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The Personal and Professional Interface

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Introduction

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

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Submissions and the Editorial Process

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Consulting Editors

Maria Gilbert and Katherine Murphy

Editorial Board Members

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Editorial

The Personal and Professional Interface

The contributors to this journal all share reflections on their personal processes and professional choices. Currently in the field the interface between the personal and the professional is at the heart of contemporary practice in many approaches to psychotherapy, including integration. The articles in this edition of the journal vary widely and yet share this focus. Our professional choices are inextricably shaped by our personal history and life experience. We welcomed the range of articles and experience linked to this process of development.

Eva Feindler provides an interesting account of her personal journey into professional integration. She demonstrates very well how this is seldom a straight and easy journey or a conscious decision in advance of setting out. She lays out an accessible description of her stance on theoretical integration and her current evolving integrative framework.

Sheila O'Sullivan explores a topic that stirs a controversial response from some people: 'Voluntary Childlessness'. Sheila looks at the wider implicit and explicit contextual factors that could be seen as usually playing out in most psychotherapeutic practice and particularly in this area. She also reflects with touching frankness on her own interest and experience in this regard.

Sally Rose translates complex neurobiological knowledge into an accessible model for understanding and addressing 'Workable Ranges of Everyday Stress an Emotion'. We appreciate her capacity to relate the knowledge and research about severe trauma to the more everyday experiences of stress and anxiety in a manner that is understandable and applicable to individuals and groups.

Penny Bradshaw has written the story of her great aunt Alice Winnicott, Donald Winnicott's first wife. This article gives the reader an insight into Alice's relationship with Winnicott as he was becoming more active and highly recognised in the field. It addresses her support of his work and reflects the challenges of being alongside a professional of his renown. Above all, Penny highlights Alice's own interest in science and art which is reflected in her excellent pottery. We see this integration as being at the heart of psychotherapy,which is in our view both a science and an art.

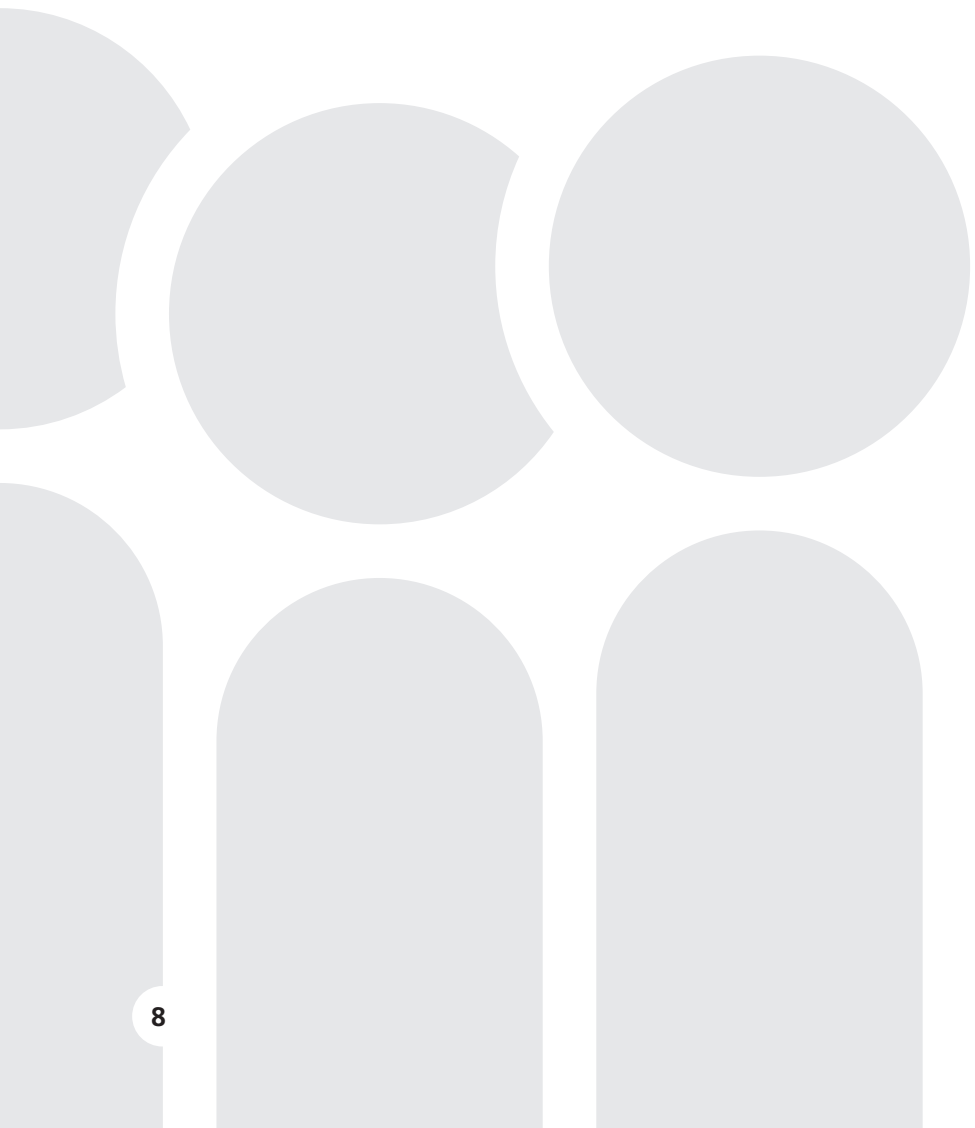
As is our practice we have included the theoretical section of Catherine Oadley's MSc dissertation in Integrative Psychotherapy at the Metanoia Institute. We have also included a film review by Albert Zandvoort.

Peer Review

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

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

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



Eva L. Feindler PhD

Transformations of Theoretical Orientation: A Clinician's Personal Journey

Abstract

Each clinician's relationship to his or her theoretical orientation—like the relationship that unfolds between a therapist and client/patient—presents as a unique and deeply personal process. While empirical research may be somewhat limited as to the processes clinicians go through in choosing their theoretical orientation, many have described their personal journeys of theoretical orientation. This article reflects a clinical psychologist's journey from her early behavioral training in the 1970's to relational psychodynamic training following life-changing events occurring during and after the 9/11 terrorism attacks in New York. She describes how over her career as an academic psychologist, administrator and practicing clinician, her theoretical perspectives have been enriched and expanded by life-altering personal experiences and a multi-year analysis. For her, it was possible, as a life long learner, to experience a theoretical transformation based on a confluence of personal and professional events. She has benefited from excellent training in both the CBT and psychodynamic traditions and believes that her clinical work was been enhanced through her theoretical integration.

Introduction

The clinical field is full of incredible theorists and researchers who for decades have helped us develop as clinicians and educators in the field of psychology. Long-standing theoretical "camps" have enriched the debate and dialogue about effective interventions for a variety of clinical populations. Of late, the psychotherapy integrationists have become active contributors to professional training. As a full-fledged academic my entire career, I never would have believed that much of my personal and professional growth later in my career would be largely influenced by "serendipity". According to the dictionary definition, serendipity is a noun meaning "finding something good without looking for it". We of course would change that to a "process"! What follows in this article, after a consideration of research and writings about how clinicians adopt theoretical orientations, is my own developmental journey towards psychotherapy integration. This transformation was not planned but rather influenced by personal events and cultural changes in the world of psychotherapy since the 1970's.

Clinician's Theoretical Orientation

Clinicians typically define their practice in terms of an allegiance to a particular theory or therapeutic orientation. In almost every approach to psychotherapy there is a need for a blend of theory, technique and experience. According to Striker (2010), theory is the structure that guides understanding of the client, and technique is what is actually done in treatment. Experience facilitates the clinician's ability to choose a technique and determine any deviations from what theory

would dictate. Boswell, Castonguay and Pincus (2009) define theoretical orientation as a pretreatment perspective that determines how therapists typically conceptualize clinical cases and approach treatment. And it would seem logical that this perspective would be honed during training and supervision and perhaps during a course of personal therapy.

Buckman and Barker (2010) suggest three possible models for the selection of orientation. They delimit an evidence-based practice (EBP) model as the selection of a treatment approach based solely on the empirical evidence of psychotherapy research. In contrast, the client-fit model guides the therapist to select the approach he or she deems as best suited to the client and their difficulties. This assumes that the therapist is able to draw on a number of theoretical perspectives and feels competent to practice from these variant perspectives. Finally, they propose a developmental model that characterizes trainees' adoption of a theoretical orientation based on their experiences passing through three distinct phases. According to this model, the development of theoretical orientations begins with the somewhat inflexible and narrow focus of novice therapists who focus solely on one approach directly following their graduation from doctoral-level training. As clinical experience accumulates, they consider other options but are unsure of when to pursue a particular orientation. Eventually they have a preferred or dominant orientation while being flexible and enjoying dialogue about other orientations. Longitudinal research on graduates from training programs with dominant theoretical orientations would help to clarify how this process actually unfolds.

Shifting Theoretical Perspectives

Across time as a professional develops, accumulated clinical experiences may give way to a shift in theoretical perspective. In his seminal book, Goldfried (2001) explores the roots of the theoretical transformations of expert therapists over time. He suggests that treatment failures/impasses and life experiences give therapists pause to consider the limitations of their approaches and increase interest in other orientations.

While empirical research may be somewhat limited as to the processes clinicians go through in choosing their theoretical orientation, many have described their personal journeys of theoretical orientation (Castonguay, 2006; Mitchell, 2004; Nuttall, 2008; Safran; 2003; Wachtel, 1997). For instance, Mitchell (2004) reflected on the tortuous path through schools of psychoanalytic thought previously deemed incompatible that culminated in his theoretical perspective as a relational psychoanalyst. Interestingly, Safran (2003) regarded the influence of Mitchell and the relational turn in psychoanalysis as the impetus to his adopting the role of a mainstream psychotherapy researcher and writer of clinical theory in both psychodynamic and cognitive and behavioral traditions. Similarly, Wachtel (1997) tracked the transformation of his position as a psychoanalyst staunchly opposed to the principles of behavior therapy to one who embraced behavior therapy as "crucial to the development of psychodynamic thought" (p. xix).

Operating counter to Wachtel's path to integration, Castonguay (2006) described his initial pursuits of psychotherapy integration as a means to escaping a deep sense of confusion and difficulties tolerating a sense of lacking control. He asserted that his personal pathway to becoming a "cognitive-behaviorist thinking integratively" has been an effort to assimilate to "repeated confrontations with the complexity of human functioning, as revealed by the seductiveness of major intellectual traditions, the untamable nature of clinical reality, and the challenge of unexpected empirical findings" (Castonguay, 2006, p. 36).

There has been a shift over the last two decades to therapists identifying with an integrative or eclectic orientation. In a 2005 survey by Orlinsky and Ronnenstad 46% of their sample of therapists reported being saliently influenced by two or more theoretical orientations. In the web survey reported by Cook, Elhai, Biyanova, and Schmurr (2010), the majority of respondents indicated identification with more than one orientation. However, it was not clear what is meant by these data: identifying oneself as integrative fails to provide an understanding of what integration looks like. And simply identifying with more than one orientation

does not clearly emerge as an integrative perspective. What is still sorely needed in the research is an understanding of the triggers and motivations for those clinicians who have shifted their theoretical lens from one to another versus those who have expanded their clinical repertoires to include multiple orientations. Further, the exact process of psychotherapy integration for the practicing clinician is just beginning to be articulated and it will be exciting to examine how this manifests in the actual treatment room.

Each clinician's relationship to his or her theoretical orientation—like the relationship that unfolds between a therapist and client/patient—presents as a unique and deeply personal process. Over the course of my 30 years as an academic psychologist, administrator and practicing clinician, my own theoretical perspectives have been enriched and expanded by life-altering personal experiences. I was initially trained in a cognitive-behavioral doctoral program where I developed an appreciation for the value of outcome measurement and working from evidence-based models where data could support interventions. At the time, research to support the efficacy of psychodynamic psychotherapy was scarce, and the theories of psychoanalysis were simply not on my radar. Actually, during my training, we behaviorists were opposed to psychoanalysis and its emphasis on unconscious processes which could not be clearly defined and the protracted course of multiple sessions per week across many years. It was not until my world was shook by crisis that I began my personal journey of exploring theoretical perspectives that had been somewhat foreign to me at the time.

A Personal Theoretical Journey

My undergraduate years at a prestigious women's liberal arts college were devoted to becoming a foreign language teacher. My father was born in Germany and my mother was a high school teacher of many languages. Although somewhat tedious, I persevered in both French and German and took a string of education classes. It seemed to me that I was simply modelling my mother's chosen profession as I inherited the same gift of language that she had always displayed. And at the time, I believe I led a mostly unexamined life! However, during a junior year semester away, I had a key transforming experience. And just maybe I needed to be in a different context to push along my development.

In need of money, I took a job as a mother's helper to a 12-year-old autistic daughter of college professors. Many of the hours spent with Elly have been well documented in a book entitled 'The Siege' written by her mother (Park, 1982). I became one of "Elly's girls", much like the ABA trainers of today, carefully implementing newly crafted behavioral contingencies that encouraged her social and adaptive living skills. I was fascinated with Elly's (albeit splintered but gifted) cognitive abilities, but more so, her contentment with her self-stimulatory repertoire and her disconnection from others; a condition that her mother coined as "willed isolation".

This experience with Elly marked the beginning of my professional life in psychology, and I eagerly rode the wave of behaviorism as it fitted my sense of self at the time. I was independent, capable, had good self-control and could fit most things into logical sequences of events and reactions. I immersed myself in a new language; fundamentally tied to experimental psychology and theories of learning, but now focused on clinical applications. The orientation fit for me, was the Zeitgeist of clinical child psychology and was the overarching philosophy of the University that offered me a full NIMH scholarship in the 70's. Any doubts I might have had were reduced to negative self-statements easily remedied by some cognitive restructuring and a focus on self-reinforcement of "beginning professional" behavior. I cannot say that I chose my theoretical orientation after careful consideration of the options available at the time. But rather, I found a program that seemed to fit the work that I was doing (My first APA conference presentation was to Division 25 on Operant conditioning and stimulus control with pigeons: Feindler and Akerlund, 1975), was an APA approved clinical program and had scholarship monies available.

My dissertation project, which subsequently led to almost 25 years of teaching, researching and writing in the field of anger management

was borne out of another passion; children whose early developmental experiences had shaped an oppositional and at times aggressive response to their environment. I had completed several externships with children in residential settings and aggression seemed always the most frequent presenting problem. Again, my CBT focus was crystal clear….it never dawned on me then as to other reasons why I might choose to dedicate myself to the topic of anger regulation! Although there are many events that brought me to my professional midlife, I'll focus for now on the epiphanies, surprises, and chances that guided my professional process. This personal journey reflects the myriad of variables that influence a clinician's theoretical orientation.

During my clinical internship year, a mistakenly scheduled job interview led me to my first teaching job at Adelphi (in the "other" psychology department). My earlier leanings toward foreign language education had changed to elementary special education for a while as an undergraduate. But it never dawned on me until that day in the spring of 1979 that I might return to my earlier love of teaching and combine it with my passion for child clinical work and my belief in the effectiveness of behavioral interventions. Having just turned 26, and never having taught a college course, I began to teach and administer a graduate program in Applied Behavioral Psychology. That Adelphi University was known for it's doctoral and postdoctoral programs in psychodynamic psychotherapy was not even on my radar.….. ahhh, the power of focus and goal attainment!

Once licensed, I established my private practice through the newly created Institute for Behavior Therapy (IBT), in New York, and eventually became a clinical supervisor in their Post Doctoral Program in child CBT. I continued to research the effectiveness of anger management with programs at residential treatment centers and published, along with a former graduate student, my first book (Adolescent Anger Control; Feindler & Ecton, 1986). Professional activities seemed to be following a logical direction, and as a tenured, associate professor, it seemed like my course was charted.

At IBT, I focused on the group practice and supervised a number of clinical students on externship and doing post-graduate work in CBT. One day, in a chance discussion with one clinician about the development of the PsyD. Program at LIU: Post, he suggested that I might want to come aboard. After meeting with the other faculty (who were psychodynamic in orientation), I decided to spend a year, while on leave of absence, teaching in a new educational environment. It all seemed rather "chancy": a new program not yet approved, one incoming class of 12 students recruited from various undergraduate departments, and a clinic with one room and no clients! Maybe in retrospect this represented a professional "risk" but it also was a transformational point in my career. There, the faculty had put their doctoral program forward as a dual orientation program mainly because the involved faculty were evenly divided between psychodynamic and behavioral practitioners. There was no actual planning about how these folks were going to live and work together, let alone how we would help students to develop their theoretical orientation. At the time there seemed not to be much consideration of theoretical integration, but an agreement about mutual respect for each other.

Since September 1990, I have had the unbelievable experiences that comes with teaching and supervising intelligent and passionate graduate students and working with colleagues who remain devoted to the training of effective, empathic and ethical clinicians. Although I have been identified with the CBT orientation, years of "exposure" to psychodynamic colleagues has impacted my own scholarly thinking and professional development both in some overt and in some unconscious ways.

My first sabbatical occurred after 18 years of teaching and was devoted to researching and co-editing two volumes on family violence (Feindler, Rathus & Silver, 2002) assessment. During that time, I also began to invest energy in other life pursuits; sailing, tennis, skiing, traveling and coaching my daughter's soccer team. So things were more balanced and humming along. Although students perceived me as competent and dedicated, there was also feedback that I was demanding, rigid, and at times too critical. These comments always stirred something in me and echoed my earlier development, rife with negative self-statements I now know were rooted in a critical parent object.

But then, in 2000, my newly retired mother was again battling various cancers and deserved attention and compassion from everyone in my family. Interestingly, I had elected to teach the family therapy course beginning in 1999 and it re-invigorated some things learned and practiced during my clinical internship year. As a treatment approach, family therapy provided a platform upon which a variety of theoretical orientations could be integrated and my interests could be expanded. Developing and teaching this course over the next years would become another professional turning point. Looking back I now realize that my passion for the areas of family violence and family dynamics remained largely unexamined…… it was simply about a chosen area of specialty and not some kind of projection process!

Additionally, anger management, although always popular, was going international (!) and I began to consult with professionals from around the country and Europe to form ICART (International Center for Aggression Replacement Training). Our first conference was planned for September 2001 and was to represent an expansion of my clinical interests and a return to my earlier love of languages and European travel. Needless to say, my departure for Sweden on the afternoon of September 11th never happened. And as the world was shocked and perspectives on life were inalterably changed, my professional orientation also shifted. CBT treatment plans arranged around behavioral goals and contingencies were over shadowed by individual and cultural experiences of rage, hate, terror, fear, despair and sorrow. Working with several World Trade Center families, my clinical skills seemed woefully inadequate compared to the tragedy they (and many others) experienced. I worked closely with a mother and her two very young children and their paternal grandparents to process the devastation subsequent to the death of a husband, father and son. There were no available manuals for grief and family trauma, and my general approach incorporating problem solving and coping strategies seemed so superficial. Indeed as my own internal shock and horror unfolded, I needed to just be with all of them, bear witness to the pain and walk with them through the seemingly endless tsunamis of sorrow. Somehow I needed to be a beacon of hope within a family thrust suddenly into deep despair! This was not exactly what I had been trained to do! Coaching Mom in the implementation of behavioral strategies in response to her two year old's intense temper tantrums hardly seemed relevant as this precious little girl screamed in my office. I felt overwhelmed with sadness as her developmental trajectory was undeniably altered and her loss manifested so behaviorally. So, we all, New Yorkers, therapists and clients alike, stumbled through, trying to comfort those with individual losses and to understand the national grief and outrage.

For me, another parallel process began as well. My mother had been again diagnosed with cancer and although I didn't know it then, was in the last year of her life. I devoted myself to "managing": managing my various jobs, her care, and my emotions using a predominantly CBT mode of coping. Five days after my 49th birthday and one month after she began her last hospital stay, my mother died from metastasized breast cancer. An internal light had for me been extinguished and suddenly other losses, some current and some historical, became more prominent. My mother's death in August of 2002 was a welcomed end to her suffering and duly, and subsequently; I went about the "management" of my own grief. Nonetheless, I found the grieving process overwhelming logic and rational thinking—unresponsive to external efforts. The sadness seemed unremitting and I became disillusioned. As I reflected back to the 9/11 families awash in tragic grief and assessed my own profound loss, I realized that I needed help for myself. Looking back, I believe that the enormity of these losses coupled with a new life as a "motherless" daughter facilitated my connections to early depression and repressed anger towards unavailable attachment figures.

Precisely nine months after her death, becoming increasingly disillusioned by my unremitting grief, I began a therapeutic journey back towards my "self". A chance referral to a therapist who "specialized" in grief led to an unplanned transformational experience. It never dawned on me to seek out a CBT therapist and I knew of no manual for Grief Management! Unbeknownst to me at the time, my therapist turned out to be a compassionate and gifted relational analyst. I then began what was a six-year process of "repairing" a broken "self."

The sequence of losses in my life had plunged me into an unremitting despair and I came to understand that persistent childhood despair had been reawakened. Until then I had never viscerally "known" how my developmental underpinnings could continue to leak through into every present day experience.

Never did I imagine that I would be in analysis multiple times per week seeking to unravel my deepest foundational structures and manage the accompanying affect. And thus, being opened to new ways of thinking in my personal therapy, I began to educate myself about more psychodynamic ways of theorizing and practicing. One of my most reliable defense mechanisms had always been my intellectual approach to understanding things that evoked significant affect. So, that of course was part of the journey! My plans were to learn about the theory and methods of relational psychoanalysis, as my own therapy had opened my eyes to the significance of early experience, unconscious processes and the possibilities of reparation. Together, we had deeply examined the relational aspects of my early development, the intrapsychic and interpersonal influences on me then and now and the complex relational matrices linked to my affective experience. Always an avid dreamer, I began to record hundreds of my dreams and learned from the "couch side" of things how to deconstruct my unconscious material. This was something my training had never prepared me for and it was truly incredible. During my reparative therapeutic journey I came to a greater self-awareness and a more cohesive and integrated "self". But I was undeniably different and my relationships, including those with my own clients, were changed. A theoretical transformation, although not planned, had begun and I was energized. Seminars and clinical supervision enabled me to better understand the theories of object-relations, self-psychology and attachment as influential in the relational practices of my therapist and countless others.

Although numbed, my professional focus, on publishing and training in anger management continued and a second ICART conference was planned for 2003 in Amsterdam. While containing my internal reflections about my own issues with unresolved anger, I made a training video on anger control (see Research Press Aggression Replacement Training) and the PsyD. program moved along. During my next sabbatical, I was invited to edit a book on the 'Comparative Treatments of Anger Disorders' (Feindler, 2006) that provided an opportunity to investigate how clinicians from multiple theoretical perspectives might have worked on a case of mine. My theoretical scope continued to broaden and here was an opportunity to merge professional and personal changes. Although much of this sabbatical was dedicated to finishing this book, my plans were also to learn about the theory and methods of relational psychotherapy, as my own therapy had opened my eyes to the significance of early experience, unconscious processes and the possibilities of reparation. I applied for acceptance into the Practitioner Program at the Jean Baker Miller Training Institute that brought so many things together for me and served as another epiphany. The RCT (Relational-Cultural Theory) model, with a strong feminist foundation, embraces a basic principle of connection as healing and growth producing (See M. Walker & W. Rosen, Eds. (2004). Disconnection, whether cognitively, emotionally or behaviorally, leads to despair, hopelessness and "condemned isolation"; I am reminded of Elly's "willed isolation" , her autistic contentment and how she had essentially "hooked" me.. Surprisingly since I attended a women's liberal arts college in the early seventies, I had missed Miller's (1976) book, 'Toward A New Psychology of Women', completely. I guess at the time, that I was already on my career path and not easily deterred. But in the spring of 2005 I became a voracious reader of all RCT work, feminist psychoanalysis and relational practice. My perspectives on loss, disconnection and the interpersonal context of healing changed, my teaching and clinical practice changed, my own relationships changed and even my tennis changed! In mid-life, I again felt like a kid now in a "theoretical candy store". I attended lectures at several Analytic Institutes, devoured all of Deborah Luepnitz's work (including the classic 1988 "Family Interpreted: Psychoanalysis, Feminism and Family Therapy") and spent hours in dialogue with others, some clinicians, some not.

As part of my Practitioner's Program project I began a qualitative investigation into the

use of self-disclosure in clinical supervision. Along with a colleague, I interviewed senior clinicians about their experiences with self-disclosure in psychodynamic supervision. The use of self in the training and supervision process always seemed fluid for me, and maybe I translated this into some type of modeling and coaching process from the CBT perspective. We wrote about our findings in a chapter in the book "Psychotherapist Revealed: Therapists Speak about self-disclosure in psychotherapy" and presented our work at APA. For me, it was further evidence for the shift in my theoretical lens while maintaining my firm footing in the education and training of psychologists. It was not only a gratifying process but also a worthwhile examination of an aspect of relational work and the inter-subjective process often overlooked.

After a summer intensive program on interpersonal psychodynamic therapy, taught by senior faculty at the William Allanson White Institute, I then began a two-year training program in New York and was part of the inaugural class of the Stephen Mitchell Center for Relational Studies. A small group of clinical practitioners, not new to the field, but new to the world of relational psychoanalysis met weekly for two years and had the amazing experience of classes taught by leading figures in the field (Aron, Harris, Dimen, Benjamin, Slochower, Stern, Davies and many others). For the first time in a very long time, I was writing up cases, preparing case presentations and attending weekly clinical supervision in addition to classes. What an amazing experience to be immersed in the world of postmodern thought and intersubjective process. There seemed to be connections everywhere for me: in clinical work, in teaching, in supervision and in my own personal life. I felt blessed to be a part of this unique and now very successful program.

During the past few years, still considering myself committed to continued professional growth, I have joined a weekly study group, run by Donna Orange, designed to first read and metabolize the Clinical Diary of Sandor Ferenczi, a controversial Hungarian analyst who had a conflicted relationship with his mentor Freud, but who was often referred to as the "mother" of psychoanalysis (Dupont, 1995). I wondered whether I was just continuing on my journey of finding "other mothers" since I had lost my own. Not a reflection a CBT clinician would have! We then went on to read the work of Donald Winnicott in chronological order (Winnicott, 1975) and I was hooked by his careful observation techniques that revealed such profound processes between mother and baby. I marveled at how much his early 1941 article entitled "The observation of infants in a set situation" was really the first published piece about methods of behavioral assessment! Wow, what an additional education … and I had also discovered the concept of a STUDY GROUP … a way of thinking together and processing theoretical material with other clinicians … not something that had ever occurred in my CBT education.

In the fall of 2008, I began a new professional journey as I assumed the directorship of the clinical program. Stress abounded, as we were up for an APA accreditation review in my first year as an administrator. How fabulous it was that we received a full 7-year accreditation and I could turn my focus to a more creative look at new initiatives we could move towards in the next phase of our program's development. When it became clear that I would lead our dual orientation program across the next few decades, I began to closely examine both the internal and external variables that influenced the development of our students' theoretical orientation. Funny, as a program we had never really asked what the students' experiences were in terms of this dual training and how they came to develop their "theoretical self". We would like to assume that our coursework, clinical experience and supervision had much to do with it. But what is also possible, is that early development, life experiences and, of course, "serendipity" all play major roles. What a parallel process to my own journey!

Although I have written little in this "new" voice and am still working to integrate my theoretical perspectives with my professional and personal experiences, I plan to continue all inquiries begun thus far and hope to have many invigorating dialogues with my colleagues and graduate students over many years to come. As I have said to many, I hope that I always remain curious! My thinking, my experiencing, my teaching as well as my writing have been transformed. Although I

still feel very "young", this midlife stage feels invigorating, cognitively, behaviorally, and most importantly emotionally. Grateful for events that have at times stunned me but nevertheless have resulted in a commitment to personal and professional growth, I can clearly state that my "status quo" was definitely challenged! It is possible, as a life long learner, to experience a theoretical transformation based on a confluence of personal and professional events. I have benefited from excellent training in both the CBT and psychodynamic traditions and believe that my clinical work has been enhanced through my theoretical transformations.

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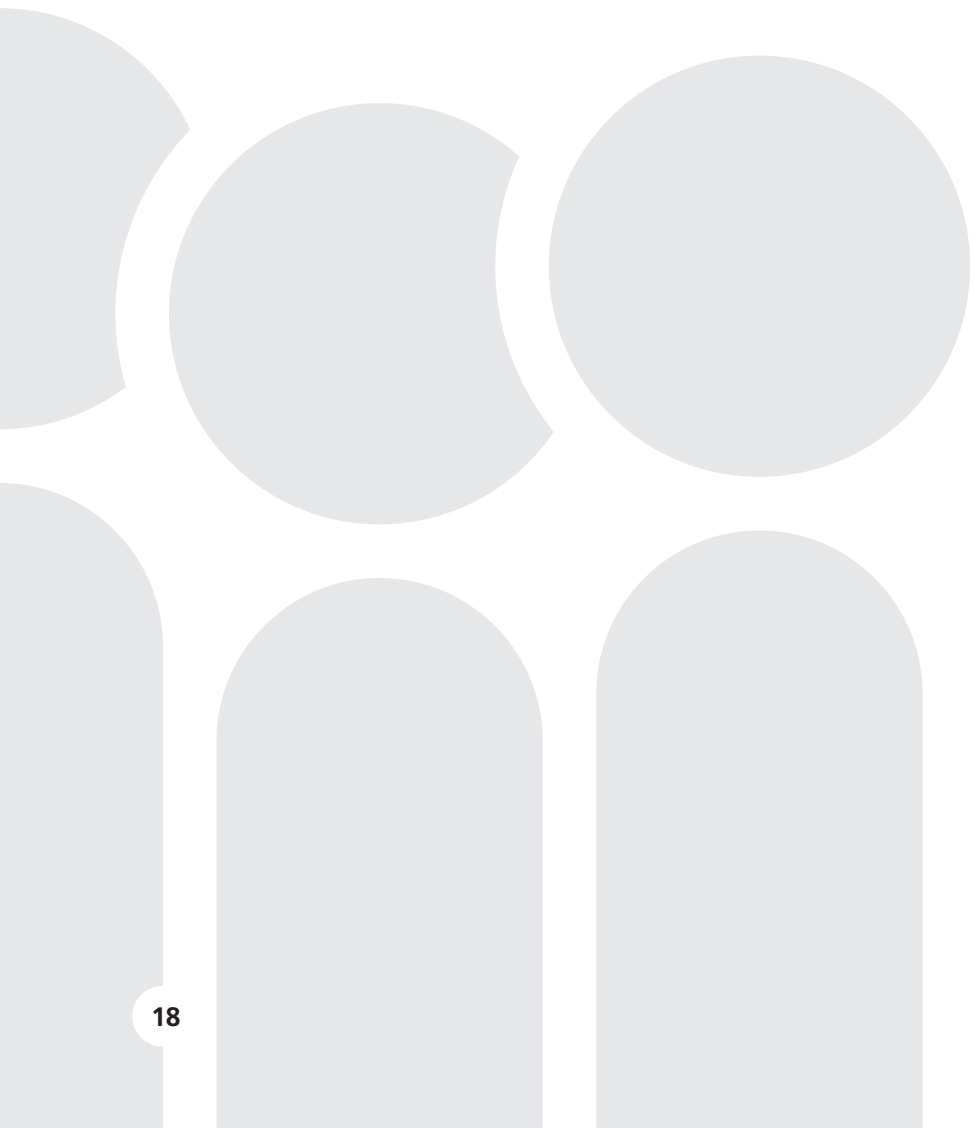

Sheila O'Sullivan

An Introduction to Voluntary Childlessness

Abstract

In this article the author is exploring the different ways that voluntary childlessness can be understood and the implications for clinical practice as an integrative psychotherapist. Psychoanalysts have tended towards pathologising the choice not to have a child, as the various theoretical approaches support an inextricable link between motherhood and femininity. On the other hand, sociologists often stress the voluntary childless choice as a transformative act whereby a woman shows considerable maturity and agency in being able to challenge the motherhood mandate. In order to explore how psychoanalysts in the twenty first century understand and conceptualise voluntary childlessness in the clinical setting, the author carried out IPA research with four participants. In this article she presents a summary of her findings and links these to the practice of integrative psychotherapy.

Introduction

The purpose of this paper is to discuss voluntary childlessness (VC) and to highlight the clinical implications of this growing phenomenon in Western societies. Voluntary childlessness is on the increase in Western societies, mainly because there are more choices open to individuals than in previous generations. Although I am interested in how men in our society are affected by the changes in reproductive choices, most of the research into this phenomenon has focused on women. There has been extensive sociological research into voluntary and involuntary childlessness whereas research by psychotherapists has focused almost entirely on infertility. More recently psychoanalysts have written about their understanding of delayed childlessness (Chodorow, 2003). Little has been written by psychoanalysts on voluntary childlessness and the literature available tends towards a pathologising approach of this choice (Bendek, 1959). Since its inception psychoanalysis has made an inextricable link between motherhood and femininity. The reason why my research literature focuses almost entirely on psychoanalysis is because until very recently (Shaw, 2011) no other therapeutic modalities have carried out research into this subject matter. As an integrative body psychotherapist I would like to develop a more contemporary, inclusive, relevant therapeutic approach relating to elective childlessness. My contention is that it is inevitable that psychotherapists in contemporary British society cannot avoid internalising the negative social attitudes towards childless women because these attitudes are part of the socio-cultural and political milieu in which we all live. The question is – how can psychotherapists bring about social change and challenge the prevalent pro-natalist position and encourage people to engage more with the existential issues? I plan to give a brief literature review in order to place the subject in context and will follow with my preliminary findings from my PhD research. These will then be discussed in the light of my own personal and clinical experiences as well as my own views about integrative psychotherapy in relation to VC.

The Politics of Pronatalism

When one considers the history of pro-natalism in the UK, it can be seen that women in particular have been under strong pressure to conform. Influential 'mother' (Gillespie, 2001) discourses have been drawn from religious, scientific and political doctrines. This discourse proposes a deterministic and essentialist view of femininity. Professionals and experts, including psychoanalysts, as well as spiritual and political leaders, use powerful narratives to legitimise convictions of a highly specific relationship between motherhood, femininity and women's social role.

Brown et al (2005) examined how British newspapers frame the issue of a falling national birth-rate as a social problem. In so far as their cultural claims are successful, procreation becomes a patriotic, religious or eugenic obligation and motherhood is constructed as the central feature of female identity (Gillespie, 2000). Another study by Giles et al (2010) examined some of the prevalent scripts that are available for women in contemporary society. They conducted a broad analysis of the coverage of this topic in British newspapers over the last two decades and their conclusion was that this emerging social phenomenon continues to provoke both scepticism and support for voluntary childless women. The political leanings of the specific newspapers affect how they connect biological reproduction to the cultural threat seen in immigration.

The medical profession has also been influential in promoting the pro-natalist attitude as women's reproductive life has been medicalised, particularly in the area of Assisted Reproductive Technology (ART). As a consequence of this cultural discourse, both involuntary and voluntary childlessness emerge as 'failed' femininity and classical psychoanalysis has inadvertently contributed to this situation. Embedded within this scientific discussion about infertility, is also a renewed concern about women's autonomy and the reproductive price of women's expanded freedoms. Some feminist writers equate women's desire for children with their oppression as women as they involve themselves in patriarchal practices. (Sandelowski, 1990). The body, particularly the female one, has come under the control of the male dominated medical and scientific discourse.

Sociologists such as Campbell (1985), argued that sociologists and demographers , have a tendency to take for granted the inevitability and desirability of parenthood (Campbell 1985:2). Mead (1962) points out that the definition of 'normalcy' in society is shaped by the cultural framework of values and images, and that all societies attempt to control reproductive activity. Campbell (1985) writes that by remaining childless both sexes are flaunting the basic assumption upon which conventional family life is founded. Domination and influence are exercised through language as well as through external force and institutional practices. Therefore, language is an important site of political struggle. Far from simply reflecting an already given social reality, language actually constructs social reality. That is why feminist poststructuralists have deconstructed given meanings, disrupted natural categories and produced alternative cultural constructions. The powerful secrets of culture lay in the interstices of language. Both etymology and semiotics work against the childless woman. For example, the word 'childless' implies a 'lack' whereas 'childfree' only suggests that the woman has refused motherhood. The 'free' woman is tinged with promiscuity, and the 'virgin' can be seen as pure and holy – or as frigid. Rich (1977) argues that the childless woman and the mother are a false polarity which has served the institutions of motherhood and heterosexuality. These simplified categories do not embrace the numerous conflicting variables involved in both parenthood and the choice to remain childfree.

The postmodern culture of reproduction seems to be sending confusing messages to women. Morrell (2000) uncovers a new form of pro-natalism that has a racist dimension. It attacks middle and working class white women who remain childless or postpone childbearing, while at the same time castigating women of colour who have children as single parents in non-optimal circumstances. Disabled women also face pressure not to mother. In contrast to this phenomenon, there is a now a pro-natalist streak in the lesbian community. Gillespie (2003) states that, paradoxically, while 'suitable' white, middle-class women have

struggled to gain the right to avoid, terminate or limit pregnancies, Native American, Black and Latina women's right for motherhood has been compromised through the practice of disproportional and non-consensual sterilisation (Davis, 1990). South Asian British women are under a particularly strong pro-natalist pressure (Culley, 2004). The current form of anti-natalism is profoundly politically motivated. It exists in form of teenage pregnancy prevention and discouragement of 'undesirable groups' (low income individuals, older women, lesbians and gay men, physically and mentally disabled individuals) from having children.

As mentioned in my introduction many have criticised psychoanalysis for its approaches to motherhood and femininity. Parker (1995) argues that these approaches, which regard motherhood as the developmental goal of femininity, are embedded in and determined by the history of psychoanalytic theorising. Acknowledging the childless woman, Parker (1995) states that psychoanalysis perpetuates the view that you are 'not a real woman unless you have had a baby' (Parker, 1995: 204). Some of the theories espoused by psychoanalysis have contributed to the inextricable link between femininity and motherhood. These include the concept of penis envy whereby a girl turns to her father as her object and gives up on her mother. Does she achieve a normal feminine development, resulting in her seeking from her father a baby as a replacement for the missing penis? Many feminists (Ireland, 1993; Morrell, 2000; Letherby, 2002; Veveers, 1980) have argued that the Freudian view of women being associated with lack is felt more acutely by childless women.

Nevertheless, it is still curious that psychoanalysts, particularly female ones, even those holding a feminist position (Chodorow, 1978; Mitchell, 1974) are still assuming that all women would be mothers. This supports my contention that the motherhood mandate has always been pervasive, and that this position remains unchallenged, particularly within psychoanalysis.

Before discussing my own personal Journey I will give a brief summary of the preliminary findings of my PhD research study. I chose to interview psychoanalysts as I wanted to find out they conceptualised and understood VC in the twenty first century.

Research Findings

Using Interpretative Phenomenological Analysis (IPA) as my methodology I interviewed four psychoanalysts. Initially I wanted to focus entirely on VC but I had great difficulty recruiting participants. I came to the conclusion that the concept of voluntary childlessness would not appeal to psychoanalysts because of their interest in unconscious processes. Therefore I decided to change my research interest to include all individuals who were childless for reasons other than a medical condition. By changing the research question, four psychoanalysts agreed to be interviewed. Below is a brief outline of my preliminary findings (Figure 1).

In master theme one the participants discussed the importance of helping their patients to make a choice about whether or not to have a child.

Master Theme	Subordinate Theme	Subordinate Theme	Subordinate Theme	Subordinate Theme
1. The therapist's attitude towards VC clients	a. Attempts to define the role	b. Expressing personal views on maternity and VC	c. Being objective – recognising the danger of projections and the importance of boundaries	
2. 'Discussing the reasons for clients' child-free choice	a. Fear of passing genetic deseases	b. Difficult childhoods	c. Mental health issues	d. Psychological immaturity/not ready to parent
3. Social pressure	a. Female body and biological destiny	b. The myth of motherhood		

Figure 1: Research Findings

Two of the participants emphasised how some of their patients had delayed childbearing and were faced with the realities of their biological clock or attempting Assisted Reproductive Technology (ART). One participant emphasised how she encouraged her younger patients to take the decision about motherhood very seriously as it seemed as if she wanted to protect them from future disappointment. Another point that was raised was that some patients had simply not made a decision either way and had 'slept walked into infertility'.

There were other very difficult choices that the participants discussed and that was when the patient had a fear of passing on a genetic illness. This was described by one participant as the most 'difficult predicament imaginable' and by another 'I would not want to be in her shoes'. It is interesting to consider whether indeed this is VC or whether it is in fact a choice forced on the individual by circumstances. Three out of four of the participants expressed concern that some patients were too immature to become parents and one of the tasks of analysis was to help them in this process, thus preparing them for parenthood. Another dilemma that arose for three of the participants was whether some of their patients would ever be able to become good parents due either to serious mental health issues or 'abysmal childhoods'. In these accounts the participants referred to the fact that some patients knew that they could not provide adequate mothering for any potential offspring so on these grounds had made a VC choice. One participant referred to this choice as a generous act and compared it to the feckless female patients who were 'having babies like there was no tomorrow'. One of the participants was a Lacanian analyst and saw her role as helping all of her patients to come to terms with a fundamental gap that is present in all human beings as a result of separation from mother as an infant.

All of the participants expressed their own personal views about motherhood and all but one stated that having children could be a crisis for many individuals. One participant was clear throughout her interview that motherhood was extremely important to her and she felt it was a natural path for most women. Another participant described how she would not have had children if had not been for her husband while another gave an account of her sister who chose not to have children and this was seen as acceptable. However, when the participants referred to their patients they took the view that the normal path for a healthy woman was to have a child. Patients by definition had problems so either having a baby or not having a baby could be a challenge.

The participants referred to their countertransference when working with their childless patients. Here it needs to be stated that they tended conflate Voluntary Childlessness, Involuntary Childlessness and Delayed Childlessness. Three of the participants referred to their fantasies where they wished for their patient to have a baby even though they knew it would not necessarily be beneficial to the mother or a potential child. As mentioned earlier the participants showed deep empathy for those patients having to make extremely difficult choices and did not want to push them in any direction. There were times when some of the participants expressed a sense of helplessness in the face of the existential dilemmas faced by their patients.

The second master theme that emerged related to how the participants understood their patients' childlessness. They tended to conflate conscious and unconscious choices and took the view that VC choice was 'not the whole story'. As mentioned earlier the participants discussed how some of their patients chose not to have children for fear of passing on a physical or mental illness. Other patients were seen as having unconsciously chosen not to have children either through fear of pregnancy, dependency or commitment. Some patients were seen as too psychologically immature to become a parent and were unable to form intimate relationships with the opposite sex. The participants discussed how some patients could cope with having a child that was not biologically their own off-spring either through adoption, surrogacy or step children.

The third theme that arose was around social pressure that was viewed differently by each of the participants. The Lacanian analyst was critical of her original Kleinian training that took the view that successful therapy with a childless woman would result in the patient having a baby. She felt this placed unconscious

pressure on analysts as well as the patient so she chose a Lacanian training as she viewed it as being more inclusive. The Lacanian theoretical approach would take the view that everyone is attempting to fill their fundamental gap and that women choose to have children to do this while others use their childlessness to account for their lack. From this perspective either having or not having a child can be viewed as a crisis. Another one of the participants spoke about the pro-natalism in the profession when she described how psychoanalysts were always happy when their borderline patients were pregnant 'when there really was nothing to be happy about'. Obviously this is an interesting ethical dilemma about who should and should not have children, and some of these points were raised in the literature review above.

In contrast to the social pressure to have children that was expressed in the previous paragraph one of the participants expressed the view that we lived in a 'have it all' society. This situation placed pressure on women to work and to be mothers as well as to have high levels of economic security before having children. She felt this pressure brought women into therapy as they felt a sense of failure both as mothers and working women. This pressure also led to delayed childbearing and for many women in modern Britain this led to facing the realities of the biological clock.

All of my participants assumed that my research interest was in the woman's experience of VC but two of the participants did include a discussion of their male patients once prompted. Except for the power of the biological clock the issues and concerns for men are no different than the female experience.

Before considering the clinical implications of VC from an integrative perspective, I will outline my own personal journey and as Romanyshn's (2007) argues it is the topic that chooses the researcher through his or her complexes rather than it being consciously chosen.

My Personal Journey

My own journey involved years of an emotional and physical roller coaster of unsuccessful attempts to become a mother that involved medical procedures, medical diagnoses and IVF treatment. Trying to come to terms with the wordless sense of grief and loss as well as wanting to understand how my body had let me down, led me into self development and ultimately training as an integrative body psychotherapist. Instinctively I knew that my creative urges needed to be re-channelled as I have always attempted to transform my difficult life experiences into something positive.

I find myself in a curious position as a researcher because I am an involuntarily childless woman specialising in the area of individuals who chose to be childfree. It is also interesting that I have chosen to focus on psychoanalysts when I am an integrative body psychotherapist. The journey to this point has had several twists and turns. I had been running some CPD workshops for psychotherapists entitled 'To Be or Not To Be – a Mother' and what became apparent during these events was the range of situations that women found themselves in with regards to motherhood. Very few had made a 'cut and dried' decision not to have children and were aware of their ambivalence which included longing, relief, curiosity, regret and grief. However, these women led full lives that often included involvement with children in their professional or personal lives. As I mentioned in the introduction my academic studies highlighted the lack of psychotherapeutic research into voluntary childlessness and as Satre (1956/1943) states things that are absent are as important as those that are present in how we see the world. From an academic perspective I became fascinated by the perplexity of the motherhood mandate and how many influences came to bear on this decision making process. Whereas psychoanalysis tended to pathologise VC, sociologists portrayed this choice in a different light where women were considered to be trail blazers, or transformative women who were refusing to be enslaved by society's expectations of what it meant to be a 'real woman'. Reading about the lives of women who actively chose to be childfree helped me on a personal level to shift my perception of my own situation. Many of these voluntarily childfree women did not feel they needed children to fulfil their creative urge. It was possible for women to

feel fully feminine, to love children but to find fulfilment outside the role of motherhood.

I will briefly outline my personal views of integration before discussing in more detail the clinical implications of my research findings.

Reflections on Integration

As an integrative body psychotherapist I am interested in how one's early life experiences have an unconscious affect on the body and one's fertility as well as maternal desire. I do not subscribe to purist theories of psychogenic infertility as this can be an overly simplistic model and can be experienced by the client as judgemental and non-empathic. There are other influences on the path to childlessness such as one's biology as the number of eggs a woman produces is determined at birth and some have argued that the biological urge (Parvens, 1975) to reproduce is stronger in some individuals than it is in others. The effect of the biological clock on women can be extremely powerful and brings a sense of urgency into any decision making. To understand the psychological dynamics affecting clients I draw on a number of approaches that includes psychoanalysis, Jungian and humanistic theories. Some psychoanalysts (Chodorow, 1978) have moved away from a drive theory towards an object relations approach as a means of understanding maternal desire. Some writers (Pines 1993) suggest that it is a woman's inability to separate from their mother that leads to an inability to form intimate relationships with the opposite sex, thus leading to either an unconscious or conscious decision to be childless. Pines (1993) also suggests that a female child's negative experience of being mothered means there is a failure to develop maternal desire thus voluntary childlessness ensues. As an integrative psychotherapist I would hold these unconscious processes in mind but I would also be open to the possibility as Ireland (1997) and others (Lisle 1996) have argued that some women had positive female role models that enabled them to have the strength to choose lifestyles that were not considered the norm. As part of my work with clients I also draw upon Jungian concepts such as archetypes, and I work with dreams and images. These can be very powerful when working with the symbolic aspect of motherhood. As part of my professional development I continue to study and read about different models of psychotherapy such as attachment theory, relational approaches and the research into neuroscience that I am striving to integrate into my practice. There are many researchers and theorists of psychoanalysis who highlighted the intersubjective nature of the therapeutic encounter. For example Benjamin (1995) states that intersubjectivity is a 'field of intersection between two subjectivities, the interplay between two different subjective worlds to define the analytic situation' (Benjamin 1995:29). The question of whether and how psychotherapy is a mutual endeavour is actually very complex. Aron (1996) argues that the patient and analyst create a unique system where there is reciprocal influence and mutual regulation (Aron, 1996:149). Although l can appreciate this position and I feel that I learn from my clients, from an ethical perspective I consider that it is important to hold in mind the inherent power imbalance in the therapeutic relationship. It is the therapist's responsibility to hold the boundaries and provide the containment. From a humanistic perspective I strive to be congruent and authentic thus placing an importance on the therapeutic relationship. Any interpretation that I might make I would consider as an offering to the client as opposed to a medical model of doctor/patient relationship. I remain close to my therapeutic roots of a 'wounded healer'. 'To be or not to be a parent' is for many people an existential issue and childlessness can evoke a spiritual exploration about looking for a deeper connection to oneself as a sense of purpose cannot be fulfilled through caring for a child. As I have a strong spiritual life with mindfulness at its centre, I am open to working with this aspect of a client's journey.

Although I am interested in the intrapsychic dynamics, I think it is important to consider too the interpsychic influences upon the client as well as the therapist. As outlined in my literature review above society, religion, culture and politics all have strong mandates about who should and should not be parents. Pressure can come from partners, parents and friends too and the decision to be or not to be a parent can cause great a strain in relationships. Not only do I attempt to integrate different theoretical models as well as societal

influences I consider the integration of my own personal experiences to be an important factor. This includes my experiences of personal therapy as well as the on-going process of coming to terms with my childlessness as I progress through different life stages.

The issue of disclosure is a controversial one in our profession and whether or not to reveal one's own 'parenthood/non-parenthood position to a client is to be considered very carefully. In relation to this subject I tend not to disclose to clients whether or not I have a child but will engage in a discussion about whether or not it would be helpful for them to know. Liebowitz (1996) writes movingly about her experience of childlessness and whether or not to disclose this information to her patients. I would concur with her view that it would depend very much on the relationship I have with my client in terms of CIarkson's (1995) model as well as the transference and countertransference present. I am very mindful that in writing this article that I am disclosing my position and this feels both scary and exciting in equal measure as I am trying to give birth to something original and thought provoking. In this instance I feel it is beneficial for the reader to understand my position in the same way I would consider in whose interest am I serving when I disclose personal information to a client?

Clinical Implications

The findings from my research highlighted some interesting and pertinent issues relating to childlessness. The issue of whether or not to be a parent is often complex and can be fraught for some individuals. There are individuals who make a VC choice because they fear having a dependent, or they are still merged with their mother or over-identified with their father. For some individuals it might be better for their mental health and that of a potential child if they remained childless. The issues raised by my participants throws up some challenging ethical dilemmas for us as therapists and recently there have been interesting discussions on this topic on the BBC Radio 4 programme entitled 'Inside the Ethics Committee'. For many men and women childlessness can be experienced as a great loss and this can propel individuals into therapy. Some people on the path to VC may choose to be sterilised, and others might have experienced multiple abortions and these experiences might be brought into the clinical setting. For others a relationship might break down because of their VC choice as it conflicts with the desire of the other. I would like to highlight another aspect of childlessness which has been touched on in my literature review.

Through my research I want to challenge the view that childlessness inevitably has to be portrayed as a tragedy and that it is unnatural for women in particular to choose this path. I am arguing there are many women (and men) who can lead full and creative lives and do not need to produce their own biological child in order to regard themselves as fully feminine and mature. Would we as therapists be as curious about why people choose to be parents as we are about those who do not choose this path? There was a time that psychoanalysis considered that it was important to analyse their patient's homosexual choices regardless of whether this was the issue that brought them into therapy. We might have VC patients who do not come to therapy about this issue. It is therefore crucial that therapists do not make assumptions about childless women as their experiences can be as varied and conflicted as those of mothers. Kamalamani (2009) argues that, when working with this growing phenomenon, therapists need to provide a spacious and supportive environment to allow the complex decision-making to unfold freely. She goes on to state that 'there is a high personal cost to resistance role' Kamalamani 2009: 32). Discussing the female decision to remain childfree, Kamalamani (2009) raised a number of interesting points. There is the inherent danger of failing to capture the diversity of individual life because one is choosing to look at it from a particular angle, when, in fact, most lives are a more complex web of interconnected events, people and phenomenon.

Electing to be childless does not equate with rejecting the symbolic potential of the womb. From a Jungian perspective, the psychic encounter of childlessness often occurs in midlife – but this midlife crossing often accentuates a woman's own particular identity evolution (Ireland, 1993). This provides an opportunity for re-framing and exploring what is missing or absent in the potential space

and may well include aspects of regret. Jung (1953) argued that it provides an opportunity for a dialogue between the conscious and unconscious parts of ourselves, which means that we are more able to face the developmental task of the second half of our life and come to terms with the inevitability of death. The adult pathway of the woman who is childless merely makes more visible this particular human challenge. Ireland (1993) argues that the path to a satisfactory adult female identity for the woman who is not a mother must include encountering her own lack of a child. This enables her to enter a transitional and potential space in order to interpret her situation, thus creating something new. By inhabiting this generative space, the childless woman expands her experiences of female subjectivity. This allows a distribution of psychic energy within her as well as lets her reconnect with her own female identity and other women. The Lacanian analyst in my research referred to the importance of coming to terms with the fundamental lack that is important for each individual regardless of whether they are a parent or not. There is less binary thinking in this position between parent and non-parent.

Another view is that it is possible for women to achieve gratification from creative expression without bearing children. Writing in the context of infertility and early menopause, Joan Raphael-Leff (1997) describes the concept of generative identity which, if successfully realised, can achieve conceptual changes in the individual. This entails freeing oneself from biological determinism by utilizing psychic cross-gender potentialities, as well developing a more abstract notion of creativity in general (as opposed to the 'physical creativity' associated with the baby). This potential for individuals to have access to male and female aspects of themselves is a thread drawn from Jung (1953), Raphael-Leff (1997) and Ireland (1993). From my own personal and clinical experience it is this capacity to transcend the physical aspect of reproduction whilst accessing and inhabiting one's creativity in the lived moment that is crucial to feeling less marginalised by one's childlessness.

As an alternative explanation, Ireland (1993) argues that the voluntary childless woman, whom she calls transformative, is saying to the world that she's on a personal quest in which motherhood plays no part. She is making a conscious decision to explore other avenues of expression for whatever maternal feelings she has, and regardless of the external questions she may get, she will affirm herself internally as she moves in the world. However research (McAllister and Clarke 1998) also shows that it is the 'ordinary' woman who is simply making an alternative lifestyle choice and would not necessarily consider herself to be a trailblazer.

Conclusion

In this paper I have outlined the complex web of pressures relating to the motherhood mandate. This includes pressure on women to become a mother as well as judgements about those who are fit to mother. Psychoanalysis has stressed the importance of parenthood as an important developmental stage so has been a contributor to the motherhood mandate. Even in the twenty first century psychoanalytic writers still consider those who choose to childless or delay pregnancy in terms of a pathology. Although there might be passing reference to the choice as a healthy one, the analysts still focuses on the problems associated with the individual. My research has highlighted how psychoanalysis and the training institutions continue to make an inextricable link between motherhood and femininity. There is further research needed to see if this is true of integrative and humanistic training. In my discussion of the clinical implications I have attempted to portray another way of viewing this growing phenomenon whereas childlessness does not always have to be viewed as a tragedy.

It is interesting to note that there is a tendency for electively childless women's to remain invisible in discussions of adult identity. One could argue that their presence challenges many unconsciously accepted preconceptions of what women should be. One of the aims of this paper has been to raise our awareness as clinicians to the strength of the motherhood mandate that exists in our society.

If the prevailing discourse in society continues to describe childlessness in negative terms, some childless women may start identifying with ideas of emptiness and deviance. Danuluk

(1992) mentions that there is no psychological theory for women who reach the menopause and do not have children. I would argue that in our post-modern society that women are faced with fighting two battles at once - the tyranny of choice and the tyranny of patriarchy. These two powerful forces can pull women in different directions. How do we as integrative psychotherapists challenge the motherhood mandate thus enabling our clients to make choices that allow them a sense of freedom and empowerment regardless of whether they choose to be parentless by Choice.

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Sally Rose

The Key to Keeping Your Balance is Knowing When You've Lost it

Abstract

The last 20 years has seen huge developments in the understanding of how relationships and affect regulation shape our brains and how we cope. Recent insights from interpersonal neurobiology about stress arousal and integration have begun to be incorporated into trauma treatment and relational psychotherapeutic work. They are, however, less evident in approaches to stress management. The proposed model, 'Workable Ranges' bridges that gap. It places relational and self-regulation of psychophysical states and the integration/coherence associated with it, as central to psychological health and functioning. Accordingly, it suggests that dysregulation via flight, fight and freeze reactions over thresholds of tolerance, compromise mental functioning and contribute to common psychological health problems and stress related conditions. Drawing on models of care-giving to best support affect-regulation and integration, the paper highlights the therapeutic value of providing this psychoeducational model of stress regulation, alongside contingent empathic attunement. The model implies that facilitated self-directed tracking and modulating of stress and emotional arousal, via conscious understanding, coached body awareness and mindfulness, can play an important role in a range of interventions.

Introduction

There is much to suggest that psychophysical stress and emotional regulation is crucial to our health and functioning as we develop (Schore, 1994; Fonagy et al., 2004; Gerhardt, 2004) and throughout our lives (Posner & Rothbart, 2000; Siegel, 2012).

Most psychotherapeutic work could be said to facilitate and support self-regulation. Allan Schore has described it as a key organising principle and goal (Carroll, 2001).

Attachment research suggests that care-giving and psychotherapeutic work that facilitate emotional self-regulation work best where there is a mixture of affective attunement and the representation and feedback of mental states. In their chapter on the social biofeedback theory of affect-mirroring, Fonagy and colleagues highlight the importance of a balance between, in the moment, attunement (contingent mirroring) with the ability to step back and draw on experience and models to represent it (marked mirroring). In this way experience is contained and the ability to interpret experience, 'reflective function' is developed (Fonagy et al., 2004).

My experience within a workplace context is that popular views of stress physiology in the field of stress management focus on the notion of autonomic balance, with a paired see-saw model of 'stress response', in which activating, flight and fight reactions are

settled and calmed by relaxation. The freeze component of de-activation with shutting down as a protective stress response has largely been ignored in stress physiology (Levine, 2010).

Hidden Stress

Intrapersonal and interpersonal processes procedures of closing up, inhibition and deadening of affect are familiar to many psychotherapists yet absent in the popular stress lexicon. Popular stress models, therefore, do a poor job of representing, 'marking' and normalising the broad range of experiences associated with being stressed. My awareness of my own tendency to inhibit stress and emotion and hold myself together contributed to my investigation of this material. In his studies of traumatic stress, Levine explicitly challenges the ignoring of the freeze response and associated reactive patterns in models of stress physiology (Levine, 1997 & 2010). Whilst the absence of affect, low mood and depression are sometimes linked to prolonged stress, they are not generally included as a stress response. It could be symptomatic of a wider cultural defence against low mood. This is palpable in the workplace where high stress arousal can be seen as a badge of honour and associated with being successful. Being at a low ebb, flat or sad on the other hand may be seen as signs of weakness or failure and can elicit feelings of shame and intolerance. Alternatively, from a psychotherapeutic perspective, the capacity to tolerate and process lower states of arousal, such as loss, disappointment, failure and guilt can be seen as an indication of psychological integration and health.

Whatever the reason for the omission of freeze reactions, the prevailing view of stress responses as fight or flight, leaves people facing the daily challenges of stress and emotional dysregulation without a comprehensive explanatory model. It is hard, therefore, for people to situate and track their immediate experience or judge whether they are regulated in the moment or over time. This anomaly leaves a gap between much psychotherapeutic theory and stress management and hinders therapists and counsellors who may wish to include patterns of stress reactivity in their formulations.

The Case for a More Comprehensive Model

Porges' research findings in the developing field of interpersonal neurobiology provide a more sophisticated hierarchy of stress reactions (Porges, 2001 & 2011). Siegel's model of neural integration correlates safe healthy arousal with mental integration and functioning (Siegel,1999). These developments have usefully been applied to understanding and treating traumatic stress by body therapists (Ogden et al., 2006), but seem not to have been taken up in everyday and work stress theories.

Working at the intensive end of stress dysregulation body oriented trauma therapists have led the way in applying the developing science of the psychophysiology of traumatic stress. A particular development has been the inclusion of psychoeducation and the coaching of safe mind and body states (Rothschild, 2000; Ogden et al., 2006). They have shown how collaboratively creating a felt sense of safety, in the here and now, can regulate traumatic stress arousal, and provide a safe basis for the processing of traumatic experience. My impression is that these developments have shifted a lot of psychotherapeutic practice in that direction across different theoretical models.

These new findings and theories broaden and strengthen attachment theory models of affect-regulation. I see 'Workable Ranges' as a way to bring these developments into broader application for therapists and with a wider general population. This work introduces 'Workable Ranges' as a conceptual framework and visual tool to explain the dynamics of stress and emotional regulation. 'Workable Ranges' of stress and emotion are characterised by safe and coherent rises and falls in stress arousal and emotional intensity. Within range we are more stable and flexible and can function well. When we go over our thresholds we become dysregulated and our functioning and health are compromised.

Attachment Strategies and Affect-regulation

Attachment theory, based on observational studies, is a theory of safety and protection from danger, yet seldom evident in approaches to everyday stress. Individual defences,

preferences and patterns of reacting to threat, are organised around biological differences and early relational experience. Internal and interpersonal attachment patterns are organised psycho-behavioural self-protection strategies (Bowlby, 1969; Crittenden, 2005, Holmes, 2001.) In psychosocial conditions that threaten the cohesion of the self they contribute to different forms of distress, physical health problems and psychopathology. Individual strategies or defences might involve either high-arousal and expression of emotion or inhibition and dampening of emotion and behavioural withdrawal (Crittenden, 2005). Secure attachments styles can be protective whilst insecure attachment presents risks in individual reactions to stressful events (Mikulicer & Florian ,1998).

Over the past couple of decades researchers and theorists in interpersonal neurobiology such as Allan Schore (1994), Louis Cozolino (2010) and Daniel Siegel (2007) have illuminated how attachment experiences of safety and our reactions to threat, shape our brains and become neural maps and habits. These works describe how safety and challenge in relational psychotherapy can re-shape and revise our brains and reactions. Models have developed that integrate these with the complexity of our nervous systems and how they evolved (Le Doux, 1988; Porges, 2011).

The Polyvagal Theory of Stress Physiology: More than Fight and Flight

In his seminal work, The Polyvagal Theory (2011), Stephen Porges brings together the evolution of the autonomic nervous system with the development of human social behaviour. This holistic model elucidates the multi-systemic hierarchical nature of stress reactions and that they are more complex than fight and flight.

Porges' research on the cranial vagus nerve led him to the notion of the 'vagal paradox'. 'This sensory nerve conveys information about our viscera to our brain', (Porges, Prengel interview, 2007) and plays a key part in the operation of the parasympathetic nervous system. He discovered two different strands of the vagal nerve, front and back that connect to different points in the brain and operate differently. One of them, the ventral vagus, works to sustain us and calm us down whilst the other, the dorsal vagus, works to shut us down i.e. to freeze. Following his research on newborns demonstrating that bodies can slow down to a life threatening degree, he challenged the established view that the parasympathetic system was always good for us by modulating high sympathetic system stress arousal. It could also be dangerous. From a lifetimes work developing understanding of both strands of the vagal nerve Porges' has added to the arousal based flight or fight 'stress response' in two significant ways (Porges. 2001, 2011). Porges has demonstrated that social engagement/attachment behaviour and shutting down and freezing are both important and necessary features of a holistic comprehensive picture of stress reactivity. Of relevance to therapists generally is the notion of a social nervous system. Porges views social engagement/attachment behaviour as a sophisticated bio-psycho-social safety system that has evolved on top of the more primitive flight, fight and freeze reactions. On a physiological level it uses the ventral vagus creating visceral, cardiac and metabolic changes and neural regulation of facial expression and verbal tone for successful communication.

Porges' has demonstrated that the autonomic nervous system reacts to changes and threats in a hierarchical manner rather than a simple balance between sympathetic and parasympathetic systems. 'The polyvagal theory is a more sophisticated and integrative view of the autonomic nervous system than previous arousal theories' (Ogden et al., 2006:29). Of particular importance here is the difference between safe healthy slowing down and relaxation and more risky shutting down.

The Social Engagement or Communication System

Being with others in a social system in which we feel safe is our most developed way of being safe and modulating stress. Depending on our attachment style and the relationships and social systems we are in, this will involve a mix of safety through distance from as well as connection with others. The 'self-engagement system' proposed by Siegel (2007:170) correlates

with concepts such as internal good objects in Object Relations theory, positive self talk in CBT or 'being with' ourselves in a compassionate and mindful way in Mindfulness Based Interventions. They could all be seen as evolved layers of our social engagement safety systems. If we pick up stress from the world around us or from our own thoughts and feelings and don't have safe social connection or interaction, a supportive inner voice or mindful presence that can settle us, the body will generate the more primitive threat reactions; flight, fight or freeze, regardless of whether there is an actual physical danger or not.

Mobilisation with Fear - The Fight or Flight Reactions:

Through the stimulation of the sympathetic nervous system our breathing rate, blood pressure, heart rate, and muscle tension, are all increased as the body is prepared for a flight or fight reaction. In this state of hyper-arousal blood is diverted away from our digestive system and skin and into our larger muscle groups. Symptoms that are associated with mobilising as a response to danger include the impulse to move, rapid heartbeat and breathing, muscle tension, anxiety, panic, mental vigilance and chaotic thinking. This acceleration of energy and arousal is the most well known aspect of reacting to a sense of danger. Attention is narrowed on to the source of threat and consciousness is closed off (Siegel, 2010:23).

Immobilisation With Fear – The Freeze Reactions:

A sudden, quick freeze response may be a first reaction to threat. This initial state of halting alarm was described by Selye as the first part of his General Adaptation Syndrome (1956). This freeze is a state of vigilance and readiness to move in flight or fight, or to settle down again. Alternately, when the body cannot sustain the prolonged mobilisation of hyper-arousal and the sense of danger continues, in one form or another, a shut down or freeze reaction may be activated. This functions to preserve energy and reduce pain.

Symptoms that are associated with immobilising as a response to danger include a loss of motivation and hope, going blank, indecision, confusion, numbing, fatigue, reduced muscle tone and mobility, feeling paralysed, stuck, frozen, passivity, mental rigidity, numbness and flatness of affect. Urges to retreat and sleep may be associated with this form of self-defence. Immobilisation as a defence has been linked with the adaptive role of hopelessness and despair (Wright. 2013:22).

Neural Integration and the Window of Tolerance

Neural integration is a key concept in interpersonal neurobiology and therapy based on it (Cozolino 2002; Siegel 2010). Siegel views neural integration as a large system view of the co-ordination of autonomic, affective and cognitive processes via 'integrative functions of the embodied brain and body-proper within a relational context' (Siegel, 2007:40). He describes how neural integration supports healthy physical and mental functioning.

The prefrontal cortex serves as a key control centre, by linking 'anatomically and functionally differentiated neural regions into an interconnection of widely distributed areas of the brain and body. Structurally, these interconnections take the form of synaptic linkages, and functionally they create co-ordination and balance' (Siegel, 2007:41).

When we get upset or out of control 'we become "dis-integrated" as energy and activity are diverted and the middle prefrontal region stops the co-ordinating and balancing of the sub cortical regions.

Without the modifying integrative functioning of the prefrontal cortex, the lower and more impulsive limbic and brain stem areas can run amok' (2012: 10-6).

Neural integration is a state of balance and inner coherence that echoes the concept of organised attachment states. Attachment and relational experiences lay down foundational patterns for an individual's own comfort zones. In particular they lead to our having different capacities to tolerate different emotions, levels of stress

arousal and states of mind and to function with them. Siegel calls this the 'window of tolerance' in which 'various intensities of emotional arousal can be processed without disrupting the functioning of the system' (Siegel,1999:253)."Our mental experience and neural firing patterns for particular emotions and situations appear to have a span of tolerance in which we can function optimally. Within that span, within the window we do well; outside the window, we push beyond tolerable levels of arousal and move either to chaos or rigidity and lose our adaptive and harmonious functioning"

CHAOS
Window of Tolerance

- -

INTEGRATION- Adaptive
Function and Harmony

- -

RIGIDITY

(Siegel.2010:51)

In keeping with the characteristics of secure attachment states of mind, Siegel describes how neural integration creates a sense of coherence and flexibility. His descriptions of how, when our tolerance thresholds of stress or particular emotions are reached, we move either to chaotic or rigid states, echo ambivalent and avoidant attachment strategies respectively. On the one side the dysregulated physical and emotional energy breaches the window of tolerance and we feel compelled to express and externalise, for example bursting out in tears or anger. On the other side when we reach the edge of tolerance we may close up, bottling up or inhibiting the energy and withdraw from contact with others.

Cozolino also links neural integration with optimal levels of arousal. Optimal arousal creates the best internal neurobiological conditions for neuroplasticity, learning and integration (Cozolino 2010:46).

Integration and Application of Models in Trauma Therapy

In the Sensorimotor model for working with traumatic stress, Ogden and colleagues (2006) synthesise and apply Siegel's concepts of 'neural integration' and 'window of tolerance' with Porges' Polyvagal Theory. Their model for understanding the regulation of autonomic arousal in relation to trauma links the ventral-vagal social nervous system with optimal arousal in the widow of tolerance. Beyond the edges of the window of tolerance, either

Theory Level of safety and regulation	Attachment Theory	The Polyvagal Theory Hierarchy of Stress Reactions Stephen Porges	Window of Tolerance Neural Intergration Daniel Siegel
Unsafe - Fear **Dysregulation** **Mobilisation**	Insecure states and defences Preoccupied with emotion, expression and contact Incoherent/reduced reflective function	Mobilised stress reactions **Flight -** Move away **Fight -** Move towards **ANS -** Sympathetic	**Chaos** **Limited Functioning**
Safety **Regulated**	Secure or stable organised attachment states Flexible responses Reflective function Coherent narrative	Social engagement stress reactions Modulation of flight, fight and freeze Safe immobilisation and relaxation **Social Nervous System** Ventral-Vagal nerve Parasympathetic ANS	Neural integration Window of tolerance of stress and emotion - Optimal arousal Greater functioning and complexity Response-Flexibility
Unsafe - Fear **Dysregulation** **Immobilisation**	Insecure states and defences Inhibited expression Dismissive of emotion Avoiding contact Incoherent/reduced reflective function	Immobilising stress reactions shut down **Freeze** Dorsal Vagal Nerve Parasympathetic ANS	**Regidity** **Limited Functioning**

Figure 1: Models of Psychophysical Safety, Stress and Emotional Reactions to Threat

side, they position sympathetic mobilisation (hyper-arousal) above it and dorsal vagal immobilisation (hypo-arousal) below it. (Ogden et al., 2006:32). Therapy is organised around explicitly creating a window of tolerance, both as respite from trauma and the optimal conditions for processing it.

A Wider Application to Working with Every Day and Work-related Stress

The understanding of stress reactivity as movements towards two poles of hyper or hypo arousal with safe optimal arousal in between has broader application. Whilst it might be crucial to bring a traumatised patient into a tolerable range the same might be said for individuals in more everyday states of stress, panic or burnout. Individual patterns of psychophysical regulation are central to how and when we are within tolerable limits of stress and emotional arousal. If neural integration is generally optimal for our well-being and functioning and for processing trauma and can be said to be an outcome of all good therapy (Cozolino 2010) then it surely must be important to any model of how we deal with every day and work-related stress.

The table in Figure 1 synthesises an attachment and interpersonal neurobiological approach to psychophysical safety and to reactions to threat. The core concepts from attachment theory, 'secure base', 'narrative coherence' and 'reflective function' that are now well established in psychotherapy (Holmes, 2001) overlap with Siegel's, neural integration (2010) and Porges' 'Polyvagal balance' (Prengel 2011). They chime together as an integrative model of stress and affect regulation.

The Workable Ranges model grew, as my role required me to develop a proactive approach to psychological stress in the workplace and provide training interventions on working with stress. A model of mind-body regulation can convey the positive effects of being balanced over time as well as the consequences and risks of beyond tolerable limits. I began to see that it had relevance to people looking to improve their functioning and performance as well as those who had work or life challenges and wanted to feel less anxious or depressed. Integration and coherence overlap with Csikszentmihalyi's concept of 'flow' (1990) and with core elements of brain friendly working such as Rock's 'Your brain at Work' (2009).

Workable Ranges of Stress and Emotion (See Figure 2)

This diagram was initially adapted from the 'Autonomic Arousal Model' (Ogden et

	Stress	Body	Emotions	Mind
Mobilisation	Hyper-arousal Flight or fight Vigilance Charged	High energy Tension Increased heart-rate & Respiration	Intense emotion Impulsivity & anger out of control Anxiety and panic	Chaos Frazzled Scattered attention racing thoughts
Acceleration	Quick-freeze		Driven	Erratically over-focussed
	Workable Ranges - Dynamic Zones of Coherence, Healthy Fuctioning and Effective - Higher or lower arousal within a workable range - Feelings and physical reactions go up and down are tolerable and can generally be considered - The activation of stress reactions and emotion is modulated - We can adapt our responses to fit the situation - We can take perspective and focus on workable action			
Brakes	Passivity Blunted reations Slow Freeze	Low energy Sluggish immobility Reduced heart-rate & respiration	Grief sadness Dulled feelings Withdrawn Low mood Hopelessness	Hard to focus - Zoned out/adbsence of thoughts Cloudy or blank mind
Immobilisation	Hypo-arousal	Shut down	Can't protest	Rigidity

Figure 2: Workable Ranges of Stress and Emotion and the Less Workable States Outside

al., 2006) that depicts the tendency of people with traumatic histories to fluctuate between hyper and hypo arousal with little time in the regulated window of tolerance between. I have adapted and extended it to a general model of psychological health, functioning, and the effects of stress and emotional reactions over time. It is a way to convey solid theoretical model in an accessible way. Though in black and white here, I usually present it in colour to compliment the spatial positioning and best convey the feeling tone of fluctuating changes bodily and mental experience.

Workable Ranges are individual ranges of stress and emotional arousal within which our experience is tolerable and workable; that is where we feel safe, can cope, adapt, function and be effective. Workable ranges of stress and emotion have safe, healthy, flexible, optimal balance at the centre and individual features of limitation, at and beyond the edges of tolerance either side. Movement out of our ranges either, towards chaos on the high side or rigidity on the low side, is due to immediate or accumulative automatic reactions to threat that exceed our resources to stabilise (Siegel, 2010). Regardless of personality type or individual differences in how we react and cope, our bodies, minds, emotions and behaviour are all balanced and flexible and most adaptable and effective when within a workable range.

In this model we see how our bodies and minds are changed by our stress reactions. The model illustrates that dysregulated stress and emotional arousal either side of our range has common effects on physical, cognitive and emotional states. By visually setting out a middle range it lends itself to tracking the progress of ordinary ups and downs, to levels of stress activation of either; the sympathetic flight and fight reactions, or the parasympathetic dorsal-vagal freeze reactions. Lying outside of healthy workable balance it makes a clear statement that both poles pose serious risks to wellbeing, health and functioning. It is important to note that this is the case regardless of whether someone is aware of it or not. It may be useful to persuade people who suffer from stress-related conditions, but say they do not 'feel' stressed, to consider stress regulation techniques or therapy.

When I present this chart, or a simplified hand drawing of it, to clients, they mostly relate to it immediately. We often use it to track recent experience.

Sonia came for a consultation as she was finding it hard to cope with a family crisis and intense work demands. She began by describing feelings of panic at certain points during the day and in the middle of the night, when her mind would start churning over one thing or another. When I showed her the diagram she could see that with one or the other issue she would be going up and down within her workable range but the stressors together had pushed her out of it. Without my prompt she began to look at the low side and said, 'I've also been feeling flat and shut down and not enjoying time with friends'.

People are able to see that their state is constantly oscillating and how, often, periods of lowness follow on from high stress activation. They 'get' that whether life has become stressful or problematic, is determined as much by whether or not they are within their threshold of tolerance at any time as by the detail of any particular stressor.

Individual Ranges

We seem to have our own 'workable ranges', individual and dynamic spans of stress and emotional arousal in which things are more or less OK. Whilst it will lie between high and low arousal for all of us, there are differences in what emotions and levels of arousal we are comfortable with. We develop more or less tolerance and preference for slightly higher or lower states and internal and interpersonal strategies for dealing with life. The limits of the range are boundaries or edges at the 'thresholds of response' that we all have to various forms and quantities of stimulation (Ogden et al., 2006:28). Some people seem to have their range at a higher level of arousal and cope well with intensity and pressure but can't stand low arousal, weariness or sadness. Whilst others have a lower range, are OK feeling a bit flat or stuck but become unsettled and alarmed by a higher intensity of arousal such as anger.

This was the case with Sonia. It became apparent through her incoherence in describing her

feelings about one family member and a work colleague, that she was uncomfortable with anger. I suggested this to her. 'I've always been like that, I like to please people and don't like conflict', she replied. She could see her feelings about the behaviour and demands of these two people pushed her out of her comfort zone, and that her difficulty in finding a way of protesting or asserting herself, were key factors in her feeling out of kilter.

Whatever the general nature of our own ranges, they will slide up and down and expand and contract over time. They will usually change over the course of a day, as we react to the world around us and to our inner experiences. When life is going all right our individual experience will wave up and down within range as the range contracts and expands. A rolling pattern of arousal and mood including being pushed to and beyond the edges of our tolerance are part and parcel of everyday life. Equilibrium may be restored through the passage of time, supportive inner talk, and behavioural adjustments such as resting, sleep, eating, exercise, social connections and enjoyable activities.

Narrow Ranges

Some people seem to have narrow workable ranges and haven't developed the resources to adapt and manage certain states. This may be due to too many threats and stressors and not enough or inconsistent regulation in formative years. This is apparent in people with borderline personalities whose fear and intolerance of stress and emotion is high. Alternately narrow workable ranges may be stem from a high level of early safety and security, unfamiliarity with interpersonal and social danger, or an approach to life that is predicated on keeping things safe and steady. We will see later how chronic stress dysregulation, like trauma can shrink workable ranges over time.

Outside of Range - Derailing into Risky Dysregulation

Being dysregulated is by the nature of it unsettling and likely to cause our automatic reactions to be stronger and more dysregulating. The more this happens, the harder it can be to break the pattern. Those of us whose workable range is on the higher side might push away emotional pain and sadness by igniting high stress arousal, excitement or business. I see this a lot in driven people whose are intolerant of slowness and lowness with little let up in their internal or external system to allow for appropriate dips and time for recovery. On the other hand, those of us whose workable range is at the lower end might be compelled to protect themselves against the chaos and uncontrollability of highly charged emotions such as of anger, by closing down and withdrawing.

Unsettled psychophysiology creates unstable states of mind that we are unfamiliar with and find it hard to navigate our way out of. It may be that a level of hyper-arousal is suddenly too much for those with lower ranges or that chronic arousal becomes unsustainable for people with higher ranges. Outside of the boundaries of our workable ranges we are likely to feel out of our comfort zone and out of our depth. Sleep disturbance can play a large part in perpetuating dysregulation. With too much hyper-arousal and threat based emotion during the day, the body and mind can't let go and settle to sleep. The following day, tiredness, or psychophysical shutting down to recover, may be experienced as a threat if we 'have to' get things done and we get going again with a surge of adrenaline and anxiety. Self-criticism, intolerance and shame can add to the perpetuation of cycles of stress reactivity. Our sense of who we are may feel threatened. We can scare ourselves more by our resistance to or interpretation of feeling out of control. One of the most common responses to my sharing the workable ranges model with clients who are struggling with life outside of their range is relief. 'So, I'm not going mad then!'

Unfortunately, as creatures of habit, we repeat and intensify our coping strategies even when they don't fit the current context or situation and need to change. Under pressure it is very hard to be flexible and change. At the very point that we need to change strategy, as we're pushing ourselves beyond range at the top, or digging ourselves in below range, it's most difficult for us to do so. We cling to our habits, that which we know. It is exacerbated by the fact that our consciousness is compromised in the grip of

either hyper-arousal or hypo-arousal (Siegel, 2010:23). From a neural integration point of view the conditions for change and learning are lost. Fear moves us out of awareness and integration towards dissociation (Cozolino, 2010:20). Our capacity to be self-aware, and to interrupt stress reactivity and settle ourselves is thwarted.

Spending too long at one side of our range, reaching a more extreme threshold can be risky and. It uses up masses of energy. I sometimes liken it to trying to remain standing on shaky ground or a wobble board at the gym. You can just about appear to be steady but it uses a lot of energy and cannot be sustained.

Unworkability - Wired and Tired – (See Figure 3)

Figure. 3 shows the movement and changes in arousal of someone who is seriously dysregulated. Chronic stress has a lot in common with traumatic stress in that people oscillate between hyper and hypo arousal, feeling out of control or overwhelmed by either extreme and with little respite in between. The pattern is maintained by each extreme state triggering the other. Workable ranges are compromised and narrowed. There is no good safe place to be. In this state the experience is of volatility, of lurching from pillar to post, unsettled. The phrase 'wired and tired', expresses it well. In this state the experience is of being too depleted to do things that might bring safe liveliness and vitality but also too agitated and charged to switch off safely and healthily. It can become completely unworkable in that the person can't function and it is really hard to, work with it, to change and transform it. People who lose their workable range in this way are in trouble. At a clinical level this can often be seen as an oscillation between the symptoms of anxiety and depression. This model supports the view that common mental health problems might be viewed as part of a bigger picture of dysregulation and disintegration (Cozolino, 2010).

Burnout and the Collapse of the Capable

In the workplace context, I have been struck by the sudden and sometimes extreme deterioration in the wellbeing and functioning of previously resilient people once their high threshold of tolerance was finally breached. Capable and conscientious staff present for help on the brink or at the point of collapse. The pattern of capable people doing and giving more, minimising their needs and sacrificing activities that nourish and resource them has been described by Tim Cantopher as the 'Curse of the Strong' (2003). He sees psychophysical

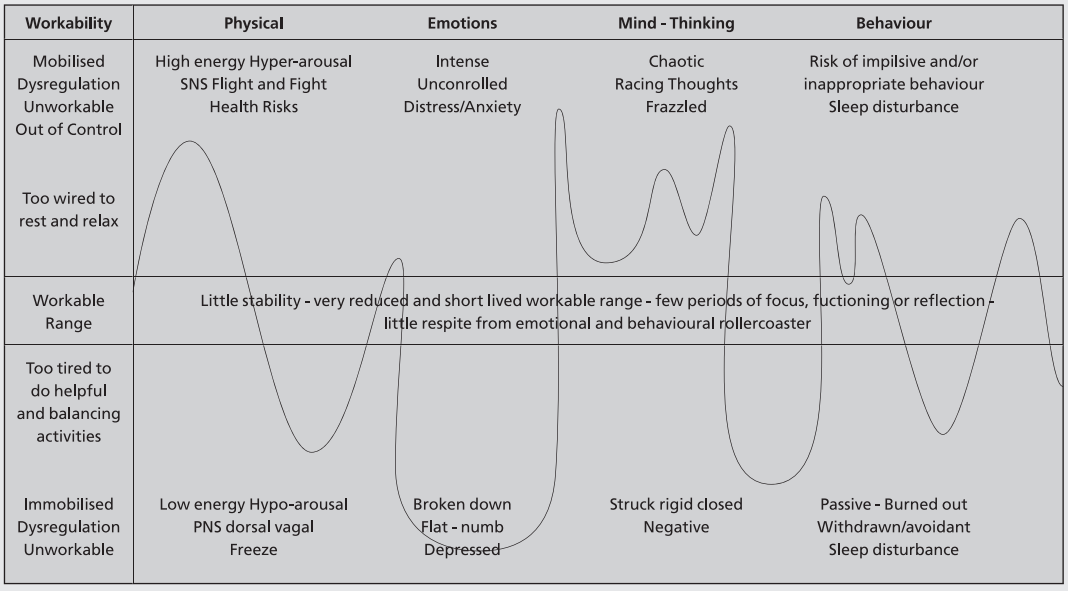

Figure 3: Unworkability Reduced Workable Range - Dysregulaed - Wired or Tired

depletion as a major factor in a lot of depression. I have been shocked by the depth of the freeze reaction or shut down in staff that 'hit the wall' or 'grind to a halt'. A significant number describe states of intrusive arousal and reactivation coupled with blank withdrawal that closely resembles traumatisation. Rothschild & Rand (2006) describe and work with these patterns in therapists and carers with therapeutic burnout or 'Compassion Fatigue'.

Implication For Practice

Psychoeducation

The Workable Ranges model provides an easy to grasp integrative model that sets a range of common experiences in a visual framework that people can readily relate to. It can be used to illustrate how different stress and emotional reactions and the cognitive processes that accompany them may be risky, either in degree or over time. It shows that psychophysical safety, supportive social or self-engagement contribute to our functioning as well as our wellbeing. My experience with clients in the roll of dysregulation is that psychoeducation of this kind can be containing. It can be particularly helpful to differentiate between safe and risky mobilising arousal and between safe immobilisation 'relaxation' and unsafe shutting down or depletion. As an accessible model it can be used to inform and empower people and can act an organising backdrop for collaborative relational therapeutic interventions. Articulating the importance of stress and emotional regulation and getting people to be curious about their bodies and minds offers a number of different entry points to restore balance and functioning. Whether it is to address stress related physical symptoms or issues in personal relationships the model provides a good starting point for the exploration of patterns of arousal and emotions. The 'marked mirroring' (Fonagy et al., 2004) of stress and emotional imbalance with this model can play a key role in a range of interventions with any client group. My experience is that explicit use of the model can map and contain experience. Conveying that well being and functioning go hand in hand can provide a rationale to motivate people to engage with self-care or therapeutic support.

Safety, Stabilisation, Regulation and Integration

It is perhaps common for integrative therapists to see regulation as a key part of interventions and prerequisite for change (Cozolino, 2010). Safety and stabilisation may be made explicit; whether as the key focus of therapy (Ogden et al., 2006) or where the conscious modulation of the fear system as a 'fear-free caregiver' (McCluskey, 2011) provides the essential foundation for creative exploration (Heard et al., 2009). Physiological and psychological safety as an imperative appears to be less established in stress management. The 'Workable Ranges' model encourages the investigation of embodied safety and stabilisation with the client. This may include facilitating social engagement (Porges, 2001) and self-engagement (Siegel, 2010), interactive or self-regulation (Beebe and Lachmann, 2002) or in body psychotherapy terms, vertical self-regulation via breathing and movement and horizontal regulation via interaction (Carroll, 2009). Mindfulness techniques can be used as a self-directed regulatory activity or a form of self-engagement creating security and safety inside.

My work suggests that the model can explicitly link experiences of being held and helped in the consulting room with the social engagement system as an effective stress response. This can support people in valuing and prioritising their personal and working relationships. The timing and method of bringing in the model will depend on the therapeutic context and contract. I often bring it in towards the end of the first session. The experience of having alien experience understood can be reassuring and stabilising.

The psychoeducational use of the model must be accompanied by and balanced with enough genuine empathic attunement. Some people need this sense of connection more than others and will not be able to move onto an explanation without it. Others search for containment through explanation and will be able to soften and feel more in touch with themselves and be more open to being helped,

if given an explanation of their experiences. When people are able to recognise and order their experience it can create collaboration on what to focus on in an intervention

Coached Body Awareness and Mindfulness

Helping people discover or restore a felt sense of safety and stability that they can recognise is likely to work best when starting with the body and working in the moment. An exploration with clients of their own resources that support psychophysical regulation can be really useful. Experiences that are likely to feel safe, settling, engaging or revitalising can be identified. I suggest that becoming conscious of the sensory experience in their bodies of feeling safe and engaged will help their body-minds know they are safe and create stability.

Practicing paying attention to direct sensory experience in the moment creates an open receptivity to experience that actively creates neural integration (Siegel, 2007: 40).

Observing and 'being with' experience opens the communication pathways in the brain that shut down when we are threatened and stressed. I apply key aspects of the Mindfulness Based Stress Reduction (Kabat-Zinn, 1990) programme in some way to all my work. This includes: body awareness, awareness of the felt signs of stress reactions, stepping back from thinking habits that amplify reactivity, building acceptance and tolerance of unfamiliar and unpleasant sensations, knowing that they will pass, choosing options of how to 'be with' difficult experience without blocking or being overwhelmed by it. These skills and attitudes can create the ability to 'respond' to dysregulating stress and emotion that undermine functioning, rather than 'reacting' automatically (Kabat-Zinn, 1990: chapter 20). If we can intentionally establish periods within our workable ranges, we can consciously develop resources and skills for regulating and tolerating unpleasant sensations, stress and emotional arousal at the edges of our range (Williams et al., 2007:144). Developing tolerance of states that we usually get caught up in, or push away, will, in time, strengthen the capacity to be both stable and flexible and in turn build resilience.

Conclusion

Porges' (2011) hierarchy or stress reactions and positive models of neural integration within a 'window of tolerance' (Siegel 2007) or optimal arousal (Cozolino 2010) provide a good basis for a model of stress and emotional regulation. How these insights have been used in the treatment of traumatic stress (Levine 2010 & Ogden, Pain and Minton 2006) provide valuable insight into psychophysical regulation that can be usefully developed and applied to broader populations.

'Workable Ranges' is a comprehensive integrative alternative to the popular models of stress management. It includes stress reactions and coping strategies that are organised around inhibition, blocking and numbing of arousal.

It can be presented visually as a general and accessible model of psychological health and balance. The model highlights the positive benefits of regulation and the value of proactively developing self-regulation skills. People with narrow or inflexible workable ranges and emotional regulation strategies and resources, and those who neglect their own experience, putting work or others first, are most vulnerable to the dysregulating effects of everyday personal and work stressors. It is suggested that using the model explicitly as psychoeducation is a good basis for a range of interventions from proactive training to intensive psychotherapy. In collaborative working with the model, the process of change involves moving from avoidance of experience to awareness and regulation of it, both at a micro level in the moment and on a larger scale over time.

My intention in this paper was to introduce 'Workable Ranges' as model to bridge interpersonal and affective neurobiology, integrative therapies and stress management. I have confidence in the immediate emotional resonance that colleagues and clients have had with it and of the theories and practices that inform it. I plan to continue to test out the application of this model with clients, and in relation to everyday and workplace stress. I am keen to explore the utility of it as a generic model for different practitioners and settings and welcome feedback.

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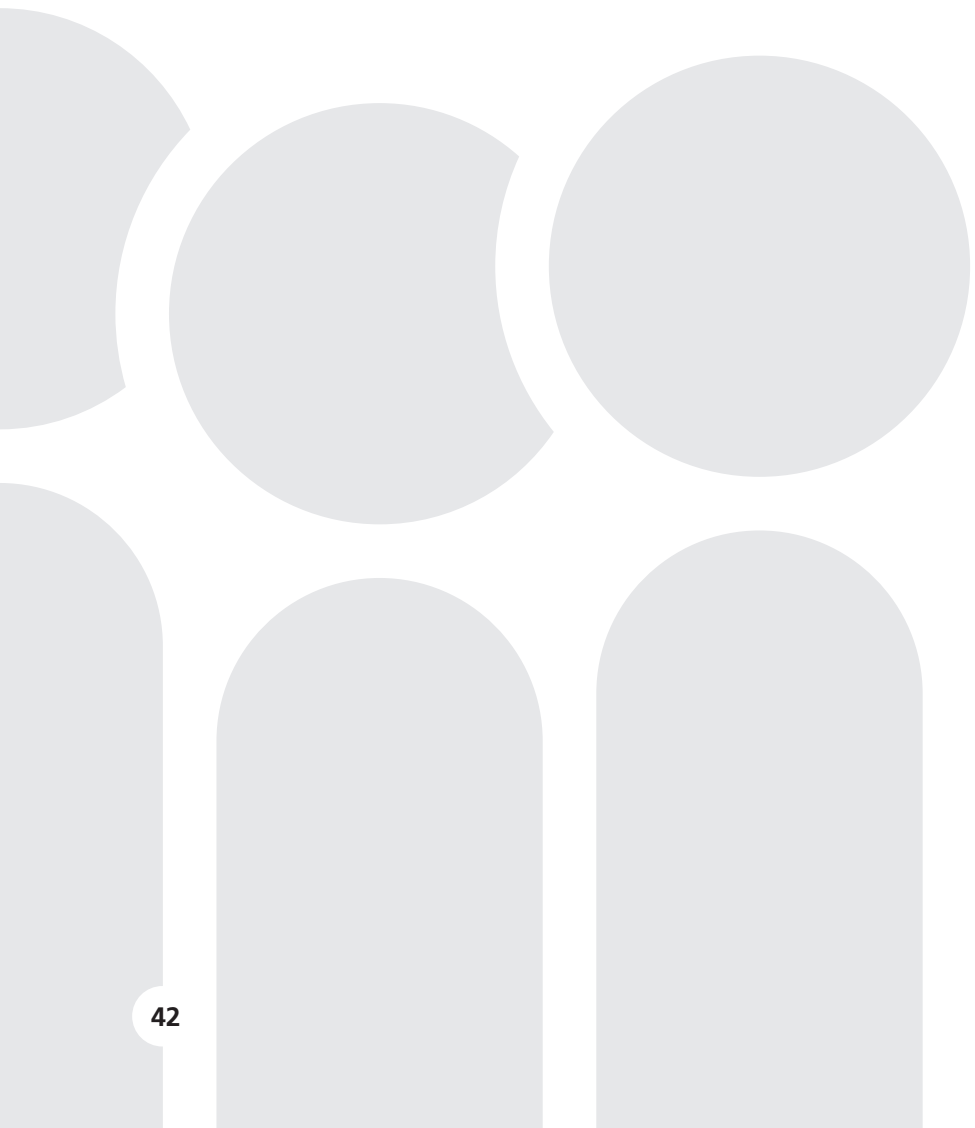

Penny Bradshaw

Alice Winnicott: A Unique Woman of Her Time or a Psychologically Disturbed and Troubled Wife of Donald Winnicott?

Abstract

While the name and work of paediatrician turned analyst Donald Winnicott is well known to psychoanalysts, psychotherapists and those working in child welfare or in academia the name of his first wife, Alice, is little known and much maligned. This paper explores the life of Alice Winnicott (nee Taylor) who lived in the shadow of this prominent man. Alice was a woman who herself accomplished a great deal for a woman in the male dominated environment of 1930s Britain. For the first time, using primary source material, this paper outlines her story.

Introduction

Alice Buxton Winnicott, (1891-1969) nee Taylor, took her surname from D.W. Winnicott and like so many women, particularly of her time, has been in the shadow of the limelight afforded to her husband of 25 years. Moreover, her story has been inaccurately and perhaps unfairly concocted from dubious or biased sources. It is, perhaps, time to bring some truth and light to her story and to consider her rich, varied life and her potential influences on Donald Winnicott.

Alice was my Great Aunt, my father's Aunt. I knew Alice for her achievements and creativity; she was both scientist and artist, one informing the other. I also knew that she had been married to Donald Winnicott. Later in life when I studied psychology and then psychotherapy, the name of Donald Winnicott kept coming up. I began to realise that Alice had been married to a rather important man. Reading biographies of Winnicott I realised that, much of the time, if Alice is mentioned at all she is mentioned in a quite negative way; none of the family stories of her achievement and enterprise are featured. In his acclaimed biographical portrait of Winnicott, Brett Kahr refers to her as "Alice, the beautiful and artistic step-daughter of a distinguished medical practitioner, worked as a potter" (Kahr 1996 p.43). A rather sexist, inaccurate and dismissive reflection of Alice who was the daughter of a successful gynaecologist, a Cambridge graduate and ran her own successful pottery business. Rodman's book 'Winnicott, life and work' (2003) referring to Alice's work at the National Physical Laboratory says "We do not know what she did in a place devoted to science." (Rodman 2003 p.53) indicating a lack of information from Alice's side of the story and clearly does not do justice to Alice as a Cambridge science graduate specialising in Mineralogy.

Generally her image out in the world is insignificant and seeming to be portrayed as something of a weight around the shoulders of such a great man. She holds a shadowy, even problematic, position in the glittering career of Winnicott. Yet Alice Taylor was a significant and interesting woman in her own right.

Alice's family

Alice was born into a middle class family in Claverdon, Warwickshire. She was one of three girls and two boys (Mary Nora Lupton, Alice Buxton, John Lupton, Pauline Matcham and James Maberly). Alice's father, John William Taylor (1851-1910), was professor of gynaecology at Birmingham University and a practicing gynaecologist at the hospital in Birmingham. Alice's mother, Florence Maberly Buxton (1856-1934) studied the Natural Sciences Tripos at Cambridge focussing her studies on botany. Mary (1890-1967) the oldest daughter, followed in her mother's footsteps and went to Cambridge. She studied for the Classical Tripos focussing on archaeology for which she was awarded first class honours in 1913. John (1894-1970) followed his father into medicine, pioneering among other things the use of X-rays in the 1920s. Pauline (1897-1981) studied music (cello) at Birmingham University and became a professional cellist with Birmingham Chamber Orchestra and later formed the Dorian Trio. Pauline spent the last part of her life running a farm in Wales where she had much acclaim for reintroducing Welsh breeds such as the Welsh Cob ponies back into Wales. James (1899-1960) studied medicine at St Bartholomew's Hospital after which he became a general practitioner and later qualified as a psychoanalyst. With his training in psychoanalysis and special interest in emotional deprivation in early childhood, James met and became friends with Donald Winnicott.

Alice's Education and Work

Alice also studied at Newnham College Cambridge, going up in 1912. She read the Natural Sciences Tripos, focussing on Mineralogy in the second part. After university Alice went to work at The National Physical Laboratory, Teddington, Middlesex, and in 1917 successfully gained a position as a 'Junior Assistant' in the Metallurgy Department. In the job specification for 'junior assistants' the gender referred to is always male showing perhaps the rarity of such posts being given to a woman at that time. In 1920 whilst working at NPL, Alice wrote an article entitled "The Casting of Pots for use in Experimental work on Optical Glass" published in the Transactions of the Society of Glass Technology, Vol, 4. The article discussed the results of experiments undertaken to ascertain how to use casting within the process of manufacturing glass pots for experimental use where uniformity of shape and size is required. This was a lengthy and highly detailed, technical and sophisticated scientific article that appeared in a reputable, industry-recognised publication. Together with Edith Irvine, Alice also wrote "On the Porosity, Strength and Absorbing Power of certain Calcium Sulphate Cements" published in 1921. The paper outlined the work they had done in experiments on the slip casting of clays under pressure.

Alice wrote a short private memoir between the years 1936-1939 and in the introduction written January 1944, she outlines that it was written "from time to time" "in any moment that I could spare from a busy life". She describes the memoir as "giving an opportunity to the reader to walk along the path I followed and to understand the reasons that led me to follow it". The memoir outlines her interest in design and pottery, focussing on her work as a ceramicist and running a pottery. Her hand made document includes her own wood cut prints as illustrations. She writes: "While working during the war of 1914-1918 with meltings of metal and glass at high temperatures I could not help being surprised at the extreme beauty of the simple Morgan fireclay crucible. How much more lovely than anything produced on the market! Such beauty and simplicity of line could not be found in any known article sold either for use domestically or for ornament's sake; I suddenly became filled with desire to produce simple, beautiful shapes in earthenware or china which

could be continuous in supply, useful and within the range of the purse of the ordinary man." This work undertaken in the National Physical Laboratory seems to have sparked an interest and desire to become involved in pottery.

Alice married Donald Winnicott in 1923, after which it seems she began to pursue her interest in pottery and design, having given up her job at NPL. Her letterhead at that time described her as a "potter and designer" living at 7 Pilgrims Lane, London NW3, the home she shared with Winnicott. In 1924 she set up her first gas kiln where experimental pots could be made. A few years later she "saved up" for an electric kiln that was set up in 1930 at her London home. She began at this point to sell small pieces in "fair numbers". Although at this time her pots were received well by the public and "several good shops", she felt it necessary to continue to develop her technique, so kept sales limited to single pots direct to the public. But her interests went further; she was not content to stay and pursue a career as a single potter. She was fired by a desire to effect change in the pottery industry: "Yet soon I began to consider things very carefully – was it really best to become merely the finest and most dexterous single potter? Was it not better to help remedy the sad state of industry – the failure of a good man to make good – the appearance in devastating numbers of cheap and meretricious articles? And I seemed to be well qualified to help in this direction both technically, artistically, and also because I enjoyed teaching and explaining."

The idea of her own pottery business began to take shape; this was in the years after the First World War: "The idea of the Building of Industries (such as a good pottery industry) for the benefit of the industry itself began to obsess me. The energy so apparent in the production of articles of destruction should be used for articles of construction. For a time of peace we were not going in the right direction. Why? All that our statesmen did was to bicker and wrangle. Our kings of industry vied with one another – not as they said, in finding out what the public wanted and supplying the need – but in forcing down the throat of a lethargic public any goods which could be bought or produced at a cheap rate and sold at as much profit as possible." Alice was noticing the state of England after the damage done to it during the war. She observed with excitement work being done in rural communities to begin to set up small local industries. Much of these small businesses being set and run by women she noted: "Here the women were seeing further than the men – was this because our best men of the right age had disappeared in a four year holocaust? It looked like it. Profiteers and self-seekers had been left behind in England to its great disadvantage."

During this period, just after the First World War and whilst living in London, Alice took up a voluntary post as a night warden in a homeless hostel. Working one night a week she learned much from the clients of the hostel who were mostly men from various locations in the North of England who had left families on foot in search of work in London. Alice enquired about introducing some crafts to the men but her request was turned down because nobody was allowed to stay in the hostel longer than one night at a time making it impossible to form an interested group. There was a small group of men that broke that rule because they were employed in cleaning and maintenance. They received no payment but food and lodgings for their work. These men were allowed to stay over a longer period and Alice was able to observe them as together they cleaned up the hostel. She introduced them to her pottery for use as ornaments to decorate

their environment and they began to grow an interest and appreciation in design and form. One day she was informed by the warden that the men had simply decided to "smash up" the old ornaments that had previously been in the hostel preferring Alice's pots to decorate their space. Alice states in her memoir "Here was a preference for beauty; especially with those who, having little connection with money, had lost touch with reality. No money – no power. No possibility of money – no pretensions. Therefore no false values in art. Is it true that people are born with a better taste than that which is later acquired associations of false value?"

It was after this experience with homeless and unemployed men in the hostel that Alice really became interested in the sad plight of the unemployed in the years between the wars. She began to think how she might help, and in her memoir she writes: "I felt I could no longer stand by as an idle spectator of the misery I saw, but must try to do something, however little or local its efforts, towards the redistribution of industry – towards regaining that which had been lost in the dignity of manual labour." Her interest being ceramics and design, she noted that many goods from this industry and others were now being imported into the country from France, Germany or even Japan. Alice observed that the English manufacturer could not compete: "Bit by bit the English artisan (except in the motor trade) was becoming a back number. German and French goods were shipped into England, then Japanese, at ridiculously low figures. Everyone (you and I) who bought them was without realising it crippling the honest manufacturer." "Unfortunately the majority of honourable fellows of the right age had been already sacrificed in 1914-1918 for their country. The irony of it worked me up almost to a state of fury, I wondered if, as man did not seem able to do anything about it, whether woman could not do a little to remedy the state of affairs." There were signs of this being done in 'Women's Institutions' up and down the country where women were producing hand made goods for low prices. With her background of scientific knowledge: "I had gone straight from my college in War-time to research for the government in refractories, and had thus acquired a general knowledge of the methods employed in all branches of the Ceramic Industry in the making of both useful and ornamental objects." She began to look into the ceramic industry, and especially in areas where there was huge unemployment, in order to be able to understand why businesses such as potteries had been unsuccessful.

She researched the potteries of Nantgarw and Swansea, South Wales, in order to better understand their successes or failures. Alice learned much from the businesses of L.Dillwyn of Nantgarw pottery and Billingsley of Swansea. Then in 1934, Alice noticed a pottery freehold for sale in Kent. Although there was not great unemployment in the area, Alice thought she might be able to begin there and hoped to develop her idea towards others perhaps copying it in other areas. Initially she did not have sufficient funds to be able acquire the pottery but the next year it came up for sale again and this time she had "slightly more capital". Alice took on the tenancy of "The Upchurch Pottery" in Rainham, Kent in May 1935. Within the rules of a strict tenancy agreement (signed by Alice and also by Winnicott as witness), Alice took on "the land, the works, and the good will but not any of the stock of pottery in hand."

"It was with great trepidation that one started out on the adventure of owning, maintaining and directing work of a pottery" Alice noted, after acquiring the pottery. She was left with a few male workers and a range of pots to continue producing as part of the business, yet she wished to be able to develop other ideas. She noted "the prospect of carrying on with the same men as before did not fill me with great enthusiasm. I had hoped to find a place where experiments could be carried out and various new self-made-up glazes tried; but was I to start work by putting good men out of employment? I decided No. If they did not like me at first, they would in time if I managed in the right manner." Alice designed from her London residence and the pottery produced her designs. As Alice's nephew Tony Bradshaw (my father) noted "She quite quickly took over the design side of things. Potteries seemed to have a standard set of designs that they would work to and produce numbers of same design. Upchurch had their own range of pots which were rather heavy, what you might expect pottery to be at the time. Alice set up doing her own designs for pots much lighter and more elegant using different glazes. Her pots became sought after by places like

Heals." Tony remembers going with her with a consignment of mugs to an exclusive cafe in Bond Street who "asked if she could get her pots to be stronger as they did keep on breaking!" As Tony observed: "Alice didn't get it exactly right but she experimented and was sought after."

In her short memoir, Alice reflected on the pottery industry at the time and the influx of machine made goods. Her observations showed her that a potter should be able to address all aspects of the producing of pots: "a potter should be an exceptional king in his own castle, and know the steps from start to finish." It seemed to Alice that the worker should be "capable and many-sided – if only for his own satisfaction and pleasure." This satisfaction from their work seemed to Alice to be lacking when many workers became machine operatives in order to produce the machine made objects that were flooding the market at that time: "The exploitation of the life of man as simply that of a mere machine tool has been tried extensively and found very definitely wanting. This misuse is, I believe, largely responsible for unsettlement and unrest at the present time." She noted that in French potteries workers were able to participate in all aspects of the pottery business from design to producing;"True craftsmen, such as these potters, were doing work which encouraged their own talents, developing their minds and gave them a sane healthy living." She proposed that the work of the potter was fulfilling and creative and even went as far as to suggest: "Self expression is part of the routine day's work and through it an inhibited nature may suddenly blossom; and even mental defect may be converted to intelligence, of which it was only the outer cloak, waiting to be cast aside." Alice was reflecting on and coming to her own conclusions about the state of mind of the ordinary worker and the state of industry in those times. She knew from her own observations how life could be better for all with work that was satisfying and used the person fully: "the chief blessing to a craft worker is that he loves his work – sometimes with such enthusiasm that it becomes almost impossible even to suggest a paid holiday from it!"

Alice obviously addressed the issue of cost of production of each item and pricing in order to make a profit and continue the business. Again taken from her memoir she outlines: "the chief stumbling block in the way of production of beautiful hand-made articles is that usually the craft, having to compete against the mass-produced article can never make sufficient profit by itself to afford a good place of display. Where this is possible – where a good firm gives a display of the right kind, or if (as at Chelsea) one has the opportunity of showing the work as it should be shown to the public- it is astounding what a difference is noticeable."

Whilst owning and running the business in Kent, Alice continued to develop her idea of helping the growing unemployment problem: "to help in the most stable way I could – to abate the steady rise in unemployment – to help to fill a long-needed want, that of bringing out the best in a worker". Wishing to make a difference to high unemployment areas, Alice returned to South Wales in 1936 and carried out (and wrote up) an extensive survey of "the distressed Valley Areas". She looked into the state of existing buildings, kilns and equipment, costs and even explored staffing opportunities, noting in Merthyr Tydfil "the men I saw here begged me to stay and teach them". She looked at the possibility of art students being given valuable work experience by incorporating them into the team at the pottery as well as "occasional visits from an outside designer to encourage". After her research Alice felt she better understood

the pitfalls and what contributed to the demise of these two pottery businesses. She also had a written summary of her survey findings to submit when applying for financial support towards building her pottery industry. She spent much time writing to many authorities including the 'Society of Friends' (a Quaker organisation) to apply for money in order to begin her work focussing on the site at Pont-y-prydd. Unfortunately she was unsuccessful in her application although the society was very sympathetic towards her enterprise. Alice regarded this period as a difficult time. Although she had thought running her own business in Kent would help her towards obtaining monies towards her further venture in South Wales it seemed that it was "perhaps the stumbling block in the way". She felt whatever she did she was "regarded as a capitalist with a private venture, and therefore with a certain amount of suspicion". Alice was disappointed to be turned down by all authorities with the power to give out money as she felt she really had a workable idea;"it was a pity - a very great pity, because in addition to a wonderful site and the opportunities of man-power we had the chance of supplying help in four ways".

Alice's last words in her memoir included in her footnote, although written in the last years of the Second World War, seem pertinent today in this climate of rising unemployment and unrest: "The life of the craftsman is the best deterrent from war – in fact the only deterrent. Joy in creation is good and lasting, the natural result is a hatred of any force that comes to destroy the lovely thing created." "The understanding the heart of the skilled man is a matter of national – I venture to say – of international urgency. You cannot waste good stuff for ever, nor starve the people of their needs, without just retribution".

Alice continued to develop her business in Kent. Tony Bradshaw explained; "Alice had a sort of William Morris approach to things/ way of seeing things. She felt the workers knew best and should be recognised for their quality of workmanship. She was keen to get the things made by her workers sold and admired. Alice promoted her own stuff: she advertised to tasteful people; she identified particular clientele; every year she took a stall at the Chelsea Flower Show to promote her pots; she went and found one or two cafes; she sold pots and mugs to a cafe in Cambridge. There were some problems that she didn't overcome, things looked beautiful but were not always practical. She produced the designs and the workers made them. Duck egg blue and the oatmeal were two of her favourite (or famous) coloured glazes that she developed herself." Alice visited the pottery sometimes weekly, sometimes once a month, from her home in Hampstead. She notes that her aims were to pay the wages of the workers, to arrange sales and firing of pots without loss of capital in order not to need to make cuts in what she saw as bad times. Alice was determined not to introduce "cheap lines" in order to make money, yet she was equally sure that she did not want to only design and make "exclusive ware". The business was very successful, selling to Heals for example. In a letter from Heal & Son Ltd, 195-199 Tottenham Court road, London W1 dated 9th November 1943, Harry Trethowan writes "Dear Mrs Winnicott, Your lovely things are going to get sold in less time than it takes to write this letter almost, so whenever there is more please let me know".

A pottery business is a difficult thing to make successful even in good times. Alice's business struggled and she eventually decided to stop trading. But in her usual fashion of not wanting to leave her workers without, she left the business to them allowing them the opportunity of continuing the work under their own direction. They too found it difficult and eventually the Claverdon and Upchurch Pottery closed down.

Alice and Donald

It is unclear how Alice met Donald Winnicott; it may have been through his Cambridge friends, as Alice studied at Cambridge. Rodman's biography suggests that Donald might have met Alice through his close friend Stanley (often called Jim) Ede who was at Cambridge with Alice (Rodman 2003). It may have been through Alice's brother James.

Alice married Donald Winnicott on 7th July 1923. They started their married life together in Surbiton, Surrey, and from there they moved into the house in Pilgrim's Lane in 1932. Donald had a study there in which he saw private patients and entertained students

and colleagues from the medical profession. The house was close to Hampstead Heath and both Alice and Donald enjoyed walking on the heath when they could. Evenings together were sometimes spent playing music, both Donald and Alice played recorder. The couple seemed to enjoy entertaining and often had guests round. Jim Ede a close friend of Donald's from boarding school recalled Alice coming downstairs in the morning clapping her hands to "strike a pleasant note for the day" (p.13 Rodman 2003) and recalls her as a "loving woman" (p.13 Rodman 2003).

Donald was working very hard during this time and would have presumably taken work home with him a lot. He also brought his work home with him in the form of patients or children to look after. As a part of his work Donald encountered children or young people that he felt he could observe better if he brought them into his home to be looked after. Alice's nephew, Tony Bradshaw, remembers conversations about how stressful this time was for Alice being the one at home: "There was an incident when Donald brought a child off the street to live with them that was tough on Alice. She had to do the caring of him, Donald would go off to work. The child was from the hospital where Donald worked and in need of care. There was of course a household on Pilgrims Lane, a cook and housekeeper, so she had help. But it was a difficult time and the child was disturbed." This boy was the subject of one of Winnicott's most famous papers "Hate in the Countertransference" (1947). In this paper he acknowledges the difficulties of looking after the child when he writes "it was really a whole-time job for the two of us together, and it was when I was out that the worst episodes took place" (Winnicott 1947). Winnicott writes of the arrangement to bring 'John' into their home: "my wife very generously took him in and kept him for three months, three months of hell" (Winnicott 1947). The other young person was 'Susan' that became a patient of Marion Milner's and the subject of her account of psycho-analytic treatment in her book 'The Hands of the Living God'. Although not much is known of Alice's experience of 'Susan' it is understood that Susan's interest in drawing and painting must have caught the attention of Alice. We see that Alice quite happily supported Donald in his work by agreeing and participating in his experimental 'fostering' of children. Although Rodman's biography of Winnicott insinuates that Alice was not in agreement with Winnicott's work and felt that it "was killing him", wishing him to become an ordinary GP in the countryside (p.54 Rodman 2003), she does seem to have been thoroughly supportive in her actions towards her husband. So Alice lived with a busy man; but she had her own life and interests to pursue.

Reflections from the Taylor/Bradshaw family on Alice's marriage and relationship with Donald Winnicott show us a different perspective than is generally put forward in biographies written about Donald. Alice and Donald at their Pilgrim's Lane address, lived close to Alice's sister Mary. Mary had married Harold Chalton Bradshaw, an architect of some repute, and they were living in Ornan Road (North London) with their three sons. Tony, the youngest son, remembered the Pilgrim's Lane house as they visited often. He remembers Donald's study, his desk and books – "a vast amount of books". Tony remembers Donald being "dedicated to work but not to the same extent as Alice's father", John W. Taylor, who had been absent from the family home in the countryside outside Birmingham. Tony remembered seeing "quite a bit of them" and Donald being "very good" to him and his brothers: "I remember we all went to the pottery (Kent) together in Donald's Humber Snipe car". Tony also remembered going on holiday with Donald and Alice in the summer of the outbreak of the Second World War. They went camping in Llanarth (Wales) where Pauline (Alice's sister) owned a farm. Tony remembered being about 13 years old at the time "they seemed happy in their marriage, they did look like it I must say."

It was generally understood that Donald's work was very important, and so Alice spent a great deal of time on her own with her work. Alice had come from this background of split family configuration with her own parents living in different houses, her father's work being the most important thing to him. Donald's growing success in his chosen profession might not have been an unfamiliar situation for her. Maybe we could even say that it might not have been that impressive to her? Alice certainly knew from her own mother that a married woman should be independent

and carry on with her own interests and not rely on her husband to fulfil her life.

At some point Alice confided in Tony's wife Betty, the now more widely known issue of the marriage not being consummated. The message from Alice to Betty, my mother, was that it was Donald that "couldn't or didn't want to". Tony reflected: "as far as one can tell it was true. He became a renowned mother and baby relations specialist yes, but that very different from mother and father relations." Tony reflected on later times in the relationship between Alice and Donald and its impact within the family: "Mary (Tony's mother and Alice's sister) did deplore what was going on between them but didn't speak to us about it. Mary didn't have great interest in disentangling human relationships; she just felt people should get on with it. In the break-up, the family felt Donald was the problem and Alice wasn't understood."

Eventually the marriage broke up in 1949 (they divorced in 1951) and Donald went to live with Clare Britton. Alice stayed in Pilgrims Lane for a while then moved to Wargrave on the river Thames. Some biographers have referred to Clare as the stronger woman that Winnicott needed, but perhaps she was the younger and more admiring woman that Winnicott wanted. Alice did not seem to idealise Winnicott and instead seemed to have wished Winnicott would dedicate less time to his work, feeling that it was putting too much of a strain on him. Perhaps we can see coming from her background she would have seen Winnicott going down a similar path as her father (in fact both did end up with heart conditions). Also there is a possibility that coming from the highly intellectual background and family that she did, Alice was not so easily impressed by Winnicott's work. Clare Britton, on the other hand, was young and highly impressed by Winnicott, as Rodman put it, having read the letters from Claire to Winnicott: "Clare is clearly full of admiration for Donald's capabilities. She asks him for reading material. She wanted desperately to develop personally" (Rodman 2003 p.92). She seemed to seek his help and direction in her own personal development.

Donald continued to keep Alice financially supported although some correspondence between Donald and Tony Bradshaw in the later years of Alice's life, thanking Tony for using his own funds towards Alice's upkeep, showed that sometimes the payments were a little late in arriving, if they arrived at all! Alice's home in Wargrave was not great; being close to the

river it kept flooding. A lot of Alice's artwork, drawings, paintings and sculpture, did not survive. She had also intended to establish her kiln in the garage but it was not high enough above the river so she was not able to do this. Tony remembers: "The Wargrave house was a pain. I remember coming home to Ornan Road (his family home in North London) and being told 'oh well Alice is here you'll have to stay in the spare room' (as Alice had been given Tony's room to stay in whilst her house was out of use) – the Wargrave house had flooded again." He remembered trying to encourage Alice to establish her kiln again and begin to make pots but he reflected "Alice got less organised and less determined, she got put off".

The sisters always had a close relationship. After living close to Mary in London, in the early 1960s, Alice went to live on the Llanarth estate close to her sister Pauline at her invitation. It seems the sisters Mary, Pauline and Alice remained close all their lives. She also visited members of the wider family up and down the country.

A very sad portrait of her later years is painted by Brett Kahr in his biographical portrait of Donald when he states "Alice had moved to a farm in Cardiganshire, in Wales, where she would spend the rest of her life unhappily and in rather a bereaved state, reminiscing about the earlier, happier days of her marriage and the pleasant times that she had spent at the Winnicott family home in Plymouth" (p.88 Kahr 1996). Alice moved to Wales to be near her sister. She spent much time with Pauline and friends. She might have been unhappy about the breakdown of her marriage to Donald and his subsequent marriage to Claire. But she did continue her life and did have family around her. She did not die "completely forlorn, and practically unremembered" (p.88 Kahr 1996). She is remembered, and fondly so. Her achievements are proudly spoken about amongst the surviving family.

Concluding Thoughts

Alice was a special woman of her time. She was not just the troubled wife of an eminent psychoanalyst. Alice was a scientist by nature; but she was also an artist. Through enquiry and research she developed ways of making unique and beautiful ceramic glazes. Psychotherapy too could be seen as bringing art and science together; as scientific theory underpins what then is a creative process of enquiry between two people in a therapeutic relationship.

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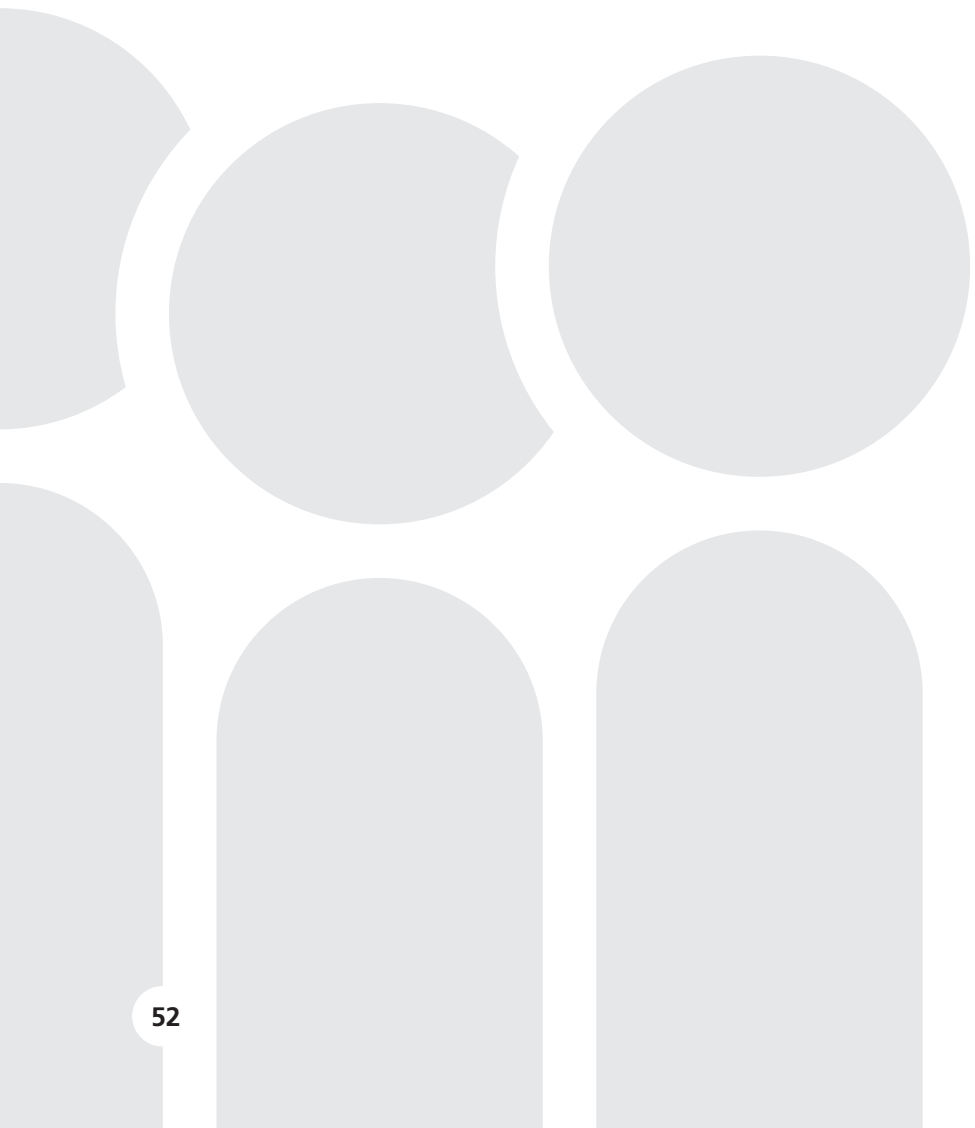

Catherine Oadley

Section A: Framework for Integration

Editor's Note

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

Introduction

"To see a world in a grain of sand
And a heaven in a wild flower
Hold infinity in the palm of your hand
And eternity in an hour"
Blake.

These lines encapsulate some of the essential beliefs and principles which lie at the heart of my Developmental Relational Model of Psychotherapy Integration. For me they speak of interconnectedness and holism; of present awareness and non duality; paradox and embodiment.

My belief in non duality or non dual consciousness, an integrating thread uniting Eastern wisdom traditions of Buddhism, Zen and mystical Sufism informs my view of the fundamental interrelationship of all beings. Loucakova, (2011, p1) defines non dual awareness as "the perspective on self and consciousness which makes one experience being and consciousness as undivided and non separate from every other consciousness which can be perceived initially as different". This belief informs a relational stance which holds a deep sense of respect and reverence for all beings within an attitude of "I-thou" (Buber 1958a).

My model is an integration of contemporary relational psychoanalysis; interpersonally informed developmental theories and broad based humanistic theory. Within this I draw primarily from attachment theories, psychosynthesis, dialogic and phenomenological two-person psychology and the body based trauma informed models of Ogden and Minton and Rothschild.

I also believe that each person is on a path toward integration and wholeness and see that this is essentially a drive towards health. I would contend that this process, whilst fundamentally relational does not preclude a search for personal meaning and finding the creative centre of one's life. I locate myself in narratives that share a view that we are fundamentally social beings; born into and sustained by relationships and that we are intrinsically relational. I agree with Mitchell that: "the interpersonal and the intrapsychic realms create, interpenetrate, and transform each other in a subtle and complex manner" (Mitchell 1988 p9). I would also add the embodied, sociocultural and spiritual domains to this formulation.

I adopt a "two person psychology" (Aron, 1991 p248) or a "regulatory systems conceptualisation" of the therapist client relationship (Aron, 1991 p248). This is congruent with Stern's intersubjective matrix, a "continuous co-creative dialogue with other

minds" (Stern, 2004 p77) which he regards as being "the overriding crucible in which interacting minds take on their current form" (Stern, 2004 p77). Into this I weave Benjamin's (1990) perspective on intersubjectivity as a developmentally achieved capacity to recognise another person as a separate and "equivalent centre of being" (Benjamin, 1990 p.185 in Mitchell and Aron 1999); Bromberg's (1998, 2006) conceptualisation of the self and work on dissociation; Mitchell's (1998;2000) intersubjective matrix and views on the self; and Aaron's (1991;1998) work upon self reflexivity and the embodied self. I agree with Benjamin upon the need to hold a tension between the intrapsychic and intersubjective and agree that they are "complementary even though they sometimes stand in oppositional relationship" (Benjamin, 1990 p.185 in Mitchell and Aron 1999).

I agree with Merleau-Ponty (1945/2002p474) that "perception is a bodily phenomenon" and integrate his holistic philosophy that "the world is wholly inside and I am wholly outside myself" (Merleau-Ponty, 1945/2002 p.474). I also hold a post modernist perspective which recognises the local, familial and cultural discourse which "come to be the forces through which experiences of individual life and body life are constituted as subjective experiences" (Harris, A 1998 p.48). I agree with Harris that "these social forces come to be both deeply internalised states and also forms of surface identity and embodiment through which ways of feeling normal, sexual, gendered, real, authentic and coherent are maintained" (Harris, A 1998 p.48 in Aron and Anderson 1998) .

Models of human beings and human growth and development I draw upon are social/contextual models, sharing some aspect of the interpersonally developed embodied brain and mind in states of relating with other interpersonally developed embodied brains and minds.

Conceptualisation of the Self

The experience of being a unitary self is in my view an "acquired, developmentally adaptive illusion" (Bromberg 1993, p397). From a neurobiological perspective Seigel concurs and quoting developmental studies he concludes that a notion of a "unitary, continuous self"(Seigel, 1999 p.229) is "an illusion our minds attempt to create" (Seigel, 1999 p.229). I agree with Bromberg that this is necessary in order to "develop a coherence and continuity that comes to be expressed as a cohesive sense of personal identity – an overarching feeling of being a self" (Bromberg, 1993, p396).

I regard the psyche as "nonunitary in origin, it is a structure that originates and continues as a multiplicity of self other configurations" (Bromberg, 1993 p396). Somewhat paradoxically I utilise Winnicott's concept of "true self" (Winnicott, 1965 p148) to reflect the experience of feeling "real" (Winnicott 1965 p148), authentic and grounded in one's embodied subjective reality which contributes to the experience of unitary selfhood. In contrast, false self relating may reflect "adaptive specialised selves without a sense of authenticity" (Seigel 1999, p231) which is accompanied by a sense of disjoin and dissonance.

Congruent with this my conceptualisation of the psyche reflects the psychosynthesis model of "subpersonalities" (Vargui 1974 p. 55) which "exist at various levels of organisation, complexity and refinement" (Vargui 1974, p.58). This is also congruent with a notion of distinct "self states" (Seigel, 1999 p230) which "emerges as various needs desires and interactive patterns coalesce into repeated patterns of being" (Seigel,2010 p245). These might be experienced as distinct selves with corresponding affective, embodied, cognitive self and self with other configurations.

Self reflexivity, the developmentally acquired "capacity to experience observe and reflect upon oneself as both a subject and an object" (Aaron 1998:5), contributes to the feeling of being a unitary self. This also facilitates movement between the subjective experience of the "me "of my multiple subpersonalities or self states and the self as knower or the "I". I view psychological health as the capacity to move with fluidity between states whilst maintaining a sense of continuity and personal authorship. I agree with Mitchell (1991) that the self is "dialectical and interpersonal" (Mitchell, 1991 p7) thus "I" always implies you in the same way that light implies dark " (Mitchell, 1991

p7). Within my model I consider the "I" to be in "transcendent immanent relationship" (Firman and Gila, 1997 p76) with the ground of being or ultimate consciousness, reflecting the paradox that the "mindful" reflective self can be both "self and no (personal) self at all, but only awareness "(Goldstein & Kornfield 1987; Kornfield 1993; Engler 2003. in Wallin 2007).

Attachment and Developmental Lens

I utilise key concepts from attachment theory to bridge domains of infant development research, affective neuroscience, and relational psychotherapy, and to inform my conceptualisation of adult affective disorders.

Bowlby's (1969b, 1973, 1980) attachment theory has been developed and expanded through the research of Ainsworth et al (1978), Main et al (1985, 1991, 1995) and Fonagy (2001), Allen & Fonagy, (2002); Fonagy et al (2002) providing a rich body of empirical research and knowledge.

I agree with Shore (2003) that "attachment theory is fundamentally a regulatory theory" (Shore, 2003, p37) in which "psychobiological attunement, interactive resonance, and the mutual synchronization and entrainment of physiological rhythms are fundamental processes that mediates attachment bond formation" (Shore, 1994, 2000a, 2000b, 2000h, 2001c). Alternatively termed the "dyadic (interactive) regulation of emotion "(Sroufe, 1996, in Shore 2003 p222), this attachment bond is mediated by "right hemisphere to right hemisphere arousal regulating transactions" (Shore, 2003 p222) between the infant/mother other dyad and therapist/client relationship.

Building upon this, the attachment informed psychoanalytic perspective of Fonagy et al (2007) and Holmes (2001, p209), integrated with infant dyadic research of Stern (1985), Beebe & Lachmann (2003), Tronick et al (1998), Gergley and Watson (1996) and Lyons Ruth (1991) deepens my understanding. Understood together these authors enable me to conceptualise the nuanced, co-created and reciprocal processes which mediate a good enough attachment bond which in my model lies at the heart of the developmental relational matrix.

Fundamental to the development of this attachment bond is the cocreation of a "secure base" (Holmes, 2001 p32). My understanding and relational stance draws upon analogues within dyadic infant research. Thus, congruent with a secure base parent I aim to offer "responsiveness mastery (Slade, 2005); mind-mindedness (Meins, 1999); the ability to repair disruptions of parent-infant (therapist-client) emotional connectedness (Tronic 1998); and reliability and consistency" (in Holmes, 2010 p34). Further, Stern has delineated nuanced intricate processes of affect attunement which he describes as "selective and cross modal imitation" (Stern, 2004 p84). Thus I may notice and attune to my client's vitality affects and explicitly communicate that I have received this via another domain, perhaps through a gesture, prosody, or vocal tone. Similarly, drawing upon the infant dyadic processes identified by the research of Gergley and Watson, (1996) I may add something of my own subjectivity through responses which are "contingent and marked" (Gergley and Watson 1996 in Holmes p35).

From a developmental perspective when this process is good enough, the infant experiences "his mental states being reflected upon" (Fonagy, p263, in Mitchell and Aron 2005) by the caregiver and thus comes to know the content of her own mind.

Mentalisation, a key concept within my model derived from the attachment literature, (Allen and Fonagy 2006; Allen et al 2008 in Holmes p4) is dependent upon earlier processes of affect attunement. It is a process closely associated with self reflexivity, mentioned earlier, which is also "the strongest indication of a secure self in adulthood" (Main, 1991; Main and Hesse, 1990 in Aron 1998 p10). The capacity for self reflexivity is correlated with an ability to remain regulated and within an optimum "window of tolerance" (Siegel, 1999 p253). I integrate this with mindfulness, whereby I practice and invite my client to "pay attention in a particular way; on purpose to the present moment and non-judgementally" (Kabat-Zinn, 1994 p4). Alongside this I utilise non dual awareness practices (Wilber, 2001) in order facilitate a deeper, embodied reflective stance upon subjective experience.

The role of both emotion and affect, defined as the experience of emotion, play a key role within my model. Panksepp's (1998) review of affective research highlights the critical role of affective states in the "psychic scaffolding" (Panksepp, 1998 in Gilbert 2011 p49) for other forms of consciousness. From a neurobiological informed attachment perspective (Shore, 2003; Seigel 1999) affect underpins the development of later processes and structures. Thus within the brain "emotion links various systems together to form a state of mind" (Seigel, 1999 p131) and "serves as a set of processes connecting one mind to another" (Seigel, 1999 p131).

Developmental research identifies "the capacity for affective expression may be innate, but the capacity for affective experiences unfolds in the course of development" (Brown, 1993 p6). To translate the implications of this research into the therapist client relationship is to recognise that in formulating a secure base "emotional connectedness is the key feature" (Holmes, 2008 p35). I agree with Maroda that the "mutually affective moment constitutes what is therapeutic between therapist and client" (Maroda, 1999 p.123, in Aron & Harris 2005). This informs my approach to working with transference - countertransference dynamics as I will discuss later.

Trauma Lens

For over two decades my professional life has involved working with relational trauma. Arising from this I believe "every trauma provides an opportunity for authentic transformation" (Levine, 1997, p193). I also hold that trauma seeks to find expression through multifarious means. This might include nightmares, enactments, self destruction and addiction, projective identification, somatic illnesses and dissociative processes. Paradoxically, I regard this as part of the psyche's drive toward integration and health and as a therapist I believe these all present opportunities toward healing.

My understanding and approach to trauma integrate affective neuroscience (Shore 2003; Seigel 2003) and attachment perspectives (Shore 2003, Fonagy et al 1996,2002), embedded and interpenetrated by a person's situatedness within a particular socio- cultural context. I integrate the work of Bromberg (1998, 2006) whose working definition I employ and whose view of trauma's impact upon the psyche is congruent with my own experiences. I also utilise his perspective on dissociation and perspective on enactments. Ogden et al (2006) and Rothschild (2000, 2003) add to this, offering integrating perspectives and a range of tools which are somatically orientated and fit well within my model.

Bromberg (2006) defines psychological trauma as "the precipitous disruption of self-continuity through the invalidation of the patterns of meaning that define the experience of "who one is" Bromberg (2006 p33). It occurs in situations experienced as overwhelming, where "self invalidation cannot be prevented or escaped and from which there is no hope of protection, relief or soothing" (Bromberg, 2006 p 33).

This may relate to relational trauma over time, where the experiences are prolonged or cumulative (Herman, 1992) or as single events in adulthood. I differentiate between the two, for whilst both might manifest symptoms outlined in DSM-IV-TR (APA 2000), dependent upon a person's attachment history, (Schore 94; Siegel 99) their capacity to cope with traumatic events in adulthood will be affected. Thus whilst research indicates that secure attachment functions as a buffer against stress and cortisol production (Gilbert, 2011 p114), insecure attachments, especially disorganised attachments impair a person's capacity to self and interactively regulate their arousal levels.

I employ Rothschild's assessment framework (Rothschild, 2000 p80) to inform my choice of interventions and relational stance. I draw upon phasic approaches to trauma (Van der Kolk, 2003 p188; Ogden et al 2006; Herman 1992) which I view as a dynamic rather than linear process. Thus I will attend to the creation of relational and intrapsychic resources, such as "putting on the break" (Rothschild 2000, p79); utilising dual awareness (Rothschild, 2000 p129); and anchors (Rothschild, 2000 p93) to maintain arousal levels within a person's "window of tolerance" (Seigel, 1999 p253). Once I feel we have established this substrate of resources thus creating safety; our focus might shift backwards

and forwards between phases dependent upon what emerges within and between both of us.

In early relational trauma, "when the secure base is the threat" (Holmes 2001, p7) and significant caregivers act as if the experience does not exist as a reality, "the level of affective destabilization becomes too great to be experienced self reflectively and integrated into ongoing self-meaning through cognitive processing" (Bromberg,2006 p33). Thus ordinary hyppocampal functioning is impeded and the experience is not "filed "(Van Der Kolk 1987b, Bromberg 2006 p184) within a cognitive schema with which it is linked. Instead, in extreme situations, these "primitive agonies", (Winnicott, 1963 p90) "threaten to overwhelm sanity and imperil psychological survival" (Bromberg, 2006 p33). As a consequence, the "normal" capacity of the mind for dissociation is "enlisted as the primary defence" (Bromberg, 2006 p33) in which the "process of dissociation…… become(s) a central organising structure in mental functioning" (Bromberg, 2006 p33). Schore regards dissociation as a "right brain survival mechanism characterologically accessed to cope with disregulation affective states" (Schore, 2003a, p42). Fluidity between states is replaced with rigidity, spontaneity and creativity compromised. Where this occurs, self states become walled off operating as a distorting lens or filter through which present moments are experienced. They may also manifest as "defensive action systems" (Ogden et al 2006 p20) determining "physical actions, sensations, emotions and cognitions" (Ogden et al 2006, p20).

Adding to this picture is the interplay of memory processing. In order to co-create a meaningful narrative and work to "shift the trauma from an autistic re-experiencing to a relational sharing" (Van Der Hart, 1993 p162-180), I recognise that traumatic memories are often encoded within procedural, symbolic domains of implicit memory rather than narrative, conscious domain of explicit memory. Importantly within this "the telling…is not relieving because the telling creates a reliving of the unprocessed affect" (Bromberg, 2006 p182) and, as he points out, this may activate dissociated shame which leaves someone feeling worse not better.

Holding this in mind I attune to the emergence of implicit, symbolic intrapsychic processes such as body sensations or symbolic dream imagery which may be fragmented and affectively charged. Here I find Ogden et al's (2006) methodology valuable and employ "bottom up processing of sensations, arousal, movement and emotions" to complement "somatically informed top-down management of symptoms, insight and understanding (Ogden et al 2006 p25).

Simultaneously I remain attuned to a range of self with other processes. Schore (2003) points out that projective identification "may be the only way that infants or severely traumatized persons can communicate their stories of distress" (Shore, 2003a p43). I thus notice what arises within my own body-mind, utilising my self observer and dual awareness to be mindful of, amongst others, shifts in my arousal levels, daydreams, sensations or emotions whilst remaining in relationship and present to my client. How I respond will be dependent upon numerous factors such as the phase of our relationship or how much my client can tolerate my subjectivity.

My responses will range from nuanced body communications, reflecting internally but not intentionally communicating to finding words to speak to what might be emerging between us. I find Bromberg's perspective on enactments valuable particularly as they relate to working with trauma. From this perspective it relates to a co created attempt to "negotiate unfinished business in those areas of selfhood where, because of traumatic experience affect regulation was not successful enough to allow further self development at the level of symbolic processing by thought and language" (Bromberg, 2006 p181). I agree, to paraphrase Bromberg, that within this relational dynamic I become "immersed at least for a time, in a dissociative process of my own and (am) objectifying (my client) no less than (she) is objectifying me" (Bromberg, 2006 p34). Through noticing moments that are jarring, what Bromberg has spoken of as "a bit off", (Bromberg, 2006 p187) and Stern terms "emotional chafing" or "subtly "wrong or contradictory, or just uncomfortable" (Stern, 2004 p208), I become aware that an enactment is taking place. Gradually as I find a way of attending to this in the moment "what was a pattern of subsymbolic communication

(the dissociative cocoon) is allowed to interface with language and thought. (Bromberg, 2006 p187) This then may move us into a "productive dialectic between here and now experience and there and then memory" (Bromberg, 2006 p188).

Social Contextual Issues

I regard the interplay of social/contextual forces as present and embedded within every dimension of my model of integration. I agree that "culture saturates subjective experience" (Dimen, 2011 p4) and that we are "fundamentally thoroughly cultural creatures (Mitchell, 2000 p xviii).

My personal experiences contribute significantly to this belief. These include: my initial engagement with the feminist movement as a young woman, and with writers such as Simone de Beauvoir (1949); Greer (1970); Eichenbaum & Orbach (1992); Friedman (1963); being part of radical social work practice during the late 80's and 90's. I developed a passionate commitment toward challenging institutionalised racism and other oppressive discriminatory practices within contexts of injustice, poverty and inequality. These coalesced in my attempts to grapple with contextual dimensions as I researched and established specialist addiction services for women whose lives were also ravaged by trauma and eating disorders. I struggled to understand, to paraphrase Orbach (1992) "how the outside got inside".

This rich experiential backdrop informs a post modernist perspective, in which I recognise that "social forces come to be both deeply internalised states and also forms of surface identity and embodiment through which ways of feeling normal, sexual, gendered, real, authentic and coherent are maintained" (Harris, 1998 p48).

I am sensitive to ways in which these forces manifest within myself, my client, and what gets co-created between us within what Altman has termed the "social third" (Altman 2009 p61 in Dimen, 2011).

I believe that transformation is made possible through a "culturally situated and personally meaningful relationship that arises and evolves and which is jointly explored" (Dimen, 2011 p4).

Within the therapeutic relationship this perspective informs a consideration of what we might be preferencing and what implicitly might be excluded between us. I attempt to explore this in a number of ways. This might be through critical enquiry, curiosity and "working responsibly with political, social, cultural material "(Samuels, p170 in Dimen, 2011). I extend self- reflexivity to the "social third" (Altman 2009 in Dimen, 2011 p61), and attempt to bring into awareness the ways in which my consciousness has become imbued with social, cultural and political ideology. I agree that this process helps the "socially embedded self" maintain a "critical perspective upon its own embeddedness" (Altman, 1995 p41).

However, because my own and my client's psyche's are profoundly "infused and delimited by discursive systems (Benjamin, p49 in Dimen, 2011) there are times when this stance does not elucidate the meanings and intentions which are so inextricably and implicitly bound up with these processes. Here I again turn to theorists such as Maroda (1991,1999, 2010), Stern (1994) and Bromberg (1998,2006) to inform how these might emerge within enactments. Thus a therapeutic impasse might create a window into our co-created and "unconscious embroilment with social ideology" (Dimen, 2011 p7).

Approach to Dysfunction

My discussion of the self, attachment, developmental and social contextual issues has centred upon processes which facilitate psychological health. This emerges out of the relational matrix of the brain-mind-body initially between significant carers and infant and then through attachment relationships throughout the lifespan held within a culture and environment that supports it. I now wish to consider ways in which an environment which threatens or severely impinges upon this developmental relational matrix may contribute toward derailments and the genesis of psychopathology.

As I have discussed emotional connectedness is critical to the formation of a secure base, As Holmes points out in dyadic relationships where this is restricted, exaggerated or uncoupled (Holmes, 2010 p35) the three variations

of insecure attachment emerge. These are identified as insecure/dismissing; insecure/preoccupied and unresolved/disorganised (Main & Goldwin 1998). These reflect variations of self and interactive affect disregulation which is argued are at the heart of both Axis 1 and Axis II disorders DSM-IV-TR (APA 2000) and critical to the "genesis of personality disorders" (Shore 2001a, 2002 in Shore 2007p10). Furthermore "Individuals at greatest risk of developing significant psychiatric disturbance are those with disorganised/disorientated attachment and unresolved trauma and grief" (Seigel, 1999 p119).

I hold in awareness that these variations of styles with respect to attachment are not fixed. They each exist upon a continuum and a person may have a variety of styles with different people or they may shift due to non therapist factors. I integrate this perspective with Johnson's (1994) humanistic framework which offers a map to further consider how derailments, occurring within critical developmental periods manifest upon a continuum from character styles to neurosis to character disorder. For example with a client who presents a dismissive style with respect to attachment I might turn to Johnson and the infant dyadic research I have discussed for a developmental perspective. This may lead me to explore the clinical literature on schizoid features such as Guntrip (1992), Yontef (2001). I simultaneously hold a relational analytic and dialogic frame as I attend to my client's implicit and explicit narrative, noticing what arises between us within the transference - countertransference. This offers a window into more nuanced disruptions within the early relational matrix which might manifest between us perhaps through mutual enactments, projective identification or impingements. As part of this integrating process, particularly when formulating an initial tentative hypothesis, I may also consult the DSM-IV-TR (APA 2000).

I have discussed processes which foster the development of the capacity for mentalisation and self reflexivity. When this gets derailed, through impingements or missatunements within the infant caregiver dyad, the infant will develop creative adjustments, congruent with their stage of emotional development. I consider that adult "pre-mentalising" states of mind such as "pretend " and "equivalence" modes of thinking (Fonagy et al. 2002) reflect these creative adjustments which "may persist in psychopathology" (Holmes, 2010 p5). Within my experience these states of mind frequently manifest with clients who present with substance misuse issues alongside dual diagnosis, particularly eating disorders, and borderline personality disorders. Within my model I integrate insights derived from Fonagy and Target (2002) alongside authors highlighted earlier in order to facilitate the development of mentalisation. Indeed research (Bateman and Fonagy 2008) indicates that mentalisation based therapy is effective in working with people with borderline personality disorders.

The Process of Change

"Dive deeply into the miracle
of life and let the tips

Of your wings be burnt by the flames
Let your feet be lacerated by the thorns
Let your heart be stirred by human emotion
And let your soul be lifted beyond the earth"
Pir Vilayat Inayat Khan

The words of this Sufi poem resonate deeply. They remind me that change is not just something my clients "do" or that I simply facilitate in them. It is a process in which I as the therapist am deeply involved at all levels of my being, body, spirit, mind, emotions.

I believe that as part of the therapeutic endeavour my heart will also be stirred by emotions my client "may need me to feel and express (in order) to find them acceptable and learn to do this for themselves" (Maroda, 1998 p82). My body may be symbolically "lacerated", through sensations and experiences for which there are not yet words; my mind open to challenge and be willing to venture into unknown landscapes, including its dark places and ideological blind spots.

Through this I am intimately involved in the change process which occurs within a context of a continual flow of "reciprocal mutual influence" (Stolorow and Atwood 1992 p3). I do not wish to imply by this that I regard the therapeutic relationship as mutually dialogic, my stance in relation to my client reflects a "one-sided

inclusion" (Jacobs L, 1991 p5) my primary focus is my client in which I utilise the multiple dimensions of my self experience to know more fully what they might be communicating.

I believe that the therapeutic relationship, in all its facets, unconscious, embodied, contextual, implicit, explicit serves as the most important conduit for change. This is consistent with findings from outcome research which suggests the therapist client relationship is the most significant factor for change. (Begin & Lambert, (78); Hill (89); Luborsky et al (1993); O'Malley et al 1983 in Lapworth et al 2001).

I now wish to turn to how I utilise the different dimensions of my model to facilitate the process of change over time. I have structured this largely through a discussion of the various dimensions of the therapeutic relationship. In practice I see these manifest as a rich and nuanced kaleidoscope. I may simultaneously attend to a number of dimensions at any one time shifting my awareness and focus within what Stern terms barely perceptible "micro-moments" (Stern, 2004, p240) interweaving between implicit, explicit, unconscious and contextual is a fluid dynamic process. Dimensions may be figural others ground dependent upon what emerges within our co-constructed dialogue.

I turn, in particular, to the relational psychoanalysts within my model who offer a common conceptual framework to consider the various interconnected dimensions of the therapeutic relationship. Ghent (1992) beautifully describes this interplay as stressing "relation not only between and among external people and things, but also between and among internal personifications and representations. It stresses process as against reified entities and the relations among processes all the way along the continuum from the physical and physiological, through the neurobiological, ultimately the psychological and for some even the spiritual" (Ghent 1992 pg xviii in Mitchell & Aron 1999).

Therapeutic Alliance

A strong evidence base exists for the efficacy of the therapeutic alliance in achieving positive outcomes, although I agree with Safran and Muran (2000) that distinguishing alliance factors from other dimensions of the therapeutic relationship is difficult to discern. Processes involved in the creation of a therapeutic alliance: affect attunement, consistency, reliability and the processes of rupture and repair, are equally involved in the creation of a secure base (Holmes 2001 p46). Within the initial phase of the work I focus on the establishment of both.

I consider rupture and repair of the alliance as inevitable and "as much about the work as are key changes and its resolution in music" (Holmes 2001 p32). It is a process which offers the possibility of expanding the co-created field, illuminating self states or offering "windows into relational schemas" (Safran and Muran 2000). Somewhat analogous is Stern's conceptualisation of "sloppiness" (Stern, 2004 p158) critical to the process of moving along, which I agree affords opportunities for "unlimited cocreativity" (Stern, 2004 p158).

Bordin's (1994) relational model emphasises the cocreated bond, goals and tasks of the therapeutic alliance. Included in this are the contractual dimensions within which I make the boundaries of the work explicit. These factors together contribute to a foundation of safety and containment, which as our relationship deepens help facilitate the cocreation of an internal representation of acquired attachment security.

During early stages of the therapeutic relationship, in which alliance factors are figural I may integrate subpersonality work, perhaps to begin to illuminate parts of self, achieve insight into a sense of "I" or recognise intrapsychic conflict. However, I recognise the limitations of this work in not attending to deeper unconscious process embedded within the relational matrix. I agree with Yeomans (1992) that this work, when conducted in isolation, with out regard for this deeper dimension "is palliative but incomplete in affecting personality change" (Yeomans, 1992 p2 in Firman and Gila 1997 p162). Similarly, I may also integrate task orientated methodology such as cognitive behavioural therapy particularly in my work with addiction or eating disorders. This serves to strengthen our alliance both through committing to shared goals and to the possibility of symptom relief. However in my view, cognitive behavioural

therapy, offered in isolation is unable to transform deep psychic and interpersonal systems which are relational in origin. I thus integrate this within a relational context in which I also remain mindful of power dynamics. For instance a client might negate her own wisdom, in preference to my perceived expertise or technical knowledge. This has the potential to disempower her whilst gratifying my own unconscious impulses which might be to impress, be useful or find answers. I attempt to counter this through my own self reflexivity and internal supervisor, maintaining an awareness of what Samuels refers to as the "micro politics" (Samuels, 2011, in Dimen 2011 p164). I see this as the interplay between both my own and my clients' power and vulnerability and need to be willing to explore this in relationship.

Work with Intrapsychic and Intersubjective Domains

As already discussed I integrate a dialogical, relational analytic perspective to inform my work within a "transitional space "(Winnicott 1970), holding a dynamic tension between intra psychic and intersubjective processes. I agree with Aron that within this therapeutic space my challenge is to maintain a balance between processes of "recognition and confirmation" of my clients' experience whilst preserving a space in which we can play with "interpersonal ambiguity" (Aron, 1991, in Mitchell & Aron 1999, p257). Similarly Bromberg speaks of the "playground" (Bromberg, 2006 p197) of a third perspective. "A space uniquely relational and still uniquely individual; a space belonging to neither person alone, and yet belonging to both and to each" (Bromberg, 2006 p197).

I attune closely to whether our explicit focus needs to be upon the internal world of my client or what is arising between us. Hycner and Jacobs (1995) refer to this as a tension between the "dialectical-intrapsychic" (Hycner & Jacob 1995 p11) which includes the internal dialogue between self as subject and self as object and the dialogical interpersonal, what occurs dynamically as "contact between " (Yontef, 1984 in Hycener & Jacobs p5) us . I again concur with Aron (1991) that a tension needs to be preserved between "responsiveness and participation on one hand and nonintrusiveness and space on the other". (Aron, 1991 p257).

The shared implicit relationship

Whilst it is something of an artificial distinction to consider the implicit distinct from explicit verbal domains, I do so in order to highlight the significance of this domain within the change process as part of the total gestalt of my model. I draw upon the Boston Change Study Process Group (2010) and Stern's (2004) work upon present moments to inform how I work with the nuanced, implicit, affective, interactive processes which "leads content" (Lyons Ruth, 2001, Boston Change Study Process Group p15). I am interested in "present moments" (Stern, 2004 p3) subjective experiences as they are occurring between me and my client. Like the worlds in a grain of sand I allude to at the beginning of this paper, they may later appear emblematic of the macrocosm. Stern (2004) proposes that a desire for intersubjective contact drives processes of moving along, through a series of co-created, unpredictable, sloppy trial by error improvisational moves. Change occurs through linking present moments creating new ways "of-being-with-the-other" (Stern, 2004 p219). These account for "the majority of incremental therapeutic change that is slow, progressive and silent" (Stern, 2004 p220). More dramatic "now moments" followed by a "moment of meeting" are seen as "the nodal events that can dramatically change a relationship or the course of therapy" (Stern, 2004 p 220). I give an example of this within my case study.

Transference - Countertransference Relationship

I regard transference dynamics as ubiquitous and involved throughout the therapeutic process. My perspective is drawn from relational analysts most significantly Maroda (1991, 1999, 2010), Mitchell (1998, 2000), Aaron (1998,2000), Bromberg (1998 ,2006) and Stern (2004) alongside those who integrate an attachment perspective such as Holmes(2001, 2010) and Fonagy et al (2002).

I work from an understanding that my own "self revelation is not an option, it is an inevitability" (Aron, 1998 in Mitchell & Aron 1999, p255). Through my accent, body language, preferences I implicitly and unintentionally disclose to my client who I am. They in turn are tuning in, subjectively preferencing and attending to dimensions of my self expression which clinical evidence suggests will confirm their own "particular interpretations of interpersonal reality" (Aron, 1996; Gill, 1983; Mitchell 1993; Renick 1999a, 1999b in Wallin, 2007 p176). From this perspective it follows that "enacting countertransference may be a precondition for recognising it" (Renick 1993 in Wallin 2007 p178). I discussed how I work with this in my section on trauma; within this context it offers the possibility that we might jointly expand our field of consciousness, affording opportunity for self awareness and transformation. In my view entanglement implies a deep, emotional engagement as the therapist. In this I draw upon Maroda, who quotes affective research to support her assertion the "emotional exchanges between therapist and patient are critical to the patient's growth and development" (Maroda, 1998, p85).

I believe, where possible, in the judicious use of explicit disclosure of my countertransference. I utilise my internal supervisor, supervision and therapy to adopt a self reflective stance. I agree with Holmes assertion that "mentalising informed use of countertransference is decentering and post modernistic" (Holmes, 2010, p30) and constantly question and reflect, moment to moment upon what I might be experiencing in relationship.

Concluding Comments

The developmental relational model of psychotherapy I present in this paper reflects where I locate myself as a psychotherapist at this point in my development. My theoretical weave is an integration of interpersonally informed developmental theories, contemporary relational analysis and broad based humanistic theory. This facilitates the creation of a number of interpenetrating lenses, through which I consider different dimensions of the therapeutic relationship. This framework deeply informs and guides my practice. Simultaneously I believe "there are more things in heaven and earth… than are dreamed of" (Shakespeare, Act 1 Scene V). I look to literature, poetry, dreams and art to illuminate both the deep mystery of the human condition and my profound sense of interconnectedness. This reminds me of the continual need to hold my theories lightly and be open to processes of not knowing, through which I may encounter another human soul with humility and grace.

"Except for the point, the still point, There would be no dance, and there is only the dance"

T.S. Eliot, Burnt Norton

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Film Review by Albert Zandvoort

Sabina Spielrein: A Pioneer of Psychotherapy

On 17 August 1904, Sabina Spielrein, a 19 year old Russian/Jewish woman was admitted to the Burghoelzli Psychiatric Hospital in Zurich, where she was treated by Carl Gustav Jung for Hysteria (Covington & Wharton, 2003). Jung uses Freud's treatment methods and Spielrein recovers well, moves on to medical studies, is involved in a passionate relationship with Jung and graduates as the first woman to obtain a doctoral degree in medicine with a dissertation on psychoanalysis: "On the psychological content of a case of schizophrenia" (1911).

In a letter to Freud on 4 June 1909, (Freud/ Jung Letters, Mcquire 1991) Jung refers to her as his first ' psychoanalytic test case' and tries to explain his romantic involvement with his patient. Freud responds on 7 June 1909 with a first mention of the concept 'Countertransference' and his own 'narrow escape' from erotic involvement with a patient.

After her graduation, Spielrein lived and practiced in Vienna, Berlin and Geneva, finally returning to Russia where she and her daughters were murdered by the Nazis.

Since the discovery of her diaries, letters and other writings in the cellar of the former Psychological Institute in Geneva in 1977, a number of articles and books have been dedicated to her life and work. (See selected references).

My own reading of Spielrein's work (Spielrein, 2002) clearly positions her as not just an early pioneer of psychoanalysis, but also as a writer and scientist who influenced both Jung and Freud, something both men admitted to in their later writings. She also became interested in neuroscience and child psychotherapy in later life and may very well have been one of the first integrative psychotherapists.

In this review, I would like to comment on three films made about her life: "My Name was Sabina Spielrein" (2002), a German-Swedish Production directed by Elisabeth Marton, the Italian production by Roberto Faenza of "The Soul Keeper" (2002), based on Aldo Carotenuto's publication of the abovementioned materials in 1982, and finally the latest blockbuster movie by David Cronenberg: "A Dangerous Method" (2011) with the screenplay by Christopher Hampton based on his play "The Talking Cure" which in turn is based on John Kerr's book "A Most Dangerous Method".

"My Name was Sabina Spielrein"

Elisabeth Marton worked seven years on this film and she has produced a veritable ode to a brilliant and complex woman who had been forgotten until the find of her documents. The film takes its title from Spielrein's 'Last Will' , where she requested that an oak be planted on her grave with the following plaque:: "I was also a human being once. My name was Sabina Spielrein."

The film starts with Spielrein's admission to the Burghoelzli Hospital, overlaid with a verbatim reading (in Swiss-German, subtitled in English) from Jung's original admission records.

Through the use of actual letters, interspersed with readings from Spielrein's diaries, Marton develops Spielrein's character in great depth, drawing the viewer ever deeper into her life story. In line with the latest research (Richebächer, 2007) the film is factually mostly correct and it is a pity that some of the more poignant scenes of the film are lost in translation. For example, the name Spielrein, used during a word association experiment connecting 'Spiel' and 'rein', is simply translated as 'fair play', rather than 'play clean' as opposed to 'dirty (i.e. sexual) games' which could induce feelings of guilt in children at the turn of the century. The crucial impact of this word association and Spielrein's psychological development is lost on many viewers. Viewers are, however, drawn into sensitively enacted scenes of Spielrein's youth, her early trauma and the effects of her father's ill treatment of her.

An important theme which appears in all three films is the impact of Wagner's "Ring des Nibelungen" on both Jung and Spielrein. Throughout her relationship with Jung, Spielrein wanted to have Jung's child, a child from her Siegfried, or Aryan hero. Finally, when she wrote her first scientific paper on " Destruction as the cause of being" she offered it to Jung as their spiritual child. (For more on this, I refer the interested reader to Lothane , 2007).

It is a pity that the film only offers a very fleeting reference to Otto Gross, who deeply influenced Jung's views on monogamy and his subsequent behaviour towards Spielrein.

The film takes us in a number of powerful black and white images to some of the places where Spielrein lived and worked – Zurich , Vienna, Berlin, and from there to Geneva where she worked with a young Piaget (whose training analyst she was). The narrator elegantly connects the mix of documentary and acted scenes, creating a coherent story of Spielrein's life.

Marton's film utilises contemporary images e.g. from Tsarist Russia, interspersed with new takes of historical scenes. But even these scenes have a timeless, dreamlike quality and create the impression of being shot while Spielrein was still alive. Many of the played scenes, e.g. the interactions between Jung and Spielrein are based on the actual correspondence between them. However, the film is clearly documentary based and the use of long distance shots sometimes removes the viewer from the actors in a way that is reminiscent of Berthold Brecht's alienation theatre – little room is left for cathartic moments and the viewer is drawn time and again into the historical/intellectual content of the film.

In the last minutes of the film, we see Spielrein moving to Moscow after the revolution, where she established herself as a pioneer of child psychology (long before Anna Freud and Melanie Klein). The film ends with her return to her hometown of Rostow on Don and a postscript indicating that her three brothers were executed by Stalin's secret police and she and her two daughters were shot by the Nazis.

The musical score of the film effectively supports the different phases of Spielrein's life i.e. Yiddish folk music to Wagner to Russian music , which, together with the title quote by Spielrein brings the story to a powerful and emotive closure.

"The Soul Keeper"

This is a docudrama based on the book by Aldo Carotenuto (1982), aimed at a wider audience than the previously discussed film. The docudrama genre is established very early with the introduction of two fictional researchers who meet in Moscow. The focus of the research is the period of Sabina Spielrein's work in the white nursery in Moscow, and the action moves between the frustrations of the researchers with the Russian librarians, acted flashbacks of Spielrein's youth and scenes of Spielrein as a young woman. The parallel story line of the developing relationship of the two researchers and their shared interest progresses the story line quite well and lessens some of the monotony experienced in the first film.

The crucial scene of Spielrein's admission and first session with Jung is portrayed with great compassion and is in line with Bleuler's (the famous director of the Burghoelzli) philosophy of care and acceptance, which was quite different from the harsh treatment culture of the day. In the course of her stay there is a powerful scene, where Jung has a dream that Spielrein may be in danger. He

wakes up, runs into the garden, finds her in a well and gently coaxes her out. This scene constitutes a shift in the dramatic narrative from darkness to the light and also moves the action to the stage where Spielrein has recovered sufficiently to be able to start her medical studies. The film now focuses very strongly on the development of the sexual relationship between Jung and Spielrein, which is also the time Jung offers her a stone which symbolises his soul. She thus becomes his soul keeper.

The regular use of the Yiddish/Russian folk song Tumbalalaika powerfully underlines the themes of love and spirituality and I have taken the liberty to quote two central verses:

"Girl, girl, I want to ask of you
What can grow, grow without rain?
What can burn and never end?
What can yearn, cry without tears?
Foolish lad, why do you have to ask?
A stone can grow, grow without rain
Love can burn and never end
A heart can yearn, cry without tears."

Although Spielrein herself refers to Jung as her lover and "poet" in her letters, there is quite a debate as to whether their relationship was sexual. (Lothane, 2007, Karger & Weismüller, 2006) To my mind, it is irrelevant if the sexual scenes are historically correct or not, since the boundary transgressions between therapist and patient are abundantly obvious from the historical material.

One of the weaknesses of this film, despite it being based on Caretonuto's book which includes the Freud letters, is the absence of any reference to Freud.

Overall, the Film portrays Spielrein in her later life as a strong and intelligent woman. Especially the scenes of her work in the White nursery honour her as a pioneer of Child psychotherapy.

Spielrein joined the Moscow Psychoanalytic Institute in 1923 and became involved with an ambitious new project in children's learning known as the Detski Dom Laboratory (which became known as the White Nursery due to the all-white furniture used). The nursery was intended to educate children based on Freud's theories. Use of discipline was avoided and children were allowed maximum freedom of movement. In one of the most powerful and emotive scenes towards the end of the film, Spielrein helps a young boy to start engaging with other children using animal assisted therapy.

At this point the historical chronology seems to unravel and time is contracted, leaving the viewer with a sense of emptiness. The use of historical actual footage is generally poorly juxtaposed with the acted scenes and is often experienced as quite jarring. It is also a pity that the actress who plays Spielrein still looks like 23 just before she is murdered by the Nazis (Spielrein was 57 at that point) whilst we see a Carl Gustav Jung aging well throughout the film. Historically the last scenes are incorrect, since Spielrein and her daughters were not killed in the Rostow Synagogue but, together with many other Jews, were killed by SS troops in a ravine outside the city.

Overall the viewer does not get entirely caught up in the drama. Several key sections are skimmed over: the background to Sabina's illness is never properly depicted and certain characters are sketchy, not least Emma Jung, who might as well not have featured, not to mention the total absence of Gross and Freud.

"A Dangerous Method"

This Hollywood film is clearly aimed at the widest possible audience. The three high profile actors portraying Spielrein (Keira Knightly), Jung (Michael Fassbender) and Freud (Viggo Mortensen) are in themselves a draw card and create high expectations for the film.

"A Dangerous Method" opens in 1904 with the arrival at Jung's Zurich clinic with Sabina Spielrein, manic and desperate, struggling with two attendants who try to constrain her. Jung is apparently her last resort. Using Freud's theories and methods, Jung has success in calming her, gaining her trust her and eventually liberating an intelligent and innovative mind.

Right from the start, a screaming Sabina Spielrein, who is dragged into the clinic against her will, provides the viewer with a powerful, visceral experience of 'hysteria" according

to Jung's initial observations as described in the original Burghoelzli hospital records:" Pat. Laughs and cries in a strangely mixed, compulsibe manner. Masses of tics; she rotates her head jerkily, sticks out her tongue, twitches her legs." (Covington & Wharton, 2003:85) What is not clear, is why Knightly, as the only actor, affects a rather strange and at times irritating German-Russian accent and for viewers not familiar with the original hospital records, the scene may seem vastly overacted.

The action quickly switches to the first session with Jung where he introduces her to the concept of psychoanalysis and begins treatment. The action follows the original historical records quite closely, building up a powerful tension between Jung, his wife and Spielrein. Using a dialogue-heavy approach, the film is skilled at the way it weaves theory with the inner lives of its characters. We are learning, yet never feel we're being taught.

The referral of Otto Gross by Freud to Jung is a pivotal scene in the film, played exquisitely by Vincent Cassel. Slowly Gross switches the roles and he seems to exert a great influence on Jung, espousing his theory of sexual liberation as the cure for many neuroses as is evidenced by the following quote: "It seems to me the measure of the true perversity of the human race, that one of its very few reliably pleasurable activities should be the subject of so much hysteria and repression." And, as in the "Soulkeeper", a strong emphasis is placed on Spielrein's and Jung's sexual relationship, which in this film is underlined by a rather graphic defloration scene followed by intimate scenes of Jung spanking and whipping Spielrein.

In 1904, Jung knew Freud only through his writings, but not long after, he travelled to Vienna to meet him, and their conversations in the film are a model of clarity and sanity and, initially, mutual adoration.

The tension between the two men mounts as their views conflict: Freud insists that sex is an underlying factor in every neurosis while Jung, interested in spiritualism and the occult, is disappointed by what he considers to be Freud's 'rigid pragmatism'.

The film portrays the intellectual love story between two men whose six-year collaboration would shake and shape modern thought, but whose temperaments, priorities and class differences would eventually drive them apart.

Overall, the film depicts the development of an intelligent and strong young woman on her journey to become a respected psychoanalyst and who develops the concepts of anima and animus as well as the death instinct long before Freud and Jung.

In conclusion, I would probably recommend "My name was Sabina Spielrein" for its historical correctness and "A Dangerous Method" for dramatic effect and Hollywood quality. "The Soulkeeper" is especially of interest to those wanting to know more about Spielrein's later life.

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