The British Journal of Psychotherapy Integration

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Differing Personal Perspectives on Integration

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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

Differing Personal Perspectives on Integration

Over the years we have moved between having a themed edition of the journal and a journal with a more free wheeling exploration of the diversity of approaches and attitudes to Psychotherapy Integration. A specifically themed edition has a dedicated Guest Editor who attends to the overall and explicit cohesion within and between, the articles of the journal in relation to the theme. Alternatively we, the Co-Editors of the journal, have collected articles from practitioners active in the field of Psychotherapy Integration in their idiosyncratic and individual ways. At some point in the collation of these articles into a completed edition of the journal, a linking thematic thread emerges.

This edition follows in the tradition of a more free-wheeling exploration of the diversity of approaches and attitudes to psychotherapy integration. What emerged as we studied these articles is the wonderfully and inevitably idiosyncratic take that each author displays on the integrative project. We appreciated the really personal investment combines with a professional critique that was embedded in each piece. Guy Timor speaks refreshingly of his personal journey as a beginning body-psychotherapist and his wrestling with the illusion of possible perfectionism. The candour and frankness with which he reflects on a piece of clinical work that marked the beginning of his practice will, we believe, prove an inspiration to beginners and seasoned practitioners alike.

Els van Ooijen writes a very personal reflective piece on the process of engaging with a Practitioner Doctorate based in her own clinical work. She conveys very well her struggles to find her own voice in the context of the requirements of a Doctoral Thesis. This article gives a rare inside view of a candidate's private 'messiness' in the process of producing what emerges as a very finished and polished project. We hope this will be supportive to other Doctoral and MSc candidates perhaps experiencing similar struggles with their final projects.

John Rowan, a well-established practitioner, philosopher and writer on varying aspects of the transpersonal in therapeutic practice has provided us with his current critical reflections on 'The Importance of the Centaur' and the developing true self in a well-researched piece of writing. We appreciated a freshness and accessibility in John's argument and style of writing, given the complexity of the material.

Ian Rory Owen provides an accessible overview of attachment dynamics both within and between therapist and client. This article can serve as an interesting lens through which therapists can assess their own attachment styles and the implications of these as the relate to clients with similar and different styles. This is particularly helpful in assessing the nature of a possible working alliance.

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

We also include two book reviews.

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.

Guy Timor

Humanising Perfectionism

Abstract

This paper introduces one of my earliest clinical experiences as a freshly-qualified body-psychotherapist, dealing with a theme that was significant and central from the beginning of therapy with the client. This case material endeavours to demonstrate ways in which the client's therapeutic journey assists in honing the therapist's therapeutic positioning and shaping his therapeutic identity.

Introduction

Notwithstanding theoretical understanding, for many psychotherapists, the first clinical years involve great difficulties in containing countertransference feelings, and moreover understanding these as central to the therapeutic relationship and the client's life. The capacity to 'get lost' within the transferential field (As Christopher Bollas, 1987, recommended) and only later process this information in therapy requires the therapist to be able to manage to observe his activated material surrounding his narcissistic injury. This is difficult to achieve except through acquiring sufficient clinical experience. The beginning therapist is thus doomed to be shaken and stirred en-route to softening his narcissistic wound and to therapeutically using his countertransference - effectively and generatively. Even though experienced therapists struggle with both the impact of their countertransference and recognising its relevance to the therapeutic work, experience, therapy and supervision usually result in a greater capacity to survive it, as well as to use it therapeutically.

This paper introduces one of my earliest clinical experiences as a freshly-qualified body-psychotherapist, dealing with a theme that was significant and central from the beginning of therapy with Sharon. This theme concerns an experience shared by many inexperienced psychotherapists at the beginning of their professional life: when countertransference material is uncontained by the therapist, powerfully confronting him with his narcissistic injury. Indeed, once outside of the training institute, the beginning therapist faces challenges that were (hopefully) contained and supported in the training milieu, having to self-regulate without the professional parental guidance.

I hope that this paper would assist newly qualified psychotherapists to be better prepared for the rollercoaster of therapeutic journeying, even though learning from other people's experience is limited in its very nature.

Sharon came to therapy at the age of thirty-five, flooded with anxieties and a sense of great emptiness, tending to dismiss her experiences and her feelings. She met me around the time of qualifying as a body-psychotherapist, and in a sense I felt (as a psychotherapist) as lost and scared as Sharon felt in her life at that time.

The therapeutic relationship with Sharon served as a significant platform for my own growth as a psychotherapist, and for Sharon – a significant platform for her

personal development and growth. This case material endeavours to demonstrate ways in which the client's therapeutic journey assists in ripening the therapist's therapeutic positioning and therapeutic identity.

The therapeutic work presented here was a journey of growth and blossoming. It was a journey of building trust and strengthening security in life and in human relations; a journey that felt, at times, Sisyphean, yet was not impossible to cross, as we were able to hold both hope and connection.

Familial and Biographic Background

Doing psychotherapy in Israel is a challenging business. We live in a country where personal traumas rest on national and multigenerational traumas. Every man serves three mandatory years in the army, every woman serves two. Exceptions are rare and position the person outside normative society. The cultural picture of Israeli demographic diversity is rich and interesting, yet outside the scope of this paper.

As a body-psychotherapist, I am particularly curious about the somatic (bodily) presentation of my client and body-reading serves as a significant part of the diagnosis and initial intake. Sharon looked highly armoured and tense, especially around the shoulder-girdle and trapezius. She seemed powerful and ready for action, yet at the same time carrying great weight, and she was exhausted. Her hair was carefully tightened and kept in place, as if it was committed to order and organisation and would not go wild.

This muscular holding could be understood in body-psychotherapy as hinting towards a masochistic character-structure. It means that the muscular holding may point towards fixation at a stage where object-relations becomes more significant, and the child struggles for its right for freedom, for her free-will and acceptance of who she is without losing connection (Ziehl, 2000). Parental-children (role-reversal, Main & Cassidy, 1988) frequently manifest, in their very bodies, the sacrifice of themselves for the other (and consequently the limited capacity to feel their own needs). Such body expressions may manifest in high muscular-charge around the shoulder-girdle, upper back and buttocks (ibid).

Sharon owns a business of corporate consulting. She is the oldest of three siblings. She considers her brother, five years her younger, to be close to her heart, whilst she has very little contact with her younger sister who lives abroad and who was diagnosed as suffering from borderline personality disorder. Both Sharon's parents are retired. As a child, her mother was abandoned by her parents and was raised in an orphanage. During her twenties, the mother had a nervous breakdown and was admitted to a psychiatric hospital.

Sharon's father is considered the underdog in his family. Physically disabled, he had suffered a great deal of bullying, mocking, criticism and neglect from his entire family in general, and particularly from his mother.

Sharon grew up in a dysfunctional home – her mother did not know how to function as a mother. There was scarcely any physical contact at home, and Sharon shared how they often did not have warm food to eat and the house was always messy and dirty, failing to provide the basic needed security of a holding environment. Her father tended to criticise her and complain most of the time, forever choosing to see the half-empty glass. Sharon felt she was never good-enough for him. Growing up, Sharon had no positive, significant or good-enough attachment figure.

According to Sharon, she was desperately missing being listened to, being seen and cared for. Her memories are of loneliness and insecurity. She spent a lot of time in solitude, occupying herself with her dolls and make-believe games. Highly creative and arty, Sharon is ambitious and driven to success and independence. She is highly sensitive, and tends to perfectionism with a strong expectancy for getting things right, alongside judgement when she fails to meet these demands for perfection. These aspects match the masochistic character-structure bodily diagnosis. Sharon described herself as somewhat obsessive for order and cleaning, since everything has to be in its right place. She reported a single good period in her life, when she felt free and open, around the time of her mandatory military service. In terms

of relationships, Sharon spoke of one long-term (four years) relationship where she occupied a placating position and kept sacrificing herself for her partner. She came to therapy wishing to commit to a personal development process.

The Narcissistic Wound of the Beginning Therapist as Potentially Obstructing the Working Through of Countertransference

In her book "The Drama of the Gifted Child," Alice Miller (1981) says: "It is often said that psychoanalysts suffer from a narcissistic disturbance… His sensibility, his empathy, his intense and differentiated emotional responsiveness, and his unusually powerful 'antennae' seem to predestine him as a child to be used—if not misused—by people with intense narcissistic needs" (p.22).

What Miller is arguing for, is that many psychotherapists share personality and biographical traits allowing them to sense, experience and respond to the narcissistic lack of their clients, later attempting to satisfy those deprivations and meeting these needs.

The sensitive therapist who is appropriately attuned to his clients, experiences in his own person many sensations, feelings and emotions, which he perceives through his interaction with the client. However, as a beginning psychotherapist, he oftentimes suffers from an inevitable insecurity, which is grounded in his lack of clinical experience. The beginning psychotherapist is as yet unfamiliar with himself as a therapist. He is not yet accustomed to the complex skill of processing his own feelings "live" during the therapeutic process, nor is he skilled in differentiating his own feelings from those transferred on to him within the therapeutic encounter. Unravelling transference dynamics arguably requires not only experience as a client whilst in training, but also acquired therapeutic experience. As a fresh psychotherapist, he might tend to interpret many of his inner processes through the lens of his 'narcissistic-wound-glasses.' Internal dialogues common to those stages might sound like that: "What should I do now with what the client is feeling? What does this difficulty, which has just emerged, say about me as a therapist?" This position is challenging to the ego-strength of the therapist and is often accompanied by helplessness - feeling so much and understanding so little. I believe that every beginning psychotherapist is faced with similar situations, each in his own way and in accordance with his personality. One therapist will placate, another will deny; one therapist might project these feelings back onto the client and yet another will continuously rationalize. In common to all these ways of responding is the difficulty in processing and containing countertransference, which is relevant to, and in dialogue with the client's inner-world, without feeling so lost inside them.

Freud's initial approach to understanding countertransference was that the therapist attributes to the client characteristics which belong to the therapist's significant attachment figures. Therefore, this transferential process hinders the therapeutic progress, requiring the of the therapist the scrutiny of self-analysis, supervision or attending psychotherapy himself.

Forerunner of relational psychotherapy, Donald Winnicott, understood countertransference as a highly useful phenomenon, assisting the therapist in extracting the implicit meaning of the therapeutic material. In fact, Winnicott (1949) was among the first analysts to acknowledge the potential contribution of countertransference to the therapeutic process. Winnicott (ibid) considered the unique personal and biographical characteristics of both therapist and client, which may together shape the nature of the transference dynamic and constrict, or indeed contribute to, the therapist's professional conduct in the therapeutic situation.

Winnicott therefore differentiated subjective and objective aspects within the countertransference phenomenon. In the subjective aspect, there are some unconscious components which may obstruct and hinder the therapeutic process and other elements which, once brought into consciousness and processed, could serve as catalysts in progressing the therapeutic process.

According to Winnicott (ibid), countertransference does not always merely signify aspects of the therapist's subjective experience. Instead, a significant part of countertransference material is projected from,

and in dialogue with the client's inner model of the world. In fact, through this transference the therapist might better understand and become familiar with his client's inner world and the nature of their constructed therapeutic relationship from inside out. Winnicott's views are widely accepted today, and have been developed in attachment theory, object relations, relational psychoanalysis and other areas (e.g, Pizer, 2006; Searles, 1979; Soth, 2005).

Wilson and Lindy (1994) expanded on the differentiation between subjective and objective countertransference. Subjective countertransference describes a personal reaction to the client's material stemming from the therapist's own unresolved biographical conflicts and his unique life-circumstances and as such is arguably unrelated to the client's inner world. Objective countertransference, on the other hand, is an expected (responsive) emotional or cognitive response, where the therapist's experience is in accordance with the client's character, behaviour and biographical traumas. Objective countertransference therefore describes ways in which the therapist 'feels' the client through his own responses. One may even argue that these two aspects are forever interacting with one another, rather than hermetically differentiated.

The beginning psychotherapist would inevitably identify with his objective countertransference. Due to his narcissistic injury (As Miller, 1981, described) he might tend to placate and pacify, mistakenly believing that the client's emotions are caused by him. This tendency for identification, while serving as building blocks for empathy, nonetheless prevents the therapist from creating the necessary differentiation between himself and the client, making it difficult to occupy an empathic stance, which would in turn allow for understanding and genuine containment of the client's emotional world.

Body psychotherapists are trained also to listen to countertransference phenomena as these manifest in their own body responses. Sometimes sensations like tiredness, agitation, breathlessness or even locked jaws may hold precious emotional information about the client and the unravelling relationship dynamics. When the therapist learns to relate to such sensations as worthy of checking with the client, rather than as obstructive personal sensations, such information may prove highly valuable for the client as well as for the therapeutic relationship. However, somatic (bodily) countertransference frequently presents itself with such potency and immediacy, that it can easily surprise and confuse even the experienced therapist. It is extremely difficult (if not impossible) for the beginning therapist to acknowledge and understand that their bodily reactions are immanently relevant to their therapeutic engagement and to their client's inner world.

In the case material below, I shall describe the feelings and sensations I felt with Sharon during the beginning of my practice as a body-psychotherapist. Naturally, my professional self-esteem was neither stabilized nor grounded at that time and my neurotic need to placate dominated my clinical decisions. I struggled to differentiate subjective and objective aspects of my countertransference, or indeed believe that the turmoil I regularly experienced might at all be connected with my client's experience.

The Beginning

During the initial consultation, Sharon spoke of her feelings of emptiness. She told me how such feelings would have usually resulted in her making a big life-change or in travelling to India, which she dearly loved. This time, however, she decided to stay and face her feelings. Sharon spoke of feeling pressure to always be in full control of her life and expressed a yearning to let go of such tight control.

Throughout our first meeting I felt frightened, struck by dread and helplessness. Not knowing how to deal with the flood of emotions, I chose to invite Sharon to do some breathwork and move her body, in ways that encouraged embodiment and in the hope of releasing some of her muscular tension. My clinical rationale was probably accepting Sharon's request to let go of control, but naturally (for me), the choice of working directly with the body also served to relieve my own fear and helplessness, as it was within my comfort zone and allowed me to 'do' rather than to tolerate the painful emotional material, which accompanied the session. While

engaging in explorative movement, Sharon felt increasingly anxious as past memories started to emerge. Sharon recalled a Vipassana meditation retreat and another workshop she attended. At this stage we slowed her movement down and came back to sit and talk, and Sharon shared her memories with me.

In the third session, after Sharon spoke about her current birthday experiences, we both fell silent and I immediately felt embarrassed and pressurized to do something. I was ready to suggest that we moved to do bodywork, but then remembered that this was my default response at these moments. I stopped, listened to my body, and noticed just how much fear I experienced. This time I decided to share this information with Sharon and she easily identified with this feeling. She claimed it related to the attentiveness with which I was listening to her; in her childhood-home nobody ever listened to her. This was the first intervention where I was able to offer a partly-processed aspect of my countertransference, and to therapeutically use my countertransference experience.
An important part of my development as a therapist involved moments where I dared to reflect my body sensations to Sharon, gradually discovering how much my own body sensations offered Sharon, a resonating experience into her own world. Consequently, my capacity to recognise and acknowledge my somatic countertransference increased with the accumulated experience of its relevance.

Later in therapy, Sharon described her tendency to belittle herself in relationships and take less and less space, practically giving herself up. She feared it might sabotage her current romantic relationship (she was in love). At the same time, I felt how the different voices inside me were 'having tantrums': each time anxiety or helplessness appeared in our connection I became paralysed. I did not know what to do. All I heard was an infinite voice inside me nervously asking: "what do I need to do? What do I need to do? What do I need to do?" Whenever strong feelings emerged in therapy they were followed by dissociation and I found myself blaming myself for being disconnected and for obstructing Sharon's emotional expression.

Sharon arrived to the next session after she and her boyfriend separated. She blamed herself for the break: it was because of her (of course) – as she emotionally overwhelmed the men in her life, leaving them no choice but to end the relationship. She felt "damaged and broken." Once more, Sharon needed to face her family's expectation of her, waiting for her to get married and provide them with a grandchild. As for me, I still failed to notice the connection between our inner voices – how that which had taken place within me was astutely relevant to Sharon and deeply affected by her as well.

One day Sharon feels broken and I place my hand over her back. She reports feeling secure and supported and collapses with a deep sob. I leave the session feeling that I managed to give Sharon support and holding. My narcissistic wound is slightly soothed, I managed to become meaningful.

During another session I occasionally felt stuck – both in the therapeutic process, and in our communication. Not knowing what to do, I opted to my default insecurity of feeling I was not good enough as a therapist. I felt that Sharon left the session unsatisfied and feared she would leave psychotherapy.

Interestingly, two days following the session Sharon phoned me, expressing her need for more support and asking if I would see her twice a week, instead of once weekly. In her experience, it was the first time for her that somebody supported her, was able to be present and committed to seeing her. She was so unfamiliar with such experiences. I dreaded the responsibility and commitment; I feared it might be too much for me.

From my current clinical perspective, it is easy to see the dissonance between my experience of a highly limited psychotherapist, forever feeling not good-enough and furthermore believing I 'sabotaged' the therapeutic process, and Sharon's experience, that my listening to her and being with her were highly meaningful and transformative for her. This dissonance assisted me in processing my narcissistic wound – it forced me to confront my distorted perception of reality and to recognise countertransference material.

But inside the sessions I still struggled. Every time silence occurred in our communication and dialogue, I would get stressed up and felt that the therapeutic process reached an impasse, was untouching and lacking of meaning for Sharon. I would then experience abandonment anxiety. At the same time, Sharon expressed her fear of abandonment in relationships. In hindsight, my own struggle held important information about the intensity of our unconscious communication dynamics, and the difficulty to remain in 'adult'.

Throughout this stage of our process together, I maintained a therapeutic stance/attitude that repressed emotions require expression and release. I tried, through touch, movement and voice, to evoke cathartic processes with Sharon. Usually these resulted in Sharon's feeling despair, failure and pain. She self-deprecated and felt damaged.

In body-psychotherapy repressed emotions are oftentimes understood to be held in the body, not only creating psychic blockages but also manifesting in muscular tension which obstructs the natural flow of life-energy (libido). The cathartic approach in body-psychotherapy postulates that bodily expression of such feelings may restore the flow and resolve both physical and psychic pain. This type of work characterised the early stages of body-psychotherapy (Lowen, 1958, 1975; Reich, 1973), as well as my initial training in body-psychotherapy.

Looking at the work we have done from my present clinical understanding, I can see how the attempted cathartic work with Sharon resulted in her repeating past experiences where she faced great expectations to succeed, to placate and satisfy her parents', particularly her father's, wishes. These expectations easily resulted in her feeling not good enough or not trying hard enough, increasing Sharon's self-criticism and eventually ending in anxiety and depression.

However, when I managed to let go of my cathartic attempts, when I approached Sharon more gently and provided her with present, supportive touch, it was I who felt she left therapy unsatisfied and that I had not given enough or was not good enough, and appropriately – I developed abandonment anxiety.

Incorporating touch in psychotherapy is a topic deserving a separate platform, and I shall therefore only briefly discuss it here. A significant part of my training in body-psychotherapy included the therapeutic use of touch. Physical contact in psychotherapy can be supportive and containing, similar to the touch used by Ferenczi (1920, 1925; Kertay & Reviere, 1993) and by Winnicott (Totton, 2006). It may also be a way for embarking on joint exploration, for amplifying affect or as a part of establishing and affirming the therapeutic relationship (touch as relational affirmation – King, 2011).

Sharon expressed great desire for excellence and perfection, in her attempt to satisfy her parents' existential and unprocessed needs. At the same time, she lived with her own unattended needs – for touch and parental presence. Whatever she gave her parents – it was never sufficient; whatever she received from them was never enough either. When I felt the impact of her existential needs I reacted with my own unprocessed wounds. Therefore, instead of helping Sharon to contain and understand the feelings she brought into therapy (and transferred – allowed these feelings to be alive in the therapeutic field) as powerful projective identification, I simply identified them as my own unattended wounds.

My supervisor at that time encouraged me to focus on my basic 'good-enoughness', telling me that my positive feelings for her were essential and curative. At the same time, I started dealing with my difficulties with therapeutic silence. I was more able to listen to the fears and anxieties I felt during therapy.

Sharon asked for more touch in therapy. She felt that it benefited her and strengthened her. It also increased her fears of feeling weak and young, needy and dependent. The Body-psychotherapeutic work with the masochistic character structure (Ziehl, 2000) may involve melting of the muscular armor to allow the oral neediness at its core to surface. We worked with supportive touch, where I was much more at home and therefore more capable of tolerating and processing my countertransferential experiences.

Sharon explored the many emotions and feelings that were present in her body. I no longer tried to amplify them cathartically. I was there, with her, at her own pace. This pace was slower. Sharon noticed her harsh self-deprecating criticism. She identified a voice telling her how ugly and fat she was; a voice that instructed her to stop breathing and obstructed the flow of sensations and emotions she was experiencing. Alongside this, another voice emerged – one that encouraged her to move, to liberate herself, to be herself.

Growing Together – from Doing to Being

Sharon met a new man – Dan.

She asked that we did less in therapy and that we spent more time being together; she asked for more presence. As we worked with touch in a sitting position Sharon began to recall strong memories of deprivation. Mum was dysfunctional; the refrigerator was empty. "Despite the Sisyphean work," says Sharon, "therapy is really good for me." She feels how something in her rigidity loosens.

At his stage, approximately eighteen months into my clinical work and about a year since starting to see Sharon, and thanks to supervisory and therapeutic support, something in me began to stabilise too. It seems that there was a greater differentiation between us, and I was less activated by my own unprocessed material and therefore more able to see Sharon's feelings and needs as separate from my own.

Many of the difficulties in therapy, and indeed the negative transference, occurred at the outskirts of our work and involved breaking of setting. Sharon left therapy and returned, time and again, to reflect her difficulty to witness her neediness – and the limitations I could offer for meeting those needs.

The therapeutic process with Sharon continued for three more years, during which she married Dan. Sharon further faced her deep childhood emotional deprivation. Her tendency to expect herself to perform and function perfectly and almost inhumanly brought her to the verge of collapse and kept her constantly exhausted and fatigued. In contrast to her internalised self-criticism, Sharon experienced me as an attachment-figure who accepted her as she was, and who continued to be with her despite her imperfection. During therapy, she oftentimes fell into the "not-good-enough and not trying hard enough" pit, but she utilized therapy – and our connection - well to emerge out of these painful places. Sharon said she neither felt she had to placate me, nor to be strong or successful for me. She was able to internalise me as a secure, positive and good enough attachment figure.

I, too, was less reactive in psychotherapy. I recognised my insecurities (my own narcissistic wound) and became less activated by it, although I still occasionally stumbled into my familiar "not knowing enough" and "not being good enough." This period in therapy was highly influenced by my training in Focusing (Gendlin, 1978, 1998) and traumawork (Levine & Frederick, 1997) and was characterised by explorative, safe and supportive touch (Totton, 2006) and a much slower pace. At that time I was still not fully able to perceive just how important the positive therapeutic relationship was for Sharon, and that it was in fact our relationship and not the therapeutic techniques that served as the axis around which therapeutic progress was formed. Alongside therapeutic interventions and 'doing' (which was mostly beneficial), we have formed a loving, attentive and accepting transferential parental relationship. It is my belief that our work offered corrective and reparative experiences to Sharon that enabled her to internalise healthier objects, thus contributing to her capacity to form good, functioning relationships.

Sharon's personal life transformed. She was more able to confront others and express her anger when she felt wronged. She allowed herself to be imperfect.

"In an Imperfect World, it is ok to be Imperfect."

Sharon got pregnant. During this turbulent time, she dealt with anxiety and fear of ending up like her own parents. She oscillated between drowning within the trauma vortex and attaching and reconnecting, time and again, to the healing vortex. Our work was more grounded in the 'real' world and we strengthened her and connected her to

every resource and positive power existing in her inner life, outer world and within the therapeutic relationship. Sharon did not arrive to our last planned session due to her giving birth. In a phone conversation following labour, Sharon shared with me how natural, smooth and organic she experienced the transition into motherhood.

Summary and Conclusion

Countertransference feelings belong not only to the therapist's unresolved issues as Freud assumed at the beginning of his career, but also carry deep and significant emotional charge from the client through to the therapist. The experienced psychotherapist is more likely to recognise when his emotional response to his clients touches his own wounds and is able to utilize personal psychotherapy and supervision to process such material. He is also more able to recognise when such emotions are part of the client's transference dynamics, and dialogue with the client to properly use it therapeutically.

The beginning psychotherapist is highly limited in his capacity to make such differentiation. He lacks perspective; he lacks experience and clinical-mileage to base such distinctions on and properly differentiate the two. The beginning therapist is likely to suffer anxiety and unavoidable emotional flooding and is prone to dealing with such phenomena through self-blame and self-criticism, repression, rationalisation, overdoing – in short, defensively.

I clearly recall the day when I first felt (not simply understood) as a transferential object; when I first experienced how the client transferred on to me material that was only loosely connected with the person I was. It was a day of clinical and personal growth. My biographic material was sufficiently processed and contained by me, allowing me to feel and observe my turmoil without being activated by it personally. A differentiation was attained, no more placating… (for now).

The ripening process of a psychotherapist is time-consuming, requiring the therapist to keep his countertransference in check by sharing it in his own therapy, supervision or in peervision. This sharing may enable him to work through the necessary process that would later allow him to develop his clinical identity. One of the greatest obstacles for an appropriate use of therapy and supervision is the shame that frequently accompanies this early stage of clinical practice, and fears that exposing such emotions will consequently unravel his limitations (and being not-good-enough as a therapist). Who would want to see such a therapist? We may argue that the therapist's narcissistic injuries and perfectionism, damages him for the second time. So, paradoxically, narcissistic injury both enables the empathic (therapeutic) position and limits it at the same time.

Despite all that was said in this paper, it is important to note that while the beginning therapist is very limited, he is still able to conduct successful therapeutic processes, and support meaningful developmental growth for clients and the therapist alike. Experience cannot be acquired other than through practice and most therapists receiving sufficient personal psychotherapy and adequate supervision will learn to contain their narcissistic injuries, allowing them to process objective countertransference emotions. The fact that many therapeutic processes are valuable even when the therapist is inexperienced is a good reminder that attentive and accepting presence potentiates meaningful processes – a good enough journey (i.e. that love transforms).

I have been fortunate enough to have a few clients who remained with me throughout the very beginning of my clinical work, enabling me to ripen and develop alongside them. Sharon's therapeutic process formed an important aspect of my ripening and maturation process as a therapist. The more centred and stabilized I became, the more I was able to assist Sharon in dealing with her life. I thank Sharon for her commitment, endurance and presence throughout the entire time.

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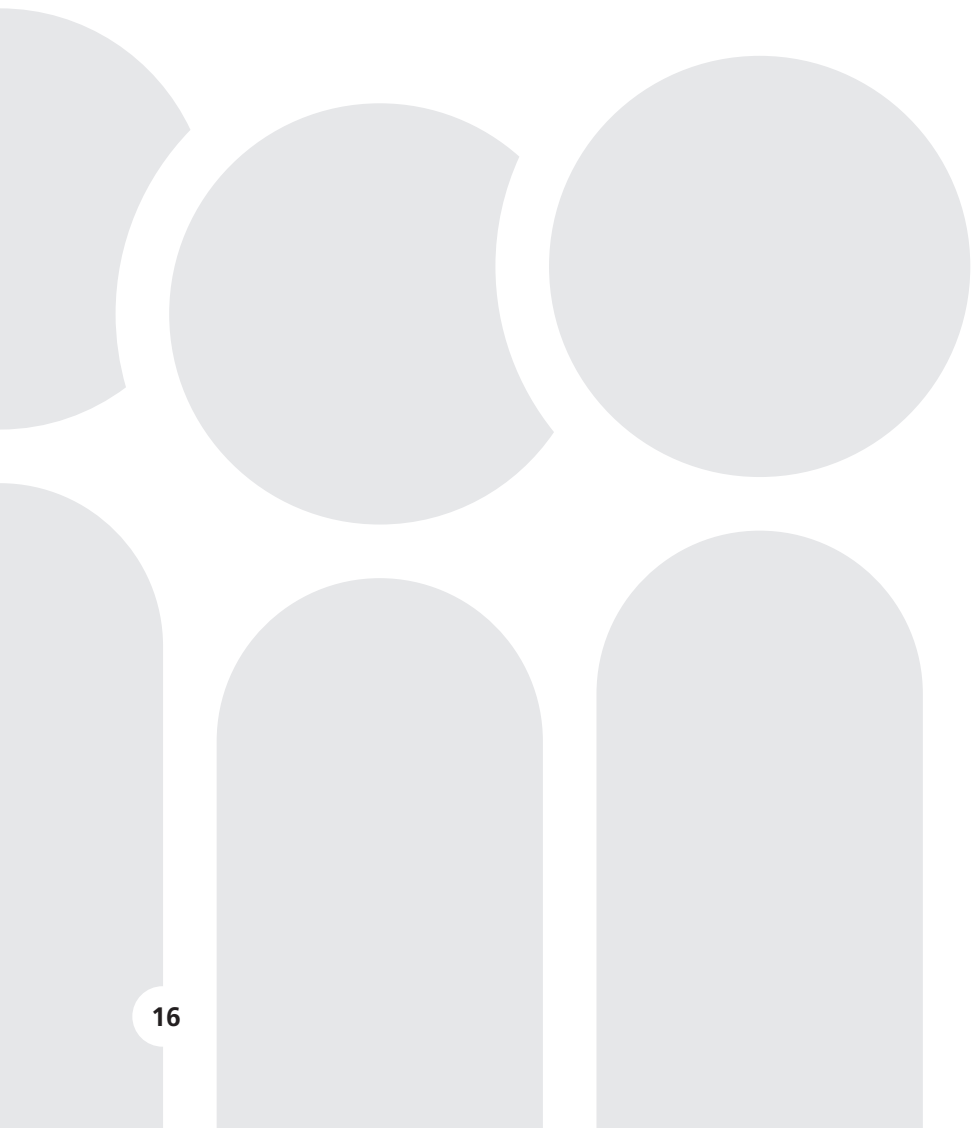

Els van Ooijen

Healing Past Hurts: Reflections on a Practitioner Doctorate

Abstract

The idea for this article came from a talk I gave recently at a research conference entitled "Remaining Inspired" at the Centre for Counselling Research, University of Wales, Newport, which prompted me to reflect on what I gained, both personally and professionally, from my experience of the practitioner doctorate programme at the Metanoia Institute, London. I aim to demonstrate the intricate links between researcher and research project, how personal core beliefs can influence the work, and how deeply therapeutic and integrating practitioner research can be.

Introduction

I heard about the development of a practitioner doctorate at Metanoia in the mid 1990s. At the time I lectured at two universities, was involved in the management of a small counselling agency and saw people privately for counselling and supervision. My person-centred counselling training had mainly focussed on brief work, but I became increasingly interested in working more long-term. So I decided to leave the doctorate until later and embarked on Humanistic and Integrative Psychotherapy training at the Bath Centre for Psychotherapy and Counselling. I had hoped to access the training half way through, but was required to start in the second year, to catch up with the psychodynamic element of the course. This was a confusing time, as throughout the year I was a student one day and a teacher the next. Inevitably I began to feel deskilled and patronised until at some point I could hold it in no longer and 'let them have it', telling the tutors exactly how I felt. I assumed that I would be thrown off the course and frankly, I no longer cared. To my surprise as well as relief, they met me head on, which was hugely liberating.

The BCPC training is long and thorough, so it took me seven years to emerge with an MA. During this time I had not thought much about the doctorate. However, no sooner had I handed in my dissertation and case study, than the post brought news from Metanoia that there were still vacancies on the next intake. I saw this as serendipitous, applied, got in and was on my way a few weeks later.

Although I do give a brief account of the actual research project, my main purpose in writing this article is to convey what the experience was like for me, and how it has helped me to feel more integrated, both personally and professionally.

The Structure of the Doctorate

From the interview onwards I loved my time at Metanoia. It was such an antidote to the inevitably infantilising experience of being a student. Here we were seen as experienced professionals whose research was likely to be valuable to the therapeutic community at large. Practitioner doctorates are different from

traditional PhDs in two important ways: firstly, work based on previous Masters research that is of a sufficiently high standard may be counted towards the doctorate; secondly rather than remaining 'objective', practitioner researchers are required to place themselves firmly in the centre of the research (Etherington, 2004; Barber, 2006). Our first project was therefore a 'review of personal and professional learning', in which we identified our professional capabilities, traced back their development and discussed how we utilise them in our work.

The exercise was very grounding, but made me realise that I have a tendency to hide my light under a bushel, as deep down I believe that if I flourish others will suffer, and so expect to get punished when I do well: a core belief developed when very young (I'll call it my 'gremlin' from now on). Like many professional caregivers my background is that of a "parentified child" who tends to feel responsible for others, is the "good child" and tends to try to mediate between people (Lackie, 1983). As the eldest of five I assumed a caretaking role from an early age, looking after my four siblings as well as my mentally and physically fragile mother. By the age of six I had concluded that authority figures do not always know best and could not be trusted to keep me safe (Bowlby, 1969, 1980; Ainsworth et al. 1978). This made me an independent thinker who never takes anything on authority, yet at the same time there was a desperate need to be seen and valued as a person, not just as someone useful. Buried deep inside me was a fear of being found out as the fraud (Casement, 2006) I felt myself to be. Years of therapy have helped me to feel much more solid, yet somewhere within there is a sense that it is not quite enough and perhaps never will be.

The Doctorate as a Game

Recognition and Accreditation of Learning (RAL) were two large projects in which we were asked to demonstrate evidence of Masters level work (RAL4) and doctoral level capability (RAL5). On reading the course handbook I was struck by the description of the doctorate as a game. "OK", I thought, "if it is a game I'd better learn the rules." Initially I didn't get it, however, and assumed that all I had to do for the RAL4 was to produce a glorified CV. On being told that this was not quite what was required I suddenly clicked, "aha, so the whole programme is a continuation of our professional efforts to date, and every piece of work follows on naturally from the one that went before." This made so much sense that I found it hard to understand why I did not 'get' this before. On reflection I realised that this was because I don't really value anything I've done….my gremlin in action again! It was a salutary realisation that this old issue was still alive and well, even after many years of personal analysis!

Given my tendency to hide and undervalue my achievements I was bowled over when told that my RAL4 submission was of sufficient standard to count as RALs 4 and 5. This valuation of my previous work was immensely healing, particularly as I had not received much recognition before.

Previous Research

On the first day Professor Derek Portwood told us "You began this doctorate years ago!" What a great thought. On going back more than twenty-five years, to the start of my research journey, I discovered that he was right, and that two related themes that continue to occupy me were there from the start: the issue of meaning; and the dichotomy between different paradigms.

Originally I qualified as a nurse, which I now realise was an attempt to create meaning in my life and receive care vicariously by caring for others. I became interested in the contrasts between caring and curing, and carried out several research projects for a Dip. Nursing, a Dip. Counselling and an MA in philosophy. I found that doctors, as well as many nurses and other health workers, were often aware that they focussed on the curing aspects of their work at the expense of caring, because they feared becoming emotionally involved and unable to cope.

For a PhD in psychology I further developed a model of nonverbal behaviour, for which I wanted to carry out observational studies in normal social situations. Although this was within the positivist paradigm (Barker, Pistrang and Elliott, 2002:55), my supervisor vetoed this idea, as not 'scientific', insisting I

do 'experiments' under laboratory conditions. Although this helped me to become well versed in the experimental method and quantitative data analysis, I became concerned about the study's limitations, as despite being statistically significant, many results appeared random and meaningless. Then, towards the end of the three-year scholarship the original author of the model I was researching published an improved version. It was similar to my ideas and backed up by the kind of research I had wanted to do in the first place! I felt that my work was now out-dated and somehow my supervisor blamed me! Thoroughly disillusioned I gave up the PhD and went back to nursing. For me this felt like a huge failure that would take me many years to come to terms with. It also confirmed my gremlin: I felt that I had been selfish, too big for my boots and got what I deserved.

Paradigm Shift

Although the abortive PhD was a long time ago, it was helpful to reflect on the experience. For me there was a dichotomy between wanting to understand people and the (at the time) modernist paradigm within psychology that valued objectivity, and thus seemed to preclude such understanding. I realised that my personal research journey has been one of living though a paradigm shift (Kuhn, 1962); it tracks the various movements within research and the helping professions, from positivist, 'scientific' research, where the researcher stands outside and 'objectively' looks at 'subjects', to a more phenomenological kind of enquiry. Kuhn showed that even in science there is no 'absolute' knowledge, as the way 'facts' are interpreted changes.

My experience confirms that we cannot divorce ourselves from our research activities, no matter how much we try. I see a link with my psychotherapeutic stance, which has much in common with Derrida's idea of 'difference': the notion that the meaning of each thing is not fixed, but determined by its relation to everything else, in an ever-changing, multi-dimensional web of meaning (Derrida, 1978). Who I am is continually shaped by my experiences and affects how I am with clients and how they experience me.

The Doctoral Research Project

Choosing the Topic

Originally I had planned to carry out action research into the development of a integrative counselling course. When I discussed this with my academic supervisor she commented on my lack of passion. She was right to do so as I have developed quite a few courses in my time, and to do so again would not therefore present a great challenge.

My reflections for the RALs, however, sparked a new idea. Why not research my own therapy practice, particularly as the doctorate had been set up with that idea in mind? I had just graduated as a Humanistic and Integrative psychotherapist, but what, I wondered, does this actually mean in practice? The first years of the Integrative training had been dominated by psychoanalytic theory, followed by an introduction to intersubjective and body-based approaches. In addition to my original person centred counselling training, I had also undertaken courses in Somatic Trauma, Gestalt, Jungian and Core Process (mindfulness-based) therapy. How, I wondered, was I integrating these different approaches, both at the level of theory and in practice, given that their philosophical underpinnings vary widely? By inquiring into my own practice, my lived experience as a therapist, I wanted to develop my own way of working and deepen my clinical acumen. I do not believe that experience alone is enough, but that it is our reflection on the experience that provides the learning (Schon, 1983). I therefore formulated the research question as follows:

> *How am I developing an integrative way of working, both through the moment-by-moment decisions made during the therapeutic process and through reflection?*

Basically the research involved a tracking of the development of my internal supervisor through deep reflection. As such it was a continuation of previous work, which resulted in two books on supervision (van Ooijen, 2000, 2003).

First I will briefly outline the actual study, before discussing what the process was like for me.

The Study

I used a heuristic methodology (Moustakas, 1990), which has six phases: initial engagement, immersion, incubation, illumination, explication and creative synthesis.

Initial engagement: I chose the research topic and developed a Learning Agreement (the research proposal).

Immersion: I wrote the literature review, developed the research protocol and carried out a pilot study. Next I collected the data as follows:

For eighteen weeks I reflected deeply on my work with three clients through "within method triangulation" (Robson, 1993), involving a variety of data collection methods:

1. Five minutes mindfulness before each session. This was already part of my normal practice and helps me get a sense of how I am feeling and creates a space to receive the client.
2. Detailed process notes following each session.
3. "Rapid writing" (van Ooijen, 2003:108) – ten times for each client.
4. Artwork: I expressed my experiences regarding the therapy process using paint, crayon and collage, three times for each client. The rapid writing and artwork were selected to access those parts of my experience that are not immediately available consciously (van Ooijen, 2003:105).
5. Focusing: Half way through the inquiry period a focusing partner led me through one thirty-minute session for each client (Gendlin, 1979).
6. Recording of all individual and peer supervision sessions.
7. I noted all my thoughts, feelings and emotions on the work in a heuristic journal, which I continued throughout all subsequent phases of the study.

Following the data collection period I took ten weeks to transcribe the tapes of all supervision and focusing sessions, and immersed myself in the data until I felt that I had completely understood the material.

Incubation: I retreated from the topic to allow an inner process to take place. This took longer than expected, yet I sensed that something was germinating inside me, although I did not feel ready to let the shoots appear above the ground. After four months I reviewed all data again in order to identify qualities, themes and meanings and took this material back to my supervisors in order to gain their perspective. This process was repeated several times during the next year.

Illumination: Here a new awareness developed, which Moustakas (1990:30) refers to as a "synthesis of fragmented knowledge" or a realisation of something that has been outside conscious awareness. However, I was not yet able to articulate it.

Explication: I continued to use "focusing, indwelling, self-searching, and self-disclosure" (Moustakas, 1990:31) to gain a deeper appreciation of the topic. Here West's (2001) views were helpful, for whom this stage involves a full examination of what has emerged, and a "teasing out layers of meaning."

Creative Synthesis: This took the form of a bricolage: core themes were expressed metaphorically (a) as a magical fantasy; (b) in the form of my conceptualisation of my work as a Caduceus; and (c) through microanalysis of 'moments' in my work with the clients.

Ethical Considerations

In deciding which research methods to employ, I encountered an internal conflict between the psychodynamic and humanistic parts of my psychotherapeutic integration. In order to investigate the impact of my reflections on work with clients, it would make sense to involve the clients directly: such co-operative inquiry (Heron, 1996) would be in line with a collaborative approach to research and humanistic values. My inner psychodynamic therapist, however, is concerned with clients' unconscious processes, and believes that the clues to people's unhappiness, distress or inner conflict as well as the seeds for change, may be found there (Bollas, 1995). Direct involvement would, I felt, pose two problems: the clients' agreement would come from their conscious mind only, and their overt participation might interfere with the normal process of the therapy.

When I presented my draft proposal to a group of colleagues, someone suggested that there seemed to be a tension between old paradigm ideology and a new paradigm (Reason and Rowan, 1981) collaborative approach to inquiry (Heron, 1996). However, at the time I felt that there was a clash between different therapeutic orientations, rather than a tension between different research paradigms; which was of course the focus of this research! I did not want to change the therapeutic frame (Gray, 1994), nor did I want to involve clients in research without their knowledge. I therefore compromised by only including new clients, who were informed of the research and gave their consent. The basis for productive long-term work lies in a solid therapeutic relationship, the foundations for which will be laid right from the beginning; it did seem useful therefore to look into the process of this early period.

In order to protect the confidentiality of clients, many writers change some details of their clients' circumstances. However, not only is it debatable to what extent such precautions are effective, there are also problems of validity. Moustakas sees the researcher as a "scientist-artist" who "develops an aesthetic rendition of the themes and essential meanings of the phenomenon", which he says can be expressed through " a narrative, story, poem, work of art, metaphor, analogy or tale" (Moustakas: 1990:51). I therefore employed the metaphor of myself as a witch encountering several creatures to describe the process: a cat who could not hunt, a nightingale who could not sing and an android who could not walk without stumbling. In addition I added microanalyses of 'moments' in therapy without providing details about the clients' story.

Gremlins

According to McLeod (2001:181) qualitative inquiry can involve "a constant flow of reflexive, self-tormenting dilemmas…." This is indeed what happened to me. Although I had thought about and addressed relevant ethical issues, I remained unhappy, but without being able to put my finger on the reason. My academic supervisor suggested I write a chapter on ethics to clarify things. This I did, reluctantly, but it made no difference as to how I felt. What made matters worse was that on completion of the chapter my computer died and I lost a large part of it, as the back-up system had, unbeknownst to me, not been working for a while. Normally I print out everything as I go along, just in case. Except this time! My peer supervisors, who were deeply involved with my research, quizzed me on what this might mean? We reflected on my sense of unhappiness and how I had no problem writing about ethics in general, but could not think clearly whenever I tried to focus on the ethics of this study. It would literally feel as if my brain hit a brick wall beyond which I could not go.

Insight emerged both gradually and suddenly. I would have a moment of absolute clarity, but could not hold on to it and forgot it again soon afterwards. Gradually, however, these moments of clarity became more frequent and I realised that I had forgotten something important – myself! So focussed had I been on doing whatever was right in respect of the clients, that I had forgotten that the focus of the research was actually on my own internal processes: the development of my own internal supervisor, rather than on my clients' stories. True, these processes were experienced within that intersubjective space, between the client and myself, however the data was all generated by me.

Basically, I had forgotten that this was a supervision project! I had also forgotten that when I sit with a client I do not blurt out everything that is going on inside me – not only would that not be therapeutic, it might seem extremely bizarre and the client would probably not feel listened to at all. For me the skill of a therapist is to use myself as a tool, to be aware of what I am experiencing, what is going on inside me (my body, senses, mind and emotions), what I am noticing about the client, what effect his has on me, and then respond in a way that conveys attunement to the client. This may take the form of a question or observation that helps the client enlarge their perspective. In other words, I aim to do or say something that is just right for that client at that time.

Talking about all this with my supervisors and critical friends helped me to realise that I had succumbed to my gremlin once again. This inquiry into my own phenomenological

experience as a therapist was, in terms of my gremlin, just about the most selfish and narcissistic thing I could possibly do. At some level I felt that punishment was only just around the corner. However, once I became clear, I realised that far from being selfish, this research was benefiting my work with all my clients as well as my teaching. Not only were the clients who were part of the study getting a good deal, the close attention and deep reflection seemed to spread to everything I did. I sensed that the deep immersion helped to take my work to a different level.

Another way in which the gremlin reared its troublesome head was in the data analysis. Initially, instead of analysing what had been going on for me, I focussed on my clients' processes and stories. I did lots of work and wrote a draft chapter. The reply from my supervisor was blunt – "you have lost your focus, this is about as boring as a whole lot of figures in quantitative research." Ouch! It was true though; I had – again – completely lost my focus. My supervisor became extremely good in recognising whenever my gremlin reared its head – even when I was blissfully unaware. For example, when I wrote an abstract for a conference she felt that it just did not do justice to what I was actually doing, in other words, I was hiding my light under a bushel again.

The Scary Swamp

I had assumed that the period of incubation would take three months at the most, but in reality there were three periods of incubation and overall it took a year! The incubation periods felt to me like being in a swamp (Schon, 1983), during which time it was hard to be clear about anything. The first period was characterised by a sense of melancholia and a fear that the entire research might be a waste of time. I was scared to come out of the swamp and look at the data, fearing that there might be nothing there of interest. When, after four months, I finally did look I was greatly relieved, as all the material seemed so rich. However, as explained above, I lost my focus and needed to get back into the swamp. When I came out for the second time I got on better, I began to get a sense that there was a great deal here of significance, but I could not see it clearly. I felt as if I was in the dark and needed to take more time, let my eyes adjust and pay intimate attention to my internal states, processes and feelings.

Towards the end of the third incubation period I felt a great struggle happening inside me. I knew that it was time to come out and yet I felt unable to do so. It was as if every time I tried to struggle out of the swamp, I lost my footing and slipped back in. Around this time several areas of the country had been hit by severe flooding… and I had booked myself into a conference that was to be held in a tented camp close to one of the affected areas. I was petrified and kept checking the conference website for the latest information. Although this stated that the conference site was safe I did not believe it and was relieved to notice a list of nearby hotels. Salvation! I booked myself into one of them and felt immediate relief that I would not have to sleep in a tent that might flood while I was asleep. Although I had not been conscious of it, that had been my fear. I had been terrified as a young child in the Netherlands during the floods of 1954. Although we did not own a television I have vivid pictures in my mind of drowned cattle and people floating on flotsam or desperately clinging on to items of furniture.

It seems that I had projected my fear of not being able to get out of the heuristic swamp onto the actual flooding situation. What if I failed again? I tried to tell myself that it would not matter if I did not succeed, but I knew that I was fooling myself as it was part of my healing process, part of helping me to escape the clutches of the gremlin that had stifled me for so much of my life. I remembered that in the Netherlands water meadows are deliberately left to flood in winter, to create fertile land for luscious grass in the spring. I began to hope that my time in the swamp might have a similar result.

Data Analysis

In order to identify processes, themes and meanings I grouped together the reflections on a number of sessions into a single map (Figure 1) ending up with five maps for each client.

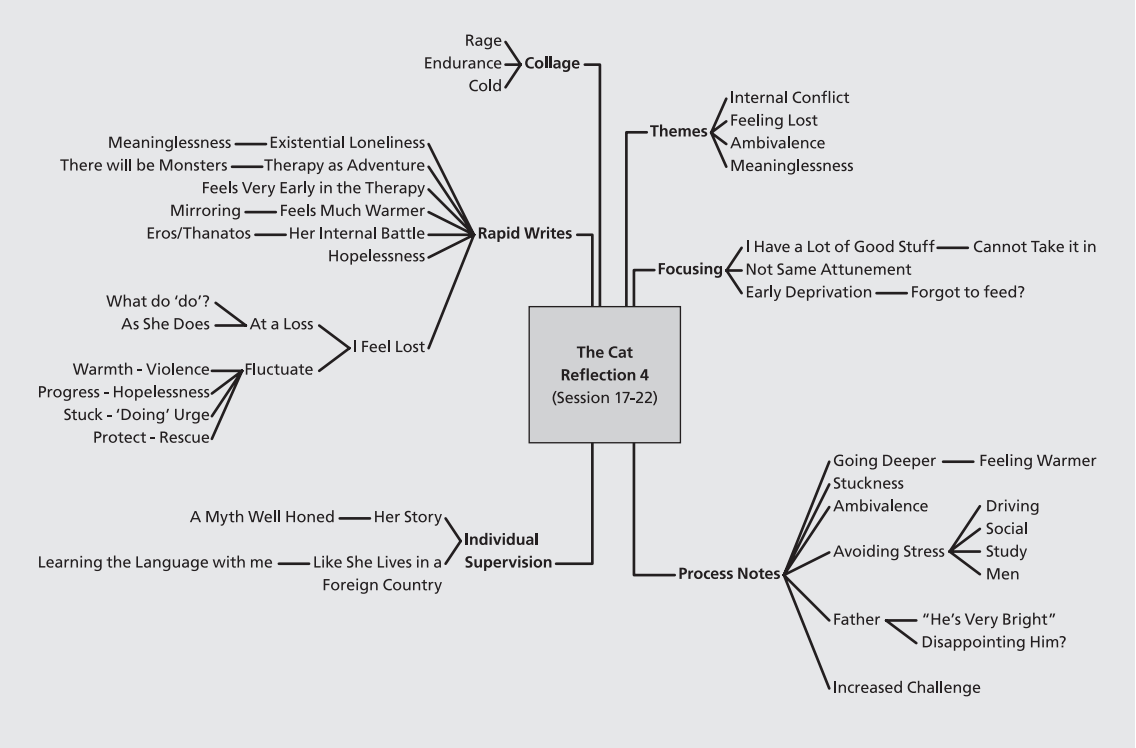

Figure 1

Next I compared what struck me to the raw data. However, the more I immersed myself in the material, the less satisfactory this linear approach seemed. I found myself going backwards and forwards over the clients' material, and time began to feel circular. All issues seemed present in every session, but I could not see them clearly, as if I was looking "through a glass darkly" (1 Corinthians 13:12).

Eventually I constructed a different set of mind maps that form the basis for the metaphorical narrative. Comprising a distillation of session notes, reflections and supervision sessions, they clarify themes for each client, illustrated by 'moment-to-moment' vignettes.

Excerpt from Narrative:

When Caryce looks into her crystal ball and asks for guidance with the bird, (Plate 1) she sees the bird, but also notices the SOS, Save our Souls! "What on earth can that mean?" she wonders and summons Rhoban. Rhoban is fascinated and muses: "Is she protecting her breast? Is she a fragile little bird?"

"Actually, yes", says Caryce, "now you mention it, she does seem very dainty. I feel that I have to take care not to startle her or she might fly away."
"Hmmm," says Rhoban, "and what about that SOS in the middle? Could that be how our little bird feels regarding her whole life? Lost? Perhaps that SOS is directed at her relationship with you?"

"Gosh", says Caryce, "I have no idea why the crystal is showing me that; nothing the little bird has told me warrants that, except….." Caryce stops and thinks. "Except", she continues, "the bird has said several times that although she likes travelling with me, she is also afraid. I wonder whether she fears that there is some dark secret that she does not want to find out about?"

Two clients left before the data analysis had been completed. In supervision I discussed whether or not I should contact the clients to show them my findings. It did not seem appropriate to confront clients with insights gained outside the boundaries of the original contract; I therefore removed anything from the narrative by which the clients could be recognised, thus ensuring complete anonymity (Figure 2).

Although the issues clients presented varied greatly, underlying themes appear remarkably similar: ambivalence regarding change; relationship issues; loss; and

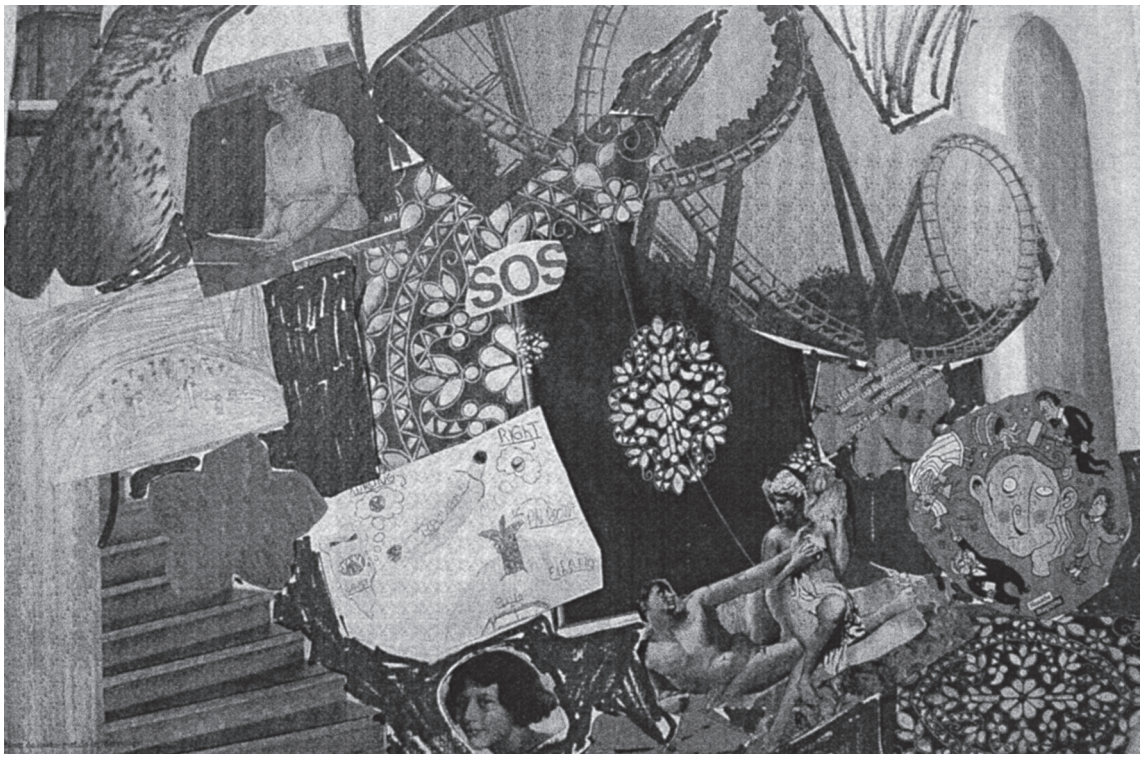

Plate 1

Sessions:	Themes:	Reflections:
1-6	Ambivalence regarding relationships Stuckness Anger Feeling unseen and unvalued Grief	I am gradually warming to her and have a sense of her as a huge baby that I want to hold and look after. I sense that she is like a very frightened and hurt, but also angry child. In supervision I have a sense of nothingness around her; wonder that she is the oral stage, but does not know how to take in nutrition. So she may need a reparative relationship, but I should take care not to overfeed her. A feeling of getting lost, as the middle child. Unavailable father.
7-11	Inner emptiness Mini ruptures and repair Ambivalence regarding relationships "Something is wrong with me"	In supervision I say I have a "hopeless" feeling. R says it reminds him of Winnicott's paper "Hate in the countertransference." I say that in my rapid writes I had the sense that I could easily hurt her, I am not a sadistic person but the teenage girl in me could be! R – well at some point you are going to hurt her, unintentionally,–will there be enough of a therapeutic relationship to process and understand it, so that the therapy can survive? If a rupture does happen it is important to repair it, or it will get killed off! Her contempt for people is masking her inner emptiness.
12-16	Ambivalence regarding relationships Stuckness	In supervision R asks me to imagine I am feeding her as a baby. I imagine breastfeeding her but she is clamped to the breast. R says, So there is something going on, but you may not discover it until you get this baby to relax. There is anxiety which indicates great hunger, plus an attempt to cling to safety. But there may be a higher problem than hunger. I have more anxiety about her, there appears to be a more overtly disturbed state, an urgency to connection. Is the clamping also to do with my anxiety as a therapist? I worry about the summer break and what this will mean to her. If I were to go to a mother and toddler group I would see her as staying close to me, holding on to my skirt. If another child takes a toy from her she will not hit out or try and snatch it back, but just cry. R thought this positive as the child who does not even cry is much more worrying.

Figure 2

Essential themes:	
Client 1 (represented by the Bird):	Ambivalence (regarding the therapy and willingness to change); relationship issues; problems with authenticity: (who or what am I? What should I do or be?); loss.
Client 2 (represented by the Android):	Ambivalence (regarding the therapy and willingness to change); relationship issues; depression; feeling different; fear of disintegration; authenticity (or lack of); search for meaning; getting lost; loss.
Client 3 (represented by the Cat):	Ambivalence and fear (regarding relationships and willingness to change); relationship issues, loss; inner emptiness; feeling different 'something is wrong with me'; existential loneliness; meaninglessness.

Figure 3

existential issues around authenticity, meaning and existence (Figure 3).

Discussion

This supervision project was designed to further develop my internal supervisor, I therefore regarded what I learnt like insights gained through supervision. The focus of this project was on my work with three clients, however, it had a profound effect on the work with all my clients - my work deepened, I felt more grounded, solid, and able to be with clients wherever they are. The two clients who left did so for different reasons; one moved away, the other did not return after the summer break. The third client had some unfortunate experiences with therapy in the past and the relationship took a while to get established. This was not easy for me, but I felt helped as well as held by the deep reflection and sharing with my supervisors. Over time the therapeutic relationship deepened and the client and I worked well together for a number of years.

My Integration

This inquiry has confirmed for me that my fundamental philosophy is humanistic; I aim to value and respect people and see the relationship as central. I engage with clients 'where they are' without attempting to fit them into a particular theory or method, and aim towards a "transpersonal" way of being (Rowan and Jacobs, 2002) where both the client and I are authentic and the connection between us happens almost despite us. When I sit with a client I let her impact on all of me (body, mind, emotion and spirit), consciously and unconsciously, so that whatever happens is created by both of us and will be different with every client and each session.

I conceptualise my way of working as a Caduceus (Figure 4). The two snakes of the Caduceus are engaged in a graceful, upward movement, swaying, separating and coming together again, in an eternal dance. The Caduceus denotes the inter-relationship between client and therapist as well as the intra-relationship within all of us between our different ways of being. The two strands of the Caduceus also convey the need for dialectic processes as well as opposites. The therapeutic process may involve clients as well as therapists being challenged on beliefs and patterns that we have always felt to be an intrinsic part of us and according to which we have lived our lives and created our relationships. I see that there is value in conflict; opposites only make sense in terms of the other. I start from the healthy

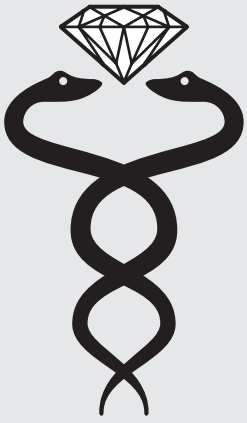

Figure 4: The Caduceus

strand of the caduceus rather than from illness in order to establish what is positive within the client, before diving into the disturbance. The Caduceus shows that there is a need for balance in therapy as over-focussing on one or the other (health or disturbance) will be either collusive or crazy making. I do not see ambivalence as negative but as an acknowledgement of a coin having two sides – or a caduceus two strands. Therapy, when it goes well, feels like a spiral dance in which we return, again and again, to the same issue, the cross over points in the Caduceus, but each time it is a little different and something new has been integrated.

Regarding the therapist this internal dance is illustrated in the narrative: Caryce wondered what it was that prevented the bird and the android from continuing their journey with her. Were they not ready to accept what she had to offer, or was it something to do with Caryce herself? Did she perhaps not fully understand what it was they needed, was she perhaps not sufficiently 'attuned' to what they were trying to communicate? Was she afraid of what she might encounter if they continued with her, or did she unconsciously feel out of her depth in some way? In other words, I believe that in order to for clients to let go of their ambivalence and attachment to old patterns (Clarkson, 1995), embrace their authentic way of being, create new meaning, and be in true relationship with others as well as themselves, the therapist needs to be able to do so too.

I describe my therapeutic stance as relational-integrative (Faris and van Ooijen, 2012), an integration of humanistic, relational-psychoanalytic and mindfulness based approaches. The continuous upward movement of the Caduceus expresses my belief in the importance of continuous integration – both for the therapist and the client. As a therapist I need to continue to process and integrate my experiences as well as any theories and models that influence me. I see many similarities and overlaps between a humanistic stance and relational psychoanalysis. Both require the therapist to be real (not hide behind a blank screen) and work with what is going on between therapist and client in the here and now. The therapeutic relationship is a vehicle through which clients may work on their relationships with others as well as with different aspects of themselves and thus achieve a more authentic relationship with themselves as well as greater internal integration.

The crystal between the open mouths of the snakes represents the five meta-themes that emerged from this inquiry: attachment and loss, ambivalence, authenticity, meaning and relationship. I have written elsewhere about how these existential themes are present in much of our work and apply to both therapist and client (Faris and van Ooijen, 2012). The Caduceus also indicates an intrasubjective process, a dance between the two poles of each theme. For example, all of us, clients and therapists alike are often not sure that we really want to change (ambivalence); we may be attached to our way of being (fear of loss) but long to let go (acceptance); we desire to let go of our false selves, but are afraid to do so (authenticity); we want to make sense of our lives but find it hard to jettison the way in which we have done this so far, as this implies a disconfirmation of our worldview, which is frightening (meaning); and lastly we all long for close relationships but fear that we may lose ourselves when we do.

This inquiry has been about my 'being' rather than my 'doing' and has helped me to re-integrate my humanistic roots and (re)-discover a more relational way of working. This re-integration has been helped, legitimised even, by the relational movement within psychoanalysis (Mitchell, 2000). I find the concepts of psychoanalytic and jungian theory, as well as those of gestalt and existentialist therapy, very helpful. My training and experience have prepared me to accompany people for a while and help them discover their own path. I do not see therapy as falling within a "medical model" (Clarkson, 1995:250) where people are 'cured' of disorders. To use an analogy, when making our way through a forest we often need to fight our way through the undergrowth and clear our path from brambles. Similarly I may occasionally need to help a client become aware of and change unhelpful thoughts or behaviours before they are able to engage in a deeper exploration, but that is only part of the work. Sometimes, however, that may be all people want to do for now, which is of course their choice.

Ultimately I see my work as part of every person's task to come to terms with what is: that we are human, with a finite life span (Yalom, 2008). Eventually we all need to give up our attachments to our defences and our struggle against life and accept what is.

Conclusion

I learnt how tenacious core beliefs can be, particularly if they develop at a very young age, and how they operate outside awareness. It helps me be with clients whose gremlins seem equally hard to overcome, even when seemingly irrational and unfounded. Despite being consciously aware of them, they can still get us when we are not looking!

For me there is a clear link between heuristic research and therapy. Both are deeply reflective and make use of the person's self as a tool, a process that cannot be hurried but has its own rhythm. For both, the same issue may need to be revisited several times. Each time some illumination happens, this then feeds back into the incubation process and effects changes under the surface, until further illumination happens.

Given my core belief that it is bad to do things for myself, particularly if I do them well, researching my own practice was challenging and risky. It was therefore not surprising that this old gremlin kept popping up all over the place. However, the greatest challenge can also present the greatest opportunity; people's positive reactions to the research and the assignments leading up to it have done much to heal my earlier hurts. This is not to say that my gremlin has gone away; after all it has taken me several years to pluck up enough courage to start writing articles on the basis of the dissertation. I do feel more solid, though, and able to say, yes I have done a doctorate and feel proud rather than guilty, which was the case in the past!

This article was prompted by a presentation at a conference entitled 'Remaining Inspired'. What continues to inspire me is the healing I have received through this doctorate. It has helped to heal past hurts through revisiting them, and through being witnessed, validated and appreciated – a clear analogy to the work I aim to do with my clients.

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John Rowan

Levels of Consciousness and the Great Gap

Abstract

There is a great tendency in the world of therapy to assume that we are basically all the same. We may have varied neuroses and psychoses, we may have varied contents in the unconscious, we may have all sorts of prejudices and fixed ideas which need unravelling, we may have numerous shadow figures and issues, we may be influenced by various archetypes and so forth, but basically we are all the same. An alternative view is that human beings are in a process of development which has various way-stations, nameable and researchable, which make a structural difference to their thinking and feeling and experiencing. In this paper I argue that the latter position, radical as it is, needs to be considered when engaging in therapy, so as not to hold back or deny this developmental process. It also makes it very clear how important the idea of authenticity can be in the therapeutic process.

Introduction

I have always been interested in the extreme. I had my first mystical experience in 1947, quite spontaneously, and without recognising it as such, at the age of 22. I was in an Indian army hospital, recovering from malaria and dengue fever, and it just happened during a sunset. I did not make much of it at the time, because I was more interested in the philosophy of Spinoza, which I had just discovered, and found very exciting and liberating. Then when I came back to England, I was introduced to the work of Hegel by a friend of mine now dead, Harold Walsby. He pointed out that the work of Hegel was all based on the idea of freedom as the highest value. And he pointed out the connection between Hegel's famous statement "Being and Nothing are one and the same" and the scientific value of taking nothing for granted. He introduced me to dialectical thinking, which I soon mastered. More importantly, he put me through a process of initiation which I later found out was derived from the Madkhyamika tradition in Buddhism, where all your basic beliefs are radically questioned. At the same time, aged 25, I had discovered Polish many-valued logic and was exploring that. At Walsby's suggestion I joined a small Marxist party, and soon became the editor of its internal theoretical journal. All these influences made me very suspicious of psychotherapy, though Christopher Caudwell, a marxist theoretician I had some use for, did have something to say about the importance of the unconscious, and Harold Walsby wrote about the connections between Marx and Freud. The main work of Walsby (1947), however, was his work on ideologies. He developed a sophisticated theory of levels, where he urged that to understand ideologies it was possible to arrange them in a developmental sequence, such that each level was more intellectually complete than its predecessor. He created, with others, an organization called the Social Science Association, the story of which can be found on the website gwiep.net.

I went on to study psychology at Birkbeck College. When I came across the work of Piaget (1954) I took to it at once. It seemed very well based, and yet to contain some surprises. The finding that five-year-olds

could not put a series of sticks of different lengths into order of length struck me as very strange. The finding that three-year-olds could not grasp the idea of a rule was even more surprising. It seemed that the obvious was not so obvious. I actually carried out some of the experiments quite informally with my own children, and checked them out for myself.

And when later on I came across the work of Maslow (1987) I was even more excited. His ideas on motivation seemed so obviously superior to the previous theories of instincts, drives, needs and so forth which had gone before. Again I was able to test this out for myself. When I was giving a lecture on motivation, I often used a test which I had devised, which simply asked people why they were here today. Step two was to ask what was behind that reason or motive. Step three – what was behind that. I carried on until they reached their own terminus – something that was so basic that they could not go behind it. And it turned out that nobody came up with a terminus of sex, hunger, or any of the other conventional 'basic drives' – they always came up with one of Maslow's motives.

Now we were always warned that Maslow was not a good researcher, and that we should therefore take his theory of levels with a pinch of salt. But what started to happen was that some much better researchers came up with exactly the same series of levels as Maslow did. Lawrence Kohlberg (1984) did his research on moral development in many different countries around the world, which was followed up by the complementary work of Carol Gilligan (1982). Jane Loevinger (1998) started her research on woman and girls, thus complementing Kohlberg, who had done his research on men and boys. Ken Wilber (2000) did his research in the library, collating about eighty writers from different countries and centuries, and finding the same levels all over again, plus a further set of levels going beyond Maslow and the others. Then came the work of Don Beck and Christopher Cowan (1996) whose ambitious attempt to look at ideologies (which they called value-memes) again came up with the same set of levels as Maslow. The work of Robert Kegan (1994), William Torbert (1991) and perhaps most of all Susanne Cook-Greuter (1999), seems to be highly regarded from a technical point of view, and they, too, come up with the very same set of levels. The relevant charts are presented on pages 36, 37 and 38.

What we now have, therefore, is a well argued and well researched set of developmental levels, which it seems to me have to be taken seriously. The most glaring feature of this work, which I have tried to underline by using the phrase 'the Great Gap', is that at a certain point there comes a great leap which many people never make. What is this leap, exactly?

One way of putting this is to say that it is the move from the false self to the true self (Winnicott), from the persona to the self (Jung), from the false self to the real self (Laing), from the unreal self to the real self (Janov), from the guiding fiction to the creative self (Adler), from the self-image to the self (Perls) and so on. But all these are perhaps oversimplified and too brief for our more critical era.

I think Wilber has the best account of this. He says, in most of his books, that it is the step from the Mental Ego to the Centaur. The Mental Ego is the level of consciousness which is most common in our Western culture, and we are all familiar with it. It has sometimes been called, rather unkindly perhaps, the consensus trance. It is a level of consciousness where we are happy to play a role in society and not question it very much. We see ourselves as a stockbroker or a navvy, a housewife or a model, an accountant or a shelf-stacker, a shop assistant or a lady of leisure. In other words, we define ourselves by our roles. This is the world of what Heidegger (1962) called Das Man – usually translated as The They. If asked the question – "Who are you?" people at this level will answer instead the different question – "What are you?" And this is what society wants. We get rewarded for playing our roles well, with money, honours, degrees, medals, recognition and prestige. And the highest we can go in this area is to the Mature Ego. Society is not interested in anything beyond this, and will not reward it.

So if we want to go beyond this in our psychosocial development, we have to do it for ourselves, on our own account. We have to step off the escalator. We have to take responsibility for our own lives. We have to cross the Great Gap. And what is on the other side? Primarily,

and most obviously, it is authenticity. Now authenticity is a difficult concept. Just because it is not a Mental Ego concept, most people have only the vaguest idea as to what it could mean. They are not satisfied with the simple statement – It is seeing through your own eyes, instead of through the eyes of others. One of the best authorities on authenticity was James Bugental (1965), who had the unique distinction of being on the editorial boards of the Journal of Humanistic Psychology and the journal Existential Analysis. He says – "It is my feeling that congruence is a part of existential authenticity, that the person who is genuinely authentic in his being-in-the-world is congruent within himself; and to the extent that one attains authentic being in his life, to that extent is he congruent." (Bugental 1981, p.108) Or again, he says - "An authentic acceptance of responsibility takes the form of commitment. The contrasting, avoidant response is blaming." (Bugental 1987), p.246.) Someone who carried the ideas of Piaget further was Riegel (1984), who emphasised that this was a move in the direction of dialectical thinking. A more recent writer is Jenny Wade (1996), who says – "Authentic consciousness differs dramatically from earlier stages because it is free from commonly recognised forms of ego-distorted cognitive and affective perception. Traditional theorists view this stage as markedly free of the ego defenses seen prior to this level, so that persons at this level are able to experience and express themselves fully (Maslow 1987; Belenky et al. 1986; Graves 1981). Their increased capacities have led Maslow and the Gravesians to designate this stage the first level of another developmental order." (p.160) What we are saying, then, is that the real self which we are aiming at in humanistic psychotherapy is not something very abstract and hard to pin down - it is situated both in the empirical realm of psychological research and in the conceptual realm of philosophy. It is closest to the self as described in existential psychotherapy, as described by Friedenberg (1973):

> *The purpose of therapeutic intervention is to support and re-establish a sense of self and personal authenticity. Not mastery of the objective environment; not effective functioning within social institutions; not freedom from the suffering caused by anxiety - though any or all of these may be concomitant outcomes of successful therapy - but personal awareness, depth of real feeling, and, above all, the conviction that one can use one's full powers, that one has the courage to be and use all one's essence in the praxis of being. (p.94)*

This seems to me a ringing and crystal clear assertion, which is echoed many times in existential writings (van Deurzen 1997, Spinelli 1994, Cooper 2003, Schneider & Krug 2010). I particularly like this quote from Ernesto Spinelli:

As authentic beings, we recognise our individuality. Further, we recognise that this individuality is not a static quality but is, rather, a set of (possibly infinite) potentialities. As such, while in the authentic mode, we maintain an independence of thought and action, and subsequently feel 'in charge' of the way our life is experienced. Rather than reacting as victims to the vicissitudes of being, we, as authentic beings, acknowledge our role in determining our actions, thought and beliefs, and thereby experience a stronger and fuller sense of integration, acceptance, 'openness' and 'aliveness' to the potentialities of being-in-the-world. (Spinelli 1989, p.109)

This, I feel, puts it in a nutshell. But it really comes to life when you see it in action. I remember well a group where a young man really got it after doing a deep piece of work on himself. He was asked to go round the group and say something to each person. And what he said, in each case, was fresh and spontaneous and unique to the person. It felt a very truthful performance, coming from the heart.

Let us now turn to another source of wisdom. Clare Graves (1981) was the researcher who developed the theory which was later taken up and further elaborated by Beck & Cowan (1996), and named by them as Spiral Dynamics. This theory says that all the stages up to and including what we have called the Mental Ego (that is, what they call the Beige, Red, Purple, Blue, Orange and Green stages) are restricted to First Tier thinking (that is, formal logic), while the stages after that adopt Second Tier thinking (which is sometimes called dialectical logic, or vision-logic). Graves calls this "A momentous leap" (Beck & Cowan p.274). This seems clear and well stated: First Tier thinking uses what is called formal, Aristotelian, Boolean,

classical or Newtonian logic. It is familiar and easily understood, and all our computers are based on it. Its fundamental tenet is "A is A". Dialectical logic, which can embrace paradox and contradiction, has a different fundamental tenet: "A is not simply A". It can immediately be seen how important this is for therapy. If a client comes into the room and I as a therapist say to myself – "Arthur is Arthur" – that gives me no hint of what might happen later. But if a client comes into the room and I say to myself – "Agnes is not simply Agnes" – that immediately opens up vistas of future change in unspecified directions.

Of course there is far more to self-actualisation than authenticity or dialectical thinking. Maslow (1987) laid down seventeen characteristics, and I added to these (Rowan 2001) to make a total of 30.

Crossing the Great Gap is therefore no small matter. It makes all the difference between thinking that is inadequate for dealing with human beings to a new and different kind of thinking which really does justice to the possibilities inherent in every therapeutic enterprise. But how is it done? I am not saying that this is the only way, but the most reliable way seems to be through the process of psychotherapy or counselling – again something which was not known in classical times. During this process all the taken-for-granted assumptions can be challenged, questioned and revised. Perhaps more importantly, the Shadow material can be opened up and transformed. I remember a very deep session where I seemed to go back to the first choice-point in my life: I had to decide whether I wanted to bother with other people or just concentrate on myself. I had taken the solitary path, the path of individualism, of not needing other people. But now I was back at the choice point. I could take either path. And this time I resolved to take the other path, of being with other people, of needing other people. A song came into my head – "I don't want to be alone" – complete with its own tune. And I began to sense a clicking of circuits in my body, like solenoids changing direction, opening and closing in a long sequence, as the new resolution took up residence. It was a new way of being. And it meant, in the next few days, that I could relate to another person in an authentic way, and really be there in the relationship. It did make a difference.

The person can often come to see through their taken-for-granted beliefs and patterns of action, and dump what needs to be dumped. But this process can sometimes be very painful, which is why most people never do it. It often takes a crisis of some kind to take a person into therapy, and it is then that the healing work can begin. Perhaps it is misleading to call it healing, because healing may suggest simply waiting for the scab to drop off. It is more like a work of transformation, where false beliefs can be challenged and dropped, and illusions seen through, which can be painful. But if therapy is a work of freedom, which I believe it potentially is, this has to be endured. Authenticity is not an easy option.

Away with the Triangle!

There is a small matter which I would like to interpolate at this point. In 1943, Abraham Maslow launched his theory of a hierarchy of needs. He later elaborated on it, and the latest edition of his book came out 44 years later (Maslow 1987). There is no triangle in this book. At some point in this period, some bright spark (probably a text editor) had the idea of printing out this hierarchy in the form of a triangle or pyramid. This produced a very attractive diagram, and later versions added colour to make it even more so. What is wrong with the triangle is that it suggests that there is an end-point to personal growth. What is also wrong is that it suggests that this end-point is not far away. So the questions that are raised here are: is there an end-point, and if so where is it?

The main writer in recent times who has suggested that there is an end-point is Ken Wilber. In his earlier work he speaks of the Ultimate. In his later work (Wilber 2000) he speaks of the Causal and the Nondual. But in both cases there is nowhere further to go. I have never seen Wilber's theory printed out as a triangle, but expect to see it soon, as the ideas trickle down into the undergraduate texts.

It may seem excessively bold to attack both Maslow and Wilber, but on this point it does seem as if they must be wrong. To call

something the Ultimate or the Highest is to say that there is nothing further, that this is the end of the line of psychospiritual development. But how can we possibly know this? Our existing experience is that every time we thought we had come to the end of the line, it turned out that there was more to do, somewhere further to go. Why should this not continue? The fact that we can't see how it could possibly continue may just be our own limitation. We don't know, and we shouldn't pretend to know.

But it is even worse if we suggest, as Maslow does and Wilber doesn't, that this marvellous end-point is just one step away. This is what I have called the one-two-three-infinity mode of counting. One is the basic needs - what Alderfer (1972) calls Existence; two is the social needs - what Alderfer calls Relatedness; three is the autonomy and authenticity needs - what Alderfer calls Growth; and everything beyond that is the realm of Being, as Maslow names the spiritual or transpersonal realm. This is too simple, and it is misleading. But Maslow is not alone.

One of the greatest mistakes made by those who are interested in these matters has been to imagine that there is just one thing called the transpersonal or the spiritual: sometimes this is named as the Self with a capital S. This is usually identified as: ultimate states, illumination, mystical union, transcendence or cosmic unity (Sutich 1980); the highest state of consciousness (White 1972); maximum or optimum consciousness (Walsh & Vaughan 1980); consciousness of the awakened one (Boorstein 1980); cosmic consciousness (Havens 1982, Keutzer 1982); Divine Ground and eternal Self (Huxley 1993); or unity with God, or unitive consciousness Underhill (1961/1930), or the Supreme Identity - in other words, the highest or deepest spiritual state which can be obtained or imagined.

To think that once we pass beyond the conventional ego we immediately enter the highest state of all is to ignore the possibility that there are stages or steps which are more than the ego and less than the highest. And in fact it has been possible not only to say that there are these intermediate stages, but also to name and describe them. People like Rolf von Eckartsberg (1981) have shown that writers in the past and present have found evidence of these graduations. But probably the most extensive and adequate version of this has been produced by Ken Wilber (2000).

He has made it clear that what Maslow was talking about, and describing in some detail, was a level of consciousness which Wilber calls the Centaur (because it is here that bodymind unity becomes obvious) and which Wade (1996) perhaps more helpfully calls the Authentic. I sometimes call it the Existential, because this is a level which is completely describable in terms of the existential way of seeing the world (Rowan 2001).

What we need instead of a triangle, therefore, is something more like a ladder. And when we put Maslow's ladder next to Wilber's ladder, we can easily see that Wilber's has more rungs.

But even Maslow's has one more rung than is usually printed out. The triangle versions all go by Motivation and Personality, whereas the extra rung is spelt out in a paper called Theory Z, reprinted in the collection The Farther Reaches of Human Nature (1973). In this chapter Maslow distinguishes between nonpeaking self-actualization and peaking self-actualization, suggesting that the former is a lower state than the latter. ('Peaking' refers to having peak experiences.) This would mean a two-stage process, whereby contact with the 'real self' (Centaur, Authentic, Existential) comes first, through a process of integration and actualization, as Mahrer (1989) has explained most adequately, and then the further stage of transcendence comes later.

In our work, therefore, it is a mistake to use the figure of a triangle to represent the Maslow model. We all thought in the 1970s that self-actualization was an immense achievement, perhaps the ultimate state of consciousness, and therefore it would be hubris indeed to claim to be self-actualised. In fact, I once heard someone say that "anyone who claims to be authentic can't possibly be authentic". But if in truth self-actualization is just a step on the way, not a final goal, it need not be a dubious statement at all. It produces an authentic person, who sees through their own eyes, no longer through the eyes of other people. This is a very worthwhile aim, and much of the humanistic spectrum

Level	Maslow	Kohlberg	Loevinger
6	**Self-actualisation** Being that self which I truly am Being all I have it in me to be Fully functioning person Authentic Creative	**Individual principles** True personal conscience Universal principles fully internalised Genuinely autonomous Selfishness B	**Autonomous: Integrated** Flexible and creative Internal conflicts faced and recognised Tolerance for ambiguity Respect for autonomy
5	**Esteem 2** Goals founded on self-evaluated standards Self -confidence	**Social contract** Utilitarian law-making Principles of general welfare Long-term goals	**Conscientiousness** Bound by self-imposed rules Differential thinking Self -aware
	The Great Gap		
4	**Esteem 1** Respect from others Social status Recognition	**Law and order** Authority maintenance Fixed social rules Find duty and do it	**Conformist 2** Seeking general rules of social conformity Justifying conformity
3	**Love and belongingness** Wish for affection Need for acceptance Need for tenderness	**Personal concordance** Good-boy morality Seeking social approval Liking to be liked	**Conformist 1** Going along with the crowd Anxiety about rejection Need for support
2	**Effectance** Mastery Imposed control Blame and retaliation Domination	**Instrumental hedonism** Naive egocentrism Horse-trading approach Profit-and-loss calculation Sefishness A	**Self-protective** Wary and exploitative People are means to ends Competitive stance Fear of being caught
1	**Safety** Defence against danger Fight or flight Fear: world is a scary place	**Obedience/Punishment** Deference to superior power Rules are external and eternal Musts and shoulds	**Impulsive** Domination by immediate cue, body feelings No reflection

After David Wright (1973), omitting lowest level of Maslow (physiological) and Loevinger (Pre-social, symbiotic).

Kohlberg,L (1984) *Essays on moral development (Vol 2 - The psychology of moral development.* San Francisco: Harper and Rowe. Loevinger, J (ed) (1998) *Technical foundations for measuring go development.* Mahwah: Lawrnec Erlbaum. Maslow, A.H. (1987) *Motivation and personality (3rd edition)* San Francisco: Harper and Row. Wright, D (1973) 'Images of human nature underlying sociological theory: A review and synthesis' Annual Meeting of the American Sociological Association.

Figure 1: Maslow's Hierarchy of Needs and Some Collateral Research

of approaches is devoted to its achievement. But it is quite a modest and achievable aim.

The Centaur and Beyond

After that digression, let us return to the main point of this essay. This level of consciousness, which we have called the Centaur, which Wade calls the Authentic, and which I have sometimes called the Existential, is something really remarkable. It is not to be found in any of the ancient classical texts, whether Greek or Asian, and in fact only emerged in the nineteenth century through the work of Kierkegaard (1987/1843). It is something specifically modern, not to be found in Buddhism or any other of the usual religions, although it is by no means hostile to religions. Most of the great existentialists, including Kierkegaard, have been religious.

Suppose we discover, then, that we have crossed the Great Gap, and have achieved authenticity or self-actualisation, what then? Here I personally find the work of Wilber offers the most useful map. He says that the next stage is equally challenging and in some ways unacceptable, or at least doubtful. He calls it the Subtle.This is a level where we encounter the Divine through concrete symbols and images: it is the realm of archetypes, of deity figures, of nature spirits, and of what Hillman (1997) calls the soul. It is also the realm of what Cortright (2007) has more recently called the psychic centre or the antaratman. John Whitmore, following Assagioli, calls it the Higher Self (Whitmore & Einzig 2007). I have now worked in this area for many years, and my book (Rowan 2005) gives many details about this. One of the most striking things about working at this level in therapy is that the phenomenon of Linking (the conscious and intentional breakdown of the boundary between therapist

Level	Piaget	Spiral Dynamics	Wilber
6	**Dialectical operations** (Klaus Riegel 1984) Beyond formal logic Integration of contradictions	**Yellow**	**Centaur 2** Vision-logic Bodymind integration Peak experiences Existential self
5	**Formal operations** Substage 2: Thinking about thinking Forethought, speculation	**Green**	**Centaur 1** Ecological imagination Awareness of awareness relative autonomy
The Great Gap			
4	**Formal operations** Substage 1: Capacity for hypothetico-deductive thinking	**Orange**	**Mental ego** Full rationality Syllogistic logic Science/mathematics
3	**Concrete operations** Ability to take role of other	**Blue**	**Mythic-membership** Dependent on roles Norm-dominated
2	**Preopertational** Mastery Incapable of seriation	**Purple/Red**	**Magical** Primary process thinking High credibility
1	**Sensoriphysical**	**Beige**	**Body ego** Archaic level of thought

Beck, DE and Cowan,CC (9196) *Spiral Dynamics: Mastering values, leadership and change.* Oxford: Blackwell. Piaget,J (1954) *The construction of reality in the child.* New York: Basic Books. Riegel, KF (1984) Chapter in ML Commons, FA Richards and C Armon (eds) *Beyond formal operations: Late adolescence and adult cognitive development.* New York: Praeger. Wilber, K (2000) *Integral psychology.* Boston: Shamabala. See also Wilber's novel 'Boomeritis' for spirited, readable, and informal description of Spiral Dynamics.

Figure 2: Maslow's Hierarchy of Needs and Some Collateral Research

and client) comes into play, and this has now been rediscovered by the person-centred school, with their concept of 'working at relational depth' (Mearns & Cooper 2005).

Beyond this is the Causal realm, where we have to give up all the symbols and images and embark on the wide ocean of spirituality, where we can speak equally of the One, the None and the All. Here there are no signposts and no landmarks, nothing to measure or describe. I used to think that it was not possible to do therapy at this level, but more recently I have discovered that it is indeed possible, although it does become something rather different, totally lacking in empathy, for example, because at this level there are no problems (Rowan 2005a).

In this area we run into a controversy which rages unchecked in the literature on mysticism. On the one hand we have the representatives of the Perennial Philosophy, of whom Wilber is one, who say that the Subtle comes before the Causal and is basically inferior to it; and on the other those who say that there are many versions of mysticism, not just the one, and that the Subtle may be equal to, and side by side with, the Causal. Mike King (2007), for example, says that the Subtle represents the bhakti approach and the Causal the jnani approach, and they are just side by side, not superior and inferior.

To a therapist it does not really matter which view we choose, so long as we recognise that these are two different things. But certainly it seems obvious to me that the Subtle is a lot more accessible, and a lot more used by transpersonal therapists, than is the Causal. It is the natural home of imagery, of guided fantasy, of the deepest dream work, of work with empty chairs, of intuition and creativity, of the fullest compassion and so forth. The Causal, by contrast, is bare and featureless: there are no problems there, and no empathy either, and most clients are not ready for it. But for the right client, at the right time, it is excellent.

The Importance of the Centaur

So let us come back to the Centaur, which is more relevant to most therapists most of the

Level	Cook-Greuter	Torbert	Kegan
6	Autonomous	Strategist	5
5	Pluralist Individualist	Individualist	4

The Great Gap

4	Conscientious	Achiever	3/4
3	Conformist Self-aware	Diplomat Expert	3
2	Opportunist	Opportunist	2/3
1	Impulsive	Impulsive	1

Cook-Greuter,SR (1999) *Postautonomous ego development: A study of its nature and measurement.* Boston: Integral Publishers. Kegan,R (1994) *In over our heads: The demands of modern life.* Cambridge: Harvard University Press. Miller, M and Cook-Greuter, S (eds) (1994) *Transcendence and mature thought in adulthood: The further reaches of adult development.* Lanham- Rowman and Littlefield. Torbert (1991) *The power of balance: Transforming self, society and scientific inquiry.* Thousand Oaks: Sage.

Figure 3: Maslow's Hierarchy of Needs and Some Collateral Research

time. So often the clients who come to me are struggling with the limitations of the Mental Ego, of the false self, and are ready, or almost ready, to cross the Great Gap. If I can help them to do this, to make that journey, I can be well satisfied with my efforts. For example, I had a client who hated women. His definition of women was a complete stereotype – they were good for sex, but dangerous otherwise, and with unpredictable minds. After a couple of years of work, he seemed to be no nearer any change. Then he was involved in a road accident, where he nearly died. When he came back into therapy he was a changed man. All the work we had done, and which had seemed to be ineffectual because only taken in at a head level, now seemed to have entered his heart. In other words, he was now in touch with his emotions, perhaps for the first time. Quite soon he was seeing a woman, and soon after that he left therapy. I later heard from him that he was married, and was expecting his first child. It seemed to me that he had genuinely moved on to the Centaur level, but I never really understood how or why. But in truth, I don't worry too much about the whys and wherefores. I do what I do, and hope for a good result, which often comes, I know not why.

I do not know how many therapists out there are in this boat with me, but I think it may be many. If any of them would like to correspond with me about the difficulties (or joys!) of working in this way, I would certainly respond. My email address is inforowan@aol.com. The poet Daniel Hoff has said – "On the way to knowledge, many things have to be acquired; on the way to wisdom, many things have to be discarded". To get from the Mental Ego to the Centaur is a process of discarding false assumptions, which is always painful, but also glorious.

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Note: It will be seen that I have placed on the Maslow chart one level which he never mentioned: Effectance. It was David Wright, a sociologist (1973, 1974), who first suggested that this was a missing level, and It immediately made sense to me. It seems not to contradict the spirit of Maslow in any way, and just seems an obvious omission.

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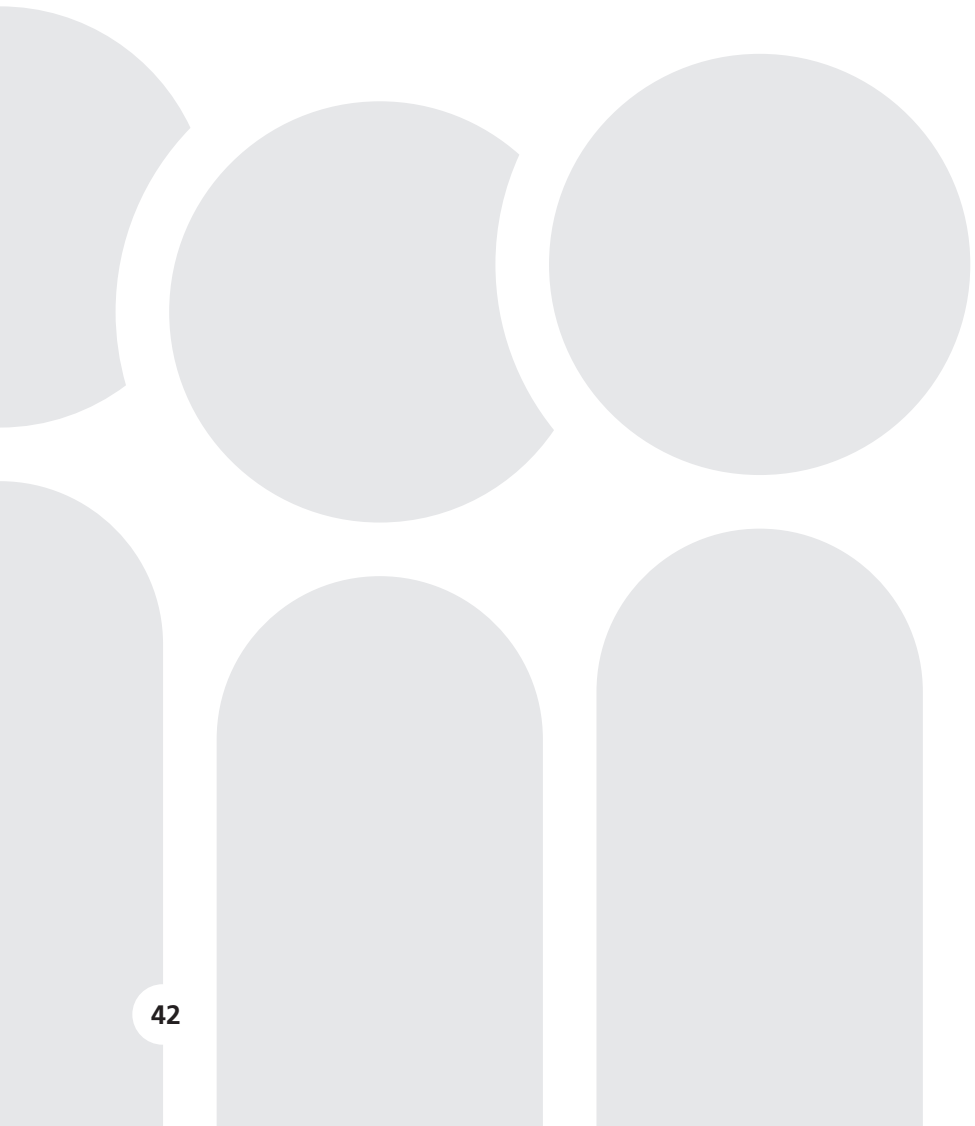
John Rowan has been interested in Maslow since 1972, and has written several papers on different aspects of his work. He has also contended for the importance and usefulness of the concept of levels of consciousness generally, first of all following Wilber pretty closely, and more recently opening out the field to more possibilities. His latest book, Personification, relates the idea to many different schools of therapy. He is a Fellow of the BPS, of the BACP and of the UKCP, and is at present helping to raise a puppy to be a guide dog for the blind.



Ian Rory Owen PhD

The Psychodynamics of Attachment in Everyday Life

Abstract

The paper brings together research findings and basic theory to help therapists of any sort identify attachment dynamics between themselves and clients, and for understanding clients in their home contexts. The term "psychodynamic" is used in its original sense from its originator Edoardo Weiss (1950). The understanding of attachment dynamics created refers to everyday living and moment to moment changes in emotion and relating, between people in a variety of contexts (Heard and Lake, 1986, 1997). The ideal for therapists is knowing how to act in the moment. So that current thoughts and feelings can be reflected on with clients in sessions. Reflections outside of the session; or through supervision, are also useful applications of the understanding of attachment. This paper makes definitive statements about attachment processes so that it becomes possible to recognise the wider clinical picture involved. One that is heedful of a developmental view of relationship styles with respect to the impacts made on children, who I here cast as innocent parties who have received a negative learning experience. I have previously argued against the Freudian meanings of the term transference, and argued instead for the adoption of mis-empathy (Owen, 2006a, 2006b, 2007).

Introduction

Given that love, friendship and gaining co-operation are three of the most important and satisfying aspects of life – and that their frustrations and disappointments are the worst, I present some findings from attachment research in adults. First, I want to comment on the style of the presentation that I am using. In order to summarise a good deal of information into a small space I resort to bringing together a list of research findings to provide a scholarly overview of different aspects of the attachment processes. I translate such material into a form that I hope therapists will recognise and apply. For the purposes of this paper, I will only be presenting that which I think is most valuable towards the aim of helping clients stay in therapy and remain able to use it (Cassidy & Shaver, 1999, Johnson & Whiffen, 2003). My focus will be more on identifying how both parties contribute towards the therapeutic relationship. I have distilled developmental and social psychological empirical findings (Shaver & Mikulincer, 2002) to aid becoming able to recognise the immediate dynamic in the room. I urge an acute sensitivity to bodily gesture, facial expression, voice tone and the content of speech – all with respect to the emotions that therapists feel. The view taken is an integrative one and a further development of my interest in theoretical and practical integration (Owen, 2009, 2011). Through sensitivity to how clients communicate verbally and non-verbally, and in relation to what therapists feel, I am hoping to communicate effectively with them, assertively and with tact, to make the therapeutic relationship a topic for discussion, to make it more secure, and so assist therapists to deliver the help that clients are seeking.

For therapists, while it is the case that practice is not an intimate relationship for them, because they do not disclose verbally about

the detail of their lives, it is the case that they self-disclose nonverbally and continually. What I am referring to is that our facial expressions, tone of voice, and whether we smile before we speak, for instance, or if the corners of our mouths might be turned down whilst we listen, are all powerful communications from us. Non-verbally, clients read us while we read them. There is a circular system of cause and effect in operation, as in all relationships, the contributions of one party lead to the contributions of the other. Yet there is something truly amazing in all relationships. The consciousness of other persons never appears "first hand" like our conscious experiences appear for us. Whilst I am not saying that all of the contents of our minds are transparent to us; what I am getting at is that we never get to experience anything as another feels it. We never have and we never will. Putting the two together then, we can only be intimate and close with people, to the extent that we communicate with them and come to know and trust that what they say concords, is congruent with, what we experience of them. In this context are considered the difficulties of the psychodynamics of two-person therapy relationships, with the focus mainly on the perspective of clients. The approach I take below is first to consider attachment dynamics as they appear generally in the everyday lives of clients (and ourselves). Only once this context is established will I consider therapy relationships.

Psychodynamics of Attachment in Everyday Life

It was Edoardo Weiss in 1950 who first coined the term psychodynamics. This word is not the sole possession or capability of the psychoanalyst or the psychodynamic psychotherapist. All human beings to some degree, even if inaccurately, are being psychodynamic when they describe and explain the "manifestations and consequences of the interaction of mental forces within the human being", (Weiss, 1950, p. 1). He was referring to conscious experiences that are "teleological" (p. 2) because they concern purposeful, aim-oriented behaviour. His opening words are: "Every human being is aware of inner driving forces whenever wishes, feelings, emotions impel him to act... he is also aware of opposing forces which restrain him from acting. When gratification is obtained through action, the driving force is felt to subside; but when action ... is checked by an interplay of emotions, either the initial psychological situation persists unaltered, or new ones arise which must be mastered", (p. 1).

In my view, psychodynamic is nothing other than being emotionally intelligent or psychologically-minded. It covers the connection between mental processes and the persons to whom they are directed. And so it is with attachment. There are three major types of attachment, secure plus two insecure types, anxious ambivalent and avoidant. (There is a fourth major type disorganised that occurs because of parenting and formative experiences that were traumatic, abusive or highly neglectful and disorganised – I won't be commenting on this although it is highly relevant to practice, Richardson, 2008). The meaning of attachment is also closely related to the conscious experiences of love and its disappointment, intimacy and self-disclosure of all types, the desire to be close and connected with other people. This is why I am first attending to the signs of secure, anxious and avoidant attachment in everyday life. Being securely attached brings with it the promise of lasting satisfaction and indicates good mental health. Anxious and avoidant processes need identifying and rectifying.

So for the sake of readability I am not going to run through the background material blow by blow, but I am now going to state some identifying aspects of the secure, anxious and avoidant processes in everyday living. The paper closes with an overview of how to work with the two insecure styles or relating. The next three sections are thumbnail portraits of the secure, anxious ambivalent and avoidant styles of consciousness and their accompanying social worlds.

Empathy of the Secure Other Seen from a Secure Perspective

Secure persons are those who can create a secure process between themselves and others most of the time, regardless of the problems and conflict that they may face. Its origins are in the context of childcare where the carers

were there for the baby at the beginning of its personal history. What was provided were consistent, tender, responses and accurate empathy, so that infants could 'see themselves in the minds of their carers' and see that their needs and emotions were acceptable even when they were distressed. The carers were there for their children and effective in providing care and promoting safe exploration. They were successful in understanding their child and so nurturing an adult who can satisfy their own needs and be both autonomous and connected to others. Secure attachment is a most interesting process worthy of detailed consideration. In adulthood through, the message is that gregariousness is good and it is perfectly acceptable to be yourself, and be open about one's distress with others particularly those who mean something and with whom we are closest, and so make a life. Here are some key aspects (Lewis, Amini & Lannon, 2000, p 73-4, Shaver & Mikulincer, 2002, p 138).

1. Secure persons can moderate their own distress. Are emotionally regulated: they soothe themselves when they are distressed and tend to the distress of others.
2. Have an accurate, positive picture of the capabilities of others and are trusting generally.
3. Have long-term relationships and friendships and maintain them. Shows love, trust, openness and sharing.
4. Are generally trusting, relaxed, assertive, have good self esteem and are accurately empathic and insightful (AKA emotionally-intelligent, psychologically minded).
5. Secure persons are loving and warm: they comfort others when they are distressed, facilitate others, accept and encourage them. They are intuitively helpful and know how to help others and may do so, even before needing to be asked.
6. Have strong social and communication skills, are more relaxed and better adjusted to contexts even if they are ambivalent about them, as they can tolerate situations that are imperfect.
7. Sets boundaries with others, is solid, reliable, calm, flexible and show creative problem-solving.

Empathy of the Anxious Ambivalent Other Seen from a Secure Perspective

Anxious ambivalent persons are those who create an anxious process between themselves and others most of the time, regardless of the interest, help and support that they may have. Technically, their attachment system is hyper-activated in that they have a hair trigger: They strongly want to go forward towards others - but are also quick to run away. In a moment, they can turn on the spot. They are confused in how they feel and appear confusing to others. They are clinging, needy and demanding when turning towards others and may be critical, angry, untrusting and rejecting. This is because the caring they received was inconsistent and their carers were unable to console their children on reunion after separation. The term "tangles" describes what anxiously-attached people do in therapy sessions and everyday life when they resist care. Past pain is close to the surface. The anxious self sees itself as insufficient in the eyes of others. Some key facets are (Shaver & Mikulincer, 2002, p 141):

1. Anxious attachment centres on emotional dys-regulation, anxiety about the nature of close connections, mistrustful, 'fussed up,' worried or pre-occupied, paranoid even, about the current quality and the future of relationships and have low self-esteem and self-doubt particularly in the absence of current real deficits of these sorts.
2. Accuses others of being out of reach or indifferent to their needs when they aren't.
3. Shows distress and anger on separation from others who are felt to be special and close. Clings, wants to be very close. Demanding or angry on reunion after separation.
4. Can over-focus on a partner, idealises others, has anxiety about relating that eventually subside on contact. Has difficulty breaking up with partners or friends even though the relationship is really over.
5. Tangles up attempts at receiving care and getting close to others, withdraws. Metaphorically 'inspects the emotional bank account'. Can be hostile, threatening and manipulative as they respond to paranoid understanding of slights that are anxiety-ridden readings of the situation rather than factual one. May

tell lies to test others. May create envy or jealousy to test whether self is cared for.

If all the above were present at one fell swoop then there are needs for clarity of the treatment and getting clients into positions where they can use what is going to be offered them as part of the skill here is making sure that they will be able to tolerate the ambiguity and worry that having therapy may cause for them.

Empathy of the Avoidant Other Seen from a Secure Perspective

Avoidant persons are those who create an avoidant process between themselves and others most of the time, regardless of the reaching out of others towards them. They are in denial and on the back foot, emotionally. Their attachment system is either weakly activated or easily deactivated. They reject, distance themselves, avoid, and move away from forms of love, connection and support. When under stress, they may temporarily become anxious ambivalent, whilst the stress is current. However, they only tolerate weak and superficial connections with others. This is due to receiving un-empathic, unresponsive, cold, neglectful, rigid and resentful parenting. The resulting indifference in the adult is the best way of maintaining a form of contact that is undemanding and has been generalised from its original source. Persons who habitually use the avoidant process, have their consciousness and emotions set low, as they feel little but are physiologically stressed. For them, their needs are unacceptable and they need to remain isolated because connection to others is fearful in itself: They have closeness anxiety rather than the expectation of feeling the warmth of human contact (Shaver & Mikulincer, 2002, p 143).

1. Avoidant persons are commitment phobic and alienated from their own attachment and intimacy needs. Originally, this was a means for surviving harsh psychological environments. But commitment phobia has become generalised needlessly, to become excessive self-reliance. Accordingly, something inherent, the potential to enjoy the warmth of human contact is repressed and the effects are long-lasting.
2. There is a lack of intimacy glue. Avoidant persons have valency of the sort that they only have the ability to connect with secure or anxious others but not with other avoidants as their abilities to form relationships are limited.
3. Angry or anxious when others get too close or too intimate. Complains that "others expect too much" and belittles them for being needy when they are not.
4. Can suddenly deactivate a connection, isolates self, and 'goes elsewhere' internally or externally. Or deactivates love and closeness through omission: There is a consistent lack of emotional intimacy, and there can be prickly criticism, and a lack of positive verbal and affectionate responses. Avoidant persons are continually stressed but passive, sometimes not expressing or even feeling the distress of isolation and 'put their emotions in a box,' metaphorically speaking.
5. Appears blank: Little emotion expressed on separation and reunion.
6. Sometimes when stressed, avoidant persons can appear as anxious-ambivalent and the repression of their own needs may be lifted for a while, as they truly express themselves – but this only happens temporarily.
7. Show pseudo-closeness with people that are known for a long time. Otherwise can be critical and unfaithful with a partner. Have a poor expression of appreciation for friends, family and partner. Feel exposed and pull away after being emotionally intimate. They may mentally divorce a partner or close friend and give them the cold shoulder. Can be vague or secretive and lack self disclosure. Ends relationships but then idealises the ex-partner.
8. Has desire for ideal partners and friends. Communicates through incongruous verbal and non-verbal ways. Does not care and invalidates others' emotions to escape intimacy. Generally, unresponsive to others, cold, lacks appreciation and valuing, over-values thinking so appearing unemotional. Ignores reasonable requests and messages for contact.

If all of the above were present in one person, traditional psychiatry would want to use the term schizoid and expect the person to feel empty and depressed perhaps because connections are not getting made.

Empirical Findings About Attachment Dynamics in Therapy

The background information above was provided to create awareness of what is going on with the three major types of dynamic process. These can be seen in what clients bring to assessment, in what they discuss about their work and home life. The aim is now to focus on dynamics between secure therapists and secure, anxious or avoidant clients. After the above, I want to turn attention to therapy relationships and consider some empirical findings to focus on key processes and relate them to turning points in therapeutic relationships, to help identify contributions from our side and the clients' side. The sum total of both contributions is a mutual creation. In doing this I refer to empirical findings by Una McCluskey in Attachment therapy with adolescents and adults (Heard, Lake & McCluskey, 2009, pp. 134-5) which is a re-working of the presentation within To be met as a person (McCluskey, 2005, pp. 81-2, 219-226). In her terminology, clients are cast as care-seekers, whilst therapists are care-givers. McCluskey (2005) identified nine major repeating patterns in a qualitative analysis of videotapes. I re-present her findings in condensed form and refer the reader to her originals to get the full picture. The first three are secure and the remainder are insecure in various ways.

1. If therapist and client are both in role as care-seeker and care-giver, then a secure process is achieved through each meeting. The therapist takes the lead in empathising and verbalising the emotions and motivations of clients back to them and they confirm whether we have understood them. The mutual process is one of co-responsiveness as they are also open to what we say. They see that they are acceptable in our eyes and they re-evaluate the meanings they had in this new light.
2. Clients present a topic assertively but therapists comments are at first irrelevant as they haven't quite empathised what they are being told. But clients persist and then the penny drops and therapists tune in more accurately, so the remainder of the meeting become like item 1 above.
3. At first clients present in an anxious and disorganised way but therapists are able to catch all the contrary nuances and then secure process is achieved, like 1 above.
4. Clients start asking for help in a secure way but therapists persistently fail to tune in and divert onto irrelevancies without catching the client's point. There is no psychological contact but 'two conversations in the same room' metaphorically speaking. Clients psychologically withdraw towards the end of the session.
5. Clients are demanding but therapists are unable to soothe their emotions. Therefore, there is disagreement and the therapist has failed to empathise. Both persons cease to have psychological contact by the end of the session.
6. Clients present their topic securely but therapists are aloof throughout and under-responsive, so clients give up presenting during the session, somewhat like item 5 above.
7. Therapists miss their clients' expression of despair. There is some slight contact before mutual withdrawal, like 5 again.
8. Clients present a topic and are highly anxious and resistant in the manner of presentation. However, therapists miss the point entirely so clients resist more than previously and end the session distressed or dismissive towards therapists' failure to empathise and contain them, similar to item 5.
9. Clients present securely but end up resistant and withdrawn or dismissive because therapists have failed to empathise the original emotion presented at the start of the session, somewhat similar to 5.

What Heard, Lake and McCluskey (2005) conclude is that why therapists fail to respond is due to the effects of anxiety on their otherwise intact ability to empathise. The inhibition of responsiveness means that they are empathised as turning away, dismissing and uncaring. In some cases, two seconds of silence is read as dismissal. If one is subject to implied criticism or sarcasm, then any comments that defend, explain, or put the blame back onto clients, can then be read as a counter-attack even if they were meant as explanation. In this situation, clients might assert themselves and re-present their topic for attention. Or maybe, they withdraw that topic (to substitute it with a safer one). But they might ultimately cease to attend – either suddenly

or just lose interest in attending, in the belief that this therapist does not understand them.

Discussion

One problem is that clients with different attachment styles read the same actions in different ways. For an avoidant client, merely mentioning that the sessions will have to come to an end (the therapist thinks it is the half-way point) is enough for avoidant clients to feel that they are being thrown out. So they don't come next week, even when they have explicitly agreed to phone and cancel - or when they have agreed to discuss complaints with you. This is what I mean about people reading each other. What I am referring to is how people empathise each other. In this case, a secure therapist had intended to help by to paving the way towards a planned ending, and agree a final focus for the treatment; but the avoidant client drew the conclusion that nothing more could be done, that the therapist couldn't be bothered with them anymore, that we were bored with them perhaps, and therefore left in a huff and felt rejected. Clients do read the implications of what we say and do, and non-verbally, how we look to them, and sometimes draw conclusions that are wildly inaccurate with respect to what we really did say or do, and what we really did intend.

However, as there is a general reluctance for clients to express their fears and worries to us, and if there is no debriefing at the end of every session to invite clients to express any misgivings to us, then it means that we have not foreseen difficulties that we could expect. In order to meet those worries and fears pre-emptively, the therapeutic relationship has to be safe enough, with sufficient prompting for clients to mention things that they feel, but are reluctant to tell us. Often their reluctance to speak up concerns the fear that we will feel criticised and that this will prejudice their care. Or, that the worries are too personal about how they see us and our abilities to help and understand them. From their perspective, they are left with the possibilities of denying the inadequacies they read in us; or hoping that we will improve in our care-giving; or continuing attending despite such hope; or valuing any small event that we have got right; or feeling hopeless and depressed and unable to improve the relationship (Heard, Lake and McCluskey, 2009, p. 139).

Without the possibility of open discussions with clients about their view of the help they are receiving, we will never be able to find out what they do and do not like about our abilities and their sense of the usefulness (or not) of what we are doing with them. Without regular review sessions, particularly at assessment and definitely at every one of the first six meetings, then there is no way of making sure that the therapeutic relationship is strong enough to continue. This is one means of minimising early drop out and making sure that clients get what they deserve and came for in the first place. The therapeutic skill is a type of assertiveness in being able to comment with tact and subtlety, on the immediate nuances of what is happening for clients, as they present us their stories which are highly complex and might be distressing to hear. Like hairdressers, we could easily cut people when we get close to them. Therefore, the skill is to be to the point but in such a way that it does not hurt too much nor alienate them from attending.

How to Work with Attachment Problems in the Therapeutic Relationship

The remainder of this paper focuses on the broad sweep of awareness and social skills required, once the basic forms of insecure attachment type have been noted in clients. (If on the other hand, readers are noting their capacity to be insecure in their homes lives and working lives, then I refer them to the many free resources on the internet so that they can test themselves and get an understanding of their own attachment style). The way that I am going to do this is to make appeal to the idea of emotional intelligence as supplied by Daniel Goleman (1995). However, I am going to take it a stage further into a means of working out how to react in a secure way. The therapeutic relationship, like any other, is the sum total of two (or more) persons. What oneself does, feels and says is only one half of the whole in individual therapy. I will arbitrarily start with what appears for a secure therapist in a sketch of how to proceed, but it might be the case that therapists are heavily focused

on what is happening for clients, which does not preclude what I am saying here. However, let us start with the most basic awareness of our emotions in relation to insecure clients.

The first step in being emotionally intelligent in a secure way is to become more aware of what oneself is already aware. In being open to 'the here and now' relationship, a therapist can get too caught up in a needy or hasty action rather than finding out what clients really do think about when they are properly engaged in therapy, collaboratively. The emotions we feel are the sum total of many factors. In the context of being a secure carer, the intellectual context described above translates into being a confident and interested therapist, who wants to know what is happening for his or her clients, and is neither closed off by their distress or overawed by its demands, or some other strong emotion about clients in total. The basic feeling-state of wanting to help, I suggest, is an openness and warmth addressed to the general public, a kindness or attitude of compassion, an attitude of tolerance and interest in the other's unique self. If there are strong emotions evoked by the non-verbal presence of a client and his manner, then these emotional forces that arise in our connection to specific clients can be understood through our emotions, thoughts and physiological reactions, concerning how it is to be a professional helper. This is a second step of understanding the psychological causes of the client on us. We are aware of the immediate situation, but that is not all.

Next, whilst still only focusing on self, the primary attitude towards clients is to be aware and to soothe-self, if necessary, whilst responding verbally. In the cases of insecure attachment which I will describe some more below, there is the case that one's own distress can stop rational and caring action. If the empirical research of John Gottman is right, he has found that within couples with discord in their relationship then when people's heart rate goes above 100 bpm (especially men), then the ability to rationalise and empathise can be lost (Gottman & Silver, 1999, p 36). The final part of the therapists' response is to make assertive verbal communication that pre-empts problems, explores the clients view with their permission, and otherwise unceasingly works to promote the therapeutic encounter as a secure event and safe haven.

Let us look at the empathic relation towards clients some more, again entirely from a secure application of the intellectual content of what has been cited above – but now turned into emotional intelligence, as it can be operationalised. The first awareness that needs checking is our empathy of what is happening for clients. For it is only they who can confirm or deny whether we are understanding them properly. The reflection with clients on our thoughts and feelings is an absolute necessity in order to check whether our empathy of them is correct (Rogers, 1986). Secondly, the psychological motivations of their emotions, understanding, thoughts, intentions to act, the meaning of what they are describing, when they explain how their family bullied them as a child, is precisely sharing and checking the accuracy of our understanding of their attachment style and our reading of their relationships with their family, for instance. Another important topic to focus on and explore, is how they see us and how they view their side of the relationship with us, but I will say more on that score below. What also arises in our empathising of clients is an anticipatory empathy of what their further responses and intentions might be, and this too needs to be checked out with them. At a higher level, there is the checking of understandings about what they say and do in our relationship and finally leading into soothing and caring actions that they can do for themselves or in other ways where we can help them be self caring.

So the remarks above indicate the application of emotional intelligence in relation to how to work and promote a secure therapeutic process in which we are responsive. We lead in making it safe for clients to be emotionally present, and speak their problems and be autonomous. Our behaviour models how to relate securely and shows that it is good to speak about distress in a safe relationship and find that meanings do change, entirely spontaneously, or through the experience of being valued and treated as a worthy person whose emotions are valid, and in a number of other ways including the use of explicit techniques to change meaning. I would suggest that towards the end of every session that approximately five minutes is spent on

rounding up what today's meeting has been like in a type of debriefing. The research on pre-empting dropout seems to support the effectiveness of monitoring the relationship, particularly during the first six sessions.

When working with anxious ambivalent clients the following point may arise. The general aim with anxious ambivalent clients is to pre-empt their protest behaviours, disappointment and anger, by speaking assertively, armed with the knowledge of their view of the world and how they might feel. They might tell you that you cannot help them, or show displeasure at not being helped by others in their lives outside, or tell you directly that you are not helping them and that you are no good. The emotions that are likely to arise in therapists in meeting these persons are of feeling overwhelmed, threatened, worried and anxious and over-helping and tangling clients up in return through feeling anxious. The formulation of their anxiety in relationships is that their current distress, when triggered, leads to poor thinking and ineffective problem-solving, which reminds them of their past distress, and that feeds their current distress. Accordingly, therapists should expect clinging and neediness, and excessive openness about problems with accompanying worry about the impact of these revelations. Contrary demands for help may be followed by rejection of oneself and criticism or lack of value to sessions which you thought went well. Unwarranted criticism and personal comments might arise including envy. At assessment there might be difficulties in getting in the room: wanting to know what will happen before attending, wanting to bring a partner into the first session or all subsequent sessions, or they are fearful and want to tell you everything at the first meeting.

Persons who are habitually avoidant present a completely different dynamic indeed, if they enter therapy at all. The overall aim with avoidant persons is to pre-empt their avoidance of attending and their avoidance of painful emotions and topics. The avoidant person will not know what to say when they attend, or might be submissive and ask for your direction, or what they may do is back out of the work in a variety of ways, by not being mentally present or by not working in the session, or cancelling or not turning up at all. The formulation of their problems is that their safety procedure is deactivating their emotions and connection to others, in order to maintain their self-reliance and self-enclosure. Accordingly, they reject both threats and support, and have no access to personal resources for doing otherwise. The emotions that will arise for therapists are that they want their clients to hurry up for they are slow, untrusting, and poor at self-disclosing, nor emotionally literate or socially skilled either. The key to working with this type of relationship dynamic is to go at their pace and to focus on the expression of emotion and the impact that that has for them. They may admit feeling distressed for several days after a session and may ask to come once a fortnight rather than once a week. I have found that asking them how you can help them may not get an answer. So I would recommend not exceeding their capacity for distress and spend a good portion of the early sessions going over what it is like to attend, and to make how they experience attending, an agenda item for each of the first few sessions. I would also recommend explicitly discussing with them, what it is that they want to discuss and to maintain their attendance on a regular basis. The avoidant client will be avoidant everywhere and with everybody. What the secure therapist models with them is the utility of taking the risk to speak out what it is they truly feel. This goes against their lifelong trend of not saying what has happened for them and what it feels like, but on the outside, as it were. They may provide excessively short answers to questions and need prompting to provide the amount of detail that is sufficient to discuss their experiences at length. It might be the case then that you hear things for the first time that have never been spoken about and have been locked away and forgotten. Avoidant persons are not demanding and are likely not to seek therapy and may see little or no value in human warmth and contact. Their attachment needs are repressed and forgotten and their lack of valued contact is something that you are indirectly working on rather than in the anxious ambivalent case where there is more friction and sparks are flying.

For me, the attachment literature is a treasure trove of material that can support the application of its findings in transforming the quality of people's lives. Knowledge of attachment styles apply to us as therapists

because at an experiential level, once we know how it feels to be secure, then our professional work also falls into place and makes sense in an unshakeable way.

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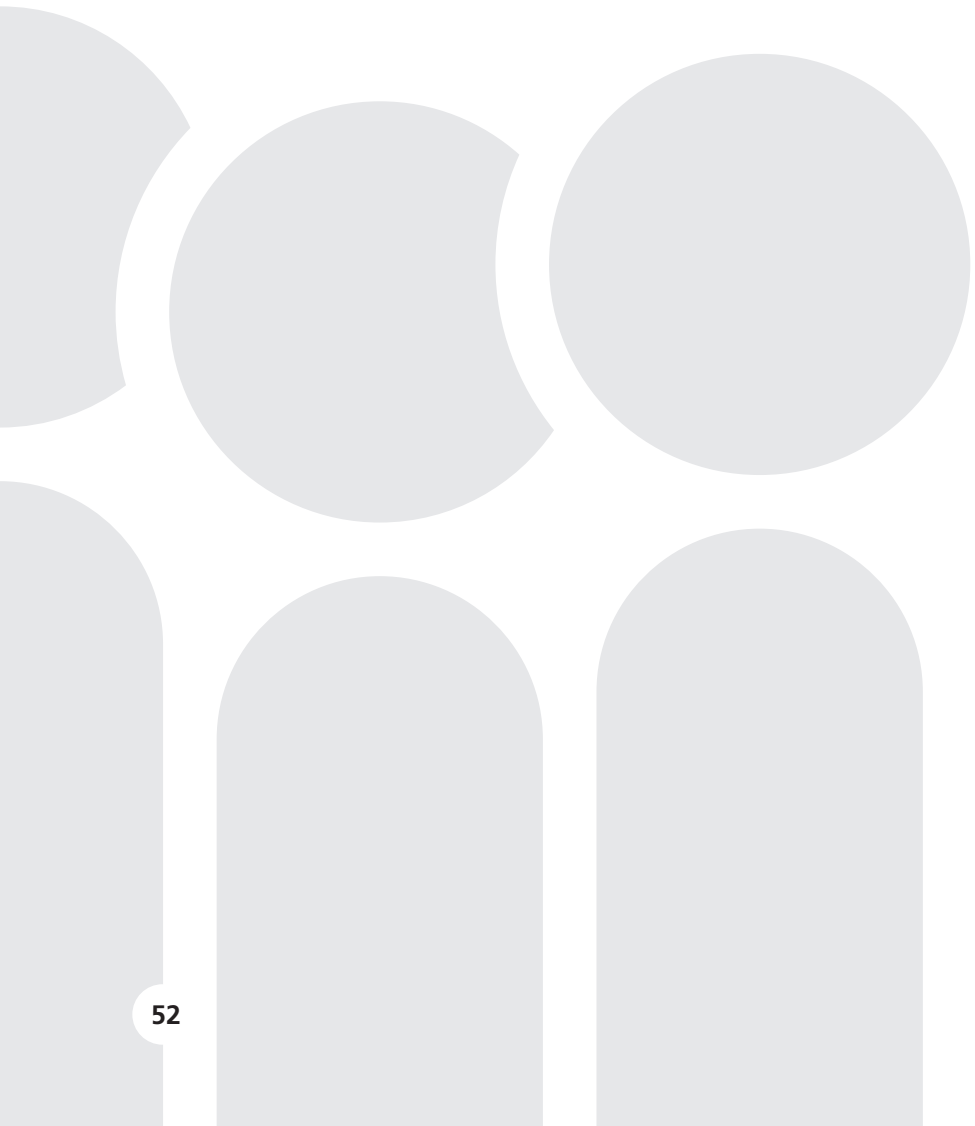

Jon McAteer

Section A - Framework for integration

Editor's Note

This material constitutes the theoretical section of a case study submitted to meet part of the requirements of the Doctorate in Counselling Psychology and Psychotherapy at Metanoia Institute. The student is required to give his own framework for integrative practice.

Summary of Integrative Framework

The foundation of my integrative framework is my view that each of us is 'thrown' into life and have to face the existential givens articulated by Yalom in Love's Executioner (1989): the inevitability of death, freedom to make our lives, ultimate aloneness and the absence of meaning. I explore these challenges in my clients' lives.

Although from one perspective we face the existential challenges alone, I also believe we try to manage these fundamental givens through our relationship with others. The relationship, then, is the next focus of my integrative model. In the relational frame I understand self with other from an intersubjective perspective. So when clients feel bad, it is something that happens in the intersubjective reality of self with other (De Young, 2003).

I am aware that much of what happens in relationship is unconscious, and this can be made explicit through examining transference and countertransference. Drawing upon the work of Stolorow and Atwood (1992, p.25), I work with two dimensions of transference, 'self object' (client looking to the therapist to meet developmental needs) and 'repetitive' (client's expectations that the therapist will repeat developmental failure from their past). These dimensions pull together key concepts from a number of psychoanalytic schools.

To help me understand the complexity of my client's relationships in the present, I also draw upon the developmental theories of Stern, Bowlby and Schore to explore repetitive patterns and developmental deficits. Specifically I look at the concepts of affect attunement (Stern, 1998), patterns of attachment (Bowlby, 1997) and right-brain-to-right-brain regulation (Schore, 2003).

Finally, I use Stephen Johnson's Character Styles (1994), which elaborates on different developmental deficits and adjustments, and how these present as characteristic personality styles.

Values and philosophical principles that inform my view of psychological therapy

I start by outlining my personal values. Firstly, I believe there is one fundamental 'given' that provides the context for life (Yalom, 1984). Everyone is mortal. We may not be consciously aware of our own mortality in every moment but ultimately we have to act, think, feel and experience our lives knowing that one day we will die. The challenge for all of us is to live our lives fully in the face of death.

During our short lives all of us have the freedom to choose how to relate to our experience (Spinelli, 2005). Although we are 'thrown' into existence (Heidegger, 1962), we choose

the meaning we ascribe to an event and the impact it has on us. I believe that all humans are capable of taking full responsibility for choosing their attitudes to their experience. For example, Frankl (2004) describes men living through the horrors of concentration camp life preserving a vestige of psychological freedom and choosing their attitude to their brutal lives.

Although in existential terms we are fundamentally alone (Yalom, 1984), relationships are still the most valuable thing we have in this world. Clarkson (2003) says, "Relationship is the first condition of being human. It circumscribes two or more individuals and creates a bond in the space between them, which is more than the sum of the parts" (p.4).

It is not only our existential selves and interpersonal relationships that define our humanity, though, but also our place in society. I do not agree with Margaret Thatcher when she said there is no such thing as society (Margaret Thatcher Foundation, 1987). We are part of society and connected to the whole of humanity.

Finally, I believe that each one of us is a unique human being. We manage the challenges of existence and relationship in our own way, and choose a path that is uniquely ours. I cannot impose my path on anyone else, and nor can they impose their path on me.

Building on these personal values, I now articulate my philosophy in psychological therapy. Yalom (1984) provides the foundation for my philosophy with the 'existential givens'. These include two of my most important values, mortality and freedom to choose, and add two further givens, isolation and search for meaning, which together form the ultimate human concerns. In my work I listen for the existential challenges that my client brings. I do not hide from the sometimes frightening truths of existence, but together with my client I take Yalom's (2008) advice and "stare into the sun" (p.9).

The question now is what do I do with these existential givens? The second plank of my philosophy in integrative psychological therapy is a commitment to the relationship. Relational contact is a way of facing and managing the existential challenges. Relationships give meaning to our lives and provide contact in the face of fundamental aloneness and mortality. My client work always recognises the importance of the relationship. De Young (2003) writes that everything a client brings is about self-with-other, and everything that happens in therapy is a self-with-other story. From this perspective the client's problems are always about relationships, and healing occurs in relationship.

Beyond individual relationships, though, I also think there is a need to take account of our relationship with society. To give me meaning in the broader context of society I also draw upon the philosophy of Action Research. I agree with Reason and Bradbury (2006, p.7) that we participate in our world and that we are part of a whole. Through action, in conjunction with all stakeholders, we have a responsibility to contribute to human well-being in a practical, everyday way. I embed the principles of Action Research in my practice. In working with my client I not only serve him/her but also aim to build pragmatic, practical knowledge that serves wider communities.

I also strive to respect the uniqueness of my client and to honour the world view they bring. Although I am interested in categories of people and patterns my client may share with others, I always try to remember that my client is unique and I try to understand what it is like to stand in their shoes.

My View of Human Beings

In this section I answer three questions about human beings: what motivates us, what is the structure of the self, and how do we develop?

What Motivates Humankind?

I understand human motivation from a number of different perspectives. I draw upon existential psychology, which looks at the motivation for staying alive, facing death and finding meaning in a meaningless world. Also I take ideas from the psychoanalytical literature, which highlights a basic motivation to relate to others

(object relations) and to achieve self-cohesion (self-psychology). I expand on these ideas below.

Firstly, I start with the most basic motivation, that of staying alive. In Frankl's (2004) account of the Nazi concentration camps, faced with relentless brutality, he says that everything not connected to the immediate task of keeping oneself alive had no value. I view this motivation as both a biological drive (Pine, 1990), and an existential concern. In my work this motivation sometimes appears in the stories of clients who have been systematically abused in childhood.

I also include Heidegger's existential perspective in my view of motivation, which can be seen in his idea of 'being-free-for-death' (1962). He writes that the complete acceptance of death can lead 'dasein' to a full and authentic life (Heidegger, 1962), and it is this acceptance of mortality that gives us life's goal. Of course facing mortality is not a conscious motivation for most of us. On the contrary, as Yalom (1894) suggests, we mainly view death as an unmitigated evil. So we are motivated to turn away from death or face it, leading to very different approaches to living.

Lastly I borrow the title from Frankl's (2004) book "Man's search for meaning" which articulates another existential motivation. Yalom (1984) encapsulates this in his question: "How does a being who needs meaning find meaning in a universe that has no meaning?" (p.423)

From a psychoanalytic perspective Pine (1990) traces motivational theory through four stages. Of these stages, the object relations and self-psychology perspective are prominent for me. Taking object relations first, Fairbairn (1952) argues that people's primary motivation is for contact with others. Siegel (1999) describes this in attachment terms and suggests that attachment is an inborn system that has a basic evolutionary purpose. So from this perspective a primary motivating force is towards relationships with others.

With a self-psychology lens, Kohut and Wolf (1978) describe the infant as being motivated to use others as self objects to tune its subjective states to achieve a coherence, self-confidence and inner security. Faulty interaction between the child and its early self-objects results in a 'damaged' self (Kohut and Wolf, 1978). From this damaged structure, people are then motivated to find self-objects to address their developmental deficiencies.

I do not neglect Freud's drive theory though. Two-person psychoanalytic developments do not cancel out the one-person drive theory of motivation. Although Mitchell (2000) says that the one-person drive perspective is accounted for in an intersubjective model, I disagree with him that the pleasure drive is only part of object seeking. I think that 'wiring' for connection (Mitchell, 2000) does not fully explain the biological 'hardwired' drive for pleasure, but may co-exist with it.

Structure of the Self – Multiple Selves

In order to better understand the makeup of each unique human, I now explore my view of the self. I do not think there is a unifying theoretical view of the self but agree with Mitchell (2000) that we are multiplicitous, not a single self. I explore my view of multiple selves below.

Existential Self

I believe that each of us has an existential core. This existential self is fundamentally alone in the world (Yalom, 1984). This self knows it is mortal and strives to give its existence meaning. It is this self that can take responsibility for its own agency or it can try to deny the existential givens of life.

Intersubjective Self

I also believe, though, that humans are inherently relational beings. I agree with Stolorow and Atwood (1992) that "the development of personal experience always takes place within an ongoing intersubjective experience" (p.9). To be fully human entails being recognised as human by other humans, and recognising others as humans (Mitchell, 2000). Stolorow and Atwood (1992) argue specifically that the child's

self can only develop in a child-caregiver two-person system of mutual regulation.

This intersubjective view of the self may seem in conflict with my existential viewpoint. Stolorow and Atwood (1992) strongly criticise the "myth of the isolated mind" (p.7). I think that our fundamental isolation and relationality co-exist though. There is often an uncomfortable tension between these selves because it is difficult to reconcile the perspectives of being isolated and connected simultaneously. However, I think it is helpful to see relationality as providing the means to manage existential isolation.

Self-in-Context

I also think it is important to view our relational selves in a broader field. I agree with Lapworth, Sills and Fish that the individual cannot be taken out of their "occupational, socioeconomic, sexual, religious, racial, linguistic and geographical context" (2001, p.69). Evans and Gilbert (2005) support this with their view that a client can only be understood from within their own cultural milieu. Also, O'Brien and Houston (2007) warn that the idea of an individual 'self' is a Western concept, and that someone from a society that places greater emphasis on social roles might not grasp the western idea of a unique individual.

The Unconscious vs. the Conscious Self

I also recognise that we have an unconscious as well as a conscious self. I think that the most important contribution to our understanding of the unconscious self comes from Freud. Although his topographical model (1915) was later considered insufficient as a map of conflict (Mitchell and Black, 1995), it does highlight the difference between unconscious processes and the conscious mind. Freud's later structural model (1923) gives me a deeper understanding of the unconscious defenses that are a powerful component of the unconscious self.

Contemporary neuropsychological work reframes Freud in terms of the implicit and explicit "synaptic selves" (Davidson, 2002, p.268). Davidson goes as far as saying "Who we are is not synonymous with who we consciously believe ourselves to be" (p.268). Schore (2003) underpins Freud's work on the unconscious self with an exploration of right-brain systems that "offer us a chance to more deeply understand not just the contents of the unconscious, but also its origin, structure and dynamics" (p.251).

Psychological Development – Theoretical Foundations

I will briefly outline here what I consider to be the most important human developmental considerations, which I will elaborate further when discussing concepts of healthy and dysfunctional development.

I start with Bowlby's work on attachment because this is the cornerstone of my understanding of infant development. I agree with Bowlby (1980) that "Intimate attachments to other human beings are the hub around which a person's life revolves, not only when he is an infant or a toddler but throughout his adolescence and his years of maturity as well" (p.442). It is our early experiences of intimate caregiver relationships that become the initial blueprint for the structure of our inner worlds (Wallin, 2007).

Attachment theory makes sense to me in evolutionary terms. The innate motivation to find a secure base through attachment is likely to improve the infant's chances of survival (Siegel, 1999). The attachment concept is also robust in that attachment is measurable experimentally and stable. Ainsworth et al's (1978) work on the strange situation provides a powerful method for measuring security of attachment and classifying attachments types. These become even more useful with Main et al's (1985) work on adult attachment classifications, which demonstrate the structural continuity of attachments through the lifespan (Wallin, 2007).

I also draw upon Stern's layered model of infant development (1998). In particular, I am interested in Stern's concept of affect attunement. Stern's focus on nonverbal caregiver-infant exchanges of affective transactions helps me understand how an infant develops its sense of intersubjective relatedness (Stern, 1998). His discussion of affect attunement also helps explain important clinical issues such as

empathy and mirroring (Stern, 1985). What is most useful to me about Stern's work is that he complements Bowlby by providing subtle observations of the infant-parent relationship in the present moment (Stern, 1998).

Kohut's work on the development of the infant self via its interplay with the early childhood caregiver environment is also important. Kohut looked at development in terms of infant experience of three types of selfobject needs: mirroring, idealized and twinship selfobjects (Mitchell and Black, 1995). The strength of Kohut's model is that it links how infants develop with how this manifests in distinct transferences, and then with how a therapist can rehabilitate the deficient structures (Kohut and Wolf, 1978).

Finally I reference the work of Schore. His emphasis is still on attachment, but his focus is on right-brain to right-brain regulatory systems that "underlie attachment and developmental change" (Schore and Schore, 2008, p.9). The importance of Schore is that he explains about the precise nature of attachment, affect attunement, selfobject development and transference in neurophysiological terms.

Integrative Problem Formulation

Healthy Development

Before discussing my approach to integrative problem formulation I will first discuss healthy human development. I emphasise though that I see healthy/optimal human development and unhealthy/dysfunctional human development as being primarily dimensional, not categorical, but I will use the distinction here to differentiate the two ends of the continuum.

The foundation for healthy human development is summarised by Winnicott (1989): "A good enough-mother and good-enough parents and a good-enough home do in fact give most babies and small children the experience of not having been significantly let down" (p.196) I expand my understanding of 'good-enough' by drawing upon the developmental work of Bowlby, Kohut and Schore.

With attachment, it is the dimension of security that is the defining characteristic of the attachment categories (Ainsworth et al, 1978). With secure attachment, which I term 'healthy', the parents' sensitive responses to a child serve to "amplify the child's positive emotional states and to modulate negative states" (Siegel, 1999, p.21). Repeated experiences of sensitive parental responses are encoded as internal representations and help the child to feel they have a 'secure base' (Holmes, 2001).

I also find Kohut's selfobject perspective useful. He describes healthy development as optimal interactions between the child and its mirroring and idealized selfobjects (Kohut and Wolf, 1978). So when a child, for example, has 'good-enough' exposure to "the proud smile of the parents" (p.417) and can look up to calm and strong parents, it is left with a "firm self" (p.414).

I use Schore's work to help me understand healthy human functioning in neuropsychological terms, and it is also useful for integrating Bowlby and Stern's theories of healthy development. In essence I agree with Schore and Schore (2008) that affect regulation is the core of human psychological functioning. Specifically, parent-infant interactions are "imprinted in an internal working model that encodes strategies of affect regulation that act at implicit nonconscious levels" (Schore and Schore, 2008, p.12). In healthy development these early experiences are regulating, laying down 'good' neurological pathways, and imprinting a secure attachment model. This also supports Stern's (1985) work on affect attunement. Where a 'good enough' parent attunes, misattunes and then accurately reattunes to their child, that child is able to become increasingly self-regulated through the development and maintenance of synaptic connections.

Concepts that Inform My Integrative Problem Formulation

Of course many, if not all, of our clients will have experienced deficiencies in childhood that result in psychological problems in later life. In this section I will explore from an integrative perspective these deficiencies, derailments

and problems which are characteristic of 'unhealthy' psychological development.

Insecure Attachment

Like secure attachment, the insecure (unhealthy) attachment styles have their roots in how the mother responded to or ignored the child's initiatives (Bowlby, 1997). I agree with Bowlby here although his focus on the mother misses the importance of other attachment figures.

Siegel (1999) makes the specific links between caregiver responses towards infants and categories of attachment. So, for example, emotionally unavailable or unresponsive parents are associated with 'avoidantly' attached infants, and parents who show frightened, frightening or disoriented communications tend to have infants identified as 'disorganised'. As we shall see later, this directly informs my work.

Inadequate Self Object Experiences

From a self psychology perspective, developmental problems evolve with problematic exposure to three types of selfobject experience (Mitchell and Black, 1995). 'Faulty' interaction between the child and its selfobjects results in a damaged self (Kohut and Wolf, 1978). Kohut and Wolf specifically identify a range of parental failures that are likely to derail the child's healthy development, such as a prolonged lack of stimulating responsiveness from selfobjects in childhood or excessive or phase-inappropriate responses. Again, this informs my clinical work via examining the transference dynamics.

Insights from Neuropsychology – Affect Dysregulation

Increasingly I use Schore work on affect dysregulation to inform my view of problematic development. Schore (2007) makes the explicit link between the unconscious affect dysregulating mechanisms in the stressed insecure infant and the symptomatic patient. I am particularly interested in Schore's emphasis on the role of right-brain implicit systems that underlie developmental change and attachment. Unhealthy development is associated with psychobiological misattunement and relational stress in the implicit, right-brain-to-right-brain caregiver-infant dyad. From Stern's (1995) perspective, then, where a parent consistently misattunes and does not reattune, the child's ability to learn to self-regulate is impaired.

Ignoring the Existential Givens

I am also interested in psychological problems arising from the ultimate concerns of human existence. Cohn (1997) suggests that it is the unaccepted aspects of existence that are the cause of psychic disturbance. Although I do not think that existential issues are the cause of all psychological dysfunction, I agree with Yalom that all of us face the fundamental givens of existence, which cause anxiety (1984). To manage our existential anxiety we develop defenses. This might be considered an 'unhealthy' response to our existential core. I think that all of us respond defensively to the existential givens, but a commitment to facing the givens is a move in the direction of existential health.

The Overwhelming Effects of Trauma

In problem formulation I make a special case for trauma, which I highlight because of its impact on the individual that is beyond 'ordinary' derailments. Herman (2001) says that trauma is caused by extraordinary events that overwhelm ordinary human adaptations to life. It is critical for me to diagnose trauma because its psychological effects often devastate a client's life. Herman (2001) describes the profound and lasting changes in physiological arousal, emotion, cognition and memory produced by trauma.

I acknowledge Herman's (2001) view that that there is a spectrum of traumatic disorders, ranging from the effects of a one-off event to the effects of repeated and prolonged abuse. I am particularly interested in the syndrome she calls complex post-traumatic stress disorder (CPTSD), which is the result of prolonged, repeated trauma. In many cases survivors of childhood abuse, presenting with

a bewildering arrange of symptoms, are best understood in the context of CPTSD diagnosis.

A Categorical View – DSM-IV-TR

Although I primarily see psychological problems as being dimensional, I acknowledge that that descriptive criteria and diagnostic categories for psychopathology can be helpful when looking at groupings of symptoms, as this may guide treatment direction. It is also a useful perspective when looking at more serious symptoms, which may significantly compromise functioning.

Mainly I use the DSM-IV as a way of describing psychopathology as it presents in the here-and-now, and to help plan treatment (DSM-IV-TR, 2000). I find DSM-IV useful because it is multi-axial and helps me refer to multiple domains of information (DSM-IV-TR, 2000). In short-term therapy I tend to be interested in Axis I as this describes symptoms of disorders that might benefit from direct interventions leading to symptomatic relief. In longer term therapy I am interested in Axis II, as this helps me identify characteristic traits that are likely to be targets for structural personality change.

I always use Axis III with a client because it encourages me to explore general medical conditions, which may of course be related to the client's psychological presentation. Similarly, Axis IV problems may also affect the "diagnosis, treatment, and prognosis of mental disorders" (DSM-IV-TR, 2000, p.41), and provide the context for the client's issues.

Personality/Character Disorders

To further my understanding of disorders of personality I turn to Johnson (1994). Rather than using the term 'personality disorder' though, Johnson refers to 'character styles, which feels less pathologising to me. Johnson (1994) presents his view of character issues in a single table, which elegantly links the developmental period to character style, core issue and expression. He also links the categorical DSM-IV system with his dimensional structural development continuum, bridging the gap between a psychopathological-categorical perspective and a developmental-dimensional perspective. Johnson provides me with a concise reference for character types that I use in problem formulation with most clients.

I find the detailed analysis of Johnson's six basic character issues very useful. For each issue Johnson explores affect, behavior and cognition, which gives both depth and breadth in formulation, and also leads into detailed therapeutic objectives.

Johnson's (1994) multi-perspective dimensional approach is valuable in clinical work. He says: "Just as any given person may best be understood by a mixture of these characterological issues, so too may he be best comprehended by a mixed model of his structural functioning" (Johnson, 1994, p.17). Not only does Johnson help me conceptualise multiple personality issues, he also encourages me to notice the client's level of functioning.

Alongside Johnson I also refer to a variety of other authors to further my understanding of specific character styles. For example, I use Guntrip to deepen my appreciation of the schizoid character. Guntrip's description of the "shut-in individual" (p.17) provides me with a rich description and explanation of the schizoid process which helps me understand the experiential world of a client with this presentation.

Process of Psychological Therapy

Theories of Change in Psychological Therapy

Before I talk about the processes of psychological therapy in my work, I will introduce my perspective on theories of change. Theories of how change occurs are important because they directly inform what I do and how I am with clients.

The Common Factors Approach

I agree with Asay and Lambert (1999) that there is little evidence to suggest that different schools of psychotherapy are more effective than any other. With this in mind, my starting

point for examining change in psychological therapy is the common factors approach.

The common factors approach suggests that there are factors of change that are shared by many schools of psychotherapy. Lambert (1992) identified four broad areas: the therapeutic relationship, extratherapeutic change, techniques and expectancy, which account for 30%, 40%, 15% and 15% of outcome variance respectively.

Much of my work focuses on change brought about by the therapeutic relationship. I find Schore's (2003) work on change through right-brain-to-right-brain communication compelling. As Schore points out, the therapist is not necessarily doing anything but rather learning to be with the client and resonating with the outward expressions of the client's inner state. I agree with Schore's interpretation of the evidence that these non verbal exchanges are a major factor of change in the therapeutic process.

I also refer to the work of Bachelor and Horvath (1999) to inform me about the specific ingredients of a successful therapeutic relationship. They too point out that research suggests a correlation between a positive alliance in early phase therapy and a positive therapeutic outcome. Specifically, the authors highlight empathy and warmth from the therapist as being robust factors in the facilitation of client change.

I am interested in Lambert 's (1992) suggestion that 40% of improvement in psychotherapy patients is as a function of client and extratherapeutic factors, which is the largest percentage of any of the common factors. Tallman and Bohart (1999) make the argument that the most important factor in therapeutic change is the client as a self-healer. This is supported by Orlinsky et al (1994) who report that a client's openness and co-operation are positively correlated with positive outcome.

Lambert also says that only 15% of the improvement of clients is attributable to techniques. Although I do not disagree with Lambert's percentage, I think that techniques might both be useful in their own right and might contribute to the effects of some of the other factors. So a technique might give the client hope and confidence in therapy, which can be healing in its own right (the placebo effect accounts for 15% of improvement according to Lambert, 1992). Also, I agree with Fosshage (2005) that explicit, conscious interpretation, in conjunction with implicit work, can be effective in facilitating change in clients with relational trauma.

Existential Factors of Change

Existential factors of change are also interesting. Change can occur around each of the existential givens, but here I highlight changing attitudes to death, the ultimate challenge. Yalom (1984, p.187) encapsulates his theory of existential change in Thomas Hardy's comment, "if a way to the Better there be, it exacts a full look at the Worst." At the heart of existential change is a commitment to confront the existential givens head-on, not hide behind defenses. This, Yalom suggests, gives a rich perspective on life's other concerns.

Unlike much of the 'effectiveness' research, Yalom (1984) does not try to provide quantitative evidence of existential change mechanisms. However, the moving clinical examples he presents are often informative to my work. Not everything we do as therapists can be captured by outcome measures.

My Clinical Practice

This section describes how I work in clinical practice, building upon all the ideas I have discussed in previous sections. I will first explore the general principles that I apply to clinical practice and then I will conclude by using Elton-Wilson's (1999) model to illustrate how I work in the temporal dimension.

The Psychotherapeutic Relationship in Clinical work

The relationship between therapist and client is not just important for the treatment, in important ways it is the treatment. Mitchell (2000) says that the "intersubjective engagement between patient and analyst

has become increasingly understood as the very fulcrum of and vehicle for the deep characterological change" (p.125).

Schore informs me that the primary target of treatment is to regulate unconscious negative affect (2007). He explains that the first principle of regulation theory is that attachment communications are "implicit, affective and nonverbal" (Schore, 2007, p.6). So much of my work is not at a conscious level but rather it is my job to receive and express unconscious nonverbal affective communications to help regulate the client's dysregulated affective states (Schore, 2007).

The question remains as to how this implicit, relational work is done in practice. Learning again from Schore (2003, 2007), in specific terms I pay attention to nonverbal communication such as facial expression, body movements, posture, gesture and tone and pitch of voice. More generally, I focus on subtle transferential communications, empathically attune to my client's emotional stress state using intensity, timing and shape (Stern, 1985) and interactively regulate their affective states. I discuss some of these in more detail in the sections below.

From Schore's (2007) perspective it is right-brain activity within the intersubjective field that is healing and 'technique' always rests on my ability to access the intersubjective implicit realm. Although I agree that much of the healing occurs via right-brain to right brain activity, I do not agree that all useful technique occurs in the unconscious co-creation. As Fosshage (2005) suggests, a multisystems view of learning, knowledge and memory, which includes the explicit domain, provides a more complex picture. Fosshage (2005) says that explicit exploratory and interpretative interventions together with a new implicit relational experience are useful when working with trauma. I use interpretations and explanations to help my clients better understand their implicit processes.

It is important to note that every therapeutic relationship is a unique meeting of two subjectivities. I bring my relational process into the room and so does my client. Bachelor and Horvath (1999) point out that the client's differential responsivity to me needs attention. As a therapist, it is my job to notice how we interact and to individualise my responses accordingly. With this in mind I use Johnson's (1994) character styles to inform how I might be with a particular client.

Using Transference and Countertranference in Psychological Therapy

Transference and countertransference are central to my therapeutic work. Schore (2003) describes the nonverbal, unconscious transference-countertransference relationship as the frontier of clinical work, and Clarkson (2003) asserts that working though the transference-countertransference relationship in therapy is one of the most potent ways of changing relational patterns.

Using countertransference is often the start-point for clinical interventions as it provides valuable clues to my client's intrapsychic processes (Hargaden and Sills, 2002). My affective responses to my client inform me about my client's characteristic ways of relating and help me formulate my approach and treatment plan. For example, I might feel a distance or lack of connection with a client, even if they are outwardly friendly and engaged. This could be an indication of a schizoid process. With this client I would be careful not to frighten them with too much warmth or intimacy but I would also be wary of staying distant and missing the opportunity of creating a relationship.

Noticing my countertransference also gives access to my 'internal supervisor (Casement, 1994), which helps me decide what to do in-the-moment and to judge the impact this might have on my client. For example, if I notice myself feeling angry with a client, I may ask them about their anger as I could be picking up their affect, projected into me. This could help them notice their feelings and give them the opportunity to explore their experience consciously with me. Or, as Maroda (2004) explores, I could also reveal my countertransference to my client, although in the case of anger I would be aware of the risk and be very careful to ensure there was a good therapeutic reason for doing this.

I sometimes use transference explicitly to help a client notice an implicit pattern of

relating with me, which may be replaying an archaic pattern. Extending the example above, if the client seemed angry with me when I had misunderstood them, I might ask if they recognised that angry feeling from their past, which could help them discover for themselves a link to past experiences.

Kohut's work on selfobject transferences also plays an important role in my clinical work. Kohut and Wolf (1978) suggest that it is my job to keep the old selfobject needs mobilized and if I succeed the client's needs will gradually be transformed into normal assertiveness and a normal perspective on ideals. For example, I actively mirror my client by paying focused attention on what they bring and clearly showing my interest in them.

Other Strategies and Interventions that Inform My Work

Hargaden and Sills (2002) emphasise the importance of providing an empathic context as the foundation for all interventions. Schore (2007) supports this by asserting that empathy is the main agent for beneficial change. To define empathy I use Rogers' (2004) powerful question: "Can I let myself enter fully into the world of his feelings and personal meanings and see these as he does?" (2004). In practice I find Casement's (1991) notion of trial identification useful here. Like Casement, I actively think and feel myself in-the-moment into the position of my client to try to experience the world from their perspective.

Related to empathy, I also use phenomenological method to help me understand the client's subjective truth. I use Spinelli's (2005) description of the rules of this method (Epoche, description and horizontalization) to try to step into my client's phenomenological world.

Empathic confrontation is another important intervention but one I use very carefully as it has the potential to feel attacking or shaming to the client. Used sensitively, though, I think it can helpfully highlight discrepancies between conflicting views that the client has expressed, which gives them the opportunity to better understand the complexities of their experience.

I also acknowledge the importance of empathic holding in therapy. Schore (2003) describes this in terms of the infant-parent dyad, with the parent tolerating the child's distress and regulating it before it is overwhelming. As a therapist I offer this containing, regulating presence to my clients (Hargaden and Sills, 2002). I note Schore's advice and try to ensure that during the client's intense negative affect, I try not to shift to a left hemisphere dominant state to verbalise the process, which might undermine implicit learning (Schore, 2003).

Yalom (1984) provides me with interventions for working with existential issues. With personal responsibility, for example, I use material that surfaces in the here-and-now of treatment that resembles a problem in my client's life outside (Yalom, 1984). So if a client says that she took my advice and followed a course of action at work, for example, I might point out that I did not give advice but merely explored options with them. This could help them to see that they projected responsibility onto me and might help them take back that responsibility.

I also sometimes work directly with anxieties about mortality. Yalom in Staring at the Sun (2008) offers some powerful interventions that I have found useful. For example, I have explored the concept of 'rippling' with a client who had persistent fears about her own death.

Working with Trauma

With complex developmental trauma I apply Judith Herman's (2001) phase approach: establishing safety, telling the story and reconnection. I am careful not to rush into the second phase without working with the client to establish some control over their own feelings and environment (Herman, 2001). I agree with Rothschild (2010) that the client knows best when they are ready (if at all) to revisit traumatic memories, so I would always explicitly agree with the client when they are ready to confront the 'horrors' of the past (Herman, 2001).

In working with trauma I always focus on providing the conditions for a trusting relationship. Although trust is important with all clients, I agree with Herman that trauma damages the patient's ability to enter

into trusting relationships, so I need to be especially careful to build trust painstakingly.

Concluding Summary - Relationships Through Time

Past experiences have a strong influence on present and future functioning (Lapworth, Sills and Fish, 2001). Acknowledging this, I use a temporal dimension to hold my clinical practice in a coherent framework. For this I draw upon Elton Wilson's (1999) adaptation of Menninger's 'triangle of insight'. I actively work with the past, the present, in-the-room and the future.

I think that the most important dimension for my work is 'in here' as this provides material for me to examine first hand with the client (Yalom, 1989). To help the client understand the importance of using 'in here' I may first explain Elton Wilson's (1999) model to them.

To use 'in here' I will often highlight to my client something that has happened between us. For example I might point out to a client that she has been very attentive to my needs by offering me a tissue after I have sneezed, pointing out that I look tired and offering to start our next session later so I do not have to get up early. Shifting to 'back then', I could ask my client if she recognised this 'looking after someone' pattern from a previous time in her life or in current relationships. In this way I can help the client notice how implicit patterns in her past repeat in her current life and with me. This gives her the opportunity to try different ways-of-being with me.

Although much of my integrative framework is based on the past and present, I also find the future dimension helpful. Tolpin's (2002) paper on forward edge transferences is informative when working 'in view'. She suggests that many forward edge 'tendrils' are missed or misinterpreted as pathology. Noticing and mirroring forward edge transferences, though, helps mobilise the client's self-agency and take responsibility for change and growth 'in view'.

Concluding Remarks

In Section A I articulated my personal values and showed how these provide the foundation for my integrative framework. I then explored my view of humans and showed how this informs my approach to integrative problem formulation. Finally I illustrated the process of psychological therapy in practice within my integrative framework.

To conclude, I would like to reemphasise that relationships are central to human development, motivation, and health, and are an essential part of healing in integrative psychological therapy. As Mitchell (2000, p.xii) puts it, "humans, like oak leaves, are not found in isolation, not possible in isolation. Human minds are fundamentally social phenomena."

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Book Review by Helen-Jane Ridgeway

Essential Research Findings; In Counselling and Psychotherapy - The Facts are Friendly

Cooper. M. (2008)A book of 239 pages; Published by Sage, London, UK.

In conjunction with BACP (British Association for Counselling & Psychotherapy).

Forewords by Michael J. Lambert, PhD and Laurie Clarke BACP Chief Executive.

Abstract

I concur with Laurie Clarke from BACP in her foreword, when she highlights the timely arrival of this book given the current climate, the changes and regulations being introduced into the profession and what she names as an "evidence-based revolution".

Mick Cooper adds a plethora of understanding by offering this book which must have been an arduous and generous undertaking. And, it does indeed do what the cover suggests; provide us with Essential Research and making "the facts [are] friendly".

So, 'Essential research findings in counselling and psychotherapy: the facts are friendly', provides trainees, students, practitioners, researchers and prospective clients with a clear, accessible map into the latest and most current research findings in the field of Counselling and Psychotherapy. Not only does author Mick Cooper provide the reader with a 'map' of current research, he also offers an easily accessible, jargon-free book, written with a refreshing measure of humour which softens the impact of some of the findings and comforts the reader whilst addressing complicated and serious topics, such as making sense of qualitative and quantitative research findings. It sets out and offers up the evidence for efficacy; the effectiveness of therapy.

Contents

As can be seen from the Contents table this book is challenging and extensive.

In his Introduction Cooper challenges the reader to take part in a Quiz, which manages to dispel some of the myths and fears often associated with research and, for those of us who can be somewhat research phobic, this is a welcomed and refreshingly different approach that certainly challenges previous thinking, perspectives and any misconceptions within

the field. Mick Cooper is mindful of not pathologising or making judgements regarding "...what is or is not normal."(pg:9,2008) and wherever possible steers away from medical connotations, for example using the term 'clients' rather than 'patients' and avoiding 'treatment' preferring 'participating in therapy'. This possibly suggests a more 'Humanistic' stance, which would indicate some bias from the author, who does share his orientation describing this as a "...'pluralistic' therapeutic framework" with a "preference for 'methodological pluralism'..." He also, very honestly, looks at how his own orientation does indeed bring a bias and how he realises this, pays attention to it and tries to minimise the impact of this wherever possible. It is no wonder then that given this 'pluralistic' frame he believes that many different forms of research are valuable and offer relevant contrary contributions at different times; he gives gravitas to both quantitative and qualitative methods of research.

He describes how he uses the terms counselling and psychotherapy 'interchangeably' throughout, due to a lack of reliable evidence indicating differences. Then however, he goes on to present research findings "based on practices that are described as 'psychotherapy'...", which leaves me questioning both the interchangeable terms and the appropriate use of the generic term 'therapy' – I am happy to say that in the very next paragraph Cooper questions these very issues himself, this level of inquiry and transparency shines throughout the pages of this book, which I believe parallels the transparency and inquiry into the profession and research pertaining to the field displayed on the pages.

He also admirably acknowledges what is not in the book; all the research findings there were no time to explore or cover; areas of limited research and unreliability. Similarly, when research is poor or patchy the author says so and gives explanations as to why.

The book then takes the reader through what the research truly reveals about the realistic state of the field of Counselling and Psychotherapy: highlighting what many people think 'works' in therapy as being misinformed, and clearly lays bare the really important factors which are often overlooked. It is readable and fosters healthy inquiry, building interest as you keep learning more about how you can change your working method and integrate methods of evaluating your practice. It explains in great depth research methods and how to understand research findings; a comprehensive review and summary of current research findings. There are a number of graphs and tables showing research findings in visual form, an added support in digesting a large amount of information.

Cooper addresses the currently very popular issues being asked by funders, organisations, professionals, registering bodies and the government about the evidence base for a particular practice or approach, and what these answers mean for funders, the profession and professionals therein, as well as for clients. For example; "Do some forms of therapy produce more effective outcomes than others? Who does therapy 'work' for? Who seems to benefit the least? How important is the relationship between client and therapist?" The book answers these types of questions and many more; it really seems to address all aspects, areas and topics, aiming to provide trainees, practitioners and researchers within counselling and psychotherapy with a comprehensive introduction; an accessible and user-friendly forage into these research findings within the field.

This should be on the reading list of any trainee and training institute because of its relevance and how it presents important issues very simply. It makes light work of wading through papers, books and articles to find the most relevant and up to date research on counselling and psychotherapy. It's a good, reliable source of information if you are preparing a presentation, writing a dissertation or paper, giving lectures and running trainings or if for any other reason you need to know more about the very wide range of therapeutic approaches. A useful time saver it cuts through the drudgery and gets directly to the information; a resource for reference that can easily be dipped in and out of to find the most relevant research for you and which can also be read in full.

It presents many of the factors associated with positive therapeutic outcomes and provides references and suggestions for further reading,

definitions of key terms, and questions for discussion. I particularly appreciate the 'Questions for Reflection' which appear at the end of each chapter, this provides opportunity to invite awareness, build reflective practice and support professional development and growth. The recommended reading offers still further support for professionals and trainees.

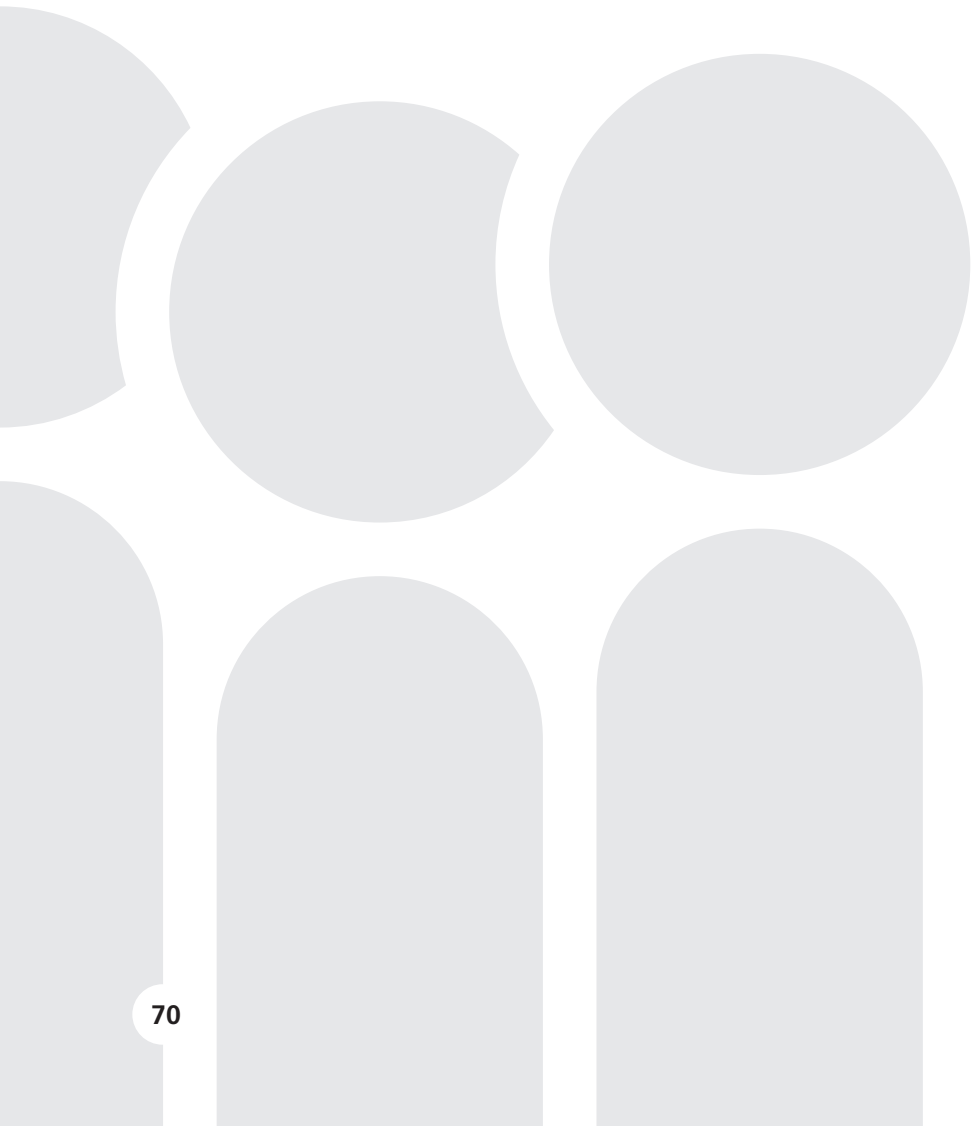
The way it is set out, giving a thesaurus, references and having sub-sections which address problematic or complicated questions is inspiring, offering a lot of information on how to practise counselling and psychotherapy effectively. In addition to setting out the research this book further ignites curiosity and triggers many personal questions whilst flagging up some tensions within Counselling and Psychotherapy. As I have already stated each chapter is inspiring in depth and how it is 'set out'; thorough and beautifully organised. Beginning with an explanation of what the chapter discusses, then the main body of the discussion / topic, suggested recommended reading, other relevant questions pertaining to the topic, research findings, implications for practice where relevant, definitions of terms, a conclusion leading into a brief summary of key findings and finally questions for reflection.

In his conclusion Cooper makes suggestions for how, as practitioners, we can conduct our own research with our clients, facilitating the use of CORE-OM outcome measure, enabling the monitoring of therapeutic practice and effective therapy. In his final 'Questions for Reflection' he invites the reader to reflect on their experience of the book as a whole and the ensuing thoughts, feelings and experiences.

There is an extensive Appendix summarising in a succinct fashion "The Efficacy and Effectiveness of Different Therapeutic Orientations" which leads us into one of the most informative and expansive Glossaries in a book of this kind I have come across.

Conclusion

Whatever your orientation, theoretical approach or background of training, this book can add value to your work. Mick Cooper has done an excellent job by pulling together an extremely broad range of research into a succinct yet useable and practical package. It is extremely well-referenced throughout. A book that students and experienced professionals will find valuable and informative, as well as supporting anyone who is exploring the possibility of seeking a therapist and wants to research what approach of therapy may best fit / match for them, this book provides the possibility of help with that decision. It encourages knowledgeable and open professionalism and supports practitioners to have 'well informed' clients. As Counsellors, Psychotherapists, researchers, trainees and other caring professionals, we have a duty to question and to encourage new thinking, growth and change; the responsibilities entailed in offering an opportunity for healing relationship, I believe Mick Cooper's book offers the support needed to make this a reality.



Book Review by Professor Maria Gilbert

Supervision in Action: A Relational Approach to Coaching and Consulting Supervision

Author: Erik de Haan

Publisher: McGraw Hill Companies

ISBN: 978 0335245772

This book on Coaching and Consulting Supervision is written in an accessible style and illustrated by the use of illustrative metaphors which capture the essence of each chapter. Some of the chapters are written collaboratively with others and reflect a useful breadth of perspective on the supervisory process. Erik de Haan's relational model of supervision addresses the complexities of the organisational context and he makes it clear that he considers supervision as essential for coaches and organisation consultants, a position that is contested by some in this field. He sees supervision as having three functions which he calls: 'developing' the person's awareness; 'gatekeeping'(monitoring fitness to practice) and 'nursing' (supportive and encouraging).

In reading this book, I felt that I was going on a journey with Erik de Haan in his own discovery of the complexities and relevance of supervision to practice. He has focused really effectively on the pitfalls for the supervisor; I would have appreciated a bit more emphasis on the benefits of supervision for facilitating a learning process. However, he discusses very well the multiple levels of reflection that help supervisees move from rigidity to flexibility. All the chapters are interspersed with examples of the supervisory process which are geared to illustrate the points that he is making. My sense was that these examples did on occasion pick up on the complexities he was discussing but most did not reflect the subtleties stressed in his relational approach to supervision. But this is a minor criticism!

The seminal chapter in the book for me is the one he co-authored with David Birch on "The organisation supervisor: shadow consulting in full colour'. I really appreciated and gained a new perspective from the sophisticated stance in this chapter, reflecting the interface between the different types of organisation supervision: organisation consulting supervision; shadow supervision; and peer supervision. The authors focus here on recognising patterns that operate below the level of conscious awareness and they reflect in an in-depth manner on how to work with the complexity of these relational dynamics in organisation supervision.

I recommend this book as an interesting and practical introductory text to those wishing to learn about relational supervision for organisation consultants and coaches.

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