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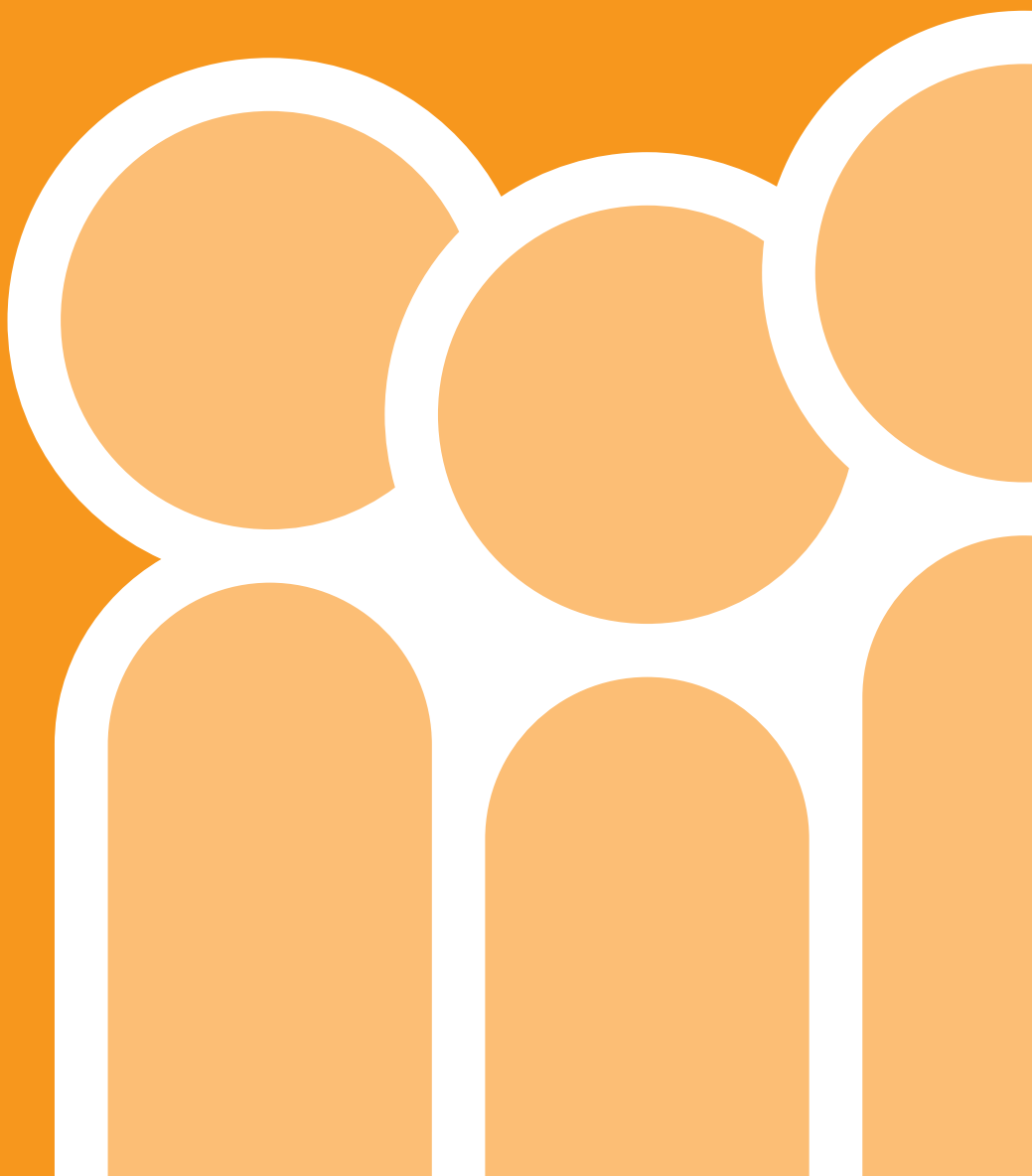
The Varied Faces of Integration



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Introduction

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

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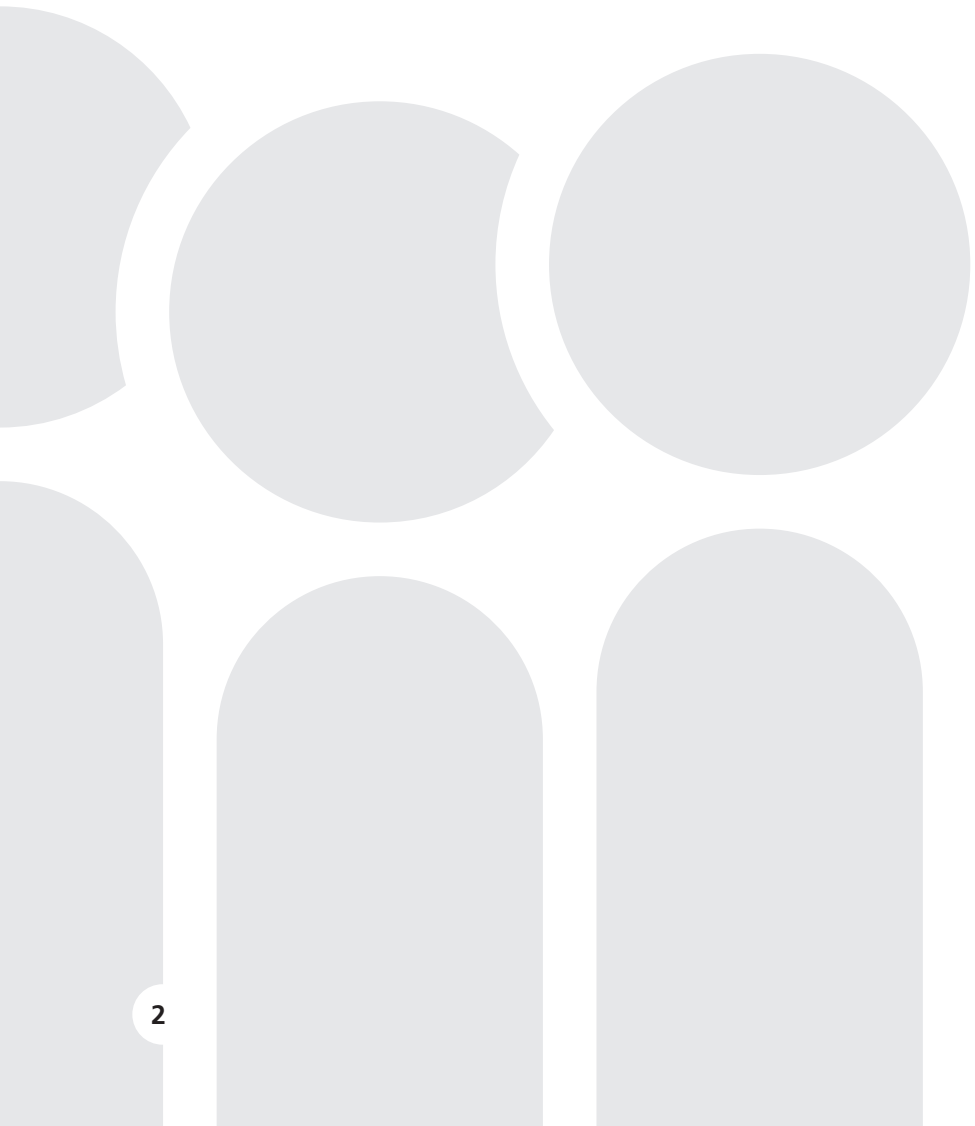

Volume 6, Issue 1 (2009)

Contents of this Issue

Editorial

The Varied Faces of Integration

In this issue we have diverse contributions related to a range of integrative themes. The authors are writing about issues that have clearly occupied their thoughts and are related to their individual areas of expertise and practice. Our aim in this issue is to show that the integrative project encompasses a broad range of reflective practice and is of relevance to a broad range of client groups.

Contents of this issue

Peter-Caleb Meades makes an impassioned plea for therapists to practise a core affirmative attitude aimed towards LGBT clients. Writing from a very personal reflective perspective, he explains the principles of sexual minority therapy as an integrative approach, offers some definitions and challenges us to examine our own internalised heterosexism and oppression.

Sue Wright provides a useful, detailed discussion of various phase-oriented models for working with trauma, then reflects on her own integrative practice to suggest a spiral rather than strictly linear approach. She offers an extended case example that provides a very accessible, experience-near exploration of holding the chaos of trauma therapy within a phased conceptual integrative framework. This article reflects Sue Wright's careful attention to detail whilst holding the wider picture in mind.

Lorraine Price explores her integration of Winnicott into her practice as a way of understanding regression to a state of dependence in her own experience in therapy as well as her clients. Her open, honest account brings to life a very personal relationship with Winnicott's position, while her case examples demonstrate her application of this personal understanding in her integrative practice. We particularly appreciated Lorraine's courage in addressing her personal issue of shame in referring to her own experience.

John Boyle begins by offering an extended discussion of the advantages and limitations of integrating different psychoanalytic theories within a single framework. He then presents his work with a very challenging client who brings complex sexual issues and a narcissistic process to the work. John shares his understanding of this psychotherapeutic process from an integrative psychoanalytic perspective.

Diana Shmukler, in an article based on her original response to a paper by Patrick Casement, elaborates on her application of Winnicott's theory to her understanding of regression with a particular emphasis on the therapist's use of self in this process. In her account she vividly brings to life the demands on the therapist of engaging in in-depth work of this nature. We particularly appreciate her capacity for reaching the reader in this way.

As is our usual tradition we publish an example of a student's final submission. In this case we include Catherine Butterly's theoretical discussion taken from her final dissertation for the Metanoia/Middlesex MSc in Integrative Psychotherapy. Catherine was awarded a distinction for the dissertation as a whole.

We also include a book review by Geoffrey Johnson on "Contemporary Body Psychotherapy: The Chiron Approach", Edited by Linda Hartley. London: Routledge 2009.

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

Peter-Caleb Meades

Sexual Minority Therapy: An Introduction to the Basics

Abstract

Despite a significant body of knowledge in the field of sexual minority therapy, LGBT people (Lesbian, Gay, Bisexual and Transgender) continue to experience prejudice, discrimination and oppression as clients, supervisees and/or trainees of the psychological therapies. The overall image that emerges from the literature is one of a meaning-making profession that paradoxically seems oblivious to a major blind spot regarding sexual minority perspectives. A review of the literature suggests that broad humanistic liberal ideas about equality and diversity are unsatisfactory and insufficient. This article introduces the basics of sexual minority therapy for both heterosexual and LGBT practitioners alike. My exploration identifies the need for substantial re-education and re-evaluation of positions, especially of heterosexism and oppressive socially constructed beliefs. Working with hypervigilance is identified as a core clinical skill and the tables get turned on heterosexism. Updating our knowledge of the basics of sexual minority therapy I think goes some way to improving the provision of enabling and affirming integrative psychotherapy processes.

Introduction

The European association for integrative psychotherapy (EAIP) has a clear statement of philosophy that defines as integrative:

> "… any methodology and integrative orientation in psychotherapy which exemplifies, or is developing towards, a conceptually coherent, principled, theoretical combination of two or more specific approaches, and/or represents a model of integration in its own right. In this regard there is a particular ethical obligation on integrative psychotherapists to dialogue with colleagues of diverse orientations and to remain informed of developments in the field" (EAIP, 2009).

With this in mind, I would like to present some ideas from the field of sexual minority therapy and to promote its core affirmative attitude toward lesbian, gay, bisexual and transgender (LGBT) clients as an important component of any ongoing and evolving integrative process. EAIP states;

> "…particular emphasis is placed on the maintenance of an attitude of respect, kindness, honesty and equality in regard to the personhood of the client in a manner which affirms the integrity and humanity both of the self and the other" (EAIP, 2009).

In writing this article I am aware that many practitioners, regardless of sexual identity, are ill-prepared to work with lesbian, gay, bisexual and transgender (LGBT) clients and that the widely held humanistic liberal ideas about equality and diversity are unsatisfactory. This may be in-part because it seems training institutes are not giving sufficient consideration to the perspectives

of sexual minority people (Davies, 2007). On the whole, it seems that therapists continue to graduate from courses that do not offer closer examination of sexual minority perspectives and produce practice that may be considered unhelpful, sometimes even perpetuating toxicity of wider societal oppression. In my opinion, it is not ok for therapists to remain in ignorant bliss in this area, accepting the client's, supervisee's or trainee's money and expecting them to provide free CPD (continuous professional development) on the subject.

I aim to share my understanding of some key issues in "Sexual Minority Therapy" and to discuss the salient definitions and themes. I hope to highlight anti-LGBT prejudice and homophobia, challenge heterosexism and draw attention to the process of internalised oppression. I will also reinforce significant ethical concerns regarding therapists' preparation for working with sexual minorities and offer some food for thought along the way. When referring to lesbian, gay, bisexual and transgender people, I will use the abbreviation LGBT.

Background

Gay affirmative therapy (Maylon, 1982) was developed and became well-known within the psychotherapy literature in the pioneering series of "Pink Therapy" books (Davies & Neal, 1996, 2000 and Neal & Davies 2000). The term 'Sexual Minority Therapy' is a very recent positive development by Davies (2009) to describe an affirming and enabling therapeutic approach to working with a broad range of variant sexual and gender minorities. These minorities include a wide range of sexual and gender identities, including those who identify as lesbian, gay, bisexual, trans (-sexual, -gender and -vestite), intersex, queer, questioning, members of the 'kink' community, and those in non-dyadic relationships (Davies, 2007). It is essential to recognise the heterogeneity of these groups and at the same time, to notice there is a common shared experience of being pathologised – as a result of heterosexist, erotophobic and binary thinking.

Essentially, Sexual Minority Therapy promotes a therapeutic attitude in which LGBT identities are viewed as viable, constructive ways of life that are wholly compatible with psychological well-being. Writing in relation to gay affirmative practice, Perlman (2003) pointed out that although this aforementioned therapeutic attitude may not sound too radical a proposition, it does require rigorous self-examination. I am aware from my own reading and research, experiences others have shared with me, and my own experiences of therapy, supervision and training, that where "affirmative practice" does seem to happen, it is largely by accident where practitioners endeavour to work in accordance with humanistic values. However, this accidental affirmative approach is not anywhere near sufficient and I agree with the view that to work consistently and successfully with lesbian, gay, and bisexual clients, a therapist (either heterosexual or LGBT) will need to do a considerable amount of re-education and re-evaluation of attitudes, beliefs, values and knowledge (Davies, 1998).

Perhaps sexual orientation is not of great concern when it comes to a client choosing an appropriate therapist but I think it is worth remembering that regardless of theoretical position, the therapist's ability to empathize with, and be accepting of their client is paramount (Davies and Neal, 1996). Inevitably this means that to work in a psychotherapy relationship with sexual minority clients, it is necessary to have a high degree of awareness of any negative (socially constructed) internalised beliefs (Perlman, 2003). In my experience of learning about anti-discriminatory practice in various training courses, I notice that transcultural and multiracial issues are quite rightly being addressed passionately and with determination. However, it is very apparent that inadequate attention is still given to understanding the complexities of sexual minorities or sexual minority therapy.

It has been well documented that there are prevailing heterosexist assumptions made regarding LGBT perspectives (Davies & Neal, 1996). I concur with this view based on personal experiences of the dominant heterosexual perspective going largely unchallenged. The exception seems to me to be when a LGBT person finds the courage to risk speaking out within the experiential or 'process' space of their group (supervision or training). My

own experience of attempting to introduce the subject of sexual orientation in groups has included various responses that range from "We get it but we don't want it rammed down our throats!" to "Come on, there's no difference between gay and straight people except for who they sleep with" and "Meterosexual…or whatever it's called these days!" As silenced as I felt at these times, these responses do at least expose a common heterosexist perspective that could open up some dialogue and opportunity for increased awareness and learning – where there is willingness. Regrettably, I have so often found myself falling back on the familiar pretence that there is no significant difference, adopting a 'straight-acting' role, and subsequently regretting my difference isn't more visible and 'in your face'.

Definitions and Themes

I recognise that sexual orientation largely refers to a person's erotic response tendencies or sexual attractions, and consists of three major components: desire, behaviour and identity. It is not within the scope of this article to expand further on these but for further reference see Drescher, Stein & Byne (2005). To think in terms of categorisation for a moment, a person's sexual orientation may be recognised as homosexual, bisexual or heterosexual;

"…this can be assessed with recognisable parameters such as the proportion of dreams and fantasies directed to one or the other sex, the sex of one's actual sexual partners, and the extent of physiological response to erotic stimuli associated with one or both sexes" (Drescher, Stein & Byne 2005, p.1936).

I think it is essential to be aware that although the terms 'sexual orientation' and 'sexual preference' are often used interchangeably amongst lay people, they have significantly different meanings in the professional literature. I understand that experts tend to use 'sexual orientation' to refer specifically to a person's involuntary, erotic response tendency, whereas 'sexual preference' implies more individual choice (Drescher, Stein & Byne, 2005). It is always worth noting the client's own choice of terminology during the initial contact and initial sessions.

I would like to emphasize the often-overlooked point that sexual orientation and sexual identity are quite distinct from each other. Acquiring a lesbian, gay or bisexual identity is conceptualised in the literature as a developmental process occurring over time (Davies & Neal, 1996; Davies, 1998; Drescher, Stein & Byne, 2005). Models of sexual identity development usually highlight a series of progressive stages involving such tasks as 'coming out', involvement in communities, establishing relationships, and integration of identity into other aspects of the self (Drescher, Stein & Byne, 2005). Therefore, sexual orientation is not equivalent to sexual identity since a person with a homosexual orientation may absolutely reject having same-sex feelings, reject a gay identity and for example, marry a person of the opposite sex in order to maintain a heterosexual identity. That said, I do not think it is helpful to think of such an attitude as psychopathological either; in working with a person who has a homosexual preference but not a homosexual identity, it is advantageous to remember that there exists a broad range of psychosocially constructed responses that people can develop to their sexual orientation.

The issues of sexual orientation and gender identity are often mistakenly linked and confused. I must confess that my knowledge of transgendered perspectives is somewhat limited and I am therefore taking steps to address this (at Pink Therapy, London). I understand that gender identity refers to one's sense of being either male or female, irrespective of biological sex, whilst gender role refers to overt gender associated social behaviour (Drescher, Stein & Byne 2005, p.1941). I understand that the term 'transgender' is as an umbrella term used to describe any individual who identifies with, and adopts, the gender role of the other biological sex. Furthermore, 'transgender' includes both transsexuals and any other individuals with gender discordant feelings:

"While gender identity describes an inner, subjective experience of being male or female, gender role and social sex role are the external markers of masculinity, femininity or androgyny. Most people, regardless of their sexual orientation, have a gender identity and gender role consistent with their biological sex, although social attitudes in some gay

and lesbian communities often do permit a greater degree of gender role flexibility" (Drescher, Stein & Byne 2005, p.1941)

Transvestism refers to fantasies and sexual urges involving cross-dressing. It is popularly, albeit mistakenly, linked with homosexuality. Most LGBT people do not cross-dress although there are some social venues that allow for public cross-dressing as a form of paid entertainment (eg. drag acts) or socially glamorous occasions like 'Gay Pride'. In fact, most cross-dressers are heterosexual men who do so in private. They are more commonly married to women who may or may not know about their interest in this (Drescher, Stein & Byne, 2005).

It may be helpful here to provide some basic statements of identity used by LGBT people. Most homosexual men refer to themselves as 'gay', homosexual women tend to refer to themselves as 'lesbian' and bisexual people often refer to themselves as 'bi'. These are culturally accepted statements of identity and self-definition that were originally borne out a movement away from medical pathology (Davies & Neal, 1996) – it is still only relatively recently that homosexuality was declassified as a mental illness in the UK (ICD 1992). A smaller number of gay and lesbian people do choose to describe themselves as 'queer', 'bent' or 'fag' (men) and 'dyke' (women) in a move to claim previously hateful terms, thereby counteracting prejudice. Both heterosexual and LGBT people commonly refer to heterosexual men and women as 'Straight'. People interested in transvestism will sometimes use 'TV'.

Unfortunately, it is not within the scope of this article to discuss the tyranny of language, although I do want to make the point that the use of nouns to describe a person's fluid process of sexuality and sexual development is restrictive. Neal (2005) argues against categorization and is in favour of sharing "infinity stories" that acknowledge limitless possibilities holding ambivalence and difference:

"I want to think about gender and sexuality as pulsatory, unending, opening processes. I know this is a less comfortable and comforting approach. It requires considerable discipline to open up to, and rest in, contingency and unknowing, incompleteness…There is no doubt that we gain confidence from categorisation. On the other hand, there is excitement and challenge to be had in surrendering ourselves to the impact of the other, being prepared to listen to those on another side, in a different place. This, for me, is the best therapeutic position" (Neal 2005, p.2).

Mental Health

There are still professionals who hold the belief that homosexuality is disordered, that a person can be cured of it, and either explicitly or implicitly continue to "treat" people for homosexuality including neurosurgery, electric shock therapy, and brain washing through intensive regular, long-term psychotherapy (Davies, 1998). PACE (the leading voluntary sector mental health organisation supporting LGBT people) concluded in their report on the Department of Health commissioned research into the treatment of lesbian and gay people in mental health organisations, that some of the problems LGBT people face stem directly from external mistreatment. They recognised that this takes the form of rejection by family or community, harassment, abuse or assault, and loss of job or housing. Other problems are thought to develop through the internalising of negative messages including; low self-esteem, drug and alcohol abuse, self-harm, depression, difficulty with intimacy, neuroses, suicide (rates of suicide attempts are cited as very high among young lesbians and gay men). Then there are people who find it difficult to come to terms with their sexuality, or are confused about their sexual identity. Some people are forced to, or may choose not to disclose their sexuality either at all, or only under certain circumstances, and are likely to suffer the stresses and psychological effects of such a 'split' existence (PACE, 1998 cited in Davies, 2007).

Davies (1996) points to the plethora of sound research showing that it is not being LGBT that is pathological, but rather it is living in a society that treats LGBT people as psychologically disturbed that causes mental ill health (Gonsiorek 1977, Hart, Robrack, Tittler, Weitz, Watson & McKee 1978, and Reiss 1980 in Davies 1997). I appreciate the analogy developed by Davies (1998) from a person-centered paradigm, to describe the shift

in 'frames-of-reference' required by therapists in understanding LGBT perspectives. I think this applies to both heterosexual and LGBT therapists. He explains that being a gay man is akin to being born speaking a different language. I think this point relates to how we as human beings make meaning, such that LGBT people have to think, speak, and behave predominantly in "Heterosexual" but it is not the 'mother tongue'. Davies (1998) for example, claims his mother tongue to be "Gay" and makes an extremely important point about the presence and workings of an "internal translator". He describes thinking, feeling, and behaving more spontaneously and naturally when amongst other gay men. When in the "country" of heterosexuals his experience is that everything he thinks, he says and he does goes through an internal translator which inevitably reduces spontaneity, (especially with emotions) and results in his being guarded and defensive. Translating in this way takes a lot of energy, which is why he recognizes "a need for time with my own 'nationals' to rest and recuperate" (Davies 1998, p.117).

Theoretical writings and research indicate that the onset, course, treatment, and prevention of mental disorders among LGBT people differ in significant ways from the heterosexual population and improvements in studies of sexual orientation and mental health morbidity show significantly elevated risks for 'stress sensitive disorders' that can be attributed to the effects of homophobia (Cochran, 2001). To my mind, it is absolutely essential that potential therapists of LGBT clients, supervisors of LGBT supervisees, and trainers of LGBT trainees, be open to examining heterosexism, in the same way they might work on sexism or racism.

Homophobia, Heterosexism and Internalised Oppression

The term 'homophobia' has been much debated in the literature and criticised in a variety of ways (Churchill 1967; Levitt & Klassen 1974; Lehne 1976; Hudson & Ricketts 1980; Niesen 1990; Herek 1991 in Davies 1996). It has been criticised for not constituting a classic phobia, as being inaccurate or misleading, and having a tendency to pathologise the individual rather than acknowledge the cultural values from which it stems. Davies (1996) argues from a sound evidence base (Freund et al. 1973; Langevin et al. 1975; Sheilds & Harriman, 1984 in Davies, 1996) that many homophobic individuals do exhibit a fear response to homosexuality that represents an individual anomaly, and whilst recognising that the origins of that fear may be culturally derived, suggests that there is good reason to continue to use the term (Davies & Neal, 1996). A definition cited by Davies (1996) is an extended definition of homophobia by Hudson & Ricketts (1980) that I think is particularly pertinent. They define homophobia as:

"The feelings of anxiety, disgust, aversion, anger, discomfort and fear that some heterosexuals experience around lesbians and gay men" (Hudson & Ricketts, 1980 in Davies & Neal 1996, p.41).

Heterosexism and anti-LGBT prejudice (homophobia) are inextricably linked as psychological processes and cultural phenomena, according to Perlman (2003). He wonders, for example, about a therapist who cannot accept that her client can ever be healthy if he continues to want anything other than a primary monogamous relationship, or a practitioner that gives shaming or disgusted looks when her client talks openly about explicit gay sex. Perlman (2003) suggests that the thoughts that support such powerful feelings are integral to the heterosexist psychological system that manifests as homophobia. From this perspective then, homophobia can be seen as an inevitable expression of SCRIPT (Moursund and Erskine, 2004) which is inevitably generated by a majority heterosexual perspective in the wider socio-cultural context. I understand "heterosexism" to be the conscious or unconscious assumption that heterosexuality is a superior, natural and 'right' life perspective,

"…It is the system by which heterosexuality is assumed to be the only acceptable and viable life option" (Blumenfeld & Raymond 1988, p.244).

Perlman (2003) focuses on the combined effects of heterosexism and homophobia and their cultural 'uses' rather than attempting to explain or understand their origins. He supposes that fundamentally, heterosexism has to do with issues of power and control,

with fear and fascination, and with the potential that exists within sexual minorities placed at the edge of society, to cast critical light on that society (Perlman, 2003).

The harmfulness of ignorant attitudes and beliefs within our culture toward sexual minorities is evident in a multitude of ways. These range from the subtle communications of the body (for example, smirking, averted eyes, turning away, frowns, snarls, closed up and/or superior body postures and so forth) to exclusion from social events, alienation from friendships, overt verbal bullying and discrimination through to 'gay bashing' and even murder (in some Islamic countries the death penalty (torture then hanging) is still actively enforced). Thinking about the meta-communication of both covert and overt prejudice, the message is essentially "don't exist", "don't be" (Perlman, 2003). Internalised homophobia (or better known as internalised oppression) can also be thought of as a system of feelings and supporting beliefs internalised from the dominant heterosexist culture. For example, Script (the old habits, the familiar ways of relating, the unquestioned, knee-jerk reactions, the rigid relational patterns (Moursund and Erskine, 2004)), may be triggered in a supervision group when discussing a gay client resulting in a shame experience or deep sense of discomfort; or anger felt toward someone who admits to being gay in a training group for daring to declare it. Since internalised oppression is said to be easier to spot in others than ourselves, two interesting questions to ponder are 'how do I oppress myself?' and 'how do I inhibit myself?'

The issue of self-disclosure by a therapist continues to be fiercely debated and therapists from different paradigms tend to hold well-defended views. I believe each of us must come to our own ethical position. My own position on this at present is that if a sexual minority client asks me directly about my sexual orientation, I will answer openly and honestly. Since the position I hold is one in which LGBT identities are viewed as viable, constructive ways of life that are wholly compatible with psychological well-being, the meta-communication of not disclosing my sexual orientation would I believe, imply the contrary. Basically, I consider disclosure a key intervention depending on the particular relationship and whether or not it is likely to 'help' the client. I have learned that it can be particularly important for LGBT clients who have had previous experiences of being ostracised and excluded from power.

I attended a group training recently where someone described an interesting experience he had when working as a teacher in a secondary school. After a great deal of giggling, a pupil stood up and asked "Sir, are you a poof?" He replied, "Now that's an interesting question: 'Poof' is a Noun, a naming word. It would be more accurate to say that I am poofing at the moment. There was a time when I wasn't poofing and there may be a time when I'm not poofing again but for now, I am poofing, yes."

Undeclared Prejudice

Thankfully, it is through our standards of practice and codes of ethics that we understand we cannot expect to be able to work with every client on every issue that presents to us in the consulting room:

"It is an indicator of professional incompetence to take on a client, where the therapist has (undeclared) prejudices or values which will clash with the client's value system and where respect for the client cannot be maintained" (Davies and Neal 1996, p.28).

Clearly, an unquestioned and unexplored heterosexist perspective is contra-indicated in constructive clinical work with sexual minority clients. I think it is important to re-state that there is a clear ethical responsibility to explore such beliefs before accepting an LGBT client for therapy. Davies and Neal (1996) present some core beliefs that they state in no uncertain terms, if held by a therapist (I add supervisors and trainers) will make it impossible for them to work respectfully with LGBT people. These include:

Beliefs that homosexuality is against God's wishes, or sinful

Beliefs that homosexuality is sick, unnatural or perverted

Beliefs that homosexuality is a sad or inferior experience to heterosexuality

Beliefs that monogamy is the only healthy way to conduct a sexual relationship

Beliefs that homosexual relationships can only be shallow, or short-lived, or sexual

Beliefs that lesbian, gay and bisexual people are more likely to sexually abuse young people, or to 'pervert' their emergent sexualities in some way;

Beliefs that homosexual parenting or family lives are not real or of equal value to heterosexual equivalents

Beliefs that bisexuals could decide to be homosexual or heterosexual instead

(Davies and Neal 1996, p.28–29)

Hypervigilance

Perlman (2003) talks about the erosion of the self from the moment an LGBT person connects with the message that their experience is wrong, bad or shameful. He points out that it is a very different experience from another minority group where for example, being a wheelchair user or being black, does not allow "passing" for the dominant group. I think there are advantages and disadvantages but essentially years of "passing" leads to erosion and denigration of the self. Consequently the experience of shame is never far away and powerfully reinforced when a therapist is unable to offer empathic understanding of the client's own LGBT experiences, or lacks understanding of personal meanings. Furthermore, I believe LGBT clients are likely to be especially hypervigilant in a therapy relationship, particularly on the 'look-out' for any indication of non-acceptance, heterosexism and oppression. In fact, Davies (2007) promotes the development of working with hypervigilance as a core skill of sexual minority therapy. He maintains that all sexual minorities would be hypervigilant to being 'mad, bad and dangerous to know' and highlights this as a normal response to oppression, heterosexism and growing up feeling different (Davies, 2007).

I agree that it is important for heterosexual therapists and LGBT therapists alike, to be fully acquainted with the different perspectives held within the LGBT communities; especially types of relationships (open and closed, multiple and single); attitudes to sex; coming out to parents and at work; issues around body image and lifestyle; oppression, prejudice and discrimination; drug and alcohol use; spirituality and religious issues. This will mean that therapists can attune more effectively to their clients as they become more familiar with the different gay perspectives on these issues, and enables the bracketing of previously held heterosexist assumptions.

Heterosexual Questionnaire

This 'tongue-in-cheek' heterosexual questionnaire turns the tables for a moment, by making heterosexuality the object of scrutiny. Heterosexual people rarely ever question the causes of their own sexual identity or their lifestyle choices. The questions are an inversion of the kind of things asked about LGBT people. As you will see, they can feel at times intrusive and impossible to answer.

What do you think caused your heterosexuality?

When and how did you first decide you were a heterosexual?

Is it possible that your heterosexuality is just a phase you may grow out of?

Is it possible that your heterosexuality stems from a neurotic fear of members of the same sex?

Isn't it possible that all you need is a good gay lover?

If heterosexuality is normal, why are a disproportionate number of mental patients heterosexual?

To whom have you disclosed your heterosexuality? How did they react?

The great majority of child molesters are heterosexuals (95 per cent). Do you really consider it safe to expose your children to heterosexual teachers?

Heterosexuals are noted for assigning themselves and each other to narrowly restricted, stereotyped sex roles. Why do you cling to such an unhealthy form of role playing?

Why do heterosexuals place so much emphasis on sex?

There seem to be very few happy heterosexuals. Techniques have been developed that you might be able to use to change your sexual orientation. Have you considered aversion therapy to change your sexual orientation?

Why are heterosexuals so promiscuous?

Why do you make a point of attributing heterosexuality to famous people? Is it to justify your own heterosexuality?

If you've never slept with a person of the same sex, how do you know you wouldn't prefer that?

Why do you insist on being so obvious and making a public spectacle of your heterosexuality? Can't you just be what you are and keep it quiet?

(Rochlin, 1992 p.203–4 cited in Davies & Neal 1996, p. 209)

Conclusion

I believe LGBT clients, supervisees and trainees have an absolute right to expect that we educate ourselves about the issues they bring if we are to invite them into close relational contact. LGBT people who want to engage with psychotherapy ought to be able to find culturally competent approaches that better address their concerns. In this article I have given an outline of some key issues in 'Sexual Minority Therapy' and discussed the essential definitions and themes. I highlighted anti-LGBT prejudice and homophobia, challenged heterosexism and drew attention to the process of internalised oppression. I reinforced ethical concerns regarding preparation for working with sexual minorities and have offered some food for thought along the way. I hope that the article may have whetted the reader's appetite to explore the various CPD opportunities in this area, gradually leading to wider availability of the kind of enabling and affirming psychotherapy approaches that LGBT people hope for.

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Sue Wright

Phase Conscious Approaches to Trauma Therapy: From Theory to Practice

Abstract

Effective therapy is only possible if our clients feel safe and this is especially true when working with the survivors of trauma. Within the field of trauma therapy, phase oriented approaches are being increasingly used in order to stabilise and resource clients before they can start to tell their story. In this article I outline a number of phased models and question how such models can be applied in practice. I use the example of a long-term case to illustrate how the therapeutic journey with survivors of extreme trauma is often one of "snakes and ladders" rather than a logical progression from stage to stage and to put forward the view that phase conscious thinking is inherently flexible and highly integrative.

Introduction

I have thought a lot recently about what it means to work in a phase conscious way[1] with people who have experienced severe trauma – comparing different approaches and trying to identify what, from my own integrative perspective – which includes paying careful attention to the psychodynamics of the therapeutic relationship and to the somatic elements of the client's process[2] – is important at each stage. This then took me to the question that prompted this article – do I actually use a phased model? Here I intend to look at how a number of theories inform phase conscious thinking and to use one long-term case, to illustrate how such thinking can be applied.

Different Phased Models

Using a framework of specific stages when treating the survivors of severe trauma developed as "best practice" in the 1990s. But the idea of phase-oriented work is not new, the first to propose such a model being Janet in the 1890s (Van der Hart & Steele, 1997). In Figure 1 I outline a number of phased models. As you will see different writers use slightly different terms and some appear to have more stages than others. But in practice they all map onto a triphasic model and all highlight certain crucial tasks in the first phase of psychological therapy. These include helping the client to regulate emotions, control impulsive behaviours, manage daily life functions and, as a result of

1. Elton Wilson's term "time conscious psychological therapy" (1996) has influenced my adoption of this phrase, rather than the more common "phase oriented approaches". I will explain why during the article.

2. I am particularly influenced by the work of Pat Ogden and her fellow trainers at the Sensorimotor Psychotherapy Institute. Sensorimotor work offers an integration of psychological and somatic approaches and draws upon recent theory in the fields of neurobiology, trauma and attachment. I apologise if ideas emerging from communications with trainers and fellow students of this training cannot be directly referenced here.

	Phase One	Phase Two	Phase Three
Van der Hart et al, 1989, 2007	Symptom Reduction & Stabilisation	Treatment of Traumatic Memories	Integration & Rehabilitation
Herman, 1982	Establishing Safety	Remembrance & Mourning	Reconnection with Ordinary Life
Kepner, 1994	1) Developing Support 2) Developing Self-functions	3) Undoing, Redoing & Mourning	4) Reconsolidation
Kluft, 1997	1) Establishing Psychotherapy 2) Preliminary Interventions 3) History Taking & Mapping	4) Metabolism of the Trauma	5) Moving Towards Integration & Learning 6) Integration & Resolution 7) Learning New Skills 8) Solidification of Gains 9) Follow-up
Elton Wilson, 1996	1) Preparation 2) Disclosure	3) Catharsis 4) Self-care 5) Renunciation	6) Empowerment

Figure 1: A Number of Phased Models

the ongoing negotiation of a therapeutic alliance, beginning a process of connecting to and using others for emotional support. Such work on establishing safety and developing emotional skills needs to occur before facing, processing and integrating traumatic memories in Phase Two. As Chu (2007) points out, "the best outcomes for patients grappling with complex posttraumatic and dissociative symptoms occur with those who attempt to gain control of themselves and their lives and persist in efforts to attain some semblance of 'normal' life". In Phase Three the focus begins to shift to the client's external world – to tackling fears of change, developing stronger relationships and facing what has been lost, including ultimately, the therapeutic relationship.

I am most familiar with the terms used by Van der Hart, Nijenhuis & Steele (2006) namely of Symptom Reduction and Stabilisation; Treatment of Traumatic Memories and Integration and Rehabilitation. Their phases are in broad terms, although not necessarily strategically, similar to those used by the reputed trauma therapist Judith Herman. She calls the three stages: Establishing Safety; Remembrance and Mourning and Reconnection with Ordinary Life (Herman, 2006). Kepner, a Gestalt therapist, outlines four overarching tasks in his work Healing Tasks (1994), but I believe that Developing Support and Developing Self-functions are both Phase One work. Where I might differ from both Kepner and Herman is in placing Mourning in the final rather than the second phase.

The 4th model is derived from Kluft's work with a specific subset of trauma victims, people with Dissociative Identity Disorder. He lists nine separate stages, but points out how they fit into a triphasic model. His paper (1997) highlights the danger of proceeding to direct work on traumatic memories [Phase Two] with such complex clients without achieving the goals of his first three stages. Also important is his stress on pacing. Even within Phase Two the traumatic memories are not focussed on in every session. Elton Wilson (1996) is the only theorist in Figure 1 whose model is generic rather than created specifically with trauma populations in mind. What it offers in addition to identifying stage specific tasks is an indication of how the nature of the therapeutic relationship needs to shift in order to provide an optimal environment for the focal themes of each phase. Note that I have included her Disclosure stage in Phase One. By this she means not so much a true working through of memories, but an initial "telling" which is often rushed through

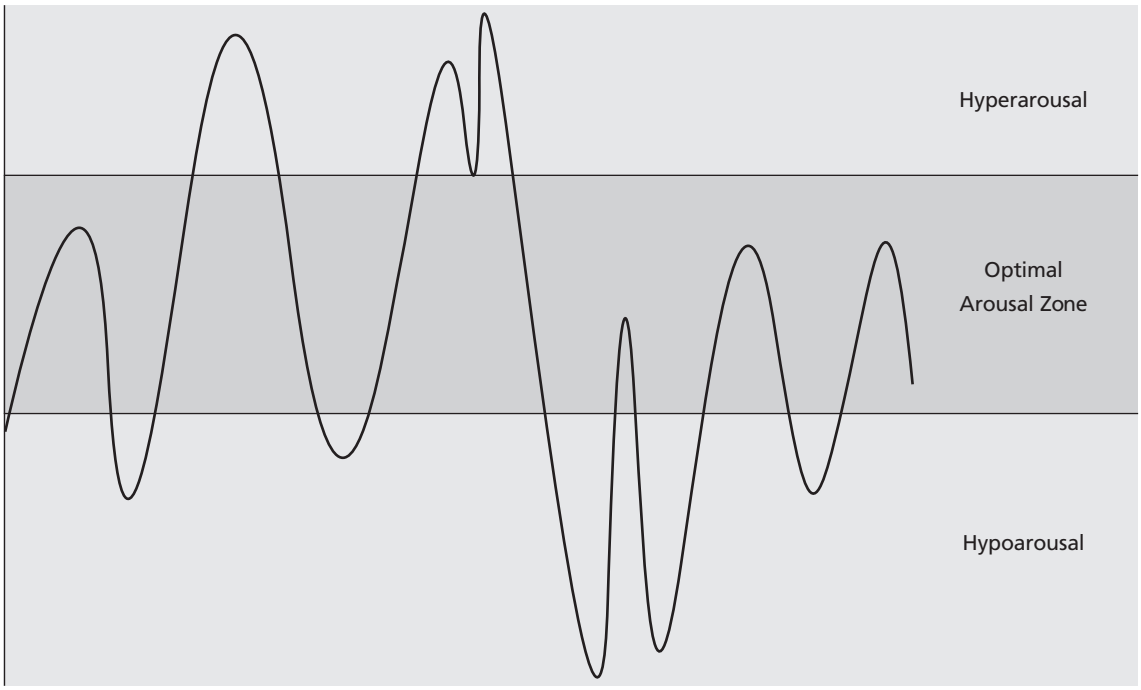

Figure 2: Window of Tolerance (Ogden et al 2000, 2006)

and can appear very factual or be punctuated by stale, repetitive grievances. Working through is, as Chu (2007) points out, a progressive process accomplished over time and very rarely achieved within a single cathartic experience.

A concept that informs me when thinking about the requirements of Phase One and about the wisdom of moving into Phase Two, is that of the Window of Tolerance. Whilst in this zone we can cope with a certain amount of emotional and physiological arousal and still "think straight", process information about our world and carry out the functions of daily life. Severely traumatised individuals are liable to rapidly slip out of the Window of Tolerance into states of hyper or hypo arousal. This may be because life events trigger overwhelming feelings or because of premature work on traumatic memories or the evocation of attachment needs within the therapeutic relationship. A crucial task of effective psychotherapy is therefore to help people to stay within the zone of optimal arousal and to learn skills to recover when dysregulated.[3]

How do Phase Oriented Models Work in practice?

Returning to my own practice, do I actually adhere to a phased model? In some senses the answer is no and there are a number of reasons for this. Firstly, trauma narratives rarely move from A to Z. They emerge in as strange and incoherent a fashion as the traumatic events would have appeared at the time, and the process with each individual client is unique and organic. This is far from a meal with three clearly defined courses. Perhaps a better metaphor is of moving up and down the gears on a car journey, because generally in trauma therapy we move backwards and forwards between phases. Such "gear changes" occur as the focus shifts between "out there" and "back then" events and between "trauma" and "developmental work".[4] Paralleling these shifts, the client is likely to switch in and out of different ego states or "emotional personalities" and the therapeutic relationship will move regularly between a transferential

3. The Window of Tolerance model originates in the work of Siegel (1999) and is used widely in Sensorimotor Psychotherapy. As Ogden emphasises, a "sliver" at a time approach is much more likely to hold the client in the Window of Tolerance and to facilitate integration. See Ogden et al 2000, 2006; Wright, 2006.

4. I use Malan's terminology (1979) of "in here", "out there" and "back then" events to help make sense of the psychodynamics of a case. See Ogden et al (2006) for distinctions between "trauma" and "developmental work".

and a more "real" relationship (Clarkson, 1990). Sometimes we need to regulate the client and bring her back into the Window of Tolerance; sometimes to teach emotional skills and at other times we need to be ready to act as witness to a narrative process or to be recruited as actors in, and at the same time make sense of, transference re-enactments.

Even if you have a collaborative plan to work on skills building [Phase One] or on a particular memory [Phase Two], present day crises may demand a return to stabilising and resourcing, or conversely pull us sooner than intended into Phase Two work because the crisis has evoked certain memories. This occurred recently with a lady I shall call Diana. She had started to use photographs as a stepping-stone for constructing a more coherent narrative of her childhood, but the plan was abandoned when her son was arrested. Although Diana was frustrated by the highjacking of her plan, and for a while we had to "put the brakes on" because chaos in the family dysregulated her, our discussions about the arrest kept returning us to the core trauma themes.

Events within the therapeutic relationship also contribute to the uneven course of trauma therapy. Sometimes this is because of the client's conscious and unconscious attempts to regulate the process ["backlash"], evidenced by changes of subject and missed appointments. Unwittingly things we do and say – sometimes from the most benign of motives or because of dissociative lapses [such as forgetting an appointment] or because, momentarily recruited as an "actor" in the process, we have reacted rather than staying reflective – can also halt the process. The important thing is that we can stay curious about the meaning behind the disruptions – about what it was about the current life difficulty or about our words and actions that "triggered" the client. If we can help him to return to the Window of Tolerance and then slowly work through the memory-related feelings, beliefs and body responses surrounding the disruption, then more of the trauma can be resolved.

I have already used the metaphor of car gears to highlight how phased approaches are not strictly linear – and this is why I prefer the term "phase conscious approaches" to "phased models".

Another analogy I use with clients is that of a spiral. It captures how people re-encounter the same issues and challenges time and time again throughout the therapy (and life) and how, in consequence, therapy needs to move back and forwards between the "tasks" and "challenges" that pertain to each phase. But each time around a loop of the spiral the client will hopefully have more resources, self-capacities and insights to deal with difficult events. Another relevant metaphor is that of a pyramid. Kepner (1994) writes, "the healing tasks are like a pyramid: the wider the base of support, the higher the pyramid can be. This is why, when progress seems stymied in later phases, we often find that we need to return to support-phase tasks and broaden the base so that we can move on".

Having acknowledged the organicity of the process and the difficulties in navigating a straight course, the overall "shape" of a long-term piece of work does fit with the idea of phases – namely a period of preparation/ trust building moving into deeper work and later widening in focus as the client begins to reconnect with and rebuild his life. The triphasic model, can therefore serve as a map to assist us at assessment and when we periodically review the work. It can also help us to predict shifts in the therapeutic alliance. Here Elton Wilson's outline of shifts in the nature of the therapeutic relationship is helpful [See Figure 3].[5] The deeper into traumatic material that you go, the more likely that dependency and attachment issues will be evoked and that Transference/Countertransference [TR/CT] material will surface – for example, that we will be experienced as a neglectful or attacking other. From the start there will certainly be hints of key transference themes and as the ending gets closer dependency and abandonment issues will come to the fore once more (Steele et al., 2001). But it is during Phase Two that the therapy is most likely to be de-railed and paradoxically facilitated by transference enactments.[6]

These rifts, enactments, call them what you will, are not things to be avoided, although they

5. Clarkson's terminology for different therapeutic relationships is adopted here (1990).

6. See the work of Davies & Frawley (1994) and Bromberg (1996, 2006).

	Focal Tasks & Issues	Focal Relationship
Preparation	Building Trust	Working Alliance (WA)
Disclosure	An Initial, Objective Narrative. In "Adult", May Be Emotionally Detached.	WA Essential TR – Noted But Not Made Focal
Catharsis	Narrates and Re-experiences from Child Ego State	TR/CT Central (Re-enactments and Dependency Issues).
Self Care	Need to Move from Punitive, Critical Self-treatment to Acceptance.	TR/CT Central; Real Relationship (RR) Emerging. WA Restated
Renunciation	Grieving, Raging and Letting Go.	RR More Focal to Replace Idealisation TR Unpacked
Empowerment	Greater Self-support & External Support. Getting on with Daily Life	WA – Discussing Ending Arrangments; RR – 2 Real People Affected by the End; TR Still Operational, Especially as Ending

Figure 3: Shifts in the Nature of the Therapeutic Relationship (Adapted from Elton Wilson, 1996)

can be unpleasant, nor necessarily signs that we are doing something wrong. Alan Schore (2007) argues that "the shared intersubjective field is crucial" – here I would add especially in Phase Two – and that "unconscious affective interactions" – in other words TR/CT dramas – "bring to life and consequently alter implicit memories and attachment styles". So, whatever we bring in terms of technique, this is really the phase when an informed use of relationship is paramount. If we stay mindful, in other words are able to reflect upon our experience, to track the client's process and to remain curious rather than judgemental about what is occurring between us, then something new and transformative can emerge.

How Long Does Each Phase Last?

Because the process is so organic it is hard to predict how long a client will need to negotiate each phase. The following scenarios illustrate how varied the "shape" of a phase conscious therapy might be:

a) Sometimes Phase One is long and protracted – indeed it may be thought of as "time expanded" if, as with a number of my clients, the fact that they are so frequently out of the Window of Tolerance entails frequent missed appointments. I do not believe that this should automatically be a reason to curtail the work. If, in an optimal way, we can adapt to the client's pace, then the work can change gear and something transformative can occur.

b) The client may eventually go though all three phases, but not all with one therapist. In a service such as the NHS we do see people who complete a course of therapy and return later for more.

c) Sometimes Phase One is short because the client has built up enough resources in other contexts and/or because there is an imperative to quickly move to the heart of the matter.

d) I have also had cases when it is only at the 11th hour that the client feels secure enough to talk about a trauma – although here I would argue that the key themes and dynamics have probably already been worked on, but without explicit reference to the story.

e) Time limits and life events may dictate an ending before everything can be dealt with or sometimes we refer a

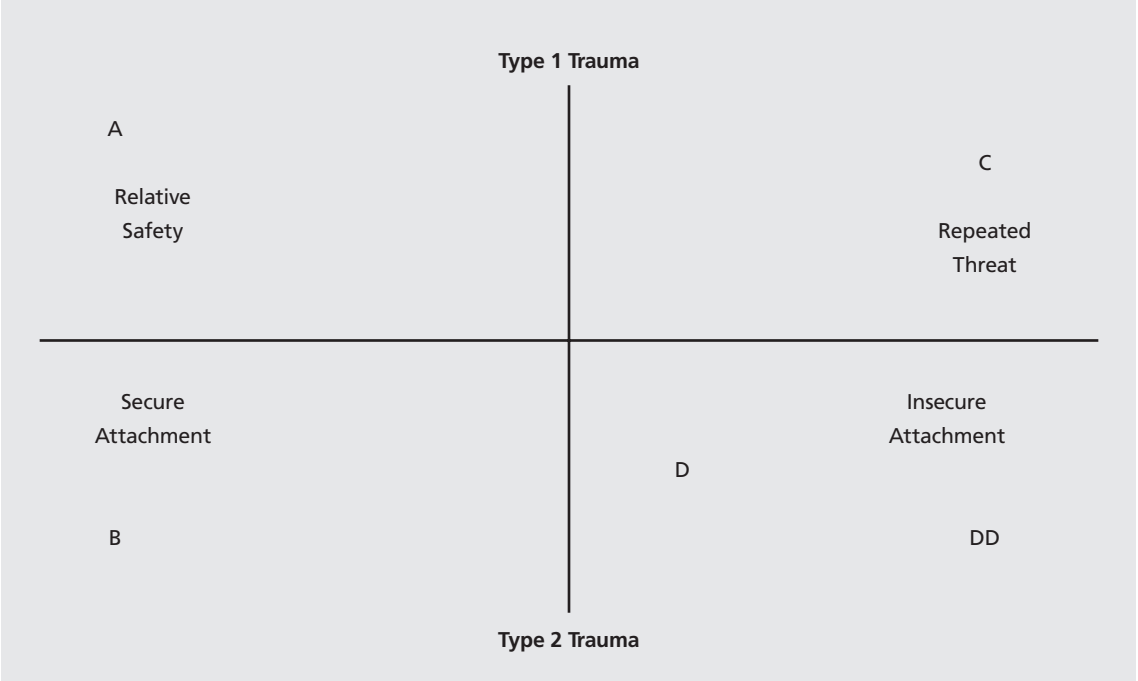

Figure 4: Which Phases are Possible for Which Clients?

client to other professionals for work on integration and rehabilitation.[7]

f) When there is flexibility to tailor the shape of the therapy to an individual's needs and pace, then spacing out contacts and ending with a series of follow ups [sometimes booked in advance, sometimes according to need] is a good way to work when we reach Phase Three. This can offer a "secure base" from which the client can slowly challenge his fear of change and of being with others whilst still having a safe space to explore these issues.[8] In statutory settings this may entail working in tandem with clinicians from other disciplines.

g) We could also consider a more spaced out start, for instance deliberately contracting for this if the client is highly ambivalent, or if this is what is happening anyway when he keeps missing sessions. Although contrary to usual practice, it can pay off to wait until a client appears ready for something more intense before we offer weekly appointments.[9]

Phased Approaches and Individual Capacities

When considering how the work with a patient might be phased, Kluft's meta-question: "should we treat traumatic memories Always? Never? Sometimes? Now? Later?" is worth holding in mind (Kluft, 1997).[10] It is certainly not to be assumed that venturing beyond Phase One work is either possible or necessary. Indeed, Van der Kolk and his co-authors argue, "when patients have gained stability, control and perspective, treatment can be terminated. There is no intrinsic value in dredging up past traumas if a patient's current life provides gratification and the present is not invaded by emotional, perceptual or behavioural intrusions from the past" (1996) – or, I would add, if such work would be far too dysregulating for a patient.

Kluft's question led me to consider how Attachment Theory might illuminate why it is that some people move through all three phases

7. In my NHS practice I might refer a patient on for Occupational Therapy or group-work. However, given the centrality of the therapeutic relationship my preference is for a client to be held in mind by one person throughout the process, even if in the third phase contacts with the primary therapist may be less regular.

8. See Van der Hart et al (2006) on the challenges of Phase Three.

9. Here I acknowledge a communication from Janina Fisher, Sensorimotor and EMDR specialist.

10. Although Kluft was asking this in relation to work with DID patients, it is useful to ask of any potential client.

relatively quickly, whilst others may only be able to manage Phase One work or, if moving to Phases Two and Three, only very slowly. If we start with the premise that high challenge demands high support, then someone whose background was one of relative safety and who could be classified as securely attached should have the resources and resilience to manage thinking about the trauma and will be more likely to seek emotional support. If she experienced a "simple trauma" (a circumscribed event classified as a Type I Trauma by Terr, 1991) then one would expect her to move quickly through the phases. On the other hand, someone with a similar background, but experiencing Type II Trauma (severe, enduring trauma), could hopefully work through Phases Two and Three, but need to do this at a much slower pace. [In Figure 4 I have indicated these hypothetical clients as "A" and "B"].

At the opposite end of the spectrum, when working with a victim of complex trauma with an insecure attachment style ["D"] and especially someone classified with disorganised attachment ["DD"], it may only be possible to do Phase One work. In the remaining quadrant in Figure 4, client "C" – insecurely attached – perhaps not because of overt trauma in early life, but because care-giving was inconsistent due to the parent's own unresolved trauma, is likely to lack resources and have a poorer prognosis after a Type I Trauma than client "a" and, I speculate, her journey through the phases will be strongly coloured by the nature of present day supports.

The other area of theory that can aid our understanding of movement between phases is mentalization theory. People who have endured Type II Traumas are often phobic about the contents of their minds (Van der Hart et al, 2006) and find it hard to distinguish between reality and fantasy. The rigours of Phase Two, which entails bringing memories to mind and reflecting upon the thoughts, emotions and body sensations which they evoke, runs counter to the instinct to avoid anything associated with the trauma. It feels safer not to contemplate the contents of one's own mind or that of others.

In order to mentalize we have to feel secure. As Holmes (2006) points out, mentalization is a "graded rather than all-or-nothing phenomena". With extreme stress "the mentalizing brain goes offline and moves into survival mode". When securely attached, which lowers physiological arousal, mentalizing becomes possible once more. Although the mentalization theorists do not use the term Window of Tolerance, in effect what they are arguing is that it is only possible to mentalize when in this zone of optimal arousal. For instance, Fonagy (2006) notes that when people have a lowered threshold for switching off mentalization because of attachment trauma, "therapists must monitor the traumatized patient's readiness to hear comments about thoughts and feelings. As arousal increases, in part in response to interpretative work, traumatised patients cannot process talk about their minds. Transference interpretations at these times, however accurate they might be, are likely to be way beyond the capacity of the patient to hear. Work to reduce arousal, must take priority so that the patient can again think of other perspectives (i.e. mentalize)". Working with the phases in mind, one can appreciate that what he is talking about is the need to return to Phase One interventions in order to re-establish reflective functioning.

Case Example

To flesh out what I am discussing let me describe one long-term case which repeatedly challenges my sense of having a clear treatment plan and at times my sense of hope.[11] This is because, whenever I think something transformative has occurred or that Marion is a little more resourced, then there is some form of crisis or backlash. She becomes more dissociative, loses her mentalizing capacity and ends up in despair about things not working and in particular about not being able to stop the flashbacks and nightmares which haunt her. During experiential work Marion often comes up with a sensation or image of a "block" – a brick wall – and this seems true for the work. Together we get stuck until a transformative moment unfreezes or unblocks the process for a while.

Like Marion I also experience moments of despair and question whether the change moments are an illusion, if indeed real change

11. I am using a pseudonym and disguising material from the case.

is possible? I wonder whether the downturns are solely because current life events keep highjacking Marion or whether I am doing something wrong, missing something, needing another technique or not integrating the transformations adequately? When I feel stuck I try to hold in mind that the "child" part of the personality needs far longer than the rational, adult self to really take on board that what she most fears is over. And if I think in a more long-term way about what has changed since I first met Marion that also keeps me optimistic.

Let me provide some brief details and then discuss observations emerging from a survey of the last six months of work with Marion. The youngest of five with an alcoholic father; a hostile, rejecting mother and a stepbrother some 12 years older who sadistically abused her from the age of 8 onwards, I imagine that Marion survived her childhood by avoiding people as best she could and by dissociating. There were no helpful, safe others to turn to and nothing she did in an attempt to stop the abuse worked. Eventually Marion "escaped" home by going to college, married at 22 and had a relatively good career until a series of stressors led to a "crash into illness". The dissociative barriers began to break down leaving her prey to unbearable visual and kinesthetic flashbacks and nightmares.

I first met Marion in a community health setting after she came out of hospital following an overdose. My first impressions were of shock to see the bloody mark on her forehead where she had been gouging herself with sharp objects and the agitated way that she was even now pressing her nails into her wrist. She was extremely distressed, barely audible and made no eye contact at all. In terms of attachment styles, I would see Marion as fitting the care-giving subtype of disorganised attachment (Liotti, 2006) and my hypothesis is that the loss of her care-taking role when her daughters left home was one of the factors contributing to becoming ill.

Looking back, I think that the first 14 or 15 months of work could be described as Phase One. Marion often arrived in or slipped into a dissociative state, so much of the work entailed bringing her into the present moment, regulating hyper and hypo arousal, teaching emotional skills such as mindfulness and anchoring techniques and crucially, weathering many crises. Towards the end of this phase it became possible to speak about "little Marion", a child part of the personality [what some call an "emotional personality"] and to start to engage her adult self [often termed the "apparently normal part of the personality"] in looking after this child part.[12]

Now 30 months on, I would say that we are in Phase Two with shifts back into Phase One work when necessary. Although Phase Two is the phase of working through traumatic memories, it is not that Marion has ever spoken in detail about the events of her childhood. What I know is based on allusions, things mentioned in occasional letters or brief references to the contents of a flashback. She can only manage tiny doses of trauma content before slipping out of the Window of Tolerance. However, over the last six months it has been possible to gradually increase the work on past memories with less evidence of dysregulation and, if it occurs, with speedier recovery.

My survey of sessions over the last 6 months highlights how we dart from subject to subject and between processing fragments of traumatic memory and regulatory work. There have been small transformative moments which include:

Work on missing protective resources – [e.g. to say "no", to push away or to move away from another person].

Challenging "child beliefs" about doing nothing – [e.g. by identifying protective things that she did do as a child].

Finding things that empower or resource Marion in the present – [e.g. music, art and her cats].

Being in touch with an emotion such as sadness or, very briefly, anger.

Experiences in the moment of feeling supported and not alone.

12. For detailed explanations of the terms "EP" and "ANP" see Van der Hart et al, 2006.

Marion often describes feeling more upright, powerful and calmer after a transformative moment. She also expresses amazement – it is as if the child self cannot believe the new information. But the new feelings are short-lived and the setbacks after each small gain are hard for us both. A familiar sequence is for something external to trigger fear. Marion feels trapped and begins to dissociate, which immediately opens a door to intrusive images. Whilst still partially in dual awareness[13] she tries to distract herself and to use regulating strategies. If this fails familiar beliefs about "nothing working" and "never doing anything right" click in. She slips out of the Window of Tolerance and in a dissociative, "child" state [EP] she takes overdoses, slashes her wrists or walks on railway tracks. When she is stable again we try to make sense of what occurred and return to Phase One methods. I shall give some examples of this process of transformation and backlash.

One week Marion felt secure enough to give titles to the most familiar nightmares and to say a little about the content of the one she named "baththime". With many pauses to regulate her, we practised how as an adult she might respond to the person who had hurt her. She said she felt powerful, but quickly slipped into guilt with the thought, "maybe I should have done something else". She arrived the next session saying that she had given up hope. She had ended her voluntary job as being around lots of people was proving too much. She wanted to hide and be invisible. When I asked what she feared most she replied, "being seen". We continued to identify memories and beliefs connected to this fear. The beliefs included, "I am worthless" and thoughts about "not doing something different". She became calmer and more optimistic after I explained that being helpless and worthless are not the same.

Seven weeks later Marion had "the best day for ages". However, she still found it difficult being with people. We worked on this theme and on the origins of her beliefs that "people won't want to be with me" and that "I will never be good enough". Here the relationship with her domineering mother was central. As an experiment we played with the idea of "cutting her mother down to size" and Marion said that she felt good about small acts of individuation in the present such as wearing clothes that her mother dislikes.

But when we next met Marion confessed to another overdose during the week. A sexual joke had reminded her of her stepbrother and left her feeling overwhelmed. We contracted to work with the "11-year-old self" that had tried to kill her. I asked what that "child" most needed and she said "reassurance". But here was a dilemma – the cognitive reassurance I offered that the abuse is over and that most men are safe and would be horrified by her story did not get through. The "child" could not believe it. However, given Marion's strong visual imagination what did help, briefly at least, was to practise seeing and altering images on an imaginary TV screen [as an introduction to using this technique with the flashback images] and also to practise visualising me as a resource.

During the ensuing month we continued work on being in groups, tracking a familiar sequence of anxiety and mentally and physically freezing, and we practised strategies to break the cycle. We explored the family interactions which had led to this pattern and Marion came up with her own sense of the missing experiences – namely for people to validate her and to say, "You've got a right to do your own thing". A major step forwards was when she said "no" to her stepbrother for the first time. But her confidence evaporated when guilt emerged. To say no went again the child's belief that she had to protect her family. I taught about this not being her job and about the distinctions between shame and guilt and we discussed how Marion might let go of the shame which belonged to others.

Marion left in a calm state and returned dysregulated once more. Her stepbrother had over-ridden her and her parents took his side. She was upset and worried about what to do next. The images returned. She felt "a nothing". For several weeks she was more troubled than usual by nightmares and flashbacks but was sufficiently regulated for us to contract to work directly on the nightmare [of oral rape] using Sensorimotor

13. When in dual awareness we can retain the capacity to observe our emotional and somatic responses to an experience.

sequencing.[14] Significantly this was the first time that Marion had been able to stay with such a process. It felt intense and moving and entailed the emergence of a number of hitherto incomplete defensive actions,[15] such as protecting her face with her hands and kicking, and ended with Marion repeatedly sipping and spitting out water in an attempt to rid herself of the felt sense of the abuser still inside her.

Marion's subsequent emails highlight the familiar "snakes and ladders" pattern of the work. She mentioned leaving feeling an unfamiliar state of calm and wanting to keep hold of the feeling. Then, a week later she reported having a few bad days. She felt helpless having tried hard to regain the calmness and ended saying that she did not know what else to do. When we met next, following a week's therapy break, finding the context for the downturn was important. I speculated that maybe she had felt abandoned by me. The need to visit her sick and still feared father, difficulties with her husband and starting to worry about a big family event also played a significant part. And so once more, we stepped back into Phase One work, thinking about practical strategies to manage these life events and to reinforce earlier work on boundaries, mindfulness and safe place visualisations.

Reflections

If I hold a short-term perspective the process feels very disjointed, demanding expedient interventions as Marion survives one crisis after another. However, from the perspective of several years, I see that this is not a case of "one step forwards, one step back". Over time there have been significant changes, the most important being Marion's growing ability to stay present as we talk about her life, rather than immediately dissociating. Furthermore, I can see that my interventions, even if spontaneous, do fall into categories and that certain themes keep occurring. For instance, sessions over the last six months have included:

Work on self-beliefs based on past experiences.

Work with the child part of the personality, whilst also attempting to integrate adult and child.

Exploring the meaning behind repeated intrusive images and nightmares.

Developing Marion's repertoire of self-regulating strategies.

My sense is that what has been going on in this second phase of work is a process of making an incoherent narrative more coherent and of integrating mind and body and child and adult parts of the personality. The process is underpinned by repeated opportunities to experience what was missing during childhood, such as experiences of agency and of meaning making and, most important, of having a "secure other" alongside her during moments of overwhelming affect.

During Phase One there was little evidence that I existed as an enduring attachment object in Marion's mind, as someone who could be recalled between sessions.[16] Perhaps this is one of the major differences between the phases – that Marion can now hold me in mind and, in parallel, is better able to reflect upon her own internal states rather than simply dissociating. In other words, she is better able to maintain a mentalizing perspective (Allen & Fonagy, 2006). She has also started to seek support from others, including making contact with me by email, rather than self-harming when she is triggered – highly significant when we bear in mind that social engagement is a higher order response to threat than freezing and dissociating (Ogden, 2006).

I believe that a major task now is to help Marion's "wise adult self" to stay "online" when events trigger "child" states of mind, in other words to develop her capacity for self-soothing and for maintaining a

14. Sequencing, an approach used in Sensorimotor Psychotherapy, entails mindfully studying sensations and micro-movements that emerge moment-by-moment in response to a "sliver" of a traumatic memory. This process facilitates the completion of involuntary bodily actions associated with the trauma (Ogden, 2006).

15. See Ogden 2006 and Levine 1997.

16. This lack of object constancy is something I have noticed with other highly dissociative clients.

mentalizing stance however bad she is feeling. I cannot predict, but my sense is that such capacities will evolve and strengthen as more memories are shared and weathered during sessions and as we move into Phase Three.

Returning to my main theme, I hope that in describing aspects of this case I have illustrated how the "snakes and ladders" journey that Marion and I are travelling can be "held" within the conceptual framework of a phased model. One of the things that is lacking in this process is the chance to follow up and really integrate work done in an individual session. As the excerpts illustrate, the focus of our attention is heavily coloured by events during Marion's week. Unlike clients with a wider Window of Tolerance, she rarely arrives with reflections about the previous session and, because I am pulled into responding to what feels urgent and immediate, I can lose touch with earlier themes. A personal challenge is therefore to maintain a wider perspective and to hold the phased model more consciously in mind as I work with clients like Marion who unwittingly and necessarily bring aspects of the original chaos and incoherence into the work itself.

Conclusions

What appeals to me about phase conscious thinking is that it is inherently flexible and collaborative. If both members of the therapeutic dyad are able to tolerate shifting sands and if the therapist can offer something responsive and optimally timed, this supports a process of evolving self-capacities including the capacity to regulate affect and to reflect on emotions and memories. Phase conscious thinking is also highly integrative. Within this more temporal framework we can apply the theory and techniques of different models in an informed way. For instance, Phase One work is likely to be more directive, include more psychoeducation and have a cognitive-behavioural bias than work in Phase Two where transferential material requires our attention. Attachment theory, mentalization theory, psychodynamic thinking, somatic approaches and current neurobiological research all underpin and integrate well with the language of phase oriented models.

Perhaps more challenging is to question how far this language can apply within the paradigms of medical and business models? In a world increasingly driven by outcome measures and targets, the time frames for psychological therapy are often externally imposed. They can be pragmatic and arbitrary rather than flexibly responsive to the client's pace. There is a drive to look for measures of change and to "move people on". I hope that my case discussion is sufficient to highlight how the "snakes and ladders" process that typifies work with clients with complex trauma disorders cannot be rushed or conceptualised in terms of "moving someone on". It is a deeply relational process and, as in all good-enough attachment relationships, development comes because of repeated reparative and containing interactions, not as a result of following a pre-planned schedule. Phase oriented models only provide a very broad map – the territory itself is only discovered as it is traversed.

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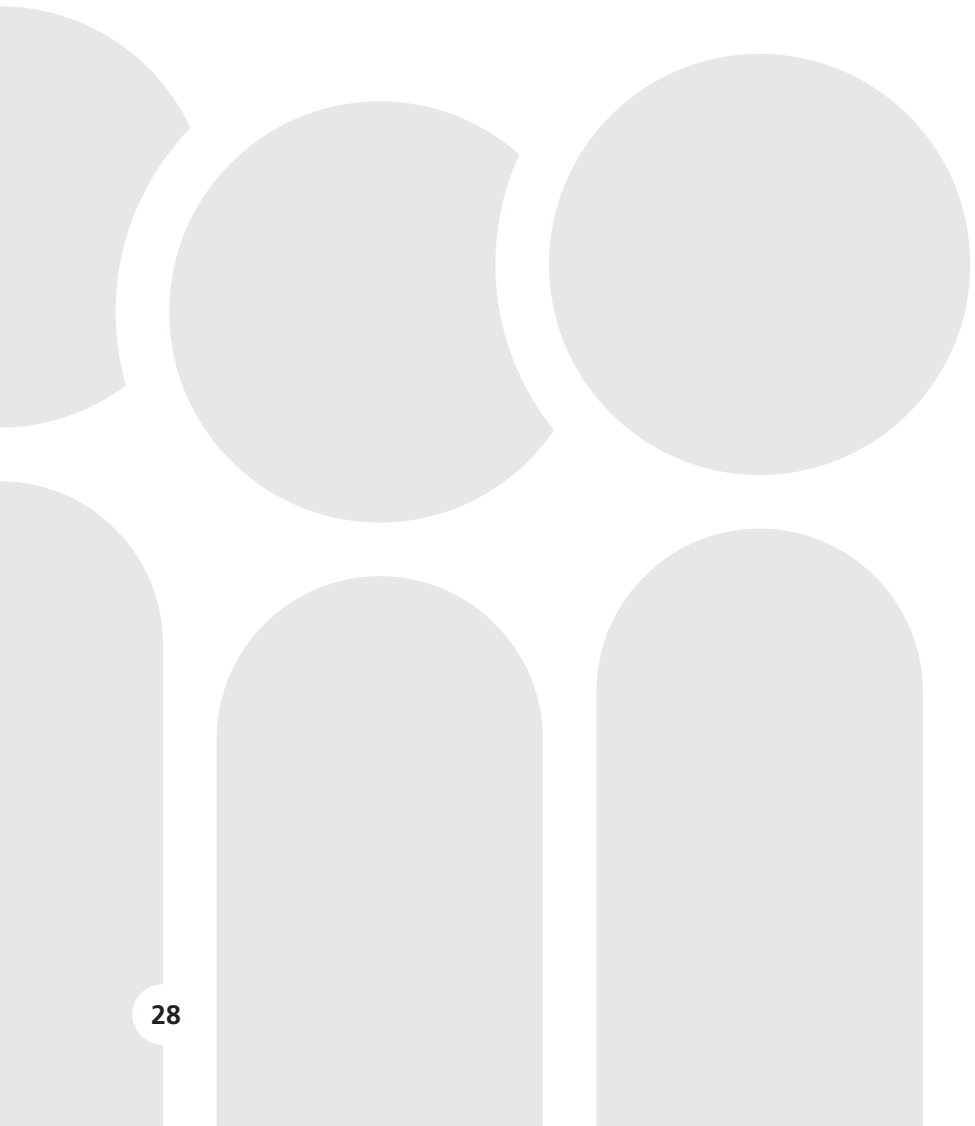

Lorraine Price

From Theory to Therapy – An Exploration of the Relevance of Winnicott's Theories in Regression to Dependency

Abstract

This paper begins by exploring my engagement with the work of D. W. Winnicott and how my own experience in undertaking therapy led me to appreciate the value of his insights in achieving a more fully integrated sense of self. After a brief description of his understanding of human development, I go on to describe how his ideas and practices are useful in enabling clients to successfully transition through what he saw to be 'regression to dependence', an aspect of the transference relationship in clients who have experienced maternal deprivation during infancy resulting in unresolved trauma. Through examples from my own practice, I examine the use and application of this theory in the contemporary practice of Integrative Psychotherapy. These sometimes chaotic and enigmatic experiences in therapy can offer new opportunities for developmental progression if the therapist is prepared to support clients through these often troubling and non-linear crises.

> *"The advantage of a regression is that it carries with it the opportunity of correction of inadequate adaptation-to–need in the past history of the patient, that is to say, in the patient's infancy management" (Winnicott 1958/1984, p 261).*

Introduction

My interest in regression to dependence was born out of my need to understand the processes I experienced in my own therapy. The writing of Donald Winnicott and other Object Relations theorists encompassed the nature of my experience and fostered my interest in their work. In deciding to use my personal experiences, as client and therapist, to illustrate this work, I confronted my fear of shaming and judgement by others about my person and my work. This experience, however, has some famous precedents. Margaret Little (1981) writing about her experience of therapy with Winnicott risked the judgement of her peers and also exposed her own work as client and therapist to scrutiny. Yet understanding this process is important in developing therapeutic practice and research, if we are to fully understand the therapeutic experience and assist practitioners and clients on the journey towards beneficial change. Writing about one's own early experience feels revealing and contains an element of shame, but I wanted to share this aspect of clinical work with others and yet not violate the intimacy which is at the heart of the therapeutic engagement. For those of us seeking to implement integrative therapeutic practice there is frustratingly little detail regarding Winnicott's actual practice. Whilst the approach is amply summarised, we know far less about the fine grain of day to day therapeutic interaction. Perhaps this

silence is a kind of self-preservation because of the risks involved in stepping outside what were the accepted norms of psychotherapy at the time. My doctoral research studies therapists' accounts of regression to dependence, focussing on their work with adult clients in psychotherapy and aiming to explore ways that therapists experience, formulate and utilize this aspect of psychotherapeutic practice. Early data suggests that shame and moving through shame is a painful part of the regression to dependence experience, so how could I write about this therapy without feeling shame?

In the middle years of the 20th century a great many therapists and thinkers, taking their cue from psychoanalysis, sought to understand adult emotional experiences by exploring the impact of events in early childhood. Winnicott, because of his dual role as paediatrician and psychoanalyst had a particular interest in the maternal relationship and its similarity to the therapeutic setting. He considered that maternal deprivation led to serious consequences in the psychology of some of his adult patients and that these needed to be addressed in the therapeutic relationship. He proposed that the therapeutic setting, because of its reliability and focus on the client, is reminiscent of early parenting experience and encourages regression to dependency (1954a). This understanding has also informed current practice and theory.

Bromberg (1991: 416–417) wrote that "Therapeutic regression refers to the raw states of cognitive disequilibrium allowed by an analytic patient as part of the progressive self-perpetuating restructuring of the self and object representations… the deeper the regression that can be safely allowed by the patient, the richer the experience and the greater its reverberation on the total organization of the self… The child in the patient is a complex creature; he is never simply the original child come to life again, but always an aspect of an aware and knowing adult. In this respect it is fair to portray the relationship between analyst and child as simultaneously real and metaphorical. Regression in one respect is a metaphor, but not only a metaphor. It is also a real state of mind." The powerful and overwhelming experiences of shame, rage, anxiety or loss of contact with reality experienced in therapy could usefully be formulated as a kind of reprise of much earlier traumatic incidents. Winnicott (1954a) described regression to dependence as an opportunity for the ego to begin anew, and realized the potential benefits for patients/clients who were not able to be helped by the traditional analytic techniques because of fragmented ego development resulting from maternal deprivation in childhood. In a conversation with the author, Richard Erskine described clients' regression as a need 'to tell their story at the emotional, physiological level of the narrative', seeing these aspects of experience as 'a form of non-verbal early communication of those neglectful and traumatic experiences'. This view of the relational and communicative aspects of regression echoes Balint (1968) who viewed regression as a demand for a certain kind of relationship, namely the early relationship into dependency, and saw that this need occurred when there was a mismatch between the infant's needs and the environmental provision. In the title of his influential book, Van Sweden (1995) describes regression to dependence as a "second opportunity for ego integration and developmental progression", which has previously been unavailable and seen in clients who have experienced maternal deprivation in early life, leaving lacunae in their ego integration.

Winnicott (1954/1984) described these patients/clients as those "whose analyses must deal with the early stages of emotional development before and up to the establishment of the personality as an entity" (p279). He recognised in these clients the "very early development of a False Self [and, in order] for treatment to be effective, there had to be a regression in search of the True Self" (p280). Clients who come to therapy with this presentation can often function relationally and yet sequester their True Self. There is a tendency to people-please, being alert to the opinions and needs of others. Intimate relationships can be difficult for them and there are deep fears of being emotionally dependent. There is often an unconscious fear of abandonment which is disguised by the search for relationship. The process of regression to dependence enables the client to re-visit early developmental stages and begin again.

The importance of Winnicott's work in my own development as a therapist was underscored at an early stage when I first

encountered therapy and this has provided a valuable source of insight to illuminate not only the theory but to enhance subsequent therapeutic liaisons with clients of my own.

When I first entered therapy I was rigid and rule bound, suffering from spontaneous regression in everyday life, chronic anxiety, a feeling of deadness, inability to deal with conflict, and fear of my own 'craziness'. I appeared to be outgoing and available to others while all the time hiding my true feelings. I was compliant to the needs of others, fearing abandonment and hopelessness. In my career I was functioning at a high level, and yet I knew there was something seriously wrong. My early life was deficient in emotional connectedness, attunement, and parental availability. My attempts to define self were treated with suspicion rather than respect. I learned how to do, not how to be. This experience resonated with Winnicott's descriptions of the 'False Self', a kind of mask or false persona which continually seeks to anticipate and adapt to the demands of others in order to maintain a relationship with them. I had a complex and highly developed 'False Self' and the work of therapy was to reconnect me with what Winnicott called the 'True Self' which has a sense of connectedness and integrated wholeness, and so achieve ego integration.

This personal experience, which so precisely mirrored Winnicott's theorisation, prompted me to explore his work in greater detail. First, I shall describe some salient aspects of his account of infant development, looking especially at how he applies this to appropriate adult patients/clients, then I shall consider, by means of some examples and my own experience, how it may be deployed in therapeutic practice.

Winnicott's Theory

The Role of Infancy in Adult Experience

In his paper on True and False Self (1960) Winnicott identifies that "experiences have led me to recognise that dependent or deeply regressed patients can teach the analyst more about early infancy than can be learned from direct observation of infants, and more than can be learned from contact with mothers who are involved with infants since what happens in the transference (in the regressed phases of some patients) is a form of infant-mother relationship" (p 141). This belief was based upon his experiences as both a paediatrician and a psychotherapist assuming a psychological base for disorder, saying that "it is possible to establish a clinical link between infant development and the psychiatric states, and likewise between infant care and the proper care of the mentally sick" (Winnicott, 1958/1984, p 158). His observations of what he considered to be normal infant development led him to believe that "The mental health of the human being is laid down in infancy by the mother, who provides an environment in which complex, but essential processes in the infant's self become completed" (p160).

The Good Enough Mother

Winnicott's theory of emotional development sees the mother as crucial, providing the infant's first environment. Healthy development of self requires the mother to be 'good enough', using her empathy to meet the infant's needs which are "at first body needs, and they gradually become ego needs as a psychology emerges out of the imaginative elaboration of physical experience" (Winnicott 1956, p 304). He saw that a failure in the holding environment as provided by the mother would lead to what he called self disorders, identifying the infant's self as "inherited potential which is experiencing a continuity of being" naming it the True Self (1960, p 148), beginning to have life through the strength given to the infant's weak ego by the mother's implementation of the infant's omnipotent expressions (Winnicott 1960, p 145). This means that the mother's preoccupation, a sort of sensitive attunement, with the infant and its needs, enables it to develop a sense of its own continuity over time; as Winnicott says, a sense of 'going on being'. The mother's implementation of the needs of the infant results in the development of a sense of 'I'-ness which will form the True Self. The holding environment has the function of reducing the number of impingements to which the infant must react. The environment must provide for physiological needs; physiology and psychology have not yet become distinct. The environmental provision should be reliable and

responsive, based on the mother's empathy and attunement and adaptive to the needs of the infant. Holding protects from physiological insult, takes account of the infant's skin sensitivity to touch, temperature, auditory sensitivity, visual sensitivity, sensitivity to falling and of the infant's lack of knowledge of the existence of anything other than its own experience. It follows the minute changes of growth and development. Holding includes the physical holding of the infant which is a form of loving, and may be the only way that the mother can show the infant her love. The basis for instinctual satisfaction and for object relationships is the handling and the general management and care of the infant. In this view, the mental health of the individual in the sense of freedom from psychosis or liability to psychosis is laid down by this maternal care. Winnicott considered that "it is in the years of one to five that the foundations of mental health are laid and here too, is to be found the nucleus of psychoneurosis" (Winnicott 1958, p 7).

Impingement

Winnicott (1954) described maternal failures as 'impingements' upon the infant's experience, affecting its sense of 'going on being'. Frequent and serious impingements can lead to failure to develop a sense of being real and fear of annihilation. Most impingements occur because of misattunement between mother and baby. When the impingements are too severe and too frequent the True Self is sequestered to avoid the risk of annihilation. In the regression the client returns to a developmental phase which is incomplete; this has previously been managed by the development of defences to compensate for this incompleteness. Within the regression to dependency process the regressive pull is in the interests of progression, i.e. for the individual to master that incomplete developmental phase. Kohut (1977, p 178) identified the single 'original development tendency' which is reactivated in the therapy, allowing the client to search for the developmentally needed, reparative relationship.

Psychotic Anxiety

For Winnicott, the idea of psychosis is closely aligned with the person's defence organisation. Rather than its present-day association with schizophrenia, psychosis is used here in its original sense to denote a loss of contact with reality, strange experiences and a sense that personality is fragmented or dislocated in some way. In Winnicott's view, during infancy the ego is too immature to manage the 'primitive agony' of serious and frequent impingement (Winnicott 1989, p 91). This leads to the development of a False Self defence and 'self disorder', at worst the complete disorganisation of the self as seen in psychosis, the "unthinkable state of affairs that underlies the defence organisation" (Winnicott, 1974). Most clients with psychotic anxiety, however, have only pockets of psychosis which can be experienced in the regression to dependency process.

In his 1974 paper entitled 'Fear of Breakdown' Winnicott described the ego's inability to encompass intense emotional experiences, a view with which Erskine (2007) concurs. Winnicott saw psychosis as 'the defensive organisation designed to protect the self' resulting from failures in the infant care process. He described the infant in a place of psychotic anxiety with feelings of annihilation, going to pieces, falling for ever, having no relation to the body, having no orientation in the world, and complete isolation without means of communication. In his view, these horrors surface in later life as psychotic or borderline-state anxieties in which one's very being seems threatened.

In similar vein, Laing (1960, p 99) described this psychosis as "simply the sudden removal of the veil of the false-self which had been serving to maintain an outer behavioural normality that may, long ago, have failed to be any reflection of the state of affairs in the secret self".

When clients are in this phase they experience the terror and rage of early maternal failure, and the therapist's task is to provide a holding environment to allow the experience and expression of these emotions. Only in an environment where all of these needs can be acknowledged, validated and appropriately met, can integration be promoted.

Regression to Dependence

This dual conception of the self, evolving as a highly developed, socially adroit False Self and a more primitive, emotional, real self can help us understand the therapeutic value of regressive experiences. One way of seeing the client's regression in therapy is as a way for them to tell the story of their developmental experience and so identify their developmental needs. This pre-verbal communication is not available to consciousness through language. Pre-verbal memories can be made manifest in behaviour patterns, emotional responses and relationships. In regression to dependency, experience is not available in the form of a narrative memory, but recollections of abandonment, neglect and cumulative trauma can be stored on a physiological level (Erskine, 2007).

Therapeutic Use of Theory

My own experience as both client and therapist, as well as my reading of Winnicott has taught me that these experiences are not unusual, and that many clients benefit from working them through. Whilst undergoing regression to dependence, clients require the same conditions and therapeutic skills on the part of the therapist as any other client, but there are additional attributes needed to work with the pre-verbal nature of the transference relationship.

Affective Attunement and Use of Countertransference

Affective attunement is required to establish the emotional connection between therapist and client. The therapist will have empathy with the client's situation, and be involved in their story. This attunement will be based on verbal and non-verbal cues and is similar to that of mother/infant in the infant's pre-verbal phase. It requires intuition, understanding and empathy which are developed through shared knowledge of the experiences of the client, the use of the unconscious material in the countertransference and the processing by the therapist of unconscious confused material, in short it means being totally in tune with the internal experiences of the client at this pre-verbal developmental level (Van Sweden 1995). Affective attunement using the countertransference allows communication of the therapist's understanding of the client's pre-verbal experiences. In these circumstance the nature of the countertransference is felt as maternal. My own experience has underscored how countertransference involves an experience of one's own infancy needs. If the therapist has not worked with these needs they may rely on the client to fulfil them, hence the need for a personal experience of this depth of work. Therapists may also experience the threat of chaos and psychotic process. This can be frightening for the therapist who has not met this in themselves. A high level of skill is needed in management and tolerance of these processes, and I feel particular insight was gained from having personally undergone these experiences.

In my own therapy I felt that I had brought a dead baby with me and I had many dreams about carrying a dead infant in a bag. In almost every way except verbally I described the existence of the split-off inert infant ego. In Winnicott's view this kind of experience results from disruptions or deficits in caregiving in infancy. In other words, this had constituted too much impingement upon myself as an infant and had made this splitting-off necessary. Over time, my therapy sessions needed to increase in frequency to contain my increasing levels of disturbance which included manifestations of psychotic anxiety during the sessions. These were always well contained and eventually my terror of my own 'craziness' was diminished by my therapist's acceptance and management of my behaviour. Throughout this period there was a movement both towards intimacy and flight from it, but I gradually allowed my infancy needs to emerge and begin to be met despite my shame about them.

These experiences then, rather than being unique or idiosyncratic, have turned out to represent a valuable source of insight in working with my clients. Careful reflection on experiences like this can enhance the empathic reach of the therapist in assisting clients with their distress.

Susan came to therapy as a highly functioning individual. She had a good job, was a high achiever, articulate and intelligent. In her forties she had discovered that nothing

satisfied her any more. Her relationship was of long standing and yet she admitted to not knowing how to love. Her major defence was intellectualisation, and she felt shamed by her regressive needs. To formulate the case in Winnicott's terms, as the therapy progressed her 'absence' of True Self became apparent as she functioned entirely from a False Self perspective where injunctions against any free, creative or spontaneous behaviour ruled. The work in therapy was to initially raise awareness of her split-off True Self, to address her experiences of maternal failure and the concurrent deficits in ego development. Winnicott's theory also provides a programmatic guide to therapy. For example, in this case it turned out to be valuable to contact her sequestered True Self so that she could let go of the carapace of her False Self while I supported her ego deficits until such time as ego integration could occur. When regressive experiences are split-off from awareness the therapeutic task is to help the client find words and establish a narrative for their experience which can then be processed and understood (Van Sweden, 1995).

Winnicott identifies infancy as a period when instinctual needs are foregrounded as a series of events occurring in practice starting with a safe setting, the process of regression to dependence, the hidden self becoming integrated into the total ego, an unfreezing of the environmental failure and the expression of anger related to this. Subsequently there can be a return from regression to dependence with instinctual needs and wishes becoming realizable (Winnicott 1958; 1984).

Relational Need

This journey through regression, dependence and eventual integration and reconstruction of the self requires careful attention to the client's needs by the therapist. Yet it is not always made clear by the client exactly what these needs are. Clients are individuals with individual needs and healing comes with recognition of the individuality of the client. Because of the pre-verbal nature of the damage many clients do not recognise their own needs and so cannot identify them to the therapist. In regression to dependency the moment-by-moment attunement of the therapist will identify nuances of behaviour which can help the client to start to recognise and acknowledge needs. My experience is that clients often picture what they need in a therapy session, but shame can be experienced which blocks identification of this need to self and to the therapist. Sometimes I ask clients if they picture how the session will be, and often needs can be associated with this. One of my own pictures was of being held in a way I saw a workshop participant being held by the facilitator. It was months before I was able to stutter out this need. Such is the power of the shame process.

As in the maternal setting, the therapeutic setting must provide physical comfort, warmth, quiet and the absence of interruption. The therapist must have an attitude of acceptance, encouragement and responsiveness. There can be a physical risk to the therapist because clients can access powerful primitive emotions of rage and fear during the regression to dependence process, but my experience suggests this is generally manageable. The question for the therapist in private practice is 'given my situation and practical facilities is this client containable and manageable by me?' When the relationship is strong enough to survive the expression of rage and fear, and the client is able to relate to the therapist from the True Self, and this is accepted by the therapist, then defences are not rebuilt and eventually the client can integrate the needs and emotions of the True Self and become whole. Successful negotiation of the regression to dependence can resolve primitive anxiety by providing reassurance and continuity of being, allowing maturity to later development. Therapists who have participated in my research so far have identified feeling moments of risk from clients whose rage was expressed. My own rage and terror scared me and it did get acted out. My therapist contained me physically and emotionally, and accepted my rage and its manifestation as one would an infant's, with tolerance and through management.

Entering into a dependent stage in therapy means undoing defences, and the resulting neediness which emerges triggering feelings of shame and wrongness. Developing infants need each stage of development to be accepted so that the experience can be retained and remembered. When the needs of a developmental phase are

met with rejection or derision the experience is painful for the infant and can become split-off from consciousness and inaccessible to memory. These split-off memory traces can be responsible for overwhelming feelings of fear or distress, this is often described as a panic attack by some clients, but being inaccessible to memory they seem irrational. These experiences may have occurred prior to the infant's development of an organized self-hood. To heal these painful feelings it is necessary to integrate these parts of experience by revisiting these developmental phases and creating a relationship and environment where developmental needs can be accepted, and a narrative formed which helps to integrate the experience (Van Sweden, 1995).

Clients who are regressed struggle to cope with cognition, thus, as Winnicott advised half a century ago, interpretation during these times is not useful and may be experienced as an impingement. Winnicott suggested that 'management' is required during this period. The quality of the relationship with the therapist is crucial; rather than interpretation or technique, their reliability and consistency is of prime importance. Indeed, Winnicott (1969) recommended avoiding interpretation since he believed it was important for the client themselves to discover the answers. However, there is an overriding framework through which the therapist is enjoined to share this particularly dependent phase in a client's therapy. That is, he proposes that because these clients did not receive reliability and consistency in maternal care they need to receive it from the therapist's behaviour. In recommending an accepting, but not overly interpretive stance on the part of the therapist, Winnicott provides valuable guidance for the therapist working with a client undergoing these kinds of regressive experiences.

A good deal can be learned through careful reflection on the feelings I have as a therapist working with clients undergoing these kinds of regressive experiences. My countertransference when working at these developmental levels usually involves maternal feelings and a desire to meet the infant ego in whatever way is necessary. This can be through eye contact, the expression of understanding, physical holding or through silence. When clients are dealing with such a high degree of psychological damage that they need to revisit these pre-verbal times, then their needs become appropriate to their developmental age of the time.

Therapists can make use of the way that their own awareness may develop as a kind of response to the patient's immaturity and dependence as they regress. In Winnicott's account, the good-enough mother is willing to let go of her identification with her infant as soon as the infant is capable of becoming separate. Because of maternal attunement and empathy the mother knows how the infant feels and is able to meet its needs for holding and environmental provision. In the therapeutic relationship this attunement and empathy is present in the maternal countertransference, and skilful use of this enables identification of and adaptation to the client's needs and recognition as the client develops and as needs change.

In the course of her therapy Elizabeth regressed to an early developmental stage and at first I would hold her in silence and watch over her whilst she drifted in what I think of as reverie. As time went on and she contacted her True Self her needs became more relational, and we moved from a symbiotic place of merger of a kind Winnicott believed to exist in very early infancy, to a two person relationship where she could distinguish between 'me' and 'not me'. These stages were not achieved easily, but were approached through extremes of need and vulnerability, pain, anger, rage and shame. Elizabeth struggled to allow herself to trust me sufficiently to be dependent. This was her second attempt at a relationship of dependency – the first had failed because her mother had emotionally abandoned her. Her question was, would I do the same? At the same time as desperately needing relationship, she was also terrified of it.

As in the mother/infant relationship, when the therapist fails to attune to the needs of the client this will be experienced as an impingement or, as Khan (1963) would describe it, a psychological affront to their sense of self. In order to meet the client's needs in regression the therapist must be reliable, non-defensive and aware of the risks involved. In this phase supporting and managing the client's experience is more necessary than verbal interpretation.

This involves accepting the client's anger and rage without interpreting it as transference or identifying previous patterns, it is not the time to offer logic or teach self-support. The client needs their experience to be validated, and for the therapist to offer necessary support within the session and sometimes outside of the session in the form of texts and phone calls or additional sessions. The process of regression to dependence, involves a frightening return to the earliest unintegrated state, which Winnicott believed would involve a primordial fear of annihilation which can be manifested in the session and have a physical reaction in the startle reflex. The therapist must be able to stay grounded in reality, retaining their sense of identity whilst being able to experience the anxiety, fear of annihilation and loss of identity that the client faces. This requires the same qualities that a 'good-enough mother' provides.

Angela struggled with the gaps between sessions. She moved from once a week, to twice a week, to three times a week, but still found she couldn't cope with the gaps. At the beginning of each session she would be full of rage at my abandonment of her between sessions. She would blame me for her predicament and demand that I made it better. As the therapy progressed she began to understand her process of desperately needing intimacy, but pushing me away, and the rage subsided to a point where she really allowed her needs to be met by me. She needed my attunement to her ego states and sufficient meeting of her infancy needs for her to experience a degree of provision rather than deprivation.

In some circumstances this kind of behaviour might be seen as evidence of 'borderline personality disorder' – in other words, an enduring condition which many mental health practitioners even nowadays see as untreatable and where the client's expressions of neediness are seen as manipulative or attention seeking. Winnicott, on the other hand offers hope that this phase may be successfully transcended through appropriate support from the therapist. Indeed, as Winnicott describes, the process is one of giving the client a capacity to use the therapist.

Dependency

During regression to dependence the nature of the transference can lose its 'as if' quality, because the client perceives the therapist in an authentic way where he/she is really the parent. The therapist does not have to become the mother to the dependent infant, only to accept the developmental needs and to offer appropriate response. During this time therapeutic misattunements can cause the client to experience deep shame and pain, but as in all therapy this can be used to deepen the relationship and with successful reparation can allow the client to feel loved.

The importance of the therapist's failure for the client must not be forgotten. This helps the client to recognize the normal failures which are a part of life and to become robust and resilient. In the dependency stage of early infant development the caregiver learns what the infant's needs are by getting it wrong and having the infant protest. Similarly, the verbal and non-verbal protests of the client assist the therapist to correctly attune to their needs. When the therapist fails the client, the transgression may seem minor, yet to the client it can be experienced as an impingement which can engender pain or rage – getting the balance right is a tightrope to be walked by the therapist during these phases. Too many impingements can result in a return to the despair of childhood and if this is not recognised by the therapist the client can terminate therapy. When my therapist failed me, usually by misattunements, I raged and felt let down once again, the pain I experienced was overwhelming and immense, and my response was to return to my normal defensive patterns and to lose hope. Even these apparent failures however serve a valuable function in that, provided that the relationship is strong enough to contain any overwhelming feelings, they are part of the process of developing independence. As Winnicott (1971 p10) says of "good-enough mothers": "as time proceeds she adapts less and less completely, gradually, according to the infant's growing ability to deal with her failure". The failure then is what prompts independence.

Development of Narrative

The regression to dependence process means that the client is in a less integrated state, and experiences elements of merger with the therapist. This recollects the original mother/infant relationship. In therapeutic contexts, the creation of a situation akin to the holding environment offers a sense of protection. This allows the client to access hitherto split-off primitive agony and rage resulting from the original maternal failure, and accounts for the possibly extreme and troubling emotions sometimes experienced in therapy, or when any interruption in the therapist/client relationship is threatened. Because of the profound and overwhelming emotions it will often have to contain, the development of the holding environment must be firmly established through a series of therapeutic successes in order to gain maximum benefit. In maternal deprivation the trauma has occurred prior to the development of language, and revisiting it provokes terror of the past experience of disintegration and breakdown. Indeed, this could be seen as a reprise of the breakdown that occurred when the False Self was created in order to protect the True Self. The therapeutic task is to help the client to begin to develop a narrative to express the experience, and words to express the primitive emotions. Although this putative trauma occurred before language had been learned, and when it is re-experienced in therapy relatively little coherent speech may be possible, ultimately "both the baby and the regressed patient in the end have no choice but to learn to speak the language – i.e., vocabulary and grammar, of the adult on whom they are dependent, the baby for his life, the regressed patient for his restoration!" (Balint 1959 p 72).

The degree of emotional effort involved in guiding distressed and regressed clients through this process of regression and the subsequent development of a coherent personal narrative means that it is essential for therapists to access supervision from practitioners experienced in this type of work so as to gain support, advice and assistance in interpreting these transferences.

Conclusion

In writing this article my aim has been to describe how the work of Winnicott helps to make sense of, and offer therapeutic opportunities for these kinds of experiences in therapy. Clients who appear very needy, demanding, angry or distressed, especially when this is at odds with their customary way of dealing with the world, can present a troubling enigma to therapists. Indeed, this kind of experience may appear to be truly 'chaotic'. However, Carroll (2002) advocates the acceptance of chaotic processes in psychotherapy, which could be seen as a 'science of chaos', the chaos of humanity, which is not linear or structured. In the case of adult clients who appear to be reliving the experiences of infancy in the process of undergoing developmental regression, their feelings may be especially chaotic and can challenge, exhaust and exasperate the therapist. Winnicott's formulation of this process and his attention to the parallels between it and infancy offers both a way of making sense of this, and a practical guide as to how it might be worked through.

The value of Integrative Psychotherapy in these cases is that it offers a means of making sense of, and prioritising clients' needs. The message from Winnicott and from contemporary Integrative Psychotherapy concerns the value of adapting to these needs, living with non-linear, non-structured experience. Unlike the movement in much contemporary psychological therapy to address problems according to a standardized protocol, this approach highlights the importance of flexibility and reflexivity in the therapist's stance. Accordingly, I have described how I draw on my own experience in making sense of the client's phenomenal world. Meeting the needs of the client can be demanding and may mean stepping outside some of the normal bounds of therapy. My experience is that where there is love, and where adequate boundaries are maintained, this is not onerous. Equally, I have highlighted how judicious interruptions in the process of parenting can represent important opportunities for the growth of independence on the part of both the child and the client. In this context I am reminded of a comment from Van Sweden (1995) who suggests that clients should be given all the love they need, not all the love they demand.

Through the process of writing this article I have also become aware of the limitations of the descriptions I have used for these experiences. The wisdom of Winnicott was to direct us to appreciate the importance of these aspects of the human condition experience which are somehow beyond language and which often appear to be more primordial. Like any intimate moment, the words belie the quality of the experience. My hope is that I have conveyed something of the excitement of discovering Winnicott's work and its ability to offer some calm and sagacious reassurance in the face of some of the more enigmatic and troubling events in therapy, and to encourage practitioners in this work to visit/revisit Winnicott's work.

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Sex, Lies and Videotape: Reflections on Psychotherapy Integration Illustrated by a Case of Internet Paedophilia

Abstract

The paper begins by briefly locating psychotherapy integration within its historical-philosophical context, before moving on to consider the place of the integrative project as it exists 'within' (as opposed to 'across') a specific psychotherapeutic paradigm (psychoanalytic). A brief appraisal of some of the risks and limitations associated with the deployment of integrative strategies within paradigms is also offered. A case presentation is used to illustrate what an integrative approach within a psychoanalytic paradigm might look like in practice. The case example is preceded by the introduction of the concepts of 'psychic retreats' and 'thick/thin-skinned narcissistic personality organizations' that were of particular assistance in understanding the psychotherapeutic process.

Introduction

> *"In relation to their systems most systematizers are like a man who has built a vast palace while he himself lives nearby in a barn; they themselves do not live in the vast systematic edifice. But in matters of the spirit this is and remains a decisive objection. Spiritually, a man's thoughts must be the building in which he lives-otherwise it's wrong" Kierkegaard, Papers and journals*

The title of this paper is taken from the eponymous 1989 movie directed by Steven Soderbergh whose themes of identity, anxiety and self-deception are mirrored in the case study part of this paper. While this paper does not attempt to map out in any detail the parallels that might arguably exist between the character of Graham portrayed in the film and a client I shall subsequently refer to as 'Adam' in the case study section of this paper, it does otherwise hint at the possibility that both Graham and Adam may share some common psychological features, not least with respect to their respective deployments of 'new' technologies as a means both to gratify and disguise their particular sexual and relational desires.

Be that as it may, for my current purposes, I would like to otherwise situate the case study part of this paper within the wider philosophical contexts of what could be termed the 'integrative project', before moving on to explore its current clinical applications from within an overarching psychoanalytic paradigm. This kind of strategy notionally places the paper within an assimilative psychodynamic approach to psychotherapy integration (Stricker & Gold, 1996), whilst seeking simultaneously both to ground and to articulate its philosophical presuppositions from within a broader historical framework.

A Historical Philosophical Context to Psychotherapy Integration

It is possible to situate many of the current debates concerning psychotherapy integration within a much broader discourse spanning the history of western philosophy from the Ancient Greeks to the present. Historically, this dialectic was inaugurated by the Pre-Socratics, although it could be plausibly argued that it reached its zenith (albeit within a metaphysical-theological frame of reference) in the various Neo-Platonic systems which sought to explore the relationship between the one and the many (Tarnas 1991, pp.84–87). Viewed from this kind of perspective, contemporary explorations into psychotherapy integration can be viewed as the immanentized residue of a much more ancient zetema (existential enquiry).

It was Levinas' assertion that ethics is 'first philosophy' (Hand [ed.], 1989, pp.75–87). It follows from this that philosophical disciplines such as epistemology (theories of knowledge) and ontology (theories of existence) are essentially 'secondary' structures, founded upon a lived, ethical experience. While contemporary debates in philosophy have tended to become polarized around formative notions of meaning within the 'Anglo-American' (linguistic-analytic) and 'Continental' (Marxist-existential) traditions respectively, Levinas' assertion of the primacy of ethics marks, I believe, a return to a more ancient conception of philosophy that views it as being essentially a way of life (Hadot, 1995).

Since the Enlightenment, we have become used to the spectacle of the philosopher as someone who is either constructing metaphysical systems or deconstructing forms of semiotic discourse. It is my belief that this conception of philosophy is essentially impoverished, and has a tendency to function in its de(con)structive aspect when introduced into contemporary debates on questions as diverse as the nature of the 'self' or the 'objectives' of contemporary psychotherapeutic practice. When Adam Phillips asserts that "understanding does not inform our morality, our morality informs the ways we have of understanding" (in Molino [ed.] 1997, p. 162), he is speaking from this older tradition, a tradition that can be traced through St Anslem's famous credo ut intelligiam ('I believe so that I may understand') to the Ancient Greek conception of philosophy as being primarily a way of life.

It is possible that certain debates in contemporary psychotherapy regarding its 'values' and 'objectives' may simultaneously mirror and amplify tensions originating within the Platonic and Sophistic schools of Ancient Greek philosophy. Platonism arose out of an external subjective field, in which notions of truth and value gathered weight against the backdrop of a transcendental horizon (Agathon). In contrast, the Sophists operated from a position in which the individual was viewed as the measure of all things (Tarnas 1991, pp. 26ff). Gomez (1999), in a brief but intriguing account of the historical vicissitudes of the 'self', has argued that this journey originates in a historical shift away from an external subjective field (Platonic; pre-Reformation Christianity), in which experiences of truth and subjectivity were located as existing within a transcendental and communal horizon, towards an internal subjective field (post-Enlightenment), in which notions of meaning and identity became situated within the locus of the individual. While contemporary accounts of subjectivity have tended to focus upon the fragmenting and deconstructive propensities of the self (Bion, Lacan), it remains to be seen where exactly this trajectory will actually take us (while deconstruction is a good prelude to rebuilding, it makes a poor goal).

At the beginning of this paper, we saw in the epigraph from Kierkegaard how theories of knowledge and existence should be intimately related to the texture of our lived experience, and from Levinas how epistemology and ontology are founded upon ethics as 'first philosophy'. This kind of fundamental interrelatedness can be conceptualized as a hermeneutic circle, which gives some indication of how the whole may be greater than its constituent parts. This philosophical 'interrelatedness' may also provide a rough heuristic guide when considering the 'congruence' or 'fit' of the epistemological, ontological and ethical presuppositions implicit within any particular approach to psychotherapy integration.

Theoretical Pluralism Within the Psychoanalytic Paradigm

Traditionally, theories of psychotherapy integration have tended to coalesce around three main orientations: technical eclecticism; common factors; and theoretical integration (Dryden [ed], 1992; Lapworth, Sills & Fish, 2001). However, Prall (2004) has cogently critiqued these three strategies and elucidated the theoretical tensions that are implicit in the quest to combine pluralism with the search for an overarching meta-paradigm. Prall argues that theories need de-centering, and that a plurality of viewpoints is required both to escape reductionist perspectives and to respond to the complexity of our clients' lived experience. This approach is not so much one of trying to 'integrate', as seeking to have a range of tools at our disposal. It means entering into a dialogue that preserves difference, but which may lead to change, even if the underlying motivation is neither assimilative nor synthetic. As a consequence of these tensions, the relationships (both conscious and unconscious) that we establish with our chosen psychotherapeutic orientations (be they analytic, humanistic, cognitive-behavioural or indeed 'integrative') are invariably complex, multivalent and over-determined with respect to their links both to the exigencies of clinical practice and to the biographical histories of their respective exponents.

It is possible for psychotherapeutic theory to be viewed from a range of perspectives including: its cultural/political context; as an internal object; as a transitional object; as a hermeneutic lens; and as an activity that needs to establish an internalized deconstructive capacity. Furthermore, every psychotherapeutic theory can (so to speak) be construed as possessing its own unconscious. That is to say, a surrounding field or penumbra into which its own repressed contents are consigned to neglect, inattention or sheer wordlessness. In the remainder of this section I would like to extend this 'problematisation' of integrative theory, whilst arguing for the potential value of applying a 'pluralist' approach to working not only 'across', but also 'within', the major psychotherapeutic paradigms (in this instance, the psychoanalytic paradigm). I would like to begin this discussion by looking briefly at Fred Pine's 'integration' of drive, ego and self psychologies in clinical practice, before moving on to consider briefly Jean White's reflections on whether this deployment of multiple perspectives can be most fruitfully conceptualized as an integrative, eclectic or pluralistic endeavour.

Contra Greenberg & Mitchell (1983), who hold that drive theory is, ultimately, incompatible with object relations, Pine argues that it is indeed possible to coherently combine the psychologies of drive, ego, object and self-

> *"My intent …is to work towards an integrative view of the substantive phenomena to which the various theories address themselves: phenomena such as urges (in the drive psychology); modes of defence and adaptation (in the ego psychology); relationships and their internalization, distortion, and repetition (in the object relations psychology); and phenomena of differentiation and boundary formation, of personal agency and authenticity, and of self esteem (in the self-psychology)" (Pine, 1990, p. 4).*

Intriguingly (and perhaps disingenuously), Pine is able to cut through the Gordian knot of metapsychology by asserting that the linking of these several psychologies "…is not so much a conceptual task as a developmental event" (ibid, p. 104). To give an example, while it may be meaningful to speak of the ages 6–12 years as a 'latency period' within the context of drive psychology, this time span is anything but latent with respect to developments in the spheres of ego, self or object relations psychologies. By a process of extrapolation, it can be argued that all human motives could be said to possess a developmental history-at least insofar as motivation, in the course of its development, becomes increasingly personalized over time. Most importantly from a clinical perspective, it is these developmentally evolved motives that are worked with in the clinical setting, rather than the (speculatively inferred) internal world of the 'observed infant'.

While Pine's approach to working across modalities located within an overarching paradigm is one that is likely to resonate with many integrative practitioners, it is an approach that is nevertheless not without its critics-

> *"…it would be philosophically naïve and omnipotent in the extreme to attempt to synthesise paradigms as diverse as the contemporary Independent, Lacanian and post-Kleinian approaches, and something crucial would be lost in such an endeavour. Even though there are striking correspondences in some areas of these theories…these theories in themselves account for why an attempt at synthesis would be dangerous nonsense…I argue for theoretical pluralism, not eclecticism. It is not only impossible but dangerously misleading to mix and match concepts that originated in different paradigms" (White 2008, pp. 147–148).*

While the application of the epithet 'dangerous' in this context might be unduly dramatic, it does nevertheless help to articulate something of the manner in which our theoretical commitments may entail real-life clinical consequences for our clients.

As a consequence of these considerations, I would argue that that it is of the utmost importance for any approach to psychotherapy integration to contain the tools necessary for its own deconstruction. In fact, this kind of de(re)constructive dialectic lies at the very heart of the psychotherapeutic enterprise, and was there from the beginning-

> *"Dissemination generates material. Cohesion brings about truths. Dissemination subverts authority. Cohesion makes sense of chaos…At no point in his [Freud's] writings did his belief in his interpretative truths ever displace a method that would always undermine him" (Bollas 1999, pp. 33, 37).*

In this approach, pluralism needs to be clearly distinguished from its 'close enemy', relativism-

> *"[p]luralism is not identical with relativism…The relativist says that the same proposition can be both true and false, depending on how you look at it. The pluralist shows that the standards of rightness associated with different versions can neither be reduced to each other nor meaningfully be taken to compete. The pluralist does not believe that the same proposition can be both true and false; he (sic) assumes that certain theories are incommensurable, i.e. not comparable with each other" (Strenger, 1991, in Jimenez, 2008, p. 581).*

In the case example section of this paper (see below), I hope to illustrate how such an approach to theoretical pluralism (located, in this instance, within an overarching psychoanalytic paradigm) got played out in clinical practice. However, I would like to preface this account with a very brief excursion into two theoretical concepts-namely psychic retreats and thick/thin-skinned narcissism-that were of particular assistance in my admittedly tentative attempts to make sense of the overall psychotherapeutic process. I am mindful that the following account is highly abbreviated, and may not do justice to alternative readings of the theories concerned. However, I would concur with the viewpoint of those writers who argue that theoretical perspectives are, necessarily, filtered through the 'personal equation' (Shamdasani, 2003) of the individual therapist, and as such, inevitably become to some degree personalized in the course of their exposition (Kantrowitz, 2008).

Psychic Retreats

The psychic retreat is a way of conceptualizing a particular constellation of object relations, defences and phantasies that are similar to, but also distinct from, the paranoid-schizoid and depressive positions described by Melanie Klein (1952). The purpose of the psychic retreat is to enable the client to avoid intolerable anxiety, through adopting a position in the analysis (and in life) that is sequestered and largely out-of-reach. However, the deployment of this borderline position comes at a considerable cost to the client's potential for psychic growth. Steiner describes this process of psychic sequestration in the following terms-

> *"The analyst observes psychic retreats as states of mind in which the patient is stuck, cut off and out of reach, and he may infer that these states arise from the operation of a powerful system of defences. The patient's view of the retreat is reflected in the descriptions which he gives and also in unconscious fantasy as it is revealed in dreams, memories and reports from everyday life…Typically, it appears as a house, a cave, a fortress, a desert island, or a similar location which is seen as an area of relative safety…in perverse, psychotic and borderline patients…the retreat…serves as an area of the mind where*

> *reality does not have to be faced, where phantasy and omnipotence can exist unchecked and where anything is permitted" (Steiner 1993, pp. 2–3).*

The perverse and occluded misrepresentation of reality characteristic of the psychic retreat is based on the account of disavowal provided by Freud in his paper on fetishism (Freud, 1927). In this paper, Freud describes how the patient adopts a stance whereby reality is neither fully acknowledged nor wholly repudiated, so that contradictory views can be held simultaneously, and are obliquely reconciled by utilizing a variety of defensive maneuvers including splitting of the ego. Steiner observes that while the rubric of 'perversion' has traditionally been assigned to the domain of sexuality, it has subsequently been extended to include the disavowal of truth and reality originally described by Freud in his 1927 paper (Steiner 1993, pp. 88–89).

Thin and Thick-skinned Narcissism

The distinction between thin-and thick-skinned narcissism originally derives from Rosenfeld (1987), although it has more recently been developed by Bateman (1998) and Britton (1998). In Rosenfeld's account, thick-skinned narcissists are highly defended and hard-to-reach, and require frequent repetitions of interpretation and confrontation if any therapeutic gains are to be consolidated. In contrast, thin-skinned narcissists are hypersensitive both in everyday life and in therapy, and are likely to be traumatized if an approach more suited to a thick-skinned narcissist is misapplied. In Bateman's account, Rosenfeld's distinction between thick-and thin-skinned narcissists is viewed as useful, and yet too schematic, as clients are thought to habitually oscillate between both positions, presenting "…an unstable clinical picture that is both a danger to and an opportunity for analytic treatment" (Bateman 1998, p. 12). Bateman further distinguishes his approach to working with pathological organizations (ibid, p. 25) from that of Steiner's, whose emphasis he characterizes as being predominantly intrapsychic, in contrast to Bateman's more avowedly interpersonal approach.

Clinical Background

My work with Adam took place some years ago when I was an integrative psychotherapy student on placement at a psychotherapy outpatients department in a hospital situated in a large city. For reasons of brevity and confidentiality it is not possible to go into Adam's history in detail. However, some relevant background can be summarized as follows. Adam was the third of four siblings (two sisters and one brother). His parents separated when he was in early adolescence-Adam noting that he henceforth became a 'father-substitute' for his mother. Adam had what he described as a 'traditionally middle-class' education, attending prep and boarding school before going to university to study fine art. He was married for several years in his mid-twenties, separating from his wife for reasons of what he described as 'emotional incompatibility'. Prior to our working together, Adam had undergone two brief periods of person-centred counselling, as well as a 5-month period of CBT. The referral for a more long-term psychodynamically informed psychotherapy was made (with Adam's consent) by his CBT therapist, who was also head of department for a psychosexual clinic. At the time when we began to work together, Adam was in his early-30s, living alone in a one-bedroom flat and was self-employed as a free-lance artist. As our work progressed, the picture was made more complex by a diagnosis of testicular cancer, which resulted in Adam suffering a partial castration.

Adam was given an initial diagnosis of 'Paraphilia' (DSM-IV, pp. 522ff). However, even when descriptively accurate, the 'diagnosis' of paraphilia may nevertheless be of limited clinical value, insofar as it contains within its compass an extremely heterogeneous collection of (legal and illegal) minority sexual orientations, ranging from paedophilia through to sexual sadism and masochism, frotteurism, fetishism, transvestism, exhibitionism and voyeurism. As a diagnostic category, it has limited utility, other than to draw attention to the presenting sexualized symptomatology of the client. Consequently, whilst the rubric of paraphilia may constitute a legitimate descriptive diagnosis, it does little to address the more clinically germane question of developing an individualised

psychotherapeutic case formulation (see Johnstone & Dallos 2006; McWilliams 1999) tailored to the very specific needs of the client.

In the 'Psychotherapy Questionnaire' that Adam completed prior to our first meeting, he expressed the belief that his sexuality had been 'deviant' since his teenage years when he first noted an attraction to teenage boys aged 13–14 years. He described a couple of awkward sexual experiences from this time, but noted that his sexuality was largely based upon complex masturbation scenarios, voyeurism and pornography. His sexual interests subsequently shifted to young teenage girls (12–18 years), which he followed through his use of magazine, video and internet pornography. He engaged in voyeurism, which entailed episodes of masturbating whilst spying on his neighbours in the dark. He also masturbated over the underwear of his mother's young female lodgers. On one occasion he had attempted to expose his erect penis to a woman on a bus, although it appears that she somehow failed to notice this. Adam's work as a freelance artist regularly brought him into contact with teenage schoolgirls and although he had not actually attempted to enact any of his sexual fantasies, he was nevertheless concerned that he might yet do so. He sought psychotherapy in order to prevent this from happening, to reduce what he described as his 'addiction' to paedophilic Internet pornography, and to find out why he found it so difficult to establish long-term relationships with women of his own age. In the initial sessions Adam gave free reign to his extensive skepticism regarding the potential value of psychotherapy, and made it clear to me that he saw little relevance in discussing his past or in exploring his dreams and fantasies as a means of seeking a deeper understanding of difficulties.

Notably, Adam did not have a computer of his own, deploying instead his mother's computer to access pornography (and concomitantly devoting a great deal of time to 'covering his tracks' once he had done so). While this arrangement was initially presented to me as a strategy for minimizing the likelihood of his activities being detected (he avoided credit card transactions for similar reasons) and for reducing the risk of a spiraling 'addiction' to what he referred to as his 'drug', he subsequently divulged a complex series of sado-masochistic fantasies in which he was both humiliated by his mother's discovery of his activities whilst simultaneously utilizing his humiliation as a means of sadistically attacking his mother's evaluation of her own abilities as a parent ('mother, look at what kind of a son you've raised! All this really is your fault!'). In these scenarios, both sadism and humiliation appeared to have become sexualized as a defence against anxiety and the risks of narcissistic depletion. In such instances, the search for the mother's hatred may constitute a reaction against maternal idealization, so that in reaction against an ersatz 'love', hatred is sought out "as a minimal sign of authenticity" (Leader, 2008, p.82).

In terms of the possible relevance of these observations to technique, it was notable that Adam's oscillation between sadism and masochism paralleled to a notable degree the movement from thick to thin-skinned narcissism alluded to earlier. It subsequently became apparent over the course of our work that any interpretations I might attempt to offer could only be used by Adam whenever his narcissism was neither omnipotently defended against (making him inaccessible to interpretation) nor too fragile and depleted for him to tolerate the narcissistic 'wounding' inherent within the act of interpretation.

Ethics

Cases such as Adam's present the therapist with complex ethical dilemmas and boundary issues, including those related to the nature and limits of confidentiality; the place of 'risk management' in psychotherapy; and the ever-present possibility of perverse and collusive enactments occurring between the therapist and the client in the course of the therapy. While Codes of Practice and guidance documents can be of assistance to practitioners in terms of highlighting principles and parameters, they cannot by their very nature provide an unambiguous algorithm for guiding discrete action in specific cases. While there is general agreement that confidentiality should not be maintained if the client presents as an imminent risk either to themselves or to others, the therapist (in conjunction with their

supervisor) is still left with the difficult task of determining (and possibly having to justify to third parties subsequently) their threshold for deciding when to break confidentiality.

While any decision to disclose specific information to third parties should (if at all possible) be discussed with the client beforehand, this may not always be possible in practice due to concerns that the actual process of doing so may itself inadvertently contribute to a catastrophic outcome. On the other hand, if the level of confidentiality offered by the therapist is too low, then there is also a risk that the client will minimize disclosure (or engage in 'pretend' therapy to satisfy the demands of external referrers, for example), thereby neutralizing the therapy and leading to an increase in risk due to drop-out or pseudo-compliance (see Bollas & Sundelson, 1995). In cases such as Adam's, the therapist will frequently be faced with the complex and anxiety-provoking task of determining (insofar as this is possible) the extent to which violent or deviant fantasy may act as a 'rehearsal' for offending or, alternatively, as a sublimation and displacement for violent/deviant impulses (see Howitt & Sheldon, 2007). In all instances, the nature and the limits of confidentiality need to be carefully negotiated with the client from the outset.

With respect to the ultimate aims of treating clients displaying a paedophilic orientation, I would concur with the viewpoint of those who argue that there "…is no need for the paedophile patient to be 'cured' of his sexual orientation to children; rather, he can be helped to develop an understanding of himself in relation to his social world with all that entails, i.e., the impossibility of enacting his sexual desires. This increased emotional connectedness to himself will allow him to be aware of something in the other as much as in himself, i.e. a child who should not be abused" (Woods 2007, p. 219).

How Trauma Can Become Triumph

The second session started with an unplanned delay, as a mix-up with reception meant that I was not informed that Adam had arrived on time. I waited in my office for 10-minutes before walking round to see if any message had been received-only to find Adam literally cowering in a side-corridor away from the main waiting-room. I remember being struck by his presentation, as much of the first session had consisted of Adam demanding-in a manner that I experienced as being petulant and narcissistic (thick-skinned)-for total control over the scheduling of our sessions. I had been equally intrigued by my counter-transference on this occasion, which was to respond to these demands in a manner that I subjectively experienced as being stern and somewhat abrupt in manner. It was only subsequently that I came to speculatively conceptualize my counter-transference response as an unconscious attempt by Adam to communicate a reparative need for a boundaried father-figure who could place limits upon his demands.

Adam was very shaken by this hiatus, and I found myself (at his request) pouring water from a bottle I kept by my chair into an empty plastic cup that he was holding (suggestive, perhaps, of a successful attempt to 'control' the therapist through projective identification?). After he had become more settled, Adam asked if I had 'forgotten' about him and I initially responded by explaining briefly the confusion at reception. Adam seemed reassured by this, and subsequently related his anxiety-state to memories of his mother 'forgetting' to collect him from the school gates, incidentally providing some indication of the transference dynamics that had been evoked in the session by this incident. I also attempted to understand the communicative aspects of the counter-transference, and how Adam seemed to locate me successively within what Bollas (1999) has described as the paternal and maternal orders of intersubjectivity.

In the next session (and for numerous sessions subsequently), Adam was-more-or-less-10-minutes late. He invariably had a more-or-less plausible explanation for this: but over time we were able to explore how he had covertly sought to reverse our respective roles by ensuring that I would now wait for him. This dynamic could be seen as an illustration of Stoller's dictum-that for the perverse character trauma is transformed into triumph (Stoller 1986, p. 59). It also exemplified the manner in which Adam sought to defend himself against events he experienced as 'traumatic' through

a reversal of roles entailing an identification with the aggressor (Freud, 1936/1993).

Sex, Lies and Videotape

In addition to whatever artistic merit they may have possessed, Adam's creative endeavours provided a complex series of aesthetic representations of his internal object-relations. To give two brief examples, Adam planned a work of conceptual art that entailed making a video of him having sex with a woman he had started a relationship with, while emphasizing to me at great length that this was 'art', and not 'pornography'. The fact that Adam had already established a link between his artistic and sexual activities (albeit only to disavow or negate this connection) meant that we were already some way towards understanding the complex process of partial repression coupled with partial idealization that contributes to the subversion of artistic creativity into aestheticism and sexual fetishism (Chasseguet-Smirgel, 1985). The relational dynamics underpinning Adam's artistry were prefigured in an earlier endeavour that he viewed as being part of the same artistic sequence, for which a previous girlfriend had provided a taped voice-over taken from Shakespeare's Hamlet-a play which, as Freud has noted, "…has its roots in the same soil as Oedipus Rex" (Freud 1900/1991, p. 366). In the course of examining his motivations for utilizing an extract from this play in this context, Adam was able to discuss the parallels that he thought existed between his mother and himself, and the incestuous bonds linking the character of Hamlet to his mother, Gertrude.

In a subsequent project, Adam made arrangements to video his father answering a series of personal questions concerning his past that mimicked and reversed the father/son relationship, and that subverted the distinctions between the artistic and therapeutic frames. It was in the course of this project that he discovered that his father had used prostitutes when he lived in Africa. Once he found this out, Adam announced that this project had been a 'failure'. Adam was subsequently able to acknowledge that his ostensibly artistic endeavour was essentially a smokescreen covering an attempt to create a situation in which he could establish an intimacy with his father that he felt had always been absent from their 'real' relationship.

This stratagem could be thought of as an attempt to transform an earlier trauma into a later triumph through taking on the role of 'reparenting' his father, although I think it would be more accurate to say that it marked a last-ditch attempt by Adam to manufacture an artistic simulacrum of the therapeutic frame in a desperate effort to heal himself through becoming his father's own 'healer'. This exemplifies Chasseguet-Smirgel's observation concerning the "… the apparently mysterious links between perversion…and aesthetics. In effect, the pervert often needs to surround himself with a exquisite and precious décor where he can contemplate the reflection of his idealized self, his anal phallus masked under an elegant disguise" (Chasseguet-Smirgel 1981, p. 527).

This kind of acting-out and role reversal was also enacted within the sessions. For example, in one session Adam began by commenting on my new spectacles before asking me why I chose them. When I responded briefly to this enquiry, but failed to elaborate, he became explosively angry. He went on to describe my response as 'banal', and insisted that people spent hours choosing their spectacles, as the process of choosing them revealed a great deal about their psychology. We eventually established that, by asking me about my spectacles, he was covertly seeking to set up a scenario in which I would discuss my thoughts and feelings about my choice, thereby giving him an opportunity to take on the role of therapist/father, just as he had sought to do with his real father through the use of artful mimicry masquerading as artistic mimesis. Once Adam had become calmer, we were able to think through and discuss the implications of this enactment (Bateman 1998, pp.12–13).

Adam's dependency upon grandiosity to compensate for an underlying sense of inner emptiness was also enacted within this same session. This enactment began with Adam congratulating me, in a manner that I experienced as being exceptionally patronizing, on having such an interesting client, before musing on whether I should be paying him, as it was clear I was learning so much through my

work with him. While this was undoubtedly true, I did not think that it necessarily followed that I should therefore be paying him for the privilege of learning from our work together. When I acknowledged as much, and asked him if he was suggesting that he thought he should become the therapist while I became the client, he became angry, exclaiming that as he was an artist he should be paid accordingly. Further investigation uncovered a recent humiliation concerning a failed attempt to date a woman he met in the course of an ongoing arts project, and we were able to establish that beneath the thin veneer of grandiosity he was desperately trying to fend off feelings of inner fragility and worthlessness. This sudden shift from grandiosity to vulnerability can also be thought of as illustrating the speed with which a shift from a thick to a thin-skinned narcissistic state of mind can take place within the psychotherapeutic process.

A Countertransference Enactment

It has been suggested that patients with a perverse characterological structure (which, to a certain extent, means all of us), "…may seek to turn the analyst into a perverse partner or accomplice" (Carignan 1999, p. 911). The following vignette provides an illustration of how this can happen.

At this session Adam arrived with a plastic bag and announced that he now felt sufficiently comfortable with me to discuss in detail his masturbatory fantasies. He then asked if he could read these fantasies to me from some notes that he had written down. I initially responded to this request by asking him to elaborate on why he couldn't discuss these fantasies with me without reference to a pre-arranged script. Adam said that he felt that in the absence of this 'script', he would never be able to give an in-depth disclosure of his fantasies. At this juncture, I felt I was faced with something of a dilemma (which, with the benefit of hindsight, was perhaps a warning that something was amiss), as I was concerned my refusal to agree to this could be interpreted by Adam as containing a double-bind sub-text, in which I would have communicated something to the effect of: "Be open with me, but don't bring me anything I can't handle". As a consequence of these deliberations, I eventually agreed to Adam's proposal.

Having received my 'consent' to this, Adam proceeded to take out a sheaf of papers from his carrier bag that he began to read from. It was only once he had done this, that I realized that his 'script' actually consisted of a palimpsest of pornographic pictures of teenage girls downloaded from the Internet overlaid with a handwritten text in which he described his masturbatory fantasies. By now it had become clear that, by acquiescing to this request, I had also allowed myself to become ensnared in a perverse collusive transference-countertransference, in which Adam and I enacted the role of two prurient schoolboys masturbating over illicit pornographic magazines (reminiscent of Adam's initial adolescent encounter with pornography discussed in previous sessions).

Having allowed myself to become enmeshed in this way, I felt that the least damaging option was to allow this enactment to run its course, monitor its consequences, and to subject these consequences to analysis in subsequent sessions. By this stage, I had already colluded in the formation of a reciprocal object relationship within which I was primed to enact the role of a punitive and rejecting superego or of a weak and collusive father. I therefore attempted to find a third position that steered a course between overt rejection (sadism) and its hidden counterpart, covert voyeurism (masochism). The level of countertransferential vigilance required was such that at the very end of the session I heaved an unobtrusive sigh of relief just as Adam was standing at the door and about to leave. Adam then suddenly turned to me, pushing the bag of pornography in my direction, whilst saying in a very child-like voice, 'but what if I'm hit by a bus on the way home?' The implied invitation mimicked a perverse child-parent interaction, within which there existed both a complicit invitation to 'clean up' the mess made by a naughty and recalcitrant child coupled with a covert 'test' to see if I would succumb to his 'offer' of illicit pornography (with Adam now operating as my prospective 'pusher'/supplier). I quietly declined both 'invitations' by responding to these implied requests with a "see you next week" as I closed the door. Subsequently I

tentatively conceptualized this episode as a partially successful attempt to recruit the therapist through projective identification into the role of a weak father who fails to set limits and colludes in the creation of a perverse identification in the transference.

Bateman (1998) offers the following illuminating commentary on the dynamics of enactment-

> *"Enactment involves the analyst as participant, vulnerable to his own transferences, susceptible to 'blind spots', and caught up in the relationship rather than alongside it…there is a theme of enactment as a positive force in treatment, even to the extent of suggesting it may form part of a corrective experience…Following enactment the analyst extricates himself, separates his own conflictual participation from that of his patient and guards against becoming self-punitive about his failure to maintain neutrality, thereby enabling the enactment to lead to understanding and progress…I consider [enactment] an inevitable occurrence in psychoanalytic work and it may be either to the detriment or benefit of analysis" (Bateman 1998, pp. 12–13).*

In subsequent sessions, I tentatively formed the impression that this enactment, whilst technically regrettable, may on this occasion have paradoxically served to consolidate a positive therapeutic alliance that was largely devoid of perverse and collusive elements. The complex relations that can exist between emotional nourishment and toxins have been described in the following illuminating terms-

> *"Emotional toxins and nourishment often are so mixed as to be indistinguishable. Even if they can be distinguished, it may be impossible for an individual to get one without the other. In order to get emotional nourishment, one may have to take in emotional toxins" (Eigen 1999, p. 1).*

Two Dreams

The first dream was recounted about 1-year into the therapy and was initially recounted towards the end of the session. The tone of Adam's voice was overtly regretful but covertly seductive, as he told me that it was a pity the session was coming to an end, because he had a dream to tell, and he knew I liked dreams (intriguingly, while I had never actually said this to Adam, he 'knew' this to be the case regardless).

> *It is night and Adam is climbing a ladder that leads up a very high tower. He has been set a task for which he has been given instructions. However, he also believes he has found a better way to fulfill his task and so he disregards the instructions. There is a rope around Adam's waist. He is dragging a heavy weight far below him, but he can't see what it is. He has to reach the top of the tower, but he doesn't think he can make it. He also thinks that he can't get down again. The mood in the dream is one of longing coupled with hopelessness.*

As there was only a very brief time in which to respond to this dream, I initially limited myself to commenting on how I had experienced Adam's narration as a kind of attempted seduction in which I was invited to take on the role of the needy supplicant. I also related my response to an earlier anecdote in which Adam had talked about two books he kept by the side of his bed. One of these books was about the use of positive thinking to heal cancer, while the other was a novel entitled *American Psycho* by Bret Easton Ellis. Adam had talked about how when he had female company, he placed the former book uppermost, placing the latter book on top whenever the company was male. He had talked about how he tried to seduce women by adopting a 'new man' persona that he associated with the book on positive thinking, a book that notably promoted the notion of self-healing without reference to the other. In contrast, Adam associated *American Psycho* with his subsequent attempts to 'dominate' these same women once they had been seduced by his 'new age' persona. It was within this frame of reference that I remarked to Adam that his 'American Psycho' persona seemed to have appeared in the session in the manner in which he had related his dream to me.

I also remarked upon the ambivalence implicit in his timing, which suggested that he wanted to tell me the dream, but did not want it to be used as a source of potential understanding. Adam acknowledged as much, having stated previously that he hoped I didn't interpret dreams, as he believed dreams were 'a load of baloney'. On such occasions, the spatial and temporal boundaries of the therapeutic frame can take on the functions of a 'mirror', in which the

client's attitudes towards the existential givens of life are enacted and have the potential to be worked with in situ in the course of the therapy.

Perelberg considers the following propositions to be central to contemporary approaches to dream analysis-

> *Dreams are expressions of the patient's current state of mind.*
>
> *Dreams, transference and the psychoanalytic process are connected.*
>
> *Both the experience and the content of dreams should be expressed in analysis.*
>
> *Attention should be paid to both the quality and usage of dreams in the course of an analysis.*
>
> *(Perelberg 2008, pp. 34–35)*

Adam's first dream may have represented a failure of Oedipal triangulation, involving a dream-subject who is striving to attain an "omnipotent phallic identity" (Perelberg 2008, p. 80) whilst simultaneously being dragged back down to earth by an unseen (maternal) weight that is attached to him (or to which he is attached) by means of an umbilicus-rope. The imagery of this dream could be linked to Adam's repeated descriptions of himself as someone who was constantly striving to achieve exceptionally high ideals (driven by the persecutory admonitions of a destructive super-ego) that were invariably subverted and fragmented into a plethora of perverse and narcissistic 'solutions' designed to prop up a fragile and beleaguered sense of self.

The second dream was as follows-

> *Adam is in a high and inaccessible castle looking through a slit window at a young teenage girl who is sunbathing in a garden. He has a dim awareness that there are other shadowy figures inside the castle who gaze out from the windows upon similar scenes, but the only figure whose identity he knows is that of his father, although for some reason they are unable to communicate. As Adam is looking out the window a little girl comes up to him and he puts his hand down her knickers and begins to touch her. In the dream he feels protected, inaccessible and lonely.*

In this dream, the castle is inaccessible and offers opportunities for voyeurism suggestive of Adam's paedophilic Internet activities. Adam associated the two young girls in the dream with his nieces, about whom he had intense sexual fantasies that he experienced as disturbing and upsetting. The father/therapist is represented as notionally present, complicitly silent and effectively incommunicado.

The abuse of the little girl could be interpreted as a classic wish-fulfillment dream (Freud, 1900/1991). The vaginal symbolism associated with the 'slit windows' could also be suggestive of a malignant regression to the womb. The presence of the incommunicado father within the castle could be interpreted as evidence of a perverse identification with the father (vis a vis his use of prostitutes) coupled with a failure of the internalization of the father as a psychological function that can structure differences between the sexes and the generations, and set limits to transgressive desire (Chasseguet-Smirgel, 1985). Intriguingly, it has been suggested that the Internet itself can be viewed as sharing many of the characteristics of a powerful, all-knowing parent who relieves boredom and loneliness; who can be summoned at will; and yet who is unable to say 'no' (Wood 2007, p. 176).

Psychic Retreats as an Organizing Pathological Structure

The second dream can be viewed from a range of perspectives-including that of psychic retreat (Steiner, 1993). The complex role of the psychic retreat as a defensive structure in Adam's psychopathology was expressed in the course of the therapy in terms as diverse as his protracted musings on Thomas Mann's *The Magic Mountain* (in which the protagonist undergoes a 7-year sojourn in a mountainous retreat) to his actual withdrawal for extended periods into his flat, during which he would spend much of his time lying on his sofa trying to fend off feelings of encroaching depression and inertia by retreating into grandiose fantasies.

The deployment of psychic retreats as a defensive pathological structure was a recurrent feature throughout my work with Adam. This was further illustrated, for example in an Oedipally

tinged fantasy that Adam elaborated upon at some length over the course of several sessions. In this fantasy, both Adam and his then-girlfriend lived in an isolated 'new age' community in which, by dint of their superior spiritual wisdom, they effectively 'ruled' over all the inhabitants as 'king' and 'queen'. However, over the course of Adam's therapy, the more ostensibly benign and 'spiritual' features of his fantasy began to unravel as he began to acknowledge the extent to which his fantasy was fuelled by feelings of rage, frustration and envy, against which he deployed the 'manifest content' of his fantasy as a psychic retreat that sequestered a 'latent' omnipotent narcissistic defence.

Conclusion

After 15-months of once-weekly psychotherapy, I referred Adam to the Portman Clinic (a specialist service offering forensic psychotherapy on an out-patient basis), where he was accepted for 3-times weekly psychoanalytic psychotherapy. My reasons for making this referral were twofold. Firstly, I was making preparations to return to Ireland and would therefore be unable to continue with our work; and secondly, both Adam and I felt he could benefit from a more intensive long-term psychotherapy that was not available in his current treatment setting. More specifically, beneath the episodic grandiosity that Adam exhibited, there was a strong sense of an as yet unreached underlying despair over lost and damaged internal objects, hinting at an unconscious experience of early developmental catastrophe that I felt was very difficult to reach in the context of the once-weekly psychotherapy I was able to offer. In the final session Adam expressed his appreciation both of the work we had completed thus far, and of the opportunity he was being given to engage more intensively with his long-standing and deep-seated difficulties around sexuality and relationships.

With respect to any potential benefits that this phase of his therapy might have had for Adam, my impression is that these were essentially limited in scope, but that it was nonetheless beneficial with respect to forestalling any propensity within Adam to act out his deviant fantasies, and to instill within him a deeper commitment to addressing on a more long-term basis his underlying psychopathology. I think it is important for therapists working with clients with complex needs, such as Adam's, not to let their therapeutic ambitions out-strip a more modest and realistic appraisal of what can be realistically achieved-and particularly within the context of a therapy that is time-limited with respect to duration and frequency of sessions. When Adam began therapy, he was highly sceptical as to its potential value for helping him address his problems. As a consequence, his initial engagement with me was hedged round with ambivalence (and, indeed, continued in this fashion-albeit to a gradually attenuating degree-to its conclusion). Yet despite this unpromising start, by the end of this particular phase of his therapy, Adam was willing to commit himself to a thrice-weekly long-term psychoanalytic psychotherapy.

This commitment in itself constituted significant progress for Adam, insofar as it evidenced a growing capacity within him to face up to some very difficult truths about himself and about what his life had become. This required Adam to tolerate a difficult therapeutic journey that was at times experienced by him as being deeply wounding to what could perhaps be described as his narcissistic omnipotent character structure (Rosenfeld, 1987). While we may often feel impelled in the counter-transference to try to distance ourselves from the very particular difficulties faced by clients such as Adam, his eventual decision to embark on this journey (despite the pain that this involved) is something that I believe we can all learn from.

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Diana Shmukler

Containing the Self and Other During Times of Mutually Created Enactments: A Personal Perspective.

Abstract

This paper has been developed from a response that I gave to a presentation, by Patrick Casement for Confer in London, Nov., 2007. I have taken the opportunity of elaborating on my initial thoughts and ideas and am grateful to be able to turn these into a written form. The paper thus in some ways is a tribute to Patrick Casement's contribution to psychotherapy while at the same time it provides me with a vehicle to describe something of the integrative position that I have come to adopt to psychotherapy. It has also created the opportunity for me to critique the broader field from a personal perspective. By way of introduction, I shall begin with a brief overview of the presentation in question, make a few personal comments in order to contextualise my response, and embed it in a theoretical and clinical frame,

Introduction: Working Through Early Trauma in the Transference

Patrick Casement's paper used material from a case of his originally described in 'On Learning from the Patient' (1985) where he presents a clinical example of the analyst's need to become the 'failing parent in some sense,' in order for the patient to recover the emotional memories that were suppressed at the time of the original trauma. This paper has become controversial and generated much discussion in that Patrick describes how, after much consideration, he refused the patient's request to hold her hand as she accessed the early trauma. This resulted in her recovering the memory of how her mother had fainted when she was about to have an operation below the age of two, leaving the young child alone with unbearable feelings. He used the new material to illustrate a number of important clinical ideas, particularly the notion of 'frozen trauma', 'self holding' (see below)

It is important to note that I practise as a psychotherapist and not a psychoanalyst. This is pertinent because it immediately speaks to the influence Patrick Casement's ideas have had on the broader field of clinical work and the enterprise of helping troubled people, beyond the analytic couch. In other words his powerful understanding and very accessibly written and widely read books have become extremely relevant to the clinical work, whether we call ourselves Independent Analysts, Relational Psychoanalysts, Psychodynamic Psychotherapists, Integrative Psychotherapists, Body Psychotherapists, Counsellors etc. The list of interested audience includes the involved public, clients, patients and others drawn to understanding themselves and themselves in relation to others and our fascination with and fear of knowing more about our conscious and unconscious selves.

In the last decade or so, the theoretical field in the helping professions, which was and of

course still is very diverse, has begun to come together and to coalesce around the notion of 'relationship'. In other words, there is a recognition of a common factor, that it seems above all else determines the efficacy of the work; this being the therapeutic relationship. The quality of this relationship seems to be fundamental to the outcome of the work (Greenberg, Rice and Elliott, 1993). Within this broad frame of helping relationship, whether we pay attention to, both the conscious and the unconscious factors or not, it seems that it is crucial for a therapist to be able to capitalise on the 'therapeutic relationship'.

What happens as we clincians listen to or read about clinical material, which has the function of demonstrating how the theory supports the work and practice we are reminded of our own cases. Thus I see one of the purposes of a presentation or a paper like this is to stimulate clinical thought and discussion. Further to allow for reflection on one's own work and ideas in relation to it. Furthermore it is in this area that Patrick Casement's contribution to the broad field lies. He has a particularly gifted capacity to 'use himself' in the service of the work and read the unconscious as well as the conscious communication through his sensitivity and containing capacity. In addition, his work also remains very close to the clinical experience. A hall mark of Casement's work is his belief in therapy being patient led rather than theory or therapist driven. His first book widely read and translated into many languages is called 'On Learning from the Patient' (1985) epitomising this stance which trusts the patient to 'know' consciously and umconsciously where the work lies. This knowing often out of our awareness emerges in sensitive process-led work.

Finally, by way of an introduction to frame this discussion, I need to mention that I have been extremely fortunate and privileged to work with Patrick Casement, who has not only supervised my work for many years now and also has been an inspiration, a teacher in every sense of the word and a wonderful mentor.

In this paper I will use therapist/analyst and analysand/patient/client interchangeably.

My Integrative Perspective;

My theoretical frame is an integrative one. It is an integration of a developmental perspective on human functioning, psychoanalytic views of unconscious processes, with some influence from the humanistic movement which was the basis of my early training as a psychotherapist. Furthermore, I too have been influenced, as have many other relationally thinking practitioners, by the recent surge of knowledge from neuroscience, attachment theory and the research on the importance of the therapeutic relationship to psychotherapy

Specifically, in the last few decades or so, the wide and disparate field of ever new forms of psychotherapy has started to come together around the notion of relationship work. This has been given impetus by the research on the effeciacy of psychotherapy as the 'common factor' (Greenberg, Rice and Elliott, 1993). In support of this relational perspective is the infant research such as for example Beebe and Lachmann (1998) as well as the neuroscience see (Schore, 2003).

As a theoretical frame for thinking about clinical ideas, I have been particularly influenced by Winnicott's (1958, 1965, 1971, 1989) ideas since I began working both as a therapist and prior to that as a researcher into factors of competence, play and health in children's development. I found in Casement's views a shared appreciation and resonance with Winnicott's ideas.

Thus Casement's thinking about clinical material as well as some of his early influences integrated well and are highly compatible with this developmental perspective as well as some of my early work. Elsewhere I have described my integrative perspective as one that is led by a developmental frame integrated with psychodynamic views of the importance of conscious and unconscious motives (Shmukler 2001, 2003, 2005). In the last decade or so I have been powerfully influenced by the relational school originally formulated by Stephen Mitchell in New York. (Mitchell: 1988 Aron, L. and Harris, A. 2005).

I found in thinking and writing about these issues, that it is extremely difficult to

establish a linear argument to the ordering of the theory, because as Madeline Davis and David Wallbridge so long ago in their book Boundary and Space (1985) commented on Winnicott's ideas, that they are interelated and somewhat circular so I do come back to and at times and make similar and seemingly repetitive points in this discussion.

Working with Early Trauma and States of Regression

The therapeutic benefits of regression and its management have long been debated in the field of long term psychodynamically based psychotherapy. In the current focus on a relational stance and the importance of the therapist's subjectivity to the process, this becomes particularly stressful when we consider the demands on the therapist in the cases of early trauma, with the resultant regression that occurs in clinical settings. It is important for me to add, that I agree with Casement's position that we do not 'make' the patient regress but attend to the regression when it inevitably occurs by the very nature of the dynamics constructed in a therapy process, although in the past I have written about therapeutically induced regressions. (Shmukler 2001, 2003). Working as I did then from a humanistically oriented perspective as a Transactional Analyst it was common to 'invite' clients into 'Child Ego States', which can be conceptualised as earlier states of functioning. This style of therapy, positioning the therapist as a 'Parent' or 'Adult' in the client's mind allows for powerful and helpful interventions to be made. The problem of reliance and dependency on as well as idealisation of the now 'benign therapist' however remains.

On the other hand under the right clinical conditions, regression is not only necessary but also inevitable. Regression seems to occur to the point of trauma in the patient's life, often early life.

I will for the purposes of this paper describe some of my own clinical work which has been previously described and presented not only with the patient's knowledge and permission but her wish that aspects of the treatment be shared with a wider public. During the course of her therapy she was both encouraged and supported by reading accounts of the treatment of others, with whom she could identify such as Nina Herman's 'my Kleinian Home'(2001, first published in 1985). The fragments described here will also be published in a far fuller and more detailed description of the work. I am using some examples from this work to illustrate some of my current thinking.

I began to work with this patient/client who had, had many years of therapy with a number of different humanistically trained therapists, who had successfully helped her to refrain from abusing her own children and helped her begin to train as a psychotherapist. However, she was far from well although when we began working her previous male therapist suggested to me that she needed a few sessions with an experienced woman therapist in order to 'finish off her work'.

The work described centres around early trauma in which aspects of it were both known and also unknown. One of Freud's original great insights of course has to do with how early trauma is related to subsequent problems in adult life. Furthermore given the right conditions, this trauma begins to be re-experienced in the clinical setting. It is this re-experience under different relational circumstances that allows for the alteration of significant processes in the psyche.

'Frozen' Trauma and Unconscious Communication

Winnicott's (1958; 1965; 1971; 1989) contribution and influence on generations of practitioners is particularly in this area of early childhood experience and the significance of early relationships on subsequent relationships, relating and relatedness, as well of course with an emphasis on trauma or relational trauma. His life's work, was devoted to making sense of, and describing the process of psychic illness or disturbance, which he understood as having its orgins in early and often preverbal experience. Having said this, there are also aspects of his ideas that are not well understood or are often quoted without the practitioner being able to truly implement the implications of these in the clinical setting. It is some of these that I want to pay attention to in this work.

The understanding that traumatic experience becomes 'frozen' allows us to think about the nature of trauma and what it means in a useful way, whether in fact we conceptualise traumatic experience as repression, or as many contemporary theorists prefer to think, in terms of dissociation.

The recent developments in neuroscience, where researchers such as Schore (2003), Van der Kolk et al (1996), Panskepp et al (1998) show how trauma shows up on brain scans provide powerful hard evidence for Freud and Winnicott's ideas where they relied on clinical evidence alone. Their view, for example of how trauma continues to have an effect, by an ongoing need to repeat itself in the present through some sort of re-enactment, unless it is therapeutically addressed would be supported by the brain research.

We also now know from clinical evidence something about the precision of the unconscious mind: a clinical point for which the neuroscience provides us with hard evidence. Furthermore we now not only have the clinical evidence for how exactly the experience is recorded but also something generally about the unconscious communication.

Early on Freud understood the power of unconscious communication and the clinical value in being able to read it. He described this as two unconscious minds tuning in to each other the way that people tuned into radios in his day (see for example Gerson, 2004). Indeed this was one of the reasons for his insistence on psychoanalysts being analysed themselves in order for them to tune their own instruments more finely to the process of the unconscious as well as the conscious communication.

What then do we think of as 'frozen'? Surely it is the affective responses to the traumatic experiences? Those responses for which there were no containers and often no language. Winnicott, in the 'Fear of Breakdown' (1989), demonstrates his ability to use evocative descriptors which have the emotional quality in adults of "unspeakable agonies", "unbearable pain" or "falling forever' (p.176). Bion (1967) elaborating on Winnicott's notions talks about 'nameless dread'. These terms show that the actual quality of the experience is one 'beyond words' and often impossible to adequately put into verbal terms. In fact these experiences are communicated or conveyed to the therapist in another way.

An analyst or therapist needs to be emotionally available to experience, the quality of the emotional repression, or to the nature of the disowned affect. Today we understand that the previously problematic clinical expressions and manifestations labelled as 'acting out' are better thought about as 'enactments'. These are a form of 'unconscious co-creation' on the part of the therapeutic dyad. This unconscious collusion is now understood to be a significant communication between therapist and client/patient. In other words, something real happens between them, which could look like a 'mistake', a conflict, a problem of some sort. This process occurs in order for real feelings to be generated so they can be communicated to the therapist who begins to feel something of the patient's emotional experience that can't be put into words.

A very common example of this process is when the therapist 'forgets', makes a mistake with an appointment, goes away for the first time, gets something important to the patient wrong. All these are examples of something real going wrong in the relationship between them, generating real feelings often of guilt or scare or perhaps anger, but also a 'worry about competence' in the therapist. In fact the client may well accuse the therapist of lack of competence, a real anxiety for most.

The opposite may also happen, in that the patient may take responsibility for the problem or mistake. Children and patients often consciously and also unconsciously strive to protect the parent/ analyst from their perceived selves which they fear the original parents found to be too much. This process has been described by Casement as one of 'self holding' (Casement, 1985; 2002; 2007).

'Self holding' is also a reflection of the child's experience of lack of containment and early experience of the "unspeakable agonies": this being what Winnicott (1989) described as the "fear of breakdown". What he so eloquently and brilliantly understood was that much experience and defense against

anxiety was a protection of the psyche or an attempt to prevent a re-experiencing of an early breakdown that had already been experienced. Winnicott suggests that where a young child is subjected to emotionally laden experience beyond their comprehension and coping capacities, when there is no 'containment' or holding, they cannot manage the full experience of the trauma and so they freeze it –as not yet quite experienced.

Then, when there is the possibility of better holding and the mind is more mature, the frozen breakdown, which had occurred but not yet been fully experienced may become available to be experienced. Only then can it begin to be put in the past, having previously been held off as if it were still likely to happen in the future. Through now being able to experience the trauma in the present, with the therapist being able to survive going through it with the patient, the breakdown can become something that is now in the past rather than being kept for ever as if it were in the future, with the attendant defenses, still to be feared as something assumed to be unmanageable. (Casement, personal communication, London, 2009).

Therapists finding themselves bombarded by powerful affective experiences in the consulting room, demanding attention and effective containment can read this as a hallmark of early trauma. Equally a different example of real affective communication between therapist and patient is the well known and well described experience in the consulting room, of fighting off an overwhelming desire to sleep. This too is one that often happens in response to trauma and highly charged unprocessed affect. I see it as the mind becoming overwhelmed and wishing to escape this unbearable affect.

Here Winnicott sees that one of the main therapeutic tasks is one of survival, survival without retailiation, collapse and withdrawal, (as I come back to below) but ultimately to process and offer it back in 'manageable doses' to the patient for them to now be able to manage themselves without becoming overwhelmed, needing to act out or withdraw themselves in to some sort of sickness.

From the clinical example described above, work which can be thought of as an illustration of enactment follows;

At some point many years into this long piece of work, my patient signed up for a workshop run on humanistically based therapy. She came to a session announcing that she would be going to this residential process the next week and consequently would be missing our next sessions. When I made the interpretation that I saw this act as a direct attack on our work she felt both confused and attacked herself. In the next session, she opened it by asking whether I had changed my mind about her attendance at this workshop. I responded by saying that she sounded as if she were needing my permission whereas I had and still did see this unnegiotated decision as an attack on our work, particularly as many of the participants regressed in these workshops seeking some experience of 're-parenting'. I added that of course I could not stop her from attending. After much deliberation she cancelled going but remained angry with me for a months for preventing her. Gradually she began to see what I had meant by how her attendance would have undermined the work we were doing.

The Use of the Object (as 'Good Enough' and Bad Parent)

I want to now talk about Winnicott's (1971) late contribution and oft quoted notion, namely that of the 'use of the object'. As I have worked with Patrick and got to grips with the clinical relevance of this concept, I am now convinced that this is one of the most significant ideas for clinical practice (Casement, 2007).

It guides us in working with the negative transference, contains and helps us manage our countertransference responses. In addition it provides for a quality of change or transformation, that is the wish and hope of all of us, for our patients and clients. We engage with them and their developmental histories, with the hope of freeing them from their troubled past, so they no longer need to either recreate it in their present relationships or live with the defenses constructed early on which inhibit the expression of their real potential for relationship and creative living. This kind

of profound transformation clinically often demands that we, as therapists, allow ourselves to be used by our clients/patients in order for them to experientially be able to both recreate the past and have a different outcome. This process I believe leads to the changes seen externally in relationships and quality of life and will probably be able to be proved shortly by means of brain scans neurologically.

Another early concept of Winnicott's was seized on with great enthusiasm, particularly by those who were humanistically and 'client centred' in their outlook. And that of course was his very important idea of the "ordinary good enough" (Winnicott 1958; 1965; 1971) mother, together with the notions of holding and containing. From a development and clinical perspective this is central concept, valuable and important to parenting and therapy. Yet it has also led to much therapeutic work being thought about and conducted along the lines of, and I will put this in inverted commas, 'the better mother' syndrome. In my example above it was partly my objection to providing 'cure' this way that led me to feel so strongly about my patient wanting to attend a regressive workshop of this 'better mother' type, with a lot of encouragement for soothing the patient in the regressed position, leaving the therapist idealised and experienced as a benign and somewhat magical healer, creating also a great deal of dependency on therapy and the therapist for positive feelings.

Of course, providing some experience in therapy of good or better mothering/ parenting is essential. I won't now go into the reparative and healing effects of establishing and finding the positive relational elements so essential to healthy dvelopment, at this time confirmed scientifically by the neuro research both on the necessity for relationship on the developing brain as well as the traumatised brain (Schore, 2003).

What is pertinent to this discussion is to consider the seductiveness of remaining or trying to be 'the better mother' where we also need to consider and understand Winnicott's (1947) trajectory of the normal developmental process, the biological neccessity of aggression and how in the movement from 'relating' to usage a child/patient matures, separates and truly comes to develop a mind of their own. I believe that one of the greatest gifts we give our patients/clients is to provide them with the experience embedded in this notion of letting them use us, to become a representation of the 'failing mother'/the bad, abandoning, depriving even abusing parent. Among the individual and universal reasons that most therapists, psychoanalysts and counsellors come to do this work is the conscious and unconscious need to help, to heal and to feel 'good', useful and important. Thus it becomes very frightening when they suddenly find themselves not only cast in the role of, but actually experiencing themselves in these persecuting ways.

I return to the notion of self holding, which as I have explained is a defensive process adopted by traumatised children, and thus is one which we commonly find clinically. Through the experience of being held by the analyst, the patient can let go and begin to give up the need to hold the self. Consequently they no longer need to control themselves and others in relationships in this way which leads to particular relational difficulties and an inhibition of spontaneity and often authenticity in addition to anxiety. The patient believes it is only because they are holding themselves that the 'good' mother /therapist both cares for and survives being with them. What is needed is an experience of the therapist's spontaneous response to them and one that they haven't been able to control. They have often not even imagined that some-one could make a gesture towards them not because they had engineered, manipulated or even requested it.

Clinical Example (from Same Case Above)

As I began to understand the value of allowing the negative transference to develop fully,I in my work with the patient, I have already described, mentioned to her that she must feel somehow disappointed that the work, which was supposed to be a 'few sessions with an experienced woman therapist', was now stretching into several years and that in fact she was feeling no better and possibly worse than ever.

Her response, which Patrick commented was an excellent example of 'unconscious communication' was; 'Yes, perhaps I am somewhat disappointed but one thing I know

about you is that if you do not know something you will do whatever you can to find out about it.' I had recently started being supervised on this case by Patrick and had begun to change tack and had stopped seeing myself as the 'better mother', in the humanistic sense, but rather to allow the patient to find and experience me as the inadequate and at times frightening and persecuting mother. Although she had no conscious way of knowing about the change in my supervision clearly she had detected a difference. Thus this intervention opened the way for her to both feel and then express more and more of first her anger and disappointment and then finally the rage she felt towards me. She now began to be able to 'use me as a representation of the mother who had so desperately let her down'.

Most of us feel comfortable and able in the face and expression of the positive transference. Far more complex and painful for the therapist/ analyst is negative transference. Winnicott was well aware of this and deals with 'Hate in the Transference' as well as countertransference in, for example, his oft quoted and important paper 'Hate in the Countertransference' (1947) providing us with a significant theoretical container, because being 'hated is far more difficult to manage. Allowing and experiencing the 'patient's hatred is the gift of providing the use of the object. In other words we step into the negative projection and allow the patient to 'use' us as a representation of the bad object. For a time, when this works well,the patient truly experiences us as the 'depriving, neglectful, uncaring or even abusing' parent. By remaining steady, clear and consistent but non defensive, slowly the patient comes to realise that we are different to the past figure. That we have remained around and available for the feelings engendered by the projections, without collapse or retaliation, and thus the patient is not keeping us surviving or all right. The patient can begin to discover that we are actually able to survive without their protection of us. Another way of addressing the problem of 'self holding'.

In this conceptualisation Winnicott (1971) takes us beyond mere projection and the use of ourselves as a transference, even bad parent figure. He tries to help us to see that when a patient has been able, in phantasy, to destroy us—then to find that we have not been destroyed—it begins to become possible for the patient to use us in a different sense, as someone who has a reality beyond the 'object' in the mind that represents the Other. That 'other' in the mind has so often been experienced as going to collapse, as going to retaliate, and therefore as needing to be treated with great caution. Once the external Other is found to lie beyond the image in the mind and omnipotent control, then a new phase of relating begins to become possible. We are found to truly have a separate mind and reality that lies beyond the omnipotence of the patient's thinking. We are neither destroyed or created or even preserved by the patient's magical thinking or careful reactions to us. They can begin to relate with a new vigour, beginning to be able to count on our own survival (Casement, personal communication, London 2009).

Thus a sense of separateness is achieved, a true knowing that you have your own mind, a separate locus of energy and that the 'other'/therapist/parent has their own mind independent of the patient and even more so that the patient elicits love/care/attention and that the therapist gives this of their own volition. As I have said, the therapist/ analyst must survive without retailation, or collapse in the face of what at times can seem like unbearable emotional pressure. This is the essence of Winnicott's baby that says 'I hate you' and you are there in the same loving way surviving their fantasied destruction. Not only is this process central to growth and development but also to the healthy capacity to feel and express aggression in a way that is growth promoting and not destructive. We, as therapists, are called upon to hold, contain and bear states of extreme emotional assault, usually what the original parents could not face and thus what the patient believes is unfaceable by themselves or others.

In Conclusion

In concluding then with a few ending remarks I would like to mention a few of Patrick's comments on ending. This is an under developed area conceptually. Certainly from the psychotherapist's perspective work often ends prematurely due to external circumstances such as a client moving away. It is a relief to hear that,according to both Winnicott and

Casement, the patient wants to finish. It does not always feel that way. Further, that they can finish when they have 'bottomed out' so to speak. That the traumatic experience has an end to it and when the worst is understood we have overcome the 'fear of the breakdown'. The breakdown that has already happened. These paradoxical ways of speaking are Winnicott's genius of capturing the way the illogical/ unconscious mind functions and accurately describes something to us and to our patients of the psychological reality of inner experience. In Winnicott's mind an early breakdown occurs in the sense that the uncontained feelings and experience seems 'unbearable'. A defence system is created to ensure that the psyche never experiences such pain again. Although often the defenses cause a lot of discomfort and distress nonetheless they always feel preferable than the possibility of re-experiencing such a collapse.

What we now understand is that as therapists we really have to be there,present and engaged at the level that is required. I believe that patients know when the therapist's attention or mind wanders, when they themselves dissociate or think that it is all transference and therefore has nothing to do with them. Allan Schore (2003) talks about 'right brain to right brain communication', which recent sophisticated infant/parent research illustrates (Beebe and Lachmann, 1990).

I was once powerfully struck when listening to a patient giving me a moving account of her experience during the war where she was growing up in an enemy country. Suddenly, although I was gripped by this 'child's story' I had another picture of the war-time scenario. As I found myself distracted, although I had not said a word she suddenly turned to me and asked me if I had heard her last few sentences. In that moment it seemed clear to me that she had picked up how my attention had wandered. I understand that 'somehow', unconsciously, certainly unintentiously and out of my awareness I had communicated my distraction. As I analyse this further, I think that it was her unconscious testing to see whether she could in fact work with and trust some-one, who would have been on the enemy's side during the war.

These therapeutic engagements takes us to the edge of our own capacities because of the emotional states involved in traumatic experience, states or terror, rage, deep grief, shame and despair are the raw material of uncontained experience.

We are helped and supported in this task by our own therapy, supervision, theory and clinical experience of surviving. Ultimately too, the ability to go to the edge of human emotional experience is part of the challenge, the rewards and perhaps even some of the motivation for this very strange and 'impossible profession'.

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Catherine Butterly

How I see Myself as an Integrative Psychotherapist Short Overview of My Approach to Integration

Editors' Note

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

My model of integration is a work in progress as I try to develop my own particular way of holding different elements of myself, my clients and various approaches to therapy in some sort of creative tension. This is a challenge, in a field barely 100 years old and with a range of difficulties and tensions within each of the 'schools' themselves. The different schools have all developed their own processes of inclusion, exclusion, and discursive practises, which follow established rituals. I often inhabit a space therefore in this process of integration, at the edges of my own doubt. This process invariably confronts and questions what I am trying to integrate and whether this must necessarily begin with a theoretical/intellectual integration that guides practise. Or whether clinical integration is possible at some level even when theoretical integration is not always clear (Norcross and Goldfried, 1987).

My approach attempts first and foremost to acknowledge the hermeneutic/interpretive aspects of psychotherapy on a continuum with the empirical/scientific, in a dialectical in-between space of both/and, subject/object, interpretation/observation, which helps me elude the politics of polarity. Using this as a guiding principle, I hope to show how my integrative model hangs together as a frame, containing within it aspects of attachment theory, relational psychoanalysis, systems theory, developmental psychology and neurobiology, worked with clinically from a position of present moment awareness and with close attention paid to the relationship. The common denominator of these schools is an interest in intersubjectivity and how every version of the Other becomes in some way a construction of the Self.

It seems to me that we all exist at the margins of the unfinished…. the unknowable…. the as yet to be arrived at (Rudnytsky, 1993) and that psychotherapy theory needs to position itself in this arena too. The project of integration encourages curiosity and takes a wide-angled view of the human person. As a practitioner, I can create a personalised framework or attitude, within which there is freedom and flexibility to move around in different registers of theory and my own and my clients' experiences.

The dissertation is an exercise in finding the transitional space in what Winnicott (1989) referred to as, a third area between inner and outer life, in my own writing too. I need to move from the 'experience-near' sense of my own subjectivity, my childhood and life experiences, which have contributed to my therapeutic journey, while also being able to pull back from this force field to create an 'objective' space, where reflective function and mentalisation (Fonagy et al, 2004) can happen in the writing.

This happens in therapy too, when I as therapist must be available as both subject and object. This is not easy as I am drawn into different levels of experience simultaneously. The holding and facilitation of these paradoxical processes, subject/object, experiential/ reflective, happens in the transitional, relational, in-between space of therapy, where painful and destructive experiences/affects from the past can be kept company with in an enlarged, relational field in more creative ways.

The Values and Philosophical Assumptions that Inform my Model

My integrative model is informed by the belief that all human beings are unique, valuable and mysterious, in some respects unknowable to either themselves or others and that in their challenges and suffering they have a right to competent treatment.

I am influenced by phenomenological philosophy, particularly Husserl, Heidegger and Hegel (Moran, 2002), who in various ways studied how phenomena appear in our consciousness and is experienced without speculations or conceptions. Pre-reflective, primary self-awareness is subjective and facilitates experiencing in an immediate way. Reflective, objective consciousness follows on from this. Both of these processes are important in my therapeutic work.

Psychotherapy can be very useful in directing attention towards our immediate felt experiences –prereflective – (Stern, 2004) becoming objects of our own reflections and allowing them to be accessed intersubjectively. We can attend to this reflective self -consciousness in present moment awareness, where in the presence of another, we can become aware of this implicit sense of self.

Phenomenologists recognised that there is something about the human person which escapes reflection. No-one is either completely transparent to self or others because according to Heidegger (1986), life is in excess of our full comprehension. Merleau-Ponty saw awareness as embedded in an intersubjective matrix. Husserl was interested in the proprioceptive-kinaesthetic sense of the body, linking it to the infant's capacity for imitation (Moran, 2002). My use of neurobiology, attachment theory and relational analysis within present moment awareness in guiding my clinical practise, is consistent with these phenomenological underpinnings.

I feel that we are transcendent beings and that this search for the "transformative object" (Bollas, 1987, p. 22) whether found in art, literature, music, spirituality, others, therapy or less healthily in drugs or other addictions, has its trace element in our earliest psychic life.

I believe too, that the self has a fundamental need for relatedness and for an empathically attuned response from the environment. When we listen through the voice of the Ego to the hidden Self, a genuine contact with another human being can be made.

My View of Human Beings and Motivational Forces

I believe that all living things have a wired-in, biological inner nature which, given the right circumstances, allows the organism to unfold in a growthful way. The human motivational system is an intersubjective system and through reproduction and group bonding people can survive. Intimacy and belongingness play a powerful role in the forming and maintaining of groups, as we negotiate the continuum between attachment and separation/ individuation. Pankseep (2005) contends that all of our affects from rage to joy are part of our evolutionary equipment serving adaptation.

Intersubjectivity has a primary place in human motivation, because we need to read each other's intentions, signals and feelings. We share our subjective worlds in order to first survive and love. Brownlow (2001) identifies five fundamental motivations – the need for attachment and affiliation, physiologic regulation, sexual pleasure, assertiveness and exploration and the need at times to react aversively and withdraw.

Stern (2005) maintains that this need to share our subjective worlds is critical for healthy psychological survival and can be seen most clearly in its absence. People with autism,

who do not appear to be immersed within an intersubjective matrix, appear unable to read the mind of the Other. This 'mindblindness' can lead to significant intersubjective failure.

Imitation and attunment allow intersubjective links to form in early life. Reciprocity, too, is seen across cultures in children's play. Later, imaginary friends allow the young child to stabilise the self by creating a dialogue with another. And when we fall in love there is an exquisite paying attention to this two-person world as we find ourselves intimately in the gaze of the other.

Pre-wired Role of Intersubjectivity

There is a growing body of evidence from empirical infant research too-(Beebe and Lachmann, 1998), neurobiology (Schore, 1994) and clinical work in relational psychoanalysis (Ogden, 1994) and (Kriegmann and Slavin, 1989), showing that psychological function is organized by pre-wired biological capacities. Gentle (1998) refers to this as an "a priori deep structure" (p. 67), which motivates humans to make meaning together along biologically determined lines. She believes that shared and universal patterns that demonstrate intersubjective meaning's evolution also shed light on how individual subjectivity is organized. She argues that, although this pre-wired intersubjective motivational system can be described in an 'a priori' way, it can only be known phenomenologically in a subject/subject relational context. Psychotherapy creates a context for this evolutionary process "which already exists but awaits creation" (p. 75) in the moment-by moment unfolding in the intersubjective space.

I believe that all humans are motivated to make meaning and that this unconscious meaning-making begins in a silent dance with our earliest caretakers. Only later in development can language be used to symbolize this process.

Human Development

In the past twenty years or so, there has been a convergence of ideas from the disciplines of neuroscience, developmental psychology and psychoanalysis. I am interested in this convergence, because it sheds light on human development from both the structural perspective of right brain development and the functional processes of the unconscious mind. Neural connections, from which the mind emerges, are shaped by our earliest attachment relationships.

In order to understand both functional and dysfunctional human development, it is important to conceptualise how the Self is constructed and how developmental derailments happen.

Construction of Subjectivity

I believe that the Self is constructed within a relational process of being with an/Other, shaping affect, dynamic unconscious processes, behaviour and cognitions. This launches the human person on a developmental path, carrying with them all of the pruning and shaping of earliest relationships into each new encounter. The circle widens to include extended family, community, schools and bigger systems.

The 'self' of classical psychoanalysis is created through complicated processes of identification. The object relationists believed that it is within a network of intersubjective relationships, that a stable sense of self is formed. Subjectivity is an end rather than a starting point, of a long, delicate process of development, where interpersonal relations intertwine with internal mental structures. Psychologically essential selfobject needs can be met in early life, only through intricate processes with primary caretakers. (Kohut, 1971, 1977).

Winnicott (1960), whose thinking I draw heavily on in my clinical work, examined the struggle of the self for individuation while maintaining closeness with others. He considered the mirroring relationship vital for both baby and client. He saw the quality of object-relations between mother and baby at the centre of the struggle for an individuated existence and believed that there is "no such thing as a baby" (p. 39) only a mother-baby set-up. One might argue that there is no such thing as a client either, only a client-therapist dyad.

I learn too from Ogden (1984) who says, and Benjamin (1990) would concur, that the infant's way of being in the world and the patient's way of being in therapy involves a progressive move towards externality, by using the subjectivity of the mother/therapist to find a space in the mind of the other.

Bollas (1987) suggests that it is the entirety of the mother's way of being present with the baby that constitutes her transformation of the infant's being and with "a good-enough mother, a tradition of generative transformations of internal and external realities is established" (p. 34). He adds that "we learn the grammar of our being, long before we learn the rules of our language" (p. 36).

Schact (1988) notes that "there are long stretches of time, when it does not matter to the baby whether he lives in his mother's face, in his own body, or whether he is in many bits, as long as the holding allows him the experience of coming together from time to time and feeling something" (p. 518) I am informed by these psychoanalysts, by trying to remain alert to the coming together of bits of the client's experience in the room and its impact on both of us.

Relational analysts speak of the gradual unfolding of subjectivity in the earliest dyad, referring to the process as mutual recognition (Aron, 1996), mutual attunment (Benjamin, 2000) or mutual influence (Stolorow and Atwood, 1992). This seems similar at a structural level to affect regulation. (Schore, 1994) The young child thus begins to gain an emerging ability to attribute internal states to others.

The Self of Neurobiology

Attachment and Affect Regulation

Because emotion serves as a central organiser in the brain, different physiological responses are engendered by different attachment patterns. The work of some contemporary neurobiologists enriches my understanding of attachment. According to Siegel (1996) both the core (here and now) and the autobiographical selves are shaped by early attachment experiences, because the right brain, dominant at this time is the centre of subjective emotional experience. Schore (1999) argues that genetic potential is shaped by attachment experiences through the psychobiological regulation of hormones, which influence gene transcription and the baby's affective state. Fonagy (2001) has built on Winnicott's ideas in attempting to identify aspects of the mirroring stimuli that allow the infant to interpret the mirroring face as a reflection of his own inner state. Interpersonal neurobiologists are now building structural links with this functional process in their work with mirror neurons in the brain. Carr, Iacaboni et al (2003) see these neurons as representing intentional states of others and the emotional resonance, fundamental to all relationships.

I find Siegel's (2007) five basic elements for fostering secure attachment, very useful in my therapeutic work. At first, shared non-verbal communication connects two minds in a collaborative, communication. This facilitates a verbal sharing of internal experience which allows the baby to develop 'mindsight'. When attuned communication is disrupted, repair is needed. As the child develops, the adult can share coherent stories, allowing her to make sense of internal and external experience. And throughout childhood, by remaining connected to the child during times of dysregulated affect, attachment figures can help the child to self-soothe. He emphasises the child's need for both connection and solitude which helps her to become both an autonomous person and attached person. All of these issues play themselves out in one way or another in therapy.

Working Models of Attachment Relationships

The right hemisphere, which develops early in life, is the storehouse of experiences of infant attachment, according to Schore (2003). Regulating strategies for coping with stress, especially relational stress are laid down in these unconscious working models of attachment. Trevarthen (1993) contends that early neurobiological affective regulation becomes embedded in all subsequent intimate relationships. I take it as a given that the client's mode of experiencing and dealing with emotionally significant others, including me, will be influenced and/or distorted by early experiences.

For Bowlby (1981) parent-child interaction patterns become internal working models (IWM's), encoded at first at subsymbolic levels during sensori-motor development and later symbolically. Ammaniti (1999) contends that in situations that elicit attachment behaviour, these models organise strategies for regulating distress. Fonagy, Gergely, Jurist and Target (2004) digress somewhat, believing that by linking attachment only to relationships means that its importance for psychic development is somewhat overlooked. They view the Interpersonal Interpretative Mechanism (IIM) as critical because of its role in filtering genetic influences and regulating stress, attention and mentalisation. The development of the brain's major self-regulatory mechanisms are shaped by attachment relationships.

Following Fonagy and Target (1997) and Grossmann (1986), I view therapy as a way of opening space, where internal working models change through affect attunment and reflective function. Stern (1985) argues that with repetition, units of experience become generalised (RIGs) and form prototypes representing actual instances. These repetitive, defensive strategies lead to the unsatisfactory resolution of needs in repetitive, unhelpful adaptations (Gilbert and Murphy, 2000).

Optimistic neuroscientific findings suggest that the brain remains open to environmental influences throughout life (Barbas, 1995) A therapeutic relationship can elicit experiences and activate mental processes, formerly repressed by co-regulating neurobiological states. The heart of psychotherapy according to Cortina and Marrone (2003) and Diamond et al (2003) is an attempt to change one's relationship to one's own affects. Helping the client with both self and mutual regulation is a very important part of my therapeutic work.

Concepts of Dysfunction

Developmental Derailments

Developmental injuries become internalised and reproduced as neurosis and other problematic patterns. When derailment occurs, it can have a variety of consequences, depending on the baby's age, frequency and severity of misattunments, physical or sexual abuse or loss. All misattunments from minor to traumatic experiences dysregulate the vulnerable young person. Research indicates that exposure to stress in early life is linked with changes in neurobiology, and can lead to an increased risk of pathology (Heim and Nemeroff, 2001).

When our psychological needs are not met by caregivers, they are experienced intensely on the bodily/ affective level. Maladaptive patterns emerge when suboptimal strategies had to be adopted to get needs met, thus carving a permanent trace into the developing neurobiological networks (Schore, 2003).

Misattuned affective parental responses deprive children of core psychological structures. (Emde, 1990). Without good enough maternal care and an adequate representation of his own needs, the child begins to internalise the actions and reactions of others and the False rather than the True self develops (Winnicott, 1965).

Character Styles and Personality Disorders

I find it helpful to be informed by Erskine (2001), Johnson (1994) and Yontef (1993) on personality styles/disorders. Yontef (1993) sees a deficiency in exercising the ego-functions of self-regulation in the character disorders and a deficit in the ability to integrate polarities into wholes. Erskine (2001) speaks of cumulative traumas, "the little missed attunments, discounts, punishments and rejections-like grains of sand that pile up until they form a dune" (p. 5).

Johnson's (1994) "characterological-development perspective" (p. 3) offers an etiological perspective on character difficulties. He views character and psychopathology, in terms of the person's complicated reaction to environmental frustration, resulting in alienation from the real Self. He describes common developmental experiences which can result in problematic adaptations of character.

Adaptations are used in early life to avoid non-optimal frustrations and persist across the lifespan when confronted, either consciously or unconsciously with similar situations. The

individual may generalise his early experience and anticipate similar responses in present time.

For example, Johnson's theory contends that individuals with schizoid issues have suffered failure in earliest attachments, will be vigilant to harsh social environments and use isolation and withdrawal to psychically survive. The defense mechanisms will be primitive-primarily denial, introjection and projection. The individual's relational needs were responded to, or not, in a negating self-other relationship and these early forms of self-negation and compromise are reproduced in current relationships.

Effects of Trauma

Neuroscience helps me understand the long-term impact on the emotional regulatory system of early stress, through a different but complementary lens. Negative affect states can inhibit the production of neural networks and their connections (van der Kolk, 1996). There is some evidence that opiods are released with repeated negative experiences, resulting in habituation to negative states and may explain the Freudian repetition compulsion. Traumatic memory is often not available for self-exploratory and reflective process, because it exists as disassociated sensory-perceptual fragments.

In cases of developmental trauma, abuse or neglect, ongoing difficulties with attachment, attention and arousal remain. Sroufe (1996) sees avoidant and anxious/ambivalent insecure attachments as a risk factor for later pathology. Disorganised attachment resulting from more severe traumas is a significant risk factor for BPD (Liotte and Intreccialagi, 2004).

A variety of variables are important when looking at trauma, such as quality of attachment, family involvement and cultural support. Neurobiological components work dynamically with the child's sociocultural context. When the body's ability to maintain homeostasis is disrupted and affect becomes dysregulated, this contributes to Axis 1 and Axis 11 disorders.

Diagnostic Categories that Inform my Problem Formation

> *'The Copernican discovery of the motion of the earth does not negate what represents the truth for us of the rising and setting of the sun' (Gadamer, 1989, as quoted in Moran, 2000, p. 266).*

I find the DSM1V (1994) very useful in informing my problem formation. Without cementing clients in diagnostic stone, it can help to shape the therapeutic relationship and in treatment planning. I believe, as I said earlier, in the idea of a pre-wired deep structure and when this malfunctions, it seems to do so in a limited and predictable variety of ways. There seems to be a remarkable similarity in symptoms in these different disorders from person to person. So in terms of my integrative model, I see the DSM 1V at the empirical/scientific end of my continuum, where I can begin to understand patterns and then I can use a phenomenological/intersubjective approach to work with the client, to see how this particular difficulty plays out in their lives. Although there are many common factors in depression, every depression unfolds in a very individual way.

With the DSM1V, we can describe behaviour in an objective way, but its phenomenological manifestations can only be known subjectively. I also rely a lot on my felt sense of the client in the intersubjective context.

It is interesting too, that in psychoanalytic writing which is very critical of the DSM1V, psychological metaphors such as, 'false-self', 'negative-introjects', 'bad self-objects' appear again and again in the literature. There is clearly a universal tendency for humans to channel experience in certain ways. The persistence of these metaphors suggests something about the structural underpinnings of subjective experience.

Shame

I am informed by literature in the last twenty years which conceptualises shame in terms of its phenomenology and developmental considerations and attempts to show how these relate to character disorders, social phobias, addictions, depression and other

difficulties. Shame appears to be a core affect in disorders of the Self. Winnicott's work (1965b) on the lack of mirroring and the False Self is a good conceptual base for this kind of thinking. Broucek (1982) contends that shame vulnerability is generated when parents fail to respond to children's pleasure in their own development. Kohut (1984) postulated an enduring link between shame and narcissism, viewing it as a failure in mirroring and approving responses early in life. He thought that shame was a reflection of the Self, overwhelmed by its infantile split-off grandiosity.

Morrison (1987) concurs with this view, contending that in order for good self-cohesion to take place, there must be age – appropriate mirroring of infantile grandiosity. When the baby is attempting to relate intersubjectively and is treated like an object, shame results and an objective self-awareness will predominate over a subjective sense of self.

I find Kaufman's (1996) work on shame very useful clinically. He argues that affect, imagery and language are the central processes shaping the Self and these processes must be engaged with, in order to effect therapeutic change. He argues that these techniques must be used in the context of a warm therapeutic relationship.

The Nature of the Psychotherapeutic Relationship

Introduction

"The scenarios are written in an unknown language, the dialogue inaudible and sometimes reduced to mime---the characters as yet unnamed. The psychic dramas of our mental theatre thus await production on the therapeutic stage. In the hope of finding meaning and easing pain, two people set out on the stage to bring the drama to life as psychic reality. The patient has only vague memories for a script, a sense of having been there before but no precise idea of the setting, character or actions to be encountered…" (Mc Dougal, 1987, p. 11).

This quote captures something very important about the therapy process. I believe that I will become an influence for a time in the life of the client and that this relationship needs to be managed carefully. I have to allow myself to be used interchangeably as both subject and object and to realise that sometimes I will be a real person and at other times more a substitute or transferential person, a kind of "ghost from the nursery" (Freiburg, S., Adelson, E. and Shapiro, V. 1975). I will need to contain the rages or longings or needs for attachment of a client, who can often shift suddenly from the present to the past and back again.

So therapy is in a sense like a piece of theatre. During the 'performance' I am both me and not-me, both real and a figment of the client's imagination. I need to have good boundaries while being permeable enough to hold the disowned parts of the clients as they work on creating a secure enough internal container to be able to hold these projections themselves. The two of us occupy a unique space where we will experience each other within a specific relational frame.

I see a number of aspects in the process of psychotherapy which may unfold differently with different clients.

Pretransference

From the first contact, I am aware of pretransference, which to start with (Meltzer, 1995) is a professional pre-formed process, where the client will have expectations, doubts and misgivings about the therapeutic relationship. So that before the work even begins there may be a host of expectations at play. I pay attention to my own impressions, sensations and responses from the first point of contact.

I have had experiences of pretransference and its implications while working in a clinic in Zimbabwe during a period of projections around race and human rights abuses. Here the colour of one's skin became a reflector of pretransferential processes, as we listened to government-sponsored monolithic constructions of white and black identity. Most people did not recognise themselves in these descriptions but they nevertheless became powerful carriers of projective material.

My own approach is to be curious in a tentative way of anything which might be around at a pretransferential level. The obvious ones are gender, culture and race. The bringing of the pretransference into the light of the first session, even when I don't get many 'facts', creates a tonality of 'me – and – you being together in this space in a curious way' and sets the atmosphere for a relational, co-constructed process.

The Working Alliance and Therapeutic Frame

My thinking on the working alliance and the therapeutic relationship-their similarities, differences and points of convergence have changed many times. I view the therapeutic relationship now as framed to some degree by the working alliance and as the bedrock of the therapeutic process, without which change will not happen. The working alliance can be viewed as one of the many kinds of relationships that the patient develops with the therapist throughout the course of treatment (Fenichel, 1941) and (Loewald, 1960).

I view the co-creation of the therapeutic frame as an important aspect of the alliance. According to Milner (1952, p. 183) "…it is by means of the illusion found in the therapeutic frame that a better adaptation to the world outside is ultimately developed". I believe that the frame allows the client some protection from the normal claims that other types of relationships make on them and that "the stated and tacit assumption of this is a critical part of the working alliance" (Casement, 1990). The physical as well as the psychological details are part of my frame. The same time, amount of time and place each week, confidentiality and an ethical code provides both clients and I secure boundaries and a sense of continuity and reliability.

Goals, objectives and tasks and other details of case management can be viewed as part of the working alliance (Bordin, 1979) which could be considered as a continuous process of interpersonal connectedness (O'Brien, 2000).

The Assessment Phase

This is part of the building of the working alliance and the therapeutic relationship. I try to hold a space to allow the client's narrative to unfold while sitting lightly in my own mind with aspects of the DSM1V, used as a guideline. I am influenced by my systemic training in believing that there is never simply one narrative that can be told about a life and hope that we will discover together as the process unfolds the shadings of abandonment or engulfment, conflicts leading to compromise formations in the guise of symptoms, as well as hidden resources and resiliencies. I also believe that language has to be used carefully because it produces reality as much as reflecting it.

I wonder from the beginning about the client's relationship to their own story, a type of meta-therapeutic perspective, seeding a sort of quizzical, wondering into our narrative. 'So what is it like for you… to think that about yourself' or in the last 15 minutes of the first session to say that 'hmm…I'm wondering what it must be like for you to have sat with me today… and told this story'. I see often that, irrespective of the answer, this kind of tentative wondering can begin a process of disidentification with a well-worn and cemented narrative, retold sometimes over an entire life-time.

I have curiosities, explored or just held in my own mind about early attachment issues and use questions from Main's (2000) Adult Attachment Interview (AAI). I try to understand developmental stages and derailments, losses, traumas, and resiliencies. I also ask about family and systemic issues, school and socio/political influences.

I have different approaches to different client problems and whether they are presenting with Axis 1 or Axis 2 challenges for example. When working with Axis 1 disorders/ challenges, I think that symptom relief is a very important first goal and I usually approach this through Cognitive Behaviour Therapy (CBT), Mindfulness Based Stress Reduction (MBSR) or forms of breathwork/stress management to address affect dysregulation. This is not an intersubjective process as such and to work like this I have to move more towards the empiricist/ object end of my integrative continuum.

When symptoms are reduced and if the client wants to continue, we move into a less active therapy process where I begin to work more experientially, exploring the underlying intrapsychic contributions to these difficulties. I believe, following Gold (1994) that change can begin in any of the tiers/registers of psychological life and rather than viewing cognition and behaviour only as epiphenomena symbolizing underlying issues, I view them as important work in themselves.

Therapeutic Relationship

"we all have our own ground to work… you just have to find what it is. It is right at the edge of yourself. At the cliff edge of life. That's the edge you need to put yourself in conversation with…." (Whyte, 2001, p. 21).

My work with Axis 11 difficulties takes me more quickly to the epicentre of the therapeutic relationship. I try from the beginning to coax and pull the implicit experiences into "the present moment" (Stern, 2004, p. 193).

Clients often present with co-morbidity, such as a borderline client suffering from anxiety, depression or an eating-disorder, or a schizoid client abusing substance. I then work with what I hope is a creative tension between an 'evidence-based' treatment protocol while carefully monitoring the moment by moment impact of this in the room. I am supported by the work of Johnson (1994) and Yontef (1993) in trying to understand the configuration of Selves in personality disorders/character styles and ways of working differently with both conscious awareness and unconscious projections which will appear in the transference. These splits and projections have to be worked with both interpersonally and intrapsychically. I find my training in Focusing (Gendlin, 1996), which works with an awareness of different 'somethings' or parts, invaluable in helping clients to begin to hold some of their disparate selves in their minds. For this I work with thoughts, sensations or images which come into awareness. Working with dreams is also very useful in understanding internal object-relations.

Running as a thread through the work is my challenge to remain engaged both relationally and emotionally. An engaged relationship triggers healing processes by allowing walled off emotional experiences to be worked with in a relational space. I need to recognise defense mechanisms and move through them layer by layer, until the client develops more affective contact with emotional experience. Helping the client to regulate affect by drawing awareness to how she is paying attention or disassociating is a key part of the process. I also remind myself of the client's capacity for self-healing when the going gets tough (Tallman and Bohart, 1999).

Transference and Countertransference

I find the work of theorists with an intersubjective perspective on transference, who view it as an assimilation of the therapeutic relationship into the thematic structures of the patient's personal preverbal subjective world, very helpful (Stolorow, 1997). Neurobiology compliments this by helping me to understand what part of the brain is operating beneath awareness during the transference.

Brockman (2000) and Frankel (1997) suggest that externalisations of aspects of the patient's internal objects can be experienced, modified, and reinternalised in the transference. Disruption and repair are part of all relationships and particularly the transference relationship. Winnicott (1969) saw the need for the analyst to be able to withstand the ruthlessness of the patient during the transference, as vital, so that the patient could understand the individual subjectivity of the analyst rather than just seeing him as an extension of his own internal life.

The Brain

I am aware when listening to a client that I am listening to a story but also to affect and neurobiology. It is important to know what biological pathways control the story. Present moment perceptions have a biological and psychological overlap with memory. In the transference, old affective memories will be stirred up and we now know from research on state dependant memory, that affect will rule over cognition when there is a routing of perception through the lower thalamo-

amgydaloid pathways. The client can not respond to logic then, so I work with sensations and perceptions in the here-and-now moment.

The Body

My body is my entry point into countertransference, as I become aware of dysregulated affect, in heat in my body and a sort of blankness of mind, particularly when people disappear psychically. With experience, I can bring myself out of this state quickly and feel that I can work well with clients who are emotionally cut-off. I try to reflect on what is happening in my own life too that could trigger me. Following Aron (1991), I understand countertransference as opening a subjective space for myself.

Types of Transference

The type of transference that seems to happen with my clients is around needs/ desires to be mothered /nurtured and I have realised that this enacts differently between the two offices that I work from. Because of my background, I am aware that this could satisfy old gratification needs in me and have to think about this carefully. This type of transference seems to be stronger, for obvious reasons, when I work from home than when I am in the more neutral space of my second office. Dreams about the therapy can be a rich source of transference material, bringing feelings about the relationship to the surface.

Silence and Space

I believe that one of the core experiences that therapy must provide is a changed relationship with inner space. So, in this third phase of therapy, I try not to speak too much and I keep much of the moment-by –moment unfolding in my own mental space until I think it may be useful to do otherwise. I think that periods of silence, allow the client to go underneath the skin of the ego and begin to make contact with the hidden/silent or core self. Particularly for clients with early developmental difficulties around separation/individuation, this allowing of the 'gap' to open is vital. Grotstein (1980, p.58) contends that "if the infant can contain this space in the absence of the object, he is able to imitate and expand his sense of space and is able therefore to be separate…. In order to be capable of representation, the self must be separated from the object". I agree with Stern (2004) who views words as not just part of a narrative but also an expressed emotional experience where "there is a blending together of the implicit and explicit" (p.194).

Ending Phase-Metatherapeutic Processing

In this final phase, the processing of emotional experiencing in the therapeutic space must be brought to some sort of completion where a sense can emerge of when enough is enough. I process with the client what it has felt like to have had a therapeutic experience with an Other/me-who has been sometimes the 'good mother' and at other times not (Klein, 1937). Some reparation with the past is a desired goal.

This metatherapeutic processing needs to happen in the context of a relationship with another as part of exploring what the experience of change feels like. And perhaps as the poet David Whyte (2001, p. 27) would see it, the client can "begin to see horizons where before we only saw walls… and re-engage with the world's conversation… which is larger than ourselves…".

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Book Review by Geoff Johnson

Contemporary Body Psychotherapy The Chiron Approach

Edited by Linda Hartley. Published by Routledge, 2009.

Contemporary Body Psychotherapy is a book that describes the Integrative work of The Chiron Centre for Body Psychotherapy. For over two decades Chiron developed an embodied, integral relational approach to psychotherapy. The book is written by a variety of trainers and therapists who have worked at Chiron.

This is a seminal book and should be required reading for any one on any course that offers an Integrative approach. Although specifically about a journey in and around body psychotherapy it is significant also because it charts what happens when different modalities join. It tells a story of difficulties, complications, worries and tensions, many which still prevail and are articulated in the book.

For the founders it is a journey that starts in the crucible of the sixties and seventies in the turmoil and excitement, the longing for freedom, the birth of the humanistic movement, a founding celebration of difference and similarity. Youth fades but values can mature and there is a witness to that here in the difficult but persistent openness to what is, '… to confront their shadow, individually and collectively, courageously deconstruct their own cherished position and to open themselves up to other approaches…' p2

I found myself wishing I was there, part of the conversations, the discussions, the heat, the honing down of position that balanced catharsis with containment and coherency with variation. This is not a neutral landscape but real world research. How change happens is not a neutral event. Crucial is how to change and absorb the other while being and remaining one's self. Without being and remaining one's self there is a challenge to authenticity and there is a challenge to be in relationship anew. Every therapist knows the stamina required to hold that inquiry.

The endeavor, the commitment within the pluralistic ethos was to resolve or at least meet, conflict, tension and diversity. Fifteen contributors tell the story without jargon, carefully tenderly walk us through the layers of their experience. Frequently compelling and stunning and gruelling, challenging assumption in head and heart. It was a book difficult to put down.

There is a family here, the Chiron family so the book is a bit in house and there is a smidgen of self referring, repetition and reply. An appreciation of families and institutions or rather appreciation of the dynamics that get played out in the diversity and triangulation that conditions development and creativity within the family softens that criticism

Curiosity about embodiment, the place of the body in psychotherapy is well met at depth. The integrative therapist understands that human beings are complex and can be understood on different levels. The perspective seeded throughout is the functional unity of body and mind. The tone is not dogmatic

is transparent and offers great human warmth and tons of information pathways for the informed practitioner or novice.

What it isn't offered is a linear academic landscape that reduces relationship to the neat and tidy. The discussion is too alive and too on going for that. What is offered is the feeling experiencing self, a rich and living source of reflection, touching and challenging, whispering in to our own process and practice.

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