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Integrating the Personal, the Professional and the Political

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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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Consulting Editors

Maria Gilbert and Katherine Murphy

Editorial Board Members

Volume 11, Issue 2 (2015)

Contents of this Issue

Editorial

Integrating the Personal, the Professional and the Political

The contributors to this journal all share thoughts on the particularity of the personal choices and life challenges as they took up the role of an integrative psychotherapist.

The personal/professional interface has been a theme across several journals reflecting a growing awareness in the field of this inevitable dynamic in the process of integration. The articles represent a diversity of concerns within a wide range of contexts. However, they have in common a focus on a developing sense of integration.

For Brad McLean, like many students of psychotherapy, this was a second or third career move, transitioning from a seemingly non-related career into the career of psychotherapist.

He explores with critical candour the challenges of transferring and transforming his professional past. He highlights how any of our professional pasts may both help and hinder taking on the role of psychotherapist.

Andri White raises the question of working with any oppressed minority and in particular people with disability, a highly under-represented group in the field of psychotherapy either as practitioners or clients. She explores some of the dynamics that can arise when practitioners are unaware of complexity of the relational interface. She draws on her personal experience to challenge some of the subtle oppressive practices that can emerge in this area of work.

Ian Rory Owen has once again submitted a paper to the journal that offers a challenging perspective on his work in the NHS as an integrative psychotherapist. His particular focus is on the interrelationship between childhood developmental patterns and what maintains these, often outdated, patterns in the current situation. He outlines levels of complexity of presenting problems and offers approaches to treatment that inform the clinician in responding appropriately to clients in a therapeutic context. What we appreciated was his emphasis on a "tailor-made approach' in response to the uniqueness of each client.

João Pereira describes the very particular context of therapeutic community for severe mental heath in which he works from an integrative-relational framework. His article reflects his own style of relational integrative practice with an emphasis on promoting the development of mentalization with clients presenting with high levels of complexity. He is working in a context of practice-based research for evaluating the outcome of this type of work.

As is our practice we have included the theoretical section of Antoinette Moriarty's MSc dissertation in Integrative Psychotherapy at the Metanoia Institute which illustrates her particular approach to integrative work.

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

Brad McLean

The Journalist and the Therapist

Abstract

In this paper, I briefly describe some of the learning and 'unlearning' that media professionals like myself need to undertake when making the transition from a field focused on seeking truth for truth's sake to one that allows the subjectivity of truth to emerge. Shifting from a media frame to a psychotherapeutic frame is no easy task. It calls on the individual to rethink, re-examine and reformulate a host of values, beliefs and principles and domains of experience. The effect can be likened to moving into a parallel universe where the rules of engagement have been flipped on their head. We all bring identities, both public and private, to our work as therapists and these formative aspects of 'self' help to shape who we are as therapists and how we work clinically. For the purposes of this paper, I write entirely from a personal perspective as a journalist and psychotherapist. I make no claim that the reflections outlined in this paper are in any way comprehensive. Indeed, I cannot hope to offer anything but a taste of these processes and issues as they have affected my own role transition, and it is important to remember that my subjectivities may not to be shared by others with media backgrounds.

Introduction

The integration of a therapist and the forming of his or her unique 'idiom' or professional identity as a practitioner is shaped and honed by an array of factors. Derived from the past and the present, these factors traverse the cognitive, emotional, social and cultural domains of our experience and our conscious and unconscious worlds. While our training, supervision and personal therapy inform the transition process from one role to another, our orientation to the work is marked by our past, which, with its inherent 'ways of being' and 'ways of seeing' can both advantage us and disadvantage us simultaneously.

One aspect of these formative experiences is our professional pasts; their influence on our identity and their influence on how we process experiences through our professional identity and the structure and meaning it provides us. Many people come to psychotherapy training from established and successful careers in other fields. For this reason, psychotherapy training involves a process of learning, unlearning, reformulation and integration, so as to work within the boundary of the therapeutic relationship in an informed, reflective and ethical manner. Critically important, of course, is ensuring that we can shake off our pasts so we can work with clinical acumen and effectiveness. Making this shift is a complex but enriching process.

I detail in this paper what I see this process might involve for journalists. Specifically the particularities of the way 'reporters' navigate the interpersonal connection and collaboration with 'interviewees', and how the lens through which the interpersonal encounter is conducted needs to change for it to be therapeutic.

Without Memory or Desire

A key skill for journalists is to get the information from the interview 'down' as quickly and as efficiently as possible and this usually means direct quotations and details. The information collected has to be rock solid and correct. Every story is an exercise in reputation management for a journalist, but other considerations must also be weighted, including the right of the public to know a 'truth', the demands of an editor for a particular type of story, and the risks and damage to relationships that may be impacted by the story being published. For these, and other reasons, journalists hold many interpersonal tensions and pressures simultaneously.

The need to get every detail down correctly generates a problem in the interpersonal arena. Subjects (interviewees) can feel objectified because the journalist is focused on the story rather than the individual. Equally, with time ticking, the journalist needs to have the detail right. Later in the paper, I will share a story about an early therapy training exercise illustrating this reflexive way of being engaged with others.

Wilfred Bion (1967), in his writing about listening without memory or desire, most coherently articulated the shift that the journalist becoming a therapist must make.

Though still controversial, in this short paper Bion urges therapists to avoid listening with memory because in doing so we try to construct a person's experience within our own past experience or needs, and as a result, we are likely to miss the unique and new aspects of the story. Further, Bion urges us to avoid listening with desire. With desire we construct the client's story with a forward look towards our desire for them, which will be entirely clouded by our own views, experience and need for the client.

For me, listening as a journalist was about holding both a memory and a desire around the story I was listening to and I, like thousands of other journalists, constructed a story within my own requirements (and that of my editors), almost taking the person's story to fit my needs and my ends. Journalists are trained to do this so nothing is missed and deadlines are reached. It is in realising that learning to allow another's story to unfold without memory or desire, believing in the process of that unfolding while holding onto my own countertransference, and staying with the story by using my own experience of it, that represents the most significant shift from journalist to therapist.

So far, I have outlined a number of areas that journalists who become therapists need to both relearn and rethink in an effort to shake off the frame within which they have previously worked. I believe such a shift is essential so that journalists can turn toward the subjectivity and complexity of working psychotherapeutically. I will begin by outlining my story and offering some insights into the world of the media (then and now), before briefly exploring some key areas of challenge and growth faced by journalists who choose to become therapists.

I do this without any delusion that my explorations will in any way be comprehensive. Equally, I recognise that just as no two therapists are alike, journalists are anything but a homogenous group – they (or we) have divergent values, ethics, skills and emphases to the work of journalism and I cannot comprehensively account for these differences.

Professional Identity

I should outline a few biographical aspects of my story to illustrate the journey I have undertaken. In terms of my work life, I spent my first ten years as a university qualified nurse working in the technically and emotionally stressful front line of trauma and intensive care nursing.

My specialty was cardiothoracic heart and lung transplantation and I taught, researched and managed in this clinical context. It was the 1990's and I was drawn to the high stress, high risk and highly autonomous nature of the work in nursing in its most acute iteration. I feel my clinical and philosophical education from nursing, with its emphasis on a biopsychosocial and spiritual framework, its holistic approach and the value it places on the unique subjectivity of the 'lived experience' underpins my psychotherapy practice to this day.

After a decade, and facing burnout and a need to re-engage academically, I looked beyond nursing to study further. Having always had a fascination for people and the media including newspapers, magazine artwork and communications broadly, I decided to study journalism. I look back now and my natural curiosity and constant thirst to know more and learn more made me an ideal candidate for journalism.

I also relished the work of specific writers and styles, including the literary journalism of Truman Capote, the confrontational interview style of Italian journalist Oriana Fallaci and the profiles written by longtime Paris Review editor, George Plimpton. Recognising that it was worthwhile following one's gut on such things, I undertook postgraduate studies in journalism at what was then the most prestigious university for journalism studies in Sydney, Australia.

Through a chance meeting, which led to the support of a career mentor and friend, I secured a job in the then very new area of digital media. It is in this environment that I learned how to write and tell a story under the pragmatic tutoring of the same mentor. Later, I went on to become an award-winning health reporter, medical news editor (covering health politics and clinical news), editor and managing editor of a multi-platform health publication. I've created and launched a digital news and opinion website for Australia's oldest and leading medical journal and I also worked as a corporate relations manager for a time. I continue to work as a health communications consultant on various projects as a background to my psychotherapy practice.

Towards the end of this period, more out of curiosity than certainty, I embarked on a foundation year integrative psychotherapy training and completed the full programme four years later. I now have a private practice in Sydney where I work full-time as an integrative/psychodynamic orientated individual and couples therapist.

The transition from journalism to psychotherapy was a challenging one that I can only describe as being a move from objectivity to subjectivity, or from the concrete to the abstract, and I fought hard against it initially. I believe it was through my own five-year weekly psychotherapy and the capacity of my trainers to withstand my challenging and questioning that I was able to move from one frame to the other. Intrinsically, I knew that psychotherapy had significant value and I believed in it strongly at 'gut' level, but I struggled with what I initially saw as an empirical evidence gap. Today, I see that struggle as a fight not to relinquish my identity as both a media and health professional and this, of course, brings with it a tension of its own.

Public Perceptions and the Profession

In the broader culture, journalists are often portrayed as being untrustworthy and unethical, caricatured as cavalier with a 'take no prisoners' approach to gaining salacious headlines (ironic given no journalist is ever responsible for the headlines put atop their stories).

Community surveys in Australia, attest to the low ranking of journalists for trustworthiness and UK surveys have found similar results. One British survey in 2009, predating the events that led to the UK Leveson Inquiry, ranked journalists as the profession least trustworthy, with less than one in five of those surveyed believing journalists tell the truth.

Public perceptions of journalists are likely to be skewed by the harsh world of tabloid media and while there are different types of journalists working for different publications with different priorities and values, I believe there is a fundamental irony regarding the public perception of journalists. As a rule, journalists believe (and rightly) that they serve a vital public function and that they have very ethical drivers for the work they do.

In the last 15 years, there have been dramatic changes in the media with a move away from quality journalism as news. 'Content' providers have to serve content hungry social and digital media platforms. Volume rather than quality has superseded the demands of famously demanding editors. Quality has suffered and, deemed too costly, investigative work has sadly receded into the background. Overall, reporting has lost depth, balance, character and the element of surprise. Changing media consumption patterns, the blurring

of media and marketing and other industry forces play a very significant part in shaping journalism both today and yesterday.

Psychological Factors

What the media produces, in my experience, is a group of intelligent and psychologically complex individuals who work within an extremely competitive environment. These individuals come from diverse backgrounds and face extremely complex situations in their day-to-day work usually with limited psychological (and other) resources. Several key issues for consideration in relation to the psychology of the media and its people include:

Media is a survival of the fittest game and attracts extremely competitive people

There is a tendency to think reductively because media focuses on producing bite-sized chunks of information for audiences without room for complexity and nuance

The addition of a byline to everything journalists write can induce persecutory feelings and, for some, a sense of constant attack and criticism – digital and social media have increased this dramatically through forums, comment sections and more direct communication access to journalists

It is extremely difficult to practise mindfulness as a journalist – the pressure to be 'across' information and events and to not 'miss' anything means tuning into information streams 24/7

Deadlines and reactive demands mean lifestyle consideration and self-care is difficult to attend to. In addition, the lifestyle is less than healthy for most

There can be a tendency to be manipulative and create non-authentic relationships with people who provide tip-offs or inside information

Media organizations are struggling to find viable commercial models, which creates work environments that are unstable, rapidly changing and exposed to powerful influences that can cause ethical and personal conflicts for journalists. This leads to a work environment in which survival drives dominate and employees live in a fearful bubble of vulnerability.

These factors seem a long way from the quietly spoken world of the empathic and open therapist. The interpersonal endeavour in psychotherapeutic relationships, with accompanying features such as clear contracts, empathic responsiveness, compassion, respect for client autonomy, and ethical and meaningful relational contact, is at the very opposite end of the interpersonal continuum to journalism. For this reason, the question could rightly be asked: "Can journalists who retrain as therapists really be trusted?" and also, "What might journalists bring to the world of therapy that enhances and takes away from their work if they retrain as therapists?"

Learning Anew – A Case in Point

In the very early days of my psychotherapy training, I had an experience that highlighted the particularities of what I needed to unlearn as a journalist endeavouring to become a psychotherapist. The exercise was a simple one: students were paired to work together to find out 'the story' of the other student and to then reflect back their learning and share this with the group. The educational objective was directed at harnessing natural inquisitiveness, curiosity and inquiry skills and to explore how we work together as a therapist and client to learn about each other. The group discussion following was intended to explore both the 'therapist' and the 'client' experience of the encounter.

With the exercise complete, I presented to the group a very thorough 'story' about the client in the encounter, which came naturally after having conducted hundreds of interviews as a journalist. Having offered up many details (noted down with pen and paper in shorthand), I felt satisfied (competitively) that I had extracted as much information as I could in the short time we had been given, and proceeded to share what I had learned about my 'client'. I even included hypotheses about him and his situation but went to great lengths to make it clear that I was only hypothesising and had no factual basis for my propositions.

When my 'client' was asked to reflect on the experience, he answered simply and clearly: "It's all true but I felt like a subject or an object and I felt nothing of the 'therapist' in the encounter at all," he said. "I actually felt like he was extracting something from me with little regard for its meaning to him or to me… it was as if he had another agenda."

The feedback represented a profound learning for me. With 12 years of experience as a journalist behind me, I had a clear sense of what needed to change for me to fully embrace both the character (or idiom) of myself as a therapist and what I needed to unlearn from my journalism training and its incumbent way of experiencing others.

Learning and Unlearning

I think you would have to give me points for curiosity in the above story. I was curious but I felt like I was 'on the clock' (deadline driven) to get the most information I could out of this gentleman. I also felt I had to do much better than everyone around me (competitive) and to find the most interesting, juicy information I could (find a unique 'angle'). I was devastated when I realised that I had essentially been objectifying people for 12 years in an effort to do my job as best I could. This is not to say that I wasn't affected by my work at times, or that I didn't feel great sympathy and empathy for certain situations I was reporting on or editing stories about, but I did realise in that moment in that exercise the core of what I needed to both learn and unlearn to become the therapist I wanted to be.

What Journalists Need to Learn to Become Therapists

Objectivity is a Myth

Objectivity underpins the conceptualisation of professional journalism and entails ideas such as fairness, facts and impartiality5. Objectivity also includes the notion of neutrality and involves valuing 'facts' highly in a hierarchy of experiences and situations. Civic and advocacy journalism disputes the value of being an 'objective' bystander because the role falls short of finding the truth, values and meaning behind what is being observed. Others have written about the myth of objectivity given that even the decision about what constitutes news is itself a subjective process. Added to this, if we consider factors like our personal histories, political and social influences, memories and social relationships (including unconscious influences) these will unwittingly inform any decision made by a journalist in formulating an angle or promoting the value of a story. The narcissism driving 'personal brand' journalism, it could be argued, is a good example of how objectivity has lost its value and primacy in the media.

To become an effective therapist, objectivity needs to be equally weighted with subjectivity and the rational limits of objectivity need to be appreciated. 'Just the facts' is only a small part of the picture and falls short of telling the psychotherapy client's real, multilayered and unique story. Seeking objective facts also has its limits therapeutically because clients' stories change and exist in a dynamic flux influenced by those they share their life with, including the therapist. It is hard to relinquish what seems like the backbone of a journalist's identity, but I found the world opened up greatly when the shackles created by the delusion of objectivity and neutrality were broken.

Subjectivity and Intersubjectivity: Meaning, Value and Utility

This has been the single hardest and most revelatory aspect of training as a therapist for me. To appreciate that there is a strong body of quality research and inquiry into subjectivity and how subjectivity could be individual and co-created was like discovering a new world.

It might sound odd, but subjectivity was only meaningful for what journalists call 'colour': the pictures drawn with words by people in media stories that place us somewhere or some time, the anecdotes told by observers or confidants. I did not appreciate the depth and value of individual subjectivity and how rich and powerfully human it is.

I had always viewed subjective experience as sort of interesting but fundamentally redundant

to discourse or the processes of information exchange. Another vital step in both learning and unlearning was to discover how myself and another person could together co-create something and that the intersubjective realm. That is, where my total experience and their total experience meet, something new and unique can be created. This was quite a startling idea and having replaced objectivity, it is the new backbone of the work I do as a therapist.

The Fight for Truth is Less Important than You Think

First and foremost journalists love to uncover the truth. They are competitive by nature and rightly believe that their civic responsibility involves uncovering the facts, knowing that most people like to hide 'the facts' from the public. Cornering people in interviews by lulling them into a false sense of camaraderie, of support, concern or admiration is often used as a device to get the reluctant interviewee to let down their guard. For example, many years ago, someone in the profession told me that the success of an interview could be judged by whether the interviewee left regretting the fact that you had got him or her to say something they did not want to tell you.

There is also that moment, sometimes on the phone, when a person tells you something, knowing you are 'on the record' and they realise that they should not have. It is a tense and silent moment filled with anxiety and excitement but it represents the deceptive nature of the interview construct. A journalist's instinct is to challenge falsehoods, sometimes aggressively, to get to the truth.

As a psychotherapist one learns that 'the truth' is a less concrete and more elusive, mysterious entity. If it feels like someone may not be completely honest, it is less of a concern and there is a sense of calm about the fact that the truth, whatever that might be, is likely to reveal itself down the track when an alliance is stronger and defenses have willingly dropped slightly. Appreciating that truth is less important than the value a client derived from the investment in phantasy or symbolic meaning, is actually quite a comforting realisation for those of us once obsessed by truth telling. One has to turn towards making meaning out of the information rather than working out whether it is right or wrong. Imagining is a creative and sustaining business that can transcend 'truth' and is best not challenged until the time is right. This stands as long as no other is being harmed.

There is no Longer a Place Reserved for You on the Sidelines

When one starts to study journalism it can be a rude shock to find out that the idea is to be completely out of the picture and the responsibility, in true news reporting and news writing, is to work hard to tell the story of others avoiding anything self-referential. One learns that it is crucial to retain the integrity of the story and to maintain the myth of objectivity. However, depending on the type of psychotherapy one practises, from a relational perspective, being 'in' the story as the therapist is a key component of the work. It was a difficult but rich transition for me to move from being distanced from what is happening to moving closer to the action and using my countertransference and affective responses as tools in the work, whether they be somatic, intellectual, emotional or unformulated. I now know they are a key part of effective therapeutic work. Using my thoughts, feelings, reactions and responses as tools to guide and influence my work represents a significant shift of learning to be in contact with others and myself.

Today, as I work with clients therapeutically, I experience the nearness of being 'in the picture', alongside the client. What would have in the past been a distraction is now tuned into with great concentration. I often feel, for example, that I am entering a new level of engagement with a client when the room becomes still; I hear my own breathing and work to regulate it and in the periphery of my vision the room's edges can become blurred. These experiences signal to me that something quite strong is happening between the client and I and it is almost always important. It is as if my body and mind have become attuned to the unconscious and the affect of the 'other'.

At other times I will pick up on feelings of distance, confusion, irritation or invisibility which signal something is being communicated

to me unconsciously, so being attuned to it is vital to the service of the work.

Time is not the Enemy

Journalism is a deadline-driven business with the clock constantly ticking as deadlines loom. For therapists, I soon discovered that to rush is counterproductive for both parties. I initially felt myself being pulled along by the 'hurry up' driver inside of me that wanted to move things along at a much faster pace, in a way trying to address the feeling that I was not doing enough. Again, this is an example of the shadow of the professional past being cast on the present. In my case, the ghosts of the deadline from journalism, and the desire to act, cure or soothe as a nurse, haunted me in the present. In combination these two forces, or drives, felt like they were pushing me to act, to move quickly to engage in the 'real' issues and to push into the serious imperatives of what was happening. Ironically this approach mostly did more to slow things down than speed them up.

Of course rhythm, pace and timing are highly individual; learning to work with a client's unique temporal needs and slowing down so that small moments can be savoured, explored and more fully experienced was both challenging and exhilarating for me. Each time I slowed down, each time I noticed a need within me to speed up and I fought it, fascinating and therapeutic things happened. Perhaps a good way to illustrate this is that as a news journalist, I felt like a greyhound racing around a track chasing a just-out-of-reach rabbit, while as a therapist, I feel like I'm taking a sensory-saturated walk in the woods. There is most definitely tension and performance anxiety in therapy but the task is so much more mindful.

Again, sensory awareness of our own bodies and reactions as therapists are vital to this process and endeavour. For me, it was an issue of taking cues from my body to guide timing. When I felt my jaw tighten, I knew it was a drive for me to say something so I would focus on relaxing my jaw and to not fill the space with unneeded words. I also learned to monitor my own reverie about the client, both in her or his presence or away from the session, often when walking my dogs of an evening or morning. Holding clients in one's head is a way to have contact with them, to almost create something about your relationship with them and to use it as a tool (which, of course, requires reality testing with them).

Clients can appear in our thoughts at unexpected times and the more this would happen, the more I would reflect about the context of this emergence of the client in my mind, asking: "Why now? Why here? What was I thinking about? What is the association?" Such therapist reveries are, in my view, a key to processing and evolving the therapeutic relationship and I have found this an important process for me.

Listening to what Someone is Truly Saying is a New Skill

This statement seems odd but it is very true. In the days before the current 'churnalism', where the main objective of production of content is to rapidly fill webpages, newsletters and social media streams, expectations on journalists were far greater. One had to get balanced points of view into a 300-word story, which meant interviewing multiple people. Time was extremely short, editors were extremely demanding and the need was to get all the comments as fast as possible and 'bash out' a story in time for the deadline. Remembering that some newspapers used to have morning and evening editions, you can image the pressure to 'get the story' and to 'get it absolutely right'. For this reason, journalists know what they need – confirmation of facts and good quotes – and the tendency is to be thinking about building the story and not listening to the individual.

Therapeutic listening is a different story. It needs careful attunement and a focus that one simply does not develop as a reporter or journalist. I often find in talking with clients I'm waiting very openly for something to grab me rather than be in a process of trying to flush it out.

Dissociation Protects Journalists but Therapists Need to Connect

In December 2014, in Sydney, we had a siege in which 17 people were held captive in a coffee

shop for 16 hours with an erratic hostage-taker. The police stormed the café and three deaths occurred. Just days later, a mother murdered eight children in one of the worse cases of matricide seen in Australian history. Mostly junior reporters begin the work on these stories and they are often ill-equipped developmentally and psychologically to deal with the situations.

Most reporters over the age of 35 can tell stories about their early on-the-job training when they were sent on their first 'death knock' (which involves going to the home of a person who has lost a loved one, often in horrific circumstances, and being told not to return to the office without a one-on-one interview with the bereaved, and "don't leave without getting a photograph of the perished loved one"). Most junior reporters have no idea about dealing with people in acute grief yet they know there is something deeply exploitative about the encounter, while simultaneously holding the idea that their career is under threat if they don't perform.

Is it any wonder journalists seem very tough and hardened? I have heard many stories about deeply distressing experiences journalists have endured and how they have been personally impacted by these events. Many struggle in relationships and I find many require constant stimulation and almost induce conflict to feel a sense of aliveness. Drinking was historically part of the culture of journalism with high rates of alcoholism, but this may be declining and may be attributable to many factors including the changing social status of journalism.

At the extreme end and on the front lines of global conflicts, journalists are exposed to mass casualties associated with natural disasters, wars and civil unrest. These, as well as exposure to distressing crime scenes and other traumas, dramatically raise the risk of PTSD among journalists.

Although I have never worked in the extreme environments of war and natural disasters, I strongly believe in cumulative trauma having a significant impact on individuals. Having seen a significant amount of trauma as a nurse, I too had to work through self-protective dissociative strategies developed over time to become capable of working as a therapist. To actually 'be in' experiences with clients is vital but preparation is needed before it can happen and this requires personal therapy and work. My personal therapy journey was focused on working through the dissociative defense I had learned through both my work in intensive care, trauma settings and in journalism.

Conclusion

Where does one end? It is a perpetual question in therapy. I end with a hope that the reader can experience something of the transition a journalist must make to become an effective therapist. The road has been a difficult one of mixed and merged identities and eventual individuation. Despite the challenges, when I think about the benefits of combining the realness and caring of nursing with the hunger to understand and the drive to communicate of journalism I can think of few better training grounds for becoming a therapist, especially the one I believe I was probably always meant to be.

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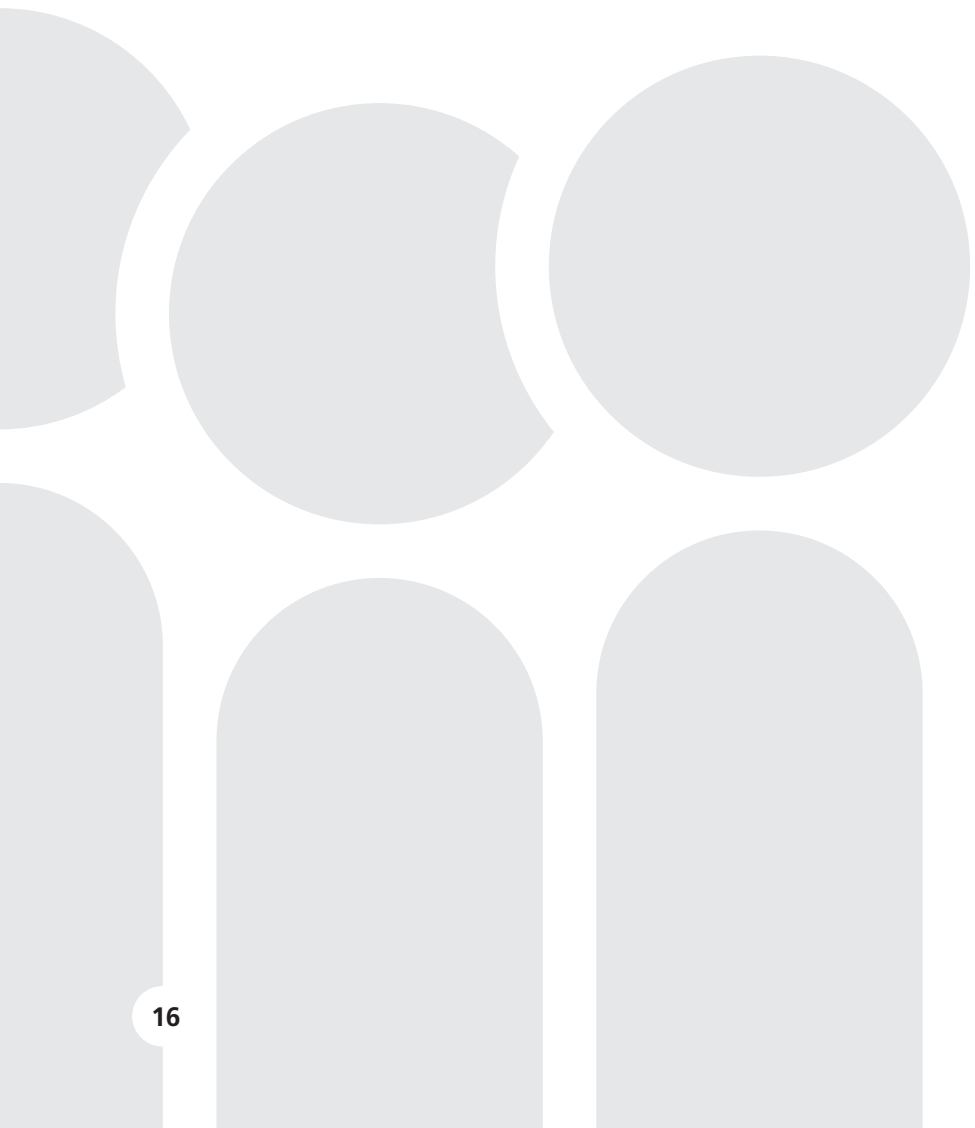
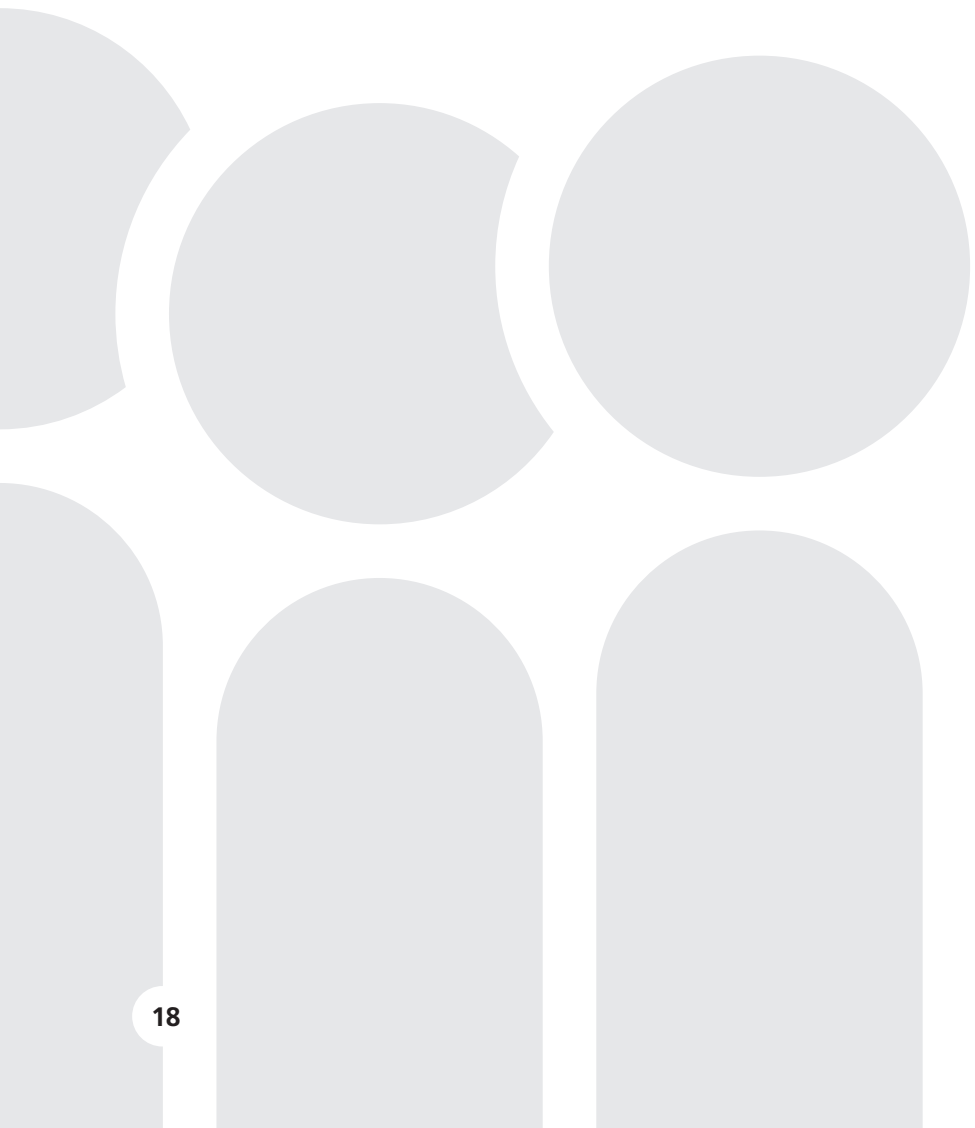




Andri White

There by the Grace of…

Abstract

According to the January 2014 figures from the Department of Work & Pensions, there are 11 million people in UK with a limiting long term illness, impairment or disability. The prevalence of disability rises steadily with age up to 45% of adults over the State Pension age. Sadly, this figure is not represented in our client base, our trainees, our training or our trainers. In this article, I attempt to explore what is behind our universal reluctance to face an existential reality. I introduce four constructs of disability and describe a supervision case study to show how they might operate. I demonstrate how our constructs can fit into Karpman's Drama Triangle and follow with a look at our hard wired neurobiological reflexes that influence our interpretations in supervision. I bring attention to the ethical implications that arise from our inability to truly grasp this issue.

There By The Grace of…

I had lunch the other day with a good friend and qualified supervisor who said, in passing, that she couldn't see what difference disability made to the therapeutic relationship as we automatically came from a position of non-judgemental acceptance. As I choked on my warm chicken salad, I realised that there was so much to say on the subject and with few guidelines in our current theoretical therapy models, I struggled to know where to begin.

Pink Therapy and Intercultural Therapy have their own relatively new models promoting understanding of the issues of racial discrimination and homophobia. Both Dominic Davies, founder and director of Pink Therapy and the late Jafar Kareem, founder and director of Nafsiyat Intercultural Therapy Centre are figures of authority from those groups who have helped create theories and models from personal experience and research. With few authoritative disabled role models in our profession, it has been difficult to challenge interpretations of often powerful and displaced responses in training, supervision groups and individual supervision, when disability is in the field. Disability Studies is a relatively new academic field focusing on the roles of people with disabilities and the systems within which they live. Tom Shakespeare is a disabled activist and research fellow at Newcastle University. He wrote,

> *"Disability is a complex dialectic of biological, psychological, cultural and socio-political factors, which cannot be extricated except with imprecision.*

The complexity, coupled with non-verbal, primitive and powerful affects evoked, makes it a difficult subject to discuss. It is the only minority group that any one of us can wake up belonging to. Although I can only be imprecise, I hope my paper will provoke discussion, particularly in the realm of supervision where we have the opportunity to educate others and ourselves.

Shakespeare points out that no-one's body works perfectly, or consistently, or eternally. He notes how different impairments have not only different implications for health

and individual capacity, but also generate different responses from the broader cultural and social environment. For example, visible impairments trigger social responses whereas invisible impairments may not and congenital impairments have different implications for self-identity than acquired impairments, depending on the developmental stage of the individual when the impairment was acquired and the level of introjected prejudices already in the individual, family or social network. These differences impact at the social and psychological level, affecting the development of a sense of entitlement, sense of self, self worth and self-identity. This will in turn impact on the relational field both internally and externally.

As a wheelchair user, it has been a perilous 40 year journey from client to integrative psychotherapist and supervisor, constantly dealing with exclusions, impingements, assumptions and interpretations that threaten to erode my sense of self and invite me to create a false self in order to enter the inner sanctum of our profession.

Michael Oliver is one of the major influences in developing a model that describes part of the field for disabled people. He developed four models of disability and it is my belief that all these models are actively in the field for all of us at all times.

The Social Model suggests that it is in our treatment of people with physical impairment that disables. Lack of access to buildings and education runs right through our society and we tell ourselves all the practical reasons why it is implacably so.

The Moral Model is the most archaic of the models, based on religious and superstitious belief which suggests that the individual's impairment is the result of divine punishment for evil deeds perpetrated either by the individual in current or previous lives or by their current or ancestral family. It is often assumed that the impaired individual is filled with envious hatred, malevolent intent and possesses an 'evil eye'.

The Tragedy Model sees the individual as a tragic victim of circumstance and portrayed as helpless, sanctified and dependent on the care of others. Some people, who have experienced childhood neglect or an impoverished emotional life, are attracted to caring for others (and sometimes abusing them) and may form relationships with people with disabilities to create a co-dependent attachment. This dynamic can become tarnished over time and lead to the punishment of the 'ungrateful disabled person' for spoiling the carer's life. It is perhaps the hardest to understand because it is masked with kindness.

The Medical Model sees either the individual's impairment or their adjustment to their impairment as the problem that defines them. In this construct, professionals become all powerful experts of the individual's needs infantilizing them as they lose self-agency to shape their own lives. In the medical and tragedy model, there is the potential to slip into, what Gilbert and Evans call 'therapeutic supervision', turning a supervisee into a patient. It is easier to adopt an authoritarian frame rather than face existential fear. Nathanson wrote,

> *"We tend to label what (or who) we do not understand, and by these labels achieve personal comfort denied the bearer of the label" (p250).*

There are gross and subtle manifestations of this construct in our profession, especially in training, where, for example, disabled trainee counsellors have been pathologised for being angry about lack of access on a course rather than address the barriers.

I once replied to a general invitation from UKCP to run a workshop at a conference entitled 'Supervising Difference'; however, when I enquired by email, the organisers could not guarantee a wheelchair accessible venue.

Around the same time two unconnected supervisees told me of two separate incidents where a student with dyslexia and a student with a hearing impairment were refused access to lecture notes in advance despite their need to prepare to be more present during class. Our work focused on encouraging the students to find their own authority and address this with their tutors. Sometimes, however, it is not authority that is required but energy to address the same issues ad nauseam.

In my experience, working with couples where disability is in the frame can lead to the supervisor/therapist losing their focus on the interface of the couple's relationship and becoming either over identified or hostile with one or other partner, depending on which model of disability was figural.

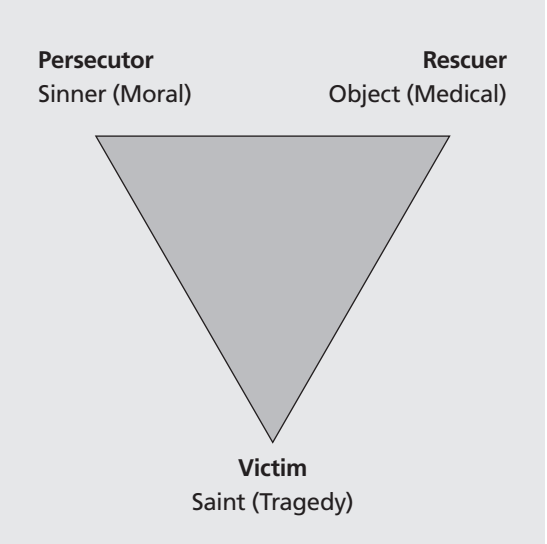
Liz and The Couple

My supervisee, Liz, felt stuck with a couple where the disabled husband was increasingly full of rage and bitterness towards his long-suffering wife who felt unable to please him no matter how much she did for him. She had originally been his carer and they had fallen in love and married. Liz had interpreted his rage as envy, still needing to come to terms with his disability and felt great sympathy for his wife who was his scape-goat. I suggested Liz hold in mind the various models to see if she interpreted their dynamics differently. Gradually, Liz could hear his voice explaining that his wife had subtly shifted from professional carer to compulsive carer and then into a subversive carer. Loving affection had turned into matronly care and sex withdrawn. She had become the dominant partner, unconsciously blocking any attempts by him to be physically independent and therefore to separate and individuate.

Viewing the models of disability through a Transactional Analysis lens, I found Karpman's Drama Triangle hugely helpful.

Stephen Karpman posited that when people slip from their authentic selves to a defensive role in relationship, they often take one of three positions on the triangle. As the drama plays out, those involved will often switch positions to take on another role in the triangle. In the following diagram, I have included the models of disability to show how neatly they fit into the drama triangle.

Because all of these constructs are in the field, all of the time, for all of us (including those with disabilities), the danger for our profession is that, when we think we are in a relationship with the individual, we are instead in relationship with our construct of their impairment.



Karpman's Drama Triangle

The discomfort that we seem to experience in the presence of impairment is so universal, I began to think that it might be a hard-wired human trait, which led me to neurobiology and our out of awareness reflexes.

Reflexes

Silvan Tomkins identified 9 hard-wired human affects, along with facial expressions, which are:

1. Excitement
2. Joy
3. Startle
4. Terror
5. Distress
6. Anger
7. Shame
8. Disgust
9. Dissmell

The affect that caught my eye was dissmell, which is associated with disgust but is connected with the olfactory system rather than the gustatory senses although they operate either simultaneously or independently. In the phenomenology of disgust, the tongue and lower lip are protruded, as though to push an offensive tasting object from the mouth, and the head is thrust forward. In dissmell, however, the nose is wrinkled and the nostrils close, the upper lip is raised, the head is drawn back and the body is drawn back. Nathanson posits that dissmell is a primitive reflexive retreat from danger in

order to aid survival. Cozolino writes "Our aversion to corpses and bodily damage puts us on guard and makes us wary of both potential predators and toxic micro-organisms" (p266). Schore describes how the sense of smell is the very first imprinting experience that begins immediately after birth and produces the first representation and recognition of the mother.

As I understand it, all our senses, except the sense of smell, are first received in the cerebral cortex where they are analysed and then forwarded to the amygdala in the limbic region of the brain. By then, the cerebral cortex has processed the raw data of sensation into highly refined interpretations of it, which later become involved in emotions in the amygdala. However, the sense of smell does not go through this process of interpretation but instead goes directly to the amygdala putting this raw data of smell on the same level as all the other processed messages. The implication of this are not lost on Nathanson who describes dissmell as the phenomenology of rejection and the cornerstone of prejudice. I was struck by the familiarity of the phenomenology of dissmell that Tomkins described after I caught polio as a child. I would often catch an expression, however subtle and fleeting, that informed me of the repellent fear I induced in some strangers. It was also how I experienced myself responding to others with profound impairments when I was extruded from mainstream society and placed in 'special school' with other excluded children for all manner of impairments.

> *"Whenever someone treats us as if we smell bad, we suffer a profound decrease in self-esteem; therefore those who are treated with dissmell must experience shame. And when people accept this label, if they are forced to agree that they are so foul as to deserve the innate response of avoidance, henceforth these people will live with chronic shame that becomes a part of the very structure of their personalities" (p125).*

I believe we need to acknowledge and accept our primitive neuronal inheritance before we can begin the process of changing the way we think about how we feel in order to behave in a more humane and ethical way. This may help to reveal a hidden truth, that a major emotionally disabling impact of physical impairment is the inexorable loss of I/Thou16 connectedness.

Ethics

My long journey in therapy has taught me that it is our responsibility to learn about the socio-political issues that impact on our clients and supervisees who belong to traditionally oppressed groups rather than expect them to teach us. To suggest that each individual has a different experience of their oppression is not without truth, however, to expect clients and supervisees to educate us each time a new therapeutic relationship is begun is another form of oppression. This is as much a truth for disability issues as it is for racial and homophobic issues. Dominic Davies, who publishes articles about sexual minority therapy issues, writes,

> *"The client is coming for therapy and, more often than not, paying for the service. It is unethical to expect them to provide the therapist with free consultancy on lesbian, gay and bisexual lifestyles and culture, unless they negotiate a reduction in their fee to reflect this!" (p27).*

However, not all disabled practitioners understand the issues themselves. At a supervision conference, I spoke to another wheelchair user who said he gave up teaching after his accident out of fairness because he would not have liked his children to be taught by a disabled teacher. Internalised discrimination can be insidiously oppressive.

I consider lack of access to be an ethical issue. The BACP's Ethical Framework (2010) bullet points fundamental values (ibid p2-3) about equality, dignity and autonomy; UKCP's Bulletin 10 writes about a commitment to accessible psychotherapy. It all sounds Utopian to me when I consider that there is still no category for wheelchair access in either organisation's 'Find a Therapist' search, despite my lobbying for over 20 years. Wheelchair accessible therapy is mostly attached to a medical setting where the I/it medical model prevails. Accessible supervision is still widely unavailable in private practice as legislation for life long house designs is still inadequate, as is the will for it. When a disabled client/supervisee needs to be assisted into the practice room, each session begins with inequality where the existential challenge is seen to be theirs, not the therapist's, as they

both struggle unconsciously to extricate themselves from the Drama Triangle.

Disabled people form a significant percentage of society. If disabled clients are excluded from therapy, they cannot take the first steps to becoming talented trainers and supervisors who will keep the discourse alive to develop coherent and humane theoretical models for training and supervision.

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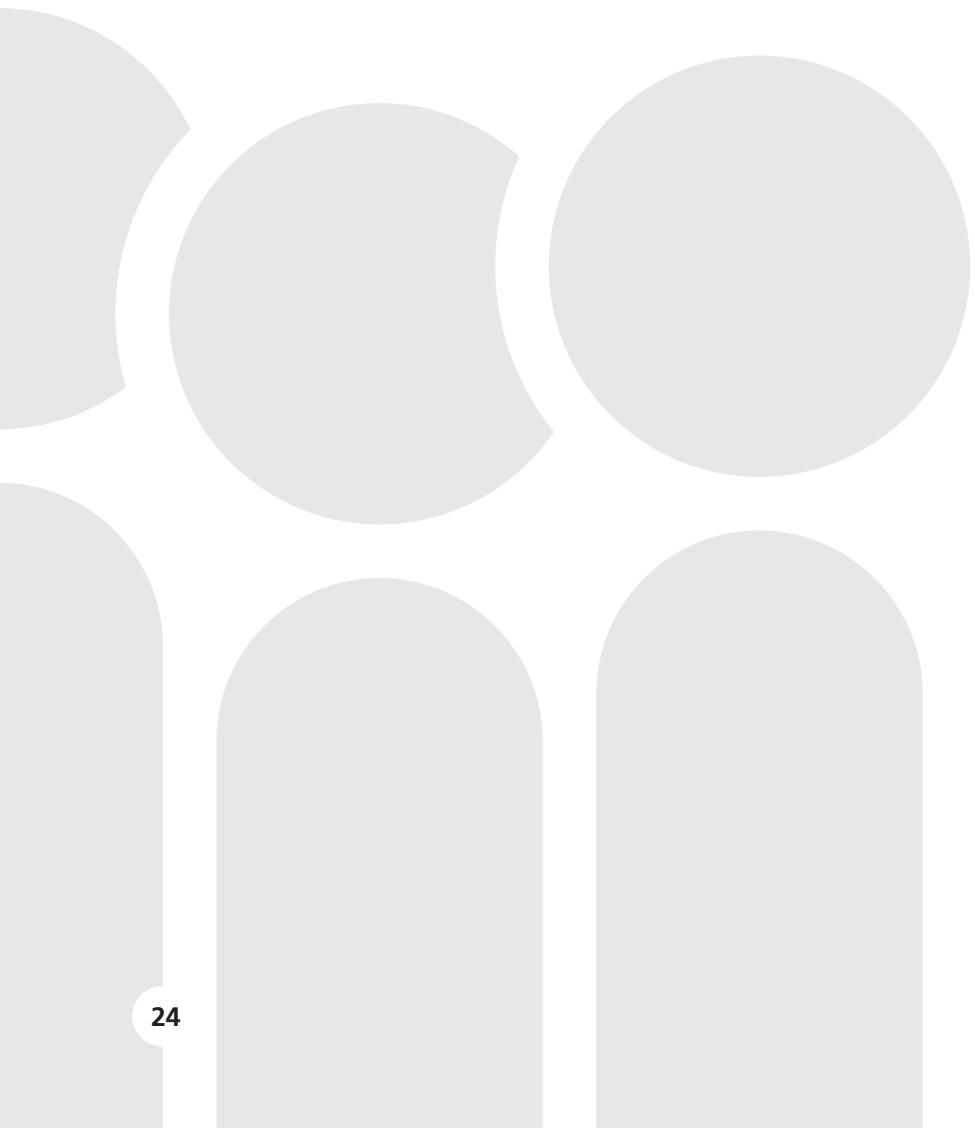

Ian Rory Owen PhD

On the Received Wisdom About Complexity and the Problems of Understanding Personality

Abstract

This paper starts by reviewing some basic points about the idea of personality in relation to the need to understand the relational styles that people have. Some brief comments are made on personality before focusing on complexity. In the received wisdom about complexity, there are two major variables, a person's personality style and their set of contextual psychological problems. Psychological problems are defined in agreement with texts like DSM-5 and ICD 10 which express the mainstream view of personality and distress offered by European and American psychiatry and psychology. These definitions are not challenged but accepted for the purpose of questioning the difference between personality and long-standing contextually-defined problems. The model of therapy commented on below includes formulation which is a way of naming the interrelations between key aspects of what *developmentally has led* to current problems and hypotheses about *what maintains them* currently.

Introduction

Phrases that point to the core of a person's personality are sayings like "that is just him", "this is typically me" and "I've always been like this" as recognitions of a person's genuine or authentic nature. The core of a person is their long-lasting habits, beliefs and skills including their sensitivities to potentially problematic scenarios and the learned associations to negativity that they defend themselves against, prior to their actual occurrence. Personality is an attempt to define the style of an ego, of an individual, in a way that is not about their many roles in life across the years but says more about their unique style or pattern of authentic capabilities. American psychiatry aimed to capture the distinctions that are recognised in clinical practice by the idea that short-term problems were disorders or syndromes, "axis I", whilst personalities were "axis II", not about contexts but entirely about the style that individuals take to all contexts (American Psychiatric Association, 1994). I am using the word syndrome to indicate that a number of presentations or variations could qualify for the decontextualised definitions of these diagnoses. The co-occurrence of axis I and axis II problems is referred to as "co-morbidity", the most complex form of distress.

However, precisely the distinction of axis I and II has been abolished in the latest version of American psychiatry's definitive text, DSM-5, for it to be replaced by a standard set of diagnostic criteria and a second more general set of criteria that is not so fixed on the classic ten types of personality "disorder" (American Psychiatric Association, 2013, 645-684, 761-781). The main justification for the creation of the two axes was that disorders or syndromes of contextually-related problems have the tendency to be triggered *and* go into remission across the life-course, with or without intervention. The bodies of information on what works in

therapy as provided by NICE in the UK, and the national bodies of other countries, all adopt the mainstream definitions of major depression or agoraphobia and these are recognisable to practitioners. Yet personality problems, as core aspects of how a person sees themselves and others in their lives, regardless of role and context, are less precise in that a person who is distressed in the long-term personality way has long-standing difficulties that are frequently recognisable as a mixture of the personality disorders defined in DSM-5. The first point to note about the connection between personality and social context is that the inside learning that persons' receive due to their upbringing is active both 'on the inside and the outside', as it were, in the sense that the private and public aspects of self are intermingled in that personality-psychology and social psychology are really one continuum where the private is what remains unexpressed and the social is what gets enacted between self and others. However, there are plenty of areas that are not agreed. McCrae and Costa, two leading personality theorists believe that childhood has no effect on personality and they do not include it in their formulation of its creation (2003, 192-8). Of course, personality is to a degree biological as well as psychosocial but when it comes to specifying the causes of distress in individuals then it is not possible to be precise just yet.

Following Erving Goffman (1959), who was the first to argue that human interactions are like the enactment of theatrical roles on a stage in a play, the performative and contextual aspects of the self in culture and society are variable due to the roles taken (worker, partner, brother, mother) and the contexts in which they are enacted (East End working class, West Yorkshire Asian). So what is not-personality is what varies over context and time; and what is truly personality entirely belongs to the individual and only changes slowly over time in the absence of severe trauma. Since Plato the personality has been judged to be a complex of habits, beliefs, associations plus the more socially-influenced aspects of attachment style and the way that the self has learned to treat itself, often built on the model of how it has been treated by others. Because of the necessity of understanding relational styles and how they indicate the type of emotional functioning and relating that can be recognised and expected (Owen, 2012), then it would seem that integrative therapy, or indeed any other form, would be well-served by being able to identify the types of thoughts, feelings and behaviours that coincide. There are repeating patterns that comprise the connection between egoic personality style and how it exists socially, in a person's life, as well as in therapy relationships. This is where the received wisdom that focuses on specific contextual syndromes is useful but limited. For what complexity means is how to understand concurrent multiple complex syndromes that interact with long-standing idiosyncratic personalities. The value of the DSM way of thinking of axis I and II is being able to record and communicate between professionals. Thus, the functioning of the terminology of "paranoid", "obsessive compulsive personality" and the syndromes of "depression" and "phobias" are useful ways of communicating. Yet the human being is complex and someone with antisocial personality disorder can be full of pride, vanity, deceit, paranoia and low self-esteem, all within the one person. In order to open these concerns for closer inspection, the following three sections define the received wisdom view of increasing levels of complexity before discussing them and commenting on how to work with them.

The Received Wisdom on Complexity

The syndromes defined in the textbooks are decontextualised in that standard definitions are given. The relation to the psychodynamics of what motivates people to act in meaningful ways shows that the specific types of rationality and emotionality form compromise formations with each other. But a personal limitation is that even across the course of a working life and seeing people at a steady rate, year in year out, unique client presentations are met that will never be repeated. There are many significant combinations of personality syndrome, clinical syndrome, lifestyle choices, sub-syndromal vulnerabilities, personal abilities and preferences. The hope of applying standardised formulations to the public is impossible because there is too much variation yet what is required is a theory that is sufficiently complex to capture the idiosyncrasy of individuals' presentations and for that to be discussible with

clients themselves. It is possible to map the events of specific clients in individual therapy through interpreting repeating psychological processes that constitute their problems in written diagrams or verbal formulations. When formulating, therapists agree with their clients concerning the nature of the meaning-making process in which they are stuck in their lives. I propose that a definitive aspect of integrative therapy is tailoring their interventions precisely to the needs of clients, and so they understand and can find new ways to provide themselves with understanding and change, because clarity about a proposed treatment provides value to the meetings. The next section discusses the increasing levels of complexity found across the full range of psychological distress.

Complexity is Empirically Found Only in Attempting Treatment

When people have no risk and more than one contextually-bound syndrome, it becomes a wonder as to know where to intervene first of all. The lowest level of complexity starts with one standard contextual syndrome where there are well-known standard formulations and interventions, the number of sessions required to treat the problem and its level of severity can be estimated in advance. If such a standard treatment is provided, it should be successful for clients to receive a permanent benefit. A functioning lifestyle is one where there is an ability to achieve across all areas of life. When there is distress, it is handled and responded to quickly by the individual and the adjustment works. There are occasional distressing and problematic events of a reactive sort with respect to real problems in contexts. These cause distress and temporary dips in functioning but can be overcome. If there are stronger, longer-lasting yet transient distresses of a reactive sort, with respect to real problems in contexts, these 'cause' longer periods of impairment of functioning yet the problems can be rectified.

There is a first level of psychological problems called a "sub-clinical" or "sub-syndromal" level of problems in personality-functioning or in relation to context. The lowest level of impairment is sub-syndromal occasional episodes of inaccurate understanding and mild negative experiences at the rate of, say, one a month. The next higher level of impairment is sub-syndromal occasional episodes of inaccurate understanding and mild negative experiences. If these occur at the rate of, say, one a week, it indicates that there is a persistence of effect due to the initial episode and the felt-consequences for how the ego manages itself. The range of problematic meanings is wide. Some of which need including and accounting for are those concerned with the general mood or particular emotional spikes of anxiety, anger, panic, contextually-specific fear or low mood in relation to specific events in specific contexts. Emotions and mood-influence can predominate from passive consciousness and take their place in the way that consciousness becomes aware of something that is distressing and gets felt as being against the self, when the emotional part is felt not to be under personal control. The ego begins to feel taken over by meanings which have little or no control and seem to spell a mood of foreboding and doom, as though there aren't many days left to live. So that feeling detached or distant from one's previous dreams and aspirations are given the meaning "failure", that is the non-attainment of a cherished dream for self. The sense of disconnection or alienation from the shared world is one where it is possible to feel an absence (where there could be safety and security). The following set of levels of treatment difficulty start with assuming that persons are motivated to attend and believe that they can be helped.

A syndrome is judged to exist when, for any frequency of occurrence, there is a consequent inability to do something necessary for the minimum performance of a role at work, home or in free time. The meaning of dysfunction is the inability to work, for instance, or to be too distressed to do child care. Because of inaccurate belief and understanding of how to respond to the distress, the self remains too distressed or otherwise incapacitated to carry out one of these roles: Because of emotional distress it becomes impossible to function in the factual sense of being able to do things that self would normally be able to achieve.

In the simple case of one psychological syndrome which appears in one context, the empirical research predicts outcomes that are well-known in advance of starting the work. However, simple psychological problems are

not recurrent across the lifespan but merely one episode, a single occurrence for less than a year, of mild to moderate severity. For instance, simple psychological problems include the following: only depression by itself, similarly only panic, phobia, social phobia, social anxiety, agoraphobia, performance anxiety, post traumatic stress disorder, generalised anxiety disorder and mild to medium severity obsessive compulsive disorder. Simple psychological problems also include relationship-distress, mood and role-change problems, pervasive anger, and life change and adjustment reactions to stressors.

At the commencement of a triggering event, and when such distress may be prolonged, the next step up in complexity is when psychological distress persists even though the initial stressor might have been absent for some time when seeking help. What constitutes complex psychological problems is not just single occurrences of a contextual syndrome. Single occurrences of psychological syndromes are rare. But, those evidence-based therapy models that are guided by the randomised control trial evidence base are in doubt as to their applicability because there is no evidence base concerning the huge array of the co-occurrences of syndromes. The empirical research on what works with single syndromes is limited in its applicability to actual individuals with complex problems. The therapeutic reality of problem of the meanings of the self to itself is incorrectly related to the professional discourse of the co-occurrence of a number of contextual problems with lifelong personality syndromes. The psychosocial consequences of them is that they entail under-achievement and what may frequently co-occur with anxiety is low mood that impairs functioning, aimlessness, poor memory and concentration, distress and poor habits of functioning due to feeling overwhelmed.

The next step up in complexity is when one syndrome is established, the amount of impairment in the performance of roles increases due to the same drivers of inaccurate understanding of how to defend self and respond to distress. The attempts at defending currently used have not worked but are still persisted with. This level of complexity includes however, a large span of complex and concurrent syndromes. These can include the frequent occurrence of unbidden thoughts, urges, images or memories that are disturbing or distressing in what they are taken to mean.

Therefore, the next level of complexity is when there are two non-standard syndromes that require tailor-made interventions and a sufficient length of treatment with relapse prevention to make sure that the gains received during therapy remain after the meetings have ended. The final phase of ensuring that positive changes made remain is called relapse prevention and requires foresight about what could go wrong after the therapy is over and how clients can work to rectify it themselves.

The next highest level of complexity is a middle ground between simplicity and complexity, a grey area. One middle case is people who have had psychiatric admissions in the past for psychosis or who have been suicidally depressed but now they want to work in therapy on something, after they have recovered from these more serious problems. The middle area of difficulty also includes cases where there have been two or more episodes of the same syndromes, suggesting there is some personal vulnerability in the personality perhaps because the recurrence has not been overcome. People with relationship-oriented problems such as on-going difficulties with their partner, work colleagues, children or parents also comprise this middle ground. This is an area of moderate psychological difficulties which may benefit from couples and family therapy as opposed to individual work.

The next higher level of complexity is when there are difficult to treat syndromes that require multiple, tailor-made interventions. There is a struggle to find the central focus of where to intervene, which reflects an actual lack of clarity that exists (and does not reflect the level of expertise of the therapist). And finally, the highest level of complexity is the co-morbidity of contextual on-off syndromes in addition to personality syndromes. However, contextual syndromes might be lifelong or persistently recurrent if they are anxiety-related or low self-esteem or shame about personal identity. And secondly, some personality syndromes are on-off because they are only triggered when there is a sense of enduring

overwhelm that does not go off when the stressors are off, but can persist for a few months or more in their external absence. The persistence may be due to triggering worry, mood problems, rumination or negative associations (negative automatic thoughts) or other mental and relational processes that maintain the distress and do not reduce it.

Complexity of Contextual Syndromes

So a fully complex case is where there are multiple context-related syndromes (but not of the personality variety). A complex case is where it becomes extremely difficult to formulate, get an agreed focus with clients themselves and sustain work on that focus. For in long-standing complexity, there may be numerous on-going crises in the person's life because their level of functioning is low and the personality factors forever prevent steady progress, weekly attendance and possibly prevent the sense of on-going progression across a series of meetings. When there are recurrent, severe and enduring syndromes with decreasing functioning across the lifespan, where there have been multiple interventions of ineffective therapy, hospitalisation and medication, all of which have not brought sustained improvement, this may indicate that there might be significant biological causes at work in the personality. But it might also be the case that the ego has not been able to understand and manage its triggers, its contexts and its reactions to them. These problems are "treatment resistant" because clients who have never responded to therapy or medication may indicate a degree of complexity. The problems of full complexity may include the presence of resistance to change, of therapy-interfering behaviours, poor relational style, difficulties in naming their thoughts and feelings, low motivation to engage in therapy and they may believe they are beyond help and incapable of change. Complexity of treatment includes those who have previously had psychiatric admissions or long-term experiences of trauma-induced psychosis, depression, schizophrenia or bipolar mood problems.

The list of what constitutes complexity can include the following: multiple lifelong problems, lifelong suicidal thoughts and feelings without intent but perhaps with a recent potentially fatal attempt at suicide during the last year. There are a group of people who ask for help but reject it once it is offered: "Treatment resistance" is likely related to an anxious ambivalent attachment style where the problem is that therapists are getting too close. But the difficulty in helping them might be for a number of reasons that need to be asked about where the first task is to help them engage. Perhaps it is because of their inaccurate empathising of other people, or what they feel and tell themselves, that makes relating with them difficult. The consequent problems entailed in working with the hard to help is that frequently at assessment, on the client-side, there is uncertainty and an estimation taking place about the therapist's ability to help. If therapists are over-cautious, then someone who can be helped is turned away with the implied message that they are beyond help. On the other hand, if therapists are over-ambitious in accepting clients who then have crises, high conflict with their partner, or other current stressors that make them feel overwhelmed and unable to continue with what was agreed as a focus of the treatment at assessment, then what follows are impasses, setbacks and difficulties that should have been found out at assessment and pre-emptively planned for instead (if that were possible).

To use an old fashioned term, the "nervous breakdown" is really a state of exhaustion brought on for a sufficiently long period of time, where individuals are exhausted, often depressed and overwhelmed. After an extended period of distress they become unable to function in one or more roles. This is a crisis in functioning that can be capable of being rectified and promoting a return to a relaxed state of coping. If there are repeated instances of crisis across the lifespan then these effects accumulate in personality-functioning because the problems of relating to others and dealing with the inevitabilities of stress and change belong solely to the individual. The remainder of the paper turns to think through how to work with complexity once it is recognised.

Clinical Reasoning Concerning Complexity and Unknown Causation

Clinical reasoning is comprised of heuristics, rules of thumb that might be generally true

and could be formulated as "if a person has "syndrome 1" then it is most efficacious to start treating … first and … second". Formulation is the crossover between the bodies of research evidence about what might work, how to maintain the relationship that holds practice together, getting informed consent for an agreed treatment, and offering clients choice and control over what they might like to work on. These things are achieved only once the pressing matters of suicidal intent, self-harm, harm to others and chronic depression have been tackled.

Practice involves balancing opposing forces where even highly experienced therapists might be working with someone who is outside of their personal clinical experience in the mixture of factors that they bring for help. There are limitations to the guidance from nationally approved considerations of the research findings on what works and what does not, in thinking how to proceed, because novel combinations of syndromes and circumstances regularly occur. There are very many opinions gained from formal research on how to treat any single syndrome (nice.org.uk). The usefulness of research on what is effective, according to randomised control trial format or common factors analysis of the therapeutic process of relating is useful as background information. However, the individual presentation of what constitutes syndromes demands a tailor-made approach to help the unique individual. The day to day work of therapy is precisely helping people change their ways of reacting even in relation to what might be biologically-inherited temperament and longstanding habits of believing, feeling and relating. Often people over-use specific mental processes in relation to specific meaningful objects. This partly explains how easy it is to jump to false conclusions without the evidence to support them. On the contrary, consciousness and its ego can be aware of their own tendencies and rein them in, but only by becoming fully aware of the mental processes and objects, through formulation, and working out how they want to try something new which often means tolerating distress and trusting themselves in being able to make changes. At a time in the future, when the human genome is fully understood, it might be possible to know individuals' biological inheritance. Until then therapists are left to understand persons in front of them, whom they have told they can help. The pragmatic answer is to get the understandings that clients have of themselves and formulate: that is represent their repeating processes and experiences to clients whilst being mindful of the findings about what works from what empirical psychology and therapy theory provide.

Discussion

On the contrary to the idea that axis I, contextual problems, as being co-morbid with axis II, personalities, are separate, there is an empirical body of knowledge that supports the view that personality and contextual syndromes can be understood together and require the following authors to be cited. Bruce Pfohl (1999) argues for recognising that the on-set of psychological disorders can be intermittent. When both are present they can co-occur with a flare up of personality functioning, which means that both contextual and relationship-oriented events and personality functioning problems are reactive and not constant. And the converse occurs, the cessation of psychological syndromes co-occurs with the cessation of syndromes of personality functioning. The same phenomenon of the variability in personality and standalone syndromes is noted by Tracie Shea and Shirley Yen (2003) who add that sub-syndromal levels of distress can occur such that the syndromes are officially absent diagnostically, but they remain as latent vulnerability or continue functioning at a residual, low strength of influence. Shea and Yen (2003, 378) have found empirically that anxiety syndromes tend to be more persistent than personality syndromes. What this means is that contextual syndromes of anxiety are better understood as the neuroticism personality factor because they have a tendency to be lifelong.

If we presume that the poorer the understanding then the more ineffective the functioning in everyday life, then the received wisdom of advancing through levels of complexity of the ability to treat problems is one where everyday functioning decreases due to the increasing complexity of distress across the lifespan. Therefore, complexity to treat is only ever the result of attempting treatment in a specific therapist-client combination. Difficulties and impasses in treatment could be conflated by

ineffective practice which is often due to not getting an adequate understanding of what is happening for clients at assessment and thereafter. The remainder of the article now returns to discuss how to treat complexity.

How to Treat Complexity

The first problem in understanding how to treat complexity is to acknowledge that for some people, they may have an interest in having therapy but that does not mean they are suited to having it. Therapy is not a panacea and therapists can never do the work that clients need to do when they apply their new understandings of their repeating problematic patterns and change their lifestyle and manner of relating. Given that the trajectory of some people's lives is that their distress and defences increase across the lifespan whilst their functioning decreases. It is a therapeutic responsibility to assess by taking a history that can begin to understand what influences have been working on them since they were a child. However, there are a number of factors that mean that persons are unsuited to having therapy at all. Some of these are clients who have complex needs:

1. But no desire to work and make changes on their lifestyle.
2. Dislike being assessed and refuse to speak about certain topics because of how it makes them feel, especially when they wish to withdraw from therapy because of distress.
3. And having a trauma-induced psychosis or dissociative identity disorder are not immediate contraindications but are two examples where clarity about causes and treatment offered will help.

However, given that assessment has been carried out and that those who are both suited to it and interested in it have been given the necessary information about what they will need to do in it, then sessions with all levels of complexity can progress. There are a number of general pointers that can be gathered from directly asking clients who have had a positive therapeutic outcome with oneself and through reading the research literature on what works in managing the therapeutic relationship. The most basic sense to be communicated from therapists, I would argue, is one of genuine interest and caring. These things are what we should have experienced in our training therapies and when we have had therapy at other times. Being cared for and having the therapist be positive towards us as clients, cannot be faked nor do I think it requires specific techniques. The basics of creating a positive working relationship with the public come from the heart, even when helping people with backgrounds full of trauma that lead them to have complex mental health needs. However, it is the employment of the intellect that goes further in being able to specify what the pieces are that make the whole. A few more points need to be made.

1. Attend to risk for clients and those about them where the need to maintain confidentiality is equally important as the need to share information. If there is a need for contact with psychiatric services, social care or psychiatric nursing then these should be pursued as a matter of priority before therapy begins particularly when there is strong suicidal intent with no protective factors or risk of violence or death through anorexia or domestic violence.
2. A general heuristic is the utility of decreasing depression before beginning a more specific focus on any other topics.
3. Therapy interfering behaviours are those where there is an anxious ambivalent attachment or avoidant attachment produces resistance of the sorts of asking for help and then preventing it being delivered or asking for help but not being willing to talk and feeling over-exposed in the process of talking about feelings. These are very different types of problem but they both indicate that either preparatory help is required, or potentially, the person is not ready yet and will need to do some sort of personal preparation before commencing some serious work which may well make them feel exposed and open to being let down by their therapist.

Once these three items are tackled, further work on agreed focuses according to the problem list of clients can be pursued.

Conclusion

The provision of integrative therapy requires a broad view of the field. The work of the integrative therapist is to integrate different types of information with the desire to create tailor-made approaches. Thinking about complexity is a way of drawing the best from the mainstream orthodoxy as exemplified in psychology and psychiatry in texts like DSM-5 and ICD 10. What these documents collate is expert opinion of colleagues about the meanings and experiences of the public. A good deal about how to rise to the challenge of complexity can be gained from understanding the orthodox approach to personality and contextually-occurring problems.

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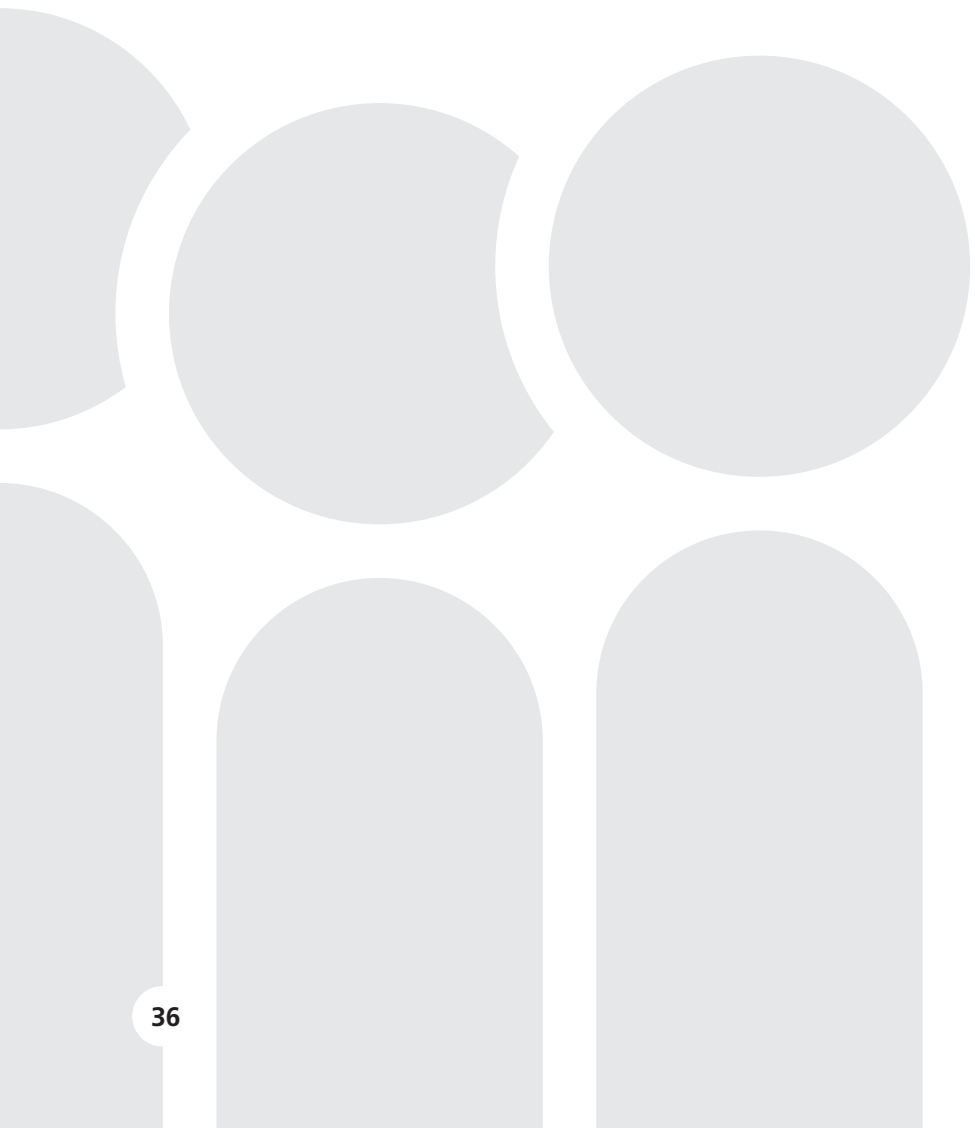

João G. Pereira

An Integrative-Relational Framework of Intervention at Casa de Alba – Therapeutic Community for Severe Mental Health

Introduction

Paper presented at the International Conference "Mental Health in Portugal: what avenues"?

Context and Origins

Casa de Alba, founded by Romão de Sousa Foundation is a Therapeutic Community for Severe Mental Health Problems in Rural Portugal which is now celebrating the first year of existence. In this article, I will start by contextualizing the beginning of the project and my state of mind when I joined it; I will then give a brief glance through the theoretical and practical inspirations behing the project as well as some difficulties faced in the materialization of my original ideas; I finish with an overview of Mentalization Based Therapies and how Casa de Alba is slowly introducing and integrating a mentalizing frame in the day to day running of the communitty.

One of the difficulties I faced when I joined the project was the re-adjustment to a 'mental health culture' that is markedly different from the one in Britain. In Portugal psychiatry is, by and large, the dominant discourse. At the same time there is a push for deinstitutionalization and the close up of large psychiatric hospitals. All the legal documents keep using a medicalized, restricted and reductionist language concerning mental health problems. In the course of the readings I made, a number of words were repeated over and over in the documents and text books: illness, rehabilitation, remediation, deficit, handicap, disability, inability, and so on… When I recently re-read the Portuguese Mental Health Law 36/98 I was struck by the tittle "The Carrier of Psychic Anomaly", a title that puts the emphasis of the problem on the individual, detaching him from the social, familial, cultural or educative context. No matter how hard I looked, I could not see mental health documents using words such as meaning, dynamic, system, society, culture, psychological, symbolic, development, expression, constructionism, etc…

I guess my point here is that psychosis, schizophrenia or any other mental health problem cannot be seen in a linear, billiard ball fashion, cause and effect way. Art Bohart, researcher in psychotherapy, says something interesting about the epistemological problem of psychotherapy research and the production of manuals: no two therapies are therefore alike at a micro level, and therefore there really is no such thing as an independent variable that is being applied in the same way across clients. If this is the case, then the RCT is a crude instrument for the study of a subtle phenomenon (Bohart, 2008).

Such a complex predicament is, no doubt, the result of a multiplicity of influences: cultural, political, familial, anthropological, sociological and psychological, as well as, of course, genetic

and biological. When something is 'mental', coming from the 'mind', it necessarily goes beyond 'brain', 'body' and even 'matter'… I am not purposing here a Cartesian split between body and mind, on the contrary. I am suggesting that to think about 'mind' is not solely to consider an 'embodied entity' but also a subjective construction, even more, an inter-subjective enterprise as it is proposed that isolated 'minds' are a myth (Stolorow and Atwood, 1992). 'Minds' are the creative and psychological co-construction of individuals under a matrix of complex relational systems. Perhaps Freud was wrong in studying intra-psychic mechanisms and structures? In the same way, the focus of neurobiological research on the brain or on DNA may be a fruitless enterprise, as many others factor can be lost. From a relational standpoint, the dis-ease or the mental health problem, would always occur at the interface between intersubjective dynamic systems.

How can we explain such things as 'ego', 'identity' and 'meaning', as well the depth of love, hate, anguish, guilt or shame - many times at the core of psychotic breakdowns - without making use of pluralistic explanations and a multitude of disciplines?

Such complexities are about human lives and demand enormous responsibility of the workers, who must be aware of their need to compete with other professionals for the 'right' explanation of the phenomena, as well as the necessity to get rid of the anxiety that 'thinking' about the pain of another arises. To follow one single explanation feels 'safer' for the practitioner, providing an anchor for his own fears, protection from the unbearable feeling of uncertainty and of 'not knowing', and a sense of organization of the 'psychotic' chaos at hand. This "safe" explanation may relieve the professional, the family or even someone who pays for the treatment. It is, however, a disservice for the client as the totality of his being is left unseen.

Theory and Practice Inspirations

Therapeutic Community Philosophy

The therapeutic community (TC) movement emerged out of the treatment of traumatized soldiers during the Second World War. It was, in many ways, a revival of the moral treatment of Pinel in nineteen century France and of Tuke in the United Kingdom. Following a period of enthusiasm, moral treatment succumbed for more than a hundred years. The TC movement brings together some of these old ideas with new ones.

Tom Main (1946) introduced the term for the first time when some UK institutions that had historically been unhelpful or iatrogenic decided to change, humanizing the services, improving life conditions and giving more power of decision and participation to the residents (preferred term for "patients"). Clark (1965) defined the concept of "Therapeutic Community Proper", meaning not only a democratization of the power to take decisions that affect the management of the house but also in decisions related to the therapeutic plan of other residents. This meant that residents would become auxiliary therapists.

Therapeutic Communities would then follow several different paths, under three main types:

1. Democratic (traditionally linked with personality disorders, prison services and young people)
2. Concept-Based (mainly linked with addictions) – started and developed in California, from 1958 onwards.
3. Anti-Psychiatry (tradition inherited mainly from R. D. Laing) – there is a total absence of hierarchy; no distinction between staff and residents; the term illness is not accepted or recognized.

Casa de Alba bends towards the democratic type, integrating contemporary relational thinking whilst detaching itself from radical anti-psychiatry models.

Main Characteristics

When entering Casa de Alba, or indeed many other therapeutic communities, the visitor will experience and observe a number of particular characteristics (Kennard, 1983):

Communal Informal environment where some of the habitual institutional boundaries are broken.

It will be difficult to distinguish between staff and residents. Sharing of feelings will be noticeable throughout the day either formally (during structured meetings) or informally within the house.

Regular Community Meetings

The main purpose of these meetings is to (Kennard, 1983):

1. Maximize the sharing of information;
2. Develop a sense of cohesion and belonging;
3. Decisions are taken together and openly (instead of being taken behind closed doors without explanation of the underlying reasons);
4. Opportunity to give and receive personal feedback (mirroring of self);
5. Vehicle to exert pressure in individuals whose attitudes or behaviour are disturbing or undesirable.

Engagement in the day to day running of the House and its management (instead of activities just to occupy).

Therapeutic communities of the democratic type share a number of beliefs and values that underpin the work (Kennard, 1983):

1. Problems are of relational nature
2. Theories such as Stern´s (2003) RIG´s – Representations of Interactions that become generalized – fit well in here. Some of these RIG´s, later named "Ways-of-Being-With", may be maladaptive causing people a number of problems.
3. Symptoms are not exempt of meaning
4. Therapy as learning (knowledge and skills)
5. Equality between staff and residents (as much as realistically possible)

Problems

There are many difficulties and problems that arise when running a therapeutic community of this kind. They are extremely difficult to manage; it is hard to be democratic all the time. There is a natural tendency to restrict and regulate the behaviour of residents, usually to the convenience of management and administration. It is important to be aware of and to resist this tendency.

Another common problems is the risk of the TC ideology being marginalized in the professional field since there is a clear attempt to abolish or dilute established positions of power (such as biological psychiatry and empirical psychology).

Evidence Base

There is evidence for the effectiveness of TC´s in mental health settings, either residential or non-residential. More than sixty studies have been undertaken in Denmark (Isohanni, 1993) and a few more in the UK (Chiesa et al, 2004). In the 60's and 70's the Henderson Hospital and the Cassel have been designated as "centres of excellence". Nevertheless, despite the evidence, TC´s have the tendency to come and go in different periods depending very often on the political and social climate of the time.

Activities at Casa De Alba

Everything that happens in Casa de Alba in taken as an opportunity to learn. The relational environment within the house is the main therapeutic tool – this is called the therapeutic milieu. Apart from the therapeutic potential of the day to day activities there are a number of formal therapies in place. Dyadic psychotherapy, group and multi-family therapy are central. A number of other activities take place over the 5-Day week and also on Saturdays (Sunday is free of activities): psychomotor therapy, art therapy, horse riding, swimming, gardening, occupational therapy, motivational groups, employment and educational tasks.

Casa de Alba is not the only therapeutic setting where such activities take place. What distinguishes Casa de Alba and other TC´s

from other traditional settings is that the focus is not on the activity or the behaviour but on the way the resident feels and thinks, his internal and relational world. These are discussed within the several "reflection points", in community meetings and in therapy.

Inovation

Most democratic therapeutic communities are underpinned in three main principles: democracy, psychoanalysis and milieu therapy. Casa de Alba makes a particular distinction and replaces psychoanalysis by mentalizing. Mentalizing, a relational-integrative concept is used to inform the democratic therapeutic milieu.

Why a Mentalization Based Service?

1. Because several studies demonstrate failures to mentalize in most areas of psychopathology (see Bateman and Fonagy, 2012)
2. Demonstrated efficacy in RCT´s (Bateman and Fonagy, 2008) and effectiveness in naturalistic studies (Pereira, 2014)
3. Healthier and better functioning services as demonstrated throughout the NHS in the UK and in other countries where many traditional services changed to mentalizing services.

Brief Outline and Principles of MBT

Historical Background and Contextualization

One of the current accepted definitions of mentalization (Allen, Fonagy and Bateman, 2008) refers to the process of implicitly and explicitly interpreting the actions of oneself and others as meaningful on the basis of intentional mental states (e.g. desires, needs, feelings, beliefs and reasons).

The concept is rooted in Theory of Mind studies on philosophy as well as the later developments in cognitive science and developmental psychology; it has been used for some time in the study of autism and schizophrenia (e.g. Baron-Cohen, Leslie and Frith, 1985; Baron Cohen, 1995) being empirically tested for the first time in 1983 when Wimmer and Perner (1983) ran a false belief experiment with three year old children.

Over the years, the psychoanalytic literature has described similar phenomena under different headings. Freud's Bindung, translated to English as binding or linking, was first formulated in 1895's 'Project for a Scientific Psychology' as the mental activity of linking psychic instinctual energy in primary process with mental 'representation' in secondary process (Freud, 1895). Reformulated along the years, this concept referred to the transformation of somatic non-mental activity into something mental, allowing 'thought' to mediate traumatic memories. Freud (1914) also stressed that this representation of internal states could fail in various ways, which is at least analogous to what is meant nowadays by mentalizing failures.

Other concepts, such as Melanie Klein's depressive position (Klein, 1945) or Wilfred Bion's (1962) alpha-function are comparable to the notion of the acquisition of Reflective Function (RF), a concept that overlaps with the construct of mentalization (Fonagy et al, 2002). For both authors, the mother-child relationship provided the basis for the development of this capacity to symbolize. Similarly, the emergence of the true self in Winnicott (1962) or the acquisition of empathy in Kohut (1977), were dependent on the caregiver's psychological understanding of the infant. Winnicott (1962) also recognized, alongside Kohut (1977) and Fairbairn (1952) that the psychological self develops through the perception of oneself in another person's mind as thinking and feeling (Fonagy et al, 2002).

In the 1960's, French psychoanalysts applied the concept of mentalization to understand psychosomatic patients who displayed a lack of symbolization of mental states (Jurist, Slade and Bergner, 2008). The construct of alexithymia has also demonstrated some overlap with aspects of mentalizing, specifically relating to self-awareness (Goerlich et al, in preparation). A review of empirical evidence relating alexithymia with substance misuse was undertaken by Taylor (1997).

Allen (2006: p.7) defined mentalizing as 'perceiving and interpreting behaviour as conjoined with intentional mental sates'. The focus on intentionality is rooted in Dennett's (1978, 1987, 1988) studies on the prediction of behaviour; a state of mind is necessarily intentional since it is impossible not to be about something or directed at something. The philosophers of mind then extended Dennett's approach to include Freud's theory of the unconscious (Hopkins 1992; Wollheim 1995). Understanding aspects of behaviour that usually make little sense, such as dreams or neurotic symptoms, in terms of unconscious beliefs, thoughts, feelings and desires would make them meaningful and possible of being understood (Fonagy et al, 2002).

Fonagy (1991: p.641) introduced mentalization into British psychoanalytic discourse by defining it as 'the capacity to conceive of conscious and unconscious mental states in oneself and others'. The contemporary application of mentalization has been developed in great part by Peter Fonagy and his colleagues from University College London (UCL) and the Anna Freud Centre. Fonagy and colleagues' current conceptualization of mentalization combine insights and ideas derived from (Jurist, Slade and Bergner, 2008):

1. Neuroscientific research about the brain and the link between brain and mind, as well as about the way early relationships affect development;
2. Attachment theory and research about the properties of early (and potentially also later therapeutic) relationships that promote, or hinder, the capacity for mentalization;
3. Theory of mind studies in developmental psychology and in philosophy

Within the above principles, Bateman and Fonagy (2004; 2006) have developed a treatment programme for Borderline Personality Disorder, a problem intimately linked with attachment difficulties, affect dysregulation and mentalizing failures. This treatment programme was given the name of Mentalization-Based-Treatment and, more recently, Mentalization Based Therapy (MBT).

MBT is a psychodynamic treatment focusing on the here and now dynamics of the therapeutic relationship, as well as the value of understanding the nature of resistance in therapy. It draws, nonetheless, on a number of different approaches and perspectives. It relies on cognitive behavioural therapy in the attempt to understand the relationship between thoughts, feelings and behaviour; on systemic therapy through the consideration of family members and their behaviours, as well as the impact these have on each other; and on social and ecological principles via an understanding of the impact of context upon mental states (deprivation, hunger, fear, etc).

MBT is, therefore, an integrative and pluralistic treatment, providing a unique space for dialogue and collaboration between psychoanalysis and related disciplines.

Fonagy and colleagues main claim is that trauma impairs mentalization (Jurist, Slade and Bergner, 2008). Not having the experience of being thought about in a contingent way impairs the capacity of the infant to feel safe to think about the social world; mentalizing and the healthy development of intersubjectivity allows for the expansion of epistemic trust in relationships, a necessary key to open up the wish to learn about the World (Fonagy, 2013).

In MBT the attachment system is seen as a survival mechanism, interpersonally built, and serving as moderator for genetic expression (Fonagy et al, 2002). The capacity to mentalize (i.e. reflective function) is assumed to develop from the experiences of attachment and the ability of the caregiver to appropriately represent and mirror the emotional states of the infant.

This intimate process, allowing the infant to gradually pay attention to, and understand, what he/she is feeling or experiencing, was described in Gergely and Watson's (1996) social biofeedback model of parental affect-mirroring and then later developed by Fonagy et al (2002) under the name of contingent marked mirroring.

Disorganized or insecure attachment styles have been linked to failures in mentalizing during adult life (Fonagy et al, 2002). In traumatic experiences of abuse, for example, it is safer for the child not to understand (mentalize) what goes on in the mind of the abuser, as this could be too frightening. Attachment trauma, in this

way, promotes a defensive withdrawal from the mental word (Fonagy and Target, 1997). Later in life, close interpersonal situations leading to the activation of the attachment system will interfere with mentalizing as they can trigger overwhelming affect. This becomes, however, a double-bind problem as mentalizing is also needed to help regulate difficult emotions.

One of the 'revolutionary' aspects of these discoveries is the assumption that classical analytic technique will not work for patients with attachment disorders and personality problems as they may induce severe instability and regression (Jurist, Slade and Bergner, 2008). The same can be inferred for interventions currently used in addiction services, like Motivational Interviewing, CBT, or any other intervention that activate the attachment system without paying attention to the mentalizing deficit of the patient. Many of these interventions do not provide the patient with the necessary mentalizing skills to be able to use and internalize that attachment (Jurist, Slade and Bergner, 2008). The therapist must be able to create in his/her mind a representation of the mental world of the patient and then aim to communicate it in a way that helps the patient organize his/her mind. In MBT the activation of attachment is carefully monitored, running alongside the development of mentalizing skills within the framework of treatment and of the transference.

As I argued elsewhere (Pereira, 2011; 2012), the above considerations augur a paradigm shift in psychoanalysis as they discredit (at least for some patients) one of the major analytic techniques: transference interpretation. To avoid inducing states of instability and severe regression, the here and now therapeutic relationship must be modelled on early development and the delicate processes of co-regulation of affect that occur in secure attachment interactions. Thereupon, the concept of mentalization is unique in its particular emphasis on development. The process of treatment in MBT is also connected with psychoanalysis as it focuses on the dyad therapist-client and on the process of therapy; however, the focus is not on insight or interpretation but on current mental states (Bateman and Fonagy, 2006).

Within the multi-disciplinary milieu described above four central concepts have grown in the MBT tradition that is worth mentioning briefly (Bateman and Fonagy, 2006; Allen, 2006).

Mentalized Affectivity

This is defined as the simultaneous 'experience' and 'knowledge' of emotion. It is a major aim of MBT.

Psychic Equivalence

This is described as one of the prementalistic modes of functioning, antedating the development of mentalization. In this mode of functioning, mental representations are not distinguished from external reality. The internal has the power and importance of the external. For example, if a young child thinks there is a monster in the closet, a monster is in the closet (world=mind). Equally, if an adult patient reverts to a psychic equivalence mode they may assume, for example, that they know what the therapist is thinking and alternative perspectives will not be considered. There is a strong conviction of being right. This may also be the case in flashbacks or paranoid delusions where mental states are experienced as real.

Pretend Mode

In this prementalistic mode there is a separation between psychic and physical reality to a point where the connection between the two can no longer be achieved. Whilst this mechanism can help children liberating themselves from the frightening experiences of psychic equivalence, the relationship with reality is lost and, at the extreme, this can resemble dissociation.

Teleological Mode of Functioning

In this prementalistic mode of functioning changes in mental states are assumed to be real only when confirmed by physical observable action contingent upon the patient's wish, belief, feeling or desire.

The teleological mode arises in circumstances where the use of the intentional stance (mentalization) is only partially accessible (Fonagy et al, 2003). Gergely and Csibra (1997) have shown the opposition between a teleological mode and an intentional one; in the teleological mode the behaviour of the other is interpreted in terms of its observable consequences, not as being driven by desire (Fonagy, 2000).

A useful example of the teleological mode of functioning can be found in the following statement from Bateman and Fonagy (2006: p.23): 'a commitment by a psychoanalyst to be available several times a week at an early hour is not experienced as an indicator of commitment. It is taken for granted as a standard template of therapeutic support. It is deviating from this template in accordance with the patient's wishes (giving them the illusion of control) that is experienced as meaningful; special acts such as checking in with patients between sessions, emailing offering weekend appointments, allowing between sessions contact, etc are demanded as physical proofs of commitment'.

A similar example could well be applied in the day to day running of drug and alcohol services: a patient who arrives late for his appointment is denied his methadone prescription and given another appointment. The patient protests violently threatening the staff member who as a result becomes even more defensive. Such acts of violence may arise because the patient is unable to monitor their own internal state and is incapable of taking the perspective of the other, who is considered hostile until proven otherwise. If the member of staff is only focused on the violent act itself, the underlying mental processes that led to the outburst will remain unchecked and unaltered, ready to fuel the next action (Bateman and Fonagy, 2004).

Fragile mentalizing will be evident when the patient regresses to earlier psychological modes of functioning: teleological, psychic equivalence and pretend mode. The aim is to develop mentalized affectivity states, particularly in the face of difficult interpersonal situations that activate the attachment system.

Treatment Structure

> *Structure is needed to form a framework around therapy that is neither intrusive nor inattentive and which, much like a benevolent uncle, can remain in the background but be around to catch things when they get out of control (Bateman and Fonagy, 2004: p.184).*

The description of the treatment structure I will use was gathered mainly from Bateman and Fonagy's (2004, 2006) treatment manuals. These manuals have been developed specifically for the treatment of Borderline Personality Disorder. However, MBT has transferable features that can be adapted to other disorders and settings. The Anna Freud Centre and University College London (UCL) are at the forefront regarding new applications of MBT in the UK. Other sites, like the Menninger Centre in the US and other international projects, for example in the Netherlands and Finland, are actively working on the development of this approach. Pereira (2014) took inspiration from Bateman and Fonagy's (2004, 2006) guidelines in his attempt to research the applications of MBT to several concomitant personality disorder types presenting with co-morbid substance addiction within an NHS Psychotherapy Service. That was a major aim of his research project and one that represented the clinical reality. Whilst Pereira (2014) was undertaking this research, another MBT study for dual diagnosis (MBT-DD) was underway in Stockholm (Philips, Kahn and Bateman, 2012) legitimizing further these ideas.

Bateman and Fonagy (2006: p.37) state that 'the overall aim of MBT is to develop a therapeutic process in which the mind of the patient becomes the focus of treatment'. They describe two variants of MBT: The first is a day hospital programme in which patients attend initially on a 5-day per week basis. The maximum length of time in this programme is 18-24 months. The second adaptation of MBT is an 18-month intensive out-patient treatment which consists of one individual session of 50 minutes per week, and one group session of 90 minutes per week. In both programmes the group therapist is different from the individual therapist.

Both variants include the use of medication and regular psychiatric reviews (within the treatment team to avoid splitting) as well

as the involvement of all relevant external agencies or parties (e.g. GP, CMHT).

In their treatment programme, Bateman and Fonagy (2006) make the general point that anything that reduces the capacity to mentalize is in clear opposition to the programme. Sexual relationships between group members ('pairing of minds'), the use of violence and aggression (taking too much 'mind space') or the use of drugs and alcohol are all seen as incompatible with engaging in the programme. 'Drugs and Alcohol alter and interfere with exploration of mental states and as such negate the overall aim of treatment' (Bateman and Fonagy, 2006: p.47). There is even some overlap between the areas of the brain responsible for mentalizing and those that are affected by drugs and alcohol (see Bateman and Fonagy, 2004; 2006).

Although I agree unreservedly with Bateman and Fonagy (2004; 2006) regarding the difficulties created by the use of drugs and alcohol, I challenge their view on addiction as exclusion criteria for treatment. I believe MBT has potential to treat these patients, who are otherwise excluded from most psychotherapeutic treatments. As a matter of fact, the authors (at least Anthony Bateman) have actually changed their minds very recently, since they are now testing MBT in patients diagnosed with BPD and Substance Use Disorder (Philips, Kahn and Bateman, 2012). Of course their inclusion in treatment must be done in a thoughtful and boundaried way and the present study is just a preliminary attempt to include some level of substance misuse in an outpatient mentalization-based psychotherapy programme. MBT programmes are also being expanded in many arenas outside the borderline constellation, and there are some interesting attempts of working with substance misusing mothers and their babies (e.g. Soderstrom and Skarderud, 2009). However, MBT had not been used, thus far, in mainstream drug and alcohol services. The randomized controlled trial under study in Stockholm is the first serious attempt of testing whether MBT works for this population and what variations are required. Another attempt, already described earlier, was made in the Netherlands, although not specific for drug addiction and delivered without modifications (Bales et al, 2010; Bales et al, 2012). Pereira (2014) studied the effectiveness of MBT for patients with mixed personality disorders whilst actively using drugs, showing that the work is possible and worthwhile.

Strategies Of Treatment

> *The mentalizing stance is an ability on the therapist's part to question continually what internal states both within his patient and within himself can explain what is happening now (Bateman and Fonagy, 2004: p.203).*

Four main strategies are recommended in Bateman and Fonagy (2004): (1) enhancing mentalization, (2) bridging the gap between affects and their representation, (3) working mostly with current mental states, and (4) keeping in mind the patient's deficits.

The task of the therapist is to facilitate the patient's understanding and identification of emotional states whilst helping him to locate them within a present context with a linking narrative to the recent and remote past.

The gap between inner experience and its representation engenders impulsivity (Bateman and Fonagy, 2004). The therapist's work is to assist in the 'elaboration of teleological modes into intentional ones, psychic equivalence into symbolic representation, and linking affects to representation' (Bateman and Fonagy, 2004: p.206)

Transference

Transference interpretations undertaken in a classic fashion are likely to generate anxiety and be experienced as abusive. It is only safe to use the 'heat' of the therapist-patient relationship and to explore different perspectives towards the middle or end of therapy or once a strong therapeutic alliance has been established and stable internal representations recognized (Bateman and Fonagy, 2004). Even then, Bateman and Fonagy (2004) caution that change in borderline patients is engendered by brief and specific interpretations rather than complex statements about the repetition of past relationships.

> *With borderline patients, transference is not used in the clinical situation as a simple repetition of the past or as displacement and should not be interpreted in this way. Transference is experienced as real, accurate, and current by the borderline patient and needs to be accepted by the treatment team in that way (Bateman and Fonagy, 2004: p.207).*

Retaining Mental Closeness

This process resembles the infant-caregiver relationship and the provision of empathic responses by the caregiver, offering feedback to the infant on his or her internal state and enabling developmental progress. The job of the therapist is to represent accurately the feeling state of the patient and its accompanying internal representations (Bateman and Fonagy, 2004).

Working with Current Mental States

Bateman and Fonagy (2004) put emphasis on the present and the 'here and now' in considering the influence of past events. This is different from continually focusing on the past; the task of the therapist is to bring the patient back to the present and link the events described with the 'here and now' (Bateman and Fonagy, 2004).

For Bateman and Fonagy (2004), the classic technique of conflict interpretation will distance the treatment from a focus on current mental states. A difficulty with second order representation in the mind of borderline patient is likely to make him respond to terms such as breast or penis not as metaphors but as the objects themselves (Bateman and Fonagy, 2004). I confirmed this several times in clinical practice and common sense has gradually and intuitively moved my stance closer to the mentalizing position.

Mentalizing in Casa De Alba

The mentalizing concepts described above are useful within the entire treatment programme. They are actively used in the supervision of therapists, for example, helping to facilitate reflection and the integration of different approaches. We do not use mentalizing as a new modality (we know that no two therapies are alike!) but as an aid for reflection and a way to focus in the main therapeutic goal of attuning with the patients` affect so that they increase mentalizing capacity and emotional regulation.

We are not using formal MBT nor do we aim to use a single form of therapy. We know from research that psychotherapy is effective, but that the type of therapy makes little difference in outcome (Lambert and Bergin, 1994; Bateman and Tyrer, 2004). What matters the most are the common elements of the different therapies, mentalizing being one of the fundamental ingredients (Pereira, 2014).

Compromise with Practice Base Research

To evaluate the effectiveness of the work, Casa de Alba established links with local Universities (e.g. Évora University) being currently involved in a number of different projects, such as the International Project for the Development of IPPS (Individualized Patient-Progress System). IPPS developed an innovative software for the monitoring and evaluation of psychological treatments. The IPPS is the first feed-back system combining standardized measures with Patient-Generated Measures. The work is done in collaboration with the CORE IMS (COREims) and is integrated in the CORE-NET System (Sales e Alves, 2012).

Conclusion

The aim of Casa de Alba is to help individuals and families affected by mental health problems, making use of Therapeutic Community theory and a range of psychological therapies and psychosocial interventions to create an environment where thought and reflection can replace unprocessed pain and acting out. Working within a relational-integrative framework, Casa de Alba has constituted a multi-disciplinary team to help look at the multiple facets of mental pain and hurt inhabiting the residents and their families. Using interpersonal relationships and the group as vehicles of transformation, the team of Casa de Alba gives priority to their

own self-awareness and personal growth to enable professionals to understand and manage difficult enactments and the recovery of mentalization in everyday interactions.

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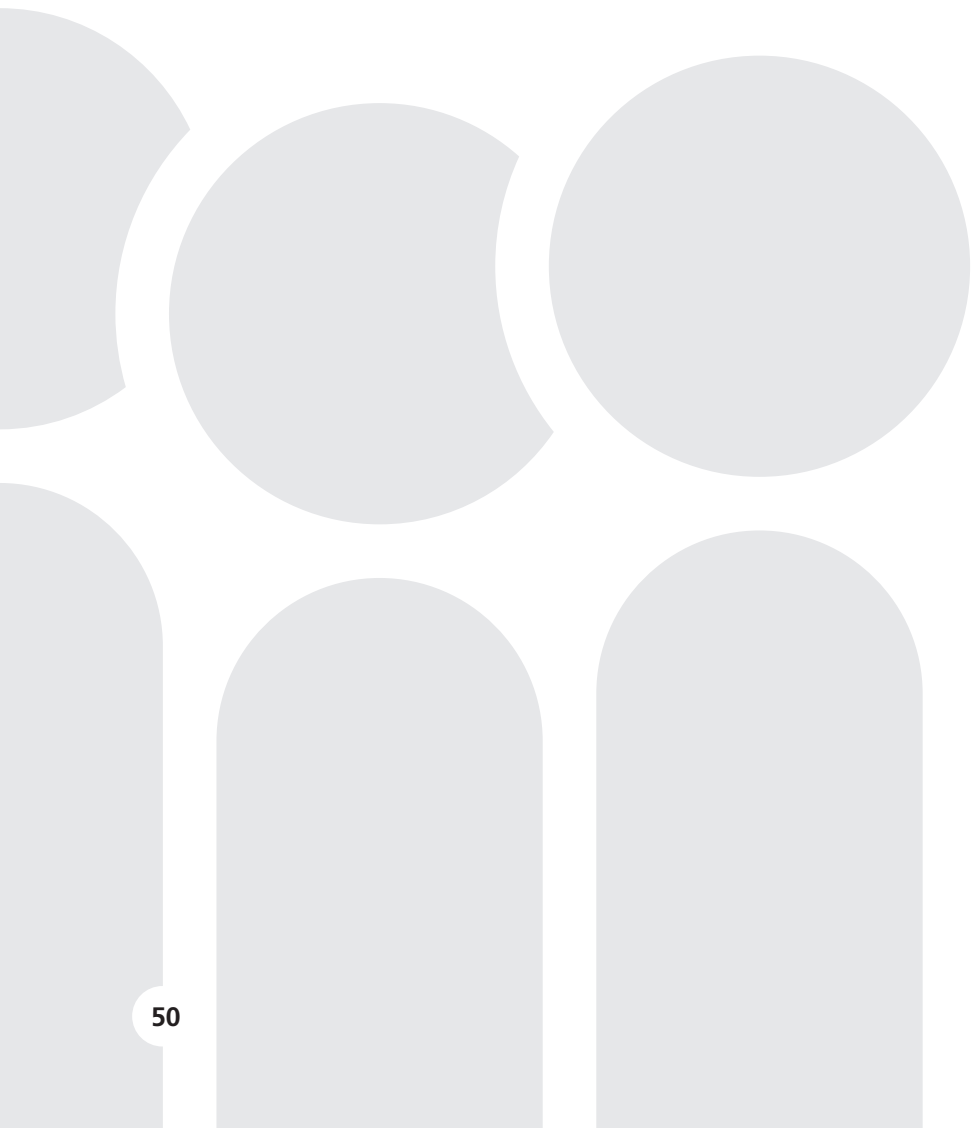

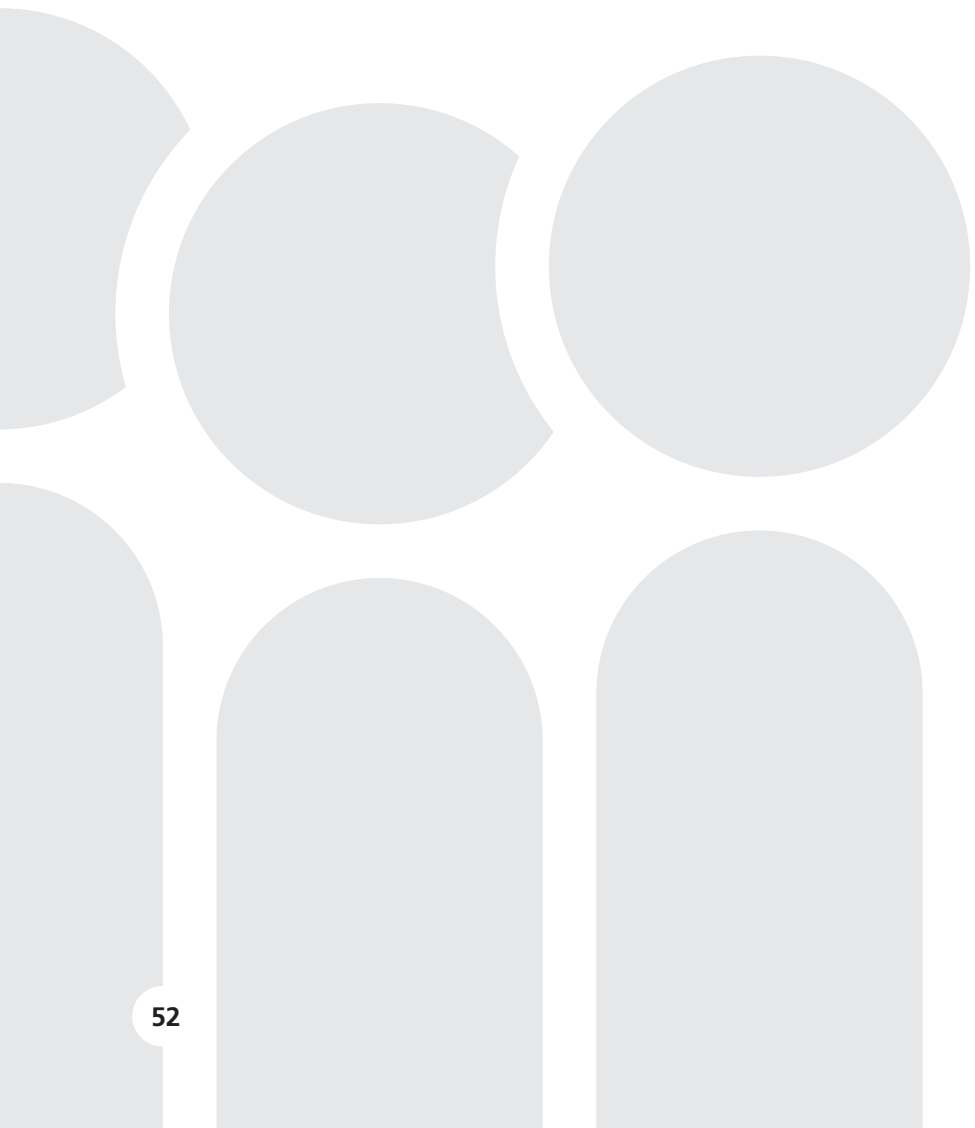

Antoinette Moriarty

Description of How the Student Sees Herself as a Practising Integrative Psychotherapist

Editor's Note

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

Introduction

> *"…to spend time on what has been discovered is to concentrate on an irrelevance. What matters is the unknown and on this the psycho-analyst must focus his attention." – Bion 1970, p. 69.*

This section outlines my model of integrative psychotherapy, my supporting values and my philosophy of practice. I begin with my understanding of what it means to be human, examining aspects of motivation that are personally significant. I then explore what I believe contributes to optimal development, before considering the impact of deficits, derailments, trauma and dissociation, and my thinking in relation to classification of disorders. Finally, I examine the process of psychotherapy and its role as a relational model of change.

Summary of my Integrative Model of Psychotherapy

I consider psychotherapy to be a co-constructed relational process of change. A containing relationship (Bion, 1959), evolving within Rogers' enduring core conditions of empathy, congruence and lack of judgment (Rogers, 1957), is the optimal environment within which clients can explore and make meaning of self-in-the-world. Meeting at 'relational depth' (Mearns and Cooper, 2005 p. xi) is made possible through the therapist's intentional use of self, her empathic attunement to, and her co-regulation, of clients. A willingness to continuously negotiate proximity and trust fosters the 'security of human relatedness' (Bromberg, 2011, p. 122) necessary for painful experiences to be felt, tolerated, named and reflected upon. By becoming aware of developmental, as well as here-and-now, dimensions of shared explicit and implicit interactions, therapist and client engage in a process of integration (Boston Change Process Study Group (BCPSG), 2008). Conscious and unconscious aspects of identity are revealed in this 'potential space' (Winnicott, 1971). Over time, a more resilient and integrated narrative of self (Siegel, 2013), enhanced self-agency (Knox, 2011) and a vitality (Stern, 1985a/2000) and aliveness in relationships - with self and with others - can emerge.

Guiding Principles and Values

The guiding principles and values that support me in my development and in my work include principally courage, generosity, inclusion and creativity.

I seek out and foster courage as, without courage, I believe the deep work of psychotherapy may neither fully begin nor be successfully resolved. I am influenced by Tillich's (1952/2000) emphasis on the courage it takes to be oneself and to take one's place in the world as oneself.

The poet Mary Oliver (2009) captures my belief in generosity: 'You give, and you are given'. This dynamic process of offering, even when it 'hurt(s) a little to give it away' (ibid.) opens our hearts to accommodate the other. Equally, the act of taking in, with grace, what another has to offer, particularly when it is painful, is what allows us to come to know even the shut-off parts of self and to move alongside another towards integration.

Inclusion features at a number of levels in my model of psychotherapy. At a Meta level, the process of psychotherapy is, of itself, inclusive; it enables us to become more fully ourselves by inviting in all elements of experience. Buber's (1937/2008) 'I-Thou' relationship is a form of inclusion-in-process and contributes significantly to my philosophical foundation. As he observed (1947/2002) to relate from this perspective requires us not simply to empathise or join another in his world - it is an extension of the self into a dialogical encounter with another. It allows 'this one person without forfeiting anything of the felt reality of his activity' to nonetheless 'live(s) through the common event from the standpoint of the other' (ibid., p. 97).

Additionally, inclusion plays an active part in where and with whom I practice psychotherapy. I have chosen to work in a setting from which no-one is excluded due to lack of financial means, diagnosis, condition or history. It is a practice that honours and respects the humanity and inherent equality in all of us - clients and therapists alike.

I view psychotherapy as an art as much as a science. The transformative nature of what unfolds between therapist and client in the de-integration, reframing and renewal is a dynamic and thus creative process. Psychotherapy is made possible when we can play with reality (Winnicott, 1971; Meares; 2005, Nolan; 2012) and create a 'third space' (Ogden, 1994) rich with potential.

Healthy Human Development

In this section I explore what I believe contributes to the healthy formation of a person. I begin by examining the centrality of human motivation to well-being, addressing motivators that hold particular resonance for me. I then consider aspects of building a self that are at the foundation of my understanding of human development.

Human Motivation

I believe in the life-long potential for growth, development and change that lies within all human beings. Maslow's framing of needs, in particular his emphasis on 'self-actualisation' (1954/2011) is alive in my work, as is the process of meaning-making - an integral part of the shared human experience. However, the elements I consider to be at the root of human motivation are love and intersubjective relatedness.

Winnicott transformed Freud's and Klein's prevailing contention that life and death instincts motivate all human thought, feeling and behaviour when he asserted that it is love that is the unifying force that drives our search for relationality and nurtures creativity. My model places love at its heart, as it is my belief that humans are above all motivated by love (Siegel 2010; Stern: 1985a/2000; 2002). Recent developments in neuroscience increasingly centre on the 'psychobiology of love' (Lewis, Amini & Lannon 2000, p. 4) in their drawing together of the sources and functions of consciousness, feelings, affects, thinking, somatic processes and behaviour. Psychotherapy engages with our emotional lives and so the search for love, the loss of love, the impact of 'good enough' love (Winnicott, 1953, p. 3) and of not enough love are the themes and texture of the work.

While the word love itself may not always be used, to me it is implicitly there in the most compelling of therapeutic theories, the most engaging observers of the human condition, and in the most committed and effective of practitioners. Carl Rogers is synonymous with 'unconditional positive regard' (1980), Rollo May offers us 'agape' and 'disinterested'

love (May, 1969, p. 319), while Ferrucci (1982) speaks of 'conscious love' (p. 182). Buber (1973) privileges love in the guise of 'presence' to the other (p. 46), while Siegel (2010) speaks of the 'open fluidity of presence' (p. 21). Winnicott (1964/1991), while locating his powerful explorations of love within the mother and baby dyad, also strikes a more universal chord when he unpacks with wonder this 'thing called love' (p. 17). As Frankl (1959/2006) concluded while in captivity during the Holocaust: 'the truth (is) - that love is the ultimate and the highest goal to which man can aspire […] the salvation of man is through love and in love' (pp. 37-38).

I see love as integral to what makes us human. Balint (1960/1992) reframed the Freudian concept of primary narcissism, replacing it with the relational concept of 'primary love' - placing the experience with primary love objects at the foundation of all subsequent relatedness. I agree with Lewis, Amini & Lannon (2000) who provide a contemporary expansion of this idea when they suggest that it is 'love makes us who we are and who we can become'.

I concur with Stern's (2004) determination of intersubjectivity as a primary motivational system that is as fundamental as sex or attachment. The emotional architecture of the brain (Panksepp & Biven, 2012; Schore, 2003; Stern, 2004) motivates us to seek relational proximity that offers mutual and profound sharing of affects, experiences and interests in order to feel alive, connected and safe. In other words, we are 'hard-wired' to form attachments (Bowlby, 1969; Stern, 2004). I believe we are equally motivated to experience life inter-subjectively through these attachments. The works of developmental researchers, such as Beebe et al. (2000; 2002; 2003; 2010), Trevarthen (1996; 1998) and Tronick (1989; 1997; 2004) resonate particularly with me as they go beyond the concept of attachment, born of a need for safety, to a deeper affective level of engagement. Intersubjectivity is mutual and reciprocal, it has prosody; both parties are knowable and engaged.

I believe we are driven to connect and in reaching towards the other become who we are. In the absence of mutually satisfying relationships we experience agonising distress, psychic loneliness - or its antithesis, engulfment - and are vulnerable to disorganisation, fragmentation and the ensuing lack of a coherent sense of self. Mitchell's (2000) contention that 'subjectivity always develops in the context of intersubjectivity' (p. 57) is central to my understanding of the development of the person. I am particularly influenced and heartened by his belief that there cannot be an individual mind - only a mind that is created and re-created by on-going interpersonal interactions.

Structure of the Person: Selfhood and 'The Body and I'

In this section I address elements that have particular meaning for me in the healthy development of a person. I explore what I believe to be the continuous process of building a self, the significance of the body in forming a core self and the relational nature of that self. I consider attachment patterns and their role in determining optimal relational and intrapsychic functioning.

I see human development primarily in terms of life-long building of selfhood. The way in which we form is influenced by genetic make-up and gene expression (Siegel, 2010; BCPS Group, 2008), trans-generational scripts (Ruppert, 2008) and life experiences. Context, environmental influences, such as culture, and personal elements of identity such as gender also feed this 'process of continuous construction' (Zeanah et al., 1989). Formation of who we are is not limited to a particular stage of life (Stern, 1985a/2000); neither is it absolute or fixed. I appreciate Sutherland's distinction between the evolving 'process' of self and the rigid 'content' of self, observing that former 'gives the self its shape as a 'felt experience' rather than a static structure that is objectively knowable' (cited in Savege Scharff, 1994, p. xix).

The fulcrum from which all experiences and relationships emanate, and from which we look out at and make sense of the world, is an embodied self. Stern (1985a/2000) contends that the 'core self' arises from the 'baby's early experience of 'self-invariants', at the centre of which is the baby's own body and its boundaries' (paraphrased in Wallin, 2007, p. 62). Freud (1923/1960) captured the inter-relatedness of body and mind when

he wrote of the ego as a 'body ego' (p. 16) derived from feelings 'springing from the surface of the body' (ibid.). Damasio (2000) also stresses the body's role in the process of development, contending that feelings are as much in the body as the brain, and that mind and body are inseparable. I believe that in becoming conscious of this intricate process we may hold what Damasio (ibid.) calls the 'key to a life examined' (p. 5) and can enter fully into the state of a 'minded organism' (ibid., p. 25); awakening to a sense of self.

Merleau-Ponty (1945/1996) believed that it is through the body we come to know the world - it exists primarily as our source of immediate experience. As he asserts 'It is a fact that I believe myself to be first of all surrounded by my body, involved in the world, situated here and now' (p. 37). This supports my explicit and implicit attention to the moment to moment experiences of the two bodies engaged in therapy.

I believe the emerging self is relational in nature; interpersonally (Schore, 2003; Stern, 1985a/2000) and systemically (De Young, 2003) created in and through significant relationships. From the beginning of life, an inner circuitry of relating is implicitly laid down from one being to another (Schore, 2000; 2001a; 2001 b; 2002; Beebe & Lachmann, 2002; Beebe, 2000); this acts as a key determinant of how all other relationships will be experienced (BCPS Group, 2008). In a 'good enough' (Winnicott, 1953, p. 113) environment an infant's self is enabled to naturally emerge through attunement within a secure attachment relationship, where it can be prized, reflected back, contained and reinforced. I am particularly drawn to Winncott's (1965) contention that a 'true' self lies within each of us; a 'silent, inviolable self, beyond all usual communication with the outside world' (p.5). It is in part elusive, an 'unthought known' (Bollas, 1987). The process of becoming conscious (Siegel, 2013) of the fullness of that self - the constructed as well as the authentic - lies at the heart of human development.

The inter-linked concepts of attachment, affect regulation and mentalisation are integral to my consideration of healthy development. I view this triad as an integrated way of conceptualising the co-created and inter-subjective nature of inner and external relationality.

Attachment is the common thread running through my appraisal of healthy development and of pathogenesis. I believe an attachment perspective reveals how self-with-other operates, deepening my understanding of affect regulation, reflective functioning, behaviour, memory and resilience - all of which have roots in early attachment. Attachment patterns are influenced through the therapeutic relationship, inviting us to develop new 'ways-of-being-with' (Stern, 1985a/2000) ourselves and others.

Bowlby's (1969;1973;1988) ground-breaking study of children's attachment to their mothers pushed our understanding of human development further along the two-person spectrum, bolstering psychoanalysis and psychotherapy away from a conflict- and drive-based theory and into a developmental and relational model. It is through these processes that a parent forms in her infant 'the foundations and scaffolding for a solid sense of identity and agency' (Knox, 2011, p.11). From formative attachment experience, we develop adaptive or maladaptive 'internal working models' (Bowlby, 1969) of relationships that, although implicit and procedural, have enduring intergenerational consequences for the type of 'intra-personal expectations and strategies' we develop (Cassidy & Shaver, 2008, p. 43). Stern (1985a/2000) believes we generalise this experience - forming from it an invisible relational blueprint or 'way-of-being-with-others' (p. xii).

Fonagy & Target (2002) assert that the entire goal of child development can be considered in terms of 'the enhancement of self-regulation' (p. 313). Our attachment system plays an integral role in this regard. Schore (2000; 2001a; 2001b; 2002) asserts that a mother's right brain to right brain co-regulation of her infant's affect is formative in the development of a secure sense of self. Beebe & Lachmann (1988) propose that "the various ways in which inner state and interactive processes have been found to be linked can be seen as organizing principles of the integration of self - and interactive - regulation" (p. 481). This implicitly-remembered experience of having been contained and met relationally is what allows the core self

to 'go on being' (Stern, 1985a/2000) in the absence of a co-regulating other. As Bernstein (2011) observes 'autonomous regulation involves self-reflective capacity' (p. 92). It is in mastering affect, thus, we become masters of our own selves, leading to a capacity to engage beyond ourselves and relate with others.

Mentalisation is a process of 'seeing ourselves from the outside and seeing others from the inside' (Asen & Fonagy, 2012, p.347). It is a central tenet of healthy development, allowing us to consider behaviour from a stance of curiosity - and in the context of underlying mental states and feelings. Fonagy & Target, (1997) term this capacity the 'reflective function' that equips us to become conscious of how we affect and are affected by the other. Patterns of mutual influence are placed into vivid relief, whilst also pointing to separateness and potential for self-agency.

Context and Diversity

Healthy development of self depends upon one's uniqueness being seen and upon seeing oneself reflected in and connected with significant others. Context and diversity are complex elements of building identity. Race, culture, gender identity, sexual orientation, politics, economics, social class and educational levels mark us out as similar to, or different from, one another.

Marshall (2004) contends that our seeking out of sameness and our discomfort with difference is linked to mirroring; beginning in infancy. A baby is validated through his sense of being 'the gleam in the mother's eye' (Kohut in Lee & Martin, 1991, p.116). Without that dimension of sameness and recognition of self in the other, we question our whole acceptability and identity (Marshall, 2004). Psychotherapy, if it is to be effective must, I believe, explicitly and respectfully address issues of diversity - between client and therapist - as well in clients' historical and immediate contexts. As Chin (1993) asserts, working with diversity 'is the valorization of alternate lifestyles, biculturality, human differences, and uniqueness in individual and group life' (p. 6). Meeting clients with an 'attitude of horizontality' (Evans & Gilbert, 2005, p. 23) is a relational way of supporting the process of life-long development of a healthy sense of self.

Integrative Problem Formulation

My integrative problem formulation offers space within which to sift through and make sense of my visceral, affective, emotional and cognitive experience of clients. In this section, I outline primary sources of thinking that inform my approach to problem formulation; namely mother-infant research, attachment theory and neuroscience as well as aspects of traditional adult psychoanalysis. I consider the role played by trauma and dissociative processes when planning treatment of distress, impaired functioning, and in extreme cases pathology.

Developmental Deficits

I believe dysfunction arises almost invariably from early developmental deficits and derailments; a function of the lack of a secure-enough attachment relationship that inhibits healthy right brain development and functioning (Schore, 2001a; Fonagy & Target, 2002; Poeggel et al., 2000), impairing the capacity to regulate painful or overwhelming affect (Schore, 2002; 2003a), compromising reflective functioning (Fonagy & Target, 1997), potentially leading to a disorganised or disturbed self-system and unsupportive models of relationships (Bowlby, 1969).

Bateman and Fonagy (2006) consider most mental disorders to be functions of 'the mind misinterpreting its own experience of itself, thus ultimately a disorder of mentalization.' (p. 8). Evolving in attachment relationships, the reflective function is vulnerable to disruption if early relational experiences do not support the development of an adequately robust sense of self and self with other. The two-way systemic nature of this disruption means that insecure or disorganised attachment experiences lead to poor mentalisation and an enfeebled sense of self; this in turn weakens attachment relationships (Bateman & Fonagy, 2012).

In healthy development, these stages are transcended, relationally, through a child's engagement in pretend play, talking and peer

group interaction (Fonagy et al., 2004), paving the way for a healthy 'theory of mind' (Allen, Fonagy & Bateman, 2006, p. 48). However, as Stolorow & Atwood describe (2000) 'in the absence of reflection, a person is unaware of his role as a constitutive subject in elaborating his personal reality' (p. 101). Psychotherapy is a process through which, they contend, a client 'acquires reflective knowledge of this unconscious structuring activity (ibid.)'.

Trauma

Trauma is an attack on the self, causing, as Janet (1889) observed, 'the breakdown of the adaptive mental processes leading to the maintenance of an integrated sense of self' (p.293). Depending on the degree of developmental trauma experienced, we are more - or less - resilient in the face of any later trauma. Occurring in adulthood, Herman (1992) observes trauma 'erodes the structure of the personality already formed' (p. 96). Occurring in childhood, however, its impact is potentially annihilating; repeated trauma in childhood 'forms and deforms the personality' (ibid., p. 96).

Trauma is defined by van der Hart et al. (2006) as an 'inescapably stressful event that overwhelms people's existing coping mechanisms' (p. 279). Janet (1925) suggested that the memory of trauma continues to resonate as `unconscious fixed ideas' that cannot be `liquidated' unless the survivor is supported to translate what has happened into a personal narrative. Mollon (2002) captures its forceful impact in his consideration of trauma as 'that which rips away the veneer of illusions that make life bearable' (p. 1). Usefully categorised by Shapiro and Maxfield (2006) as 'large-t trauma', such as murder of a parent, and the more familiar 'small-t trauma', which takes the shape of ongoing experiences of 'fear, helplessness, humiliation, shame, and/or abandonment in relation to attachment figures who provided no repair' (ibid.). This latter form of trauma, also known as 'relational' (Schore, 2002) or 'cumulative' trauma (Kahn, 1997) is an important element of my problem formulation.

I consider the capacity to successfully integrate trauma and its fall-out as being inextricably linked to attachment history (Schore, 2002; Siegel, 1999). The pendulum of emotional reactivity, from hyper- to hypo-arousal, accompanied by disturbances in the core of personal selfhood, are particularly damaging to a trauma client's ability to self-regulate. Schore (2003) makes the link between Bowlby's (1969) identification of two opposing responses to attachment separation - protest and despair - and trauma responses of hyper-arousal and hypo-arousal. Bromberg (2011) links this to the dissociative spectrum, observing that a key determinant of whether trauma can be integrated, and thus healed, lies in developmental relational history: on whether or not there was sufficient containment provided to allow disruptions and derailments to be experienced as 'interpersonally reparable', as part of what he terms 'the give and take of a good relationship' (p. 4). When this is not available, we are, he argues, at the mercy of a 'dissociated affective tsunami that lies just beyond reach — unless we are supported to reach into those parts that were traumatically severed, arrested or silenced'(ibid., p. 5).

Trauma is an important aspect to consider when assessing and treating psychopathology. It affects how we process information, regulate affective, cognitive and bodily responses, and can cause alterations in personal identity.

Dissociative Processes

Spiers (2006) suggests responses to trauma often involve some form of fragmentation, denial and dissociation. While a naturally occurring protective mechanism in the face of threat, if experienced regularly in infancy and in childhood, dissociation leads to a 'sensitized and compromised neurobiology' (Cassidy & Shaver, 2008, p. 728), one in which dissociation is easily activated, even in mildly stressful situations (ibid.). The therapeutic encounter itself can fall into this category for many traumatised clients; causing signs and symptoms of dissociation to emerge in the room.

Where there has been a long history of disorganised attachment, dissociation can be developed as a coping strategy (Liotti, 2006; Lyons Ruth & Spielman, 2004; Fonagy & Bateman, 2006). I agree, however, with Meares' (1998) suggestion that milder

versions of dissociation can equally occur in securely attached adults who, in stressful situations, are sprung back into an early state of helplessness, where lack of self-agency dominates, through what he calls a 'traumatic memory system' (cited in Knox, 2011, p. 12).

There are varying degrees of dissociation - from Dissociative Identity Disorder to un-integrated elements of experiencing - united in their relational and developmental roots. Bromberg's (2011) proposal of 'me' and 'not-me' states of self, which accentuates the role of what might be considered non-pathological dissociation in the building of a self, holds particular resonance for me. Shifting 'self-states', as he aptly terms this, is a creative way of managing the lack of a safe, reliable, relational context in which to process painful affect-laden experiences contained in those states; originally and 'here-and-now'.

Wachtel (2008) has expanded my consideration of dissociation with his placing of what he terms 'knowing' and 'not knowing' (p.147) at the centre of the therapeutic endeavour. This perspective is concerned with relationally recalling and verbalising painful material. It is equally about associating disavowed experiences with other marginalised aspects of the self in order to achieve integration; the reward for becoming aware of the full 'emotional meaning' (ibid.) of unprocessed experiences.

Psychopathology

I concur with Atwood and Stolorow's (1984) contention that pathogenesis may be 'understood in terms of severe disjunctions or asynchronies that occur between the structures of subjectivity of parents and child, whereby the child's primary developmental needs do not meet with the requisite responsiveness from self-objects' (p. 69).

Classification of Mental Disorders, Personality Styles and Disorders

I consider the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) a useful lens through which to consider classified disorders. It is, however, important to me to look beneath symptoms to the likely developmental and environmental contributory factors underpinning any diagnosis. I agree with Siegel's (2013) assertion that 'we can reformulate the DSM by offering first a definition of health as integration' (p. 16-6) and by regarding disorders 'as clusters of chaotic and/or rigid symptoms that [….] are examples of impaired integration' (ibid.p.16-3). This is reinforced by Schore's (2005) contention that personality disorders are functions of impaired developmental regulation, and are, thus, it would seem to me, most usefully assessed from an integrative, attachment perspective.

Johnson's (1994) consideration of disturbance along a continuum - ranging from style, to character, to disorder - is particularly compatible with my intersubjective perspective. It acknowledges that each of us - therapist and client - has developed adaptive and mal-adaptive personality traits as ways of managing distress. Therapy is a process through which patterns become conscious. Sperry's (2003) hopeful and pragmatic perspective on the diagnosis and treatment of personality disorders also resonates with me. He states that effective psychotherapy can 'facilitate movement from personality-disordered functioning to adequate personality-style functioning or even to optimal functioning' (p. 11). Masterson's (2004) study of the aetiology and treatment of personality disorders, linking early mother-infant engagement with later developmental arrests of the self, provides a frame from which I make sense of transference and countertransference.

I am influenced by Bernstein's (2011) invitation to explore the potential that lies in this place of apparent crisis, when he asks us to understand 'pathology as a call for help' (p. 112). When engaged in challenging work, I am drawn back to McWilliams' (2011) reminder to consider personality structures through the medium of therapeutic values such as 'curiosity, respect, compassion, devotion, integrity, and the willingness to admit mistakes and limitations' (p. 1).

In conclusion, I am guided by Hycner's (1991) observation that 'a diagnosis is a short-hand manner of describing a style, which can be very helpful, yet it can just as easily obscure the existential reality of that person' (p.108).

Process of Integrative Psychotherapy

Nature of the Psychotherapy Relationship

My integrative framework emphasises the inter-subjective dimension of the psychotherapeutic relationship. This way of working calls for a 'more engaged, encouraging and accepting' therapist than the neutral or objective role traditionally played in psychoanalysis (Mearns and Cooper, 2005 p. 220). I enter the field with clients, bringing my subjectivity to bear, in an effort to enhance clients' capacity for self-reflection and individuation. To work in this way is to balance upon Ehrenberg's 'intimate edge', that 'point of maximum and acknowledged contact at any given moment in a relationship without fusion, without violation of the separateness and integrity of each participant' (1992, p. 33).

I seek my client within myself (Bollas, 1987) as much as in their words and behaviour. I am alert to and attuning to unconscious, as well as conscious, communication. This implicit relational space I enter with clients cannot be experienced identically by both players (Bromberg, 2011). We share 'states' (ibid., p. 119) and fire mirror neuron responses in each other (BCPSG, 2008). However, it is therapeutic and facilitates change precisely because when we work together, it is to negotiate 'otherness' (Bromberg, 2011). Whilst I immerse myself in a client's world, I retain a necessary separateness. This is what enables me to act as 'converter of either-or to both-and.' (Wachtel, 2008, p. 293). Remaining myself, in contact with my vulnerability, as much as with my capacities, models a way of being that can tolerate ambiguity. Clients come to know their 'not me' is as valid and worthy as their more familiar 'me' (Bromberg, 2011). Within an emerging 'third' relational space (Ogden, 1994) the complex and gradual process of integrating conflicting elements of experience and identity unfolds.

I have found working relationally more personally challenging than holding a purely humanistic stance, as I did in my early practice. I open myself to being challenged, becoming conscious of and owning my part in enactments, encountering disavowed parts of myself; being changed. I concur with Kahn (1997) when he observes this relationship 'is at a level of greater complexity and maturity than one based on empathy' (p. 112). Clarkson (2003) captures the essence of the endeavour when she contends that the 'relationship is the work' (p. xvi,).

Process of Change and Change Factors

While change is the only constant, I have come to the view that effective therapy offers neither simply affirmation nor an over-emphasis on change. It is indeed a process, and to be enabled, the therapeutic relationship will need to hold the 'dialectical tension' (Wachtel, 2008, p. 274) between these complimentary positions.

Consciousness and Integration

I experience psychotherapy as a creative process of acquiring consciousness of self and self-other patterns of relating. As whatever is arises, that which is causing disturbance may be transcended and transformed. This is comparable with Beisser's (1970) paradoxical theory of change - it is only when we fully become who we are that we can move into a different way of being. I am influenced by Adam Phillips' (2007) interpretation of Ferenczi's move away from the classical Freudian understanding of change occurring through revealing and resolving unconscious conflict, to one in which a 'shift in consciousness' (in Epstein, M. 1995, p. 5) is the instrument of change. As Phillips suggests, a client 'is not cured by free-associating, he is cured when he can free-associate' (ibid.).

I see the un-conscious not in terms of sealed off intrapsychic drives, motivations, memories and fantasies, but rather in relational terms, as implicit 'internal working models' (Bowlby, 1988) of self in the world. These 'unconscious structures' (Stolorow et al., 2000) shape our way of being with others, mobilise defences and inform how we are in relationship (cited in Knox, 2011). I understand those early structures not as holding the roots of all disturbances and requiring excavation, but rather as subject to influence and change. I relate more fully to the on-going nature contained in Mitchell's (1988a) view that our early experiences are particularly powerful as they 'set [ ] in motion a complex process' (p. 289) through which

we build a relational self, with whatever we encounter and experience throughout our lives. I appreciate Wachtel's (2008) cyclical-contextual model, suggesting it is not simply the unconscious internal structures that define our reality, but also how we engage with others in ways that maintain familiar patterns, and the impact of the context of our lives on how we behave and are received by the world.

In my work I bring clients' inner struggle to conscious awareness by slowing down and bringing attention to their 'moment to moment' experiences. To experience the effects of distress, anger, shame, avoidance, resistance and longings relationally, rather than intra-psychically, is of itself transformative. It allows us to build meaning together of what unfolds and to trace the look-alike from the past as it arises in the present. This integrative function has been an important aspect of my own development. Consequently, I prioritise this process of gaining consciousness of splits and outward projections, and how these invisibly influence intersubjective experiences.

Orange (2010) argues that if the therapist is to understand her client in depth, she will need to 'make contact with the rejected, warded-off parts of the personality' (p. 267). I draw attention to multiple selves and self-states (Bromberg, 2011), inviting clients to speak from different parts of themselves, often using visualisation (e.g. the critical bird and the supportive bird sitting on either shoulder) to bring parts to life so they may, in time, become known and integrated. I do this by working with what passes between clients and myself, as much as by working with material from clients' lives outside therapy.

My capacity to use my self is developing over time. My growing separateness from clients' unconscious processes allows me to retain my own theory of mind in the work. Drawing upon dreams I may have of clients, visceral responses, associations or images, I have access to fertile sources of understanding my clients. Knowing what, if any of that, to share with clients, and when, is a further therapeutic strategy.

Integration is slow and delicate work. I am mindful of Winnicott's (1974) re-working of Freud's conception of the unconscious as arising from conflict and repression. Instead, he contends, it is more affectively and emotionally charged, and so may be better understood as a function of 'fear of breakdown to an earlier state of helplessness' (p.104). It is an important part of the process that I create enough space and safety for clients to experience their own underlying fear. Only when this is held and contained can the deeper work of bringing disparate parts of self together into a whole begin.

Reframing and instilling Hope

Frank & Frank (1991) identified a range of common factors that influence change. Those that resonate in particular with me are that hope is evoked and new ways of understanding one's self are endorsed. Returning to the mutuality required when working intersubjectively, I am reminded of Wampold's (2009) entreaty that for therapy to work the therapist must believe it will be effective and convey that to her client. The client's own mastery is mobilised when he can feel the therapist's 'hope and optimism' (p. 4) in his ability to reach his therapeutic goals. These findings underline the importance of the collaborative or co-creative nature of the therapy dyad, wherein clients can take in the therapist's reframed perspective of them and their world, gradually making it their own (Ogden, 1977; Aron, 1996).

Creative interventions, such as use of imagery, stories, dream-work and literature are regular tools I use to make contact with clients and infuse hope into our dialogue. The 'potential space' (Winnicott, 1971) these creative forms offer allows us to 'suspend our usual patterns of relating and to tolerate uncertainty, tension and wonder' (Nolan, 2012, p. xx).

Practising New Ways of Being

My particular emphasis on the co-regulating function of the therapeutic encounter means that I value attention to and processing of moment-to-moment experiences through tracking of breath and body, inviting clients to pay mindful attention to their own experiences and affects. This raises awareness of inner processes and invites clients into a new and more connected relationship with themselves.

I agree with Fonagy's (1995) contention that when working with clients who have experienced developmental deficits, therapy must move beyond the interpretation of conflict to supporting and strengthening clients' capacity to tolerate conflict. Working from an integrative perspective, rather than a purely humanistic one, has meant that I move beyond tracking and mirroring, into empathic confrontation and challenge, when appropriate. In my experience interpretations are most effective when they carry an intersubjective dimension and aim towards 'reactivation of the patient's concern with mental states in himself and in his object' (Fonagy and Target, 1995a, pp.498-499).

Given my background in education, I draw upon a psycho-educational way of engaging where appropriate, and consider it relational and empowering of clients to share knowledge that may enable them to understand themselves in a new way. Wachtel (2008) observes that this work 'calls for interventions that will disrupt the vicious circles and create virtuous circles in their place, new patterns that expand rather than constrict the person's experience and that create their own self-perpetuating consequences'(p. 269). Supporting clients to break from destructive patterns, create new scripts, and enter ever more fully into self-agency (Knox, 2011) is a powerful vehicle for change.

Relationship as an Instrument of Change

I consider the relationship between client and therapist as the foundation for change. I have learned the importance of creating and holding a tight and clear frame (Kernberg, 2003), within which the relationship can take root and challenging and painful processes may be held.

As Wallin (2007) asserts it is here through this new, negotiated, relationship clients learn to 'deconstruct the attachment patterns of the past and to construct new ones in the present' (p. 2). Therapists, through the quality of their contact with clients, invite safe connection with dissociated and disavowed elements of experience. My warm relational style offers me a 'contact door' (Ware, 1983) that can, where appropriate, reduce fear in the other, and convey an empathically attuned presence, thereby allowing trust and mutuality to take root. As Bromberg (1993, p. 276) clarifies:

> *'The ability of an individual to allow his self-truth to be altered by the impact of an 'other' depends on the existence of a relationship in which the other can be experienced as someone who, paradoxically, both accepts the validity of the patient's inner reality and participates in the here-and-now act of constructing a negotiated reality discrepant with it.'*

Lapworth and Sills (2010) observe that the relational dimension acts as a unifier across a variety of models, accounting, arguably, for the growth of integrative psychotherapy (Norcross, 2002). The common factors approach to therapy (Hubble, et al., 1999; Lambert, 1992) equally emphasises the 'quality and strength of the collaborative relationship between client and therapist in therapy' (Horvath et al., 1994, p. 41).

Modalities of Relating

The therapeutic relationship takes many forms depending on context and stage of therapy, developmental history and needs of the client, organising principles of each unique dyad, and level of attachment and security being offered and accepted.

In my experience of working relationally, we are always moving towards a real relationship, through a continuously negotiated Working Alliance (Safran & Muran, 2006). Clarkson's (2003) model of five 'states' of therapeutic relationships (p. xxi) provides me with a comprehensive framework. Arriving at that point may involve deviation into developmentally-required regressive states. The reparative relationship often comes to the fore at an early stage, so a Working Alliance may form. I believe an important part of the process of psychotherapy involves clients' use of the therapist as a 'transitional object' (Winnicott, 1953, p.1), who can tolerate and thus contain (Bion, 1963), providing relief where previously none was available.

Transference seems an inevitable and important aspect of the therapeutic relationship. It offers a way back into and so out of unresolved relational dilemmas. The often unbearable intimacy of a more authentic way of relating can

be side-stepped for as long as a client may need. Counter-transference or, as Casement (2001) aptly describes it, 'communication by impact' (p. 73) is an important part of how I come to understand and 'meet' my clients. Attending to my bodily responses provides me with an immediate sense of what my client's world is like, from the 'inside out' (Fonagy & Target, 1998, p. 699). As McLaughlin (2005) reminds us, 'we do become the bad that was done to us' (p. 44) and my powerful visceral responses provide me with a felt-sense of what clients have endured in relationships. My two-person perspective (Wachtel, 2008) allows me to recognise this 'bottom-up' route into feelings as related to who I am - as much as what is being evoked in me is related to who my client is.

The Boston Change Process Study Group (2010) advocates a move away from an earlier emphasis on working primarily, or exclusively, through transference and offering interventions, and into the field of advanced developmental and attachment theory. This way of engaging seeks to make conscious implicit relational knowing that determines, based on our developmental and attachment history, 'how' we are interpersonally (Fonagy, 1998, p. 3) rather than 'who' we are. While accepting that the past is always with us in the present, this alternative perspective makes sense of the moment-to-moment relating that evolves when two minds meet and are 'moving along' (BCPSG, 2010, p. 9) towards change.

A client's struggle with existential aspects of being may bring a transpersonal element into the process and the symbolism of who we are for the other - culturally, socio-economically, racially or in terms of gender - may invite a representational dimension to the relationship.

Ultimately, it is in experiencing all of these forms of relating with the other that changes to self, that equip us for real relationships, can, in time, emerge.

Rupture and Repair

I believe it is our felt sense of another's willingness and capacity to contain and accept all aspects of experience non-judgmentally that fosters relationships. I have learned that explicitly adopting an attitude of curiosity to thoughts, affects, feelings and bodily experiences frees both of us to observe rather than judge what arises. This can expand clients' - and my own - tolerance of potentially destabilising experiences and emotions. The continuously vacillating gap between proximity and distance is made part of the work, rather than problematised or avoided.

As Enfield and Levinson (2006) observe, repairing of ruptures is a cornerstone of intersubjectivity. In keeping with my co-created perspective, I understand ruptures as belonging neither to therapist nor client, but as an emergent and almost inevitable property of real contact with another. Such 'failures in mentalization'(Bateman & Fonagy, 2006, p. 101) can arise as a result of clients' replaying old patterns in the transference; but also when our respective organising principles conjoin out of my awareness; when I miss my client; lose my ground, abandon my own theory of mind or lose my separateness. A rupture brings us abruptly to a renewed consciousness of each other. It opens up an opportunity to process together something that, should it remain hidden within my client's intrapsychic world, may be disturbing, fear-inducing, de-stabilizing. It is important that I show my client I am willing to hear about how I have contributed to our discord - and that I have the means to make amends.

Conclusion

Psychotherapy is a relational process through which we engage with another in piecing together the disparate trail of our lives, enlivening, growing and becoming resilient, creative and loving human beings, as we travel together towards change.

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