic 'self-objects' during childhood. If the carer is not available during traumatic episodes, unable to protect or indeed is the source of abusive behaviour then this over-exposure to stress can lead the child to internalise the world as a dangerous place and to feel helpless. As a therapist I have to be mindful that the dismantling of adaptive coping strategies can fundamentally undermine a person's sense of safety and thus create emotional responses associated with the primary traumatic experiences (fight, flight and/or dissociation). The distorted beliefs are frequently acted out through transference and countertransference during therapy. Herman (1993) describes how such distorted core beliefs are based on a desperate attempt at adaptation:

> *"She must find a way of finding trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness" (p. 96).*

Idealised pictures of parental care, often described by child and adult victims, are based on the fundamental need for attachment to the abuser in order to survive. Trauma based attachment (James, 1994) is very powerful and complex and has to be recognised and empathised with in therapy as a survival strategy rather than being discarded. The above example of Justin illustrates how such distortions had been developed during childhood and had started to become entrenched. Justin's beliefs must not be attacked but they need to be challenged indirectly through corrective, alternative developmental experiences.

Mollon (1996) describes the impaired ability of victims to differentiate self from the powerful distortions of the abuser and how this leads to disturbance on different levels of the personality. There appears to be agreement amongst writers in the field of trauma that the need to regain control for survivors of abuse is a central theme (Mollon, 1996; Herman, 1992; Salter, 1995; Bass et al, 1988).

The variety of these bodily and emotional symptoms calls for a holistic approach to trauma work that bridges the traditional split between body and mind (Van der Kolk, 1996). Rothschild (2003) advocates that therapists should be trained in a number of theoretical approaches that can be used to adapt the intervention to the particular needs of clients' individual responses to trauma. Whilst I agree with this, I think that the ongoing consideration of the developmental issues that have been disturbed by the trauma and how this may be represented in the therapeutic relationship, are of great importance. In line with the general developmental tasks, the healing tasks and phases of healing from trauma have to relate to trauma related deficits. In this context Kepner (2003) points out that healing from trauma is growth. He usefully describes how the developmental issues relate to phases of healing during the course of therapy.

Developmental Attachment And Affect Regulation

The above example of Justin's behaviour acutely demonstrates how traumatised children frequently struggle with regulating their emotions. The permanently raised emotional arousal can easily trigger impulsive and oppositional behaviour.

Attachment theory, developed by John Bowlby during the 50's and 60's, proposes a universal human need for close relationship with others. It recognises the importance of the infant and growing child developing 'internal working models' (Holmes, 1993), which are representational systems based on the relational experiences of infants with their primary attachment figure. These experiences are internalised and are used as templates for later relationships. The development of the internal working model is governed by stress and how available the primary carer is to relieve anxiety or discomfort. Fonagy et al (2004) refer to this being a 'dyadic regulatory system' and make an important link with the capacity for affect regulation being acquired through moment-to-moment attuned responsiveness of the caregiver.

Fonagy et al. (2004), see affect as being the 'driving' force for the development of the self. Affect manifests itself on a conscious and subconscious level, developing out of the relational context as well as being located as internal psychic and bodily experiences. It is through the secure playful mirroring and attuned interactions with the caregiver, that children gradually learn to integrate internal states with the outside world and that internal terror or pain can be contained and soothed by the attuned understanding and responsiveness of the caregiver. This enables children to make the important developmental transition of moving from the state of psychic equivalence to acquiring the capacity for mentalization (Fonagy et al, 2004), i.e. learning to differentiate between internal affect states and external reality in the sense that internal states do not inevitably spill out into their environment. It allows children to learn how to make sense of the actions of self and others on the basis of intentional mental states, such as desires, feelings and beliefs (Bateman et al., 2004).

These developmental steps enable children to master the important developmental task of affect regulation. In the absence of sufficiently attuned parenting and the parent's ability to contain the infant's

anxieties, rather than getting overwhelmed, the development of affect regulation will be impaired. It can be challenging to communicate these complex developmental issues to carers who have not been exposed to this kind of psychological thinking before.

During a consultation session with Ian, a relatively new foster carer and part time farm labourer with a very practical no nonsense approach, we discussed how the two teenage boys Ian and his wife had in their care, were struggling to settle in the placement. Having discussed some of the developmental issues, described above in relation to the boys, Ian suddenly said: "So with us the boys are really still like babies!" I knew at this moment that we were getting somewhere.

Therapeutic Parenting - The Reality Of Caring For Traumatised Children With Attachment Difficulties

A great deal of work goes into the teaching and education of new foster carers in preparation for the care of children with traumatic backgrounds and attachment difficulties. However, it is difficult to prepare them for the actual reality of being with and caring for these children. This often results in steep learning curves for less experienced carers in dealing with seemingly bizarre behavioural patterns. An initial honeymoon with the children may soon be replaced by increasingly oppositional, controlling and/or aggressive behaviour. Simple requests, for example to clean the teeth, may be responded to with furious outbursts. This is due to difficulties with affect regulation and relates to the negative images of self that these children have internalised. It can also directly relate to past trauma if a particular action by the carer resonates with previous traumatic experiences. Carers need to provide nurturing care to children who seem to be emotionally programmed to reject their efforts and to hurt the carers emotionally and possibly physically. They often look for and find the carer's vulnerable areas and push those emotional buttons whenever they can, preserving a sense of power and control. The higher the level of intimacy that is achieved, in spite of the above, the more vulnerable the foster children may feel due to their developing emotional dependency. Historically, it has often not been safe to be vulnerable and dependent. They need to undermine intimate relationships in order the re-gain control. The (unconscious) ultimate aim is the self-fulfilling prophecy of being rejected, confirming shaming scripts (Kaufman, 1996; Hughes, 2007) about the self, of being worthless. In spite of the above difficulties, carers often find the internal strength and compassion to provide the nurturing care that these children need until they eventually manage to settle. However, this process can take many months or even years.

Motivational Routes Of Foster Carers

Foster Carers are motivated to come into fostering for various reasons. Very often they want to help children from difficult backgrounds. Like in other helping professions, it is not uncommon for carers to be motivated by their own hurtful or traumatic experiences as children. Fostering can be an empathic response of wanting to help children who have had similar experiences to their own. On a more subconscious level it can possibly also be a way of dealing with still unresolved personal trauma.

A foster carer, who had herself experienced sexual abuse and physical violence by men as a child, came to see me because she was upset about feeling easily intimidated by male foster children, if they showed a certain level of aggression. At those moments, her ability to think rationally disappeared and she just wanted to run away from the situations. Some of the boys she had had in her care seemed to find and then target this vulnerability very quickly, causing her to feel even more anxious. We discussed the connection between the current difficulties and her childhood trauma. The carer had in the past undertaken a couple of brief periods of therapy. She agreed to contemplate undertaking some longer-term therapy at a local counselling and psychotherapy centre that I was able to recommend. In the meanwhile we agreed to respect her current vulnerability and not to knowingly place boys with her who were likely to be aggressive or violent.

The increasing recognition of the important and difficult work that foster carers undertake, combined with the shortage of carers and the

increasing competition amongst statutory and independent foster care providers has resulted in the average pay for foster carers having increased significantly over the last years. Consequently, it is now more common for carers to financially depend on their income from fostering. This financial incentive has increasingly become a motivating factor for the work. Although there is nothing essentially wrong with this, it can become problematic when it prevents carers from acknowledging when they have reached breaking point with children in their care.

Contextual And Systemic Factors In Foster Families

Foster carers may be at a life stage where their own children have left home, leaving a gap that needs to be filled. Others have their own children still living at home when starting to foster and hope that the foster children will integrate within the existing family. The systemic dynamics in a family setting that includes birth or stepchildren as well as foster children are complex. Styles of parenting that were good enough or appropriate for birth children often need to be significantly adapted and changed for foster children. It is common for issues relating to insecurities and unmet needs to emerge within family systems. This can also affect couples without children if, for example, one carer feels marginalised by the emerging bond between their partner and the foster child.

The Carers Reflective Ability – The Intersubjective Experience

Foster children need opportunities for emotionally corrective experiences that they can learn to internalise over time. The challenge for carers is to sustain the necessary positive relational engagement with the children. This requires them to be able to be reflective about the process, not just in relation to the children but also in relation to their own processes and what is co-created between them. It is likely that foster children will consciously and subconsciously seek out areas of vulnerability in their carers, provoking the self-fulfilling punitive, shaming and rejecting response from the carer that these children have learned to expect. In my experience, some carers are so guarded against the possibility of being rejecting of the children, that they struggle to assert appropriate boundaries early enough in the relationship, thus failing to provide sufficient containment to children who desperately need clear boundaries that provide them with predictability and safety.

The carer's relapse into depression and anxiety in the introductory case example is an example of someone trying to compensate for personal childhood trauma, providing unlimited nurture but struggling to tolerate the less acceptable negative and angry emotional responses to the child. If unwanted emotional responses have to be suppressed too severely this can create emotional and somatic responses in the carer. It is not uncommon for foster carers with underlying emotional vulnerabilities to encounter mental health difficulties when being faced with the challenge of fostering traumatised children.

Relevant (traumatic) life experiences of carers that relate to the children's experiences can help carers to be empathic towards the children's plight but if carers have not sufficiently worked through their own issues this can become problematic. Even if they are prepared to undertake their personal work, the children in their care with their desperate demands on them often do not allow for the necessary emotional space and time. For this very reason psychotherapists are required to undertake their own personal therapy to prepare them for their jobs and/or support them while working as therapists. Carers, involved in therapeutic parenting should ideally have a similar level of preparation in the form of personal therapy and training.

Understandably foster carers sometimes struggle to remain emotionally connected with the upsetting content of the children's worries in their care.

> *Ten-year-old Jake had been taken into care four years previously due to his mother's mental health difficulties. He had been with his carers, June and Mark, for about three years and had come to see me initially for individual and then joint therapy with June for the last 18 months.*

June had talked to me about her struggle to cope with Jake when he seemed to withdraw into angry sulking moods, often swearing under his breath. June had talked in a somewhat idealised way about her childhood and her relationship with her father in particular. In her family culture it seemed difficult to voice negative emotions overtly. Overall, June had been providing excellent care for Jake and had shown a great ability to be attuned to Jake's moods and to remain empathic, patient and supportive. The therapy sessions had been used to allow Jake to express his confusions and negative emotions, make connections with possible underlying reasons and to provide an emotional container, supporting June with experiencing and coping with the, for her, sometimes disturbing and upsetting content. One of the most intense experiences occurred during a session when we had talked about Jake's future life and June had described how a previous foster child who was now an adult still came to see her on a regular basis. Jake's facial expression suddenly darkened and he said that he was going to be dead. It emerged that discussing the future had triggered anxiety in Jake and he had re-connected with the trauma of his birth mother's belief that his blood had been poisoned, that he was going to die and needed regular bleeding. June felt clearly upset by this and her eyes welled up and this was acknowledged and discussed during the session. During the following session Jake had switched back to his more optimistic, healthy beliefs and was able to talk about the future, including how he wanted to have children when he was an adult. I am sure that being able to voice his trauma related fear and have it received, processed and contained by us during the session was a key experience for Jake and his carer and that this supported their ability to deal with similar experiences outside of therapy.

The Complexity Of Therapeutic Intervention

The initial motivational factors that led carers into fostering may well clash with the reality of the demands that are made on them. Many are able to grow with these challenges, at times providing admirable care for very challenging children. Others are unable to do so and they may give up fostering, but often only after some painful experiences for them and the children in their care.

Carers, who are not motivated to be reflective in relation to their own, personal processes, are more likely to be resistant to therapeutic intervention, which tries to be inclusive of this. Research suggests a clear link between the subjective experience of the client's (foster carer's) subjective experience and expectation in relation to therapeutic work and positive outcomes (Lambert, 1992 in Hubble et al, 1999). As a therapist, working with carers in such situations, I have to be careful not to engage in an unproductive power struggle. The focus of therapy may shift from the child to the carer, but this will only be productive if the therapeutic relationship is strong enough to support this and the aim of therapy is supported by everyone participating. Whilst in individual therapy the client is the main focus, in this area of work the well being of the children is paramount. This can make it more difficult to sustain positive therapeutic relationships with carers, as transference phenomena become more complex. As a therapist working in this area, I often feel emotionally pulled in different directions, sometimes trying to perform delicate balancing acts. Research indicates that what matters for a positive outcome is not what the therapist perceives or wishes for but how the client, in this case the foster carer, perceives the therapeutic relationship (Tallman et al., 2002).

Linda and Garry had been fostering two teenage boys, aged 13 and 15 for the last year. Linda had repeatedly talked about feeling bullied and controlled by the older of the two boys, Tom. This caused her to emotionally and physically avoid him, intensifying Tom's attempts to 'find' her. Tom expressed these attempts through clingy and controlling behaviour. Linda seemed to be highly anxious and quickly became tearful when discussing these issues. During a consultation with the carers I shared my subjective sense that Linda's own processes seemed to be playing a significant part in what was happening. Linda then acknowledged how Tom reminded her of her father, whom she had experienced as bullying and abusive during her childhood. It emerged that during her assessment she had only talked about experiences with her more supportive stepfather but had negated her birth father's

existence. Linda strongly resisted my suggestions that there seemed to be a need for her to explore these issues during her own therapy. She was desperate to close down any further discussion and initially accused me of being aggressive in trying to force her to explore these issues. In the transference I had become the aggressor for her at this point and she remained firmly in the victim position, whilst her husband attempted to rescue her by getting angry with me. In the countertransference I felt indeed as if my challenge had been almost abusive. I also felt a deep sense of Linda's shame in relation to the experiences with her father. Linda eventually agreed to undertake some time limited work with another therapist but soon after the couple decided to move to another foster care provider, thus avoiding further therapeutic engagement or challenge. The relationship with Tom further deteriorated and he temporarily moved back to his mother's house.

It is important that the reflective therapeutic model is introduced to new foster carers as soon as possible through meetings, group participation and training events so that they can assimilate this approach. It is also important that it is recognised and supported by the wider professional support system. For this reason Foster Care Associates (FCA), the independent foster care provider I work for, have adopted the 'Team Parenting Approach' that encourages this kind of reflective approach for the whole supportive system in the child's life by convening regular 'Team Parenting Meetings' which are facilitated by therapists.

Developmental Attachment And Therapeutic Parenting

Dan Hughes (2006) describes "the attitude" (p.89) that is required for therapeutic parenting of traumatised children with serious attachment difficulties. It describes the relational qualities that carers and therapists need to bring to caring and working therapeutically with these children and identifies five features that are essential and which are actually very similar to the attitude that a parent has when she is in synchrony with her infant or toddler. The features are playful, loving, accepting, curious and empathic.

Interestingly, this attitude is reminiscent of Rogers' (1967) 'core conditions' of unconditional positive regard, empathy and congruence. This may not be surprising, as the aim for Hughes and Rogers is to establish and maintain a safe and supportive therapeutic relationship.

Children and young people in foster care consciously or subconsciously recognise very well when they get 'the attitude" from their carer and when not.

Daniel, aged 16, was unsettled by the prospect of having to move on from his foster placement, towards semi-independent living. When we reviewed his last years in foster care he was very clear that Jill, his current foster carer, had been incredibly supportive towards him, something that he had not experienced at all from his previous carers. His ability, during an ending session with Jill, to describe and appreciate what Jill had provided for him, brought tears to Jill's eyes, when she described how much she cared about him but was being faced with the ending of the placement, having to send Daniel on his way towards independent living. However, Paul had been very reluctant to acquire the necessary independent skills, resulting in Jill having to constantly 'nag' him in relation to his self-care skills. During this session I had asked both to write down what they would miss and not miss about each other. Whilst Jill wrote down that she would not miss having to nag Paul, he wrote down that he would miss it. When we explored this further he was able to acknowledge that, for him, the nagging represented nurture and signified that Jill cared about him, rather than giving up.[2]

Hughes argues that if the child is to begin to respond to the interventions provided, the attitude needs to become the background atmosphere, both in the family and in therapy. The carer has to learn to internalise and

2. Young people who have grown up within their birth families often stay at home until they are in their twenties. It seems bizarre that the young people in the care system who are often least likely to be emotionally equipped for independent living, often get forced to leave their foster homes when they are 16 years old. I very much welcome the current initiative by the government to increase this to the age of 18.

truly feel this attitude and maintain it in her relationship with the child, for both reciprocal enjoyment as well as relationship repair after shame experiences. Once this shift has been made by the carer the parenting becomes a lot easier, regardless of how outrageous the child's behaviour is. This does not mean that conflict is avoided but the carer will assert her/his boundaries from a clear but always empathic position. This includes, if necessary, holding the child to keep her/him and other people safe, as opposed to it being a reactive, angry response. In the above case example, Justin calmed down soon after he had been held and seemed quite content afterwards before quickly starting to revert to demanding (controlling) behaviour.

Hughes' (2006; 1997) approach also advocates frequent physical contact between the carer and the child, including brief touching and cuddles for children (with their consent and in a playful way). This sort of parenting is challenging within a culture where professionals and carers have become so aware of the misuse of power. Safeguarding policies that have been introduced to protect children in care from abuse can also have the effect of carers and professionals feeling paranoid about allegations being made against them. Foster carers often feel that they have been actively discouraged by the local authority social workers from initiating physical contact with the children in their care. Local authorities also often do not allow their carers to hold children at all, unless in real life and death situations. To implement the style of parenting that Dan Hughes advocates, special agreements may have to be made with the local authority social workers to safeguard the children and the carers.

Finding Appropriate Carers

It has been the experience of Foster Care Associates and other fostering organisations that it is difficult to recruit appropriate carers. The assessment process is time consuming and expensive and doubts have been raised about the usefulness of the assessments in predicting if carers are going to turn out to be suitable for caring for often very challenging children. Carers who, on paper, seemed to bring all the right qualities and motivation, emerged as sometimes utterly unsuitable and dropped out early during their careers as carers.

When looking back at the Assessment forms (Form Fs) of such carers, it was sometimes possible to see discrepancies or gaps in the assessment. Some assessments simply seemed to remain on a very superficial level, sometimes taking statements about idealised childhoods on face value, rather than testing or challenging this. It also seemed that information regarding past emotional instabilities in the histories of carers were not always taken seriously enough as a possible indicator of what might re-emerge in situations of high stress. Understandably, the carers may wish to present in a positive light and Form F assessors may also be tempted by a wish for a harmonic assessment process, rather than having to challenge and eventually tell candidates that they are not suitable for the job. It is simply not enough to recruit carers who want to be nurturing. There needs to be evidence that they would be able to sustain certain key qualities under circumstances of high stress. Unlike therapists, who only have to sustain 'the attitude' for the therapeutic hour and go home at the end of the day, foster carers are often faced with this challenge 24/7, particularly if the children in their care have been excluded from school.

So what are the qualities we are looking for in carers? I think that most people would agree that we want carers who are nurturing, empathic, reflective, motivated and energetic but also calm enough to have a soothing effect on the children in their care. They need to be able to listen and be able to communicate well and be psychologically minded and have a sufficient level of emotional intelligence. We want them to be grounded and resilient, being able to sustain this in prolonged episodes of high stress. We want them to remain curious about the meanings of the children's behaviours but also about their own processes in challenging conditions so that they do not easily get shamed and close down emotionally. We do not want perfect carers but carers who are willing to learn from their mistakes, just as Casement (1985) suggests for therapists.

The Adult Attachment Interview As Additional Assessment Measure For Foster Carers

The above dilemmas have triggered discussions within the FCA therapy team about the possibility of using the Adult Attachment Interview (AAI) developed by George, Kaplan and Main (1985) as an additional component, early during the assessment process with foster carers. AAIs with expectant mothers are said to be up to 80 per cent accurate in predicting the subsequent attachment patterns of their babies (Archer et al., 2003). This is based on the child developing a particular attachment style as a result of their dyadic relationship experiences with primary care givers. The AAI is designed to explore the interviewee's capacity to give a coherent narrative account of early parental/ care giving relationships and experiences.

Some sample questions from the AAI are:

I'd like you to choose five adjectives that reflect your childhood relationship with your mother. This might take some time, and then I'm going to ask you why you chose them. (Repeated for father)

To which parent did you feel closest and why? Why isn't there this feeling with the other parent?

When you were upset as a child, what would you do?

What is the first time you remember being separated from your parents?

How did you and they respond? (Sonkin, 2005).

Archer (2005) refers to the classification of four main styles of adult attachment. 'Autonomous' adults are able to give succinct, relevant and detailed verbal accounts of their experiences of being parented and place a high value on attachment relationships. Their reflections on self and others are coherent. 'Dismissing' and 'preoccupied' attachment patterns in adults are linked to lack of coherence, indicating some discontinuity or dissociation of mental contents. For example, one of my colleagues recently interviewed an applicant who described a very positive childhood but felt unable to support this with any detailed memories and, in fact, was unable to memorise large parts of her childhood. Techniques of questioning from the AAI were useful in clarifying this contradiction, which otherwise may have been missed. The 'preoccupied' adult may get flooded with memories from childhood and adulthood, frequently generating feelings of anger and frustration or a sense of resignation that difficulties cannot be overcome and still intrude into the present.

The use of the AAI is still relatively new in the field of fostering and adoption. Archer et al. (2003) point towards possible advantages that the use of the AAI could bring:

Reduce the amount of time spent on home studies

Provide a more evidence-based approach

Be an effective tool to predict support needs

Minimise individual practitioner idiosyncrasies

Assist in the matching process

More readily predict adults at risk of re-enacting their early abuse

Provide objective criteria to justify non-acceptance of would-be applicants on appeal (p. 49).

However, the process of undertaking the AAI and the scoring required is time intensive and also applicants may be concerned to learn that the intention of the AAI is to 'surprise the unconscious' (George et al, 1985 in Archer et al. 2003).

The AAI of prospective carers has to be used and matched, if possible, with the assessments of the children, ideally before, or soon after, placement. These assessments explore the therapeutic needs of children for specific styles of care and therapeutic intervention and how carers can be supported with delivering the kind of substitute care that the children need. Whilst it seems clear that children's trauma related attachment styles can become very entrenched, there is also research evidence (Hodges, 2000) that suggests that children can create newer, healthier attachment representations in parallel

with their original, distorted ones. For example Justin, in the initial case example, started to express alternative views about not needing to be hard in order not to be seen as a 'pushover', whilst living with his foster carer. However, when feeling stressed or when being put in a contextual situation that resonated with his previous childhood experiences, he reverted to the old pattern of behaviour. It is even more complex to try and forecast the developmental attachment routes of traumatised children in foster care into adulthood. I think that the above issues are highly significant for therapists working with adult survivors of abuse, particular when thinking along the lines of the co-created, intersubjective therapeutic relationship dynamics.

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Zoe Lodrick

Psychological Trauma – What Every Trauma Worker Should Know

Abstract

In this paper I outline the basis of psychological trauma. I surmise what happens to the human brain and nervous system at the point of trauma, and during trauma recall (both choiceful and intrusive). I discuss how, and why, some people may be more susceptible to developing traumatic symptomatology, and possible reasons for the repeat victimization experienced by so many victims/survivors of interpersonal trauma. I suggest how psychotherapists, and other trauma workers, might use this knowledge to support the client to recover, and to sustain themselves in undertaking trauma work.

Introduction

A traumatic incident is one in which a person experiences, witnesses or, in certain circumstances, hears about a (real or perceived) threat to the physical and/or psychological integrity of self, or others, whereby the person's response involves great fear, horror and/or helplessness (APA, 2000; Rothschild, 2000). Exposure of a child to the sexualized behaviour of adults or older children, regardless of whether the child responds with great fear, horror and/or helplessness, also constitutes a traumatic incident, due to the developmentally inappropriate nature of the sexualized behaviour(s) (APA, 2000), and the child's inability to give informed consent

Traumatic experience, and traumatization, can be subdivided into: primary trauma, secondary trauma, vicarious trauma and trans-generational trauma. People susceptible to primary trauma are present when the traumatic incident occurs; secondary trauma is a possibility for people who witness the aftermath of a traumatic incident; vicarious trauma is potentially a concern for people who hear about traumatic incidents (psychotherapists for example); and trans-generational trauma is a term sometimes used to describe the traumatic symptomatology displayed by the descendants of trauma survivors. Following exposure to traumatic stimuli some people become traumatized. I discuss the possible reasons for some people being more susceptible to developing post-trauma symptomatology in this paper. It is important to note that although traumatization frequently occurs following a single traumatic incident the condition is also an accumulative one. This is especially significant to anyone who works in an environment where they are exposed to traumatic stimuli (primary, secondary and/or vicarious) for example members of the emergency services, armed forces, medics and those engaged in psychological therapies with traumatized people.

Arguably, what separates people who are traumatized from those who once had something unpleasant happen to them, is a difficulty for the former with past/present differentiation (Herman, 1992; van der Kolk, 1989 & 1996). For the traumatized individual

some aspect of the trauma is experienced as a here and now reality. In this paper I offer a framework for understanding why some people become stuck in an aspect of the trauma, and how this knowledge might inform recovery.

Neurobiology Of Trauma – A Basic Outline

The human brain is immensely complex and I do not profess to be a neurobiologist. I have, however, found the neurobiological research to be invaluable in understanding how the human animal behaves when threatened, and how these behaviours might be the key to understanding traumatization and, subsequently, recovery.

Humans are mammals, very highly advanced mammals, but mammals all the same. The human brain has evolved to incorporate, amongst other things, the capacity for: language, reasoning, creativity, philosophy and self-awareness. The higher brain functioning enjoyed by humans sets us apart from other mammals. Yet the human brain evolved to possess advanced capabilities, and the higher levels rest upon more instinctive and reflexive structures – figuratively and literally.

The human brain is hierarchically organized into three sections: the lower, or reptilian, brain incorporates the brain stem which is primarily associated with the unconscious regulation of internal homeostasis (van der Kolk, 2003); the upper brain, or neo-cortex, is responsible for higher brain functions (Siegel, 1999), analysis of the external world (van der Kolk, 2003), and self-awareness and consciousness (Lanius et al., 2006); and the middle, or limbic, brain which surrounds the reptilian brain, is found in all mammals and is involved with learning, motivation, memory, emotional regulation and some social behaviour (Cozolino, 2002; Lanius et al., 2006). Additionally, the brain consists of two hemispheres: right and left. The two sides of the brain, for the most part, work together yet specialize in differing functions (Siegel, 1999). The left brain is generally accepted to be closely identified with cortical functioning and the right more densely connected with the limbic and reptilian brain (Cozolino, 2002). The left brain is concerned with what Siegel refers to as the "three L's – linear, logical, linguistic" (Siegel 2003, p15); and the right brain is connected with the body, regulation of the autonomic nervous system (ANS), nonverbal aspects of language and more emotional functions (Cozolino, 2002; Siegel, 2003).

Significantly, in terms of trauma, the structures largely involved in responding to threat are located in the lower and mid sections of the (predominantly) right brain. This means when threatened human beings respond, initially at least, instinctively and reflexively.

Most people will have had an experience of responding to something perceived as threatening before they were aware of the threat. For example, a man walking through the Australian bush might find himself immobilized moments before his higher brain functions process the snake-like-stick on the floor. He responds instinctively to the snake-like object with behaviour most likely to ensure survival. It is some moments later that his neo-cortex processes the finer detail and assesses the stick to be less threatening than originally perceived. The reason for the brain processing information in this way is simple: it prioritizes survival. The capacity for philosophical theorising is worth little to a man who just stood on a venomous snake!

The Significance Of The Amygdala

"The amygdala is the key component in neural networks involved with fear, attachment, early memory, and emotional experience throughout life" (Cozolino, 2002: 71).

The human brain is wired up in such a way that survival is given precedence. The amygdala's role in survival is paramount. Every piece of sensory input that enters our brain is routed via the thalamus (in the reptilian brain) and then to the amygdala (in the limbic brain) (Cozolino, 2002; van der Kolk, 1996a). The neural pathway from the thalamus to the amygdala is fast- and necessarily so (LeDoux, 1996). The amygdala filters the information searching out threat. If any threat is recognised, whether real or perceived, the hypothalamus is immediately stimulated to respond. It does so by triggering the release of stress hormones to prepare the body to defend itself (Cozolino, 2002), and by alerting the sympathetic

branch of the ANS to become highly aroused in readiness to meet the threat (Ogden & Minton, 2000; Rothschild, 2000; Siegel, 1999).

A split second after the thalamus sends sensory information to the amygdala it begins the much slower neural process of sending the same information to the hippocampal and cortical circuits for further evaluation (LeDoux, 1996). The findings of the hippocampus and cortex are then relayed back to the amygdala. In the previous example, of the man and the stick that resembles a snake, the amygdala will be encouraged to calm (motionless sticks do not usually pose a threat to physical or psychological integrity).

Terror overwhelms higher brain functioning (Siegel, 2003), as "the focus on immediate survival supersedes all medium- and long-term goals" (Cozolino 2002, p252). Possible reasons for this include the necessity of the brain to surrender oxygen to the body, and the high levels of stress hormones such as cortisol (Ogden et al., 2006), and norepinephrine (Cozolino, 2002) affecting hippocampal functioning (van der Kolk, 1996a).

When the structures of the brain lose, or lack, integration, dissociation may occur (Cozolino, 2002). "In trauma, dissociation seems to be the favoured means of enabling a person to endure experiences that are at the moment beyond endurance" (Levine 1997, p138). While dissociation is a creative way of surviving in the moment, it bodes ill for future psychological and physical wellbeing (van der Hart et al., 2006).

The Five Fs

The human system broadly responds in one (or more) of five predictable ways when threatened. 'Fight, flight and freeze' are well documented responses to threat (Levine, 1997); to these I add 'friend' and 'flop' (Ogden and Minton, 2000; Porges, 1995 & 2004). The five Fs, are instigated by the amygdala upon detection of threat. The amygdala responds to the threat in the way it perceives will most likely lead to survival.

Friend is the earliest defensive strategy available to us. At birth the human infant's amygdala is operational (Cozolino, 2002), and they utilize their cry in order to bring a caregiver to them. The non-mobile baby has to rely upon calling a protector to its aid, in the same way that the terrified adult screams in the hope that rescue will come. Once mobile the child may move toward another for protection, and with language comes the potential to negotiate, plead or bribe one's way out of danger. Throughout life when fearful most humans will activate their social engagement system (Porges, 1995).

The social engagement system, or friend response to threat, is evident in the child who smiles or even laughs when being chastised. To smile when fearful is likely to be an unconscious attempt to engage socially with the person causing the fear.

Fight, as a survival strategy, is fairly self explanatory. The threatened individual may respond with overt aggression or more subtle 'fight behaviours', for example saying "no".

Flight is any means the individual uses to put space between themselves and the threat. It may involve sprinting away from the perceived danger, but is more likely exhibited as backing away or, particularly in children, as hiding.

When the amygdala deems that friend, fight or flight are not likely to be successful it will elicit a freeze response. Levine points out that immobility has several advantages to mammals when threatened by a predator, namely: that the predator has less chance of detecting immobile prey; that many predatory animals will not eat meat that they consider to be dead; and that if the predator does kill, the freeze mechanism provides a natural analgesic (Levine, 1997). Between mammals of the same species the freeze response indicates submission, with the victorious animal recognising their dominance and leaving the subordinate animal alone. In the majority of inter-personal threats between humans however, the advent of one party freezing is often either ignored or taken as consent to the assault (whether verbal, physical or sexual).

Flop occurs if, and when, the freeze mechanism fails. The moment the threat increases, despite freeze having intended to put an end to the situation, the amygdala will trigger the ANS

to swing from predominantly sympathetic activation to parasympathetic activation (Rothschild, 2000). The body will shift from a position of catatonic musculature tension (as is observed in 'freeze') to a 'floppy' state, whereby muscle tension is lost and both body and mind become malleable (hippocampal and cortical functioning will very likely be severely impaired at this point). The survival purpose of the flop state is evident: if 'impact' is going to occur the likelihood of surviving it will be increased if the body yields, and psychologically, in the short-term at least, the situation will be more bearable if the higher brain functions are 'offline'. People who have elicited flop as a survival mechanism are very submissive and will make little or no outward protest concerning what is happening to them. They will bend to the will of the person perceived as threatening in an attempt to stay alive.

Which 'F' And Why?

It is my contention that the survival strategy adopted in any given situation will depend on a number of factors, namely:

What is most likely to ensure survival (and also maintain vital attachments)?

What worked in the past?

What was unsuccessful in the past?

Different survival strategies are ideally suited to certain threatening situations; for example, flight would be well employed upon hearing a fire alarm, yet to flee from a hungry tiger is inadvisable. The reflexive response of the amygdala is informed by the genetically encoded information, shared by all humans, regarding the nature of certain threats (Levine, 1997), and the individual's subjective experience that has resulted in the pairing of a fear response with certain stimuli (Cozolino, 2002).

Because the purpose of the five Fs is survival, success will be gauged in survival terms; "success doesn't mean winning, it means surviving, and it doesn't really matter how you get there. The object is to stay alive until the danger is past." (Levine 1997, p96). Successfully used strategies will be reinforced and strategies employed but unsuccessful, will be less likely to be used in future.

A person who is successful in actively defending against a threat (i.e. utilizes friend, fight or flight) is less likely to become traumatized than someone who uses passive defences (freeze or flop) (Herman, 1992; van der Kolk 1996). If active defences are weakened, by lack of success, and/or passive defences strengthened through successful utilization, the likelihood of a person becoming traumatized and/or a repeat victim of trauma are increased. I will illustrate this point with an example:

Jenny was sexually abused throughout her childhood by her father, her uncles and a number of other men. Some years later Jenny was standing at the side of the road waiting for her friend (who was 10ft away buying greengrocery from a market stall). A car pulled up alongside Jenny and the man inside (one of the men who had abused Jenny as a child) opened the back door and said, "Get in". Jenny got into the car and the man reached back and closed the door. He then drove her to a flat, took her inside, and raped her.

I met Jenny a few weeks after that incident. In our initial psychotherapy sessions she was furious with herself for getting in the car, she ruminated over questions such as "why didn't I run, or shout, or say 'no'?" and berated herself with "I'm such an idiot, when will I learn?" Of course, when judging herself so harshly, Jenny had the benefit of the hippocampal and cortical functioning that had been unavailable to her when she chose to obey the man's command. Jenny had responded in the way her amygdala had been 'programmed' to respond. The traumatic experiences of her childhood would, undoubtedly, have resulted in a coupling of this man's presence with an amygdala-mediated flop response; a response that would have been reinforced by its repeated 'success' throughout her childhood (in much the same way that our genetic heritage favours and reinforces a freeze reaction to the presence of a snake). The fact that many years had passed since she had last seen the man was of no consequence, the neural networks that mediate reflexive fear responses are "context free, meaning that [they] contain no information about the location, time, or perspective from which the

learning took place" (Cozolino 2002, p246). Hippocampal input is required to ascribe a sense of time (LeDoux, 1996) – to both experience and memory – and with the level of fear Jenny was experiencing hippocampal processes would be unlikely to function. As a result Jenny would not have been able to support herself with the reality that many years had passed since her last encounter with this man, nor with the fact that she is now a grown woman with other options available to her.

Sadly, the consequences of the amygdala's learnt response can be grave for the most vulnerable people in our society. Fear results in a lowering of, the predominantly left brain, cortical and hippocampal functioning (van der Kolk, 1996a) and the individual becomes "dependent upon the neural circuits that evolved to provide adaptive defences for more primitive vertebrates" (Porges 2004, p24), the upshot of the fast reflexive response to perceived threat, is that longer-term wellbeing is too frequently compromised for short-term survival (Siegel, 1999).

Because the amygdala is densely linked into the neurological processing of both fear and attachment (Cozolino, 2002), survival and maintaining attachments are inextricably intertwined (Porges, 2004). Bessel van der Kolk maintains that terrified people do not move away from danger toward safety, rather that people fleeing threatening situations move toward 'home', the familiar, or their attachment object (van der Kolk, 2004). This has significant implications for individuals who perceive threat in their 'home' and/or perpetrated by someone they love. When confronted with a significant threat from someone depended upon, most people respond in a way that best ensures continued attachment to that person. Meaning, that even when escape is objectively possible, the likelihood of the amygdala eliciting a fight or flight response is low. This, coupled with the amygdala's tendency to replicate previously 'successful' survival strategies, results in many people being vulnerable to repeated (verbal, physical and/or sexual) assaults by their 'loved ones'.

If you have ever found yourself wondering why people 'go back for more', consider a time you had your heart broken by someone ending a relationship with you. I imagine there were family and friends willing to support and comfort you – yet I also imagine the person you wanted was the one who had caused the pain in the first place. Logical? No. But logic isn't the amygdala's strong point – survival and attachment are.

The extent to which we use attachment as a survival strategy can be observed in the phenomena referred to as Stockholm syndrome (van der Kolk, 1996). The term Stockholm syndrome was adopted after a 1973 bank siege in Sweden resulted in the hostages 'protecting' the criminals who had taken them captive, resisting rescue and ultimately refusing to give evidence against the hostage takers. Stockholm syndrome or trauma bonds result in the victim experiencing positive feelings toward their victimizer, negative feelings toward potential rescuers, and an inability to engage in behaviours that will assist detachment or release (Carnes, 1997). It develops after just four days of captivity within which the victim fears for their life, is isolated from other people and is subject to cruelty interspersed with small kindnesses. Hostage situations are relatively rare yet the described conditions are frighteningly common in domestic situations (Herman, 1992).

Why Are Some People More Susceptible To Traumatization?

Experience of trauma is part of the human condition (van der Kolk & McFarlane, 1996), and in a world where all creatures are located somewhere in the food chain, nature has evolved mechanisms to contend with the terror inherent in existence (Levine, 1997). Yet, despite these mechanisms, some people develop traumatic symptomatology following a traumatic incident. Symptoms of psychological traumatization include: the persistent re-experiencing of the traumatic event whilst (unsuccessfully) trying to avoid stimuli associated with it (APA, 2000); an inability to modulate ANS arousal (Ogden et al, 2006; Rothschild, 2000; Siegel, 1999); somatic symptoms (Briere & Scott, 2006); alterations in sense of self and identity (Herman, 1992); and compulsive re-exposure to, or re-enactment of, the trauma (Herman, 1992; van der Kolk & McFarlane, 1996).

Traumatic symptomatology has, at its foundation, a lack of sufficient neural integration (Cozolino, 2002; van der Kolk, 2003). The debilitating symptoms suffered by so many traumatized individuals are manifestations of survival strategies (the five Fs), at a time when survival strategies are objectively not needed. The person's nervous system continues to respond as if they are in danger - days, weeks, months even decades after the threat is passed.

There are a number of possible reasons for some people being more susceptible to developing traumatic symptoms. Notably, a person is more likely to become traumatized if:

they are very young (Schore, 2003) or very old when the incident occurs (Briere & Scott, 2006);

they have previous experience of trauma (van der Kolk, 1989);

they experience early life relational/ developmental deficit (Schore, 2001);

they are in captivity when the trauma occurs (Herman, 1992);

they utilize passive defences (freeze and/or flop) at the time of the incident (Levine, 1997), or are rendered immobile by some other means – anaesthesia for example (van der Kolk, 2003);

they dissociate at the time of the incident and/or exhibit dissociative symptoms immediately afterwards (McFarlane & Yehuda, 1996; van der Hart et al, 2006);

they do not discharge their high autonomic arousal levels once the threat had passed (Levine,1997);

they do not receive sufficient social and psychological support after the trauma has ended (Briere & Scott, 2006).

Additionally, interpersonal traumas, "whereby the incident is of human design" (APA 2000, p464), render the victim particularly vulnerable to traumatization (van der Kolk et al, 2007). The element of betrayal inherent in such traumas (Salter, A. 1995; Freyd, 1996) adds complexity to the task of recovery not observed with non-interpersonal trauma.

The Cyclic Nature Of Trauma

"Traumatized people lead traumatic and traumatizing lives" (van der Kolk & McFarlane 1996, p11). Notions of repetition are central to most models of psychotherapy (Moursund & Erskine, 2004; O'Brien & Houston, 2000) and for traumatized individuals their day to day existence is plagued with intrusive replays of the original trauma. van der Kolk (1989) argues that contrary to Freud's belief that repetition is an attempt to gain mastery, traumatized individuals rarely do so and, the cycling of behaviours, cognitions and affect associated with the trauma merely cause more suffering to the victim and the people around them. Trauma re-enactments are common and take the forms of: revictimization, self-injurious and self-harming behaviours and externalizing the trauma by victimizing others (van der Kolk & McFarlane, 1996).

My close colleague, Kim Hosier, illustrates the concept of trauma re-enactment with an ice-skating metaphor: If a skater makes a circuit of the ice, a shallow groove will be left. If the skater then repeats the circuit the groove will deepen. Add a third, fourth and fifth circuit and the groove becomes significant. Soon the skater will find taking a different route across the ice difficult, and to do so will take concentration and effort. Should the skater manage to alter her route there is high probability that she will slip back into the groove created by the original circuit. Kim contends that psychotherapy with traumatized people is all about helping them to make different patterns in the ice.

In neurobiological terms the 'grooves in the ice' are neural networks created by the firing, and wiring, together of neurons. This is the basis of all learning (Cozolino, 2002). Without the capacity of the brain to create readily, and unconsciously, activated neural pathways it would be necessary to relearn how to walk every time. Indeed, the neural pathways that govern walking were organized at a time when hippocampal and cortical functioning were under-developed (similar neurological conditions to those elicited

by trauma) yet walking is something we remember how to do, even if we do not recall how we learnt to do it (Cozolino, 2002). The habitual patters of behaviour that result in the cycling of trauma are encoded similarly.

For traumatized individuals memories of trauma are determined differently to non-traumatic memories. The hippocampus and cortical regions of the brain are central to the mediation and storage of explicit memory, which is autobiographical, organized by language, adaptable, contextualized and subject to conscious organization and recall (Cozolino, 2002; Siegel, 1999). Because trauma disrupts hippocampal and cortical functioning their vital role in mediating explicit memory is also disrupted. As a result traumatic experiences are more likely to be stored predominantly as implicit memory (Cozolino, 2002; LeDoux, 1996; Siegel, 1999), which is emotional, sensory, less adaptable, context-free, and concerned with unconscious procedural learning (Cozolino, 2002; Rothschild, 2000).

Let us again consider Jenny's experience outlined earlier in this article. When told to get into the car she did, and only afterwards did she berate herself for not having elicited an active defence: "why didn't I run, or shout, or say 'no'?" (shouting would have constituted a 'friend response', saying "no" a 'fight response' and running a 'flight response'). Remember, when threatened the human system responds reflexively with amygdala-mediated defences, and because the amygdala is densely linked to implicit memory (including implicit data about previous traumas) it will be hyper-sensitive to any trigger related to previous trauma. As outlined earlier the amygdala has a tendency to generalize (e.g. snake-like objects elicit the same response as snakes) and coupled with the context free form of implicit memory this is a cocktail for trauma replay.

For traumatized individuals to break the trauma cycle they must be supported to assign the original trauma to the past, where it belongs.

Principles Of Recovery From Trauma

I have thus far outlined current neurobiological thinking concerning the human response to threat. A basic understanding of the processes involved is essential to any trauma worker. Because implicit memory is context free whenever it is triggered the traumatized client will re-experience, to a greater or lesser extent, the amygdala-mediated survival response and the ANS (autonomic nervous system) activation, experienced at the time of the incident. Memory can be triggered unconsciously within therapy (stimuli that cause intrusive non-choiceful recall and/or replay of the incident) and also consciously (when we ask, or encourage, our clients to talk about their traumatic experiences). Whether consciously or unconsciously elicited, unless the client is actively supported toward regulating their out-of-context fear response, the likelihood is that recall will simply add another groove to their trauma script.

In this section it is not my intention to present a model for working with trauma, there are many excellent models available (Herman, 1992; Ogden el al, 2006; Rothschild, 2000; Shapiro, 1995), instead I intend to outline some basic principles that will be readily integrated into most therapeutic paradigms. I will briefly address each of the principles:

Prepare well: A solid working alliance is essential to trauma work. The client needs to be well enough resourced (Shapiro, 1995), both internally and externally, before you can begin to process the trauma.

Support the client to remain within their window of tolerance (Siegel, 1999). "Each of us has a 'window of tolerance' in which various intensities of emotional arousal can be processed without disrupting the functioning of the system" (Siegel 1999, p253). Emotional arousal beyond tolerable levels results in either hyper-arousal (which roughly correlates with fight and flight) or hypo-arousal (akin to freeze and flop) of the ANS (Ogden & Minton, 2000; Siegel, 1999).

The client's experience of hyper or hypo arousal, during a psychotherapy session, is likely to indicate a replay of the original trauma, and a displaced (in time) fight, flight, freeze or flop response. It is important to support the client (and yourself) in countering the effects of hyper and hypo arousal and thus remaining

in, or returning to, the window of tolerance. Only when the client is firmly within their window of tolerance will they possess the integrative brain functioning necessary for recovery. My clinical experience suggests that a combination of the following techniques work well in helping the person to remain within their window of tolerance and also in expanding the breadth of the window:

Monitor and manage respiration (note: breathing is the only function of the ANS that most people can bring under conscious control). To regulate hyper-arousal (fight/flight) encourage the client to 'blow out' through their mouth; for hypo-arousal (freeze/flop) encourage the client to take deep in breaths.

Draw attention to the current, non-threatening, reality. You can do this in a multitude of ways. For example you might state: "right here, right now nothing bad is happening", or "you are remembering something that already happened, it is not happening now – it is a memory"; or you might ask the client to look around the room and name the things that are familiar to them.

Ensure that cortical and hippocampal functioning remain available to the client. If functioning appears to be significantly impaired ask the client simple cortical questions like: "how many fingers am I holding up", "what colour is that lamp", or "how many panes can you count in that window". Keep the questions simple and observable.

Ensure that neither you nor your client becomes immobilized during sessions. If you discover either, or both, of you are frozen immediately act to rectify the situation. Start with small movements, for example encourage the client to wiggle their toes (obviously it is important to explain why you are doing this).

Ground, the client, through their body, to the here and now (Rothschild, 2000). There are many ways of doing this and it is especially useful for clients who experience periods of dissociation, depersonalization and/or derealization during sessions. You might, for example, bring the client's attention to the physical sensation of the ground under their feet and perhaps suggest that the client pushes into the ground (as if to push their chair over backwards, but without actually doing so).

Utilize what you know of your client's good experiences, relationships and 'safe place' (Shapiro, 1995), to slow the process down (Rothschild, 2000). For example, if you know your client feels safe in his garden encourage him to imagine himself there and to describe what he sees, hears, smells, tastes and feels; or if your client has a beloved pet encourage them to conjure up an image/sense of that pet as if they are with them now.

At all times aim to expand the client's window of tolerance and their neurological integration. Putting narrative to traumatic experience increases integration among neural networks (van der Kolk, 1996a) however, it is imperative that you only do this whilst the client is contained within their window of tolerance. It is also important to recognise that the 'story' is therapeutically less important than the present moment experience. Bring your attention, and that of the client, to the moment by moment experiencing of cognitions, emotions, five-sense perception, movement, inner body sensation and the shifting relationship between them (Ogden et al., 2006).

Work toward symptom reduction, be patient and encourage the client to be patient too. The implicit memories being addressed, whether directly or indirectly, are often as hard wired into the brain as the way we walk. If you have limited time to work, focus on managing the symptoms and increasing the client's resources.

Be predictable. Clients need to be able to rely on your 'sameness' – trauma is about dysregulation and you need to model regulation. Traumatized clients will, frequently, be hypervigilant and will pick up any changes in you and their environment. Often their senses are spookily astute, yet they will tend to interpret their findings within their traumatic experience. For example a woman who was physically abused by her sadistic mother might interpret your tiredness (induced by antihistamine) as being an indicator that she has angered you and that she is in danger.

Know that "recovery can only take place in the context of relationships….In her

renewed connections with other people, the survivor re-creates the psychological faculties that were damaged or deformed by the traumatic experience" (Herman 1992, p133). And, above all be vigilant for the 'pull' to re-create the client's trauma!

Sustenance For The Trauma Worker

Fear is readily transferred from being to being, to increase the likelihood of the herd, pack or the clan's survival (Levine, 1997). This is very useful when genuine danger is present, however for workers who spend hours in close proximity with traumatized individuals the effect on their ANS can be profound. For that reason it is vital that anyone who works with trauma, not only supports their client to regulate their nervous system, but ensures they attend to their own – both within, and after, sessions.

The psychotherapist needs to be attentive to their own ANS activation to ensure that they remain within their window of tolerance. Indeed, the therapist who becomes adept at paying mindful attention to their own ANS and bodily states will have a useful barometer for what might be occurring within their client. If a therapist recognises a significant swing toward either hyper or hypo activation they must first attend to their own need for regulation before concerning themselves with their client. This might seem harsh to the empathically attuned psychotherapist but a dysregulated therapist is of little use to his or her client(s).

Similarly, I strongly recommend that therapists actively choose not to imagine the traumatic scene as the client tells their story (this is not easy for clinicians and that is why I suggest an active decision not to 'go there'). Instead attune to the client's current ANS activation and provide vital support to the client in remaining sufficiently grounded in the here and now.

In conversations with colleagues I have recognised that it seems to be a common experience that, despite good diary management, clinicians will sometimes find that all of their most traumatized clients are coming on the same day. Ensure you have time between sessions to attend to your needs and, ideally, have colleagues available to support you in noticing what you are missing.

It almost goes without saying that good, regular, supervision is imperative for anyone undertaking trauma work. Ideally your supervisor should be familiar with the effects of vicarious traumatization and burn out, and should be vigilant at recognising when you are 'stepping into' some form of trauma replay. A good solid supervisory alliance is essential if the therapist is to feel safe enough to allow the depth of supervision necessary for this type of work. The mechanisms of friend, fight, flight, freeze and flop will almost certainly be evident in the supervisory process, as will traumatic re-enactment, and the reactions so often experienced by trauma survivors themselves will, from time to time, be elicited; notable among them are: denial, withdrawal, disgust, admiration, voyeurism and blame.

Conclusion

Trauma has a dis-integrative impact on brain functioning. The dissociation between neural networks is, initially at least, intended to optimize the individual's chance of survival. For some people the dissociation and lack of integration persist and a wide array of traumatic symptomatology are exhibited. Psychotherapy with traumatized individuals should ideally aim to increase neural integration, top to bottom (Ogden et al., 2006), and left to right (Shapiro, 1995). Neural integration is increased when the client is supported to remain within their window of tolerance and, previously dissociated, cognitions, affect and body sensations are reconnected. With neural integration comes better regulation of the ANS and associated symptom reduction. Traumatic experiences can then be assigned to the past, where they belong, and the once traumatized individual is released from the cyclic nature of trauma.

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Philippa Perry

Working With Dissociation

Abstract

In my experience of the British psychotherapy world there is a general interest in the implications of dissociation but the need to sharply vary technique is less well understood. Without attempting to be comprehensive, this paper surveys recent clinical writing on the techniques and management required when faced with dissociation in general and dissociative identity disorder in particular. For clinicians in this community where object relations on the one hand and a humanistic approach on the other have been in the ascendancy, considerable re-learning on the part of many (though of course not all) therapists maybe necessary.

I give an example of a mis-diagnosed client, ways of diagnosing dissociation and ways of treating dissociation. I draw on a variety of approaches including: psychoanalysis, sensorimotor psychotherapy, ego state therapy and neuroscience.

Introduction: Sue's Story

Sue is a real person but identifying details have been changed. It has never been possible for me to work with Sue because we live in different parts of the country but we have been in email contact for ten years. Her story is my motivation for writing this article. Sue has been through several therapies and blocks of counselling sessions and has been given countless diagnoses including: borderline, bi-polar, depression, resistant to therapy, troublemaker etc. So who is she? She is a 28-year-old single mother, a qualified specialist nurse, who has managed to get her own home and run her life in a responsible way. She is intelligent and articulate and copes with the normal stresses and strains of work. She had a good circle of friends. This has been a difficult accomplishment because she has had to learn that she cannot share all of herself with friends if they are to remain friends and she has had to learn that people do not respond well to her testing the limits of their friendship, but she has learnt this and continues to learn it.

She may have learnt it but it has not helped her deal with her dissociation or her post-traumatic stress disorder. She suffers terrifying flashbacks when her mother's boyfriend is raping her 9-year-old self. Unfortunately this happened to Sue regularly from the ages of 9 to 12. She not only suffers these flashbacks but also lives with the fear of having them all the time. Even when not having the visual part of the flashbacks, sometimes it is as though she is 9 years old again and feeling the hopelessness of her situation then as though it is happening now. She feels the emotional pain of her mother's betrayal and even if cognitively she knows what happened to her is not her fault, it does not feel that way in her body. She feels ashamed, dirty, ruined and she hates her body. Sometimes at a loss to know what the pain is, or where it comes from, or how to stop it, she takes a sharp blade and cuts the flesh of her thighs. This helps her to zone out from the pain, be in control of the pain and it temporarily calms and restores her.

Sometimes she gets bad headaches and neck pain and then switches into an angry adolescent persona who cannot believe she can continue to manage bringing up her son, going to play group, going to work and remembering to pay her council tax. When she is in this state she believes her son would be better off without her. It is as though she has no access to the sensible adult that runs her life so well.

When she fully inhabits the adult part of her she can doubt the abuse took place and wants to think she imagined the whole thing.

Another National Health Service time limited therapy has just ended. It took her a while to share with the therapist and then as she was beginning to trust her, the therapy was over. The pain she had managed to dissociate from before therapy she was now experiencing intensely and daily and was at a loss to know what to do about it. She is suffering flashbacks and fear of flashbacks. She had no spare money for private treatment. She is angry and nearly every evening after work or a day with her son the switch to an adolescent persona happens. It sometimes means her three year old son will possibly have to put himself to bed and he may be shouted at or even smacked.

She has learnt to regulate her moods to some extent without cutting but she often feels now, that self-harming is her best option and only by drawing her anger, emailing the Samaritans and thrusting her hands onto ice cubes in the freezer can she sometimes manage to put off self-harm as a way of coping.

Why haven't the numerous therapies that Sue has been through since she was 18 helped her significantly?

Firstly because they have all been time limited, Sue has never had enough time to trust the counsellor, therapist, the psychiatric nurse, the psychiatrist, the psychologist before they have ended, or she has learnt to trust the practitioner but the relationship was then terminated before the work could begin in earnest, and Sue is then re-traumatised by the abandonment.

Secondly because it would appear that our profession is not sufficiently familiar with working with dissociation or dissociative states, or even diagnosing them. Colin Ross reports that most patients with dissociative identity disorder see several therapists and have an average of seven diagnoses before finally finding someone who understands the dissociative aspect of their behaviour (Ross, 1989).

What Is Dissociation?

According to Schore (2007) it is an involuntary, automatic, passive biological coping mechanism. When the hyperarousal in the organism is too high, the heart rate drops significantly into a state of hypoarousal. Sensory information comes into the limbic system but there is an internal severance so that the information does not pass into regions of the brain that could process what is happening into memory. This means that experience or emotion, rather than being processed in the normal way into accessible memory, is blocked from the conscious self. This passive coping strategy is manifest as detachment from an unbearable situation: the escape when there is no escape; a last resort defensive strategy and involuntary disengagement. Schore (2007) quoted Kalsched (2005) who said that affect in the body is severed from its corresponding images in the mind and thereby an unbearably painful meaning is obliterated.

A dissociative state could be described as living from a zoned out or blanked out position, or switching to and from that position. This is sometimes known as Depersonalization Disorder, (DSM-IV), or sometimes people dissociate by switching to a completely separate ego state, this state might not necessarily be aware of other ego states housed in the same body, known as Dissociative Identity Disorder in DSM-IV.

Different therapeutic disciplines have different names for these ego states. They are sometimes known as "alters", "personas", "psychic states", "split off parts", "self states", "states", "dissociated states" and "ego states". The important thing to remember is that they are not metaphors but actual states of being that came about through dissociating from an event that happened. I use the different names interchangeably throughout this article. In this article when I refer to a "child ego state"

what I mean is a dissociated separate state that is not as developed as the adult part of the patient as the dissociation happened when the patient was a child and the development of that state was arrested at that time.

The formation of a separate ego state can occur as a result of chronic trauma, such as sexual abuse by a trusted parent. Messler Davies & Frawley (1994, p62) argue that "the enormity of the betrayal and of the physical and psychological violation is too great for the ego to tolerate…it is too overstimulating [and overwhelming] to be processed and recorded along the usual channels, [so] it is cordoned off and established as a separate psychic state within the personality, creating two (or more) ego states that alternate in consciousness and, under different internal and external circumstances, emerge to think, behave, remember and feel."

From my clinical experience, clients have shown me that the boundaries between ego states can vary from porous, where the different states do have knowledge of each other to dense where they do not. The porousness can be in one direction only, for example, when an adult alter has knowledge of a child alter but the child alter does not have knowledge of the adult alter. This can be frightening. If a person is only experiencing their child alter they can feel, for example, that they will die if they are alone. Braun (1986) points out that dissociation is a separating process that extends through a continuum from normal and adaptive differentiation to other extremes of pathological dissociation, like dissociative identity disorder. He also points out that dissociation can occur in one or more specific spheres, such as "behaviour, affect, sensation, and knowledge." He calls this the BASK theory of dissociation, (Braun, 1988, quoted in Watkins and Watkins 1997, p39). I think it is important to bear in mind that dissociation happens on a scale, we all dissociate to some extent.

Why Does The Body Dissociate?

Dissociation is an automated survival strategy. Human beings and other mammals dissociate in order to escape from the overwhelming emotions associated with trauma.

"When abuse is so psychologically and physically painful the terrified child has only three options: She can die, and some children do; she can disintegrate into a complete psychosis, and some children do; or she can dissociate…" (Watkins and Watkins 1997, p.43). In a staring competition between my cat and a mouse he has cornered, I have witnessed the mouse die of fright; it appears that the mouse's ability to dissociate was impaired. A man is hurtled through a windscreen and escapes death by landing on the grass; he has no recollection of the journey, from before the accident happened to when he awoke in hospital. He blanks out but does not die of fright. He may, however, subsequently suffer from flashbacks or difficulty in controlling emotions, for example anger, or becoming more unfeeling than before the accident, and somatic pains for which no physical cause can be found.

What's The Difference Between Dissociation And Repression?

Repression is when a memory is processed and encoded and then pushed down to be forgotten and all this happens within the same ego state. If the memory is like coffee grounds, they are actively pushed down to the bottom of the pot. It is like a horizontal movement. Whereas dissociative memory is not processed by being encoded or put into language but makes more a vertical jump forming another ego state. To continue with my coffee ground simile, the grounds do not even go into the pot but become a separate pot altogether. Frawley and Messler Davies (1994, p66) describe the difference,

"Repression is an active process through which the ego attains mastery over conflictual material. Dissociation, on the other hand, is the last ditch effort of an overwhelmed ego to salvage some semblance of adequate mental functioning… Repression brings about the forgetting of once familiar mental contents (i.e. events, affects, identifications, etc.). Dissociation can occur between categories of mental events, for example, good and bad experiences with the same object, between certain events and their affective representation… between events and the meaning of those events…perhaps even between events and the words that symbolically represent them. Therefore, a patient can be aware of an abusive trauma in one state and

completely unaware of its existence in another. Likewise, a patient can retain memories of an event but have absolutely no access to their emotional impact except within an alternative state of consciousness." Some people only dissociate very rarely and spend most of their lives functioning in an adult persona. Then an event may trigger a switch into, say a sort of howling baby state, and a formerly very stable person can become very distressed, unable to think through the situation and may become suicidal. The material that is causing this is not repressed because it has never been remembered and then forgotten. It became a separate psychic state and stayed the age it was at the time of whatever the trauma was that occurred.

The Dangers Of Dissociation

The issue is that once the trauma is over and the threat no longer exists, the body having learnt to easily dissociate will do so in a way that can interfere with life functioning, which is what makes it maladaptive in the present, or as Schore (2007) puts it: "Dissociation represents an effective short-term strategy that is detrimental to long-term function".

In adult survivors of childhood sexual abuse, the child that was abused becomes a separate ego state, or 'alter' and does not continue to develop. This is not the same as 'an inner child' or imagined part, used in role-play in some therapies, but a real separate identity. The part that did not dissociate carries on developing, growing, learning and becomes adult. Sometimes external or internal stimuli trigger the younger part to emerge, for example a common trigger is the threat of or actual abandonment. The patient may experience a flashback to the abuse as though it was happening again in the present together with the emotions felt at the time, or the emotions triggered by the original events may be felt again without visual memory. The emotional and often physical pain experienced during these episodes is so chronic that the adult part may want to kill this child part off to find relief from the pain, or the child part wants to kill itself. As the child part has not the cognitive powers of the adult, they may not realise that to kill themselves means that the adult part would not survive. So there is a real risk of suicide in this client group.

For example, Belinda (not her real name) is a highly successful, high earning city lawyer with a circle of friends. She told me that she had been surfing suicide web sites. When I made enquiries around this I learnt that ever since she has met this man that she is getting on with okay, she has felt really needy, like a needy baby and that it is unbearable. Belinda says this needy part is so insatiable for reassurance that she has sabotaged every relationship that she has been in, or could have been in. On further enquiry she reveals she cannot think of a way to stop feeling like this other than killing herself. On further examination we learn that it is not all of herself she wants to kill off but just the needy part which hurts so much although she feels it does not matter that the adult part dies too as she feels that part is a fake and it will only be a matter of time before she is found out.

Messler Davies and Frawley (1991, p281) put it: "It is remarkable to observe the degree to which most survivors can painstakingly erect the semblance of a functioning, adaptive, interpersonally related self around the screaming core of a wounded and abandoned child". A disadvantage of this semblance of functionality is that people around the client, including some mental health workers do not identify that the client's risk of suicide and/or self harm is considerably heightened.

How To Diagnose Dissociation

Dissociation can be difficult to diagnose and creating a psychologically safe environment and empathetic tracking is more important that a diagnosis in the initial stages of therapy. However, I believe it is necessary to understand the structure of the different self-states in the one person and for the client to understand that too if the therapy is to bring about permanent improvement in the client's life.

A danger of not diagnosing dissociation is that the therapist can inappropriately challenge a client. For example when I challenged a client I will call Joan about her simplistic reasoning – drinking coffee means I am bad – it only made her feel more isolated,

lonely and confused. This is because it was not an age appropriate intervention and I took the reasoning on face value rather than looking for the meaning behind it.

If the possibility of different self states is not thoroughly understood by the therapist there is a danger that the therapist can side with the presenting alter in wanting to eliminate parts of the client's personality. Messler Davies and Frawley (1991) point out the dangers of this collusion with the adult alter in denying the reality of the child alter. They say that, it may be comforting for the therapeutic pair to intellectualize and dismiss the "as yet dimly illuminated perceptions, which cause such panic and terror" and perhaps pass them off as Oedipal fantasies. This represents a secondary betrayal of the child whose original abuse may have been denied or pushed aside and it also damages the fragile reality testing system of the patient. It may be simple for the adult self of the client and the therapist to agree on a strategy that appears to silence the child and at the same time make sense of the nightmares. The client may even feel contained by such an approach and, while in treatment, feel safe. However on ending treatment the limited effectiveness of such an approach becomes clear. Many therapists report having patients who have supposedly completed other treatments but where the raw, primitive, internal world of the abused child ego-state has not been processed. When this is the case trauma re-surfaces in flashbacks and/or in potentially harmful re-enactments and/or in an inability to self-regulate.

Even though the DSM-IV (p529) in the criteria for Dissociation Identity Disorder talks about "distinct identities or personality states," (my italics) the differences may not be that obvious. In some clients, the ego states are distinct but they may not at first appear to be so, which is one of the reasons that this disorder often goes unnoticed and therefore untreated.

It took me a long time to realise when I was working with Joan that when she started to obsess about her coffee drinking and what a bad person she was for drinking it, that a possible reason for the obsession was to blank out the feelings about an event that had happened during the week. The indicators that alerted me to this being a separate ego state, rather than just an obsession was her thinking seemed far more limited and rigid than it normally was and she could not remember the coffee conversations when I referred to them later. It can also be argued that dissociation and dissociative identity disorder occurs along a continuum so a patient may not present as obviously as 'Sybil' who had her story dramatized in a Hollywood movie about multiple personality disorder.

People come to therapy for many, many reasons, e.g. stress, anxiety, panic attacks, depression, feeling chaotic, relationship difficulties, etc., etc. A person who dissociates will come for just the same reason or reasons as anybody else. The initial goal of the therapist will be to learn why the client wants therapy and to take a thorough history to determine the most likely direction to proceed. It may not be at all obvious that a client is dissociative. Below, I discuss certain signs and criteria than can alert the therapist that their patient could dissociate; they might not all be present but if any of them are it might be worth looking out for in order to better understand the client so that the most expedient techniques in treatment are used.

As an aide memoir I have put these in alphabetical order: Amnesia; Borderline; Conflictions/Contradictions; Countertransference; Dissociation and Experiences Flashbacks. I call this the "The ABCCCDEF Guide to Dissociation Diagnostics".

Amnesia

Amnesia that occurs currently and/or tracks of time that cannot be accounted for can be an indicator that the client dissociates. If a client reports having no memory, for example, before the age of twelve, that memory may have been dissociated. Once, a client was telling me about his school days when he became very interested in my carpet and asked me lots of questions about it. I managed after about ten minutes to get him back to the subject. At the end of the session I referred to his interest in my carpet and he could not remember asking about it, or our conversation about it. Nor was he surprised that he had no recollection of that conversation because he reported that he

often blanked out. Sometimes memories may appear to be patchy, incomplete and reported out of sequence: a client may be able to give reports of affect and sensation but be unable to put these experiences into a sequential narrative, or may be able to remember events but not the feelings that they evoked.

There may be unexplainable physical symptoms e.g. stomach aches, headaches, backache, neck pain, these may be able to be explained as body memories, the narrative for which has been dissociated (Ogden, 2007). Dissociative clients often doubt their own memory and may ask the therapist what is true. The amnesia in people who dissociate is more serious that normal forgetfulness.

Borderline Tendencies

The criteria for borderline personality disorder are often met or nearly met by people with dissociative disorders. They may have a chaotic lifestyle that often includes re-traumatising incidents and relationship difficulties. Like borderline clients they have often seen several different therapists before without making much progress. It is also usual for people who dissociate to have had a number of different diagnoses.

Conflictions/Contradictions

Mood swings can be an indicator for a dissociative disorder as the swing may actually be a switch from one alter to another. In the same way, it may appear that the client alternates from being able to self-regulate well to being unable to self-regulate. Along with mood swings and other differences, look out for conflicting information. For example a dissociative client may say something like, "I had tons of friends" then later, "I always felt alone." This is because one alter may have had friends and another alter had no external or even internal contact. Another sudden change you may notice or may be reported to you by a dissociative client is their suddenly freezing and feeling unable to move or make a simple decision or feeling unable to complete a task that would be thought to be well within his/her capability. For example Joan who has a degree and has worked as a teacher, had to do a simple stock taking task that just involved counting a few boxes. She reported freezing, feeling tearful and feeling completely overwhelmed by what seemed a very complex task, a reaction she was very confused about later. These types of reports by a client of behaviour that she struggles to understand and seems unable to control, and that go beyond ordinary ambivalence, can be an indication of a dissociative disorder. Also be aware of subtle changes in voice tone or even accent and different styles of dressing and self-presentation as these may mean that a different alter is present.

Countertransference

In the countertransference, you may notice a feeling of a break of contact, or a change in tone or atmosphere in the room. Schore (2007) describes this as the "Therapist's somatic countertransference to patient's subtle expressions of right brain dissociative hypoarousal". When Joan, the client mentioned above, started talking about coffee it felt to me as though, the person that had been sitting with me, had floated away and there was a shell of her there instead. I noticed that I physically slumped when this happened and felt a feeling of emptiness. Sometimes it is as though you feel your client is acting out of character and yet if you challenge the client about this, they have great difficulty in understanding you and your challenge may feel attacking and/or disorientating to them.

Dissociation

Patients report that they are 'tuned out' or 'blank' and are not aware of anything; sometimes going fuzzy or zoning out in response to the therapist's questions or interpretations. The individual has recurrent experiences of feeling as if he is walking in a fog or a dream. Clients report that it seems as if they are observing themselves, yet they feel detached from their surroundings. (Haddock, 2001). They may report a sensation of floating up to the ceiling and looking down on themselves.

Experiencing Flashbacks

Memory that has been dissociated can re-surface in the form of flashbacks. A flashback experience is like reliving an event that happened as though it is actually happening again. It may not be a complete memory. It can include images, sounds, smells, or feelings, all of these sensations or just one of them. After the 7th July tube bombing in London, many of the rescue workers could not stop themselves having the flashback of the smell of the tunnel for months afterwards (Emerald, 2007). Flashbacks sometimes have triggers (such as the anniversary date of the event or particular sounds or smells) but flashbacks may also occur without a specific trigger, even when the person is relaxed.

There are various questionnaires to measure and diagnose dissociation and these are available from The International Society for the Study of Dissociation. http://www.isst-d.org/ (Haddock, 2001).

How To Treat Dissociative Disorders

Stages Of Therapy

Pierre Janet, the father of dissociation, in 1898 identified three stages in its treatment (Ogden, 2007).

Symptom Reduction and Stabilization

Treatment of Traumatic Memory

Personality (re)integration and (re)habilitation.

I would add to these, a primary condition, that of establishing a good working alliance.

Working Alliance And Symptom Reduction And Stabilization

Crucial to the therapy will not be so much what to do but how to be (Schore, 2007). Whatever techniques are used, as in all therapy, a good working alliance is absolutely necessary if positive change is to occur. When working with a plurality of ego states a clinician needs to be on her guard and be able to practice inclusion with each state. Unlike working with clients who do not have such a fragmented self this will entail what may feel like contradiction. It is important to remember the boundary between ego states can fluctuate and sometimes an ego state believes in is own separate existence and believes that it can interact with the outside world without its co-existing ego states. I find Watkins and Watkins' suggestion helpful when they propose working as a family therapist, the separate ego states being the members of a family (Watkins & Watkins, 1997). They suggest that it is important to make all the 'family members' feel safe and that no one will be banished even if another family member wishes that to happen. When working with a person with separate ego states it can be important, like it is for a couple therapist, to take on board both people, to practise inclusion with each state and not to side with one state at the expense of another. An angry adolescent persona is going to be more of a challenge than a younger hurt child or a functional adult but it is important not to alienate any part of the person. Your working alliance is not just with the ego state that first presents in therapy.

For example, when I worked with Joan, when the part of her obsessed with coffee drinking appeared and how bad she was to drink it, I used not be able to engage with this part of her. When I realised that this was a separate state rather than a mood or a conscious choice, I adjusted to this state and was able to empathise with it more. I found that this state was young, it was the part that thought if she could identify a behaviour that was bad and stop it, then she would be able to control her parents' cruelty towards her. Her adult part recognised the search for this bad behaviour and she was gradually able to notice when she switched into 'coffee lady' and she was able to gradually reason with 'coffee lady' in a way I had been completely unable to do before either of us recognised her as a separate alter. Fraser (2003) says that to ignore the clients' subjective reality of such ego states often leads to therapeutic failure, a fruitless focus solely on the comorbid conditions, termination of therapy, or a flight to another therapist.

Part of establishing stabilization and getting a firm ground for the work to build on is for the treatment to be open-ended. This is not

so they go on forever but because some of the alters or ego states within a person will need longer to trust the therapist than others and before the work can truly start, the alters need to know that the goal of therapy is to integrate them, or to get them all aware of each other and working together and not to annihilate any of them. If there is a known end date for the therapy, some alters might not present themselves in the therapy at all.

The patient may or may not know that they dissociate or switch to alternative ego states because one of the functions of dissociation is to block off the chaos from consciousness. To have the diagnosis may be of great relief to some clients, and to others it might even create a new set of problems. I feel the best time to give the diagnosis is when the client needs to make sense of how he is feeling. Sometimes it may be helpful to present it as a diagnosis and with other clients as an interpretation or a sense making suggestion. It is also important to go at the client's pace. She may need to answer and wrestle with many psychoeducational and existential questions before going any further (Haddock, 2001).

I suggested to Belinda that maybe what she called her needy part could be a part of her that split off and dissociated because of the way she had been abandoned and abused as a child and this part of her was mostly quiet until the chance of a visceral relationship awakened her again. Belinda resonated with what I said and was relieved. I told her that rather than kill off the baby part she needed to hear her, empathise with her, understand her and care for her. When Belinda switched to this needy baby-like alter, I cared for her and responded to her, and felt with her in an age appropriate way. The adult part of Belinda has been working to do this too and the need for this type of unconditional love from potential partners towards this part of her has therefore considerably lessened along with her fantasies about suicide. I am uncertain whether Belinda could be diagnosed with a full blown dissociative identity disorder but bearing that dynamic in mind helped me make the interpretations that made a difference to her increasing self-awareness and improved self management and helped me see that such a successful, functioning adult can also be a very needy child that needs caring for like a young child.

Messler Davies and Frawley (1991), report that it is nearly always the adult-self who presents herself for treatment. Only when she trusts the therapist, will a different persona, usually a child-self, emerge. This child self needs acceptance and acknowledgement, love and validation given by the therapist in age-appropriate responses. Only by entering, rather than interpreting, the dissociated world of the abused child, can the therapist 'know' through his own countertransferences, the overwhelming episodes of betrayal and distortion that first led to the fragmentation of experience.

This way of being in dialogue is described by Scott Peck (1978) as the willingness of the therapist to extend himself or herself for the purpose of nurturing the patient's growth, a 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. Buber (1947) indicates in his writings how the psychotherapist, to establish a genuine dialogical relationship, needs to practice what he calls inclusion. He likens it a bold swinging, demanding the most intensive stirring of one's being into the life of the other. In other words, the therapist needs to be able, as much as is humanly possible, to attempt to experience what the client is experiencing, from her side of the dialogue. Schore (2007) stresses the importance of 'right brain to right brain' nonverbal communication and says that psychotherapy can be seen as more the 'affect communicating cure' rather than the 'talking cure'. An effective and affective, right brain to right brain, therapeutic alliance in itself helps to act as a mood stabilizer. By 'right brain to right brain' Schore means interaction of the patient's unconscious primary process system and the therapist's unconscious primary process system. Practising intersubjectivity can be a challenge for the therapist when, for example, the therapist is presented with an extremely bleak picture with which it is hard to identify or with very simplistic thinking such as my example with Joan when she emphatically states that her drinking coffee means that she is a bad person, or when

the therapist is presented with an opposite view than what was previously presented.

Part of the stabilization process is creating safety. (Messler Davies & Frawley 1994, p66) write: "It is not uncommon for analysts to feel that such patients are on the verge of a psychotic decompensation and to inadvertently resort to heroic rescue measures – inappropriate overmedication, hospitalisation, even shock treatments – in an effort to stem the tide of what looks like a burgeoning psychosis…[this can] communicate to the patient the analyst's inability to understand the material that is emerging and the patient's fearful reaction to it." They go on to say that it may be necessary for the therapist to work with a psychiatrist in case medication or even residential care would support the therapeutic pair. Although medication and hospitalisation are needed on occasion to support some patients through the re-emergence of chaotic experiences, it is important that the therapist does not overreact. If the therapist goes into a sort of parallel process, the panic in the therapeutic pair could spiral. To create containment and safety the therapist should remain calm. Any medication or residential care must be understood as temporary supportive measures to contain traumatic re-enactments whilst the therapeutic pair processes them to give them language, meaning and to organise them. Medication and residential care are not adequate long-term solutions. The therapist should see chaotic experiences not as psychotic ravings but rather the courageous attempts of a previously traumatized patient to make sense of her dissociated states. This will go a long way towards establishing meaning that will help to contain episodes in treatment. If hospitalization or medications are necessary, they should be viewed by the therapeutic pair as aids to help them open up the work, not to shut it down. Schore (2007) reports that in response to the patient's hypoarousal (slowing heart beat, frontal cortex functions switching off), the therapist can unconsciously, in attempt to rouse the client, go into hyperarousal and he says that this is counter-indicated for successful treatment outcome.

It is useful to work with patients on an out of hours emergency plan, including relaxation techniques, grounding techniques, numbers to ring and other activities such as journaling, emailing and art work to help keep them safe.

An advantage of giving a diagnosis is that it normalizes and therefore aids the stabilization process. Shame is a normal response if a client views herself as defective in any way. Patients might fear being found out by others and want to disappear or even rely on dissociation as a way to disappear and avoid further shame. Schore (2007) reminds us that "Shame throws a flooding light upon the individual, who then experiences a sense of displeasure plus the compelling desire to disappear from view, and an impulse to bury one's face, or to sink, right then and there, into the ground which impels him to crawl through a hole and culminates in feeling as if he could die." So working with, rather that ignoring shame is important, as it is often a factor in suicide ideation. Shame and the desire of one ego state to annihilate another ego state means it is important to point out that dissociation is a normal human reaction providing a life saving defence in the face of seemingly life threatening situations. It is also normal for the body to continue to use dissociation after the threat of the trauma has passed. It has worked so the body unconsciously carries on using it and this may cause further splitting in the personality.

It may be important to teach the client about their negative beliefs because until there is awareness about these there is the probability that they could sabotage the work later on. Again, it is vital to go at the client's pace and at each alter's pace. Each alter may have their own negative beliefs and the therapist will be able to employ sophisticated language with one alter but another alter may be much younger and need a lot more understanding as to why the beliefs are there and how they are held before they can be challenged, if they can be at all. The world may be an easier place to live if we have the innate expectation that most people are nice, it is a safe place and we can expect many of our needs to be met but early trauma teaches us just the opposite, then the world is a dangerous, frightening place, others are not to be trusted and I never get what I need therefore there is something very wrong with me, I am bad. Quite often alters will do their best to convince the therapist that they are 'bad'. Knowing to expect this allows for the possibility of welcoming

whatever parts present and understanding them and giving meaning to what they do present and what part they play in protecting the person. Van der Kolk reported (2007) that a patient of his said that she felt so lonely when in response to her, 'I am bad', van der Kolk replied, 'no you're not'. It is important to process and/or interpret and to give meaning to challenging behaviour rather than reacting to it. A client having awareness of thinking patterns is useful. However a lot of what is felt is not in the language centre of the brain, so a cognitive approach alone will not, in my opinion, work.

I suggested to Joan that the reason that 'coffee lady' appears is to put her in charge of any rejection she feels around her. If she is responsible for being bad by drinking coffee and people reject her because she is bad she feels in control because she knows how she has caused the badness. It was after this interpretation that Joan could begin to integrate the 'coffee lady' and feel real tenderness for the very young person who had invented her.

Developing awareness of how the internal system works is an important part of the stabilization process. Sometimes it is helpful to use art or flowcharts, or writing as well as talking. "The purpose of illustrating the system is to increase awareness and further increase stability. If a therapist jumps into trauma work before gaining a general understanding of the client's internal system, it can help to create much unnecessary chaos and pain" (Haddock 2001, p128). It is also important to remember there can be a fluidity and plasticity to ego states and their boundaries, so maps may need updating as the therapy progresses.

Drawing time lines, making maps, art therapy and other structured activities are not for everyone; talking over time is the best way to increase awareness of their internal states for some people. For others it will be necessary to do a certain amount of bodywork to show clients how their somatic organization affects how they feel and to teach them how they experience themselves somatically. Each alter may also be experienced differently by the body and/or might hold the body differently. It may also be important to learn together the signs that indicate that arousal is exceeding the body's ability to tolerate it and to teach grounding techniques to help self-regulation.

Telling the stories of the trauma is part of the trauma work but it should never be forced to happen. But the ground can be laid for telling stories by giving the patient permission to tell their stories. If an experience is clouded in shame, it is in danger of remaining hidden and if it remains hidden it does not stand a chance of being processed.

The stabilization stage or grounding may take a long time and it is important to have a solid ground of relationship with the therapist, coping skills, and a mutual awareness of the client's internal system of ego-states before moving on to trauma work. Stabilization is also something it will be necessary to come back to and continually revise as the work progresses.

Treatment Of Traumatic

Memory Treatment of the traumatic memory is the processing of the events in the client's life that have caused him or her to dissociate. Along with the telling of the story and working through the feelings that go with the story is a risk of re-traumatizing the patient and even a risk of further splitting and the creation of more alters. There is more to telling the story of a trauma than language. A lot of memory is held implicitly. This means that a sensation in the body may be reproduced but there is not a narrative that goes with it. Fragments of memory, flashbacks, nightmares need to be disclosed and encoded and processed into language and/or into an awareness of what happens in the here and now in the client's body. Through the recovery of memory and by talking through it, or drawing it, in as much detail as possible, and understanding how it affects the body and by working with the body so that the client can learn to know her somatic reaction to it, the fear of the memory can be diminished and the risk of re-traumatization lessened.

"As the adult [ego-state] listens to the child [ego-states's] words and slowly begins to understand their significance, new meaning is given to previously inexplicable symptoms… the interpenetration of these two personas provides each with some compensation for

this intensely painful process… There is new compassion for this former enemy and a wish to heal her wounds. Because the adult slowly comes to allow the child back into a shared consciousness, she can also provide the child with some sorely needed parenting" (Frawley and Messler Davies 1991, p288). The treatment can be extremely painful for the client and there needs to be grieving and mourning. There has been a traumatic and irreversible loss of childhood. It is normal for the work not to run smoothly, but with setbacks and complications in the transference and countertransference.

It is also common that in tandem with the work with the separate ego states the client will bring immediate crises that she is experiencing in her life. The emergence of the adolescent persona may threaten to sabotage the work by being so angry at the impossibility of adequate compensation for the loss of childhood and the necessity of doing the therapeutic work, and by having to continually re-live the pain of what happened in order to process it. Where it was necessary to enter the world of the hurt child, it is necessary to interpret the adolescent behaviour (Frawley and Messler Davies, 1991). Quite often this adolescent persona is a manifestation of the patient's alliance with her abuser, an internalized sadistic force, hence the need for firm boundaries. This alter needs to understand that the therapist and the host do not want to destroy her but integrate her into the whole person where her hitherto destructive anger can be transformed into assertiveness and strength.

I have summed up some of these ideas about ways of working through the trauma with this client group in the following list. These are meant as suggestions rather than prescriptions, as how the work can proceed will vary in each therapeutic pair:

Have planned sessions by discussing the goals beforehand and the containment techniques in place that have been learnt in the stabilization stage. It is a good idea to plan the work if possible so that small pieces of trauma are dealt with at any given time in manageable sections.

Include adult and child alters in the telling, they may have different experiences of the same event, or they may carry different aspects of the same event. For example, one may remember the sequence and another the emotion, another the pain.

Process the work somatically as well as in language. Shift the client's attention from the narrative to what is happening in her body and work with the implicit memory in the body. Examples of interventions may be: How is it to feel the trembling? Stay with the physical sensation. What is happening now? What happens when you open your eyes? What happens if I move my chair back? When you tell me that, what's happening inside you? Try drawing as an alternative to talking if indicated.

Using visualization techniques have been found to be effective (Fraser, 2003). For example "When working with memories, therapists often have a client imagine a video room that meets her every need…When the room is exactly as she wants it to be, the client is asked to play a video of the memory being worked on. She knows that at any time she can mute the sound, speed up the tape, pause the tape, and so on. Processing is practised in this way so that the client begins to feel some mastery over the memory. Then, with practice, she can use this technique on her own when faced with intrusive thoughts and disturbing pictures that are associated with past trauma" (Haddock 2001, p132).

Fraser (2003) describes his "Dissociative Table Technique". In this technique the therapist uses guided visualization to bring all the alters to a table to negotiate between them and to increase understanding between them. While the patient is in the visualization the therapist can do individual and group therapy, as it were, with all the alters. The full script and suggestions for bringing more reluctant alters to the visualized table is available on-line at http://www.haworthpress.com/store/product.asp?sku=J229.

Thinking of the client's affect, the top of the scale is hyperarounsal – flashbacks etc, the bottom of the scale is hypoarounsal – dissociation, blanking out. In the middle is a comfort zone. To make progress we need to be working at the boundaries of the comfort zone, rather than in the centre of it (Ogden, 2007; Schore, 2007). We also need to take care

that we do not work beyond the boundaries to lessen the risk of re-traumatization.

Expect Anger. The emergence of the adolescent persona. Whereas it is necessary to enter the world of the child self and be empathetic rather than interpret, with the adolescent it is necessary to set boundaries and interpret the behaviour rather than try to rescue this part, (Messler Davies & Frawley, 1991). Empathy has a place when working with adolescent personas and right brain to right brain communication is essential, but it is important to maintain strict boundaries. For example, if an adolescent persona is obsessing about ways in which to commit suicide, it is an idea to limit the amount of time you are willing to spend on this so that time can be spent on the process of the obsession rather than the its content.

Expect Grief. Tremendous amounts of grief work need to take place, related to the abuse, the abandonment and the effects it has had on the client's life.

EMDR techniques can be incorporated into the therapy to help diminish flashbacks, once stabilization is established. A client can see a primary therapist and an EMDR therapist at the same time and can sign a release form so that they can co-ordinate treatment.

"The key to working with dissociated affect is the co-creation of a stronger signal of the felt sense – the therapist serves as a source of autonomic feedback of the patient's dissociated unconscious affect" (Schore, 2007).

Get expert supervision from different supervisors, e.g. trauma work specialists, dissociation specialists, body work psychotherapists and if you get stuck as a therapeutic pair, discuss together seeing a consultant to help you work through, for example, transference, countertransference difficulties.

Sometimes the belief of 'if only I'd got it right this wouldn't have happened to me' persists. That belief gives hope in childhood that the child has some control whereas, in fact, he has none. It persists into adulthood and the person still tries to get it right for other people at his own expense. Felicity de Zuleta proposes that the therapist encourages the patient to express independence from her caregiver in order to give information to the patient about their attachment. Getting them to say, "I [name] am a xx year old adult. I don't need you any more". This can be carried out using silent language to minimize the feelings of shame. De Zuleta proposes that it is the thought of separating from the imaged caregiver that informs the patient of how terrified he or she still is of letting go of the attachment to the caregiver (De Zuleta, 2007).

Become familiar with the trauma literature and latest research into trauma treatments, attending conferences and workshops where research on dissociation is presented.

This list is not exhaustive.

A large part of the cure will be affected by the relationship between the therapeutic pair. For our early trauma patients to get well again, they will have to suffer through a re-traumatization in their transferences. Schore (2007) quoting Kalsched (2003) said that this repetition in the transference will the person's way of remembering, and may actually lead to the potential healing of the trauma, provided that the therapist and patient can survive the therapeutic rupture and subsequent repair that such transformation requires.

Personality (Re)integration And (Re)habilitation

Unlike stabilization followed by trauma work, integration is a stage that does not necessarily happen in an order but is a process that happens throughout the therapy. It is an increasing awareness in each alter of the other alters, co-operation and interpenetration between them and a significant lessening in automatic dissociation. During trauma work, memories previously held just in one alter with be held in more which will help blur the boundaries between the separate states. It is important that the therapist does not send a message to clients that the goal of therapy is to fuse internal parts, because if this does not happen the client may feel that he has failed. A realistic goal is that the parts become increasingly aware of each other.

The idea of a stage of post-integration therapy creates a space for a practice time for using coping methods that have been learned in the therapy as alternatives to dissociating. It also gives time for the client to come to terms with what it means to no longer dissociate or to dissociate less; for example being unified does not necessarily mean the end of suffering, life still happens and bad stuff will still happen. In other words it gives time for a client to come to terms with the existential realities of life. It will also be a time when the client learns to grow in areas that may have previously been frozen, learning to live life with more confidence and self-belief. Continuing with therapy for a while is also important for dealing with inevitable slip ups and set backs that may occur as well as providing support for healthier relationships, more confidence in the work place and the wider community.

Conclusion

Bromberg (2006) quoted by Schore (2007): "If psychoanalysis is to remain a theory relevant to understanding the mind, and a therapeutic process relevant to healing the mind, certain concepts, such as unconscious conflict, interpretation of resistance, and unconscious fantasy, need to be rethought in the light of our current understanding of self-states and dissociation."

There are continuing professional development courses available on working with dissociation but I feel that dissociative disorders are sufficiently common to warrant a module on the subject being included in all psychotherapy trainings.

Schore (2007) informs us that the APA Presidential Task Force on Evidence Based Practice (2006) has come to realise that "Research suggests that sensitivity and flexibility in the administration of therapeutic interventions produces better outcomes that rigid application of… principles."

And Sue? She found the Pottergate Centre for Dissociation and Trauma (http://www.dissociation.co.uk/). They can give her a list of therapists trained in working with dissociation in her area but she has not found one yet within travelling distance who will offer a reduced fee. Having an assessment at the centre would cost her over £1,000 that she has not got. Sue's G.P. is looking into the possibility of getting art therapy for her. She has been told she is not eligible for another course of psychotherapy on the National Health Service. She is finding it harder and harder not to resort to the habit of self-harming once more.

If you have any comments or questions, I can be contacted by email philippaperry@aol.com

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Sue Jones

The Shadow In Our Psychotherapy Training Institutes: Integrating Mindfulness And Restorative Justice As A Medium For Transparency

Abstract

The aim of this study was to explore shadow and transparency in our psychotherapy training institutes. A qualitative methodological design was used to gather and analyse phenomenological data from forty four psychotherapy trainers from a variety of orientations. The results were drawn from grounded theory and are represented in the Shadow and Transparency (SAT) Model which illustrates the identified shadow themes. The author describes a method of addressing these shadow themes by using Mindfulness and Restorative justice in the training setting as a medium for transparency.

Introduction

The context and motivation for the research emanated from my own experience as a trainee, trainer and now Head of a psychotherapy institute. As a trainee and trainer in several organisations I had witnessed at first hand the enormous distress that can happen when things go wrong. As a trainee I would stay quiet and co-operate compliantly with those I had trusted to be in charge of my training and future career. Making a complaint would not have been an option out of fear of being seen as a 'bad' therapist. As a trainer, although more confident, I found myself in situations that were confusing and unsettling; reluctant to complain for fear of being side-lined and confused about the culture as I saw it.

As a new Head of a training institute colleagues and I grappled with the ground blocks to ensure as far as was possible, that the ethos, structure and procedures would be those that we could work with and live by. Our hearts were in the process and it was a serious business. The question at that point was – how could we avoid the problems we had in the past witnessed and sometimes been inadvertently entangled in, if they were in a sense invisible - implicit rather than explicit?

The topic of shadow and transparency within our training institutes is surely an important one. In the current litigious climate we have seen a sharp increase in the number of complaints and civil actions made against psychotherapists and counsellors as practitioners. I believe that an increase in the number of complaints made by trainees within our training institutes will follow and that there are 'blind spots' in our places of learning.

This led to me conducting a small study aimed at exploring the effects of complaints procedures in organisations by gathering and analysing themes from focus groups (Jones, 2003). The results showed that complaints are experienced as destructive and traumatising and therefore avoided. For the 'complainer' and the 'complained against' the findings are the

same. This reinforced my view that complaints procedures, as they commonly stood, were only the tip of the iceberg. It was as if the boats that floated on top of the surface were hinting at, but not revealing, what was lurking beneath.

Thus began this doctoral project. My intention was:

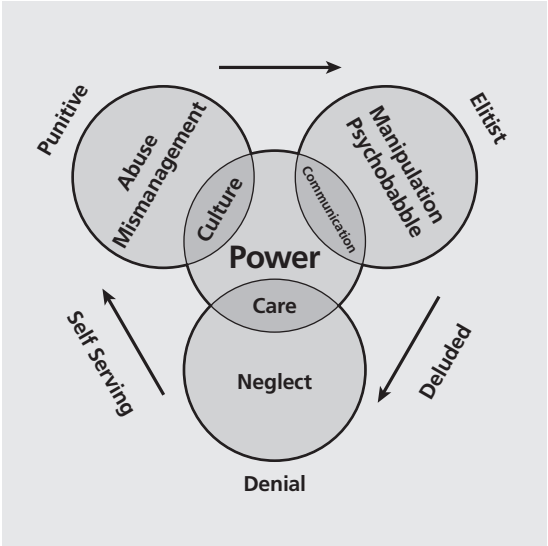
To explore whether problems in psychotherapy institutes were any different from those in other organisations.

To identify the shadow in psychotherapy institutes from evidence based data.

To experiment in my own institute with a way of keeping potential shadow issues in the light and to encourage transparency.

It began with examining the field outside psychotherapy and asking the question 'are the problems we see we any different from those within other types of organisations?' I followed this by analysing phenomenological data from forty four psychotherapy trainers from a variety of orientations. Thirty psychotherapists were interviewed in their institute settings and fourteen psychotherapy trainers were interviewed outside.

What follows is the Shadow and Transparency Model which represents the grounded theory that emanated from this data.



The Shadow and Transparency (SAT) Model
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I have attempted in this project to bring into awareness the aspects of the shadow that are consistent and widespread in our psychotherapy learning environments. Results from the field suggested that consistent areas of concern such as power and communication appear in all types of organisations. However, in psychotherapy we have our own particular flavour of the same issues, as seen for example in the use of psychobabble to defend against threat. What perhaps makes psychotherapy institutes most worrying is that we are in the business of understanding the complexities of the mind and use the vehicle of relationship in our work and yet the themes that came out of the data showed clear relational dysfunction centred around a phenomenon of power.

The Findings

It Was Deduced That:

The psychotherapy training environment means that aspects of dependency and the wounded healer with the intersubjectivity that these bring, alongside the rhetoric of the subject, create a dissonance between what we as trainers say - and what we actually do.

Unconscious shadow behaviours are ubiquitous in all areas of concern and identified generally as mismanagement, abusive management, neglect, manipulative communication and the misuse of psychobabble.

Deeper shadow descriptions associated with the psychotherapy training system are surmised from the data as punitive, elitist, deluded, denying and self-serving. These represent the disparity between the rhetoric used in psychotherapy training institutes and the reality identified within the analyses.

From the data it was seen that psychotherapy institutions have similar broad organisational difficulties as in the wider field. However, the subject of psychotherapy, the pressures and demands put on trainers and the particular transferential difficulties that arise, contribute to a training environment where specific shadow dynamics can be seen (see SAT Model). This creates a dissonance between what we as trainers say - and what we actually do.

Findings In Relation To Existing Literature

Culture: Power And Psychotherapy Training

Robertson (1993) in his paper on cult characteristics and psychotherapy institutions warns of the implicit learning that occurs and the impact dysfunctional training systems have on emerging therapists. He lists eight cult characteristics found in psychotherapy institutes: a closed system, group conformity, idealisation of the leader, scapegoating, charismatic mission, denial of shadow, group narcissism and secrets (Robertson, 1993). I found elements of each of these embedded in the data.

Diamond (1993) wrote about the unconscious life of organisations suggesting that the unconscious actions and covert goals in a work group correspond to the development of the leader. He purports that the earlier the wound of the leader the more primitive and regressed the group is, in order to defend against the anxiety of identity annihilation. Kernberg (1998) later wrote about institutional problems in psychoanalytic education highlighting the unconscious regression and transferential dynamics that get re-enacted.

Psychotherapy institutes frequently begin with a leader's passion and drive. Kets de Vries (1984; 2001) suggests that the revered omnipotent leader invites idealisation in a dependent culture; individuals then want to merge with the all-powerful leader, share power and have a secure feeling of oneness. He also describes the devaluation of others that occurs and how individuals who challenge the system are side-lined or expelled.

The findings in this study support Kets de Vries' observations as can be seen in this statement made by a psychotherapist who was relating an experience of a trainer she described as narcissistic.

"A trainer was leading a day's workshop and turned up after lunch. When we protested, we were told 'If you don't like it you can leave'".

Robertson (1993) suggests that this type of leadership can lead to sexual acting out when high expectations can trap the leader into an inflated role of supplying unmet dependency needs. Stories of sexual acting out, dependency and abuse of the transferential relationship can all be seen within the data and support the literature of Robertson (1993), Diamond (1993) and Kets de Vries (1984).

The Danger Of Passion And The 'Guru'

There were many stories in this research of dramas attached to the much loved charismatic trainer and supporting the literature above. These included favoured students who passed examinations with a nod and a wink and students who were employed and elevated to a particular status despite the reservations of other senior staff. All of these were described as being in an atmosphere where certain students became an inner circle and adoration of the 'guru' was the norm. Three interviewees described how tentative protesters were often shamed with brutal humiliation in front of their peers and the subtle and un-named promise of future success if aligned with the trainer.

Narcissism Or Heroism?

Gabriel (1999) purports that all leaders have narcissistic desires and want to be respected, recognised and admired. This he suggests is kept partially in check by the super-ego. Gabriel goes on to assume that what distinguishes the narcissistic leader from the heroic leader is the focus of attention. The heroic leader will look outwards for opportunities for achievement whereas the narcissistic leader looks outward for admiration and love. He/she does not see this as a fixed position but a risky one if the subordinates collude with the narcissist's need for idealisation. This, I suggest, makes for risky situations in psychotherapy training institutes due to the transferential and developmental component of training and the power of the leader. The findings in this study support the literature of Gabriel in that the culture of each institute revolved around the leader and his/her vision (Gabriel, 1999).

Power And Management Structure

I gathered many narratives about difficulties with leadership and management. Everyone had stories to tell about ethical breaches, struggles with egos, conflicting methods of theory and practice, poor communication, burn-out, secrets, narcissism and covert abuse.

Leaders have power and how they use and understand it impacts on the whole system. Leadership as an organisational and psychological process is different from management (Zaleznic 1977; 1991; Burns, 1978). The leaders within our training establishments are usually psychotherapists who have achieved in their profession and have a vision in the training field. These leaders often fill managerial roles. The data in this research study revealed that these roles are not as clearly understood as they would be in the corporate world. The leaders in the psychotherapy institutes examined had very little or no managerial training and were juggling teaching with successful private practices. Institutes are expensive to run and an enormous amount of voluntary time and hard work enables them to survive. I suggest that muddled and overworked management may be in part due to the financial constrictions which define job descriptions, and in part due to the continuing ambiguity of the dual roles required such as being at the coal face and teaching students who are vulnerable to dependency. In addition, being a competent and effective decision maker and leader of the ship and crew, may need skills which are different from those which define a good trainer or practitioner.

The research data also supported the literature of Halpin (2005) who describes the personality type of the therapist as being idealistic and capable of great devotion to a person, purpose or cause. The research findings suggest that characteristics that may work in individual practice contribute to the problems in institute settings. The transcripts identified problems which demonstrate this eg: very able psychotherapists being described as 'unable to take authority', sexual breaches of ethics, unspoken competition and an independency that gets in the way of teamwork and the cohesive running of a business.

Gordon-Brown (2002) suggests: 'in groups based on the ethos and attitude of love, those concerned with caring, the power struggle is terrific, and it's always unconscious'.

Implicit in Gordon-Brown's statement is that the psychotherapist can be driven by love of the task meaning that they consciously choose to enter a profession where they are hands-on 'healers'. The fundamental values of the therapeutic relationship are commonly seen as providing 'love' for the client (Rogers, 1951). The combination of individuals choosing a caring profession where the ethos is a relationship of 'love' supports Gordon-Brown's statement which suggests that this leaves the psychotherapist intrinsically valuing him/herself for this and thus driving underground the more difficult areas such as envy, greed and competition (Guggenbuhl-Craig, 1971). The findings support this literature in that conflict was described as difficult and hidden.

Walton (2005) describes leadership as a vital field of study due to the impact upon us all of bad, absent or deluded leadership. Kellerman (2004) holds that leadership comes in the form of a web and does not happen in a vacuum. He suggests that the followers are part of the web.

The nature of psychotherapy training induces students to regress at times and look to their trainers as parental containers. The combination of busy people at the top of our institutes, trainers used to autonomy and self direction and students who are looking to their seniors for personal growth, is a dangerous one. It is surely as difficult for the leader and trainer as it is for the student. The difficulty for those in hierarchical positions is the responsibility that it carries. Psychotherapists who never leave the mothership and stay as trainers are like children who never leave home. This may inhibit individuation. Green (2003) describes the need for individuation which is necessary for growth, healthy identity, separation and the appropriate taking of responsibility. I suggest that the culture, seen in many institutes, of students being selected and trained up as trainers within the system, is a conscious effort by leaders to maintain continuity of ethos and an unconscious drive to lessen the fear of outside influences and potentially minimise transparency. The lure

of the narcissistic leader may be to reinforce his/her vision through his/her mirroring needs provided by adoring unindividuated students who may never want to leave home.

I believe that these closed systems and incestuous cultures are fertile ground for the shadow. The data shows that those who speak out can be pathologised or scapegoated. I suggest that humanistic values are perhaps used as a defence by those in positions of power to suppress and confuse issues of competition, envy and neglect. Leaders are also often fearful of losing staff so unconsciously collude with the taming of difficult feelings. These organisational cultures impact on the student who implicitly 'learns' about how the 'parents' manage our family system: 'Do as I say, not as I do.'

In every institute I found passionate, committed trainers who were prepared to work until they drop at the expense of their own needs. This seemed to be the accepted culture. Institutes were often run on a shoe-string with the leader working long unpaid hours. Trainers spoke of commitment to students being compromised by limited financial resources leading to minimal secretarial support, poor equipment, unpaid meetings, and all other extra responsibilities. This resulted in poor attendance at meetings, envy within the team, fantasies that others were being paid more and many gripes about feeling undervalued.

I discovered that the people at the top are learning as they go. Leaders seemed to muddle psychotherapeutic skills with leadership skills and were often unable to use their authority appropriately. Staff longed for structure and meetings were filled with facilitation of emotional issues at the expense of tasks being done.

Conversely when the figure at the top was authoritarian in style this too led to difficulties. Staff felt unable to complain, taking on a language of complicity and 'groupthink' (Janis, 1972). I was told of situations where the repressed anger and feelings of powerlessness filtered down to conflicts within the staff team and in the worst scenario, in communication with the students.

Care: Power And The Wounded Healer

The findings support the literature in that people drawn to work in the psychotherapy profession are frequently wounded healers in danger of taking the role of healer/guru and leaving the sickness side at the feet of the patient (Sedgwick 1994; Guggenbuhl-Craig 1968; 1971). Menzies Lyth (1988) writes of detachment and avoidance that are inbuilt into the nursing system to defend against anxiety and in turn contribute to the stress of the students. I believe that the findings support this literature in that the shadow can be in the hard work expected and seen within the psychotherapy systems alongside the neglect of others. For trainees the idealised tutor may temporarily become the needed idealised parental imago. A leader's vision may be inspirational and hold the ideal thus creating an institutional culture that may have a transpersonal edge (Robertson, 1993). This I believe can make a dangerous combination for the vulnerable student.

The shadow of care is neglect and abuse. In the teaching arena where there is a potential pupil/teacher transferential relationship of idealisation we can see the possible consequences where an adored charismatic teacher may project and then pathologise the student leaving a trail of disappointment and confusion within the victim. The data supports the work of Bion (1961; 1962; 1970), Menzies Lyth (1988) and Huffington et al (2004) who all consider dynamics within group settings and the specific difficulties that face leaders and staff.

Students are struggling with a training that requires the uncovering, understanding and integration of repressed aspects of themselves. Stressed and busy trainers are contributing with the necessary commitments that institutes require. For those in management, and perhaps particularly the leaders, talking to others outside the organisation may open up potential fear of competition, failure and shame. I believe that this is fertile ground for shadow issues and ample reason for unconsciously creating the myth of 'Everything's fine here'.

Communication: Power And Emotional Literacy

Emotional literacy (Goleman, 1996) is at the heart of psychotherapy. What I found was that the ability to express emotional states is a mixed blessing. Like the use of power, it can be consciously or unconsciously misused. At its worst it can be used to attune to another and then corrupt or control. It may also be used as justification for bad decision making by rationalising one's own behaviours as 'feeling right'.

This can be seen within one of the individual interviews eg:

'She left the course making a complaint. He (the trainer) said she unconsciously saw him as her with-holding father and wanted him to be affectionate so he was and that made it ok'.

Particularly worryingly was that emotional literacy seemed to be used as a defensive attack against personal threat. This was described to me by many as unnecessary 'psychobabble' or 'manipulative use of psychopathology'. Conflict very frequently appeared to be managed by staff using psychopathology as a powerful tool. Pathologising and scapegoating the other was an issue that arose time and time again, leading to the curious situation of psychotherapists whose skills lie in therapeutic relating and open communication, using theory in order to close down communication.

I found secrets everywhere. In each institute and each narrative, statements were made about misdemeanours of others and then described as 'confidential'. The concept of confidentiality both enabled these to be told and enabled them to remain secret. I was told of several situations where the breach of sexual boundaries by a trainer remained a secret as 'the student's confidentiality had to be protected'. I recognise that the nature of the research might have invited the breaking of confidentiality but this left me feeling uneasy about how we use our understanding of confidentiality in psychotherapy.

I was surprised to find how few forums in general there were for open dialogue. Where there were staff meetings they were not obligatory, poorly attended or agendas were so packed there was little time for free communication. I found that what was really being felt by individuals was not able to be openly transparent in the system. A tendency to control by pathologising, combined with a 'be nice' culture drove conflict and any emergence of shadow underground.

I found frequent evidence of narcissistic leaders who required their 'followers' to admire them and share their vision. Although this can be found in any non-training organisation my belief is that this, combined with the closed and incestuous system of recruitment, which seemed to be common practice, becomes a narcissistic culture characterised by closed thinking, a strongly idealised organisational self image and stagnation of ideas. In the data this type of culture seemed to linger even after a leader had left. The organisation was unable to look inwards and if challenged pushed all undesirable aspects outside on to a safe target or alternatively scapegoated someone within who could then be pushed out or sidelined, leaving the power where it was and the system intact. This supports the work on cultic behaviours (Robertson, 1993) and defence against anxiety (Menzies-Lyth, 1988). The grandiose self image survived despite the cuckoo having flown the nest.

One Way Forward: An Experimental Model To Facilitate Transparency

Bi-monthly staff Mindfulness groups and the use of systemic Restorative Justice was integral to our own in-house system and monitored by action research cycles throughout the life cycle of the research project. This was an attempt to test whether Mindfulness and Restorative Justice could be a way of working with the shadow and encourage transparency. The ethical dynamics of this part of the research and the dual relationships brought about by 'insider research' were considered in depth (Van Heugton 2004; Reinhartz 1979; Roth 1989). A more detailed description of this is available from the author as space precludes this in this paper.

It Was Deduced That:

The presence of a model of a Mindfulness group and Restorative Justice within a system makes a significant difference to the generalised feelings of satisfaction in communication, a sense of being valued within the institute and a feeling of shared power.

A focus on group awareness of relational dynamics through a Mindfulness and Restorative Justice model in a psychotherapy training environment lessens the potential for shadow dynamics by creating a safe arena for difficulties to be addressed.

Fewer grievances occur when a model of Mindfulness and Restorative Justice principles are in situ. There is less fear and resolution is more likely.

Conclusion

The difference between other systems and psychotherapy is the subject that we teach and the potential for dependency of our students in a frame which promotes trust and disclosure as part of the process of training. The model of teaching which occurs within psychotherapy puts emphasis on the understanding of internal emotional states and personal self awareness. This inadvertently invites the students into a state of dependency with those in the position of tutorship. Alongside this is the tutor who in the transferential role of 'parent' teaches about trust and the therapeutic relationship. Young (1996) suggests that some of the most neurotic acting-out behaviour imaginable is routinely perpetrated by psychoanalytic organisations and lays this at the feet of the practitioners within them.

Significance And Potential Applications For This Work

Kearns (2006) reflects on the current climate of practice and writes that complaints and civil actions against psychotherapists and counsellors are on the increase. Her words, although about clients and practitioners, are perhaps a warning that this may be a universal development. Psychotherapy institutes may just be one step behind. I suggest that we consider seriously research and literature pertaining to issues in training that include grappling with the collective shadow. It is in the knowing and owning of this and the development of an improved relational style of handling complaints that will help us be better trainers.

'Injuries that happen in relationship need to be addressed in relationship' (Kearns, 2006).

According to Kearns (2006, p1) practitioners are being traumatised and current complaint procedures from accrediting bodies are "unthought through and lead to the escalation of disputes rather than containment, mediation and resolution". She refers to psychotherapy training institutes managing complaints without the embodiment of the philosophy that is the in-house rhetoric. It is paradoxical that in institutional settings, where trainers who possess the necessary skills to support effective mediation and who are themselves models for their students, are still bound by complaint procedures that are punitive rather than relational.

I hope that institutes and accrediting bodies will be able to make use of these findings as a window into the inner life of psychotherapy institutes. I offer the following for reflection and consideration: more transparency and self reflection by management and trainers within psychotherapy training institutes. The purpose of this would be to transcend the possibilities of inertia, where a hierarchy can unconsciously encourage a culture where challenge is avoided, thereby leading to potential conscious and unconscious abuses of power.

For psychotherapy institutes to integrate Restorative Justice within their organisations. whereby both complainer and complained against are respected and a negotiated way forward is found based on the needs of the 'victim' and relevant responsibilities of all concerned, thus leading to a more satisfying, less punitive and shame-based culture.

For psychotherapy trainings and accrediting bodies to seriously consider the dimensions of shadow and the SAT Model in the design of organisational complaint procedures. The purpose of this would be to raise awareness

of those who are in the position to guide the profession and model healthier functioning.

For psychotherapy institutes to consider using the practice of Mindfulness in management as an aid to non-oppressive and transparent communications.

Further details of the research is available on request by email and contains more detail on the background of literature, methodology and research findings. A more detailed account can be given of the ethical and transferential implications of the 'insider research' conducted within Matrix where the author holds the position of Head.

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Michael Soth

The 'Integrative Project' As A Phase Within The Development From Holistic-humanistic To Integral-relational Body Psychotherapy

Abstract

After clarifying some principles of an integral notion of development, I discuss the 'integrative project' as a significant phase within the development of Chiron Body Psychotherapy. I describe it as a quantum leap beyond Chiron's original 'habitual therapeutic position' which was built on disavowed 'medical model' assumptions, and describe 'integration' in terms of the multi-dimensional bodymind whole. Touching briefly on the two phases that followed – the 'relational turn' and the 'fractal self' – I prepare the ground for a considerations of the deficiencies and critiques of the 'integrative project' within the Chiron context. I suggest that drawing from a diversity of modalities, approaches and paradigms does not necessarily alert the integrative practitioner to enactments which occur a) via therapeutic thinking, feeling or action or b) when switching between modalities, and that an 'integral' awareness of parallel processes may be required to do justice to the client's unconscious construction of the therapist and the therapeutic space.

Introduction

The Chiron Centre for Body Psychotherapy is winding down its activities as a HIPS training organisation after about 25 years of involvement in the psychotherapeutic field in the UK. Over this time we have developed Body Psychotherapy beyond its origins and traditional framework, and the integrative project has been an important aspect of this development. 'Integration' had specific meanings and connotations in the context of Body Psychotherapy, as well as particular developmental functions in the evolution of Chiron. In a book to be published in 2008, edited by Linda Hartley, some of the Chiron trainers and practitioners reflect on the development and current state of our work. For my contribution to this book, I wrote an overview of the phases of that development, describing the quantum leaps and transformations which occurred over the 25 years, trying to focus on the substance of the revisions in terms of theory, technique and meta-psychology. Here I want to outline some of the gifts and some of the pitfalls of the 'integrative project' at Chiron, and the leap beyond integrative into Integral-relational Body Psychotherapy.

Principles in reflecting on past development

As in an individual's journey, in reflecting on past developments I look for transformative phases as crises and turning points which structure the process. One question which arises is: what qualifies a change to be classified as a quantum leap? What is best described as slow, incremental change and what constitutes a paradigm shift?

This apparently simple question gets us into tricky meta-psychological territory concerning our implicit assumptions around 'development'. Let me make explicit some characteristics of my current notion of 'development', a notion which itself has developed and changed quite radically over the years.

Caveat: Beyond Linearity

Although I will present the development of Chiron work as a sequence of theoretical shifts, it is important to remember that this is a linear abstraction imposed on the messiness of the actual developmental process. A journey has been made, and in looking back on the path we identify particular stations along the way which we can now connect in our mind as if the route had been there all along. However, as the poet Antonio Machado reminds us: "You traveller - there are no paths, only wind trails on the sea!" With hindsight we may recognise that certain stations were necessary preparations for what was to follow. But there is a difference between recognising an overall meaningful unfolding and the presumption to therefore be able to predict, manage or control the process.

How My Notions Of 'Development' Have Developed

My own notions of development have themselves developed, from a fairly idealised linear conception (imaged as a journey up the mountain of 'truth' to some pinnacle of self-realisation), to the less predictable, multi-dimensional, contextual-relational and paradoxical view I have of the process now. This parallels in some ways the increasing complexity and differentiation in the development of Wilber's integral meta-model (Reynolds, 2001) over the last three decades (which I refer to although I have some problems with it). See Figure 1.

These principles inform both my therapeutic thinking about my clients' changes as well as my own, and in this chapter I am aiming to present some reflections on my professional development within the context of Chiron in a way intended to be consistent with these principles.

Translation, Contradiction, Transformation – Thesis, Antithesis, Synthesis

An integral perspective suggests that development occurs incrementally within an established structure (via 'translation',

Some Basic Assumptions And Principles Of An Integral Perspective On 'Development:
Not simply linear progression; if we need a geometric metaphor: spirallic
Occurs both incrementally and in sudden leaps (both continuous and disconnected)
Multi-modal and multi-dimensional (along different developmental lines)
In complex systems, development has aspects of both chaos and order
Proceeds in overall holarchic fashion, with ever more complex, embracing and qualitatively 'higher' systems emerging from and through the structures of previously established ones (epigenetic)
In 'healthy' development, each new level brings something qualitatively new and unforeseen which both transcends and includes prior levels
With hindsight it can often be recognised that development does seem to have followed an overall dialectic (Hegel's thesis - antithesis - synthesis), which can be reductively interpreted as linearity
At each developmental threshold, transformation involves the breakdown or death of an old, partial and previously exclusive and dogmatic identity and the emergence of a new more complex and embracing sense of self
Development is, therefore, a painful, messy affair (one step forward, two steps back)
Each new level has its potentialities and dangers ("with great power comes great responsibility")
Not all development is positive: there is regression as well as progression, and regression in the service of progression
Development can be pathological e.g. 'dissociate and repress' instead of 'transcend and include'

Figure 1

Wilber 1984), until forces both from within and from without the system push towards a breakdown of that structure. At that point development occurs in more radical fashion (via 'transformation', ibid), and an emergent process may allow a new structure to organise itself – in terms of human identity: a more embracing sense of self.

Whenever a previous identity is challenged and eventually transcended, an experience of loss and death occurs – this is a necessary ingredient in transformation. Certain cherished assumptions and identifications will need to be shed. The new identity recognises these losses – with the benefit of hindsight - as manifestations of an outgrown partiality. From the perspective of the original identity, however, these losses may appear as betrayals and compromises, as a 'watering down' of essential principles. Both as a community of practitioners and as a training organisation we had to struggle with these questions and the tension between stability and the continuing transcendence of that stable identity.

Because a detailed enquiry into a transformative process often reveals some degree of swinging from one extreme into another (as part of the breakdown of the old identity - Jung's 'enantiodromia'), I use a third term 'contradiction' alongside 'translation' and 'transformation' to characterise that particular phase of the process. For the sake of clarification, we may liken this conception to Hegel's three steps of thesis – antithesis – synthesis, with the latter corresponding to Wilber's notion of 'transcend and include'. Inasmuch as 'synthesis' constitutes an 'integration' of 'thesis' and 'antithesis', these notions also can inform and clarify our understanding of 'integration' itself as a process that goes through phases and that can, therefore, be incomplete. The question as to what constitutes an 'incomplete' paradigm shift, and what may be possible criteria for 'completion', will occupy me as a background theme throughout this paper.

The Phases Of Chiron's Development

When applied to the last 25 years of Chiron's development, the principles above generated the following overview over the phases and quantum leaps, with the 'integrative project' being of central importance.

This distinction is debatable, as in some ways we may consider each phase as just a further incremental extension of the previous one. However, in my view this would fail to take into account the radical discontinuities involved in each of the suggested shifts.

The shift from the humanistic-holistic towards an integrative perspective, for example, was not simply one of increasingly including the theories and techniques of other approaches. There were profound paradigm clashes at stake which we needed to engage with both professionally and personally. The more we took on board an object relations perspective, the more we had a language to become precise about not just the client's inner world, but also our own, including which aspects of our internal dynamic we were projecting into the field of psychotherapy (anthropologists have been criticised for projecting their own psychology into the 'blank screen' of the culture they are studying - as psychotherapists we are subject to the same phenomenon in relation to the field of our profession and its traditions).

As my theme here is only that part of the development which we can suitably call the 'integrative project' (rather than the whole sequence of phases and quantum leaps), I cannot expand on this here, but see the forthcoming book (Soth, 2008) for my experience of the deconstruction of holistic-humanistic idealism.

The Potential And Pitfalls Of The 'Integrative Project': From Eclecticism Towards Integration

In the late 1980's we were recognising the tribal parochialisms and schisms of the fragmented psychotherapeutic field as a weakness of the profession. What emerged first was an attempt to escape the limitations imposed by the dogmatic and self-replicating sub-cultures of the therapeutic schools through drawing eclectically on a range of techniques from across the various approaches. Whilst this eclecticism heralded the first dawning of a deeply needed integrative impulse, it was soon recognised that it came with its own set of problems: the

benefits derived from the increased flexibility and creativity gained by the eclectic therapist were often outweighed by the client feeling like a confused guinea pig. A chameleon-like therapist, selecting the most effective technique pragmatically from a wide and contradictory range of tools, does not necessarily provide a reliable relationship or safe therapeutic space.

We recognised that particular techniques had evolved and were consistent with the underlying paradigms, value systems and attitudes of particular therapeutic stances, and that it was disturbing to pretend that one could simply 'mix and match' approaches in a utilitarian fashion. The integrative project emerged as an attempt to overcome these shortcomings of eclecticism, but in my opinion its different branches have only partially succeeded in responding to this valid critique.

The inherent structure and coherence provided by the dogmatism of the traditional therapeutic schools gave the practitioner operating within each framework a holding and consistency which integrative therapists tend to lack. I remember one of my psychoanalytic supervisors admitting to me towards the end of our work together that - whilst she partially admired the passion and impetus of my integrative impulse – she certainly did not envy the degree of internal conflict, confusion and uncertainty that came as part of the package. Whilst there are certain dangers of inexperienced analysts practising in restrictive textbook fashion, she acknowledged, most experienced practitioners would have come to terms with the limitations of their own approach and learnt to work appropriately within them, thus feeling supported and held by a tradition and a framework which they could rely on to have stood the test of time.

Integration distinguished itself from eclecticism by recognising the profound differences and contradictions between the approaches, and the often irreconcilable conflicts between them on a philosophical level. Before integration could be possible, practitioners would have to deeply immerse themselves in the respective theories, belief systems and practice communities of contradictory approaches, in order to appreciate them 'from within'. The attempt to integrate the diverse approaches into some over-arching meta-model would not work, without severely damaging the integrity of each approach, or appropriating one theory into another whilst fudging some of its inherent principles. The search for another ground or position – beyond

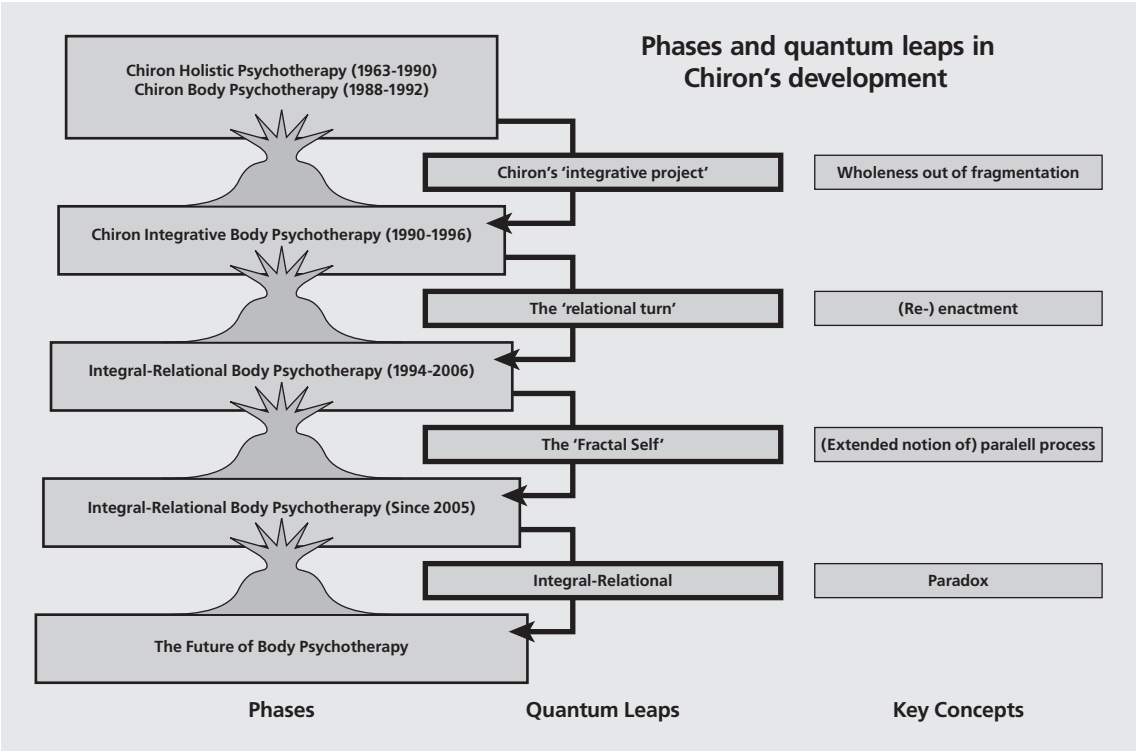

Figure 2

theory and technique - from which to integrate led to a recognition of 'common factors', shared by all approaches but transcending theory.

Diversifying And Expanding Our Range: Clarkson's Five Modalities Based On Kinship Metaphors

For us at Chiron in the early 1990's, the most significant and influential integrative attempt in this direction was Clarkson's model, suggesting that beyond the particular theories and their implicit relational preferences, working alliance, reparative, transference-countertransference, authentic and transpersonal elements were part and parcel of every therapeutic relationship across the diverse approaches, whether they were conceptualising these elements or not (as all readers are familiar with this model, I will not expand on it here). The five modalities (as extended at Metanoia throught the cultural sixth) might be present or significant in varying proportions, but they could now all be considered valid and necessary. Clarkson's model formulated an integration which had implicitly been inherent in Chiron from the beginning – all six modalities had an important place within the Chiron training.

What we appreciated about the model was its explicit naming of the modalities, but more importantly – as it was based on likening the client-therapist relationship to kinship bonds - it opened the door to relational metaphors as a foundation for the integrative project. Rather than focussing on the client's needs and pathology only (which then was assumed to require a particular theory and intervention), Clarkson helped therapists pay attention to the phenomenology of the relationship, including the therapist's relational stance and attitude. Whilst these modalities were formulated and are being used largely as deliberately chosen therapeutic stances in the context of a treatment plan – which I would consider an important but partial perspective, as will become clearer later - Clarkson's model has nevertheless provided one of the main conceptualisations that helps many therapists, including Body Psychotherapists, break the mould of their original training and reach across different approaches and theories in an attempt to find a wider, more integrative range of understanding and responding to clients.

Integration In Terms Of The Multi-dimensional Bodymind 'Whole'

The tradition of Body Psychotherapy had its own avenue into 'integration', based on the often over-simplified and over-idealised notion of 'bodymind integration'. As an idealised notion, 'bodymind integration' was seen as the antidote, the simple logical opposite, to the 'body/mind split', diagnosed as the root of all neurosis and the problems of modern Western civilisation. Body Psychotherapy validly recognised the dissociation of the mind from the body, and the body's repression and control by the mind (implicit in Freud's work with hysteria and notions like 'embodiment', the 'organismic self' and holistic paradigms), but elevated 'bodymind integration' and the healing of the 'body/mind split' into something of a 'holy grail', the normative goal and objective of 'good' Body Psychotherapy.

However, perceiving and assessing the whole that is the bodymind does not have to precipitate a biased, one-sided, goal-oriented agenda-driven procedure, although that is how many traditional Body Psychotherapists did use the notion of 'bodymind integration' – as something they saw themselves as responsible for bringing about (Soth,2006). Whenever we have a notion of any differentiated 'whole', with its sub-systems and inter-linked elements, we can sense and can analyse its organisational coherence. Our right-brain intuitively perceives its shape and pattern, its Gestalt: the system can be integrated or fragmented, conflicted or synergistic, in a creative or dis-integrating phase of its life-cycle, depending on the inter-relationship of the constituent elements. As therapists we tend to have a well-developed intuitive grasp of how the client's system is organised (a more detailed description of the bodymind whole would distinguish physical, emotional, imaginal and mental processes as dinstinct, but linked and inter-related aspects, both in terms of subjective experience and interpersonal expression). In Body Psychotherapy training we aim to enhance and develop that sensitivity and perceptiveness so it becomes a self-reflexive,

trained capacity rather than a humanly given, largely unconsciously functioning gift.

In 1999 I tried to re-formulate the concepts both of 'body/mind split' and 'bodymind integration' in such a way as to remove their objectifying and idealising connotations and bring them into the relational sphere. Rather than using 'bodymind integration' as a normative objective, I proposed to use it as a tool of intersubjective perception and involvement (Soth, 1999). I was rejecting some of the objectifying tendencies inherent in the Body Psychotherapy tradition (which in practice actually perpetuate dualism and body/mind splitting (Soth, 1997), but was salvaging and building on some meta-psychological principles implicit in Reich's 'functionalism':

a) that the developmental psyche-soma history of the person is 'recorded' both psychically and physically: it is encoded in memory on a psychological-mental level and embodied as emotional anatomy on a somatic level (Reich, Boyesen, Pert). The body's 'character armour' is the frozen landscape of fixated developments and traumatic history, giving substance to the notion of 'body memory'.

b) that the organisation of subjective, psychological experience is reflected in the organisation of the bodymind system as a whole, and vice versa (i.e. body, mind and psyche are different sides of the same coin). For example, a fragmented sense of self is reflected in a fragmentation of bodymind experience, both internally and subjectively as well as communicated externally and relationally. A coherent sense of self is reflected in a coherence of body, mind and psyche (and this does not in my mind imply a privileging of coherence over fragmentation, assuming that a coherent self is 'better' than a fragmented one. I will come back to the dichotomy between unification and multiplicity, integration versus dis-integration later).

c) that the organisation of the whole is reflected also on each of its constituent levels (e.g. the conflicts between physical, emotional, imaginal and mental processes, i.e. the structure and shape of the whole, are also manifest on each separate level), and…

d) that therefore what happens on one level is reflected – as we will see later: via parallel process – on all other levels. Dissociation, for example, manifests as a disconnection between body and mind, but that disconnection is also reflected on each level, e.g. on a physical level between head and chest, or on a mental level through forgetting what was just said a minute ago.

A process of psychological integration is inextricably linked with an integration of the bodymind, indeed - in this holistic way of thinking - they are seen like the paradoxical wave and particle dimensions of light. One aspect of such integration is a subjective sense of embodiment, Winnicott's 'indwelling of the psyche in the soma'. Another aspect is an inclusiveness in terms of all the diverse aspects and bodymind levels of human experience which together contribute to a person's sense of self and being in the world.

Integration, therefore, can be thought of in terms of the congruence and coherence (or incongruence and fragmentation) of the various levels of the multi-dimensional bodymind. And integrative Body Psychotherapy could be formulated in terms of the range of human experience which it sets out to address and engage in the room – both in terms of the client's experience and our own, theoretically and practically. The whole spectrum of bodymind processes (see Fig. 3) is seen as matrix of communicative channels through which intrapsychic and interpersonal experience is organised.

From Integration Of Approaches To Integration Of The Practitioner (Role And Person) = The 'Wounded Healer'

The notion of the multi-dimensional bodymind whole and its integration or dis-integration can, of course, be applied to any human process, clients and therapists. What if we apply it specifically to ourselves as integrative therapists?

If our own emotional history as therapists - with both its wounds and capacities - is manifest in our bodymind presence (which is readily intuited by our client's right brain), there is nowhere to hide and it becomes

essential to accept and inhabit ourselves as 'wounded healers'. As the name 'Chiron' suggests, this was always a significant point of reference throughout the development of our work. But within the culture of our organisation, it was understood more as a humanistic background value and attitude rather than taken through to specific aspects of the moment-to-moment client-therapist interaction. That became possible only later on, once I began to think in terms of enactment and re-enactment (Soth, 1999).

Nevertheless, the notion of the 'wounded healer' acquired more substance during the integrative phase of Chiron's development, allowing a formulation of the complex connection between the therapist's person and role, and the possible integration of these (Ukapi Journal, Volume 3, Issue 2). It is well-understood throughout the integrative community but not always explicitly formulated, that attempts at integration which focus only on the practitioner's professional expertise (knowledge and skills) are bound to be limited. A therapist's professional integration depends largely on their own inner integration. One's inner integration, as for example conceptualised through Jung's individuation process, is a function of one's own process as a person which in turn depends to a large degree on the relationship to one's shadow and wounds. The image of the 'wounded healer' thus inspires an integration of the therapist's personal and professional selves which is a precondition for any thorough integration of the diverse therapeutic theories and approaches. Applying Reich's concept of 'character' to how the therapist's person fills the professional role (or – in other words - how the practitioner imagines and constructs the role through their personal psychology), at Chiron the notion of the therapist's 'habitual position' became central in our thinking about therapy itself as well as therapy training.

The Therapist's 'Habitual Position': The Implicit Relational Stance Underlying Theory And Technique

When we want to characterise a particular psychotherapeutic approach, traditionally we tend to define it in terms of its theory and technique. However, closer inspection reveals that this convention harks back to psychotherapy's 19th century origins and is rooted in what postmodern epistemology calls the 'myth of the given': the assumption that our scientific theorising and resulting technical applications are based in an objective perception and understanding of reality as 'out there'. It is assumed that - like doctors - therapists base their interventions (their technique) in dealing with a particular 'case' on a quasi-scientific application of established general principles

Levels of Bodymind Process
Physiological and biochemical processes (the interlinked hormonal, neurological, endocrinal and immune systems, also vegetative & metabolic systems)
Energetic perception
Autonomous nervous system (sympathetic & parasympathetic) regulated processes
Vitality affect / "felt sense"
Sensations, proprioceptions
Inner movements, excitation, trembling etc.
Impulses (manifesting instincts/drives or object-seeking needs)
Spontaneous gestures / outer movements
Raw emotion
Breath
Complex Feelings
Images, fantasies, dreams
Mental: concrete-operational thoughts (language)
Mental: formal-operational thoughts (including voices, internal dialogue)
Self-reflexive though / meta-level thinking

Figure 3

(theory), translating accurate perception and diagnosis into an appropriate 'treatment plan'.

However, what significantly influences the way theory and technique arrive on the client's end of the therapeutic relationship, is a third factor: the therapist's underlying or implicit relational stance (Fig. 4). This stance, although rationalised through the practitioner's models and beliefs, is often taken for granted and outside awareness, both intrapsychically and in its impact on the client.

As 'wounded healers' and 'reflective practitioners', we can turn our own psychological theories upon ourselves, not only in the sense that every therapist is also a client, but to reflect on how we function within our therapeutic role when at work. It is in regard to our implicit relational stance as therapists that Reich's holistic characterological understanding of habitual positions and their developmental origins can make a profound contribution.

A Characterological Understanding Of The Therapist's Relational Stance And 'Habitual Position'

In Reich's understanding, rigidly-held positions, on all bodymind levels from muscular to cognitive, indicate the presence of a defensive character armour which has both repressive and protective functions. He sees all perceiving and thinking as arising in the context of character and the emotional wounding at the root of it. Beliefs, assumptions and world views of all kinds arise through a personal, subjective history and are conditioned by it. Our current view of reality, however convincing it appears to us, carries the scars of that emotional history, all the more so if it is denied and unconscious.

Applying this to ourselves as therapists, the five steps of character formation (Johnson 1994), as an adaptation to internalised developmental wounding, can be seen to inform a therapist's implicit relational stance and 'habitual position' (which is not meant to imply a static, singular position - it is more accurate to think of the habitual position as a relationship with at least two poles, like Masterson's 'relational units', or sets of interrelated stances or a matrix of attractors in a complex system; there are certain theoretical inconsistencies and weaknesses in character structure theory (which I cannot address here). Body Psychotherapy, following in the footsteps of Reich gives us some tools needed to apprehend the defensive uses of our own theory and practice, manifesting in therapists' habitual patterns of relating to ourselves and others and contributing

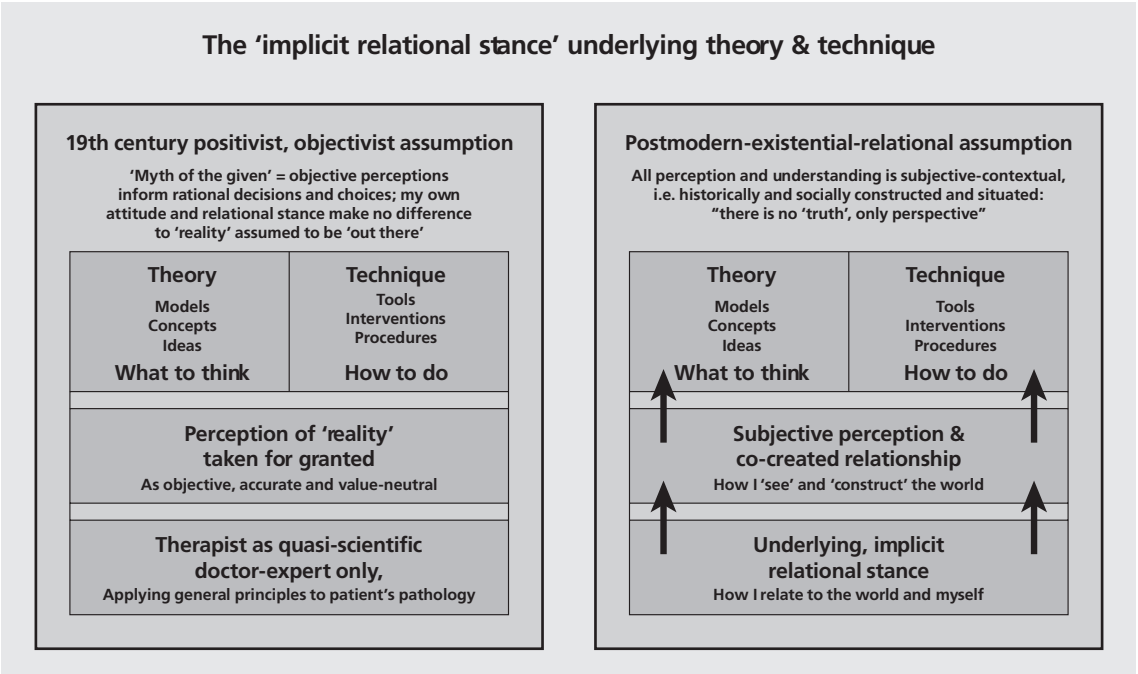

Figure 4

to the rigid dogmatisms maintaining the schisms within the psychotherapeutic field.

The Disavowed, But Pervasive 'Medical Model' As The Therapist's Habitual Position In Traditional Body Psychotherapy

What attracts students to a particular psychotherapeutic training are not just the beliefs and values, but also the defensive uses which these beliefs can be put to. Certain aspects of the implicit relational position may also be shared throughout an organisation, and this was the case at Chiron: we inherited a tradition which philosophically was firmly opposed to the exploitation, neglect and objectification of the body, but which actually perpetuated objectifying assumptions through its shared relational stance.

In terms of the sub-cultural background of Chiron's origins, we were firmly rooted in and committed to humanistic values of equality, transparency, authenticity and were opposed to power-over, imposed authority and hierarchy. We were influenced by anti-psychiatry, and like Laing questioned pathologising labels and diagnosis altogether, being more interested in growth and transformation than – as we saw it at the time - pessimism and illness.

However, the Reichian tradition - we began to realise - had always had a strong bias towards the therapist as expert-doctor (Soth, 2006), and had followed standard medical procedure in terms of examination, diagnosis, application of theory and prescription/treatment. For most of us, our everyday practice was pervaded by 'medical model' implications and interventions, even whilst we were forcefully opposed to any notion of therapy as 'treatment' on a meta-psychological level. These contradictory stances co-existed side by side, but split off from each other, in the background, communicating themselves as subliminal double-messages to our clients.

In pursuing the integrative project we had come across incisive critiques of these 'medical model' assumptions (Hillman, Buber, Gadamer), but whilst some aspects of our identity had been deconstructed through integration, the 'medical model' had remained a secure, albeit ambiguous, pillar of our habitual stance. On the contrary: to some extent every new theory and technique we were learning about and integrating was feeding into our expert knowledge and skill, thus enhancing our omnipotent 'doctor' status, making it more comprehensive and powerful and thus more compelling.

The 'Relational Turn'

Ultimately it is through engagement in relationship – with clients and with each other - that these habitual constructions of the therapeutic position were confronted and thus revealed their limiting consequences. In practice, we were holding on to attitudes and beliefs which were not commensurate with the depth characterological work we were professing to offer, and actually undermined and restricted the relational space necessary for such work to occur. I locate the 'relational turn' at Chiron in the mid-1990's, although it took another 10 years before I published a coherent account (Soth, 2006).

In my view, the relational turn constitutes a quantum leap beyond the integrative phase, because beyond having deconstructed hidden habitual postions and then acquired greater relational flexibility between an integrative diversity of therapeutic stances, I now recognised that any position I take as a therapist is influenced by the client's unconscious construction. Any habitual position on the therapist's part can be considered a defensive mechanism against pressures arising out of the transference.

With hindsight it is easy to see that we were part of a wider movement and that similar ideas (e.g. the 'countertransference revolution') informed the cutting edge in other approaches. There were advantages to remaining relatively undisturbed and unpublicised: we were exploring the relational dynamics through our inherited bodymind perspective and were coming at it fresh, without the often confusing historical baggage and dualistic terminology, and could thus develop a holistic phenomenology of the therapeutic relationship from the ground up (Soth, 2005).

The 19th Century Legacy: Dualistic Conception Of Doctor-patient And Body-mind Relationship

As I have suggested elsewhere (Soth, 2007), we were thus beginning to address – in a two-pronged approach - what I see as the two main dualisms pervading the last 100 years of psychotherapy, restricting our practice and our theorising: the doctor-patient and the body-mind dualism. As in our clients, underneath the bewildering surface fragmentation of the psychotherapeutic field lies a continual avoidance of painful and unresolved legacies, reaching all the way back to the origins of the profession in the dualistic, positivist, reductionist zeitgeist of the late 19th century. I have called this the 'birth trauma' of psychotherapy (Soth, 2006).

Over the last 100 years these dualisms have been challenged and comprehensively de-constructed, but in that process they have often only been contradicted rather than 'resolved' or transformed. Both the relational reaction against 'medical model' assumptions (which often reacts against the medical model conception of therapy as treatment only by postulating it as relationship only), and the holistic reaction against mind-over-body-dualism (which often reacts against the dualistic conception of mind-over-body as split only by postulating it as whole only) often get stuck in anti-positions. A complete paradigm shift in terms of these dualisms would require more than an anti-thetical contradiction: it would require a third position or synthesis, which – as I have suggested (Soth, 2007; see also Pizer, S. 1998) – is characterised by the capacity to hold the polarised positions in a paradoxical embrace (therapy as treatment and therapy as relationship; body/mind split and bodymind whole).

It is only when we transcend these dualisms (rather than merely contradict and fight against them through a decidedly anti-dualistic philosophy (Soth, 2006), that some of the paradoxes inherent in psychotherapeutic work can be embraced as necessary and creative. Much of the fragmentation pervading psychotherapy theory and training is structured by an avoidance of the paradox at the heart of therapy: that the helping relationship we aim to provide involves both the healing as well as the replication of the client's wounding in and through therapy, what we call enactment, or – if we think in developmental terms - re-enactment. For the client the equivalent subjective experience is that the transformation of their pain – a transformation which they both seek and avoid (often largely unconsciously) - can occur through the whole bodymind's surrender to the pain in this relationship here and now.

'Parallel Process' And The 'Fractal Self'

From a therapeutic stance which can sustain and live the embrace of this paradox, we notice that our therapeutic thoughts, feelings and actions become the vehicle for enactments, and that our struggles in the countertransference with and against these enactments parallel the transference,the client's conflict becomes the therapist's conflict (Soth, 2005).

When we recognise that our conflicted therapeutic impulses – feeling torn between different approaches and principles moment-to-moment – reflect and parallel the conflicts in the client's inner world, we are inclined to take the multitude of therapeutic theories and techniques less seriously and are less identified with their literal 'truth' or validity. Through apprehending the enactment dynamics as parallel processes between transference and countertransference, between inner and outer, body and mind, individual and collective, interpersonal and intrapsychic dimensions as they get communicated, externalised and internalised in relationship, we appreciate the wholeness underlying (and co-existing with) the reality of fragmentation, in the client, in ourselves and the field we belong to. Parallel process is the 'glue' which turns a heap into an integral whole, allowing a glimpse into what I have called the 'fractal self', thus extending the notion of 'wholeness' implicit in Reich's original impulse and bodymind functionalism into the relational domain and beyond.

An awareness of parallel process helps us stay connected with how multi-layered and multi-dimensional polarised issues hang together and reflect each other across all the levels from the biological to the emotional, psychological and mental, and beyond the intra-psychic into the interpersonal and

collective domains. It thus helps us to engage in an 'integral' manner which does not take refuge in privileging or absolutising certain domains at the expense of others, which only ever leads to one-sided, biased and unworkable solutions.

Through parallel process we begin to understand how pathology maintains itself, both individually and collectively: how patterns of uncontained conflict and denied pain replicate themselves through being enacted, internalised and externalised from one person to the next, across all our relationships and down the generations like falling dominoes, in the hope of finally finding containment somewhere.

Without a recognition that the supposedly 'helping relationship' needs to be 'unhelpful', that it needs to involve re-enactment of the client's wounding, and that the practitioner needs at times to be helplessly available to participating in these patterns so they can transform themselves, therapists and their profession are part of the problem of such blind replication.

Through encouraging us to keep experientially participating in enactments and to surrender to them, the integral view of 'fractal self' facilitates an experience of a priori passionate relatedness (Spinelli, 2007) from which a potential 'third position' beyond polarisation and fragmentation can arise, whatever the particular conflict or issue. Beyond the specific paradoxes central to our profession, it thus opens the door to inhabiting a fundamental sense of paradox in all existential struggles and relational contexts. From such a perspective, it also becomes apparent how the pathologies of our profession maintain themselves. This may help us engage with the established splits and faultlines running through psychotherapy as we know it.

Deficiencies And Critiques Of The Integrative Project At Chiron

As suggested in Fig. 1, in my opinion the 'relational turn' heralds the possible transcendence of the 'integrative project' and a paradigm shift beyond it into an 'integral-relational' perspective. Again, rather than thinking of this shift as an incremental extension only, I emphasise the discontinuity, the necessary dis-integration of the previous perspective. In this last section, therefore, let me suggest what it is about the integrative project – at least in its manifestation within the Chiron context – that had to die.

Papers in previous issues of this journal have addressed some of the pitfalls and complexities of the term 'integration' (Prall; Spinelli). 'Integration', although badly needed originally (where would we be without it – perish the thought!), over the years has inevitably become a buzzword, evoking similar idealisations as 'bodymind integration' did for Body Psychotherapists. If understood with some finality, as Werner Prall has pointed out, it leads itself ad absurdum, as it ends up denying the very diversity and dialogical attitude which it depends upon as its raison d'etre. The tension between unification and multiplicity must not be erased or diminished by idealising or absolutising one over the other, else we lose the essence of the integrative impulse. This critique addresses the potential reification of 'integration' rather than seeing it – as Prall illustrates - as a continuing dialectical and diversifying process. Ernesto Spinelli has questioned how our integrative ideas match up with our lived reality both as persons and as therapists, and challenged the wishful thinking which underestimates and denies the degree of dis-integration inherent in our own lives and practice. He sees our 'divided self' at the root of our integrative impulse, but the danger of conceptualising integration in individualistic terms (an essentially solipsistic notion) leads to a denial of the contextual, relationally embedded nature of the self. These are strong and valid critiques.

But I think we can go a step further: it is not just that 'integration' is an idealised notion which can be used to deny and perpetuate our sense of actual dis-integration. We can understand dis-integration (as in practice many therapists do, see Field) as a necessary process essential to psychotherapy, as an aspect of the integrative process which needs to be valued and embraced.

If integration is understood and practiced as an 'anti-disintegration' procedure, it becomes dangerous to itself and the essence of the therapeutic process. If, however,

'integration' can be understood as a third position, embracing both disintegration and integration as complementary processes, then the meaning of the term moves closer to a perspective which I prefer to call 'integral'. For me, this term, borrowed from Wilber, implies a) the embracing of paradox as the 'gateless gate' between the dualistic polarities, and b) a relational notion of multi-dimensional parallel process which ties together the many dimensions and multiplicities. This, I propose, is best understood as a quantum leap beyond the integrative project, rather than another facet of it.

The 'Medical Model' Within The 'Integrative Project'

Whether we conceive of integration as a comprehensive, non-partisan spectrum of therapeutic possibilities in terms of Clarkson's model, or a multi-dimensional bodymind model comprising the whole spectrum of intra-psychic and interpersonal communication, this pluralistic validation and appreciation of many channels and modalities represents a quantum leap beyond the traditional dogmatism inherent in the fragmentation of the field. However, unless we pay attention to the therapist's implicit relational stance and relational enactments, our integrative endeavours may remain limited to the realm of theory and technique. Within such limitations, it is perfectly possible to passionately and comprehensively work towards integrating the theories and techniques of all available approaches whilst maintaining an unquestioned underlying 'medical model' position – this might on the surface do justice to the theories of the various approaches, but not their inherent spirit which requires contradictory and irreconcilable differences in terms of relational stances.

How Might An Implicit 'Medical Model' Position Manifest In Integrative Practice?

A common application of integrative ideas involves an assessment of the client as to which therapeutic theory, modality or technique would be most helpful at a certain stage in the process. The treatment plan is then constructed on the basis of assumptions concerning, for example, the client's pathology, therapeutic needs, motivation and capacity for psychological reflection. Instead of being restricted to the models and interventions of one particular therapeutic tradition, the integrative therapist supposedly chooses what's most appropriate from the whole range. Confronted with a vast diversity of clients and issues, we assume that this must improve the chances of selecting the 'right' approach for each particular situation, and that is undoubtedly true.

But who does the choosing? What are our assumptions about the agency and subjectivity and relational engagement of the therapist who functions in this fashion?

Admittedly, they would have to be using their empathic attunement and subjectivity to assess and judge and select the 'right' treatment, so we are implying that the practitioner must make use of their emotional, relational, non-objective personal as well as professional skills and capacities. But we are also implying that these subjective perceptions and impressions then have to feed into a quasi-medical assessment and reflection which in turn leads to quasi-medical conclusions and interpretations, meant to be as helpful to the client in the same way that a doctor's intervention is meant to be helpful. We are assuming that there is a 'right' intervention which can be supported by our theory and therefore anticipate a beneficial effect. Therapeutic perception, reflection, understanding and intervention are then conceived of in quasi-medical terms, drawing on the therapist's subjectivity, but observing standards of objectivity and implying the therapist's capacity for agency, choice and reliable, quasi-objective insight into what is 'helpful'.

Are These Assumptions Helpful In Carrying Out Our 'Impossible Profession'?

I don't think so – at best they are partial, at worst downright destructive to the actual phenomenology of the therapist's internal struggle. They do not do justice to my moment-to-moment experience when engaged in the therapeutic relationship. They do not take account of the degree to which

the therapist's functioning is subsumed by unconscious processes, and actually shield us against an awareness of how we are constructed by the client's unconscious. They do not do justice to the paradox at the heart of the therapeutic endeavour. I take them to be remnants of the 19th century doctor-patient dualism, and unhelpful in sensitising us to the relational complexities and our subjective participation in enactments.

There is no space here to illustrate this in detail (see Soth, 2008), but such assumptions imply a working alliance between the client's and the therapist's ego, as if there was some reliable part of the therapist that can remain untainted by enactments, capable of maintaining a 'helpful', reflective perspective on them. In my experience, this is a fanciful notion and wishful thinking. Enactments are unconscious, and pervade all of the therapist's subjectivity: they may show up anywhere in the therapist's bodymind process and anywhere in the therapist's personal or professional self, including therapeutic impulses and intentions presumed to be 'helpful'. Enactments happen via the therapist's reflections and interventions, not alongside or in spite of them.

This is especially true in moments when the integrative practitioner switches between modalities or paradigms: assuming that all paradigms have validity, the unconscious significance of the switch as an enactment can escape attention. In my opinion it requires an integral – rather than an integrative - perspective, to support such attention and to provide – through awareness of parallel process - the relational 'glue' that holds together the diverse, but potentially fragmented plurality in and through enactment.

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Ailin Kelleher

A Place To Live: Journeying Through Unlived States In The Therapeutic Relationship. The Exploration Continues

Explanatory Note

This is an extract from a longer piece of writing titled "Space and Themes of Silence and Search: An Exploration of Unlived States". This work was part of my submission for a Diploma in Humanistic and Integrative Psychotherapy successfully completed in January 2004. A year later I returned to my study in order to explore further the trauma at the core of these states, in a dissertation which I successfully submitted for a Post Qualifying MA in Humanistic and Integrative Psychotherapy (Bath Centre for Psychotherapy and Counselling/ Middlesex University) in September 2006.

Introduction

In the novel *Like Water for Chocolate* there is a theory of aliveness. It goes as follows.

"Each of us is born with a box of matches inside us, but we can't strike them all by ourselves; we need oxygen and a candle to help. In this case, the oxygen, for example, would come from the breath of the person you love; the candle could be any kind of food, music, caress, word or sound that engenders the explosion that lights one of the matches. For a moment we are dazzled by an intense emotion. A pleasant warmth grows within us, fading slowly as time goes by, until a new explosion comes along to revive it. Each person has to discover what will set off those explosions in order to live, since the combustion that occurs when one of them is ignited is what nourishes the soul. That fire is in short its food. If one does not find out in time what will set off these explosions, the box of matches dampens and not a single match will ever be lighted.

If that happens, the soul flees from the body and goes to wander in the deepest shades, trying in vain to find food to nourish itself, unaware that only the body it left behind, cold and defenceless, is capable of providing that food." (Esquivel 1989, pp115–116).

This is a theory of the relational origins of the self. The flame of life within cannot be lit without the breath of a loved one and such a situation makes it impossible to use the substance of experience, food, music, caress, word, which comes to us through the body. The wrenching apart of body and soul / mind is what occurs when a person largely experiences an absence of response to what is alive and vibrant within us.

I would like to add to this theory. There is a survivor, for one cannot live without having had some of the matches lit. The survivor has a vague sense of something precious that has been known and goes in search, knowing somewhere deep in her being what she needs in order to live. She can only realise it when she finds it however, because that is when another

match will be lit. When enough matches have been lit the heat produced may warm the body and tempt the soul out of the shade. Meanwhile the survivor, unaware of all that has happened, makes what she can of the situation she finds herself in. Internally, however, there is an empty space where large areas of her self, deprived of oxygen, deprived of food, haven't come into being. I call these states of being unlived states.

Unlived States

According to Spinelli (1989), we live in an interpreted world. The way we perceive things is inseparable from our personal experience and how we organise our experience. Intersubjectivists (Stolorow and Atwood, 1992) understand this process to be embedded in relational contexts in which beliefs are established which govern the organisation of experience. In unlived states both the beliefs and the unbearable contexts are deeply concealed. Perception of the world is filtered through these hidden experiences.

Perhaps this is the secret life that Winnicott talks about when he says:

"… one has to allow for the possibility that there cannot be a complete destruction of a human individual's capacity for creative living and that, even in the most extreme case of compliance… hidden away somewhere there exists a secret life that is satisfactory because of its being creative or original to that human being. Its unsatisfactoriness must be measured in terms of its being hidden, its lack of enrichment through living experience"(Winnicott 1971, p68).

For Hillman it is the acorn, "a concealed invisible potential" (1996, p123). Intersubjectivity theorists refer to it as an "organising subjective centre" (Stolorow and Atwood, 1992). In unlived states it is traumatically concealed, inaccessible, unlived. In the story the survivor goes in search with this within her and I believe that for the survivor who comes to therapy the search is for access to this more authentic unlived place.

My ongoing exploration of unlived states is inherent in what I have created in the process of becoming the person I now am. Reflecting on the process my image is of being on the frontier of an unknown place, pursuing something I am unsure of, with another. The exploration of unlived states has also been important in my development as a therapist. In fact I see it as the core of me. With the client I am at the frontier of an unknown place. With the client I search with her for her meaning. However, I bring to that meeting my experience and what I have made of my experience.

Certain theories helped me make sense of my experience and gave me words to describe an explore it: Winnicott's ideas on boundaries and space and his understanding of creativity (1971), Bollas's theory of the unthought known (1987). From Bion's extension of projective identification as a communication and as the origin of thinking I came to see the possibility of movement in relationship. Also his container/contained model showed me a way of being as a therapist (1962). Intersubjectivity theory with its central theme of contextualisation brought forth the possibility of hope when it seemed like there was nowhere to go (Stolorow and Atwood, 1992). It gave me a different context to think within, creating space for waiting and emergence in relationship. For me the therapeutic relationship has been most important in transforming these states. There I am on the edge, the frontier.

"In health the infant creates what is in fact lying around waiting to be found. But in health the object is created not found…. A good object is no good to the infant unless created by the infant. Shall I say, created out of need? Yet the object must be found in order to be created. This has to be accepted as a paradox…"(Winnicott 1965, p181).

Winnicott, and other object relations theorists, believed that at the earliest phases the infant existed in an undifferentiated state with no awareness of herself as separate from the carer. Stern however, has developed a theory, based on observational evidence, which states that awareness of various senses of self exists from birth (1985). It follows that the infant has an experience with what is found and makes something of it. In as much as the infant puts something of herself into it, you could say the infant creates and finds something. Her subjective experience is part of the creation.

When what is found is a responsive other then both subjectivities are part of the experience and for the infant a selfobject need (Kohut, 1971) is met. What of experiences the infant has while alone? What if not enough is found in the close, intimate space? What if the response is too painful? What does the infant make of it? Perhaps then a wall is built, a rigid structure, instead of a threshold that can be crossed over and back, making relationship possible. This is where unlived states originate.

The Creation Of Space

My client R desires to live with access to all that is in her but is in despair that she feels so cut off from others finding relationships impossible, usually getting to the point where she or the other withdraws. She cannot understand how others seem to be able to ride above adversity, carry on with their lives and make decisions. This puts her in touch with a soul destroying self-loathing part of herself and she attacks herself to the point of despair. She feels trapped, unable to move forward in her life.

Freezing in the face of decisions, she wants to work out the best action to take. Trapped, it feels like she wants me to rescue her, but cannot receive what I offer. My personal image of this place is of floating; potentially sinking in the sea, unable to reach for a hand that might mean life, lest it be pulled away and I drown, spiralling down into the abyss, alone. This image expresses two experiences a client may be in contact with in therapy: the terror of re-traumatisation, and the hope for something different. This different context may not necessitate a withdrawal from her subjective experience. Such a context may allow her to enter the depths of her experience. The coincidence of these two positions, hope and terror is the edge of self-experience, the still point. Nothing can be done. In the image it is impossible to move.

As therapist I have learned that at this edge the urge to act prematurely is very strong for the client, but also for the therapist. The challenge is to stay with the fear or whatever is there, to wait for the words, to trust that it is possible for something to emerge. For the therapist this means a digging deeper to search within her own experience, trusting that the client 'knows', that she has certain capacities, which in the presence of a receptive other, will facilitate the realisation of her subjective experience given the space and time. This brings to mind Heidegger's thinking on human creativity as discussed by Spinelli:

"an act of revelation or unconcealedness regarding the truth of our existence. It is a means of 'unveiling' that which is present, but is also hidden from everyday awareness"(Spinelli 2001, p136).

Stern describes the change in self-experience of the infant in the presence of what he terms a self regulating-other. What is important is

"the actual being with someone (a self regulating other) such that self feelings are importantly changed"(Stern, 1985).

During all contact episodes, including those involving regulation of the infant's security or transformation of important states, as happens, for example around feeding, the perception of self and other is of two separate core selves. In the presence of a self-regulating other the infant experiences an alteration of her feeling state. Though created by self with other, it is a movement in self-state without impingement, made by the infant.

R has recently become more aware of a child part that wants to dance and play music. Another part of her seems to have a stranglehold on this child keeping her locked behind barriers, stamped on and bullied. Opposing states arise in relation to me. She experiences a connection which she cannot understand. It feels good; there is hope. At times she attacks, in quite a subtle way. I have felt a deep inadequacy and have felt frozen. At the still point we are in touch with the terror. She searches for the edge from which she can escape or dive into life. I want to find an edge where I can meet her in the place she is in and I think that is also what she hopes for.

With R my attempts to empathise with the bullied child threatened re-traumatisation. My wish was to illuminate a context which might make sense of her experience, saying that it was understandable that she might feel like this, because as a child she had not

received responses which helped her manage her experience. However, instead this touched an unbearable shame in her self-deficiency in being unable to elicit validating responses from her parents, as her siblings seemed to have managed. My misattunement threatened to re-traumatise and perhaps came out of my own need to rescue her. She did not accept my hand. In order to be able to receive her inadequacy and to imagine what it was like for her, I had to withdraw to the landscape of my own experiences of inadequacy and shame. This allowed us to sink into her experience.

On Finding And Being Found

My growing sense is that I as therapist am a self-regulating 'other', open to the client's communications, and in as much as I am able to be with the unbearable tension at the still point, to this extent will it be possible for me to attune to the inner state of the client. What I have realised is that working with unlived states, I sometimes need to withdraw from the edge into the deeper shade of my own experience. This makes it possible to bring more to the edge. I believe that this constant striving to be authentically present with the client is the route to healing. Experiences in therapy where the client is able to be lost with the therapist who is open to being lost, by which I mean having to find meaning within his own experience, create space and promote the possibility of a lived experience. This illustrates Stern's view that through self-regulation we regulate others (Stern, 1985). In this context the integrity of self and other is maintained, and there is space for a different response on the part of the client. There is mutual self-differentiation.

Buber describes this in expressing the need for mutuality between the child and the caregiver. The other

"need possess none of the perfections which the child may dream he possesses; but he must be really there. In order to be and to remain truly present to the child he must have gathered the child's presence into his own store as one of the bearers of his communion with the world, one of the focuses of his responsibilities for the world…Then there is reality between them, there is mutuality" (Buber 1947, pp125–126).

The process creates a sense of boundedness to a hitherto unbearable experience. In this context the client does not have to abandon her experience; she does not have to freeze; she can feel what is there.

Reflecting on the image at the beginning of this section, the life or death image of sinking, and the hand being offered, the hand could be experienced as saviour or abuser. Both notions, however, are in danger of usurping the individual's experience by taking her away from where she is now, breaching the core self of the client. Neither validates the experience of the other. For me then the image is a metaphor for the self-regulating other, who is there, in the same place as the experiencing subject. For both, the other is there to be found. In this context the client does not have to jump over the edge, which allows for the possibility of sinking further into her unlived experience.

R has experienced therapy as a safety net, but one that can develop holes. The repair of these holes in relationship creates space. The sense of stillness and rigidity, feeling trapped and unable to move, gives way to more fluid experience. I see this as the origin of a sense of a place within which to dwell and have lived, interactional experiences between us, to break the silence, to speak – psychological experience, which may then be encompassed within her experiential horizons.

The Language Of Silence

Winnicott cautions against

"insulting the delicacy of what is preverbal, unverbalised and unverbalisable except perhaps in poetry" (Winnicott 1971, p112).

Hillman writes

"So many words are available once we close the psychology book and open the novel "(1996, p174).

In my exploration, words I have discovered in novels and poetry have helped me digest experiences. Making these words my own I have learned my own language, creating pictures of wordless experiences. Many find words in

poetry and metaphor when it is difficult to say exactly what is going on. M conveyed much about how disconnected she felt from her own centre, and her despair about her inability to have an impact when she said. 'I feel as if I am pressing down on the accelerator of my car, but the harder I press the slower it goes.' The metaphor makes an analogy, creates a scene, an image, which penetrates to many levels at once. It resonates with something deep within, giving a felt sense which seems to bypass cognitive processes. I call it the language of silence.

Levin (1991) has presented evidence which indicates that metaphors are powerful because they resonate with the most fundamental levels of experience, serving as 'bridges' in a number of ways. Relating one sensation to another they create bridges between sensory modalities. This is how Stern (1985) has shown that mothers attune to their infants' experiences, not by mirroring the infants' expression exactly, but by matching the shape, intensity, vitality affects, hedonic tone in a different mode, thus capturing the inner state of the child. Because of the ambiguity of metaphor, it arouses activity in both the right and left hemispheres of the brain, a bridge connecting hemispheres; the linguistic elements stimulating the left, the non-linguistic stimulating the right hemispheres respectively, thus resonating at multiple levels of experience and meaning. Also the unexpected combination of ideas in a metaphor surprises the listener, arousing interest.

According to Levin metaphor seems to create the general level of affective arousal for "synthetic activity" (1991, p12). By this I understand that metaphor provides a means of safely accessing the raw data of experience or "experiential matrix", which Stern refers to as "the fundamental domain of human subjectivity" (1985, p67). In therapy this is a connection to the source of new life, because of the potential for different experiences of self to emerge in a validating, responsive context.

Images

For me images arising in the intersubjective space are metaphors and sources of powerful language. In my experience the image comes first, arising from the still point in the intersubjective or intrasubjective space. In unlived states there is no image. However, the presence of the client, her gesture, way of relating, has an impact on the therapist, and in my experience, often evokes powerful imagery. What I have found is that attuning to my own bodily experiences and sensations, and allowing imagery, I eventually find words.

My client B's fear was that others, including me, would reject her if they saw what she is really like. Believing her 'vitality' is unwanted, it is hard for her to imagine that anyone could bear her feelings. She hits a wall where her experience does not make sense. This stops her ability to think and she tries to explain what it is like. She knew she was disconnecting but was aware of berating her partner, and me, for withdrawing from her. My attempts to make sense, threatened to re-traumatise. She repeated, 'I can't explain it.' In this place thoughts go, words to explain what is happening go. She feels hopeless.

In the session maybe it felt like I could not bear her. An image of sinking came to me, the still point, and an unbearable inability to do anything. This is when I hit a wall and stopped thinking or feeling. I had seen in her eyes what I could only describe as a madness and felt frightened. I remembered seeing that look in my mother's eyes as a child and I think this is where I stopped being able to think; this is where I froze and went blank. I was no longer present, I had died inside, frozen by a look experienced as annihilating.

Reflecting on the image later I realised that something had been given up on. I see this place as a feature of unlived states. There is terror of abandonment in the vast empty space, where she will be left with the chaos and the confusion, and the realisation that no one will ever come to where she is. There is the horror of usurpation, that her experience will be taken away and made into something it is not for the sake of another's sanity, and that she will cease to be. Her terror is of such annihilation. We are on the edge of abandoning something vital. For B consistent absence of response to her subjective experience, which allowed no way out, for her 'vitality', had been her experience. In the close space it feels as if there can only be one survivor, in this situation she or I.

B arrived twenty minutes late for the following session. Waiting, I felt anxious about something slipping away. I was close to my own edge but the image of sinking, had connected me with my terror. I began thinking of what it might mean for both of us.

In the session I expressed something of what I had experienced, that I had felt something slipping away, and a sense of an impossibility of staying in this place. She responded that that was how it felt for her - impossible to stay connected. She disclosed her sense of something having changed between us, which she also felt between her and her partner. She said it felt ok in a way, but it also felt like she had lost something. When I asked where she felt this in her body she pointed to her stomach and said it was a sinking feeling. An image of a baby, floating in space, with an umbilical chord attached to nothing emerged, a baby, disconnected from life sustaining material, also deprived of an outlet for unwanted material that needs to be evacuated.

I see this image emerging as part of the process in the moment, but also as an expression of a memory of other interrupted experiences of self, memories of disconnection or abandonment, memories of self loss. Perhaps this image shared could re-connect B with something that had become broken; a process of emergence arrested before completion. Attuning to her experience might re-establish a channel of communication between us, one that had been cut off when some need of mine to explain her experience impinged. Such a response may ease the horror of usurpation, giving hope, thus easing the terror of abandonment.

I said it felt as if she had been disconnected from a source of nourishment like when the umbilical cord is cut prematurely and baby is disconnected from something vital. B said nothing but she seemed calmed. I felt my experience shift to the level of sensation moving through my body. It felt as if we were both connected to something moving within.

The image as metaphor as well as the words and how they were expressed, seemed to bring resonance from discord, movement from stillness, in attuning to the most fundamental levels of experience. In so doing there was resolution, but for me something else happens. My experience is that such attunement rekindles earlier memories of attunement, body memories, just as looking at a photograph can rekindle memories of joy or sadness. I think this happens in both participants simultaneously, connecting, both to the raw data of experience, the 'experiential matrix', the personal source of life and vitality. The pleasant somatic resonance, experienced at these moments, I believe is a result of this process. Using the imagery of the theory of aliveness in the introduction it is as if a match has been lit igniting a flame that spreads through the body, re-finding in the experience the precious thing lost long ago. Perhaps this is the other as transformational object (Bollas, 1987) for both. For the client self-experience has importantly changed in the presence a 'self-regulating other' (Stern, 1985). They are both in tune, connected to the source. Buber's belief that it is in such meeting that healing takes place resonates with my experience of the transformation of unlived states (Buber, 1947). Happening in the here and now it is also remembered, and now it is known: a moment in the history of the self, connecting to other moments.

Memory And Imagination

A sense of continuity or self-history is fundamental to the sense of being an aware subject living in a world felt as one's own. And memory may be what makes this possible. Memory as I use it refers to the capacity to pre-verbally encode lived, interactional experiences, so that a sense of self with a history or "going-on-being'" (Winnicott 1965, p86) is established. For example, the basic units of such memory for Stern (1985) are Representations of Interactions that become Generalised. RIG's encode all the attributes of the generalised lived episodes, and also contain expectations of self and other in relationship. For intersubjectivists the organising principles of a person's subjective world are psychological structures, formed in specific contexts, which partly shape the experience of self and other (Stolorow and Atwood, 1992). In unlived states these 'memories' are unconscious, perhaps manifesting in an "idiom of being and relating" which Bollas (1987) calls the "unthought known".

I have thought of images as transitional phenomena; the imagination's way of presenting what cannot be directly experienced because it is unknown or unmanageable. On the boundary between known and unknown, the image itself is conscious, but it can also contain layers of hidden meaning, layers of experience of a transitional form.

Hillman describes a way of working with images. He talks about image-sense, a way of being with the image which is different from looking at a picture. It is not about interpreting. It involves going to the image, being there, feeling it, turning it around in order to experience what is there. It requires an inner freedom to allow imagery so that new insights emerge. This is sensing the image – imagining, which is different from knowing about the image-symbolising (Hillman, 1979).

I was telling my therapist about an image I had on waking that morning. It was of a beautiful bird in a cage. The cage door was open, but the bird remained inside still and silent. He responded that the difficulty leaving the cage seemed to symbolize my life at the time. Nothing happened. It made sense. It was nothing new. A silence ensued; then my therapist wondered what it would be like for someone to enter the cage. The impact was immediate. His words went straight to my heart where I felt a terror. My terror of being completely taken over by another's reality was revealed to me and I experienced it then and there.

This image represents for me the trauma at the core of unlived states. There is no movement. I imagine what my therapist may have experienced with the image to be something like the following: 'the bird is still and silent, un-breathing, but with eyes wide open, looking, perhaps waiting. The door is open, but the way out is not clear. It is as if the bird doesn't know she can fly. Does she know she has wings? Has she ever seen another bird? It seems not'. This makes more sense than a fear of leaving. I feel a desire to move closer but a fear of what might happen. The image, however, allows an intermediate space- a transitional space for play. The therapist's response of expanding the metaphor changes the scene. Suddenly there is movement, from the heart through breath. There is expression, like a baby from the womb being shocked into using her own breathing organs. There is life.

Hobson promotes a similar way of being with images, a way which reveals hidden activity and involves a kind of coming to life. He describes the movement from fantasy to imagination as

"a special instance of how psychotherapy involves a discovery of activity in apparent passivity" (Hobson 1985, p14).

Passive fantasy is a term he uses for images occurring spontaneously, sometimes unwanted intrusions, as in nightmares or flashbacks. Like Hillman, he advocates an active willingness to allow images to emerge, an expectant waiting so that the "mood", for which the image is a "fantastic analogy", can express itself. This is active fantasy or what Hobson terms "a symbolical attitude". Cultivating and promoting a "symbolical attitude" is important for this is how one can learn to develop a capacity for "imaginative activity" an even more active stance, thinking about the image and viewing it with a critical eye (Hobson 1985, pp101–103). For me "imaginative activity" is "imagining" as Hillman describes it, taking to the image thoughts of contexts present and past, while maintaining an open receptive attitude to the details of the image and how they might change. This is important because hidden in the image is something of how the person experiences being, and being in the world with others, as well as the means of revealing what is hidden. Thus the image is a "living symbol" (Hobson 1985, p199). A symbolical attitude to the image of the bird in the cage with the open door views this image not only as a communication of a fear of leaving the cage, but also as a "living symbol". The imaginative activity of my therapist, the expanding of the metaphor, gives immediacy and vividness to the expression of a hidden experience.

Images thus may be seen as a first level of organisation emerging from, but remaining still embedded in the raw data of experience, what Stern calls the "experiential matrix……the fundamental domain of human subjectivity", and Hobson terms the "ground of experience" which is "the source of creativity" (1985, p82). As new insight

emerges we remain in touch with this level of undifferentiated, pre-reflective experiencing.

In unlived states images hold memories in suspended animation, similar to what Bollas (1987) describes in the "unthought known". This he describes as a kind of knowledge, not yet mentally realized, stored in the being of the individual. A somatic knowledge, it contains wordless memories of being and relating, and being related to, from infancy and early childhood. It resonates with what Donna Orange terms "emotional memory" which she describes as

"any form or part of experience that largely bypass cognitive processes and carries significant residues from the intersubjective world of the past" (Orange 1995, p113).

The concept of "implicit memories" (Rothchild, 2000) of pre-verbal and non-verbal experiences is similar. I understand the "unthought known" to be memories of being and interacting, including memories of the contexts in which they were laid down, encoded in how that person is in relationship. Though unavailable to the individual the "unthought known" is present in all the nuances of being and behaviour, and becomes known to another in relationship through the imagery which emerges. In the words of Hillman,

"The supposedly concealed is also on view and subject to keen sight" (1996, p123).

Within the image of the bird in the open cage are encoded memories of self-experience which had not been seen and responded to, and therefore had not been lived. Subject to keen sight the hidden terror was lived and witnessed, thus validated. In remembering and living thus something timeless is bounded by an event in the history of the self. Cycles of experience are complete.

What may also be discovered are beliefs about the self in relationship, the underlying principles which shape the individual's experience (Stolorow and Atwood 1992, p29). These pre-reflectively encoded beliefs, which are emotional rather than cognitive, are what keep the person encaged, though the door is open. Remembering, reliving, fully living what has been held suspended means that these beliefs can be reflected upon. For B her belief that in relationship there could be only one survivor because her vitality, her aliveness, became unbearable, indeed dangerous, was recognised

In the therapeutic relationship the therapist's capacity for actively imagining various possibilities extends the horizon of experiencing for the client, providing space for remembering states, and living hidden experiences, which in turn increases the client's domain of reflective self awareness. This brings to mind the words of Santayana (1920):

"in imagination not in perception lies the substance of experience while science and reason are its chastened and ultimate forms" (Santayana in Milner 1971, p27).

New experiences are lived, untangled from the timeless, repetitive state of blankness. In a responsive validating context new memories are created. New possibilities may be envisioned. There is the possibility of choice. We come to remember / know our history, but also a new history may be lived. The latter doesn't replace the former however, though the process is freeing. It frees the imagination. The bird will fly.

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Book Review by Dr Anna Sorensen

Touch Papers: Dialogues On Touch In The Psychoanalytic Space, Edited By Graeme Galton, 2006, Karnac, London

Perhaps this book could have been titled, 'Touch – have we come full circle?', since many of the contributors start their discussion with reference to Freud's early use of head pressure to augment analysis!

This is a brief, readable collection of essays by well-respected psychoanalytic practitioners reflecting on the question of touch in the therapeutic setting. The aim is to challenge the taboo of talking about touch and to stimulate discussion. The foreword by Susie Orbach outlines the major tenets for discussion:

"Several discussions dominate the discourse on touch in psychoanalysis. The first is that it is wrong, inappropriate, and unsafe: touch initiated by the therapist is invasive, potentially transgressive, and may bypass important psychic material. Another assumption is that when touch occurs it is because the patient has regressed and that a developmental deficit has brought it into the therapy. Yet another assumption is to see touch as a one-off occurrence that was either unfortunate, that worked in this particular instance, or was a close shave.

"Such assumptions are so embedded in psychoanalytic thinking about touch that we have a very sparse literature on touch within the therapy relationship. Further, there is the idea that since we all agree that touch is not a good idea, there is very little to discuss." opening paragraphs, p xiii

"We need to engender a discipline-wide conversation and research project that would provide the kind of information that would help us formulate questions that need addressing in order for a proper evaluation of the role of touch to be considered." p xvi.

Orbach's final call is for psychoanalysis to "embrace the new scholarship that would defetishize the taboo on discourse about touch." p xviii.

The encouragement is only to put touch on the agenda for discussion, and to develop a current body of experience regarding touch and the impact on the therapeutic process. Diamond (chapter 7, p79) says of her contribution, "The purpose of this exploration is to identify preconceived prejudices concerning touch and to open up the space to consider touch afresh as a form of communication".

The classic view in psychoanalytic therapy is that touch is inappropriate and unsafe, and may bypass important psychic material. Psychic conflict is to be symbolised, put into words often through therapist making interpretations of unconscious material. Practitioners holding this view as the primary or only means of achieving psychological change are understandably against touch

between therapist and patient, or any other boundary violation. I was interested to learn (p47) that the psychoanalytic code of ethics states "physical contact should be avoided".

Orbach is encouraging interrogation of the 'canon', rather that blind ingesting of traditional boundaries. There may be a pragmatic necessity to review the usually lengthy psychoanalytic contract in the light of service provision and financial constraints on therapy currently. Review is especially relevant in the light of current research into attachment theory, neurophysiology of memory and the importance of embodied experience. Several contributors mention the relevance of the distinction now made between explicit, declarative knowledge and implicit, procedural knowledge. Stern is quoted (p75) "… just as an interpretation is the therapeutic event that rearranges the patient's conscious declarative knowledge,… a 'moment of meeting' is the event that rearranges implicit relational knowing for patient and analyst alike". Also "Real emotional change is not achieved through conscious reflection, but through altering the procedural interpersonal sense" (Diamond, p95). The thought is postulated that touch may at times be the catalyst of a moment of meeting. Another Stern quote I liked is, "The ultimate magic of attachment is touch. And the magic enters through the skin" (quoted by Bosanquet, p42).

Orbach (along with many of the contributors) stresses the paucity of written case material involving touch. I found it interesting to see the same few examples discussed by different practitioners from differing perspectives.

This is a diverse collection of essays, each of which is short and readable. However, each contributor is starting from base, outlining the field and their personal experience of touch. This leads to significant overlap, with viewpoints converging and diverging. Although I found that interesting, there was limited space to explore in any depth the specific experiences, and especially of those therapies that do combine talking cure with body awareness and touch.

Several contributors talk movingly of their work with children and the place of touch in that context. It is pointed out the embodied awareness may not include physical touch between therapist and patient, but be in the imaginal realm, verbal exploration, client self touching, phenomenological enquiry. Farrell makes a passionate call for therapists to develop an increased awareness of their own body and that of their client, allowing this to impact the work indirectly (as in the countertransference) and directly as in verbal exploration. The question is raised as to whether there are circumstances of patient childhood deprivation that necessitate touch in the therapeutic relationship for "the provision of primary experience" p10, 39, 90–94. The possibility is raised that touch is essential for the "re-wiring" of the brain and on-going possibility of analysis in such patients.

It is pointed out by several contributors (Sinason,p 60; King, p 61; Farrell, p 97) that the personality of the therapist contributes unconsciously to the choice of training, and the style of therapeutic practice that evolves.

There is a chapter by Nick Totten, body psychotherapist, which is of a flavour different from the other contributions. He is at ease with touch, the rationale behind whether and when to touch, and the need for specific training if touch is to be part of the therapeutic method.

Overall the intention of this book is to stimulate reflection on the place of touch, and the more important underlying question of what actually facilitates change. Successful interpretation is affect-laden, enabling the client to feel understood and 'held' in all their complexity. Does that 'holding' ever beneficially extend into the physical reality? Is it purely unconscious? Is it made explicit through dialogue and emotional expression alone? I have found myself reflecting deeply on these issues, and my practice has been impacted by reading the testimonies and challenges of others. As such I consider this book to be effective in achieving the goals stated, at least with me!

I think touch and, more important, our awareness of our embodiment in the room with the client is an essential topic for discussion. There is now clear evidence of the neurophysiological basis of change and resumption of ego development, and access to

research on early infant development. Further evidence for the impact of embodied awareness is also coming from mindfulness based therapy practices. Also therapists are more commonly working with childhood trauma, and we are pressured to show cost-effective intervention. Embodied awareness perhaps holds the potency to support deep work in a shorter time.

Where to from here? In the forward Orbach suggests an anonymous questionnaire to survey psychoanalytic (and, I hope, humanistic!) therapists on experiences and practice regarding the use of countertransference and touch etc. Results of such a survey could form the basis for discussion and be useful information for ongoing training and new research. The encouragement of this book, which seems wise, is for psychoanalytic traditions to re-think these questions coherently, rather than have a piecemeal more superficial incorporation of experiential practices from other traditions.

Dr Anna Sorensen

Book review by Helen-Jane Ridgeway

Who's Afraid Of The Teddy Bear's Picnic? A Story Of Sexual Abuse & Recovery Through Psychotherapy. Pam Smart, (2006) Essex: Chipmunkapublishing

This memoir speaks of human struggle, trauma and abuse, the search for meaning, and healing through psychotherapy ultimately leading to recovery.

In her biography 'Who's afraid of the teddy bear's picnic?' Smart tells her story in a candid and honest way. At no time does she make any attempt to make what is on the page palatable to the reader; instead she is bold, frank and simply straightforward in her often stark descriptions. That is not to say that she does not take responsibility for the impact of what she recounts, on the contrary, she does so in a measured way, taking obvious care not to overwhelm the reader.

Smart takes us on her journey beginning with the rejection, abandonment, early relational rupture at the hands of her primary caregiver and the severe disruption of early attachments. The story exposes the child's horrific and heinous experience of unspeakable abuse within the family system, and through a child's eyes details the experience of being in care in large institutions during the 1950's in Britain. This story tells of systems that were flawed, how children and young people fell through the net whilst in care and how authorities and professionals have all too often missed what is really going on, too busy to 'see' behind the behaviour. In addition it opens up to display a society that also all too often buries its head in the sand and adopts the attitude that it 'doesn't want to know'.

The story continues by chronicling the acting out of a disturbed, desperate and often terrified teenager. Smart authentically shares the rage she felt and subsequently turned against herself in the form of behaviours, suicidal threats and deliberate actual self-harm. Alternating between being numb to all feeling and being flooded with emotion, whatever feeling state predominated in each moment seemed to last forever, her physical and emotional pain seemed continuous and excruciating. She often resorted to a variety of desperate, impulsive behaviours as a route to providing a quick fix for painful, seemingly endless emotions, such as loneliness and anger. Whilst continuing her unsuccessful journey through several psychiatric hospitals and a variety of drug treatments, there are times in the book where she shows how environmental ruptures can exacerbate dissociative symptoms and become a part of the enactment scenario. Smart was eventually offered treatment at the Henderson hospital; during her time there it becomes clear that this period marks the long hoped for start in her process of recovery.

Previously considered a 'hopeless case' she faced difficulties in acquiring psychotherapy resulting in her being labelled untreatable. Smart demonstrates her tenacity and the inherent in-built human desire to strive for healthy relationships, both with self and

others; a motivational force that kept her going until one psychotherapist took a risk and a leap of faith. In the belief that the symptoms, presenting issues and high levels of dysfunction were treatable this psychotherapist took on the task of working with a young woman who was acting out with alarming frequency.

Is it because it shakes our value systems to the core when we have to take on board the capacity that humans have for evil and harm, that professionals can engage in conscious and unconscious thought-processes when disorders are thought to be untreatable, which can then perpetuate family silences and secrets, passed down from generation to generation? Pam Smart had the courage and humility to do something different and risk an attempt at breaking that cycle, deciding not to collude with the dysfunction. A dysfunction she recognised would result in the transgenerational passing down of her script and of the abuse, potentially manifesting in the maladaptive behaviour of her own children.

She describes her treatment in psychotherapy against the backdrop of a painful web, spun out of a tortuous childhood so full of abuse, deceit, lies and torment that it constantly threatened to destroy the working alliance. Smart details certain trauma approaches, including re-parenting and EMDR. By divulging the story of her engagement and her experience of the therapeutic relationship she implicitly explores and makes reference to the process of dealing with trauma and abuse in therapy and relates the phases embodied in this process. This is more explicitly narrated in her 'reflections in hindsight' chapters, when she shares her reflective processes from the benefit of hindsight and from her newly integrated, functioning adult ego. From a clinical stance I would have appreciated more of a focus on these reflections and further exploration of the aspects of the therapeutic relationship and interventions.

Smart addresses the severity of dissociative disorders and PTSD, showing how the impact of these disorders of the 'self'/ personality, can and do affect individuals. How childhood abuse and environments of neglect can lead to a profound disassociation making it impossible for the individual to be grounded emotionally and exist from moment to moment in quality and intensity. She does this by revealing to the reader her struggle to understand what was happening to her and to make sense of, and manage her symptoms and how through therapy she learnt to curb impulses and tolerate painful emotions. If it were not for the professionals, as experienced by Smart, who went the extra mile then maybe these kinds of symptoms and issues would have remained in the realms of 'untreatable'. Without these professionals many more individuals could be left trying to manage the unmanageable, with no hope for change or their need for professional support being met. This story endeavours to add a plethora of understanding by its generous sharing of experience, to the field of Mental Health, psychotherapy, social work and many other caring professions.

This book highlights the tensions experienced between ethical stances and the pushing of boundaries in the interest of the patient and furthering of theories and methods for treating trauma, whilst at the same acknowledging and taking on board what it means to be human and the responsibilities entailed in offering an opportunity for healing relationship. By acknowledging that organisations, systems and psychotherapeutic processes are often still flawed, it reminds us that we have a duty to question these aspects and to encourage new thinking, growth and change; this is what Smart is challenging us to do. That is not to say that I support certain therapeutic interventions, for example the engaging of holidaying with one's past therapist which I believe are contrary to certain ethical tenets.

Through her story Smart shows the struggle she experienced in her aim towards forgiveness of the perpetrators of her abuse, in order for her to 'move on' and so that healing could occur, a healing that eventually led to her becoming a psychotherapist herself. This book endeavours to provide a source of hope and empowerment for those who have suffered and continue to suffer in the aftermath of trauma and abuse. Through the recounting of her experience, she strives to encourage others to seek out recovery and in the final chapter clearly states this as a portion of her intent.

Without wishing to belittle the importance of 'telling one's story' and the powerful healing

often attained in such a declaration, this book does raise certain questions. In an already saturated market where the trend is to tell the world our stories, by its consumption are we in fact fostering a culture of voyeurs? And, as psychotherapists, who so often are wounded healers themselves, should we or should we not, forego these levels of disclosing our story in the public domain, in favour of a duty of care to our clients after considering what the impact of such disclosures may have on them?

In addition to posing many questions and flagging up some tensions within the caring professions, this book also brings with it a morale boost to the field of psychotherapy as a whole and in particular the branches of relational and integrating therapies. By recounting the process of her personal integration of the parts of her 'self' that had been 'split off', she implicitly demonstrates the treatment impact of integrating different models, theories and ways of working to 'fit' individual clients' needs, whilst still considering the wider context in which certain issues are embedded.

This book upholds Fairbairn's hypothesis that 'we are relationship seeking' and that the ego is not solely pleasure seeking but rather 'person' seeking. It shows the need for a 'secure base' and attachment relationships to significant others throughout our lifetime as advocated by Bowlby. It ultimately shows how therapy can at times provide this, further demonstrating psychotherapy in terms of subjectivity and intersubjectivity and as both an intra-relational and inter-relational process.

It is heartening that this book was made possible with grant funding from the Arts council; however it would have benefited greatly with the involvement of an empathic editor in order to do the story the justice it deserves.

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