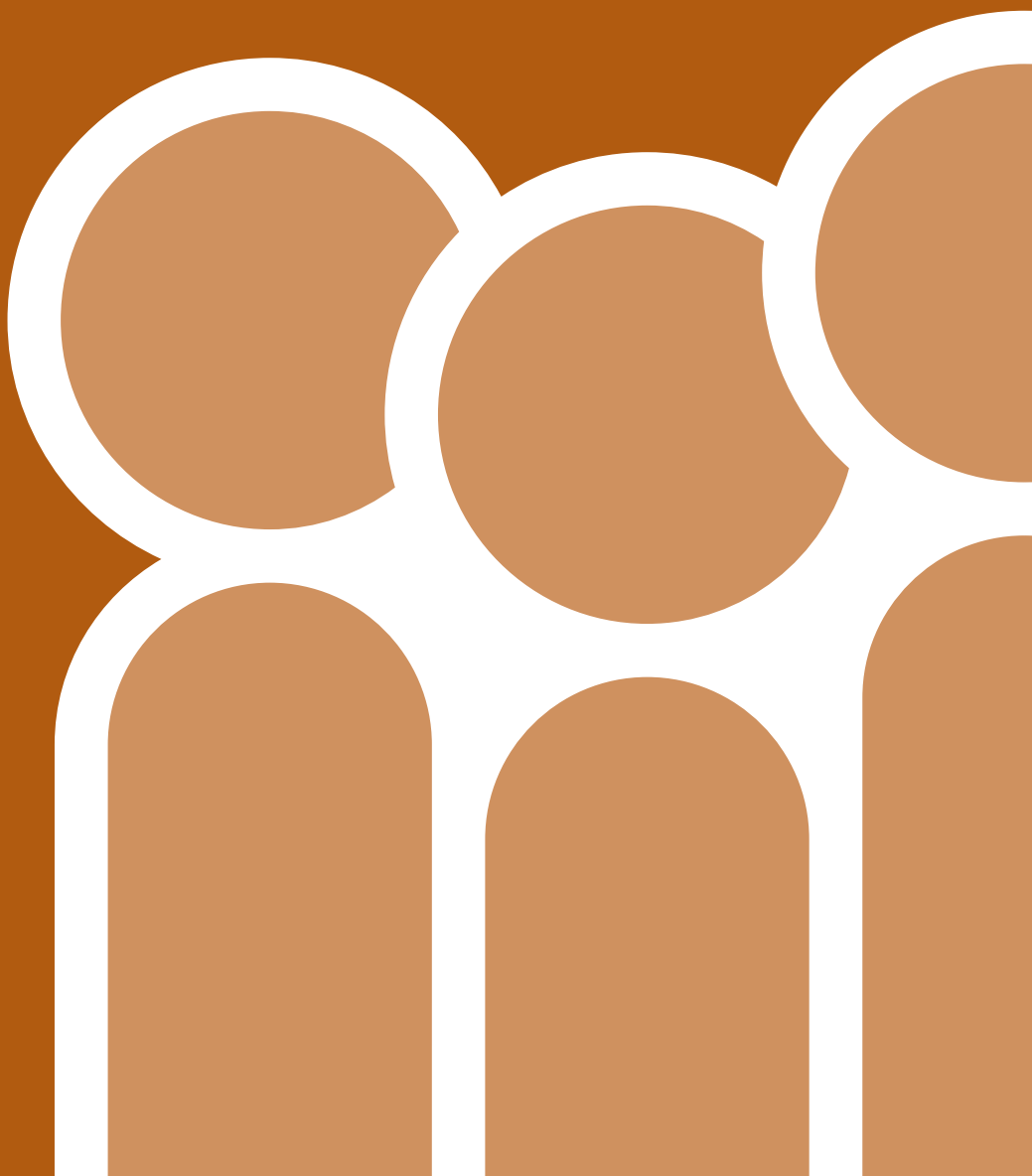
The British Journal of Psychotherapy Integration

*Volume 6, Issue 2 (2009)*

# Aspects of the Integrative Endeavour



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# The British Journal of Psychotherapy Integration

**Introduction**

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

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**Submissions**

Future volumes of this journal will be on theme issues based in an integrative perspective. Two members of the editorial board will act as co-editors with the support of the two consulting editors. If you are interested in submitting please visit our web site (www.ukapi.com/journal/) and download a copy of the submission guidelines.

**Consulting Editors**

Maria Gilbert and Katherine Murphy

**Editorial Board Members**

*Volume 6, Issue 2 (2009)*

# Contents of this Issue

*Editorial*

# Aspects of the Integrative Endeavour

In this issue we have a range of contributions related to the practice of integrative psychotherapy. The contributions range through the areas of research, clinical work and even marketing your integrative practice! Once again in this issue we cover a breadth of issues that impact upon the integrative practitioner.

### Contents of This Issue

Pam Scott presents the findings of her research into the use of humour in psychotherapy. In the author's words "this study aims to get humour out of the closet and on to the couch". Pam certainly succeeds in engaging the reader in this endeavour in her report on a carefully conducted research study. This study explores humour from the perspectives of developmental theory, cultural difference, character style and affect regulation. Overall Pam discusses how to assess when humour enhances or inhibits the psychotherapeutic process.

John Rowan develops his thinking on sub-personalities which he now refers to in dialogical theory as "I-positions". From an integrative relational perspective he explores his particular interest in the dynamic relationships amongst our population of internal I-positions. He considers the implications for practice of taking this position on the client's internal world in order to understand the multiplicity within the person. Towards the end of the article he issues a challenge from a mystical position to the concepts he is presenting in his questioning of the very existence of an 'I'. John Rowan sees this material as 'revolutionary' and we invite the reader to enjoy his challenge.

Lucia Swanepoel addresses the question of whether integration is a conscious choice rather than an innate process of growth and survival that is universal. She integrates evolutionary theory and complexity theory with intersubjectivity and neuroscience to argue that human beings are inherently adaptive and therefore even "one-model therapists" are inevitably integrative. Lucia's stance suggest that all psychotherapists of any orientation are in a constant process of growth an integration as they develop in the course of their practice. So the point Lucia makes is that is not a question of whether we integrate but of what we integrate.

Tamar Posner combines her personal experience of the death of a sibling in adulthood with her own research study into this subject. She highlights the lack of research that would illuminate her own and others' experience of sibling loss in adulthood. Central to this process was the subsequent painful loss of the prior relationship with her parents and with her own experience of her childhood. In this moving article, Tamar makes it clear how the loss of a sibling in adulthood may cut across a person's life and affect all subsequent experience.

Phillipa Perry challenges us to think about how a prospective client can find a suitable therapist in a marketplace that is often difficult and confusing to the newcomer. We decided to include this article in our journal because we do see this as an important area for exploration and one that is not often overtly addressed

in the profession. Addressing us directly she combines personal reflections and anecdotes with solid advice and impassioned plea for us to be more transparent with prospective clients.

As is our usual tradition we publish an example of a student's final submission. In this case we include Fiona McKinney's theoretical model of integration taken from her final dissertation and case study for the Metanoia/ Middlesex Doctorate in Counselling Psychology and Psychotherapy. Fiona was awarded a distinction for the dissertation as a whole.

We also include a book review by Steven Smith of 'The Making of Psychotherapists – An Anthropological Analysis' by James Davies.

**Sharon Cornford** and **Maria Gilbert**,
Co-editors of this issue.

*Pam Scott*

# The Therapeutic Double act and Comic 3rd in Counselling and Psychotherapy

**Abstract**

Theorists have claimed that humour can enhance the therapeutic process, but there has been a paucity of empirical research. Semi-structured interviews were conducted separately with eight experienced therapists practising from an integrative perspective, to explore their thoughts and feelings about humour in therapy from their experiences as therapists with clients, and as clients themselves. A grounded theory method was implemented to create theoretical categories, which included density of patterns, and variations. Findings indicated that therapists performed an assessment process regarding the appropriateness of using or responding to humour. The assessment process was influenced by characteristics of the relationship, characteristics of the therapist, and characteristics of the client. Humour could enhance the therapeutic process when used or responded to appropriately, but could hinder the therapeutic process when used or responded to inappropriately. Findings suggested two approaches to humour in therapy. The intentional/conscious use of humour such as jokes, exaggeration and role-play, and the spontaneous/unconscious emergence of humorous moments of interaction.

## Introduction

Literature has tended to be for or against humour in therapy, with those against very much in the minority. Those in favour suggest that humour can be insightful, liberating and transformative (Fry & Salameh, 1987; Strean, 1994; Lemma, 2000; Franzini, 2001; Ringstrom, 2001; Seligman, 2002; Ellis, 2006; Newirth, 2006; Goldin & Bordin et al, 2006; Cremer, 2008). Literature against suggests that humour serves as a defence or coercion, to trivialise or cover up negative transference/countertransference, and can be experienced by the client as mocking (Kubie,1994: Altman, 2006). However there has been a paucity of empirical research, and little documented discussion of humour, which explains the complex processes between therapist and client that determine whether humour has a positive or a negative effect.

## Definition of Therapeutic Humour

"A humorous attitude is an adult form of mental play with a serious purpose, to combine self understanding with the emergence of forbidden or unacknowledged thought in a socially acceptable manner" Richman (1996, p561).

## The Structure and Function of Humour

Freud (1905–27) thought that jokes consist of two trains of thought, conscious logic and unconscious primary process. Koestler (1964, p51) referred to these as bisociation or double mindedness, and Matte-Blanco (1975/1988) called this bi-logic. Conscious logic is the logic of science and rational thinking, and unconscious logic is the logic of art and

emotional experience. Humour and the ability to appreciate jokes rely upon an inter-play between conscious and unconscious frames of reference. This enables us to synthesise a clash of ideas, and imagine other possibilities.

The foundations of humour are laid down in early relationships. Freud's original theory, that humour was a release of tension, has been given a more interactive dimension by intersubjective theorists who have documented how infants seek out stimulation, such as in the game of peek-a-boo for example (Stern 1985). Klein (1961) and Winnicott (1971) stressed the importance of humour and play for healthy development, as a bridge between fantasy and reality, to relinquish perfection and integrate conflicting feelings of good and bad. Bollas (1995, p243) noted that the parents are the infant's "first encounter with the clown" nurturing through disappointments and excitements. The humorous interchange functions as a transformational process whereby the infant finds itself held in the mind of a (m)other in a heightened moment of interaction (Pine, 1981). Trevarthen (1986) and Reddy (2008) have documented how infants use teasing and mucking about as a pre-requisite to developing a theory of mind.

### Research Questions

How can humour enhance or hinder the therapeutic process, and more specifically what kind of humour, and when might it be appropriate or not?

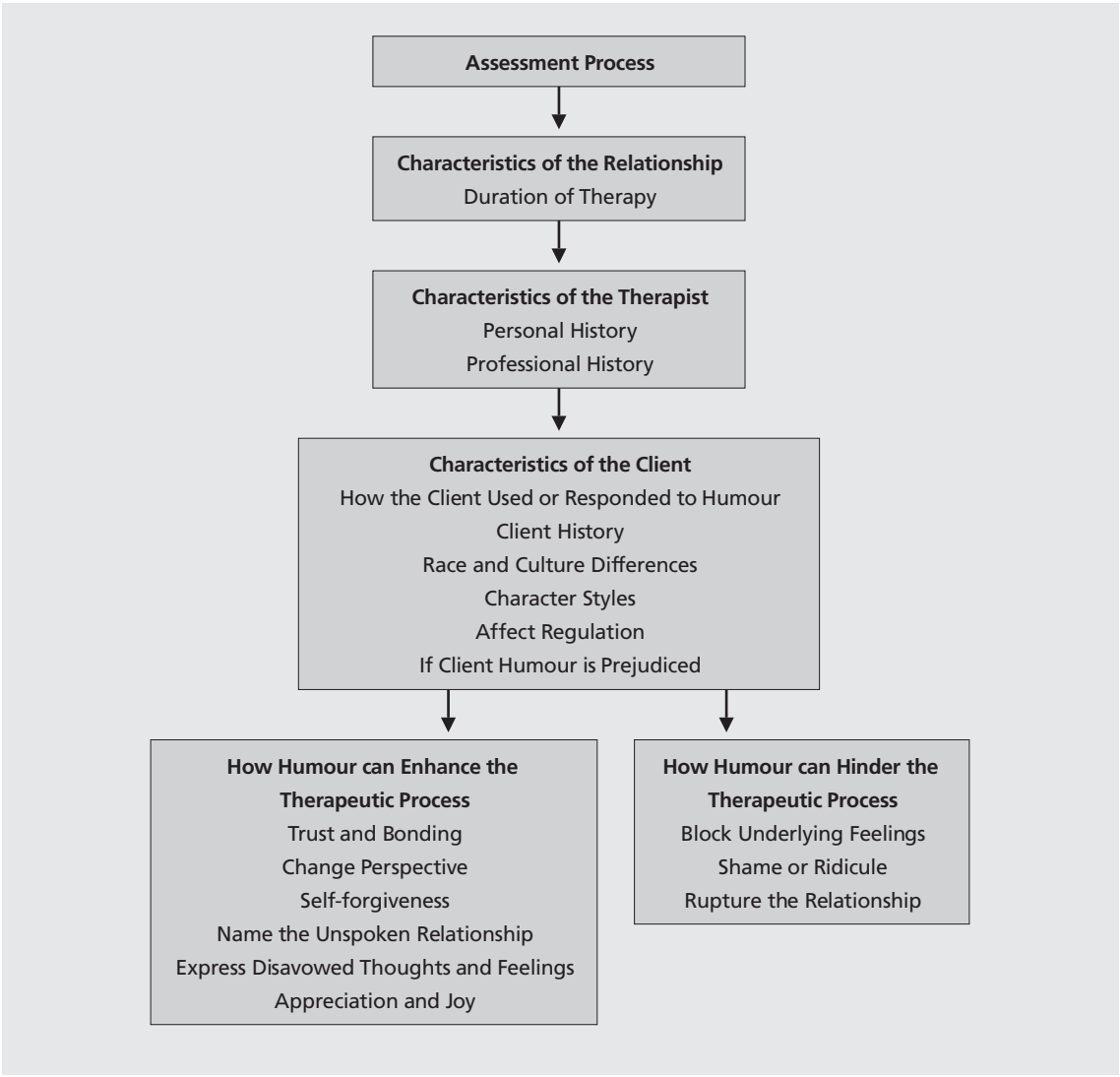


*Figure 1: Conceptual Model of the Findings*

### Contribution to the Field

This study aims to get humour out of the closet and onto the couch. To generate knowledge and develop a theory, which is grounded in practice and offers guidance so that personal styles can be developed in the best interest of each individual client.

### Overall Findings

Overall findings suggested that therapists who used/responded to humour in therapy performed an assessment process to decide whether humour was appropriate or not. The assessment process formed a core category and was influenced by three other categories, each containing sub-categories, which represented variations within each. For example the category characteristics of the relationship was influenced by the duration of therapy. The category characteristics of the therapist, was influenced by personal and professional history. The category characteristics of the client, was influenced by how the client used or responded to humour, client history, race and culture differences, character styles, affect regulation, and if client humour is prejudiced. When humour was used/responded to appropriately it enhanced the therapeutic process by creating trust and bonding, changing perspective, self-forgiveness, expressing disavowed thoughts and feelings, and appreciation and joy. When humour was used/responded to inappropriately it could hinder the therapeutic process by blocking underlying feelings, shaming or ridiculing, and rupturing the relationship. There were two approaches to humour in therapy. The intentional/conscious use of humour such as jokes, exaggeration, and role-play, and the spontaneous/unconscious emergence of humorous moments of interaction.

The assessment process was ongoing, and although the categories were inter-related I will highlight each one separately and discuss some of the salient points of the main findings. The enhancing and hindering potential of humour will be incorporated and the effects highlighted in bold font.

### Assessing Characteristics of the Relationship

Therapists' assessments of the appropriateness of using, or responding to humour included being aware of their own motives, and of how their humour might be experienced or interpreted by each individual client.

> *"When I feel the desire to laugh or to crack a joke or whatever, I am questioning it, if there is some urging in me I am saying to myself what's this about, what would a laugh at this point mean". P1*

Because therapists had regular reviews with their clients, as part of ongoing assessment, it was possible for them to offer reflections from their clients' perspective. The following quote is an example given by a participant from a review session of how humour offered hope through trust and bonding to a client who had been feeling suicidal at the beginning of her therapy.

> *"She said, what was most helpful was when you said to me we're not going to be able to do this work together if you kill yourself, and we both laughed… Because she knew it wasn't a standard therapeutic intervention, but what she said was, by saying it like that, it was clear that you were hopeful". P8*

This example also illustrates the therapist's skill in balancing the comic and tragic aspects of life. Participants reported that the variations between the types of humour they used and responded to were influenced by the duration of therapy. The use of intentional/conscious humour such as jokes, role-play or exaggeration, were used in short and long-term therapy. Spontaneous/unconscious humour, which was often expressed through empathic teasing, was more likely to emerge in longer-term work, where the risk of rupture could be repaired.

The joke can effect change because it pivots on double meanings and incongruity. The punch line pulls a switch on existing frames of reference to change perspective. One participant gave this example of a joke they occasionally used, which had created insight for clients.

> *"There's a family and they've moved into this house and they're very happy there, but there's a problem, there's a poltergeist, it's throwing things around… and they're all starting to get quite ill, and dad and mum decide we're leaving here… they put*

*all their furniture in a huge truck, and one of the neighbours walks by and says what's happening here, and the tarpaulin comes up and a voice says 'we ' re moving'. It's a lovely joke about you can't move away from yourself. Changing your job or moving to a different part of the country, or moving abroad is not going to be the solution to your issues, you've got to face the ghost". P1*

Sometimes jokes can be used as a short cut to the unconscious. They can work to normalise and offer insight into the continuing influence of the disavowed. Intentional humour was considered a useful tool, but always with the client's process in mind.

*"It's like using humour to develop a particular language between the two of us… a humour of recognition". P2*

Role-play could facilitate self-forgiveness by challenging negative thoughts and behaviours. One of the advantages of interviewing therapists as participants was that they had experienced being clients themselves, and could reflect on the effects that other therapists' humour had on themselves.

*"I did experience humour which is a transaction that I have also used. Many years ago I was very upset about something… and I went into therapy berating myself… I went on for a while. My therapist said I'll tell you what, since you won't give it up, we'll get in a judge and jury shall we. Come on we'll line them up here, now then we'll put them in an imaginary, guilty or not guilty, guilty, and we better ask the judge now what the punishment is going to be, go on, be the judge… Maybe the therapist interacted a bit with the judge, are you sure, that heavy a punishment! It was playful. Somehow seeing the ridiculousness of it either as the client or the jury, it enabled me to move from berating to giggling. All in a very short breadth of time, I put the whole thing into perspective and let myself off the hook." P1*

These kinds of paradoxical interventions work as a counter-conditioning, to point out absurdities, and free clients from the grip of crippling metaphors. They also model a sense of fun and mastery, which facilitate appreciation and joy.

*"I feel that when things that have been held onto and then released there is room for laughter where there wasn't room before". P2*

Because humour speaks directly to unconscious primary process, this can be a channel of least resistance for some clients. Another way in which humour could enhance the therapeutic process was by naming the unspoken relationship. This was achieved by a kind of 'hamming it up' to exaggerate what was going on between therapist and client, as a way of getting through to clients who distanced themselves from experiencing.

*"I can think of one particular woman I worked with who was very down on herself, she was a mature woman, but she was nevertheless going through that adolescent phase where nothing you said made any difference, and I absolutely remember joking with her… saying something like, nothing I say is going to make any difference is it No! No! No! and you know, hamming it up again, and that made her smile. It was a kind of warming process of just sharing the reality… She was very cut off really, but it named what was happening… It was a meeting point… We could give something up at this point, but that didn't mean giving up on the relationship. What it did for us was it started to deepen the relationship". P4*

This example demonstrates an alternative to classical analytic transference counter-transference interpretation, which cut through the confluence and worked to resolve an impasse. Working with the client's resistance through humour mitigated transference counter-transference fantasy, and transformed the familiar, whereby an interpretation may have been experienced as critical, continuing the re-enactment and reinforcing passivity. Humour enabled the therapist to engage with disavowed aspects of the client. This is also an example of how intersubjective realities can create a 'comic 3rd' possibility, which facilitated implicit unconscious material to become explicit and conscious (Ogden, 1994; Benjamin, 2000). The humorous interchange functioned as a transformational process whereby the client found herself being held in the mind of the therapist in a heightened moment of interaction (Pine, 1981; Trevarthen, 1986; Reddy, 2008).

All participants thought that humour could sometimes be a helpful intervention with clients who adopted a passive style. It was thought that beneath the presentation there was often a playfulness that had not been allowed during childhood. If the therapist could nurture this while in transferential mode, this could enhance the therapeutic process by expressing forbidden thoughts and feelings.

> *"I would experience sharp humour from someone with a passive aggressive adaptation and I may feel inclined to give it back, but I might go, ooh ouch, as a way to highlight what had happened. I do that with someone I've seen for a number of years and she had a difficult history, and she doesn't own her anger but will grunt at me, and I may do the same, or say, uh, your mad at me today, so I will engage her that way, and I hope when I'm doing it, that it's acknowledging it, rather than belittling it… It's like there's a child behind the door and I'm trying to woo them out, some acknowledgement of the fear and the anger". P5*

This further demonstrates therapists' skills of joining and elaborating intersubjective realities, and how the provision of a play space can address developmental issues and nurture what may have been forbidden during childhood. This is akin to Winnicott's (1964) offering small doses of reality, or a transmutation of unbearable feelings, which the client may have disavowed. Humour, when used and responded to appropriately can be a healthy vehicle through which to express aggression. However timing was crucial as participants explained that many of the examples of empathic teasing would have hindered the early stages of therapy.

> *"Now he (the client) can quite freely and aggressively insult me in the work, and he couldn't have done that initially. I mean he'll come sometimes and say you bastard, if I'd got him under the radar (laughs)". P6*

> *"I don't think it's entirely equal the relationship, but I think humour makes it more equal" P8*

Awareness of self and other and the intersubjective matrix was considered vital for assessing whether humour is appropriate or not.

**Assessing Characteristics of the Therapist**

The category, characteristics of the therapist was influenced by personal and professional history. For some, humour had been an important part of childhood.

> *"I can be playful. I think it emerges as something that's part of me". P1*

Others had not discovered humour until later in their lives.

> *"It simply wasn't allowed when I was growing up, but the more I've grown up, the more I've realised that I am humorous." P3*

Whether humour had been part of childhood or not, its experience or discovery was valued by all participants as an important aspect in their lives and awareness of the impact its discovery could have.

> *"It feels like an opening, and chemically it releases hormones in the body". P7*

Participants expressed a strong belief in the need to be congruent and considered bringing their humour to the therapeutic setting to be in line with this belief.

> *"I use all of myself. I enjoy humour and if I were to cut humour from who I am, I wouldn't be who I am in the room with the client, and I think that if I'm not who I am, then that's going to be picked up by the client's unconscious anyway". P2*

Although the inclusion of their whole person was important for being congruent, all participants said that this did not mean expressing or responding to humour whenever they felt its promptings.

> *"I think it's a bit like being a ball revolving in the water, you are yourself but you don't always show, it's not like a flat thing…" P4*

There were variations in therapists' style and type of humour but all saw humour as providing a play space. Self-awareness was vital so that therapists did not to use humour for their own narcissistic purposes, to put people down, or as defenses for their own difficulties, which could block underlying feelings for clients.

*"I'm not there for any more narcissistic reasons than any of us who become therapists". P4*

*"There is a temptation I think sometimes for me, particularly if someone is grandiose or wants to abuse me, but not interact with me, I can feel myself wanting to be mean… and it's not funny… it's not appropriate. When I'm in the therapy room the intention is to understand it rather than act it out". P5*

Some participants had negative experiences as clients in their own therapy when their humour had not been met. These experiences had provided learning in how a lack of humour by the therapist can hinder the therapeutic process by shaming or ridiculing the client or rupturing the relationship.

*"So he (therapist) said something like, I wish you wouldn't joke there. So that felt a bit punitive. It felt like I was not being met… I think to cut across the client's humour can be dangerous… I'm not saying you collude with the joker, but if you meet the joker on his terms of reference, so that's he's got the courage as it were, to show more of himself… I think it's important not to exclude any part of the person that comes for therapy. And I think not all of us are completely integrated human beings. A lot of us have split off parts that are also coming for therapy, but not always presenting themselves… If a part thinks it's going to be killed off it might move away from therapy even though that part wants to kill off all the other parts of the self". P2*

Two participants had experienced humour during their training but said it was never discussed as a serious therapeutic intervention, and six had experienced strong disapproval of humour.

*"Was humour welcome, NO. Humour was pathologised. It was considered acting out, avoiding". P3*

All said they had benefited more with therapists and supervisors who validated humour. One participant almost lost their first client by retracting her humour at the advise of one supervisor who disapproved, until a change of supervisor.

*"She (the client) would always joke, and I would laugh because it was funny… but that's not how my supervisor described it. She said it was avoidance, all a deflection and she was just trying to lure me into this faux intimacy. So I went back to my client and I tried very hard not to laugh, I tried not to respond to it and it was absolutely excruciating because clearly that was the way we had made a connection with each other so she couldn't understand where I'd gone. Then I had supervision with another supervisor who was so different… I relaxed and of course it was the way to be able to connect… It was a way of gaining trust… and one of the issues with this client was that she had felt tremendously rejected body and soul by her mother, and reparatively I could delight in her like a mother can delight in a child. She became much more embodied, and rounded and purposeful and productive and all those things that one would hope to discover. And I do know to me it can also be a defence. There was a grain of truth in what the first supervisor said, that I was coming from a scared part of me, and that is one of my defences so it could get in the way." P4*

This is an example of how a change of supervision helped the therapist to work creatively with her own way of being, and become mindful of how her own defences could block underlying feelings. Thus, this worked to validate the client, and to dissolve defences.

*"I do think sometimes you can take things on the surface, and that doesn't mean you can't address what's underneath". P8*

Findings imply that humour and serious therapeutic interventions are not mutually exclusive.

### Assessing Characteristics of the Client

All participants stressed that the most important factor, in their assessment of whether humour was appropriate or not, was how the client used or responded to humour. Different types of humour were seen to have different functions, for different people, at differing times in their lives, and at differing stages of therapy.

### Client History

The nature of laughter, and the type of humour clients used offered information

to the therapist about the function this had served in the client's history. Just as humour can validate a client's way of being, it can also block underlying feelings. It was therefore considered appropriate to respect clients' humour without colluding with defences.

*"Somebody last week who was talking about… some horrible things in her history… and she would just laugh and say well you just have to get on with it, and that wouldn't be productive for me to laugh with her because actually it wasn't funny, it was how she managed it… but I usually choose my moment, generally not in the first session. But what I do notice is that once it is named, it gradually stops being used as a defense, over time." P5*

This implies that when underlying issues are acknowledged it may feel safer for the client to express thoughts and feelings that were once un-manageable. This also gives a clear message that the therapist can both empathise, and cope with underlying horrors. If the therapist colludes with the client's defences, the client may also use humour to protect the therapist.

Client history gives information regarding the possibility that humour, however well intended could also be experienced by clients as shaming and ridiculing.

*"I remember saying something with genuine affection and appreciation of her, but she heard it differently. She had grown up in a violent household where everybody was sarcastic… She was hurt, and the next week we spoke about it, and I knew immediately it had not been received in the spirit in which it had been intended." P5*

**Race and Cultural Difference**

The sample group represented limited diversity of American, Canadian, Irish, and English, and therefore the findings for race and cultural differences were not generalisable. However all participants agreed that particular attention is needed when expressing humour between therapists and clients who are racially and culturally different from each other.

*"I think humour is somewhat cultural, and I think you have to watch humour that could be disrespectful. Certainly I would be more careful using humour in Africa. People that I worked with wouldn't have felt comfortable with me joking with them and probably could have been seen as down putting… because for them the power differential was quite big, people didn't make eye contact, and also the kinds of things you joke about are different." P8*

Participants' experiences of being different were considered an advantage when working with diversity, as this made it easier to understand and empathise with being an outsider.

*"I don't always get English humour, well there's the passive aggressive I guess, which I do get, but Americans tend to tease… Probably as an American I can get away with using humour a bit differently because people from America are more direct, and with each other we understand that, but I learnt to put a brake on." P5*

It was also considered important not to make assumptions, and to respect individual experience. Examples demonstrated differences between British, African and American and between being black and white despite a shared language.

*"Race and culture are very important, we can all take on a different culture, but it's like we can't be black if we're white." P3*

Findings also draw attention to factors, which may mean that something gets lost in translation when therapist and client do not share a mother tongue, but communicate in English. An implicit linguistic power dynamic in the English language may also be unwittingly used by therapists, and experienced by clients as offensive (Lago & Thompson, 1996; Moodley & Palmer, 2006). Institutionalised racism, sexism, homophobia, as well as attitudes towards disability and special needs, become internalised through our language.

*"I don't use very sexual humour. I think humour can be seen as seductive… I wouldn't want to be seducing someone with it, nor would I want to be seduced by it." P8*

*"I would not laugh at religious beliefs or at a person's family because that can be disrespectful". P1*

These are particularly important issues in relation to humour's potential to re-enforce stereotypes and prejudices. Cultural empathy requires more effort than cultural sensitivity. Culture emerges within emotional involvement and dialogue and therefore is open to be known by those who engage in it (Reddy, 2006).

### Character Styles

Character style influenced the degree of humorous expression and depended on whether the client was able to balance contradiction, or how robust they were. With clients who have a fragile self-process, an intrapsychic mode with little intrusion of the therapist's subjectivity, is necessary for longer periods to maintain structure and containment. Therefore providing a play space to create trust and bonding may be more appropriate for some clients in short term therapy than using humour to change perspective, or challenge behaviour. However an ability to laugh at one's own foibles was considered a sign of recovery. This implies that humour is a vital resource towards growth and change, and can both facilitate and be the result of therapy. This was exemplified by one participant who described a client as having an obsessional compulsive neurosis but who was beginning to accept the imperfections of his literary hero.

> *"He said to me one day, and it's difficult to convey this, but in the moment it was very funny. He said, I've been thinking about Dostoevsky, I think he had some faults you know. So I smiled at him and I said, well we can't all be perfect can we, and we both fell about laughing… The play of both mutual appreciation and play of mind, but also the oblique comment upon his obsessional compulsive perfectionism, that came out in that moment. If I was to put it, a dead pan serious psychoanalytic interpretation like, so you even perfectionise Dostoevsky, that would have been the sarcastic interpretive view, which would have been cruel… it wouldn't have involved the element of celebration that there was in the magnificence of the O.C.D. that can even perfectionise and re-construct Dostoevsky… Three years ago he wouldn't have been able to get that. He wouldn't have been able to criticise Dostoevsky to start of with. Dostoevsky would have been on an un-removable pedestal." P6*

The play of mind 'you know that I know' was a way for the therapist to both play a role in, and serve as author of the client's unconscious (Ringstrom, 2001). The humorous interchange functioned as a transformational process with the client's capacity to find the therapist thinking of the client, in the client's own mind and what Fonagy & Target (2003) refer to as 'mentalisation'. This kind of intervention would not have been used earlier when the client was unable to relinquish perfection and integrate the good and the bad. When clients can trust that the new object is different from the old object they can begin to risk the new subject (Cooper & Levit, 1998).

Clients do not come to therapy to have a laugh. They usually come because they have problems and because they want to find solutions to living a more fully functioning life. The therapeutic relationship is a privileged space for the therapist who needs to be aware that a client's humorous façade can conceal pain. However, if we pay attention only to a client's fragility and pain we may miss the client's valuable resilience, which has kept their coping mechanisms intact. The use of humour through empathic teasing assumes that clients are not as psychologically fragile as is sometimes considered. It is like saying this is what you do to sabotage yourself but I still like you any way. Challenging pathology through humour can offer a lightness of touch, which can be a catalyst for growth.

### Affect Regulation

Developmental theory helps us to understand the importance of humour in childhood, and how humour in therapy with adults can address developmental difficulties. All participants drew from concepts of 'aesthetic distance' to assess the kind of humour that might help to stimulate clients who distanced themselves from their feelings, or to re-assure clients who could be overwhelmed by feelings (Bettelheim, 1960; Ventis, 1987; Pierce, 1994; Shore, 1994).

> *"So if you take a line of experience as in the schizoid where everything is reviewed, but the actual experience itself is minimum, that's an over distant perspective, and an under distant perspective is like running in front of the car because the ball is there and I want the ball… like no thought…*

*So I think the function of humour, for me, is to bring levity to this, which can actually make me think about an experience, or to bring feeling into a literal sense where it is purely head." P4*

Some humour, like the unexpected punch line in the joke, or exaggeration was seen to be a short cut through defences against feelings.

*"However good people are at rationalising their behaviour there is a part of them that wants to break free." P2*

Affect regulation was considered an important aspect of therapy especially with clients who were hyperaroused, or suffering from Post Traumatic Stress symptoms. There were some types of humour, which in spite of not producing laughter nevertheless offered re-assurance. This was compared to a parent who offers humour or a smile as reassurance to a child that has fallen over, or had an accident. This is not laughing at the child. The parent shows concern, but does not catastrophise the situation. The smile says, she can manage and cope with this, and this may offer a different experience, of mutual and ongoing affect regulation, to a client who has not experienced this (Beebe & Lachmann, 1994).

*"Sometimes someone will come to me with something that feels to them dreadful, but feels for me, I can help here, so I might smile then because I feel a sense of relief that you know there's somewhere we can go with this… I can hold what they're bringing. I can manage. Hopefully I can help with the self regulation because that smile might be picked up by part of them and it might work." P2*

For some clients the capacity to adopt a humorous perspective on their predicament, even if it involves a degree of denial, may nevertheless represent a developmental achievement. Early attachments influence contact styles between what Wheeler (1991) called confluence and isolation in which clients may seek comfort from symbiosis, or maintain distance. It is important for the therapist to be aware of clients' individual contact style, and provide 'aesthetic distance' in the contact boundary so as not to over or under stimulate affect.

Although the potential for rupturing the relationship through the risk of humour was minimised by therapist mindfulness, findings indicated that sometimes ruptures could not be avoided.

*"I think the effect is the same as when there are other potential breeches in the relationship… you've got to have the relationship where the whole thing can be worked through." P8*

Ruptures when empathically attuned to create opportunities for repair. It is through 'disruption and repair' that it is possible to maintain engagement with another, that despite inevitable strains and mismatches, experiences of coping, efficacy, re-righting and hope are re-enforced (Beebe & Lachmann, 1994). In this way clients may experience themselves differently from negative childhood experiences.

**If Client Humour is Prejudiced**

It was considered detrimental to the therapeutic relationship to use or respond to humour, which could be offensive.

*"I really couldn't work with someone here who was racist or sexist or homophobic. I wouldn't find it funny." P1*

Although findings demonstrated variations in personal ethics in whether therapist disclosed feelings in relation to clients' prejudice, the findings suggest that by not laughing, therapists were endeavouring to model a more constructive and ethical way of being.

*"She said something personal about me and I was furious, and I said that has made me angry… It was cloaked in humour, but it wasn't humorous, it was very personal, and I felt attacked." P3*

*"I think a client is entitled to say what they want… I wouldn't laugh, and I would look at what was behind it." P8*

The question of whether to challenge clients' prejudices is interesting in relation to therapists' own value systems. Even more important than challenging prejudices within our clients is the need to identify and challenge prejudices within ourselves.

I wish to acknowledge my co-researchers in this endeavour. Findings in this study demonstrated that therapists were committed to developing an awareness of their own values, attitudes and prejudices so that these did not become camouflaged in a cloak of humour.

### Conclusions and Implications

Whether it is used/responded to as a warm welcome at the beginning of therapy, to offer reassurance, alternative ways of looking at things, or as a more risky challenge through empathic teasing within a strong working alliance, humour is a vital ingredient in therapy. This is not the kind of humour that relies on wit, or jokes, or being funny, but the kind of therapeutic humour that has a more philosophical tone and sets our pain in a larger perspective. Therapeutic humour rearranges implicit relational knowledge in a way that re-contextualises past experiences in the present into new possibilities for communication (Stern, 2004). I have called this transition 'the comic 3rd' after Ogden's (1994) concept of 'the analytic 3rd'. The analytic third represents the relational unconscious, which contains undeveloped resources. This offers a lightness of touch to tap into these undeveloped resources, and provides relief through which previously denied and unprocessed aspects of the self can be experienced and expressed. Humour helps to deepen the therapeutic process and makes this simultaneously tolerable and joyful. Humour through empathic attunement fosters a sense of mastery, and provides a route towards integration.

Humour can hinder the therapeutic process, but the assessment process performed by therapists in this study minimise potential risks. It is also important to bear it in mind that responding negatively, or not responding to clients' humour can also be insulting or discounting, and an inability on the therapist's part to create a humorous space can miss opportunities for growth and change. Winnicott (1971, p54) asserted that,

> *"If the therapist cannot play, then he is not suitable to work. If the patient cannot play, then something needs to be done to enable the patient to become able to play after which psychotherapy may begin."*

Findings demonstrated that humour is more likely to be used and responded to appropriately if it is acknowledged as part of the human condition and not ignored or left out of the therapy room as if this were possible or sensible. However the assessment of both intentional, and spontaneous humour require skills, which involve the ability to work with intrapsychic, interpersonal and intersubjective processes both conscious and unconscious. They involve spontaneity and control, both the art and the science of therapy.

It seems paradoxical in itself perhaps that humour that is spontaneous can be controlled. However, the participants for this research explained that their humour like any other emotion was available but not always visible or expressed. So although the internal promptings of humour may be spontaneous, therapists have some control over if or how they express it. Indeed findings suggest that therapists are more likely to be able to control humour when it is acknowledged as part of them, and not denied. This was exemplified by one participant who said, "in the beginning I tried to be correct but sometimes it escaped."

Therapists who incorporate their own sense of humour into the therapeutic endeavour not only encourage discouraged clients, but model humour as a valuable resource for their own sense of hope. Humour is also a preventative tool for stress and professional burnout. This was evident in participants' willingness and generosity in their contributions to this study.

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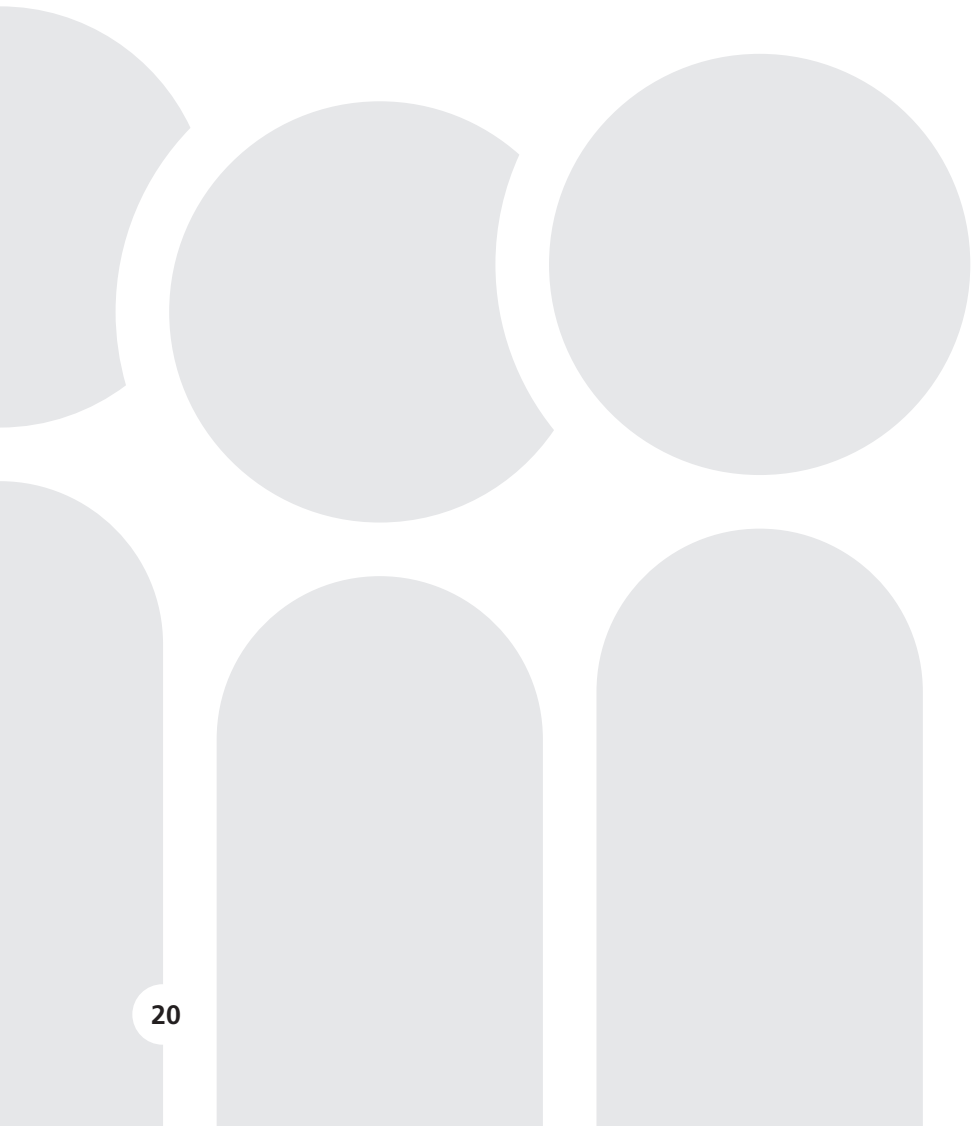

*John Rowan*

# The Internal Relational

**Abstract**

In this paper the issue raised is that of how the relational approach – so important today – is to deal with the internal relations between subpersonalities, ego states or parts – all those things which have now been rechristened in dialogical self theory as I-positions. Some possible answers are given through examples, and a discussion of the unconscious. There is a particular interest in the Shadow, and some further examples of the new work by people in the new field of the dialogical self. Finally there is a discussion of the self – how can we have an I-Thou relationship if there is no I and no Thou? This is very much an introductory paper rather than any presentation of new research, but it raises an issue which does seem important.

**Introduction**

We have all been influenced by the recent upsurge in the use of relational approaches and relational thinking. The psychoanalysts have been at it, the gestaltists have been at it, the existentialists have been at it, the person-centred people have been at it: there seems no end to it. I personally have been very much influenced by it, particularly by the work of Rich Hycner and Philip Lichtenberg.

But what about the internal side of this? What about the relations between the different parts of ourselves – the internal society? I have been writing about this for a number of years now, but have only recently been thinking about the relational side of the matter. Yet this is clearly something worth thinking about.

This is all the more so because of recent developments in the field of internal multiplicity. I have been particularly impressed by the work of Hubert Hermans in Nijmegen, and by his colleagues on the International Journal of Dialogical Science, Giancarlo Dimaggio in Rome and João Salgado in Minho, Portugal. They have introduced the nomenclature of I-positions instead of the more common subpersonalities, ego states or parts. By using the term I-positions we find it much easier to avoid the temptations to reification inherent in these earlier versions, and also the difficulty in applying the older nomenclature to transpersonal subjects such as the soul, the spirit or God.

The statement which Hermans has used in a number of his books and research articles is that we can conceive of the self in terms of "a dynamic multiplicity of relatively autonomous I-positions in the landscape of the mind" (2004, p19). This opens the path to a way of thinking about the person which is very interested in all the ways in which these I-positions may relate one to another.

**The Unconscious**

It is clear at once that, if we have this population of I-positions, we can think about the unconscious much more specifically. Instead of having just one unconscious – a broad approximation to the variety within – we are

able to specify more precisely which internal I-position we are talking about. For example, a psychoanalyst might say to a patient – "Although at a conscious level you may think it is fine for me to take a six-week summer holiday, at an unconscious level you may experience fear or anger at such a gap." But it seems to me much more useful to be able to say – "Although at a surface level you may think it is fine for me to take a six-week summer holiday, there may be within you a two-year-old child who experiences fear of being abandoned, a four-year-old child who feels rage at being treated unfairly, a sixteen-year-old who experiences anger at being ignored, and possibly other I-positions with a variety of other reactions." To probe this with the client obviously gives us more opportunities to get to the heart of the matter, whatever that may turn out to be. We simply give each of these characters a voice, and enable them to speak their truth.

The same applies to the therapist. What is often called countertransferance, and assigned to the unconscious, is more elegantly referred to a specific person within the therapist. For example, suppose a therapist, in any situation involving children, takes the child's side every time, we might normally say that at an unconscious level the therapist is a child, or defends children, or is guilty about a child, or whatever. But it seems to me more elegant and more correct to say that we have within the therapist at least one, and maybe more than one, character who has this need to defend children. We can then find out who this person is, precisely and definitively, and have a conversation with this character, in the therapist's own therapy.

**Typical Relations**

So if we are interested in the internal relations, what are they like? One classic relationship was described by Fritz Perls: the relationship between the Top Dog and the Underdog. As he pointed out, the Top Dog had been very well described by Freud under the heading of the Superego, but Freud had never taken the second step of describing the Underdog. Yet they form a classic combination, which Perls also called the famous self-torture game. This is obviously a toxic relationship which seriously calls for some treatment. And Perls and his colleagues have given many examples of how this may be done.

Another classic relationship is Parent and Child. This can take many forms, but it crops up again and again in all forms of therapy. Whether we are looking at attachment theory, at regression therapies, at classic psychoanalysis or at many other versions of dealing with the family of origin, the parent-child relationship comes up again and again. Internalised parents and children have to be dealt with and met.

Quite common is the relationship which has never been named very consistently, that between the part of the person which feels impatient, never doing enough, missing opportunities, not completing projects, never achieving what is possible and so forth; and the other part of the person which feels too pushed, too imposed upon, too hurried and harried, and just wants to take it easy. This second party may procrastinate, engage in displacement activities, avoid engagement, make excuses and seek to be an exception.

These are all examples of conflict or disagreement, but also to be found are more cooperative examples. These may involve the Nurturing Parent, the Higher Self, the Higher Power or other positive and helpful characters.

All these have been written up and studied often. But there are other and more subtle relationships, such as the one described by James Vargiu:

This is a session with a woman who discovered within herself three characters – the Hag, the Doubter and the Idealist. The Hag comes across as being critical and twisted, the Doubter is afraid and mistrusting, and the Idealist has unrealistic ideals, refuses to accept her limitations, and her spirituality is pretentious and desperate. In the course of the session, another character appears, who is not so clear at first, a greater self, a higher self. This higher self looks at the others and sees them very clearly for what they are. The therapist then suggests that the Hag, the Doubter and the Idealist go for a climb up a mountain, watched by the higher self. When they reach the top of the mountain, the higher self sees them looking at each other and leaning in together and flowing into one. A

new person is formed. The client says – "And she has a bearing that's not puffed up, or on an ego trip, but sure of herself, knowing who she is. She's very, very solid." (Vargiu 1974, WB26). The client then goes into this new character and becomes her. There is some further work in this session, and a good deal of consolidation and working through after the session, but that is the main gist of what happens. It can be seen that the I-positions are capable of transformation, and this is very characteristic of the way they are handled in psychosynthesis, which is itself an integral approach.

Another example comes from my own book from 1990. A woman had two I-positions called 'Can't Cope' and 'Bill the Gaoler'. 'Can't Cope' would not let her wash up the dishes and 'Bill the Gaoler' would not let her leave the house without washing up the dishes. So she wandered around the house, not being able to wash up the dishes and not being able to go out either. When we got these two characters talking to each other, we found that a reconciliation was possible, which enabled her both to wash up the dishes and to walk out of the house quite independently. By taking the relationship seriously, and not aiming at elimination of any one of the parties, a real reconciliation could emerge naturally.

So I-positions can arise and depart, can transform, can merge or split, can be taken over by others – all sorts of permutations and combinations are possible.

**Outcomes**

And this brings us to the question of outcomes. One of the striking things about the case histories and case vignettes one reads in books on psychotherapy or counselling or coaching is that most of them are so minimal. The outcomes are not really very impressive. My own view is that most therapists have horizons which are too low. They do not expect much to change and then not much does change. I am more impressed by the work of therapists who speak of great transformations and important breakthroughs.

"Sometimes in the evening, as I look across at my husband and children, or in the day at my students in school, I feel blessed in my peace and joy, and marvel at how far I've come. When I think of how I used to spend all day bingeing and running away from the horrible pain of my life, I feel great gratitude to Ruth and the therapy. From the first session to the last, I have been on a journey of discovery, a journey into life. And I have continued to grow on my own. Now when things bother me, I can usually breathe and get in touch with what is going on, and even use it to expand. I am glad for my life, glad to be on a lifelong path of exploration and growth" (Wolfert 1996, p.79).

If we never get experiences like this, it seems to me that we are falling short of the full potential of psychotherapy. As James Bugental used to say, psychotherapy can be a life-changing experience if we allow it to be so, and it is distressing to me personally to find so many case studies that stop short long before the final stage is reached, and with no sign that there even could be anything further beyond the diminution of symptoms.

"What amazes me most is the knowledge/gut feeling that binge drinking is not a part of ME anymore. I choose not to be a binge drinker not by abstaining, but by knowing that is not who I am. I have changed, not because of external threats – job firing, divorce, abandonment – but because I was a fool who saw what a fool I was and who chose to change because I was not that person. I do not fear alcohol anymore! I am regaining daily a greater sense of self-power and testing out my beliefs in my limitless abilities. I feel soft and vulnerable and porous to the universe – my armor is dropping off, and I am truly being reborn in the sense of knowing that I am in charge of myself" (Schutz 1981, p.387).

If these are the results which psychotherapy can bring about, why do we so often settle for less?

**Dealing With the Shadow**

One of the crazy things about psychotherapy is the way in which each school has its own vocabulary, which no other school is entitled to use. Jung's idea of the Shadow is one example of this. Here is a genuinely useful concept, usable by anyone, but if you use it, you are immediately labelled as a Jungian, with all the

connected stereotypes that go with that. Well, I am not a Jungian, but I use it regularly.

It is particularly usefull in dealing with a particular stage of therapy which is very common in my experience. Clients often come in having played roles quite successfully for many years, and now wanting to meet the person behind all the roles. In the terms made popular by Ken Wilber, they want to move from the 'Mental Ego' to the 'Centaur level' of psychosocial development. In other words they are in the process of moving from an inauthentic position to an authentic one, or from a conventional stage to a postconventional stage of development, or from a self-image to a self – there are many ways of putting this, but they all add up to the same thing. It is a process which always involves dealing with the Shadow, because the Shadow includes all those aspects of the person that are inauthentic, that are partial, that are not under control, that give trouble in various ways until they are met and properly dealt with, and that prevent the person from being truly authentic.

One way of dealing with Shadow material is to name it, and then to engage with this. And the rules of engagement are quite simple. First we identify the problem area and give it a name, and perhaps a visual label. Secondly we talk to it and clarify the question of what we want from it. Thirdly we become that problem and speak for it, commencing a dialogue that can then continue, leading to some kind of resolution sooner or later. And as we deal with each problem in this way, the Shadow gradually dissipates and eventually becomes just a colourful facet of the person which causes no trouble. The rule is that as soon as Shadow material is brought into the light, it weakens as a separate being, and becomes capable of integration with the rest of the person. One client put it this way: "One afternoon, some time after I had started my work on subpersonalities [the old nomenclature for what we now call I-positions], I had an image of myself sitting in the middle of a circle of African huts, and in each of them were living my subpersonalities. Up to then they had been so strong that they could take turns in grabbing at me until one succeeded in holding me prisoner for a while. It might have lasted for ten minutes or ten years. I had no control… But then as I was sitting there, I sensed that this domination was coming to an end. Suddenly, for the first time, I truly felt, 'I can go into this hut or that one, and I can come out. And I don't have to stay there if I choose not to.' And afterwards, this mastery started to take effect not only in an imaginary static situation, like that of the African huts, but also in the dynamics of life, when I had to respond to various situations" (Ferrucci 1982, pp.52–3).

This is useful work, and it becomes very possible for this kind of thing to happen once we start to work with the Shadow in this way. A working-class woman, one of my clients, once said to me – "What I don't understand is how in here I take myself apart into alll these different parts, and yet when I go out of here I feel more whole!"

Working with the Shadow is very important, because it is the work which therapy can do and meditation cannot. Wilber (2006) has in his Chapter 6 a full and fair discussion of exactly why meditation can never deal with the Shadow, just as therapy can never give you an experience of the Causal. These are two different tasks, two different kind of work, and one cannot substitute for the other.

### The New Work

The interest in all this work has been further aroused recently because of the number of new approaches to psychotherapy now using the notion of I-positions or something very similar. In narrative therapy, for example, it is common to bring to life some important creatures, such as the 'Fear Monster', 'Sneaky Wee', 'Sneaky Poo', 'Concentration', 'Tantrums', 'Misery', 'Guilt', 'Bad Habits', 'Zak' (cannabis) and 'Sugar' (diabetes). By working directly with such characters, they found that they could confirm the adage – "The person is not the problem. The problem is the problem" (White, M & Epston, D (1990). Jill Freedman and Gene Combs have added such I-positions as 'Bravery' and 'Self-Blame' (Freedman & Combs 1996). In the work with such entities, the relationship shifts from sheer frustration and opposition to some other kind of accommodation which works well for the person involved. Not only the internal relationships get into the process, however. In Chapter 2 of the book by White and Epston, the authors make it

clear that all the relationships in the family were affected too. Dealing with problems in this way – externalising and personifying them – can have wide ranging ramifications.

Another new approach to therapy is opening up the realm of multiplicity within the person. William Stiles, who goes back and forth between Ohio and Sheffield, has developed what he calls assimilation theory, which again has produced a large research programme to explore the idea of listening to the different voices which emerge during the course of therapy (Stiles & Glick. 2002). Again the effort has been to identify the relationships which emerge between these different voices. For example, one of their papers (Honos-Webb et al., 1999) includes a case study of 'Jan', a 42-year-old white female. The researchers found that two main themes had emerged in the 16 sessions of the process: 'superwoman' and 'good-girl'. Each of these had a top-dog/underdog split: for the superwoman they were strength, endurance and independence versus feelings of dependency or weakness. For the good-girl they were approval seeking versus self-putdowns of various kinds. Jan also found it difficult to legitimate any of her own feelings.

At the beginning, Jan was unable to become aware of her neediness and weakness. Neither the 'superwoman' nor the 'good-girl' were able to recognise any such thing. But as therapy progressed, the neediness started to emerge and be recognised. At the same time the 'superwoman' started to ease off and be more ready to let other people do things.

The 'good-girl' became more and more aware that she was giving up a lot to gain the approval of other people. She became more and more able to give responsibility to other people to do various tasks, and less inclined to take everything on herself.

The authors say: "We found it useful to construe this process as building meaning bridges between active internal voices representing the initially opposed experiences. Initially, for example, Jan's top-dog superwoman voice opposed and suppressed her emerging underdog voice of neediness and dependency. By the end of treatment, however, these voices could coexist and influence her behaviour flexibly" (Honos-Webb et al. 1999, p.457). They go on to say: "The result of the assimilarion of a previously unwanted voice into the self was not internal consistency but rather an increased differentiation and complexity" (ibid, p.458).

They argue that mature multivoicedness can be distinguished from pathological fragmentation by the fact that voices are integrated and engaged in dialogue with one another in a constructive way. And they end up by suggesting that the methodology for tracking voices could be extended to include more than two voices. This is clearly about the internal relationships between the I-positions which had been discovered and worked with.

Another recent school which has used this kind approach is the experiential psychotherapy school, and these people make the point that this approach is very suitable for dealing with the vexed question of shame. "The experience of shame is therefore a good implicit marker of an attributional split, and Two-Chair Dialogue is an excellent means of explicating this process of internalized shame" (Greenberg at al. 1993, p.191).

They also make the point that this way of working is important for handling Post-Traumatic Stress Disorder. "Two kinds of conflict split occur often in PTSD: First, self-blame for one's victimization is a form of self-evaluation split… and is readily worked with as a conflict split between a blaming, critical aspect of self and a guilty or shame-ridden aspect. Second, 'anxiety splits' involve a vulnerable self facing a 'coaching' or 'catastrophising' aspect of the self that dwells on fear-inducing situations" (Elliott et al. 1998, pp.263–4). This now seems to be a well established and well researched finding. All the time we are learning more about these internal relations and how they can be used in therapy.

**But What About the Self?**

The astute reader will have spotted a great difficulty with the concept of the person as multiple. If we are really all these different characters, what happens to the self? What happens to the I-Thou if there is no I and no Thou?

There seem to be at least four lines of thought which can lead in different ways to the resolution of this dilemma. The first of these, and the most obvious, is simply to put the 'I' and the 'Thou' into quotes. Then we could say that the 'I' is simply the way an I-position appears in certain contexts, and that humanistic discourse favours this way of talking. This would enable us to continue to use the terms with the approval of social constructionists. However, this usage might not be acceptable to many of those within humanistic psychology, because it is difficult to think of oneself as something in quotes.

The second position we could take up is to say that the 'I' is real only in a particular context. If we participate in the humanistic psychology language community, we can very easily talk about the 'I', because it makes sense in terms of other constructs like self-actualization, authenticity and autonomy, all of which form part of that field of discourse. We would not be claiming universal or exclusive validity for that field, but simply saying that it was as legitimate as any other. This would be taking very much the Wilber (1997) line that what we have is a series of nested truths, none of which can stand alone, each of which depends on others. We would be arguing that the 'I' was a text in a context, and in that sense valid and meaningful.

A third line to take would be to say that the 'I' is not a theoretical construct. In fact, as we can see quite easily in issue after issue of the Journal of Humanistic Psychology, no one has ever come up with a good theoretical description or empirical investigation of the 'I'. I have suggested that this is because the 'I' is not a concept but an experience. When we have a breakthrough into what Ken Wilber (2000) calls the 'Centaur stage' of psychospiritual development, we have an experience which we in humanistic psychology have named as an experience of the 'I' or the 'I Am' (May, 1983). While we are having that experience, which is usually for only a brief period at first, though it may well extend over time, we are authentic. We relate to others in an authentic way; we own our bodies in a new way; other people experience us as clear and direct and truthful. It is basically an ecstatic experience, and I believe it is a mystical experience, although on the foothills of mysticism, rather than on the great heights. After it, we are more likely to say that we own our experience in a new way.

Like all mystical experiences, it is ineffable. That is, it goes beyond the categories of our ordinary discourse. It can only be described in paradox, or in poetry. If we try to bring it down into everyday discourse, the language of the consensus trance, as it has been called, we can only distort and misrepresent it. From this second point of view, we would want to say that social constructionism in all its forms is firmly located at this lower level. It glories in reducing all forms of experience to some form of conversation. It relies totally on language (hence the emphasis on the text) and regards anything which cannot be put into language as not really existing at all. Just as the positivists (arch enemies of the constructionists) used to say that anything which could not be empirically tested was excluded from the field of science, and therefore beyond the pale, just so the constructionists say now that anything which cannot be part of a form of discourse is excluded from their consideration, and beyond the pale. So if mystical experiences cannot be forms of discourse, and if contacting the 'I' is a mystical experience, the 'I' is beyond the pale so far as they are concerned.

Of these three positions (we shall come to the fourth in a moment), it is the third which puts us in the greatest difficulty with academia. Academia mistrusts and hates anything which cannot be put in a book. Whether positivist or constructionist, academics continually try to put beyond the pale anything which is experiential. That is why psychotherapy courses have such a hard time persuading academics that such things as experiential training groups, personal therapy or supervision belong at all in their field. They are hard to assess, hard to describe, hard to evaluate. They are potentially messy and hard to control. And so we have the spectacle of academic courses in psychotherapy and counselling which include no practice at all. There are some of these now and I predict that there will be more in the future. In a group, in one's own therapy and even in supervision one may have a breakthrough: one may have a mystical experience – even one which may change one's life. This is not controllable: and if there is one thing which academics are about it is control. It does not

matter whether they are old nasty positivists or new shiny constructionists, they are all about control. Nietzsche would have laughed.

The fourth position we could take up is to say that behind and beneath the constructivist positions we have been looking at there is a more fundamental issue – that of dialectical thinking. The humanistic position is the Centaur position, and Centaur thinking is vision-logic, dialectical logic (Wilber 2000; Rowan 2001). If we think dialectically, it is clear that we have all the time been saying something paradoxical. If we say that we believe in I-positions, and also believe in a real 'I', this is a huge contradiction. Where is the truth?

The truth, as Hegel used to say, is the whole. It is only when we can say everything at once that we can say – "This is the truth!" But since we cannot say everything at once, we must agree with the constructivists and the discourse analysts and the Lacanians and so forth that we have no basis, we have no foundation. And so we come back to the shunyata. We come back to the mystical assertion that the final realisation of the 'I' is that there is no I. In the same way, there is no I-position either. They are both inadequate ways of saying what has to be said if we take up a mystical position. However, this does not mean that there is no use in such concepts. They can be very useful so long as we do not give them an ontological status they do not deserve. Of course, we are here working at the very limits of human thought, and being forced into the land of paradox – but maybe that is the way things are when we come to the final reckoning.

## Conclusion

We could of course continue with many more examples, but perhaps this will be sufficient to make the point that these internal relations are of great interest and concern. We could also go on giving more and more examples of new schools of psychotherapy which use such thinking, such as Schema Therapy (Young et al., 2003), Person-Centred Therapy (Mearns & Thorne, 2000), the Odyssey System (Bogart, 2007) and Constructivist Psychotherapy (Neimeyer, 2009). This is clearly a growing point in the current climate, perhaps encouraged by the tendency of Cognitive Behaviour Therapy to grab and use anything and everything that might be useful to it. But let that suffice for now.

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**John Rowan** has been working in the field of multiplicity within the person since the early 70s, and his new book called Personification is scheduled to come out in December 2009. He thinks it is revolutionary.

*Lucia Swanepoel*

# 'To Integrate or not to Integrate?' Is That Really the Question?

**Abstract**

The terms 'Integrative Psychotherapy' and 'Integrative Psychotherapist' have become well established, and increasingly respected, within the psychotherapeutic field and for those of us ascribing to this model have become a way of identifying ourselves and our practice. In this paper I attempt to put to one side this personal investment and challenge the reader to consider with me the appropriation of this term, and in doing so to question the role of integration and the idea of choice.

## Do We Really Choose to Be Integrative?

How often do we ask ourselves why we choose an integrative approach to our practice? Perhaps we began with one model and diversified, or perhaps we were always a little sceptical and suspicious of the 'one truth' route to psychological health. In this paper I want to ask the question 'Do we really choose to be integrative?' For if we hold the position that we choose to be integrative, we imply that there also exists the possibility of choosing to be 'non-integrative'. I put to you the argument that perhaps we have less choice in the matter than we believe, for I propose that integration is the natural order of things, not just in the field of psychotherapy but as an optimal meta-approach to being in the world. That in order to survive in any environment we need to adapt to its influence, and in order to adapt we need to integrate new information and experiences into existing understandings. Integration can thus be seen as an essential process in the 'adaptive endeavour', and integral to living, and working, optimally. I suggest therefore that as living organisms we have no option but to integrate, with most of our integration happening on levels to which the concept of the conscious or non-conscious would not apply. Although we may consciously choose to align ourselves with an 'integrative approach' to psychotherapy, my belief is that we are 'doing what comes naturally'. That integration is a sine qua non of being.

## Adaptation and Integration: The Natural Order of Things?

In order to progress my argument on how adaptation and integration play such an integral part in life and psychotherapy we must address the two 'meta-theories' which form the cornerstones of my discussion. The first of these is that of Evolutionary Theory, for we cannot begin without acknowledging Darwin's (1968) contribution to our understanding of the importance of adaptation to survival. Whilst Darwin's ideas were initially claimed by the biological sciences (Burghardt, 2009), 150 years after the first printing of 'The Origin of the Species' the principles of adaptation have been and will continue to be explored and accepted in the behavioural sciences. Simply put, and adequate for our purposes, we might define adaptation in an evolutionary sense as a process whereby an organism, through

responding to its environment, becomes better able to live in the habitat in which it finds itself.

The second meta-theory, to which I now turn, is that of Complexity Theory and more specifically its offshoot, the Theory of Complex Adaptive Systems. Perhaps less familiar and mainstream than Evolutionary Theory and therefore in need of a little elaboration, I ask the reader to bear with me while I outline briefly below the main tenets of complexity theory which pertain to our current consideration of adaptation and integration.

One of the more 'accessible' definitions of Complexity Theory is offered by Masterpasqua (1998) who speaks of it as a "study of evolving systems consisting of many agents whose joint transactions lead to self-organised adaptation" (pg 30). Elaborating on this one could say that Complexity Theory more specifically argues that a system is influenced by both internal and external forces which continually affect the underlying order of the system, and causes it to 'self-organise', or adapt to its environment. For our purposes let us concentrate on the term "self-organised adaptation" as offered by Masterpasqua (1998), as it is here that the process of adaptation and integration takes place, and let us expand the notion of "influence" by introducing the concept of Complex Adaptive Systems. It is with this focus that the 'inter-relatedness' between systems will be highlighted, and will allow us to explore how this 'inter-relatedness', or 'relationship' if you will, both drives systems to adapt and facilitates their integration.

In defining complex adaptive systems Waldrop, (1992) cites four main characteristics.

> *a) Firstly complex adaptive systems are not centrally controlled, but respond to internal and external influences, adapting to these influences through the process of self-organisation.*
>
> *b) Secondly they are constructed of heterarchically (as opposed to hierarchically) arranged elements whose arrangement is responsive to the system's context, and are therefore constantly rearranging their components as they gain experience.*
>
> *c) Thirdly complex adaptive systems anticipate the future through earlier internal models that emerge as a result of system-environment transactions, which we might conceptualise as being the result of earlier self-organisation, integration and adaptation.*
>
> *d) Lastly complex adaptive systems never reach equilibrium, but continue to evolve, adjusting themselves to the environment as they perpetually integrate new information.*

In order to be optimally adaptive, systems exist on the 'edge of chaos', namely open enough to change, yet closed enough to maintain stability. This allows the system to be influenced by its environment, and to integrate important new information essential for its survival without decomposing when challenged. In the words of Miller (1999), "Complex Adaptive systems are constantly making just good enough adaptations to the environment to permit them to change whilst maintaining order" (pg 358). A closed system is unable to integrate new influences through self-organisation and is therefore unable to adapt. And here I want to make an important point – namely that non-integration is maladaptive, and is not a healthy system's preferred position.

Complexity Theory and Complex Adaptive Systems have been clearly identified and researched in biological, neurological and psychological systems (Barton, 1994; Butz, 1997; Chamberlain et al, 1998; Masterpasqua, 1998; Schore, 1994) and many principles from complexity theory are evident, assumed or explicitly mentioned in the writings on intersubjectivity (Aron, 2006; Carroll, 2005), affect regulation (Schore, 1994) and neurobiology (Damasio, 2000; Schore, 1994). Furthermore as chaos and complexity theories are inherently developmental in nature (Masterpasqua, 1998), they fit well with the notion of adaptation as understood by evolution.

Let me suggest then that as human beings we are driven to adapt to our environment through self-organisation or integration – which I propose we might use interchangeably. This is not a choice but a given, for we are compelled to adjust to our environment in order to develop and survive. Can we really argue that this would be any different in our psychotherapeutic endeavours, as we interact with the client in the clinical environment, or as our current

understandings of therapy are challenged by new theories and research? However, let me not jump ahead, but first turn to understanding how relationship, adaptation and integration applies to us as individuals in the world, before narrowing the focus to us as psychotherapists embracing an integrative model.

### The Adaptive Self and Its Integration

With due apologies to Waldrop (1992) for oversimplification, let us take his characteristics of Complex Adaptive Systems, and apply these to ourselves in our role as human beings. As a starting point I suggest that we can accept that:

*a) An individual is changed by their interaction with, or relationship to, the environment, including other individuals.*

*b) We use existing understandings gained through experience to make sense of the world.*

*c) This existing understanding of the world is amended and rearranged through the integration of new information.*

*d) In order to develop, and survive, we are continually challenged to adapt and integrate in response to changes in the environment.*

In other words one might reasonably argue that an individual is constantly adapting to the environment through contact, and in order to do this integrates new information and experiences into existing understandings of the self in relation to other – a true 'self-organisation'.

An individual is changed by their interaction with, or relationship to, the environment, including other individuals. Human beings are compelled to be in relationship for survival and developmental reasons, and our relationship to others both drives us to adapt and simultaneously allows us to adapt. We are born into relationship, develop through relationship and live our lives through relationship. This is true on all levels from the sociological through to the psychological and the neurological. Our social nature demands that we find ways of accommodating the subjectivity of the other in order to live together, and recent neuroscience has demonstrated unequivocally the essential role of relationship in the psychological and physiological development of humans (Beebe et al, 1998; Schore, 1994; Siegel, 1999). We cannot therefore escape the fact that change happens in relationship, and we would be hard pressed I think, to argue that we can remain uninfluenced by our relationship to our environment and the others who share it.

I would suggest that all psychological theories implicitly accept that as human beings we are committed to adapting to our environment. In fact it is difficult to find a psychological theory that is not in some way trying to explain the ways in which an individual is making adaptations to the presence of others in their world. Take for instance their negotiation of Freud's (1905) 'oedipal complex', Kohut's (1971) 'optimal frustration' or Benjamin's (1995) understanding of other as subject. In all of these theories the individual is placed in a position of having to adapt themselves to the influence or existence of the other. However if, as I suggest above, we consider the adaptive endeavour to consist of three different components, namely relationship, integration and adaptation, then I believe that historically we might understand different theories as attempts to explain different aspects of the adaptive endeavour.

Whilst earlier theories which focused on the intra-psychic process, including psychoanalysis and some object-relations theorists (Fairbain, 1952; Gomez, 1997; Guntrip, 1971; Klein, 1987), placed the emphasis on how we assimilate the information gained from the outside environment into our selves – the self-organisation or integration aspect of the 'adaptive endeavour'. Later theories turned their attention more explicitly to considering the importance of 'the other' in determining both, the need for, and the process of, integration. For instance we might consider later object-relation theorists, (Balint, 1992; Bowlby, 1997; Gomez, 1997; Winnicott, 1965), self psychology (Kohut, 1971) and humanistic traditions, as moving the focus to include more prominently the role of the inter-psychic, which in turn moved the spotlight more fully onto the role of the relationship in the process of adaptation.

However, in my view, these theories fall short of elucidating the adaptive process which drives

us as organisms, because of their inability to incorporate fully the relational and the integrative aspects in such a way that the ongoing necessity for adaptation is recognised and explained. To my mind it is the emergence of Intersubjectivity Theory and the recent understandings from Neuroscience, both of which encapsulate the characteristics of Complex Adaptive Systems as cited above, which add the final piece. Through acknowledging the mutual influence of individuals in relationship and addressing as they do the inevitability of many systems adapting to each other simultaneously and continually, they recognise the dynamic and inescapable nature of adaptation. Or in the words of Stolorow et al, (1992), they "bring to focus both the individual's world of inner experience and its embeddedness with other such worlds in a continual flow of reciprocal mutual influence" (p.8).

A proviso must be introduced at this point to explain the exceptions to this neat assertion that we interact, integrate, adapt and develop. To do this we must remind ourselves of another important component of complex adaptive systems, namely the need to exist on the 'edge of chaos' and the importance of the 'openness of the system to be influenced', for a closed system cannot integrate new information and therefore will not adapt.

We use existing understandings gained through experience to make sense of the world.

There are many examples from theory of how we make sense of the world through the use of existing understandings, for example Stolorow and Lachman (1984 – 1985) speak of 'unconscious organising principles' and both Bowlby's (1997) Internal Working Models and Stern's (1985) RIGS offer theories which consider these structures. I suggest that for our purposes we use the generic term 'schema' to encapsulate the various terms for existing understandings, and propose that through placing the concept of schemas alongside the Theory of Complex Adaptive Systems we can see how in our terminology, schemas are created through the integration of information gained through relationship with others, and allow for adaption to the environment. Miller (1999) too argues from this perspective, hypothesizing that mental schemas are in essence the building blocks of the human complex adaptive system. He goes on to describe them as representing the "organised state of the many elements that make up a lived experience" (pg 361) and points out that they are important in making sense of and regulating self-experience and affect, as well as attributing meaning to experiences and drawing conclusions about past and future adaptations.

This existing understanding of the world is amended and rearranged through the integration of new information. For in order to develop, and survive, we are continually challenged to adapt and integrate in response to changes in the environment.

Environments are not static, and they call for continuing adaptation. Human beings are not all the same, or even consistent across time, and our relationships with each other calls for a constant readjustment of our internal understanding of the world. Faced with the option of how to manage the ongoing exposure to information coming in from the environment, individuals are faced with a number of choices. Firstly there is the possibility of remaining closed to outside influence and opportunities for adaptation. However this creates the situation of a system which is fixed in its schemas and is therefore both vulnerable and maladaptive. The second option is to begin afresh with each new contact, discarding old schemas and substituting a new schema to fit the current situation.This too creates an unstable system, which loses valuable learning each time a new challenge is presented – a situation which would certainly not have been beneficial to our evolutionary survival. The third option is to continually add more and more information to existing understandings. Without the process of integrating new information with old, this too would destabilize the system – threatening to overload schemas as more information, some of which might be contradictory, is added. No, the optimal way to adapt to a changing environment must be to re-arrange existing structures to include new information in an integrated way. That is to build on existing structures without destroying them either by discarding earlier adaptations, or by overburdening them with too much information which then cannot be utilized optimally.

Stern's (1985) contribution to infant development, outlining the role of attunement in the development of the human brain, offers a concrete example of how existing structures are re-arranged through reciprocal contact with others to allow for the integration of new information. This has been further developed in the work of Beebe et al (1998), and in Schore's (1994) theory of affect regulation where he demonstrates how early schemas can be adjusted through later relationships, thus arguing for their dynamic and malleable properties throughout life.

### 'Integrative' Therapist or 'Human' Therapist?

Having considered the case for the individual as a complex adaptive system – which in relationship to others continually integrates information through a dynamic process of self-organisation, can we reasonably suggest that as therapists the demands for adaptation are any less? Let us take the points we agreed in the previous section and substitute the words 'an individual' with 'a therapist'.

> *a) A therapist is changed by their interaction with, or relationship to, the environment, including other therapists, clients or theories.*
>
> *b) Therapists use existing understandings gained through experience to make sense of the world in which they work*
>
> *c) This existing understanding of the world is amended and rearranged through the integration of new information.*
>
> *d) In order to develop, and survive, therapists are continually challenged to adapt and integrate in response to changes in the environment.*

Again I would suggest that these assertions are not foreign statements that sit in opposition to how we view ourselves as therapists, but a continuation of principles which are familiar to us as human beings.

As living organisms we are constantly adjusting to the environment, and the ability to integrate is our lifeblood. Without it we would neither be able to adapt to new challenges and to learn from them, nor would we be able to influence others as they influence us. As a therapist this can be no different. At a fundamental level the very essence of our work involves relationship with another, thus bringing into contact the schemas of both our systems. This calls on us to consider adapting if we are to accommodate the 'other' in the room, and if we are to facilitate change. The openness of our systems to influence, and our ability to integrate new information through self-organisation of existing schemas, is what allows us to be dynamically present in the moment.

All therapists would surely see the process of therapy as being the opportunity for clients to be better 'adapted to the world', having integrated new understandings of themselves and their experiences, and being open enough as a Complex Adaptive system to continue responding and adapting to changing environments. The meeting of therapist and client schemas in the therapeutic space, provides contextual feedback to both client and therapist, and calls on each to make adaptations to the influence of the other. New insights and understanding are integrated into existing systems that are used for making sense of the world and are self-organised into modified schemas. Therapeutic change takes place as a result of the interplay between the therapist as complex adaptive system and client as complex adaptive system, both of which move through the process of relating, integrating and adapting.

However the 'environment' to which the therapist is exposed incorporates more than that of the client interaction. We are brought into contact with other therapists, alternative theories, new research findings and employment contexts in a constantly changing professional environment – not to mention the broader environment outside of our professional identity.The relationships we form with these other systems, influence us both consciously and unconsciously, and compel us to adapt in order to be optimally responsive. Just as our manner of adaptation as a human being is to integrate new information, so too does this principle apply to our practice as a therapist. Thus I propose that it is not the choice of whether to integrate or not to integrate which makes us 'integrative' therapists, but rather the fact that we are 'human' therapists.

**Integrative Psychotherapy – A Truism?**

To write this paper I have spent some time pondering my understanding of the term 'Integrative Psychotherapy'. Do I understand the term as referring to a school of therapy or a state of being? And does this make a difference to the argument that I put forward and the conclusion that I reach?

In attempting to hold the first position, namely that Integrative Psychotherapy is a 'school of therapy', I began with asking the question, 'What are we integrating and how?' Magnavita (2008 citing Norcross and Newman, 1992) suggests that there have been various approaches to psychotherapy integration, listing four dominant ones – technical eclecticism, theoretical integration, assimilative integration, and common factors. He names assimilative integration and common factors as providing the strongest foundation to the integrative movement, however these approaches seem to me to address only the integration of theory. Furthermore, they imply a consciousness in the process which to me dismisses theoretical influences which have been assimilated on a non-conscious level – as well as ignoring the existence of individual schemas which determine the very nature of the integration. This left me challenging the notion that there can be a school of integrative psychotherapy based only on the conscious integration of theoretical models. Furthermore from my position of conceptualizing human beings as complex adaptive systems who self-organise unique internal schemas as a result of interaction with others, I can only reach the conclusion that there must be as many integrations as there are therapists.

I found myself trying to solve this dilemma by adopting the more inclusive stance of seeing Integrative Psychotherapy as referring to a 'state of being', or a perhaps a therapeutic mindset. But again I am puzzled by the implication that 'to integrate or not to integrate' is a conscious choice. I agree that is it possible to espouse an openness to new ideas and theories and to embrace a willingness to incorporate (integrate) these into existing understandings. Moreover, I accept that we can consciously choose to eschew a particular theory, and through a 'closed system' chose not to integrate it into our psychotherapy schema. However if we take the term to refer to more than just conscious theory building, I fail to see how we can choose not to integrate in the broader sense of the term.

But where does that leave our 'one model' colleagues? In much the same boat I would imagine, for either way I am left with the conclusion that all therapists, by virtue of being human, must be integrative regardless of their allegiance to any particular model. Certainly I believe that it would be wrong, through naming ourselves as 'integrative' therapists, to infer that others are 'non-integrative'. Few therapists would argue that practicing therapy is anything but a complex process, regardless of their 'formal' alliance to a purist or an integrative model. Those holding to one model of practice would most likely agree that they are continually integrating knowledge from the therapeutic alliance, their theoretical knowledge and their own understanding of what it means to be in the world. I suggest that in order to adapt to different clients, different presentations, and different circumstances, all therapists are continually called upon to adapt practices, theories, and their own understanding of self.

Furthermore, as a product of adaptation, if they are a 'good enough' therapist open to relationship with the environment, they will integrate continually, albeit sometimes unconsciously, and without an overt acknowledgement of being 'integrative'. Therefore I would argue that the choice is not in being integrative per se, but in the decision of what to integrate. In other words, the determination of what 'type' of therapist one becomes is not based on the choice of whether to be 'purist' or 'integrative', but is based on what we choose to be consciously influenced by. I use the word 'consciously' deliberately here to remind us again that there is much which goes on in relationship, to which we adapt, but of which we have no awareness.

**End Thoughts**

When I began this paper my aim was to offer a thoughtful consideration of our assumption that we 'chose' to be 'Integrative' psychotherapists, to present a challenge to how we view ourselves in relation to 'other' psychotherapists

and to confront the implicit belief that in naming ourselves as 'integrative' there was a possibility of choosing to be 'non-integrative'.

However as my argument developed I became more aware of the shadow side of using the term to define myself.The temptation to think that somehow, whilst deceiving ourselves that integration is down to choice, we have more insight into the practice of psychotherapy, seems to me somewhat self-righteous – not to mention incongruous with many of the theories we embrace. In the worst sense it tempts us to raise ourselves above those who haven't 'seen the light', and is perhaps no different from the accusations levelled at our colleagues who ascribe to a one theory model.

I don't offer an alternative term to 'Integrative Psychotherapist'. To be sure, I am far more moved by the suggestion of a unified science (Magnavita, 2008), than I am by 'naming' my self as any 'type' of therapist. However the point of which I am increasingly convinced, is that we don't hold the rights to the term 'integrative' even though we might choose to make this element of the psychotherapeutic practice foremost when identifying ourselves and our therapeutic practice.

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*Tamar Posner*

# Backward Shadow: The Implications of Sibling Death on Perceptions of Childhood

**Abstract**

While there is now a growing body of research into the experiences of siblings bereaved as children or as adolescents, the phenomenon of adult sibling loss has, to date, received comparatively little attention. This paper highlights some of the issues with which adult survivors of sibling death have to contend, considers possible implications for the practice of psychotherapy, and suggests potential areas for further research.

## Introduction

As a young adult, I experienced the sudden and unexpected death of one of my brothers. In the years since that event, I have wondered about the extent to which my experiences, then and since, have been unique or universal and I have asked myself many questions in an attempt to resolve that issue. Amongst those questions, one has consistently intrigued me:

> *"What has been the impact of a sibling's death on other survivors' perceptions of childhood?" To this I have since added: "What might be helpful for psychotherapists – especially those who are not themselves survivors of a sibling death in adulthood – to understand so that their practice may be better informed?"*

The requirement, as part of my submission for an MA in Integrative Psychotherapy and Counselling, to submit a dissertation on a subject of my choosing provided an opportunity to widen the context of my questioning; this I did by undertaking a short study based on interviews with six people who had also lost a sibling and by reviewing such relevant literature as I was able to find. While my primary interest was in the experience of sibling death in adulthood, the interview process itself caused me to broaden my field of enquiry and include aspects of childhood sibling loss as a basis for comparison. My interviewees for the most part were, like myself, trainee psychotherapists; the exception was a volunteer who heard about my project from her own therapist.

## Considerations of Applicability and Ethics

It is arguable that a research cohort of psychotherapy trainees, for whom a capacity for reflectivity is a pre-requisite, might preclude the straightforward applicability of any findings from this study to a general, and possibly less contemplative population; however, it is my view that these considerations in themselves could usefully inform the practice of psychotherapy.

Another factor taken into account when considering participants for this study was the high probability that, inviting people to share with me recollections of their brother's or sister's death, would stir painful memories. I felt ethically bound to exercise an appropriate duty of care towards my participants and to ensure, as far as reasonably practicable, that they would have a safe and holding space in which

they could, if they chose, discuss participation in my study and any personal consequences that might ensue. For this reason my interviewees were selected from training institutions that require students to be in personal therapy for the duration of their training.

### My Brother's Death and Its Immediate Aftermath

I was just short of my thirty-second birthday when my brother 'Joshua' – 18 months my junior – died. There was no suspicion that foul play was in anyway involved – it was an accident, caused by carbon monoxide poisoning – and, once the post-mortem had been held, arrangements were made for my parents to fly the body abroad for burial in the family cemetery. Of the rest of the immediate aftermath I remember little apart from the fact that, when Joshua died, my parents, my other brother and I retreated further into ourselves where we coped with our grief, by ourselves, as best we could. I was left trying to contend with my grief for Joshua and a sense of helplessness in the face of my parents' suffering; I was capable only of withdrawal in an attempt to protect myself from further pain. Nor did I realise then, as I have belatedly come to realise since, that in my need for comfort I wanted to turn, child-like, to my parents completely oblivious of the fact that they did not have within them the resources with which to console me.

### Resentment Versus Curiosity

It is now 28 years later and for most of the intervening years I have carried my memories like some kind of shameful secret, a dark boulder sitting heavily behind me and blocking much of the view when I choose to look back. Since Joshua's death I have suffered other major losses that have been devastating in their own ways but I have not experienced those events as challenging my very existence. When Joshua died it was different: my mother was the only one of us who ever spoke his name aloud in family circles, and when she did it was often to voice some memory of him as a child. Bearing in mind there was only a year and a half between Joshua and myself, I had my own recollections of many of the events my mother described and of my own part in them. And therein lay the problem: my mother's memories belonged exclusively to Joshua and were unable to accommodate anything I might have done, seen or said at the time. And so, when Joshua died, not only did I lose one of my brothers, but simultaneously, and shockingly unexpectedly, I experienced the eradication of an entire aspect of my identity; I saw myself as a strange and empty shell of an adult with no history and no substance. I retreated further behind my wall of silent resentment.

For many years I have been able to paper over that particular crack, by treading lightly whenever anything has taken me near it and by choosing to focus my attention on where I am going, not where I have come from. However, more recently I have begun tentatively to explore more of my past and my resentment has gradually given way to curiosity: was my experience really so unique? If so, what made it so? And what are the experiences to which I am referring?

### Disenfranchised Grief

Disenfranchised grief is a term coined by Kenneth Doka (1998, cited in DeVita-Raeburn, 2004, p58) in the context of divorced spouses mourning the death of their former partners. These were people who were often denied the right to their grief because they were no longer perceived as having a 'legitimate' relationship with the deceased. However, as Doka himself came to realise, disenfranchised grief is equally applicable to other groups of people, for example: those who have suffered miscarriages or undergone abortions; children or the mentally impaired who tend to grieve differently from the majority of adults or are perceived as unable to have an understanding of death (ibid).

That grief for a dead sibling should also fall into the category of disenfranchised grief may at first seem surprising. However, let us consider what happened to the man whose theories about the human psyche have been held in such high regard for so long, namely, Sigmund Freud. Freud was a firstborn child whose brother Julius, younger by less than a year, died from an intestinal infection at the age of six months. Not only is it probable that Freud's parents were

emotionally unavailable to Sigmund in the immediate aftermath of Julius's death, it is also the case that by the time Freud was ten years old, he had four younger sisters and another younger brother, all of whom were in competition with him for his parents' attention. Given this history it is perhaps understandable that, for Freud, rivalry and a desire to be rid of these interlopers if at all possible, coloured his view of sibling relationships to such an extent that he overlooked other aspects of siblings and sibling loss. (Breger, 2000 cited in DeVita-Raeburn 2004, p59). It was only in the 1950's, well after Freud's death, that child development research and the significance of the mother-child bond began to flourish but it was not until the 1980's and the publication of 'The Sibling Bond' (Bank and Kahn, 1982) that the sibling relationship began to be acknowledged as important and a significant factor in people's lives.

The first book on sibling loss – 'Unspoken Grief' – focused on personal experience of sibling loss in childhood (Rosen, 1986). 'Sibling Loss' (Fanos, 1996) was published ten years later and again was triggered by personal experience. Rosen and Fanos both came to the conclusion that, with few exceptions, sibling loss tended to go unseen and unacknowledged; as a result, unexpressed grief could pervade the lives of surviving siblings for many years after the event. And Kenneth Doka observed that, when a child dies: "The focal point is always on other relationships … The sibling relationship, wherever it is in the life-cycle, is just very easy to neglect" (Doka, 1998 cited in DeVita-Raeburn 2004, p59).

The truth of that last statement was evident in all the interviews I conducted. For those who, like myself, were adults themselves when their brother died – and we all lost brothers – the focus, including our own focus, was indeed on the parents and, in the one case where both parents had pre-deceased their son, my subject expressed her relief that they had been spared the trauma. Of two who were not adults – one lost her brother while she was still a toddler and the other was herself born after her brother's death – both reported that the presumption, explicit or implied, that they were not affected was, from their experience, deeply mistaken.

While there is now a growing body of research into the experiences of siblings bereaved as children or as adolescents (eg Heiney, 1991; Brent et al, 1993; Davids, 1993; Rosen, 1995; Davies, 1999; Packman et al 2006; Christian, 2007) the phenomenon of adult sibling loss has, to date, received comparatively little attention. In his doctoral thesis on sibling loss in young adulthood, presented to the University of Pretoria, South Africa, Eleferia Woodrow describes sibling loss as: "… a triple loss: the loss of the sibling, of the family unit and of the parents in their familiar sense." He goes on: "As loss threatens with fragmentation … the desire for stability and continuity becomes paramount … In sustaining primary attachments, a facade contains their grief as the need to remain functional dominates and the reality of the pain is evaded, their grief postponed" (Woodrow, 2008). Not only does this resonate with my own experience, it also suggests that as adults, in our desperation to avoid overwhelming emotion, we may well disenfranchise ourselves.

### The Stiff Upper Lip

'The Stiff Upper Lip', in my perception a close cousin to disenfranchised grief, came into being as a result of the First World War. Until that time it was recognised that death had a lifelong impact on survivors (DeVita-Raeburn 2004, p140) and, during the Victorian era, in the days of mourning dress, black-edged stationery and locks of the dear-departed's hair contained in lockets or tied with purple ribbon, widows and widowers would, both literally and metaphorically, wear the loss for years (Neimeyer, cited in DeVita-Raeburn 2004, p140). However, the ability to engage in high profile mourning was completely swept aside by the sheer scale of the hundreds of thousands of bodies brought back from the front lines between 1914 and 1918. In such a climate it fast became one's patriotic duty to distance oneself and to repress one's grieving; and so the 'The Stiff Upper Lip' was born and became the model for grief, not just in Europe but in America too. "In our culture we tend to deny death, its magnitude and even its possibility. So, too, with our grief …" (Charles & Charles 2006, p74).

For those participants in my study whose parents, like my own, had memories of one or both World Wars, the need to 'be strong' in the face of grief was paramount.

### Silence, Guilt and Anger

Just as the phenomenon of the stiff upper lip seems to me to be to be closely allied with disenfranchised grief, so it also appears to me that silence in its turn can be a way of maintaining a stiff upper lip. Three of my participants spoke of their perceived need to grieve in silence – or at least to keep their grief away from parental view. One participant remarked on her sense that the silencing came from 'society in general and not just the family' while from another I got the distinct impression that her silence, as well as helping her parents to avoid becoming overwhelmed by their grief, was also in conformity with the societal stricture that displays of grief were not 'the done thing' and that a 'stiff upper lip' was what was expected. "Many children learn from their wounded parents that to raise up a dead sibling's image is treacherous or disloyal" (Bank & Khan 1982, p275).

For one of my participants there were additionally feelings of guilt to contend with; her brother's death was discovered two days after both she and her parents had, for different reasons, changed their minds about paying him a visit. Recently and several years after the event, having thought about this on her own account, she has been at pains to try to reassure her mother that 'since there was no fault, there should be no guilt'.

I call the kind of grief that this participant and her parents quite understandably wrestled with 'the grief of magical thinking'. It is predicated on the belief that if only something had not happened, or had turned out differently, then everything else would also have turned out differently, which is to say, better. In this particular instance there is no real indication of exactly when the death did occur so it is just as likely that, had the visits gone ahead, it would simply have been discovered earlier. The motivation for a bereaved family's silence has been described as the avoidance of blame: "The guilt maintained by these unrealistic beliefs remains intact and intense, with each individual locked in a struggle with his own conscience and unable to share such painful feelings" (Krell and Rabkin 1979, p473).

As well as guilt – about how they felt and/or about what they did or did not do – some of the surviving siblings I interviewed talked to me about their anger. I have already mentioned that I 'retreated behind a wall of silence and resentment' when I found myself being written out of my own childhood but one of the participants who struggled with a similar phenomenon was able to attribute it to her parents' coping strategies. This has enabled me, belatedly, to be more accepting of my own predicament.

Another participant described a different aspect of resentment and anger arising from her perception that, in her grief, her mother is unable to celebrate her son's life and remains focused exclusively on his death. Here the tables are turned and it is the surviving sibling who, by avoiding any mention of her brother at home, is imposing silence on the parent.

### Possible Implications for Psychotherapists

At the beginning of this project I thought that the fact I was interviewing people about their experience of sibling death, rather than engaging in a therapy session with them, would require of me different skills from those I usually employ in the consulting room. It took only one interview for me to understand that this was not the case. I realised that what I was actually seeking was insight into my participants' lived experience so I needed them to talk 'from' rather than 'about' that experience and I recognised that my ability to integrate myself in the relationship, remain congruent with my feelings and communicate empathic understanding would be critical to engendering an atmosphere of safety and trust, within which often painful recollections could be shared. This is in essence not very different from what I endeavour to do with the clients who come to me for therapy although, in the greater time I have to spend with my therapy clients, we are additionally striving to effect therapeutic change (Rogers 1957, p96). It seems I am not the only psychotherapist/researcher to have made this discovery; Andrew Reeves, reporting in 'Therapy Today' on the BACP Research Conference 2009, makes reference to research: "… that is beginning to identify the similarities between a research interview and

a therapeutic encounter. Clients interviewed for research purposes can sometimes feel more 'helped' than by the original therapy they were describing" (Reeves 2009, p7)

This inclines me to offer some perceptions for further consideration.

The first of these concerns some of the qualities a qualitative researcher into the events that shape people's lives ought ideally to possess. On my own project, although I knew that my empathic understanding was informed both by my personal experience of sibling death in adulthood and by my psychotherapy training, it was the experience of being a therapy client myself that I was most keenly aware of in the presence of my participants. It is perhaps worthy of note that a colleague whose interest is in the impact of childhood sibling death on survivors' adult lives, also found that her experience of personal therapy has significantly and favourably influenced her ability to conduct her research.

I would also suggest that some therapeutic approaches might be better suited to exploring the kind of experience I was interested in than others. I was in daily psychoanalytic therapy when my brother died but during the six months that elapsed between my announcement of the death to my analyst and my decision to end the therapy, that subject and its repercussions were, as far as I can recall, never referred to again. To be fair, both of us were probably too shocked to confront the situation immediately but that 'conspiracy of silence' and the fact that my analyst never once enquired of me how I was coping was, for me, just another tacit indication that my grieving was not worthy of attention.

That raises another issue: the phenomenon of 'hidden grief'. As has been stated earlier in this paper, for many people, particularly adults I would suggest, the combination of the requirement to 'sustain primary attachments' and 'the need to remain functional' (Woodrow, 2008) are likely to result in repression of the grieving process; add to that surviving siblings' struggle with the phenomenon, also described earlier, of disenfranchised grief, and it may well take some time for a client to be able to focus on their grief in therapy. It is possible that, for some therapists, hidden grief may be a blind spot that needs to be brought into awareness; or it may be that this is an area to which more attention needs to be paid in supervision and/or in training.

A further point I would make, which was referred to by all of my participants and which carries additional weight in the light of the several references I came across as to how easily the feelings of bereaved siblings can be overlooked, relates to the therapeutic value to be derived from having the opportunity to speak about the event exclusively from the perspective of the survivor. The phenomenon described in the emerging research into similarities between a research interview and a therapeutic encounter does, I suggest, bear this out.

**Conclusions and Suggestions for Further Research**

There is no question that the death of a sibling, no matter when it occurs in the lifecycle, has an impact on surviving siblings' perceptions of childhood. If the death occurs in the survivor's own childhood it inevitably leads to wistful wonderings about what growing up might have been like had it not occurred. For adults there can be a sense that a part of their childhood died along with their sibling and has become, like their sibling, a ghost that haunts their dreams. Put another way, a sibling's death in adulthood casts a backward shadow over their childhood that hides precious memories from view.

In this paper I have touched only lightly on an area ripe for further research. What, for example, can be made of the fact that all my participants were female and all the deceased were male? Does this imply anything about women's capacity for survival or is it simply a reflection of their greater preparedness to talk about their experiences? If men were to talk about their experience of sibling death, in what ways might their stories differ from those told by women? And what else might this tell us? The fact that a high proportion of my reference material is derived from sources outside mainstream academic literature is another indication that there is further potential for research in this field; I get the impression that the authors of most of the books I consulted had written the

books they would have wanted to read – and interestingly, all those authors were women!

The experience of conducting and writing up this research was both intellectually rewarding and therapeutically beneficial. It required me to re-visit and to re-assess the impact my brother's death has had on me; on occasion, it provided me with insights that have given meaning to what for a long time has felt inexplicable. My thanks to all those who joined with me in this endeavour and supported me along the way.

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*Phillipa Perry*

# Relational Marketing?

**Abstract**

Lets start at the beginning, the very beginning. How does a new therapy relationship start? Does it start with a potential client drawn to a title such as "The Road Less Travelled" by Scott Peck in an Oxfam book shop? Maybe they buy the book and read it and think, one day I'll do that, I'll sort myself out with a therapist. Or was that just my beginning? How do clients find that road in? Maybe they pore over the problem pages in magazines and keep seeing the advice to visit a professional counsellor? Maybe they read your blog or follow your twitter?

There are words in the vocabulary that might incite curiosity in some such as psychologist, psychic, counsellor, psychiatrist, healer, psychotherapist, shaman, priest, mental health nurse, agony aunt. You may read those words and have different feelings for each one, but somebody else might not have such a differentiated reaction to the separate words. Somehow the message may filter down into some people that help could be available, a sort of talking help. How does it filter down? Some people, like my long suffering daughter, are born into households where there are discussions about the relative merits of the theories of Freud or Assagioli, but I am sure it is also possible to achieve a great age without having heard of either of them.

When does a client's relationship with you actually start? Does it start when they see counselling recommended on the Daily Mirror's problem page, or does it start with a well publicised pop psychology book? Does it start when they see your name and notice your nearby postcode in the Yellow Pages? Or is it more likely to begin when they notice their put-upon friend beginning to become assertive and happier who tells them about that kind old woman she has being seeing once a week for the past year?

I posit that the hope generated by the problem page and pop psychology books and magazines, newspaper articles that mention therapy, the pub and the internet has a lot to do with generating the optimism needed for a client to make contact with a therapist. Hang on, did I just say the pub? I did, I remember one client telling me that she overheard her boss talking about his therapy with me in the pub and she waited until she could speak to him alone and got my number. I am concerned about how chance plays such a large part in bringing client and therapist together.

So therapy is out there, somewhere in the ether, but how do you find the right therapist? Okay, you probably have the answer to that as you are a therapist but put yourself in the place of someone who is not. Someone who does not know anyone who has every had any therapy, who harbours a belief that only mad people need it and yet they have a feeling, an uneasy feeling, that it could help them.

Psychotherapy is a relationship. It is two people in a room. It is an important relationship, maybe it is the most important relationship you will ever have. Is it right that what could be so pivotal for the potential client feels like putting their hand into a bran tub and seeing

what they pull out? For the uninitiated choosing a therapist is like that. There is no common consensus of where to start, or how to look.

It is okay for us, the psychotherapists to rely on chance conversations in a pub to bring us clients. We can only see twenty or so people a week, if we are good at our job, word of mouth will eventually fill our practice, we do not have to worry about the potential clients who have no way of finding us. Do we?

We have many wonderful books, case studies and theoretical tracks that illustrate and delineate and clarify theory and personal approaches to practicing talking therapies but how many of them pay much attention to how the client got into the room in the first place? Here are some of my case studies, I'm afraid rather than wonderful, they are tales of trial, error, persistence, despair and luck:

> *An acquaintance told me that her partner had gone to the doctor for an erectile dysfunction problem. The doctor referred this forty-eight year old man to a female counsellor who looked about twenty-two; he felt too embarrassed to talk to such a young and attractive woman about his problem and he did not return, nor did he look for a private therapist, largely because they did not know where to start looking; he felt demotivated to do anything further about his problem after this experience. Chance brought them to me and I was able to find a suitable therapist for them. Good outcomes like these should not be so dependent upon chance encounters.*

> *A colleague told me that when she first came to this country – before the days of the Internet – she was so desperate that she rang round the Yellow Pages until she found someone who answered the telephone with a received pronunciation accent. She does not recommend this as a way of finding a psychotherapist, as her experience was one of wasted time, lost money, and emotional damage with a practitioner who appeared to take advantage of her ignorance and vulnerability and got her involved with some sort of cult, an expensive cult, financially and emotionally.*

> *More recently someone else told me she used Google to find a therapist and came across a respectable, official looking site with a list of names. The names were all she had to go on and so she chose someone with the surname of Wolf as she liked Wolves. After a few sessions with her Wolf she asked for more feedback, Dr. Wolf did not give the sort of feedback she was after but he was able to refer her to her current therapist who does. If only she could have gone straight to her current therapist she would have saved herself some time and money.*

I know that gathered anecdotes does not equal research but I have heard enough sorry tales and been approached by enough potential clients to be concerned at the ways in which people are being introduced to therapy. One cannot disregard the emotional and mental state of the individual who is seeking support and to be put through such experiences cannot help their general well being, not the mention their perception of the sector. Should potential clients have something more to base their decision on than prejudices about pronunciation and a liking for animal names? I think they should.

What I am proposing is that we talk more about who we are and what we do. I propose that we completely throw off the shackles of the old psychoanalytic idea that therapists should be anonymous. Yes, I do believe that we may still be covertly ruled by the maxim of abstinence and anonymity that analysts once believed an absolute necessary in order to allow transferences to happen. Transferences will happen anyway, there is no way of stopping them, even if you are Carl Rogers. There is still a whiff of anything less than complete boundaried discretion being somehow unprofessional and possibly beneath us. Would we have got into this mess with the Health Professions Council trying to squeeze us into a medical model had we been more relational with the world, had we talked more about what it is we do, had we demystified psychotherapy before they tried to do it for us?

I am not so much concerned with educating government about what we do, although that is vital, so much as communicating with the public at large. It is all very well our sharing our methods and beliefs in journals and conferences with each other but we need to talk in jargon free language to lay people as well. Let us end the client's lucky dip, or more often unlucky dip with their choice of therapist.

I would like to see every therapist with a web site, like a shop window, where they expose their beliefs about change, about the pros and cons of therapy, with photographs and not stock images, their own photographs possibly of their room or themselves or both and a thorough description of how they, personally approach working as a psychotherapist. I want beliefs, practicalities, influences, special areas of interest and research projects laid bare. I want this because I feel anything less is not fair on the client. I would also like therapists to be active in their communities, talking to doctors, local employers, local clubs and people. We have a duty to share with other people what it is we do so they can reject us or use or recommend us. If a therapist is asked what it is they do and if the other is interested, they deserve a full answer.

It is great that more therapists now have an internet presence and some of them really give you a flavour of the person which must be very helpful to the potential, searching client. Trauma therapist Robin Francine keeps a blog in which she gives non jargon descriptions of how she works. For example,

> *'…If I'm attached to the client (which I must be), I'll feel his hopelessness and despair. I must metabolize it, and when it's digested, find a way to hold it, without buying into it…'*

Another good example of a therapist explaining themselves is Tim Le Bon's web site and blog which explains how he integrates philosophy into how he works. I am even happy to see those websites that are generalised and vague, they are not much better than the yellow pages: a list of psychological problems; a list of qualifications all hung together with a stock image of nature and perhaps a new age logo, perhaps even written in the third person. There are hundreds of these. How is the potential client going to start a relationship with a stock image and an unoriginal web site. Are we not behind the idea that we facilitate people to become more fully themselves rather than an unaware bundle of introjects from their past? Would it be terrible to show some of our own individuality so that the potential client has a better chance of choosing between us? However, any website is better than none, it at least gives the potential client a chance to find you.

I approached the problem of making my website by imagining what it would be like to be using the internet to try to find a therapist. How would a potential client even relate to the word therapist? What would that mean to them? I imagined what fears they might have about the process, how daunting they might be finding it, I asked a lot of people about their hesitations about therapy and I tried on the site to talk about some of those hesitations. What I was trying to demonstrate was that I would try and see things from their angle. I listed some of the common reservations about asking for help, for example,

> *'I don't deserve to have this time devoted to me. The therapist should be helping someone who really needs it …' and then I posted my reply, 'The fact that you've enquired about counselling and psychotherapy services indicates that a part of your really does want help but you are not feeling good enough about yourself to feel okay with receiving comfort and professional help. You may have learned from your family that "you should not be selfish" or that you "don't deserve anything good." My belief is that it is always worth challenging such assumptions …'*

I also talked about how I approach my work, my beliefs about my work, and how I work, in as jargon free language as I could manage. Here is another example

> *"Whilst I think it is important to challenge self-destructive strategy/behaviour I believe it is important to aim to understand the feelings that lie beneath it by inquiring, imagining and checking out assumptions (mine and the client's). If I understand the feeling behind a behaviour and can empathise with it, I can hopefully help to raise awareness of the behaviour or strategy in a way less likely to shame the client. I believe that empathy creates the best context for growth."*

I thought having a web site that was somewhat different would put some clients off and that this would be a good thing, because if they don't like my style wouldn't it be better that they discover that before wasting money on me? If they do like it, then their optimism about working with you will be raised. If their psychic beliefs chime with yours they have a better chance of a successful outcome with you (Hubble,

Duncan Miller, 1999). In other words, your work together could be given the best possible start.

Having a website that says more about you as an individual practitioner, rather than a website that looks like so many others has a disadvantage. There is a limit to the number of clients you are able to work with if you are going to be working at your top potential, so some of your time will be spent in the public service of referring the clients you cannot see because you are working to capacity to your less visible colleagues. It does not feel good to disappoint a potential client by being unable to see them and it is important to try to generate some positive pre-transference in them about the people you refer them onto.

Even if it isn't in you to talk more openly about how you work and if you have no inclination to advertise on the world wide web, or to publish a book or give talks and I would not want to recommend incongruence, please do give some thought, not to how you are going to get clients but to how clients are going to find you, because it would be a shame if they found something or somebody less useful instead. Also I think it is worth pondering about how their journey to find you influences your work together and how it helps or hinders the client's progress.

I believe it is important to realise that your work with your clients potentially starts long before they first get in touch with you and you have a choice about whether you attempt to influence that work or not. It is great that the relational movement has got us taking on the client's perspective more and more, lets now take on board the potential client's perspective as well.

**Websites That Offer Individual Flavours:**

www.andrewsamuels.com

www.timlebon.com

traumatherapy.typepad.com/trauma_attachment_therapy/2007/07/long-term-clien.html

www.allankelly.com

www.counselling4london.net/phdi/p1.nsf/supppages/1168?opendocument&part=3

What you'll notice about these sites is that they are all different, they are current, lively and like marmite, 'you'll love 'em or hate 'em'.

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# An Integrative Developmental Relational Model

**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 her own framework for integrative practice.

## Section A – Model of Integration

### A1. Introduction and Summary of Framework

My evolving integrative approach to psychological therapy conceptualises a 'fusion' between intrapsychic structure and interpersonal patterns. I draw on developmental theories and neuroscientific research that centralise the infant/caretaker dyad. These include theories of object relations (Bowlby, 1988; Winnicott, 1965), self psychology (Kohut, 1977; 1971), developmental theories of Stern (1985) and Beebe & Lachmann (2002). Internal Working Models (Bowlby, 1988) or RIGS (Stern, 1985) are held in certain life scripts, or schemas (Berne, 1964) which shape personality and are continuously re-enforced and co-created in our relationships with others throughout lifespan.

I believe that within this systemic, co-created matrix the dichotomy of the interpersonal and intrapsychic realms are constantly re-negotiated and are mutually reliant. I draw on the idea that co-creation (Beebe & Lachmann, 2002) and intersubjectivity (Stolorow & Atwood, 1992) of therapist and client is core to the process of repair. I work with aspects of the implicit relationship, self-object transference and countertransference as well as the more explicit real relationship. I particularly conceptualise the reciprocal regulation of arousal and affect as central to the therapeutic relationship and psychological change.

### A2. Philospohy Beliefs and Values

My beliefs and values are influenced by Bugental's (1965) view that human beings cannot be reduced to 'components' and are embedded in a uniquely human context. While our human consciousness differentiates us from other mammals I understand life as 'a constant process of becoming'. I see an individual's expression of choice, self mastery and meaning-making as a co-created action of participation not speculation (Kierkegaard, 1846). Amidst the uncertainty of existence I believe the certainty of an individual's subjective experience defines their truth and reality which is paradoxically co-created with others.

Rollo May (1967) talks of the human dilemma as holding the polarities between 'object and subject' and thus making meaning of ourselves in the world. This is perhaps Buber's curiosity when he said "hence the I of man is twofold" (Buber 1923, p11). I believe a dialogical approach explores the ambiguity and uncertainty of being alive and allows us, in the spirit of openness and curiosity, to negotiate polarities and accept pluralism and dichotomy.

My philosophical position sees both the uniqueness of the individual and the interconnectedness with others at the centre of human experience and the simultaneous search for individuality and mutuality at the heart of human struggle. This belief underpins my current integrative approach to psychological therapy and informs my view of human motivation and functionality.

### A3. View of the Person

#### 3.1 The Complexity of Human Motivation

I understand human motivation as multidimensional, designed to ensure independent survival and growth and embedded in 'mutually regulating' systems (Lichtenberg, 1991). While I recognise our drive to meet physical needs, I focus on a person's psychological search for selfhood, mastery and meaning; belonging, comfort and closeness. In Kulka's words, "the human raison d'etre is creation of experience of significant selfhood, even if this goal can only be realized within the contextual cradle of relations with another" (1997, p186).

#### 3.2 Multidimensional Relational View of Self

i) Interpersonal Self – Self to Other

I believe individuals are 'simultaneously, complementarily and optimally designed' to be in an interactive reciprocal system (Stern, 1985). I see this co regulated and co-determined experience to be at the centre of human experience and motivation. While we negotiate maturation and seek consistency, we face the dilemma of solitude and togetherness, hope and disappointment, love and hate, life and death. Relationships provide love, esteem and value; understanding and acceptance; a feeling of being known and an arena for expression, communion and support.

ii) Intrapsychic Self – Self to Self

I see the human need for expression of self as a continuous "organising and reorganising" process of "experiential integration" (Stern 1985, p71). Within the multifaceted self is 'I', the 'subjective self' which 'observes, organises, and interprets experience' (Evans & Gilbert 2005, p51) and the 'me', which I see as a 'conceptual self' constructed by the 'I', and experienced as an internalised object holding my views, values and beliefs of the world (Stern, 1985). I also conceptualise a higher functioning self that holds the tension between observations of self-as-object and reflections on experience of self-as-subject (Fonaghy, 2002). I believe a person's capacity to move with flexibility between these polarities of self underpins self worth and self agency (Evans & Gilbert, 2005).

iii) Cultural and Contextual Self – Self to Selves

My approach considers the implications of cultural and contextual diversity and holds an "attitude of equalisation" to ensure true contact (Evans & Gilbert 2005, p58). I think individuals are "profoundly context sensitive and context dependent" (Atwood & Stolorow 1992, p773) and have a "multiplicity' self state 'populations' " which function autonomously and are called upon to optimise experience in the context of our external worlds (Polster 1995, p10).

iv) The Central Organising Function of Affect

I view affect as the central organising principle of motivation and human development and I understand it to create a "sense of self across state transitions, thereby allowing for a continuity of inner experience" (Schore 1994, p498). I see this aspect of self to exist before the development of language and to continue throughout life. I recognise an unconscious 'archaic' self as responsible for managing instinctive impulses and affects. This implicit, pre-reflective self is often sensed as 'the unthought known' (Bollas, 1987).

v) Understanding Experience and Making Meaning of Self and Other in the World

As human beings we are 'meaning-seeking creatures' and I understand meaninglessness to create an individual's experience of hopelessness and despair (Yalom, 2001). I see a person's capacity for reflective function as essential to healthy functioning as it allows the individual to connect to the meaning

of emotions and to construct a meaningful narrative of their experience (Fonaghy, 2002).

### 3.3 Developmental Considerations Leading to Functionality and Health

I conceptualise healthy human functioning as a person's capacity to sustain healthy relationships, to impact and be impacted by others, without 'losing a sense of self' (Bartholomew, Henderson & Dutton, 2001). I believe this capacity for intimacy and autonomy emerges from the 'good enough' quality of the minutiae in the mother-infant exchange and that it is simultaneously co-constructed. This early reciprocity builds an individual's capacity to regulate stress, navigate growth and integrate cognitive, affective and behavioural experience. It engenders a sense of self mastery, a capacity for making meaning and a tolerance for transition, flux and change. In my view, although we are born with a genetic influence and a temperamental template, a person's development relies on the culturally embedded nature of their early relational interactions. I blend Bowlby's (1988) attachment theory Stern's (1985) interpersonal development theory and the work of Schore (1994) to conceptualise my theoretical framework of human functionality.

i) Attachment Security – The Touchstone of Functionality

I understand the infant is born into a 'reciprocal interactive' relationship (Beebe & Lachmann, 2002) with mother which ensures essential physical and psychological safety. I see the formation of self and self regulatory functions to develop within this unique rhythmic dyad, and maternal attunement as key to creating a positive self concept and healthy self functioning (Kohut, 1977). Mothers' of securely attached babies were emotionally sensitive and responsive to the child's needs and 'responded more promptly when the infants cry, look and smile' (Siegel, 1999). They talked to their babies more and held them with affection and joy. Within this experience of 'primary intersubjectivity' (Trevarthen, 1993), the mother's unique expression of "psychobiological attunement, misattunement, and reattunement, to the inner subjective feeling state of the infant begins to create cycles of social engagement and disengagement in the infant" (Schore 1994, p97). I see this experience as central to an emerging sense of selfhood and affectivity in the 'emergent' and the 'core' self (Stern, 1985).

ii) Implicit Relational Patterns

By six months with the onset of locomotion and a secure attachment, a new sense of self mastery and confident curiosity about the world emerges (Holmes, 2001). The infant extends the perimeter of the proximity to mother, and explores the world with a certainty of the mother's availability as the secure base. The infant is now able to use mother as 'soother' at points of reunion following distress of separation and has developed a 'confident expectation' (Winnicott, 1971) that disruptions to emotional homeostasis will be repaired. This creates a model of self as loved and valued, and of other as loving and trustworthy (Bretherton, 1992). I see these experiences of separation and reunion as crucial to the organisation of implicit interpersonal expectations through lifespan.

The infant's internalised experience of the mother's availability, predictability and reliability sets an 'evocative constancy' at about 16–18 months (Schore, 1994). The child is now able to evoke an internalised regulatory object in times of distress, and return to functioning. With this implicit expectation that disruptions to emotional homeostasis will be repaired, the infant can now negotiate leaving and being left, while maintaining a sense of self cohesion. I believe this signifies a gain in the infant's capacity for self regulation and the beginnings of the move from "complementary power to mutual understanding" (Benjamin 1995, p11).

iii) Individuality and Mutuality

I incorporate Stern's (1985) view that the child's exploration and reunion is 'equally devoted to the seeking and creating of intersubjective union with another'. In this simultaneous experience of connection and separation I believe the infant must navigate 'the paradox of recognition' (Benjamin, 1995). In recognising self as separate, the child tolerates the destruction of other and as she continues to need the attunement of mother, she must negotiate the ambiguity of connection/disconnection and similarity/difference. While I like Malher et al's (1975)

attention to the rapprochement phase and their ideas of separation and individuation, I believe dependency is not a phase to be outgrown, but autonomy and interrelatedness, rather than being dichotomous, are two sides of the same coin (Stern, 1989). I understand that this early negotiation of mutuality and individuality allows the child to recognise herself as separate, and confidently approach others for comfort and emotional support.

iv) Affect, The Main Event

Like Tomkins (1990) I view affective experience as 'the main event' and believe the primary function of attachment is the dyadic regulation of emotion (Stroufe, 1996). While the infant experiences 'rushing, fading and exploding vitality affects' her capacity to regulate arousal 'stress' is regulated by the mother's sensitive 'cross-modal matching' and 'affect synchrony' (Stern, 1985). This maternal 'empathic attunement' allows the child to integrate her affective experience and begin to rely more on self regulation rather than other regulation within the interactive reciprocal system (Beebe & Lachmann, 2002). I see the co-regulated amplification of positive affect, reduction of negative affective, moderation of arousal and confidence in emotional expression to create a sense of self cohesion despite affective state transitions (Schore, 1994).

v) Verbal Language and the Development of a Theory of Mind

I see language as 'crossmodal' and 'affect laden' (Stern, 1985) and understand that thought begins in "imaginal dialogues that represent the child's autobiographical narrative of her affective experience" (Schore 1995, p489). As the child experiences greater autonomy she can hold abstract symbols and schemas and begins to hold an objective view of self. With this capacity for 'reflective function' the child can reflect on her own internal state as well as the internal state of mother (Fonaghy, 2002). She can now negotiate experiences of shared meaning while continuing to participate in an evolving 'mutual reciprocal relationship' (Stern, 1985).

I think to incorporate Wright's (1991) concept of the 'third person perspective' at this stage is useful. He describes the expansion of the child's experience from 'self' in the dyad with mother, to a 'self' in a system with others. I believe this marks the beginning of the child's capacity to see 'self as object' and 'self as subject' in the context of relationships with others in the world.

vi) Social Learning and the Development of Agency and Self Mastery.

The child's environment now becomes an arena for emotional socialisation and social learning (Bandura, 1977). I think parents' who model comfort with their own affective experience and respond positively to their children's affects and behaviours, support a positive learning environment which re-enforces the child's self efficacy and self esteem. Self efficacy is the result of a secure attachment experience and is expressed as a person's capacity for self agency and confidence in the positive outcome of their actions in the world. This continuously re-enforces the experience of positive social learning, supports self expression and a belief of self mastery.

vii) Support from Neurobiology for Attachment Theory

I draw on Schore's (1994) view that the child's secure attachment experience creates neurological 'synaptogenesis' (cell growth) in the emotion generating limbic system of the infant brain. I believe this neuronal mapping is particularly active in experiences of repair following 'stress induced dyadic mismatches' or 'attunement breaks' (Stern; 1985) and that these neural pathways underlie internal and intrapersonal regulatory functions 'sub-served by prefrontal internal working models' (Schore, 1994).

To summarize, I see a person's capacity for mutuality and individuality shaped by early, experiences of separation and reunion within the attachment dyad. These transactions are experienced as 'states of affect' which, when consistently repeated, become embedded in neurobiological pathways creating 'personality orientations' and 'ways of being with' (Stern, 1985). I draw on Evans and Gilbert's (2005), view that an individual's ability to move comfortably between self states of 'I as subject' and 'me as object', and capacity for 'interpersonal flexibility'

between closeness and distance with others, is essential to effective human functioning.

### A4. Human Dysfunction and Derailment

An infant will adapt to suboptimal interactions and 'precociously foreclose on the development of a healthy sense of self, other and the world' (Mitchell, 2000). I believe early empathic failure and unrepaired disruptions to attunement lead to derailment of affect. This determines insecure attachment patterns, shapes distorted schematic beliefs about self and other, and leads to maladaptive and enduring intrapsychic and interpersonal patterns in adulthood. In the next section I will explore how I conceptualise early affect derailment as the central causal factor underlying human dysfunction and psychological disorder.

### 4.1 Developmental Derailments

i) Negotiation of Relational Contact and Regulation

I believe a child's insecure attachment behaviour is a regulatory strategy developed to manage intolerable experience of affective overwhelm and underwhelm, in times of unrepaired parental misattunement (Beebe & Lachmann, 2002). In attempting to regulate emotional homeostasis, the child learns to attend excessively to an unpredictable caregiver, or to turn away from a caregiver who is unavailable. I believe these strategies heighten the experience of positive affect, reducing negative affect thus securing a semblance of regulation and felt safety. These individuals develop internal configurations of self and other that shape either an avoidant/dismissive attachment style of over-regulated affect and externalising behaviours, or a preoccupied/fearful style of under-regulated affect and internalising behaviours (Bartholomew & Horowitz, 1991).

Like Tomkins (1993) my approach sees the deactivation of arousal and minimisation of affect as the key motivation for the 'avoidant' and 'dismissive' adult. Parents of individuals with an avoidant style, were rejecting at points of reunion and emotionally distanced. These people expect interpersonal contact to be rejecting of their emotional needs and experience anxiety in intimate situations. They believe to initiate contact will elicit aversion, not empathy and keep emotional distance from others to manage the threat of emotional engulfment. These individuals have a positive view of others and a negative view of self, and while terrified of closeness, they unconsciously crave connection to others. People with dismissive attachment behaviours tend to be compulsively self reliant and in emotional control (Johnson & Whiffen, 2003). This over-regulated affect creates an intolerable 'affect hunger' and a pattern of unpredictable 'affect eruptions' in close relationships (Tomkins, 1991). They hold a positive concept of self and a negative concept of others. This permanent disposition of low arousal leads to a limited capacity for positive or negative emotions and a person's susceptibility to internalised disturbances of overregulation like depression, bi-polar illness and anxiety disorders (Siegel, 1999).

Individuals with preoccupied styles have had early experiences of partial affect regulation with mothers who only show enthusiasm at reunion. The infant was left to remain close hoping to capitalise on the restricted supply of attention. I believe this to inhibit exploration and create diffidence with autonomy (Schore, 1994). As adults these people have a positive model of other and negative concept of self. They "blame themselves for lack of love, are overly dependent, have intense feelings of worthlessness and experience an excessive need for others' approval" (Bartholomew and Horowitz 1991, p229). They show characteristically high demands for support and responsiveness from others and high levels of anxiety at a hint of rejection or abandonment. Unable to avert from Mum's unpredictable gaze, this pattern is linked to expressions of intense emotion and susceptibility to under-regulatory disturbances (Schore, 2003).

I believe preoccupied and fearful individuals share attachment dependence on others but differ in how they respond to anxiety and how they approach others for support. Fearful individuals are hypersensitive to approval and will avoid intimacy entirely due to their expectation of rejection. They do not expect others to be responsive and

they shy from asking for support altogether. They have a negative view of themselves and of others. (Bartholomew et al, 2001)

ii) Affect Dysregulation, Fragmentation of Self and Compromised Mutuality

A child who remains in a state of 'dysregulated' affect will repress and 'split off' unwanted or frightening feelings, particularly aggression and shame. This fragmentation of self represents the first 'narcissistic injury' and disrupts the infant's internal coherence with implosions of shame and outbursts of rage (Stolorow & Atwood, 1992). In the absence of regulatory repair shame becomes part of the internalised self concept, creating cognitions of 'failure and demoralisation' (Pine, 1990). I understand shame to impede the experience of other emotions in 'shame affect binds' (Schore, 2002). When an emotion has been internalised in a negative experience it is continuously re-felt in a state of shame. I use the idea that in adulthood shame inhibits confident expression of affect, and signals the existence of an inhibited or unconscious emotion.

I see shame to indicate a failure in early attachment experience and person's inability to use self and other effectively in a regulating system. This diminishes a person's capacity for self awareness and ability to attend to others (Evans & Gilbert, 2005). This skewed interactive 'tilt' of a person's insecure attachment pattern creates an "excessive self regulation at the expense of mutual regulation leading to withdrawal, whereas over-vigilance is characterised by excessive monitoring of the partner, at the expense of self regulation" (2005, p76).

**4.2 Effects of Trauma on Developmental and Pathological Responses**

i) Reciprocity of Neurobiology and Developmental Dysfunction

Consistent experiences of unrepaired misattunement and dysregulated affect create 'toxic stress' (van der Kolk, McFarlane & Weisaeth 1996) in the young brain which induces excessive cell death and over-pruning to neural connections responsible for emotion regulation. I draw on Chugani's (1996) study of maternally deprived Romanian orphans to illustrate the reciprocity between maternal misattunement and neurological dysfunction. The MRI scans of these children showed a' virtual black hole' where the hippocampus is located. While the amygdala processes the emotional and sensory content of experience and is fully developed at birth, the hippocampus holds autobiographical and memory functions and matures in the third year of life. The disrupted interplay between these two parts of the brain impedes the cohesive integration of emotional and narrative material.

When a person's capacity for self and other regulation is severely compromised I believe the individual becomes neurologically predisposed to consistent states of hyper-arousal, (associated with childhood abuse), and hypo-arousal (associated with childhood neglect). These people are vulnerable to continuous and cumulative experiences of overwhelm or underwhelm throughout life which I believe underpins psychological dysfunction and disorder (Schore 2002; 1994). Schore's (2002) ideas of 'early relational trauma' fit well with the developmental relational framework of my current integrative approach.

ii) Early Relational Trauma and Psychopathology

I view early relational trauma as the result of extreme parental inconsistency and abuse in the first two years of life. As the attachment figure becomes both the source of soothing, and the source of threat, the child experiences unpredictable activation and deactivation of the attachment system. This creates a 'disorganised' attachment pattern (Main & Solomon, 1991) and a 'disorienting' internalised representation of 'self-interacting-with-a-misattuned-dysregualting other' (Schore, 2002). The experience results in the critical loss of self and self-regulatory function, as well as an impaired capacity for autobiographical coherence (Holmes, 2001). These individuals suffer 'chaotic' affective experience and 'inrecouperable stress' (van der Kolk, 1996). In the absence of an effective regulatory other they use dissociation to regulate extreme disruption to affect regulation, struggle with self integration and encounter interpersonal difficulties (Herman

& van der Kolk, 1987). I see these underlying structures to mediate psychological dysfunction and increase a person's vulnerability to psychopathology (Bradley, 2000). These people often manage the painful dilemma of being with self and other in the world by self medicating with addiction to alcohol and drugs and self regulating with eating disorders and deliberate self harm (Kantzian, 1990).

I understand that parent's difficulty in attending to the "initiatives of the child results in the collapse of the intersubjective space with only one party's subjective reality being acknowledged" (Lyons-Ruth 2005. p 327). This impairs the individual's capacity to "integrate conflicting representations and to reflect on the subjective views of self and other" (2005, p 327). I see this loss of reflective function to create a rigidity characteristic of more severe personality disorder and psychopathology (Fonaghy, 2002).

**A5. Diagnosis and Problem Formulation**

I believe psychological dysfunction and disorder share aetiology embedded in early relational developmental history and affect dysregulation (Schore, 2003). Although laid down through state dependent experience in infancy and early childhood, I see adolescence as a widely ignored milestone and believe it is here that characterological styles and psychological disorder begin to emerge. The adolescent period is particularly growth enhancing for certain personalities, but for others with developmentally over-pruned, cortical-sub cortical circuits this stage can be emotionally overwhelming and 'disorganising' (Schore, 2002).

I see personality to reflect the interface between a person's intrapsychic structures and interpersonal organisation and borrow Johnson's (1994) idea that the stage of developmental disruption shapes specific personality features and configurations. Disruption to early attachment is linked to oral/dependent and schizoid/avoidant structures; formation of 'self' to borderline, narcissistic and masochistic features and 'self in system' issues to histrionic, obsessive compulsive patterns.

I distinguish between a person's problematic personality 'features' and 'disorder' by attending to their level of reflective awareness of the problematic patterns. I believe when 'features' become 'fixed' in psychic structures and the individual shows inflexibility in the process of transformation (Beebe & Lachmann, 2002) a more serious 'personality disorder' probably exists. I again draw on Johnson's (1994) idea that shared characteristics of personality structure can be arranged on a continuum from the mildest 'character style', to moderate 'neurosis', to the severest 'disorder'.

While I acknowledge the usefulness of the DSM-IV-TR (APA, 2000) in classifying Axis I symptomology, I view the attempts of the medical model to understand personality as less reliable. As an integrative psychological therapist I ask "how do I account for this person's actions and experience in this particular context" rather than "is this person suffering from a disorder or not" (Pilgrim 2000, p 302). I use Smith Benjamin's (2003) interpersonal diagnostic model which incorporates DSM-IV (APA, 2000) Axis II terminology, yet integrates an interpersonal perspective. I value her consideration of the client's perception of others, their responses to others, and their internalised beliefs of self and other. This echoes my own developmental integrative approach as it focuses on the reciprocity of interpersonal patterns and self concept and explores how a person's past experience maintains and determines current difficulties.

**A6. Process of Change**

My view of change is consistent with my view of functionality and derailment. I believe that therapy is the search for a new balance between autonomy and mutuality, and is therefore embedded in the complexity of the therapeutic relationship as it echoes and organises self structures, relational and regulatory patterns.

Research reflects my relational approach to therapy integration. While client motivation and readiness (Elton-Wilson, 1996; Prochaska & DiClemente, 1992), extra-therapeutic factors, placebo effects, and techniques, are shown to influence change, the relationship

is regarded as the most significant predictor of outcome and change in therapy (Wampold, 2001; Hubble, Duncan & Scott, 2000; Horvath and Symonds, 1991).

I believe change occurs within a co-constructed therapeutic relationship at implicit and explicit levels. I value Schore's (2003) idea that changes to implicit organisation and patterns of expectation occur at a neuronal level in the right hemisphere of the brain. This is rooted in the recurring, affective transactions between therapist and client which influence the updating of internal working model configurations. I believe this marks an important change for a theory of 'therapeutic action' and is based on the belief that these implicit, interactive patterns are set on an early trajectory which can be changed at the implicit level without verbal reflection (Boston Change Study Process Group, 2008).

I also incorporate Stiles et al's (1990) systemic, assimilation model as it sits well with my current integrative approach. They view change to occur when new cognitive, affective and behavioural experiences are integrated into existing schemas and particularly value the identification and integration of 'warded off feelings' (Holmes, 2001). 'The experience of change is a sequential process; moving from negative affect to acceptance and mastery, along with becoming clearer about the nature of the problem before insight is reached' (Giankis & Carey, 2008). For me this highlights the importance of supporting the client's capacity for reflective function and mentalization in the change process (Fonaghy, 2002).

i) Stages of Therapy

I see change as a 'process that unfolds over time' and not a singular event (Prochaska and DiClemente, 1992), and incorporate Evans and Gilbert (2005) view of the stages of the therapeutic process; I-it position (which focus's on collaborative approach of client and therapist to the facilitation of pattern recognition and intrapscyhic change), to a focus on the I-thou relationship (which switches focus to the therapeutic relationship) and the I-Thou of mutuality. I see this 'evolution' as compatible with my current integrative approach and central to the process of therapy. I use Smith Benjamin's 5 core treatment foci of; i) developing a collaborative relationship, ii) facilitating pattern recognition, iii) blocking maladaptive patterns, iv) strengthening the will to give up maladaptive patterns, v) facilitating new learning. I integrate aspects of Kepner's (1996) Healing Tasks model particularly aspects of building social and self support functions. I also take from Johnson's (1994) approach that each character style requires a specific approach to cognitive, affective and behavioural intervention.

**A7. The Process of Therapy**

I borrow the words of Pat Ogden; 'in recent years, psychotherapy has begun to shift its emphasis from models of cognitive development to the significance of affect in an inter-subjective context. Psychotherapy is being redefined as the affect communicating cure rather than the talking cure' (2008).

**7.1 The Process in the Room**

I blend theories of intersubjectivity (Stolorow & Atwood, 1992; Ogden, 1994), relational psychoanalysis (Mitchell & Aron, 1999), developmental theories of self (Stern, 1985), self function (Kohut1977) and interactive regulation (Beebe & Lachmann, 2002) to conceptualise the process of therapy. I use Gelso & Carter's (1985) view that manifestations of the therapeutic relationship are central to the therapeutic process and see this as embedded in the phenomenological 'here and now' in the room with the client. I focus on the Kohutian (1977) use of empathy and self object function as well as working closely with affect regulation and techniques involving 'use of self' in the countertransference as described by Maroda (2004; 2002).

I understand therapy as a 'reciprocal process of mutual influence' and 'a dialogue between two personal universes' (Atwood & Stolorow 1984, p4). Like the early dyadic experience of infant and mother in which the self is organised and shaped by the inter-subjective system, I see adult dysfunction and affect derailment to be re-organised in the co-constructed dyad between therapist and client.

I use Mitchell's (2002) contagious excitement about the potential to combine a 'one person' and 'two person' approach as it informs the potency of my integrative endeavour. This tension 'between persons' and 'within minds' is ambiguous and paradoxical, comprising conscious and unconscious dimensions across time. My approach sees the fusion of space and time occurring in the intersubjective space as it is expressed in the 'here and now' of the therapeutic relationship. I believe the implicit and explicit transactions between therapist and client are as significant as early exchanges between infant and mother and are central to the process of change in the therapeutic work (Stern 2004).

### 7.2. Alignment and Repair

While I attend to the collaborative agreement of tasks and goals I consider the quality of the emotional alignment and felt safety of the client as central to the work (Bordin, 1979). I borrow Stern's (1985) view that a similarity of timing, intensity, and contouring of affect and arousal, brings two people into a similar state which facilitates intimacy and attachment. My focus is to join the client and share her inner state by "amplifying" positive affect and "synchronising transactions" (Beebe & Lachmann 2002, p 223). I think this empathic 'non verbal, psychobiological attunement' provides the interactive background needed to invite the client into the security of an attachment relationship and alliance.

I view the inevitability of 'ruptures' to the therapeutic alliance and the negotiation of repair, to paradoxically represent the potential 'heart of the change process' (Safran et al, 2001). I am vigilant about noticing and attending to signals of a 'rupture' in work with clients. These might include non payment of fees, lack of punctuality, missed sessions, anger or change in the contact style and engagement with me in the room. The client might hold negative expectations or feelings about me that need to be expressed. Safran et al (2001) describe the smart therapist as one who directly focuses on weakness in alliance, ignoring this did not improve outcome. I approach this work with openness and in the spirit of collaborative curiosity and believe a 'threat exposed and articulated' can be reparative and transformational in the therapeutic work (Clarkson, 2003).

I integrate Beebe and Lachmann's (2002) view that within an explicit 'rupture' is an implicit disruption to the mutual coordination of affect and arousal. I 'track and match' my client's affect state, maintain a mid range of arousal and support my client's confidence in emotional expression. I focus on heightening positive affective experience as I believe this supports the integration of new experience and change in neurological pathways (Schore, 2002). I repair regulatory disruptions and misattunements particularly when arousal is outside the optimum mid-range and the client is in a state of hyper-arousal (Beebe & Lachmann, 2002). I believe it is within this shared struggle of dyadic, 're-attunement' that self structures and maladaptive relational expectations are repaired. In working with client's under-regulated strategies I draw on the trauma literature and explore 'anchoring', breathing techniques and calming visualisations, (Rothschild, 2000). I incorporate techniques of 'mindfulness' and interpersonal skill development (Linehan, 1993). Working with overregulated and alexithymic (Krystal, 1988) clients I use 'constant empathic enquiry' (Stolorow & Atwood, 1992), role model my comfort with affective experience and disclose my affective countertransference (if appropriate) to the client with intelligence and sensitivity (Maroda, 2002).

### 7.3 Implicit Relational Communication

The Boston Change Process Study Group (2008) conceptualise a dynamic 'implicit relational knowing' (2008; Lyons-Ruth, 1998b) as the basic structure that shapes each interpersonal relationship and influences a person's "subjectivity and unconscious within that particular relationship" (Gerson 2004, p72). I incorporate Gerson's (2004) view of the 'relational unconscious' and Ogden's (1994) 'analytic third' to understand the uniqueness of the co -created dyad between the implicit subjectivities of therapist and client.

Like Stolorow & Atwood's (1992), I believe the boundary between implicit knowing and conscious awareness is fluid and fluctuating

in the intersubjective context. I believe 'unformulated experience' (Stern, 1989) seeks expression in the context of the therapeutic relationship and is particularly evoked at the contact boundary between therapist and client. This implicit communication is central the co-created process of implicit and explicit repair and I understand it to find expression in projective identification, transference, countertransference and relational enactments.

i) Enactments, Transference and Projective Identification.

I believe enactments in therapy create an opportunity for implicit relational patterns to be revised without becoming conscious (Gerson, 2004). "When implicit and powerful affect laden schemas are played out, and disruption and repair are negotiated, a person's implicit enactive representations" are revised (Lyons-Ruth 2005, p 316). I understand this is jointly co-ordinated between therapist and client and draw on Ryle and Kerr's (2002) idea of 'reciprocal roles' in which the 'relational unconscious' (Gerson, 2004) of both therapist and client co-create an enactment of past relational patterns without language or symbolic form.

I believe the client's 'unvalidated unconscious' (Stolorow & Atwood, 1992) is characterised by dissociated affective states rather than symbolically elaborated feelings, and is created by experiences of early relational trauma (Schore, 2002). I understand these 'split off' fragments of affective experience are transferred, or projected into the implicit field and then felt as a bodily state by the therapist. I see therapy as a means to 'strengthen the validity in the client's subjective experience' (Stolorow & Atwood 1992, p116) and to translate this early implicit experience into symbolic and verbal form. I understand this as the client's 'strivings for needed vitalizing and soothing experiences' (Kohut, 1977) and I see these self object transferences as an 'urgent appeal for interactive regulation' emanating from the client's repetitious intrapsychic and relational configurations (Schore 2003, p92). I see this as an opportunity to support the client's new experience of co-regulated affective experience and to build self-regulatory function and self cohesion.

I am sensitive to Storlorow's (1992) idea that self object transferences are polarised. At one end the client hopes that the therapist will offer a 'corrective emotional experience' (Alexander & French, 1946) and at the other, fears that existing expectations will be confirmed and there will be a repetition of the original trauma.

ii) Countertransference

Central to my approach is my use of my countertransference. I value my role as 'objective director' and 'subjective participant' and maintain agility of movement between the two (Bugental, 1987). In working with implicit affective material I use Winnicott's (1971) idea of an 'intermediate zone of experience' in which I use the inner space 'between symbol and symbolised' to get a felt sense of this rich implicit material. I use my capacity for 'reflective function' to distinguish between a felt sense of subjective experience and my observations of this process.

I see 'the body as the basis of human intersubjectivity' (Schore, 2003) and attend to my posture in the chair, my rhythm of breathing, my muscle tension, and bodily sensations. I often visualize in the form of 'primary metaphors', which I also believe to emerge from sensorimotor experience. I pay particular attention to experiences of fantasy and distracting thoughts and feelings as this represents implicit communication about the client's process in the relationship with me (Stolorow & Atwood, 1992). My experience of somatic sensation, symbolic imagery or seemingly meaningless verbal syntax is part of the implicit communication in the transactional space which holds potent information about the client's process and the co-creation in the 'analytic third' (Ogden, 1994; Atwood & Stolorow 1992).

### 7.4 Explicit Collaborative Dialogue

I see language in therapy as a means of communicating 'pre-reflective' material and the central vehicle through which meaning can be explored and co-constructed. The Boston Change Process Study Group (2008) describes 'altero-centric participation' as a sharing of the sense of another's feelings and

intent through 'elements of spoken sound' (2008, p133). They suggest the spoken word is not just 'disincarnated symbols but a pathway to direct embodied experience. I agree with Sartre (1976) when he reflects that the spoken word reveals nothing new 'it simply discloses and thematizes what is already familiar in the pre-reflective lived experience'

I understand the delicate tension between language and implicit knowing and believe they can be 'worst of enemies' or the 'best of friends' (Stern, 1985). The misuse of language can "drive a wedge between two simultaneous forms of interpersonal experience: as it is lived and as it is verbally represented. This can cause a split in the experiences of self" (BCPSG 2008, p141). With this in mind, I value the integrity of the 'dialogical encounter' and attend to my own authenticity, congruence and honesty in my communication. For me this might range from 'chatty interactions' (Gelso & Carter 1985, p186) to more intimate disclosures of appreciation and mutuality through which each will "nourish and be nourished" (Clarkson, 2003). At all times I focus on the need for >coherent dialogue that is truthful and collaborative" (Ruth-Lyons 2005, p317).

I view the integration of early affective experience into a co-constructed narrative as "a central component of therapeutic organisation" (Holmes 1993, p150) and believe this 'knitting' together of implicit affective experience and explicit narrative understanding to create a neurobiological integration between amygdala and hippocampus. I believe the building of a coherent autobiographical narrative in therapy, supports the client's capacity for 'reflective function' (Fonaghy, 2002) organises implicit experience and the ongoing process of personal integration and repair.

As a relational psychological therapist I see dialogical exchange as a great connector of one individual to another and I incorporate Maroda's (2002) view that 'emotional honesty' is a key to good treatment. I value the appropriate use of self disclosure as it can confirm the client's sense of reality and reflect how she impacts me, the therapist and others in her world. I see the affective communication of "emotional reality between therapist and client as an essential dynamic that needs to be explored" (2002, p195). I am consistently sensitive to the client's level of tolerance for an experience of more true mutuality in the "real relationship" (Clarkson 2003, p164). I am conscious to preserve the integrity of any self disclosure and endeavour to ensure it is intelligently used in the service of the client. I consider supervision and personal therapy intrinsic to the process of clinical work as see it as professional integrity to maintain a boundary between my material and that of the client.

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*Book Review by Steven B Smith*

# The Making of Psychotherapists – An Anthropological Analysis

By James Davies. Published by Karnac Books Ltd., 2009.

James Davies has produced an unprecedented book that is stimulating, challenging and unequivocal in its claims. In brief, he exposes the invidious nature of the "socialisation process" (p.5) that underpins the 'selection', 'training' and 'post-qualification' journey that psychodynamic and psychoanalytic training institutes exert upon its applicants, trainees and qualified practitioners. However, it is important to note at the outset that Davies research study is not about testing the 'truth' or 'falsity' of psychoanalytic ideas per se (p.12). Rather, this book is about boldly uncovering the "… hidden, covert or 'unintentional'…"(p.8) devices that these institutes utilise to safeguard their continuing identity and their 'production' of practitioners who will sustain the knowledge, values and practices of that given 'psychotherapeutic community'.

By revealing these devices the author aims to offer a viable critique of the psychoanalytic institute 'from within' to offer vital insights to reinvigorate and renew the psychoanalytic undertaking. In this work he, therefore, listens to the voices of those trainees who have felt the unyielding nature of these devices and how ultimately, 'schoolism' (Clarkson, 1997) has thwarted their personal growth and professional development. Indeed, Davies appeals for the restoration of the dialectic process inherent in any authentic dialogue, from both 'within' and 'between' the various psychoanalytic schools. It is a call to the psychodynamic and psychoanalytic institutes for genuine "openness … [and] … a willingness for vulnerability and the courage to sit with ambiguity and uncertainty" (Evans & Gilbert 2005, p15). I do not disagree with his assertion that listening to the critical voices 'from within' the psychoanalytic or psychodynamic institute is pivotal to renewal. While I applaud this, I would, however, also like to appreciate his unparalleled application of anthropology – bringing a discipline 'from without' – to the psychoanalytic enterprise to spearhead his argument and produce this fascinating book. I will return to this point later, but in the meantime what are these 'objectionable mechanisms' that Davies uncovers?

In essence, the mechanisms that Davies exposes are: (a), the 'exclusion' of trainees (p.5) in the face of theoretical and clinical disagreement – often labelled as 'dissident' or 'defiant' by the institute; (b), 'secondary elaboration' to dismiss and reframe the disagreement – this is where a story is strung together to take the trainee away from their claims and thereby, uphold the 'truth' claims of the institute; and (c), the active "coaxing and grooming" (p.1) of trainees to engender 'imaginations' and 'dispositions' (p.5) that reinforces allegiance to the institute with the promise of increased 'social status' and a place to 'truly belong' – not dissimilar to religious and political movements. Having highlighted these devices I will now turn to the structure of Davies' book, providing

'broad brush strokes' to capture the essence and central argument of each chapter.

In Chapter 1 he charts the historical rise and fall of the psychodynamic paradigm. Then Davies goes on to systematically review the different 'vehicles' or 'mechanisms' that consciously and unconsciously are 'used' to communicate and uphold modality allegiance, compliance and collusion. In Chapters 2 & 3 he explores how pre-training psychotherapy, is a form of 'institutional vetting' and 'psychoanalytic socialisation'. Then in Chapter 4 he focuses upon the seminar encounter and how this is designed to underscore 'affirmative' and 'sectarian' attitudes, rather than 'critical' and 'academic' ones. Moving on to Chapter 5 Davies reflects upon the 'maintenance of certainty' and how this is achieved by 'deflecting doubt' externally by designating patients, outsiders and competitors as 'the problem'. In Chapter 6 he reflects upon how clinical supervision is an arena that 'reifies aetiology' so that trainees treat patients in a 'time honoured' and predictable way. Then in Chapter 7 he evaluates the impact of 'trainee dependency on senior practitioners' within the institute and how this ensures an assimilation of the 'pervading ideology'. Finally, in Chapter 8 Davies concludes that the fields of ethics, politics and communal life, combine together to diminish trainee creativity and innovation, suppress critical debate, and protect the 'conservatism' of the psychoanalytic institute. All these are designed strategies to guard against open dialogue, authentic engagement and a critical appreciation of multiple paradigms.

Once you have read this work, my felt sense is that you cannot be unaffected by Davies persuasive, challenging and thoughtful discussion as he critiques the psychoanalytic and psychodynamic 'socialisation process'; and yet, Davies is quick to alert us to prior attempts within in the 'psychoanalytic fold' to interpret the 'straight-jacket' of 'psychoanalytic conservatism' and address the "resistance to cross fertilization of ideas necessary for theoretical development and reform … and … improved practice" (p.15). He cites several writers that have executed insightful explanations to explore this perennial problem by applying the psychoanalytic discourse, from itself, to itself. These considerations include, Cremerius' (1990) belief that the field of psychoanalysis is caught-up in 'Oedipal rivalry'; Lousada's (2000) observation that each psychoanalytic school is unable to establish 'libidinal cathexis' with the other; and, Figlio's (1993) assertion that trainees 'internalise key figures' within the psychoanalytic tradition and that 'mutual hostility' arises once a 'different loyalty' is detected within another trainee.

Collectively, these works are attempting to 'tease-out' and expose these unconscious conflicts and neuroses, in order to work through them and create open dialogue 'within' and 'between' these psychoanalytic institutes. A Jungian parallel here might be the mythical creature of 'uroboros', the serpent coiled into a circle, devouring its own tail: "As a symbol, the uroboros suggests a primal state involving darkness and self-destruction as well as fecundity and potential creativity" (Samuels, Shorter & Plaut 2007, p158). Davies navigates through this time-honoured terrain by fearlessly pursuing and 'drawing-out the shadows' of the psychoanalytic and psychodynamic institute and their 'socialisation process' through the application of his anthropological discourse. Here, I believe, Davies has shown great ingenuity and creativity by rigorously applying these methods of enquiry in an unprecedented way.

On a more critical note one might argue that some of the terms Davies employs could be dismissed as 'emotionally provocative' or perhaps, 'reactionary'. I would suggest that, in the best sense of the word, he is using the language of 'revolution'. Based upon his research findings, Davies is offering a constructive critique that challenges the psychoanalytic and psychodynamic "institutions of affirmation" (p.2) to encourage the "doubt of discourse" (p.8) so characteristic of post-modernism. In this way he believes that this would facilitate critical reflection and thereby engender self-agency and creative innovation among trainees, trainers and institutes in terms of theory and practice. The 'revolution' is not about condemning the psychodynamic project outright, but rather a revolt that makes a sophisticated and impassioned plea for the transformation and renewal of the psychoanalytic movement in the British context. Some might, rather perceptively and wryly, counter that 'revolution' is surely about a bloody and violent annihilation of

the status quo. However, Davies is clear that his 'insurgency' is about dismantling the 'mechanisms' that buffer critical reflection and prevents theoretical and clinical renewal of the psychoanalytic and psychodynamic endeavour.

My key criticism of this book is to do with the unanswered questions about 'why' Davies is 'driven' by this project and 'how' he 'locates' himself within its central enquiry and indeed, resulting book. To my mind we are only provided 'partial answers' to these questions. Davies reflects upon researchers from the disciplines of psychology, sociology and anthropology both here and in USA; he notes that these researchers have attempted to apply their non-psychoanalytic discourse to the psychodynamic institute and met with unparalleled resistance and point blank refusal. Here James Davies reveals his unique positioning in gaining access to these institutes within the British context, disclosing that "… I was not always an 'outsider', for my story begins with my formal training in psychodynamic psychotherapy at a well-known training institute in London; a training that I put aside after two years to pursue other interests" (p.21).

While this gives us crucial information about his relationship to his research project he fails to outline the resumption and completion of his psychotherapeutic training. My distinct sense from his use of language and his quest for the spirit of openness and dialogue is that upon resuming his training he has affiliated himself with a more integrative stance or at least a psychoanalytically pluralistic one. If this is so, then to hear more about his personal transference and countertransference dynamics would have enriched our understanding of his relationship to this compelling, impassioned and thoughtful project, and indeed, further calibrated his claims. This is where I believe the research field is currently at: rather than seeing the personal investment of the researcher being at odds with the topic of enquiry, it is the pivotal 'lynch-pin' that drives and ignites the work. All that is needed is for this dynamic to be harnessed and monitored to avoid 'outright collusion' or 'outright collision' with the topic at hand. Despite my criticism about the need for further personal and biographical disclosure, my distinct impression is that James has neither 'colluded' nor 'collided' with the issue at hand.

On a final and somewhat cautionary note, it is perhaps worthy, for those of us 'within' the humanistic institutes, to take note of the instructive insights that this book provides. While we may sincerely aspire to the post-modern qualities of openness, dialogue and the honouring of many truths, it is nevertheless, important for us to take heed of this book. To do so, would involve monitoring our own self-satisfaction about our celebration of multiplicity and acknowledging that our relationship to truth can all too readily become wedded and closed, particularly in the face of uncertainty, anxiety and when faced with something so other; whether that be a different modality or individual or group. Despite our earnestness about openness, as trainers and trainees, we need to guard against complacency, lest we unwittingly and unknowingly become agents of "formidable institutional forces" (p.2) of a different kind, that instils theoretical, clinical and institutional allegiance, at all costs.

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