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The British Journal of Psychotherapy Integration

Introduction

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

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Contents of this Issue

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Editorial

In this issue, we include a range of contributions from practitioners who identify themselves as integrative psychotherapists. Each provides insight into the person of the psychotherapist through personal as well as theoretical reflection. What links these authors, in our view, is the courage underlying each author's endeavour. This is manifested through creative ways of working with clients, personal self-disclosure, and an attitude of perseverance and determination in the face of challenging clinical work, or personal circumstance.

Viki Jones has written a rich and moving account of her work with a profoundly deaf man within a secure hospital setting. Viki draws on her experience as an Integrative Art Psychotherapist to explore multiple and creative ways of communicating non-verbally, as well as the multifaceted nature of relational exchange. Viki courageously describes the challenges of working with her client's way of coping and relating in response to his severe communication difficulties, as well as the progress they made together. She sensitively tracks their journey over two years, highlighting pertinent themes in their work and the creation of a shared language.

Saira Razzaq dares us to fail, presenting the reader with thought provoking ideas around therapist failure, uncertainty and exposure in the psychotherapeutic endeavour. Saira explores the possibility of finding opportunities in our most vulnerable moments as practitioners, by integrating mindfulness practice and creative indifference. Saira makes particular reference to the training journey, however her invitation to trust that moments of discomfort and dis-integration can lead to opportunity, insight and compassion is applicable to every level of experience.

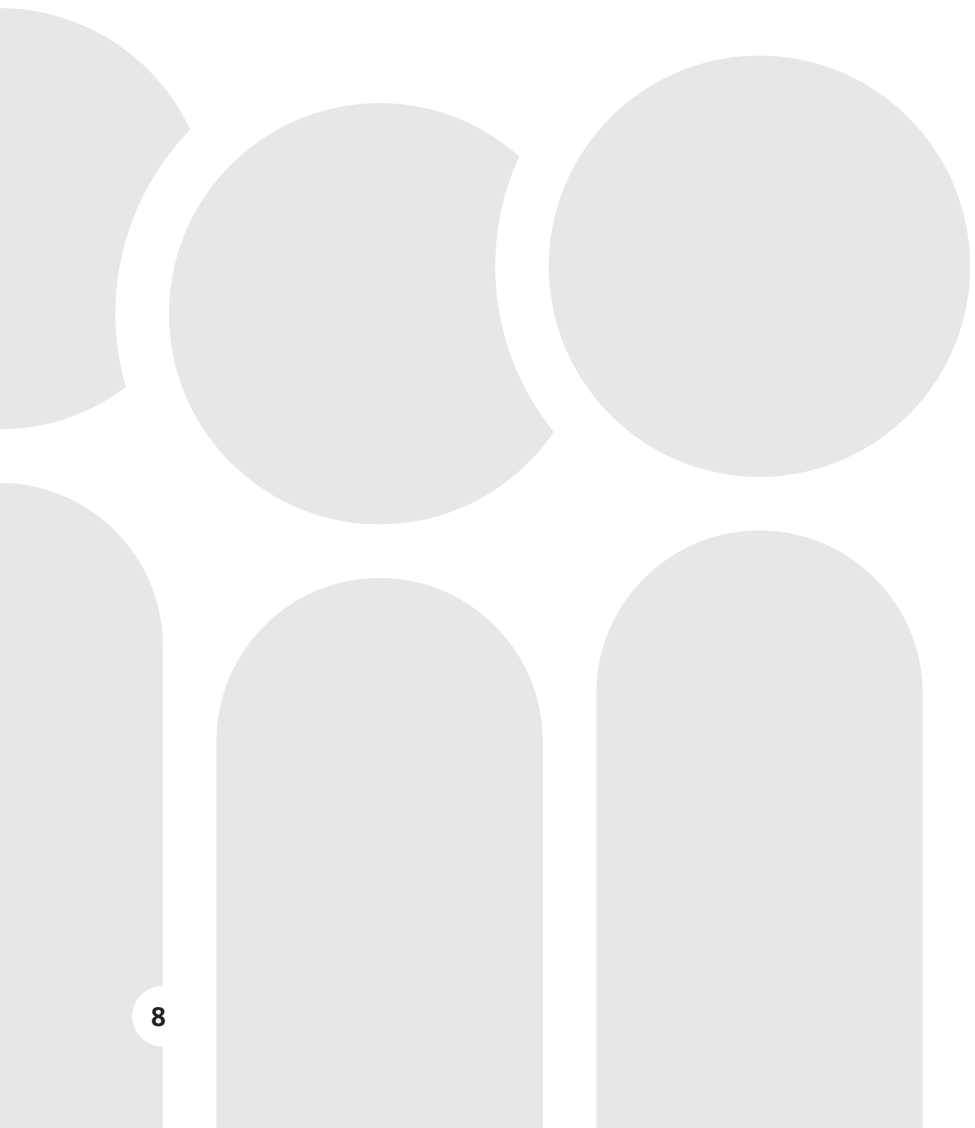
Shinar Pinkas-Samet explores disorganised attachment organisation from a body psychotherapy perspective, drawing on her clinical experience and innovative ways of working with eating, and attention deficit disorders. Shinar integrates literature from body psychotherapy, attachment, child mental health, and trauma. She thoughtfully argues that working with traumatized bodies, requires us to adopt a deep familiarity with fragmentation through embodiment, in order to move through somatic developmental stages to support recovery.

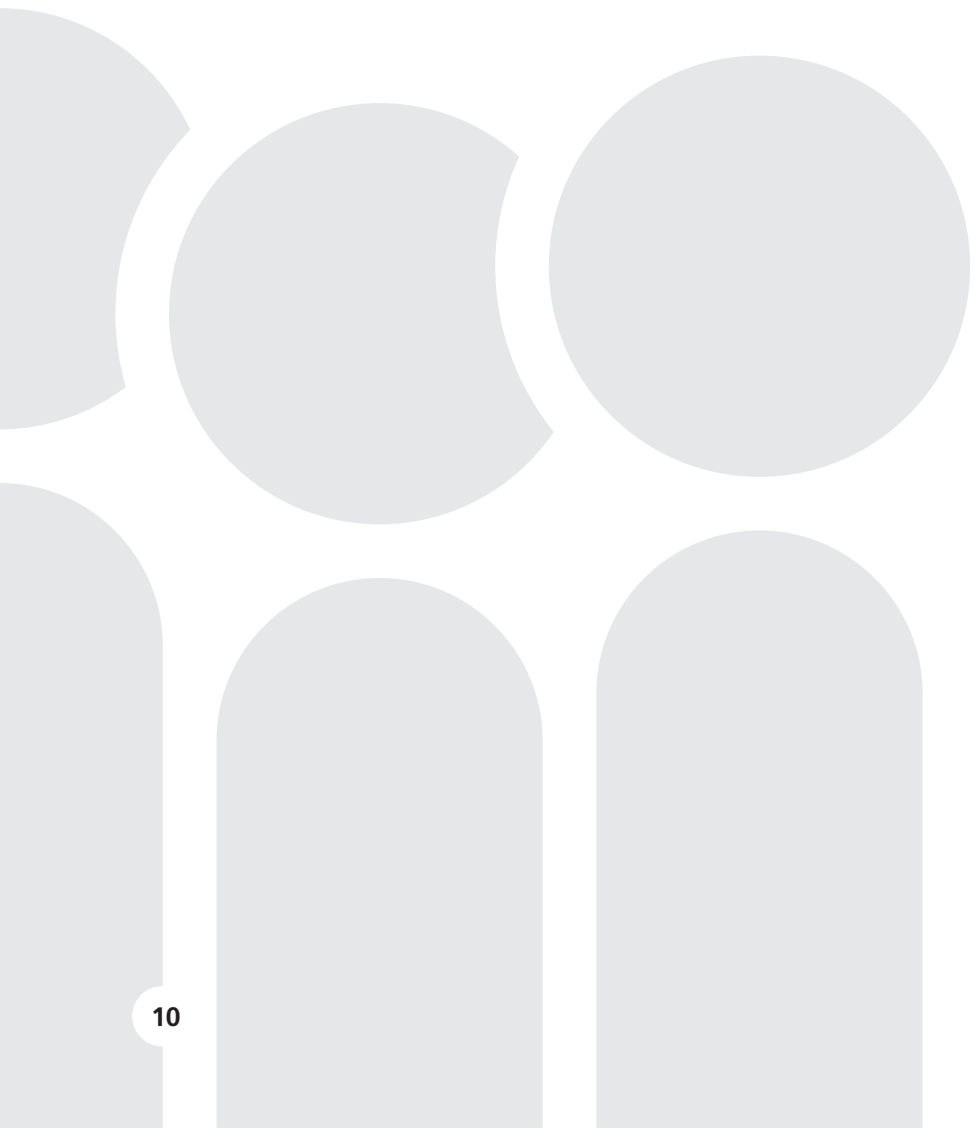
Patrick Casement poignantly shares his personal journey through receiving a diagnosis of Burkitt's lymphoma, his treatment and survival. Patrick takes the reader through the realities of his time in hospital, the challenging decisions he and his family were face with, and his relationships with professionals in charge of his care. He does this with humor, grace and courage, such that this paper is a source of inspiration.

As is our usual tradition we publish an example of a student's final written submission for their qualification. In this edition we include Megan Stafford's integrative approach to the practice of psychotherapy.

Finally we include a book review: 'Forced Endings in Psychotherapy and Psychoanalysis. Attachment and loss in retirement' by Anne Power (2016).

Megan Stafford, Katherine Murphy, and **Maria Gilbert** Consulting Editors.





Viki Jones

Of Mice and Men: A Story of an Emerging Therapy Relationship

Abstract

In this case study, I describe my therapeutic journey with Keith, a profoundly deaf man who was referred to Art Psychotherapy whilst living within a secure hospital. As an Art Psychotherapist and Integrative Psychotherapist, I found the idea of working with an individual who struggled to understand even sign language, challenging. With guidance and support from an interpreter, who was present throughout each session, we were able to work through some very difficult ways of relating and communicating. I begin by looking at Keith's history, his way of relating to others, and some aspects of his personality style. I move on to discuss how he and I were able to make use of transitional objects - Keith's treasured collection of model mice - to begin the process of communicating with each other. However, Keith's difficulty in grasping the concept of 'feelings' and in communicating his own emotions resulted in a period of stagnation and power play, which is described in some detail. I then explain how the introduction of a Russian doll helped Keith begin identifying and communicating his feelings, aided by his own decision to involve his toy mice. Out of this emerged a shared symbolic language through which Keith could at last express his feelings and engage in the therapeutic relationship in a more meaningful way. I end by reflecting on the gains and ambiguities of my long therapeutic journey with Keith.

Key Words

Therapeutic Relationship, BSL (British Sign Language), Creativity, Transitional Object, Transference.

Introducing Keith

Keith[1] grew up profoundly deaf[2] within a large hearing family. As a child, he attended a school for the deaf. At that time deaf children were discouraged from communication using their hands; the method of education was oral and aural. Keith coped with his schooling by avoiding formal learning in favour of working creatively. Approximately 10 years ago Keith's Mother passed away.

From his teens until his early adulthood Keith worked on a farm, enjoying the experience of driving farm vehicles and working with animals. He retains a keen interest in animals, especially mice and rats.

In later life, Keith abused alcohol and was responsible for a number of sexually motivated offences which eventually led to his involvement with secure psychiatric services.

1. Keith is a pseudonym.
2. Throughout this paper I use the word 'deaf' rather than the capitalised 'Deaf'; I prefer not to distinguish between the two terms, while appreciating the different social and cultural connotations attaching to them.

He was sentenced to a secure hospital after an episode in which he attacked a woman who had rejected his sexual advances. In hospital he presented in similar ways towards female members of staff: making sexual advances and then being hostile and aggressive when boundaries were reaffirmed.

At the age of 58 Keith engaged with therapy. Keith made little use of British Sign Language (BSL) and did not use his voice to communicate except at times of significant distress. He often used gesture, mime and unorthodox signing to communicate. He used his limited BSL vocabulary to list information rather than link concepts together; for instance, when describing a picture, he listed the objects portrayed in it rather than attempt to summarise what the picture was about.

Keith frequently produced signs that others did not understand, making it difficult for his communicative partner to establish his meaning. At times he feigned understanding, or avoided contact with the interpreter. The use of lip patterns seemed to confuse him and hinder his understanding. The frustration he felt when attempting to communicate with others was considerable, resulting in episodes of aggression and violence. His anger was exacerbated when he sought to communicate the subtleties of emotion, making his emotional understanding almost impossible to ascertain.

First Impressions

I met Keith regularly when working on his ward. I found his methods of communicating and interacting odd, coercive and very complex. At times, he would play with his collection of toy mice, inviting others to use the tiny figures to communicate with him. At such moments he appeared proud, jovial and almost excessively eager to interact with others. Sometimes this could feel intrusive, allowing the other person little room to exit the communication.

The impact on his audience was interesting. Some people were put off by his odd behaviour and failure to adhere to social cues in interactions. Others were initially intrigued, only to be discouraged by his overt enthusiasm and forceful method of interacting: he would sometimes interrupt conversations, or deliberately target certain staff members.

I developed an image of Keith as a panther, stalking his prey like Bagheera from Rudyard Kipling's Mowgli stories in The Jungle Book. "Everybody knew Bagheera, and nobody cared to cross his path; for he was as cunning… bold….and reckless. But he had a voice as soft as wild honey dripping from a tree" (Kipling, 1894/1994, p.18). Although seemingly friendly and approachable, I felt uneasy around Keith when he lured me into his 'playful' bouts of communication. I wanted to keep him at a distance, but I was also intrigued: my intuition told me there was something much more complex taking place. Racker (cited in Clarkson, 2003, p. 95) describes this as a complementary or 'reactive' counter-transference: one in which powerful responses are induced in the therapist, responses which have echoes - real or imagined - from the patient's past. The therapist then acts in ways which complement the patient's experience.

Keith was referred to Art Psychotherapy in the hope that he might benefit from an opportunity to express himself creatively while building a therapeutic relationship. I felt anxious about working with him, not only because of the difficulty of communicating with him but also because his physical presence - his walk, his stance, his head movements - seemed intimidating. He used his body as if pouncing on his prey and not letting go, perhaps even getting pleasure from toying with his interactive partner. Colleagues on the ward likened him to a shark whose demeanour might be affable but whose "scary cold eyes say something different." Eager to interact, Keith would almost force himself upon others.

Such behaviour was in contrast to my own experience, for I have spent much of my life seeking to remain unseen and unheard. To be working with another so energetic in his efforts to reveal himself visually was a profoundly uncomfortable prospect. There is a particular challenge for me when working with deaf clients: how can I stay hidden when I must communicate visually? The prospect of working with Keith left me with very raw feelings of failure, shame and discomfort. At the same time, my interest had been whetted.

Given his severe communication difficulties, Keith had thus far responded poorly to treatment. There was also some evidence of hopelessness associated with his depressive symptoms. At the point of his referral to therapy, he had little insight into his difficulties with anger and general dangerousness. He had no insight into the relationship between his alcohol use and his offending, and he appeared to have entrenched anti-social attitudes towards women. There was evidence of day-to-day behavioural instability, with aggressive responses to everyday frustrations. When angry, Keith would close his eyes or turn his head away, thereby avoiding any attempt at de-escalation.

Initially we began with traditional art materials – paper, pencils, coloured pencils, felt pens and such. We would work for 1 hour in the presence of an interpreter. Keith would describe - through his imagery and then through attempted dialogue – his subsequent confusion about the death of his mother. We spent many sessions attempting to think together and allowing expression of his present state.

Early Therapy

Keith had an extensive collection of toy mice, some of which he kept in his room. The oddity of this situation has led to its importance often being overlooked. In fact, Keith appeared to use his mice to self-soothe; he seemed to derive comfort from rubbing his mice against his face at moments of apparent emotional discomfort.

During our early work together Keith communicated something about his mother having once given him a pet mouse. This mouse lived in a cage in his bedroom, but was often allowed to crawl over the boy and his bed. It occurred to me that mice might remind him of his mother and by that token offer relief from emotional distress.

For Keith, mice seemed to constitute something of a transitional object[3]. On the surface, such an object can appear healthy, simply a physical object which takes the place of the mother-child bond. His attachment to his mice possibly indicated that he was actually capable of recognising something of what was him and what was not: a differentiation between him and others.

Yet Keith's method of communication suggested that for him there was only himself in his world; he seemed to have little awareness of others' feelings. This has persisted throughout his life, rather than being simply a development stage. As we worked together, it became apparent to me that the death of Keith's Mother created a traumatic ending and a forced separation that left him feeling vulnerable and without a caregiver. This made him detach and become more independent through the use of his transitional objects.

It occurred to me that through play and communication with his transitional objects, Keith could recognise that there were others around him with their own set of emotional responses and personality traits. By using his toys to communicate he could attempt to widen his support network by relating to others.

Keith often slept with one particular mouse on his face (his grey one). Winnicott notes that "patterns set in infancy may persist into childhood, so that the original soft object continues to be absolutely necessary at bedtime or at time of loneliness or when a depressed mood threatens" (cited in Scharff, 1995, p. 201). During one session Keith communicated something of the disturbance and difficult feelings he experienced when staff did routine observations during the night[4]. He also conveyed that he viewed himself as flawed or 'less than' others. Keeping his grey mouse on his face was an efficient coping mechanism to block out the light (switched on for routine checks) and soothe uncomfortable feelings.

3. A transitional object is a term coined by Winnicott (1953) to describe something in which a child has an emotional investment, often as a replacement for, or alternative to, a care-giver. This object may be used by the child to separate from the care-giver or to consider 'what is me' and 'what isn't me' so as to recognise the difference between what is the self and what is not the self.
4. Staff routinely and on a 24-hour basis observe patients within a set time frame to maintain safety and promote health benefits.

Keith seemed aware that his interest in mice often had a negative or comical effect upon others. There was a sense in which he seemed to be doing this deliberately to get a reaction. On some level he was able to be noticed and acknowledged, albeit for reasons other than his true self. Perhaps this was how he had learnt to have an impact.

It struck me that perhaps Keith's anger was being projected and I was identifying – as in projective identification[5] - with anger and frustration being his internal experience. But he had also learnt that the outward expression of his internal experience was not allowed and did not get his needs met. His anger needed to be expressed through other means in order for him to feel some level of satisfaction.

Keith's learnt behaviour was to act the fool, making others feel frustrated and annoyed. By thus keeping others at a distance, he stayed 'safe' psychologically. When feeling angry and frustrated, he got others to act this out on his behalf, keeping his true self hidden and his interaction with others at a superficial, and therefore 'safer', level.

During our work together, Keith often used images conveyed through mime and gesture to tell a story: about his time working on a farm, his interest in mice, his perception of his Mother's death and his understanding of family dynamics. By means of this non-verbal, non-sign expression, he was able to communicate something of how he was feeling. Rather than communicating via a word or sign, he embodied the feeling to communicate.

As sessions progressed I found Keith increasingly enigmatic. At times he appeared deeply sad, with unshed tears glazing his eyes; he would maintain intense eye contact as if willing the other to understand his experience even in the absence of words or signs. But when asked 'what are you feeling now?' he struggled to understand. This left me with a potent mix of feelings: frustration, failure, shame, inadequacy. After working with him for quite some time, the interpreter and I concluded that he did not understand the word/sign for 'feeling'. But then, how could he? The word/sign 'feeling' describes an abstract concept. The word or sign for a specific feeling would describe that feeling. The word/sign 'feeling' then becomes unimportant and has no meaning.

How could Keith possibly know what the sign/word 'feeling' meant in relation to his experiences? Like all of us, he experienced feeling through sensation. If no one had ever been able to understand his experience of sensation and show/tell him the word/sign for this 'feeling', then of course he would have no knowledge of this word/sign. How does a child learn that feeling 'sad' is related to their experience and sensation of that specific feeling? How do they know that what they 'feel' is in fact 'sadness'?

As I worked with Keith, I found that asking questions such as, 'Are you feeling happy?' (or sad, angry, confused, and so on) helped us move closer to a shared understanding of experience - or at least begin communicating about 'feeling'. The embodiment of the feeling by the interpreter when showing the sign for that particular feeling acted as a mirror which showed Keith how to express and embody that particular feeling. Sometimes the sign for a particular feeling is more descriptive and informative than the word for it; for example, 'calm' is signed by a soothing motion in the chest area. In such cases, the word loses power, becoming irrelevant, absurd and far-removed from being-ness. Given the ability of the sign to embody sensation, this form of communicating revealed itself to be more explanatory, descriptive and meaningful.

Power Struggles and Stagnation

When Keith was asked about his feelings during sessions, he would invariably communicate feeling 'okay', even if he appeared sad. This would signal the start of a long process of

5. 'Projective identification is a term first coined by Klein (1946) to describe a defence against an intolerable, painful or dangerous idea or belief about the self that the projecting person cannot accept. Segal notes that "in projective identification, parts of the self… are split off and projected into the external object which then becomes…controlled and identified with the projected parts" (cited by Heitzler, 2011, p. 23). According to Clarkson (2003, p. 63), "projective identification can elicit reactive counter transference."

checking and rechecking his understanding which could feel like a game of cat and mouse or a power struggle. I sensed that at times he knew exactly how he was feeling but did not want to share this. His presentation readily betrayed his declining mood and growing frustration, but he continued to present a 'smiley' face.

Keith had been given a simple scale to help him communicate. On it were depicted three faces: a sad one, a straight-lipped one and a smiling one. This scale was nowhere near sophisticated enough to cover the range and complexities of his experiences, yet it was something he felt comfortable using. Perhaps he enjoyed the simplicity the scale allowed him in communicating: by 'ticking the boxes' he could hide his true self, along with his struggle to communicate. The limited choices, while reductive of his experiences and ability, increased his ability to engage at a purely superficial level. They also invited engagement in a power struggle: the incongruity between Keith's actual demeanour and his 'face' of choice would increase staff frustration, leaving him in the powerful position of denying staff something they wanted or needed from him.

Keith's frustration with me increased, as did mine with him, and the work seemed to stagnate. My initial hopes dwindled as he arrived at sessions unwilling to engage. His presentation would indicate frustration and I would feel stuck and a failure. Visually expressing his recognition that therapy was hard, Keith would fist his hands, then move them to and from his head in a movement that seemed emulative of head-banging. He used this movement to convey to his team his experience of our work together, which compounded my feelings of failure and shame. I felt impotent, rejected, humiliated and resistant to working with him further.

Due to Keith's lack of capacity to engage in more 'verbal' cognitive therapies, it was decided by the clinical team that he needed to continue creative therapy, which was seen as the key to his progress. I needed to find a route forward for the two of us.

Aware that I was rejecting him, I again wondered about his previous experience of women. This led me to reflect on Keith's own sense of being rejected and humiliated. It struck me that his response to this also involved rejection: he would seek out feelings more familiar to him and therefore less challenging in the short term. I recognised that it was the challenge of therapy that Keith was rejecting, rather than me as an individual. Although directed towards me, his negativity was a means by which he could avoid 'naming' or processing uncomfortable feelings - and having these witnessed by another as never before. The resulting fear and apprehension were further complicated by his yearning to be seen and understood.

Despite these new insights into Keith's process I still felt hurt and betrayed. According to Racker (cited in Clarkson, 2003, p.95), a concordant counter-transferential response of shame is where the therapist feels shame in response to the patient's feeling of shame. I felt reluctant to meet Keith, and wondered if I was experiencing a parallel process[6].

During supervision I was able to recognise my own feelings of shame and find a way to prevent these impacting my work with Keith. Rather than recreate his past experiences (or my own), it was important to find a creative, relational way forward.

Keith and I agreed to meet for our next session. We already had some 50 sessions behind us, but this was long-term therapy and I hoped we could reconnect and repair our therapeutic relationship.

Progress: Creating a Shared Language

We sat down together, Keith, the interpreter and I.

Looking strained, Keith described his feelings by moving his fists towards his head in a movement which indicated pain and anguish. This was his emotional response to attempting

6. According to Clarkson (2003, p.104), parallel process is "a way to describe the pattern of the patient-psychotherapist transference/countertransference relationship or the interpersonal pattern of the dyadic psychotherapeutic relationship."

to communicate in therapy. He communicated something that resembled an internal stirring, a confusion of emotions building up in his belly and expressed through his head-banging. "No more, finished, fed up", he indicated through sign. His eyes told me something different. He looked sad, difficult to reach and scared of his feelings. I found some empathy for his struggle and realised my frustration was also his. We (the interpreter and I) told him we understood how he was feeling: we could see. We described how difficult it was for him to communicate his feelings, and how difficult it was for us to understand each other.

When we met again the following week, Keith seemed eager to get started. He began to recount an incident earlier in the week where he had been aggressive. He seemed anxious and keen for to me to understand, communicating that he had waited until our session because he wanted to explain the details to me. He signed "waiting, waiting" with a look of such desperation that I grasped he placed some value in our work and our relationship.

During this session, Keith described how earlier in the week he had not been sleeping properly because of pain at night and of concerns about a friend. He had then got up for the day and had been asked to attend vocational activities, in the course of which he had become aggressive. He was apologetic about this, and wanted others to understand how this incident had happened.

I explained to him that other people had no awareness of his feelings and experiences. Indeed, how could they if he gave them no inkling before his behaviour escalated to the point where he became aggressive? Helped by the interpreter, I strove to communicate my interest in his experience. I described how everyone has feelings inside that can grow and become unmanageable. He seemed shocked both by the information that others did not intuitively know how he felt 'inside' and by the bombshell that others have feelings inside, too.

We ended the session with our relationship seemingly repaired. I felt more hopeful and committed to our work. That Keith had waited to share something with me seemed to suggest that he had some trust in me after all.

Then I gave more thought to what had happened between us. Earlier, Keith's very visual communication of his inner pain had left me shamed, as if I had failed and then been cast aside as unimportant. Now, at this latest session, he had presented as eager to communicate with me. He had then given me some vital information about his feelings and what had led to an explosive event. That he had waited to tell me this made me feel needed and important. Was he perhaps putting me in an idealised position, only to reject me at a time of his own choosing? It seemed possible the power struggle was still in play, and that it had abusive undercurrents.

For our next session, I decided to take along a blank-faced Russian doll. Keith evidently enjoyed holding this tactile wooden object and began to play, first placing the dolls inside one another, then taking them out and arranging them on the table. I then explained that the outermost (largest) doll represented Keith himself, using his initials to confirm this. We spent the whole session engaged in play.

Between sessions, Keith had found out that a visit to the crematorium to see his mother's memorial was a possibility. Waiting to find out whether the visit would go ahead was proving a challenge.

The following session, Keith seemed interested in playing with just the outermost doll (himself). We placed a book on the table to represent the hospital, and put the doll on top of it to indicate him inside the hospital. Through play, we were able to spend some time thinking about the trip to the crematorium and how he might feel at each stage of the trip. Communicating through sign, gesture and mime, transferential information, and observation, the three of us - Keith, the interpreter and myself - thought about our own likely reactions, the things we noticed about Keith, our responses to him, and what was suggested by intuition. Through this method, Keith was able to communicate considerable grief, fear and confusion. Eventually, after 'play' during numerous sessions, he seemed ready to undertake the gruelling, emotional visit.

On his return, we used the outer layer doll as a means for Keith to explain how the visit had gone. He seemed excited by this, as if

wanting me to know. He arrived at the next session with three differently coloured sugar mice from his collection, which he lined up in order of shade. He then spent time putting the mice, in the same order, inside the outermost doll, then taking them out again.

As already noted, Keith uses his favourite grey mouse as protection against things that make him uneasy, whether feelings, bright lights or intrusive staff. He is often to be seen stroking his face with the mouse, and sometimes attempts to stroke others' faces with it, too. At this particular session, he began stroking the blank face of the Russian doll with the grey mouse. We wondered what this might mean for him, eventually concluding that as well as being soothing, this use of a transitional object indicated there was something happening internally that he needed to soothe. We then called this mouse his 'self soothe' mouse. The room felt tense with expectation. Then we - the interpreter and I - watched as Keith spontaneously communicated something to us. Something in his manner of communication suggested a process building up over time. He also seemed to convey an awareness of difference, as if all these different 'mice' were to be found inside him.

Keith arrived at the next session wanting to play with the outermost doll again. Again he lined up his coloured sugared mice and put them in and out of the doll. Then he produced a small yellow pompom he had brought along and placed this inside the doll as well. After some further play he lined up all these objects on the table. I pointed at the yellow pompom while the interpreter signed 'tell me'. He communicated that the pompom was something like 'anger', a sensation in his lower abdomen which he illustrated by spreading his fingers in an outward motion that was like an explosion. (We subsequently used three pompoms of differing size to indicate degrees of anger: extreme, moderate and mild.)

After the session the interpreter and I felt inspired by his communication. We discussed how he had differentiated his feelings, shown intensity, and spontaneously added more. It was obvious that he had thought about this method of expression between sessions and that it carried deep personal meaning for him. Not only had he allowed us to witness his expression of emotion, he had also permitted us to participate in mutual play and therefore communication. This was a huge step forward for all three of us.

The following session, I brought along paper mice for Keith to colour in (by this stage his sugar mice were a bit the worse for wear and needed replacing). He coloured these paper substitutes in shades identical to those of the originals, and we spent time getting used to the new mice through play and placement. I asked him through the interpreter to 'choose which one today'. Keith picked out a couple of the mice and then spontaneously used his body to show where he felt those particular 'feelings'. Once again we were impressed by his ability to communicate in his own way. It seemed a point had been reached where he felt both 'heard' and 'seen'.

After this, the spontaneous communication kept coming. After lining up the coloured mice and indicating that they were inside him by putting them inside the doll, Keith asked for a pen and paper. He drew an outline of a man and indicated that this was him: this was the same as the outermost layer of the Russian doll. He placed the coloured mice in order down the left-hand side, with the yellow pompom at the bottom, parallel with the lower abdomen. He then drew various lines on the figure's torso and cross-referenced them to the coloured mice (see Figure 1). This gave us more information about what he was trying to express.

The white mouse, Keith communicated, was a flat line in the chest area that represented 'OK', 'calm', and 'happy'. The orange mouse was indicated by a wavy line, an 'up and down' feeling in the lower chest. The green mouse was a more spiky line, located in the upper abdomen; Keith communicated 'spike' in sign but this could also have been 'painful', suggesting that this is how he 'feels' this feeling. The yellow mouse was placed lower down the torso. Keith signed 'circles of sadness' as he drew circles in the lower stomach. While doing this he became tearful. He then placed the yellow pompom even lower down the abdomen, again indicating this to be an explosion. By outward and upward movements, he communicated that this explosion was related to feelings

becoming 'too big', which led to behaviour that usually ended with him being placed in 'seclusion' for his own safety and that of others. He indicated that this was 'bad'.

During therapy, Keith often gave the impression that acknowledging he had any feelings at all was wrong or bad in some way - that feelings of any description were not permissible. I therefore made a point of communicating that having feelings was okay and that everyone had them. He was genuinely shocked by this, unaware that anger was something experienced by others, myself included. I clarified that while having feelings was okay, acting them out in certain ways (for example, hitting or hurting) was not acceptable. This gave us the opportunity to communicate about other, more useful ways of relating. Once again, Keith was able to communicate how he felt without words/signs. Without shame or concealment, he differentiated between emotional responses and explained how these built up inside him.

I made a chart (see figure 1) displaying his human outline with the coloured mice, pompoms and associated lines in position and brought it along for him to keep. This made him tearful. He began describing his memories of going to school and being forced to read and write despite feeling incapable (he can write a few words, including his name, and often uses initials). He described in mime how one day he had walked out of his classroom after becoming angry. Animated, he was eager to tell me how different things were for him now: others could communicate with him and he had found a way to communicate with those around him.

To make the chart more serviceable to Keith and others, we decided to laminate the paper coloured mice. Keith drew the corresponding expressive lines on the back of each mouse to help others grasp which mouse related to which feeling, and I added some words, too. Keith subsequently attached the laminated mice to a key-ring so he could carry them with him at all times. He keeps the key-ring in his pocket and uses the mice regularly to indicate his 'in the moment' feelings to others.

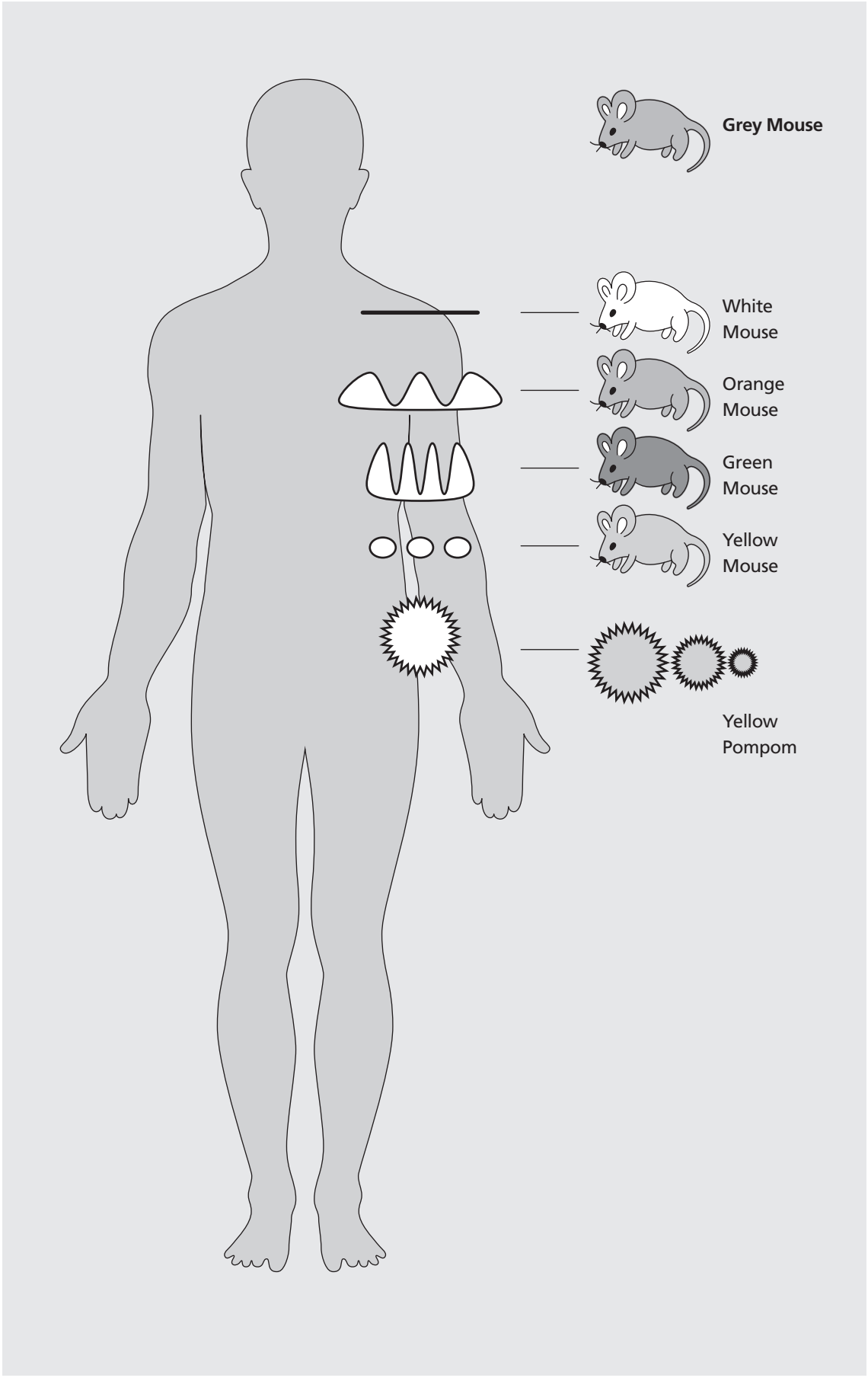
Reflection

Throughout my work with Keith I found myself oscillating between fear of failure and exhilaration, between feelings of rejection and shame and moments of triumph and inspiration. This to-and-fro motion was in tune with the frustration I was experiencing in my attempts to communicate with Keith, for whom I felt growing compassion. It was as if my feelings were also a representation of his: in a sense I was experiencing his everyday experiences. Once we had found a language through which we could communicate we were able to engage in a more genuine therapeutic relationship, one in which both of us could be understood.

Despite this, I am left pondering how useful this new way of communicating is to Keith. Engaging in communication using his own symbols - his mice - has allowed him to express himself and reduce his resort to acts of aggression and frustration. He has also been able to access other, more structured programmes. At the same time, could it not also be the case that this new language has to some extent reinforced his isolation by underlining his uniqueness? Has it made him appear even more different and therefore more open to rejection?

Previous to our work together, Keith's aggression was possibly an expression of his frustration, isolation and powerlessness. This kept relationships minimal and didn't allow for mutual communication. It is my hope that the connection we have made has helped achieve some healing at a profound level, enabling him to make better, more authentic connections with others in the future. Certainly his awareness of others has improved: he is demonstrating much more interest in his surroundings and in the people around him. We agreed to end therapy after approximately 2 years of weekly sessions. This enabled Keith to put his progress into practice outside of our therapy, with a view that he could come back to our work together if he needs to in the future.

Gaining Keith's informed consent to write this paper was a challenge. Helping him understand what I was asking of him was difficult yet essential. In the end, we were able to do it through the use of imagery: Keith's



Feelings Chart

own, and some I had created to symbolise the two of us and the work we have done together.

Acknowledgements

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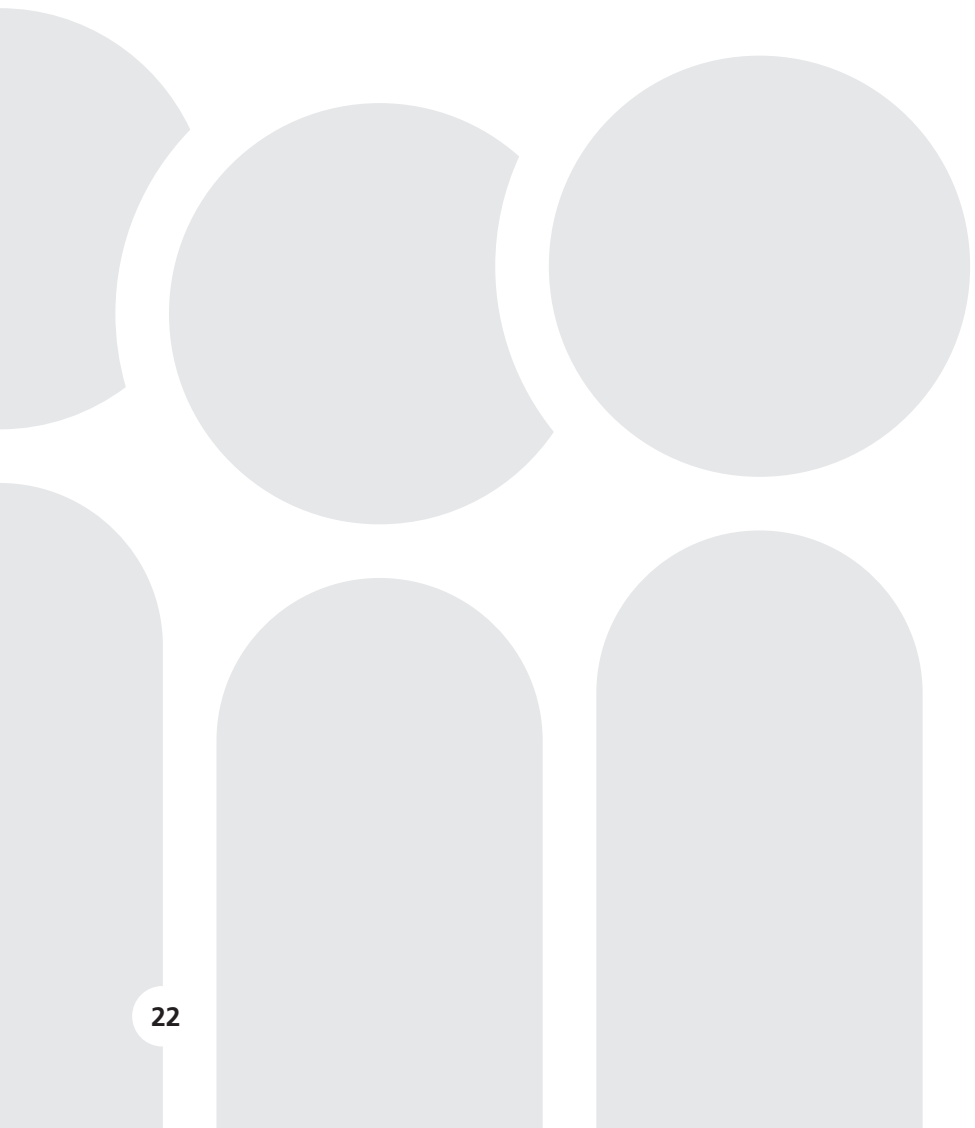

Saira Razzaq

Being with What Is: How Creative Indifference Makes a Difference

Abstract

This paper aims to explore the therapist's relationship to failure, exposure and uncertainty particularly whilst in training. The impact of this can be both a complex and overwhelming process. I intend to explore how therapists can meet this disentanglement through the integration of mindfulness practices. In particular, the use of creative indifference, which is a way of embracing emergent clinical material with creativity and authenticity that honors the intersubjective encounter.

Introduction

> *"Life will break you. Nobody can protect you from that, and living alone won't either, for solitude will also break you with its yearning. You have to love. You have to feel. It is the reason you are here on earth. You are here to risk your heart. You are here to be swallowed up. And when it happens that you are broken, or betrayed, or left, or hurt, or death brushes near, let yourself sit by an apple tree and listen to the apples falling all around you in heaps, wasting their sweetness. Tell yourself you tasted as many as you could." (Erdrich, 2006).*

I often fail in my work with clients; I have daily routine failures and more significant ones, when I feel lost at sea. I believe these times present an opportunity to explore the limiting binaries of success and failure. In embracing the therapeutic journey creatively we risk exposure and the possibility of becoming unstuck. At one point everything that I held certain in my life as an integrative therapist became ambiguous, and it felt like the solid ground under my feet was disintegrating. The best consolation I found was to view the mess and uncertain obscurities of therapy as creative fundamentals. These became opportunities and were made possible by engaging with my vulnerability that could be accessed by integrating mindfulness practices, where unknowing and knowing more deeply could be directly felt and experienced.

As the poet Jalal ad-Din Mohammed Rumi, (1207-1273) says:

> *"Out beyond ideas of wrongdoing*
> *And right doing*
> *There is a field.*
> *I'll meet you there."*

Daring to Relate to Failure

As an Integrative Psychotherapist and Module Leader on the Doctorate in Counselling Psychology and Psychotherapy by Professional studies at Metanioa, I can see how our relationship to failure, exposure and shame becomes part of the landscape on the training journey. The deconstruction of self that occurs as we embark on such training can feel breathtakingly precarious at times. Particularly as in some familial histories, failure may have been disallowed. Therefore it can have quite forbidding qualities. Yet failure helps us understand our self-agency

beyond the dualistic notion of incompetence or omnipotence, failure and success (Rolef Ben-Shahar and Shaut, 2016). The task is how to learn to fail again better or at least differently and we need to normalize our failures and the work with the shame that this evokes.

Easily said! When I think of all those enactments that I saw too late and that were lost, or ruptures that could not be repaired. Or those clients that would strike a chord with me because of my own history and I momentarily regressed into 4-year-old child. Those clients that never returned and I could not fathom why. Those occasions when, within the relational meeting, I could not meet the sheer depth of my client's despair with the therapeutic gaze or attention. This is a complex process to bear for us all, and we have to live with that felt helplessness and confusion. I know this both from my own my clinical work and with the trainees that I supervise - that when we struggle to make sense of our felt sense of inadequacy with clients, sometimes we contract into 'what do I do next mode.' When we feel deskilled and constricted, the default pull may be going into 'fixing', which offers the illusion of reprieve from our perceived inadequacy by providing technique. Often just simple presence, or nonverbal embodied contact, might have been more helpful. Often we try for something too hard to distance ourselves from the shame of our therapeutic ideal.

Benjamin (2016) suggests that when the therapist feels exposed, dis-regulated, and is struggling to help the client regulate themselves, they can experience this as a sense of failure, and as harming and exposing. Benjamin (2016) suggests we need to accept the limitation of insight and create a space of reflection, which becomes a shared vital 'third'. By examining our own part in this process something shifts as we surrender. The third then, can give failure or an impasse a positive function as we move away from blame, accusation and shaming.

The Transpersonal and Contemplative Practices

Hycner and Jacobs (1995) say we over emphasis our separateness and this can deny experiences that are bigger than ourselves. Indeed as socially relational beings we are not going to achieve absolute autonomy or ultimate separateness. Rather as Beebe and Lachman (2002) argue we have a life long need for 'interaffectivity' and 'subject-to-subject relating'. The transpersonal perspective goes further and includes a universal consciousness, the recognition of the infinite mysteries and the unknown. Bobrow (2010) suggests that within the transpersonal, the 'compulsive separateness' between self and other is dissolved. This duality collapses in Zen Psychotherapy, that considers the 'not two' which cuts through a subject/object concept by suggesting that, if we divide things up, we fail to capture the rich interwoven fabric of humanity. This is where the basic nature of integration rests and universal consciousness is emphasized.

As Krishnamurti (2010) says, the whole universe is in you and you are the whole universe. Or we can take from Rumi's (1273) idea, when he says that, "you are not a drop in the ocean. You are the entire ocean in a drop" (Barks and Moyne, 2004). We can also borrow from Blake (1863) in the Auguries of Innocence:

> *"To see a World in a Grain of Sand*
> *And a Heaven in a Wild Flower*
> *Hold Infinity in the palm of your hand*
> *And Eternity in an hour".*

We know of Jung's (1991) predisposition towards eastern philosophies. Jung was the first person to talk about the transpersonal in psychoanalysis. However, the transpersonal has no real founder, basic text or explicit methodology. We sometimes separate the spiritual dimension of the psychological meeting, but rather than see transpersonal as a separate construct, both practices can be seen as complementary and potentiating - they are both concerned with self-awareness, ambiguity, liberation, embracing curiosity and are experience near, in the effort to help facilitate the integration of self (Bobrow, 2010).

Spiritual enlightenment is associated with deepening, redefining and personalizing, by questioning, 'Who am I?', 'How do I find meaning?', 'What do I really want?' and not striving for the answers to these questions but dwelling within the questions. Cortright (1997) suggests that transpersonal holds the basic assumption that our essential nature is spiritual in as much we have a need to express

wholeness, growth and expanded consciousness. We move from the limited boundaries of the ego to access an enhanced capacity for wisdom, creativity, unconditional love and compassion, as the individual is waking from a more limited personal identity to a more expanded, universal one. Within this there may be an acknowledgement of the human spiritual quest.

In the transpersonal field Buber's (1971) ideas of the 'I–Thou' relationship requires a receptivity to this kind of position. Buber suggests that wholeness or 'interhumanness' requires a level of action, a surrendering and relational grace. Grace is defined as the presence of mutuality and these moments take us to the depths of interpersonal meeting, and the sacred. Real living is in the meeting, this bond or 'God presence' can be felt in this 'in-between'.

Many aspects of traditional therapy are similar to and have been drawn from contemplative practices. The act of 'evenly hovering attentiveness' draws on our observing self and describes a double consciousness (Gabbard 1999), which means we are pulled into the client's world whilst maintaining an observing quality. This expansive position is similar to the transpersonal idea of 'witnessing awareness'. This witness coexists alongside a normal consciousness as another layer of awareness, and as the part of you that is awakening. Witnessing yourself is like directing the beam of a flashlight back at itself with less attachment or judgment. The distinction is within the witness awareness; this would be one's soul or 'beingness'. The witnessing awareness also helps us recognize what is described in mindfulness as our 'reclining habits' or conditioned responses to emotional pain and we see our 'habits standing up'. For example, the impact of getting triggered emotionally means we can better interrupt cycles of conditioned responses by practicing acceptance and a clearer sense of what arises passes, as we embrace the idea of impermanence.

Other examples include, Bion's (1974) ideas that the therapist approaches every session like the first, being open to new possibilities as they arise and relating to the immediacy of what is unfolding. This also possesses what Stern (2004) describes as 'courting surprise'. This is similar to the concept of 'beginner minds' with its comparable openness, eagerness, and lack of preconceptions even when working at a level of complexity. Stern's (2004) ideas of 'moments of meeting' bring to mind the principle of paying attention on purpose that can create authenticity, immediacy and compassionate contact.

Neuroscience research has highlighted how mindfulness can contribute to self-regulation, anxiety reduction and the development of empathy. The evidence put forth by Siegel (2010) suggests that mindfulness helps develop the prefrontal cortex - altering the architecture of the brain, strengthening emotional responses, attention and mirroring, and supporting immune functioning. This helps us tolerate ambiguity and improves self-regulation and interconnecting circuits of the brain. Siegel (2010) advocates that mindfulness is being aware of the mind itself as we wake up to our experiences. This position offers discernment in which the mind's activities help us recognize that this is not the totality of who you are. The mind is attuning to its own state and that is why mindfulness can feel positive; these practices allow for greater compassion and empathetic capacities. Mindfulness and meditation practices, offer a real metanoia, which is a form of spiritual conversion and healing. Bobrow (2010) says that genuine meditation practices are subversive as they change our assumptions about the way we think things are as well as their organization. It helps with 'unlearning' and 'unknowing' processes that we encounter in the training to become therapists.

However, I believe mindfulness has become popular and overused these days and we seem to have hijacked these ancient traditions without fully deepening our own practices first, or even aggrandizing the practice of mindfulness, as a special skill that sets one apart. Perhaps we need to immerse ourselves in these ancient traditions before we teach them to our clients. The message of mindfulness is an invitation to tune into the dimensionality of who we are. In our search for an authentic experience, we want reprieve from burn out and the professionalization of busyness which has become a signifier of success. In what I view as our high-action ADHD culture, therapists, at times, make interventions or interpretations when no action is required because they are on autopilot or riddled by anxiety. Mindfulness awareness creates a distance between thoughts and actions. The

practice helps in making us aware of the state of being we are in, to pause and decide whether an action or intervention is really needed.

Mindfulness as a Path to Training Ourselves to be with What Is

Inevitably, when we move into deconstruction in psychotherapy training, it induces uncertainty and anxiety. It is impossible for you to go on as you were before, so you must go on as you never have. Symbolically speaking the doctoral journey is like taking the risk to travel into the darkest woods, and once there, much cannot be identified or felt if you are moving at 'high speed'. There is value in identifying what your patterning might be when you get overwhelmed, anxious or exposed on the training journey. These emotions are inevitable, and even crucial to the endeavour.

The doctoral journey requires courage that candidates often do not know they had. A trainee once described this training as climbing a steep mountain, but I think of it more like an inverted mountain. There are times when you are deep into mud and it can be bleak. At other times, it's like not much is happening and its winter-like. It is important to trust that as we encounter these difficulties there is tremendous opportunity to meet with our sense of discomfort with what we do not yet know due to experiential gaps in our knowledge and what we are grappling to know. Wallin (2015) suggest therapists need binocular vision, keeping one eye on the client, and one eye on ourselves. When we are stretched, the first things we often give up are the very things that nourish us because they seem 'optional'. We are only left with work or other stressors that often deplete our resources and with nothing to replenish us, exhaustion is the result. We can suffer the inevitable burn out by over extending ourselves in the service of others or through vicarious traumatization. We learn that self-care is not just a response to crisis, but a daily practice within our practice. This is not just a reaction to stress but a way of being.

This is even more crucial as psychotherapy training requires the discovery of innovative ideas, which can often sound 'out there' or 'strange' and this requires courage and resourcefulness. There cannot be vision without vulnerability. As Mitchell (1993, pg 116) writes, "One of the great benefits of the analytic process is that the more the analysand can tolerate experiencing multiple versions of himself, the stronger and more resilient and durable he experiences himself to be." I believe David Bowie deconstructed normative ideas about gender, music, class, race and death with great creativity and embraced multiplicity of selves and stances. What I have taken from him, is that therapists might need a similar stance of inventiveness, challenging norms and recreating ourselves.

To adopt this inventiveness we have to get more comfortable with discomfort. It is uncomfortable to propose a research idea that might not work so well, to put what you think and believe on the line. It is also uncomfortable to risk the urge to settle. Sometimes, discomfort is where our work might begin. One's vulnerability may also give rise to compassion and the use of our wise mind.

The doctoral journey is more than learning about one's specific strengths and most candidates have strong intellectual abilities. Rather, it is giving one's intellect a resting place so other strengths can emerge, like being present and embracing exactly where you are. Sometimes, its not just attending to what I am going to do as a therapist today but 'how am I going to be' as we attempt to align ourselves as authentic beings in our intersubjective contact. We may not always have to try and frantically add something onto our selves; we can recognize that when we are being ourselves this the best version of who we are. As Macy (1995, cited in Bobrow, 2010, page 11), a Buddhist scholar and ecologist says, "We don't erase the self. We see through it. Throughout our life we have been trying so hard to fix that 'I' that we have been lugging around. So when we drop the endless struggle to improve it or punish it, to make it noble to mortify it, or to sacrifice it, the relief is tremendous."

Contrast this with the Derek Walcott poem, 'Love after Love' (1984):

"The time will come when,
With elation you will greet yourself arriving at your own door,

In your own mirror and each will
smile at the other's welcome,

And say, sit here. Eat.

You will love again the stranger who was your self.

Give wine. Give bread.

Give back your heart to itself, to the
stranger who has loved you all your life,

Whom you ignored for another,
who knows you by heart.

Take down the love letters from the bookshelf,
the photographs, the desperate notes, peel
your own image from the mirror.

Sit. Feast on your life"

How might we feast on being a therapist who is able to rest in the domain of their authenticity? The task may involve pointing your self in the direction of growth, training yourself to get comfortable with your highest potential and uncomfortable enough to sit with your emergent fears as you take steps to support the shifts that are required. Transformation equally means leaning into the authenticity and strength that is already there. The mindful definition of transformation is 'reordering experience'. The failures you meet as you train, offer core insights, if we stave this off or close this down it will not allow for the rich succulent creative learning that is required. This is hard to do, as it can be experienced as so raw and exposing. However, I think the opportunity here is to use failure as fuel to learn to fail better.

Trainees often describe feeling overwhelmed by the vast amount of learning, that is required and much of this is an inside out process. It feels like there is much to do and wide-ranging material to integrate. Trainees have to be wary of getting caught up in a small narrow identity and tighten their bodies and minds for what is round the corner, tensing or bracing themselves against the next process report they have to deliver! It may be useful to consider what one's relationship might be to letting go and giving up our fixed need for ultimate control. The psychologist and meditation teacher, Tara Brach (2012) gives the example of pilots in the 1950's that were attempting to fly at altitudes higher than had ever been achieved. The first pilots to face this challenge responded by frantically trying to steady their planes when they went out of control and they would cling to the controls for dear life as they were reeling to their death. It was discovered that when they let go of the controls, however counterintuitive this seemed, in the planet's denser atmosphere the plane righted itself. Sometimes this control mode means our senses or aliveness narrows or squashes our creativity, rather than allowing for a vaster, more oceanic self. This pause gives rise to the possibility of a new choice, as by letting go of the 'controls' to some degree and attending to the moment, we are more likely to find the flow of presence, greater aliveness and embodied contact.

Creative Indifference as an Emergent Space

The tension between 'being with' and 'doing' are inherently culturally specific. In western cultures we often feel a need to do something to relieve suffering. Some therapists believe that they are there to help relieve suffering 'for and with' their clients. However, doing something to lessen suffering and being with accepting suffering are not incompatible positions. Sometimes the context or the client's anxieties may not allow for that unfolding process. We do not need to negate or supersede the 'doing' and 'being' positions either and it may be more important that we consider how they co-exist. I suggest that trainees explore their preferred therapeutic stance, and whether this is one of the 'active helpful therapist' who is there to comfort and be useful to the client. Reflecting on our stance gives us some understanding of what is implicit in our promise to be relational. Which alternative stance might we be prepared to consider experimenting with?

Creative indifference offers a potential space to engage with these concepts and ideas and it is a key doctoral determinant. The original term 'creative indifference' comes from Friedlander (1966) and was adopted by Perls' within Gestalt thinking. Creative indifference is creating the self without form (Frambach, 2003). The paradox of creative indifference as not simply about 'being' rather it is an attitudinal position and not a technique. Neither is it

a position of indifference, rather you are deeply involved but not invested in the outcome that influences the work. This means recognizing that feelings like fury and tenderness, for example, should not be isolated from each other as mutually exclusive contradictions, but experienced as mutually related in the totality of experience. This balance between action and non-action that sometimes has opposing qualities co-exists at the same time.

Creative indifference was originally described as the ability to remain at a neutral point, we know neutrality is not possible, but what is inferred here is not about being overly attached to a theoretical or emotional polarity that might be at play in every moment of awareness. Accordingly, creative indifference is the point where differences and polarities might dissolve. What this means in simpler terms is that creative indifference means reflexively viewing our position with a level of analytical distance embedded in empathetic connection. This means that, as your therapist, I am not attached to you changing in any particular way; I do not need you to change in order to feel good about myself as a therapist. As a therapist you may hold an instrumental position, but creative indifference would let your being inform your doing. Nothing is forced.

This attitudinal foundation is a non-striving one, embracing one's humility and offering the practice of letting go of our desires to obtain a result. Nothing to strive for or attain means we create a 'space'. In this space potentiality resides, it requires a level of submission and surrender, taking our hands off the controls and deeply trusting in the therapeutic relational meeting. When we relinquish our need to 'fix' the client, or our overextended need to help them, there is a palpable impact on the relational field. There is greater potential for freedom and creativity and a fully present self. Rumi calls the center of our being 'the placeless place'. It is about inhabiting a realm within oneself that transcends roles, definitions and limitations, and is a creative void. We may feel uncertain and even scared of the void or nothingness. Perls (1969, cited in Clarkson and Mackewn, 1993, page 54) says, "When we accept and enter this nothingness, the void, then the desert starts to bloom. The empty void becomes alive, is being filled. The sterile void becomes the fertile void".

Sometimes therapists ask paradoxically but usefully, how do I do this? What helps? I think we need a certain commitment to uncertainty, to lean into a kind of openness and to be aware of what is given 'here and now' in our experiential field. This involves a basic gesture of allowing an indiscriminate acceptance of experience which may be said to involve, in turn, a relinquishing of our expectations. Bion (1974) borrowed the term 'negative capability' from the poet John Keats, to describe the capacity to tolerate both being in uncertainty and unknowing in order to allow, as yet unimagined, creative possibilities to emerge. Bion (1974) describes this 'negative capability' as becoming adept in tolerating and finding a resting place in what we do not know, and this means we can lean into any direction, with a degree of non-attachment.

Cooper and Mearns (2008) say that working at relational depth is letting go of the intensity of our desire to understand the other, as well as getting caught up in the content, or need to discern. We often have a profound need to be useful to the client, which is sometimes related to covert narcissistic vulnerabilities in the therapist. This covert narcissism means avoiding being seen as imperfect and unhelpful by the client, thereby avoiding a perceived fear of being devalued and or experiencing emptiness. The therapist may try to lessen the client's negative emotions of anger and disappointment due to this and the effect is a lost opportunity for growth and acceptance (Luchner et al. 2008).

I think we need a certain commitment to uncertainty if we want to truly work creatively and recognize that we are not always required to persistently 'improve' or 'prove' ourselves. Rather we could consider focusing on how mindfulness reveals aspects of 'experience' and finding gaps or even stillness between our thoughts. The focus of the 'being mode' is accepting and allowing what is without any immediate pressure to change it. This helps the therapist tune in, in particular ways. Attention involves a stimuli and response to this stimuli. In this space there is a gap in our thoughts, which offers freedom and choice to decide our response and adopt 'choiceless awareness'.

'Choiceless awareness' is the practice of responding to each new moment without

the burden of its past history, or of making future projections. When the mind does not cling anywhere, not even to the idea of not clinging anywhere, it is not laden with judgments and we can see the nature of things more clearly. Creativity operates best in an open safe space, which helps us create new ideas and make learning our own.

Conclusion

There is value in tolerating and learning from our missteps as therapists, and acting mindfully to identify a 'resting place' that can anchor us. The doctoral training calls for a pioneering spirit and the need for a sometimes dissenting voice that is willing to find its own authority and truth. It requires not just an engagement with our growing edge, but also our 'vital edge', that is a stance that activates a relational heart where our deep creative possibilities reside and where we can find meaning and imaginative bounty.

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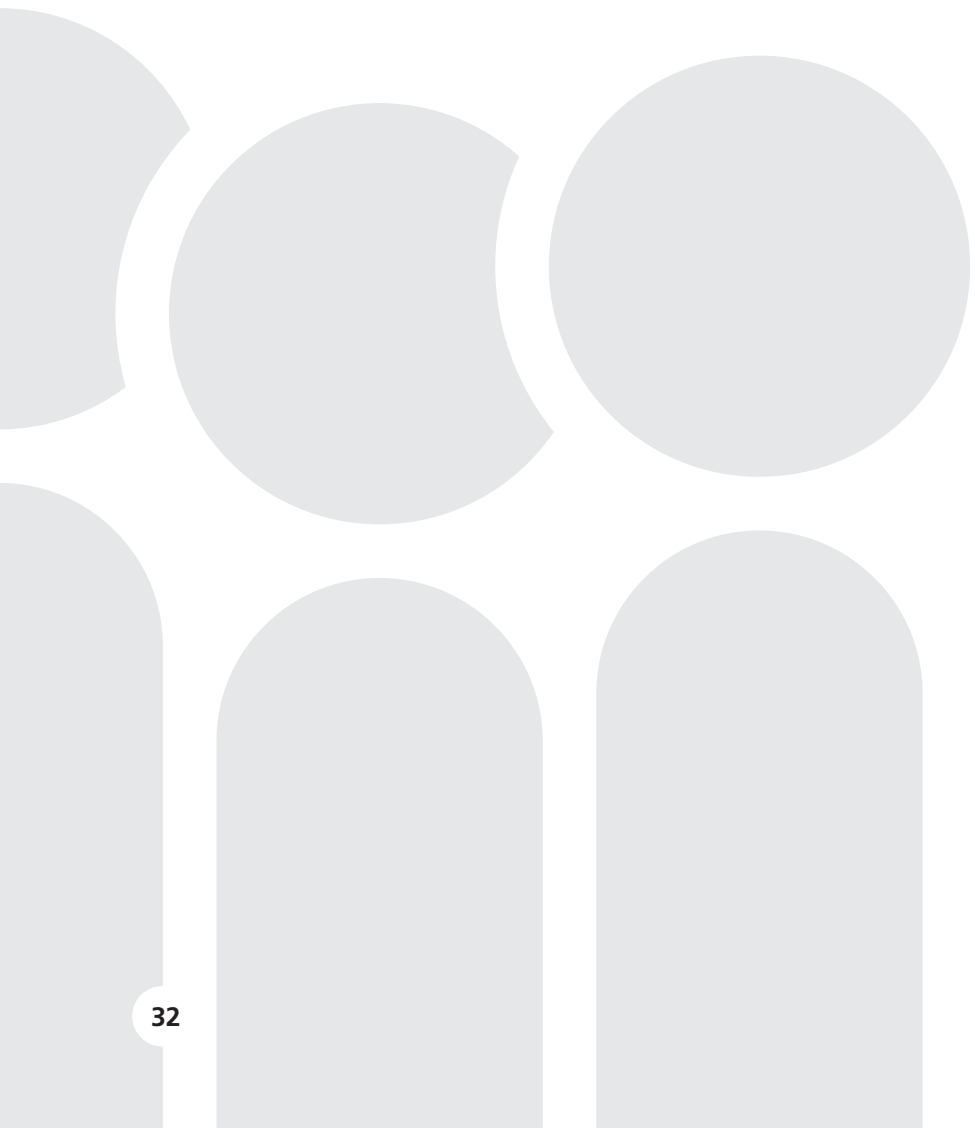

Shinar Pinkas-Samet

Humpty Dumpty Sat on the Wall: Somatic Aspects of Disorganised Attachment Organisation

Abstract

This paper discusses somatic aspects of disorganised attachment organisation from a body psychotherapy perspective. It explores, via a case study and theoretical discussion, ways of working relationally through the therapist's and client's bodies with fragmented body perception and self-perception. The paper examines eating disorders and attention deficit disorders through an attachment lens and argues that the therapist's willingness to work with her own body disorganisation may support her in developing a securer attachment with her client. Instead of aiming for integration, the paper suggests recognising and honouring bodily dissociation, perhaps even celebrating the protective functions therein.

Keywords: fragments, disorganised attachment, eating disorders, embodiment, breakdown disintegration.

Humpty Dumpty sat on a wall,
Humpty Dumpty had a great fall;
All the king's horses and all the king's men
Couldn't put Humpty together again.

Introduction

Much has been written about working with people with a disorganised attachment style, yet the focus is mostly on the psychological, sociological and forensic aspects of disorganisation (Hesse & Main, 2000; Hinshelwood, 2002; Liotti, 2004; Lyons-Ruth et al., 2004; Sinason, 2002), on infant research (Stern, 1985), or the mentalization of disorganised attachment (Fonagy, 2002; 2003). While Allan Schore (1994; 2003) has done a great service to the psychotherapy community by researching the psychophysiology and neurophysiology of attachment, I want to demonstrate somatic aspects of disorganised attachment, in diagnosis and clinical intervention. I hope to illuminate how crucial the body (and the unfinished body) is for working with disorganised attachment, and offer some relational ways of approaching it. Using a clinical demonstration and theoretical conceptualisations, I explore embodied ways of working with disorganised attachment patterns. The case presented is an amalgamation of a few clinical cases, and all details have been sufficiently modified to ensure client anonymity.

Anna, What's Two Plus Two?

Round and round they circle her and laugh. She's got no way out; they block her exit. So she answers, "Four." Then, "And four plus four?" She responds, "Eight," her voice quivering. "And eight plus eight?" Everybody becomes silent. She hesitates, "Sixteen." "And sixteen plus sixteen?" That's it. The numbers become fuzzy. Until now she knew it by heart; nonetheless she

tries. She cannot count with her fingers because they will all see her and mock her. She decides to attempt an escape. She runs, pushes, looks for an open space. "You cannot leave until you answer," she hears them rejoicing. She kicks and bites, screaming, "I don't know, ok? I don't know, I don't know, just let me out", but they do not let her out. Hands, arms, legs, legs, mouth-foam, chattering teeth, stomach shaking with laughter; she no longer sees them. Only body organs, severed, fragmented, unrelated to other body organs. A pile of organs which happen to come together. And then, an inner hand loosens, another hand moves away and she can escape through there, she can disappear. Upon returning home she throws up, pinching her arm, the folds of her stomach, her cheeks. It's too much, she says to herself, too much body.

She told me of this event indifferently. A few moments previously I had asked her to put down her headphones. I asked that because she was listening to heavy metal music and the volume was too high even for me, who sat in front of her. So she took them off carelessly and told me her story, followed by: "is it enough for today? Can I put my headphones back?"

> *"Yes you can," I replied. She listened some more. The song was over. "There are many wrinkles around your mouth," she told me. "I cannot look at your face, cause that's all I see. That and the stain you've got on your right cheek."*
>
> *"So what happens when you focus on my stain and my wrinkles?"*
>
> *"Then I despise you."*

And that's what our relationship looks like. One moment she will share a very painful experience, only to hurt me in the following moment. She will expose a facet of her worldview to me then weave a web of lies. She will call me on the phone, desperately seeking help, and then miss two sessions. She will cry then avoid eye-contact, get mad at me, and tell me she never wants to see me again.

This is not a sadomasochistic pattern of relating. She does not seek to hurt herself or me. Rather, this is her attachment style, the way she is able to relate to the world. Understanding this helps the way I currently work with her, and assists my understanding of eating disorders.

Martha, her mother, comes from Canada. She is neither Canadian nor Israeli, however, split to her core, reflected in her inability to finish sentences or ideas. She is unclear with herself and incoherent to her surrounding, and is both emotionally absent and very anxious. She exercises excessively, and her presence is elusive. As Mary Main (Main & Solomon, 1990) recognised, disorganised attachment is characterised by confusing, incoherent and unexpected patterns of relating to self and others. Traumas pass through generations (Feldman, 2015) - a mother with a disorganised mother, and then a daughter with a disorganised attachment. Predicting Anna's responses is difficult, both Anna and her mother are daughters to highly distressed, psychologically absent mothers.

Is Anna's disorganised attachment style connected to an internal-organic experience, as a child who suffered from attention-deficit and was severely dyslexic? How much of it is influenced by her mother's disconnection and the role-reversal between them (discussed below)? Could working directly with the somatic aspects of her disorganisation support the therapeutic process?

Half-baked Relationships and Unfinished Selves

Alongside her individual sessions, Anna arrived with her parents to monthly meetings. They later attended family therapy but at that stage, I was trying to understand the family dynamics. The meetings were not framed as therapy. I noticed that when Anna came with her parents her heals ascended, as if they left the ground and floated. She rocked her legs as if saying: look at me, I have no balance. Her makeup felt too black, her shirt seemed too cut. I experienced her miniskirt as very short. In the clinic, there was an armchair for one and a couch for two. Anna sat with David, her father on the couch, cuddling into his body. In our work together, she was unwilling to speak about their relationship. Martha sat on the armchair.

In one session, I could see Anna's underpants and noticed that her mother saw them too.

Martha found it hard to focus her eyes, they wandered, scared, from side to side. Martha was a very skinny woman, and appeared neurotic and unconfident. Martha's mother tongue was French and her sentences were jumbled up like a word salad. Being next to her felt strange, half-baked – as if she was not fully formed, as if our conversations were incomplete; as if her being was partial. Marta would begin an English language sentence and finish it half way; leaving it hanging in the air. At other times, parts of her sentences were in French, which I do not understand, so I was left with a void. She spoke with her hands, as if her hands plucked at a handkerchief or undid the lattice of a fabric. She began a movement and the movement would freeze midway, and Martha would freeze too. Martha scarcely looked at her husband, but she did look at Anna. It seemed she loved her but was also apprehensive, fearful of her responses, scared of the power Anna possessed, and of her aggression.

Her husband, unlike her, was very sure of his identity. At least culturally, he held no splits – he was an Israeli, a handyman and builder; he was impatient. In one meeting, upon entering the room he waved a bulk of notes at Anna and asked her, "Do you want it? Do you want the money? Then attend the family event today." Anna responded by flirting with him, she stretched her legs and said: "I will come with you to the family event, but the money – it's not enough." He looked at her, smiling and teased her further, "shall I give you more?" Then he looked at me, "Does she deserve it? Has she been doing her therapy well?" I was dumbstruck and stared at Martha. She played with an invisible neckless and looked at me scared. "What?" She asked, "Did you say anything?" Anna stomped her foot. "Say yes," she begged me, "Say yes." The father took more and more money out of his pocket. "Put the money back in your pocket please," I said. This was the first sentence I was able to utter.

I found myself immersed in their family chaos, unable to find my arms and legs. I recall Anna's description of being bullied for her dyslexia, and I felt just like her. I noticed I was unable to think of anything during the meeting. With Martha, something kept surfacing then fading away and the father left me feeling completely helpless. I couldn't sense Anna at all during the meeting, she was absent or perhaps immersed in other people's needs. I understood this to be a key to our work. Ash (2009) argues that a single approach with structured boundaries cannot work with clients with a disorganised attachment style. Instead, we need to find pockets of 'not-therapy' places, areas where we – at least partially – agree to challenge psychotherapeutic boundaries and roles to fully experience our clients. I can feel Anna only through working with my own body, and often without words. I have found that disorganised attachment is hard to understand in words, as these are simply not there – not in a form of language.

Silverman (1998) argues that it is not the pleasure principle that babies follow, but instead the security principle. The baby seeks to feel safe. The sense of self develops through formative intimate relationship, primarily with our attachment figures. These relationships first and foremost manifest in external regulation of the babies biological functioning. With time, such regulatory functions develop into a unique pattern of relating with the caregiver. When empathic failures occur, inconsistency, gross misattunement or incapability of the caregiver to form this external regulation of the baby's physiological functioning, can lead to the developing self of the child being harmed, and her capacity to form intimate relationships and to regulate herself biologically or emotionally, can be compromised (Beebe, Lachmann & Jaffe, 1997).

Between her parents, Anna is both the bridge and the buffer. She is the child-baby-princess but also the seductive, sweet-talking partner to her father. I would like to note that there has been no sexual abuse. Her father admires Anna's beauty and aliveness, possibly compared with her mother's greyness, but Anna is sexually safe. Anna shifts between roles and identities, locked in different bodies, and still lacking balance. Her imbalance is, at least in part, a result of living in an 'unfinished' body, which characterises – in my opinion – many eating disorder sufferers. Anna has yet to develop her own spine; one that can hold a body; one that can stabilise her.

The Other Side of Infinity

I see Anna for therapy in the Eating-Disorders centre of a major hospital. She is sixteen. She suffers from a severe eating disorder. She fasts, binges, purges, and lies. There's a lot of lying. She avoids communication with her surroundings. She denies suffering from an eating disorder. Anna is also highly dyslectic. In relationships Anna is very seductive; and her relationships with her family are complex and chaotic.

Everything about her is fragmented, including her speech. A few sentences in each hour emerging from a different world, disconnected from the preceding sentence or the following sentences. My sense of her innate disintegration seems to manifests in her artwork (collages of women from magazines). She tears these images of women apart, cutting the organs, eyelashes, wrists, noses, mouths, even teeth if she manages to. The result is one woman comprised of a thousand other women, with a thousand organs. Hundreds of mirrors reflecting pieces of Anna. Despite the multiplicity, the women are quite homogenised – always half-naked, sporting an indifferent look. She constructs and deconstructs them, spreading them apart and re-collating. Carefully, she glues them on cardboard. For some of them she creates a Plasticine body.

One day she arrived with two spatulas. Surprised, I raised an eyebrow. She laughed. "My dad is a builder," she said, "I spent all my childhoods with spatulas." She worked the spatula with great skill but only in one direction: narrowing down. She scraped at the Plasticine, reducing the body's contours more and more and more. "Like Giacometti", I said. She was pleased with this comparison.

Anna is untouchable, her body inaccessible. We cannot speak about binging or throwing up, however much I try. She doesn't like being analysed nor interpreted. She says she does not want to die, only narrow down more and more. 'Until what?' is the obvious question but it's the wrong one. "Shrinking is endless," she told me once I agreed to let go of that question. "It is simply the other side of infinity."

It took me a while to understand that, in order to reach her and help her I needed to let go of the question 'why?' She had already said she didn't wish to die. I understood that I needed to see the world through her eyes. Eating disorders, learning and attention deficits, cognitive dissonances, polarities, dissociations and disorientation – these are all words and labels and diagnoses. But what, I wondered, did Anna see when she looked at the world? Much of her pain is bodily-related in terms of her perception of space, orientation, and her dissociative experiences (Orbach, 1978; 1986). I wondered how I could use body psychotherapy theory and practice to better grasp her worldview and assist her when her physical, vital body was inaccessible for therapy and unresponsive to words. Following Totton (2015), I believe that understanding the body, and working in an embodied way, can significantly contribute to relational, attachment and projective techniques.

How does Anna see the world I wonder? The world she inhabits is a severed one, cut into pieces. It has no continuity of words or sensations, rather there are flashes of body, a word fading away, aversion to sensations, limited movement, strong and purified feelings, and dysregulated volcanos. Something inside Anna will erupt, and then becomes intangible. She often finds it hard to explain, "I don't know how to say it," she says, "but sometimes I feel I need to gather myself, to connect it all with a string. Sometimes I look at my body and each organ is in a different place: the head is in one place, the hand in another, the leg is amputated; each organ is in different proportions, sometimes I don't know where it belongs." I believe that Anna expresses through her body not only how she perceives the world, but also how she communicates in it.

In another session we stood in front of an imaginary mirror. "What do you see?" I asked. "I see my stomach, I see how bloated it is. I cannot see what it connects to. I can see my bum. I touch it and it is very soft. I know it's connected to my back, but I cannot feel it. I see the inside of my thigh, and as I look at it – it grows. Can you see?" She marks with her hand in the air, "it's already here," and at this point she indicated a huge thigh, far greater than her body. I understood. The world in her eyes was incomplete. Her disorganised

style, an internal disintegration and an eating disorder, together distort her perception of the world. I also understood that we could not work with an entire body, we could only work with fragments, one part at a time.

And What if I Wasn't a Body?

Classic body psychotherapy practice seeks to integrate body and mind, viewing embodiment as a desired state. My questions include, do we need to feel comfortable with both our mind and body? Should we always be conscious of our body at any given time? What about clients who wish to remain unseen? What about clients who wish to work with feelings and mind but not body? Is this always pathological?

I believe there is value in being bodiless, in the ability to fly, to wander about, to dissociate. This could be worthwhile and protective if we recognise that sometimes the body is the very scene of trauma. How do we work with a client whose body is the source of trauma?

Seeking to always integrate body and mind can sometimes be disrespectful. The body does not always seek integration but is instead cyclical, pulsating – constructing and deconstructing, de-structuring and then rebuilding, like the cells in our body, like body tissues. When we look at teenagers suffering from eating disorders through this lens, we are called to adopt a deep familiarity with fragmentation, a severed and cut body. These are frequent somatic markers of disorganised attachment style.

Humpty Dumpty, or a Prematurely-created Body

For many sufferers of eating disorders, the basic sense of existence is different from that of an adult (Bloom et al. 1994). A healthy perception of existence may include a sense of "I am here, my body organs are boundaried, I can tell the difference between myself and the world, and where my body is positioned against another body". We can compare body-perception to self-perception in babies. Bick (1968), for instance, portrays a rather passive baby experiencing his body and mind indistinctively, as scattered part-objects held together by the skin. The baby's personality parts, which are still undifferentiated from his body, are held by the skin that functions like a boundary, a border. Babies, according to Bick (1968), require a containing object and for that reason they move towards sensory objects (such as a nipple), to temporarily strengthen their attention and personality.

Such holding is experienced as skin. Until the containing function can be experienced and internalised over time, the baby senses that he may 'spill out' every second. The mother's ability to save the baby from his distress is seen as a strengthening function for his 'psychological skin', thus easing the sense of threat which results from a lack of integration (Symington, 1985). When disruptions to the internalisation and containing object occur – as a result of an inappropriate object or difficulties in the process of internalisation (and with Anna, both were prevalent) - the fear of self-parts spilling out remains. As a result the person may develop a 'second skin', a substitute for the 'primary skin' which was inadequately structured (Bick, 1968). In other words, when the mother is physically or emotionally absent, the baby is required to adopt self-regulatory skills to protect herself from the catastrophic dread of spilling out into a void (Symington, 1985). The baby may develop a repetitive movement, which is perceived as a holding skin. When movement ceases, the baby experiences holes in the skin and her anxiety increases. A baby may also hold certain muscles rigidly, thus creating a tight layer through which she cannot spill (ibid). These descriptions, which present somatic aspects of disorganised attachment, are strategies for developing a second skin, or a sensory ground (Ogden, 2006). In sum, the baby attempts to create a sense of boundary which closes in gaps in her self-perception, gaps which the primary attachment figure has failed to regulate. Without these attempts, the dread of disintegration (the fear of breakdown) may continue throughout life (Symington, 1985).

Tustin (1992) considered autism as a post-traumatic response to premature awareness of bodily separation, set against the baby's innate predisposition towards extreme merging. The baby experiences her separation from her mother's body as loss of part of herself and the basis for bodily understanding is therefore

wounded to start with. That is, the baby's relationship with her body and her mother are indistinguishable, and attachment patterns are not simply about relationship with the world and psyches, but between bodies: one body seeking to teach another body how to perceive the world, how to be in the world. When the body-to-body relationship is harmed, the somatic base of a baby – not only the autistic child – may be distorted and disorganised.

Winnicott (1963) too, discussed the prematurely created body, resulting in a withdrawing body and establishment of an inconsistent psychological foundation. Winnicott (1963) defined a fear of disintegration or breakdown, as primitive torment following a breakdown taking place so early during development that the baby was not there to experience it. This breakdown is a generic name for an intolerable experience, too horrid to conceive, resulting from a lack of physical or emotional holding. A person who experienced such a breakdown would forcefully avoid it using dissociative defences and other defence mechanism. Equally, it is only through a breakdown that healing can occur, and where he could occasionally feel himself (Kolker, 2009). This is parallel to Anna's attachment experience in the world – the fear of unnamed disintegration fostered a strong bodily sense of holding and an obsessive control of the body accompanied by dread, such that Anna would imagine that if she was to let go of control, her organs would scatter everywhere, and she might spill out with nobody available to put her back together again.

Anna's movements are disturbed, disorganised – motoric centres were damaged at such an early age, like organs scattered outside and psychic matters in, with neither containment nor holding. Anna did not internalise her parents, as if their body was not imprinted in her psyche. There is no site for building foundations for her, only floating pieces. Dissociation and disintegration is a bodily experience at its very core (Rolef Ben-Shahar, 2009): and I am asked to experience it together with Anna.

It became clear that my own bodily presence was crucial for Anna: She did not seek words, but rather someone with a benevolent presence, a body who can absorb and digest her own body parts. I have torn my body open for her, letting in her amputated organs and her incomplete and severed body parts. I have tried to understand what it is like to have one eye like this, and one like that, a short arm and a longer one, a large head and small body. I have tried to imagine it in my body. "What are you doing?" she once asked me and I explained. She laughed. We then tried it together. Anna stretched one leg and contracted the other. Then she curled in a ball and reached out a hand. I held her fingertips for a second and she let go of my hand. When I left the room I suddenly didn't know where I was. I couldn't feel my left leg, it dragged behind me, only a few steps until I found something to hold on to. It was very scary.

"Sometimes I can look at another person as a diaspora of organs, where I can choose something and leave the rest behind," she told me when her collage work was finished. "It feels like a supermarket – I can choose whatever I want, whatever I like. I have the control. There is no genetics, no body defences, no memories carved as scars into the body: I can take someone else's skin, I can be a thousand organs rather than one person". We sat in front of each other. I asked her to look at me and choose three of my body organs (not too emotionally changed, not too big). She looked at me and named the first organ, waiting, looking. When she had, had enough she moved to the second, then the third. We then swapped – I looked at her and chose three body parts of hers. "What was it like for you?" she asked me. "You looked at my teeth," I replied, "and I thought of my front teeth. Two of them are yellow and I looked at you looking at my teeth and they started to grow, really grow out of my mouth. I wanted it over, I forced my mouth shut."

These practices are not commonplace in body psychotherapy, they do not seek to bring the severed parts together, they allow for bodily dissociation. Because some people cannot connect with the wish to integrate, some need to respect and honour their disconnection, their dissociation. Can we recognise and acknowledge unformed body parts, parts that cannot be embodied? The parts that are shy and withdrawn?

Between a Transition-object and a Voodoo Doll

For a long period with Anna she was sewing a doll. I brought her materials and asked her, instead of sculpting herself, to take a single organ in her body and give it life. This projective-somatic work was indirect, we could not directly work with her body or body image. I did not project my body image onto the doll; it was not a cursed voodoo doll that received all that I hated about my body – it was partial, a doll representing a single organ. One small step.

Similar to narrative processes outlined by White & Epston (1990), I asked Anna to externalise an organ she struggled with, and we both tried to understand it with projective interventions such as art as therapy. We were engaged in building an outside body, not inside of us; a second skin of sorts, but not instead of her first skin. A second skin that attempted to gradually expose and create the first skin, seeing it with the holes, tears and dissociations therein. We wished to acknowledge exiled parts of herself (Gilligan, 1997) and to honour the withdrawn and shamed and dissociated parts. We wanted to make an external home for the parts that could not find one inside. It was not Anna's entire body-ness which was symbolised then, but a part of her – we symbolised a part-object. We were creating fresh, tangible body parts so that we could explore them and give them form.

Over and over, Anna would try to strangle her doll, at one point even hanging her up and sticking pins into its body. For a while, it would became a voodoo doll. This 'shame-doll' had a huge puffed belly, and it was a victim of many stabbings. The doll had small arms and legs and a stem-like neck, and her face was disproportionately small. Anna folded the arms and legs into the stomach, or she would tie the organs together, wrap them up and then loosen them free. Sometimes she would sew organs into the belly and then untie them. Fabric would tear and be replaced. One day Anna stuck an eye to the stomach and a mouth on the doll's back. It would make her laugh. She would then ask me to buy her Velcro and we begin to change the organs' places. The doll could smell from its heart, sigh with its eyes, tickle with its eyelashes. During this time, Anna's purging significantly subsided.

Becoming a Body

When Anna agreed to let me listen to her favourite songs, we began to work with movement. I don't know if you could call it movement therapy, as there was no real continuity of movement. We improvised together - impulses and reflexes. She would shiver, scream, and cry. Her movements were involuntary. At this point I felt I was with a pre-body, a raw matter not yet materialised. She would open and closes her fists, from a tight fist to a widely spread-hand. She would lay on the floor for a long time, spread out. Sometimes her body would shake while I would sit by her side. It would feel like there was very little to do and a lot to be. Sometimes I would try to gather everything up and physically hold her together. Though this felt mostly impossible. At times I was filled with anxiety – I did not know exactly what we were doing. At other times I struggled to formulate my thoughts clearly and my mind would scatter to a thousand other places, away from this open, demanding, empty and hurting place of Anna, and of my own. Sometimes I listened to the music (heavy metal) and noticed the many screams and heavy breathing and gasps of unclear words contained within it. Sometimes it was like a nightmare; at other times I understood it as her inner music.

Bowlby (1988) believed that the attachment system is active, mutual and continues on throughout life. For Bowlby, attachment is prewired within us as social organisms and includes the instinctive responses of the baby, such as sucking, crying, smiling and humming. Bowlby's attachment system is based on biology and sociology.

Currently, in my work with Anna, I understand that I need to be a body. Anna, my child, is throwing a tantrum and I need to be a pure body of instinct. A body teaching another body how to become. Perhaps this represents the clearest sense of a bodily relationship in psychotherapy. Anna and I meet across our own attachment styles and dialogue between needs which includes a bodily negotiation of needs.

Orbach (2003) considered the body as searching to become. Becoming (and perhaps this is the beauty of psychotherapy and in the body itself), can happen all the time, as long as

there is another body allowing the body to become, to change shape, to let go and be seen, to fall apart or take shape. A body takes shape only when another body is present.

Conclusion

When seen through an attachment theory lens, one of the main functions of therapy is rehabilitating formative relationships, offering an alternative secure attachment which can then be internalised. Since attachment is first of the body, it is important to learn the body directly from the body, as an experiential learning, in order to bodily attach (and to offer body attachment) to our clients. It is an act of faith, believing that it is possible to earn secure attachment (Roisman et al. 2002).

Oftentimes, however, we do exactly the opposite – we narrow our bodily presence, sinking into a reverie where the body fades away until we become a floating consciousness. Yet many clients, like Anna, need a present body, a meaningful body, an existing body, not merely a consciousness to be with. Anna, like others, needs a caring, loving, communicating, perceiving and sensing body next to her to learn how to be herself. Since her own upbringing did not allow for her body to form, she became in therapy what she could not at home.

At the end of her paper on relationality and attachment, White (2008) lists some principles of relational work, and I would like to conclude my paper by noting her first and last principles, both of which summarise my work with Anna, and with many clients whose disorganised attachment style calls for a body against which to form:

1. The psyche is experienced from our bodies in relation to others
2. Cure comes from mourning, the rediscovery of meaning and the liberation of desire, subjectivity and creativity within the self-other relationship.

Therapy with clients who suffer from eating disorders is frequently unsuccessful. I believe this is in part because the cognitive distortions, accompanying eating disorders, often stem from distorted body-perceptions, and what I called here 'unfinished bodies'. Perhaps, in order to support recovery, the therapist and client need to embody the fragmented, the unfinished and the 'pre-bodied' experiences – to move through somatic developmental stages and allow the client to become a body.

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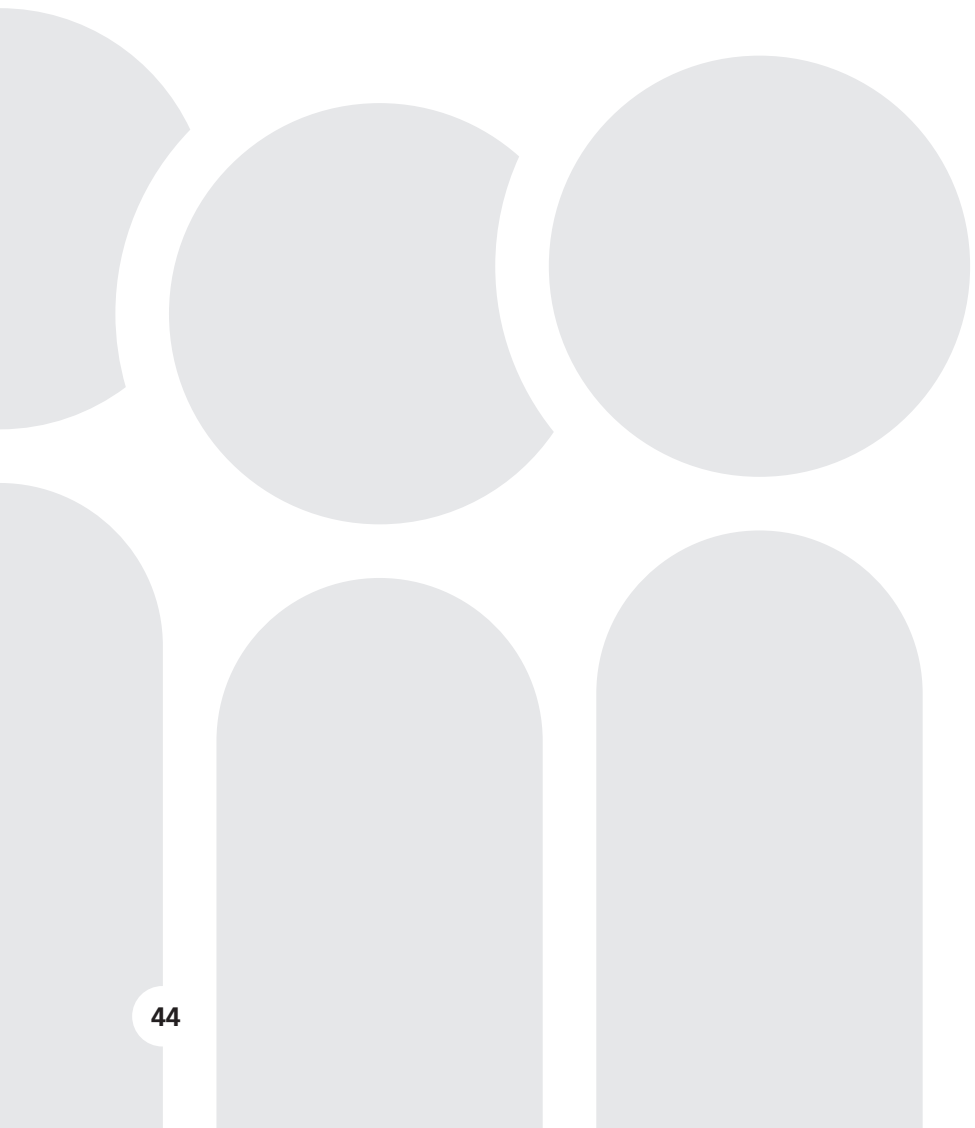


Patrick Casement

The Journey: My Time with Cancer

Preamble

Ever since I came out of hospital (three years ago) I have several times been asked if I would be writing up my experience of cancer. Until now I have always said that I would not do that, for several reasons. Although I have no problem in talking about my experience, my reluctance had mainly been because I did not want to alarm people. Not all cancer patients go through what I went through.

Another reason for my hesitating to write it up had been because I have ended up where not all patients are privileged to arrive. A strange thing about my cancer, Burkitt's lymphoma, is that it usually does not come back once it has been completely cleared. How lucky I am that my consultant can tell me that I am now unlikely to see my cancer again. I wish the same good fortune could be shared by all cancer patients. Nevertheless, it may be that other people can gain something from hearing that even a very serious cancer can be survived; can even be beaten. And the treatment of cancer is getting better every year. So I have, after all, decided to write about my rather extraordinary journey.

Finding that I Had Cancer

We were due to leave for New Zealand on the 10th December, 2011, but I had been having slight discomfort in my stomach -- for a month or so before.

My GP at the time had examined me and had decreed that this was a flare up of my existing hiatus hernia. But, a few weeks later he said it might be gastritis. Being concerned not to risk spoiling our trip to New Zealand, followed by four weeks with our daughter and grandchildren in Sydney, I decided to cut out any foods or liquids that might exacerbate my gastric condition. I therefore decided not to have any wine at all.

After about 7 days, I declared proudly to my wife (Margaret) that she should also try to go without wine. I had lost ten pounds in seven days. Fantastic! But she didn't think it was quite as fantastic as I did. No one should lose that amount of weight in such a short time. She wanted our GP to investigate, to rule out the possibility of cancer.

As we had only ten days to go, before leaving for New Zealand, the GP was able to arrange for me to have an endoscopy and a colonoscopy within the next few days.

On the following Tuesday I saw a new GP to discuss the results from those recent tests and we were told that there was "something there." It was therefore arranged for me to come in the next day for a blood test.

When I woke on the Wednesday morning I was suddenly feeling more ill than I could ever remember having felt before. I told Margaret that we should not wait until my appointment for the blood test. I felt that I had to get within immediate reach of a doctor, even though I didn't have an appointment. We therefore went in to the morning surgery, saying that I was willing to

wait for any doctor who was able to see me. I was prepared to wait all day, if necessary.

The new GP (from the previous evening), who happened to be on duty that morning, took one look at me across the waiting room and insisted that he see me straight away. I have no idea what he noticed, but he discovered that my pulse was running at 220. Not good.

I was immediately transferred, in a wheel chair, to an ambulance that had been called; and, within minutes, I was taken to the direct admission suite of the Royal Free Hospital (RFH), where a crisis team was already waiting to deal with me. Then, for some seven hours those doctors worked on me to bring my pulse down to a safer rate. They even tried using pressure points, and whatever else; but not before they had tried the more usual treatment of digitalis, or whatever. I heard them prescribe the usual dose, followed by a double dose, and then I heard them say: "We've never tried this before, but I think we should try doubling again."

Eventually, I was taken up to the heart unit on floor 10 of the RFH, where I was linked up to all manner of monitors, with something like 14 wires attached to me.

I remember that I was sweating a lot. Also, for some reason, I was left in my day clothes -- for quite some time. I can now only assume that this may have been in order not to put me through needless stress in getting me into a hospital gown. It seemed like several days before I was washed. Eventually, being embarrassed by how much I then smelled, I apologized for this to a junior doctor. But he kindly replied: "You don't smell bad. You smell quite nice!"

I think it was on the second day that I met my consultant, Kate. She was very straight with us, and it soon became clear that, after I had been through various scans, I not only had a lymphoma but I also had a number of significant blood clots in my lungs. These would have to be treated alongside my cancer, but the treatment was going to be very complicated and I would have to remain in hospital for some time.

The initial chemo I began to receive had been a preliminary treatment, this being administered through a mechanically controlled pump, monitored by a lovely Portuguese nurse called Manuel. He was very attentive, and he knew to act immediately when I reported to him -- half way through the chemo being pumped into me -- that I was becoming extremely dizzy. He said that my body was clearly not able to take this chemo and he stopped it straight away.

We learned the next day that there was by then a more accurate diagnosis. I had Burkitt's lymphoma. This was far advanced, stage four, and we were told that it was also very aggressive. However, Kate explained that this was not necessarily a bad thing. As the cancer would be growing very rapidly it would also be more vulnerable to the treatment, but they would have to use their most aggressive chemo in order to take it on.

On my second day in hospital we discovered that the lymphoma had closed off my stomach. This meant that I could not be given any food by mouth. For the first month I received only a saline drip; I never understood why I could not be given anything more nutritious than that until the second month, but throughout I totally trusted the team's judgement. In all I lost something like 56 pounds in 56 days. A fantastic diet for losing weight, but not to be recommended! I became Belsen-like in my thinness, my legs just bones. But the interesting thing about it was that I never once felt hungry.

Mostly, I was very well nursed. And sometimes I was lucky enough to be looked after by those who were truly dedicated to nursing. It was easy to tell that, and I would then always tell them: "You are a really good nurse." I wanted them to know that.

However, there was one nurse who seemed to have no sensitivity at all. On one of my first nights in the heart unit I was not getting to sleep. I wanted to ask for another sleeping pill but didn't want to buzz the nurse. Perhaps I could ask when he next came in to see me, which was usually every hour or two. When he eventually came it was about 1.0 am. I was then firmly told "no sleeping pills could be given after midnight." How absurd, I thought, as I was hardly going to be driving a car the next day. But, No. So, I was left to get to sleep, or not, for the rest of the night.

Then at about 3.0 am, I having just dosed off to sleep, this night nurse came back to see me. He had a tube in one hand and said that he was going to have to insert this into my nose, as my stomach had to be drained of any liquid that might collect there, now that my stomach had been closed off. I asked why it had to be done there and then, as I had only just got to sleep. He said that in the notes it stated that this tube should be inserted "as soon as possible." But could it not have been left until the morning? No, it had to be done there and then. So, this nurse shoved the tube down my nose, and did this so roughly that my throat subsequently became ulcerated, which continued to trouble me for all of the two months that the tube had to be in my nose.

After a week or so in the heart unit, I forget exactly how long, I was transferred to the lymphoma unit where I was put into a single room. I then remained in isolation throughout, to preserve sufficient sterility while my immunity remained low or zero. At such times, any visitors who came to see me had to be equipped with sterile gloves and an apron; and mostly they kept to a safe distance from me. We got quite used to this.

In preparation for my main chemo treatment, which I was told would be four courses altogether, I had to be given a special line which was inserted into a vein. This line was multiple and was to be used for giving me the chemo, but also (I think) for giving me saline and for taking bloods as often as necessary.

That procedure initially went well. But when I was about to start the first really aggressive chemo treatment, a duty doctor came to see me before leaving the hospital for the weekend. It was 6.0 pm. When this doctor looked at the line, which had been inserted to a point very near my heart, she noticed that it was forming clots. "That line must come out immediately."

The junior doctor who came to remove the line then told me he was very impressed that a doctor about to go off duty had recognized the problem. He said: "that was a very good spot." But the next problem was to find another suitable line (multiple) and to find someone suitably trained to insert it.

In the meantime, Bishop Peter Wheatley (then Bishop of Edmonton) came to see me to give me what I thought of as the "almost" Last Rites. Actually, it was the "unction of healing". I told him of the line problem and that they might not be able to get my chemo started until Monday, giving the cancer free rein for another several days. He said: "We'll just have to pray." Almost immediately after he'd said that, someone came into my room to tell me that they had unexpectedly found someone still in the hospital (being then late on a Friday) who would be able to insert the line. So, all was well. I said to the bishop, "That was the quickest answer to prayer I've ever come across."

When I started that chemo, the first full chemo, I didn't know what to expect. It was very strange. I found myself sinking into a state of such low energy that every movement seemed to require of me more energy than I felt able to summon up. That deep lethargy was absolutely the worst thing about the treatment. Fortunately, however, I never once had the experience of nausea that one so often hears mentioned in relation to chemotherapy. The doctors and nurses were marvelous. They kept me completely protected from nausea throughout my entire time in hospital, my five months there. I wish that all chemo patients could be similarly protected from nausea. Also, I was never once in pain.

After some days I was given a shower, sitting in a chair. This was my first full wash since being admitted. It was glorious. But the next time I was showered, for some reason I didn't understand, I was left sitting naked on the chair (forgotten), only partly dried, and I became progressively cold. Eventually, when a nurse did come back, I was shivering so much that I couldn't control it. By then I was suffering from hypothermia, so I was wrapped completely in tin foil. It felt as if I had been prepared "oven ready", as with a chicken. For some days the tinfoil was included in the makeup of my bed. It made a huge difference.

At some stage I was very fortunate to be given an airbed as there was a risk that I might develop bedsores, which fortunately I never did. I was also treated to the luxury of at least three pillows, even though I learned that these were in rather short supply.

My treatments, I was told by Kate, were extremely complicated as I had to be treated for the blood clots in my lungs as well as for the cancer. For the clots I needed to be given blood thinning treatment, which would reduce one of the two blood clotting systems in the body. But I then would need to recover from that before I could be given the next chemo, which would reduce the other blood clotting system. If I was depleted of both clotting systems at the same time there would be a risk of my dying from internal haemorrhage. These complications meant that the doctors had to keep a constant watch on my various blood levels, choosing the most opportune moment for each next step of the treatment: for the chemo or for dissolving the blood clots.

Margaret noticed that, for the first two months, I was too ill to know how ill I was. An example of that became apparent when I dropped something from my bed, in the night, and I didn't want to call for help. Surely, I could get out of bed to pick it up myself. But, once I was standing on my feet (the first time for quite a while) I immediately became extremely dizzy. That was the last thing I knew. I was later found, unconscious, lying on the floor. No one knew exactly how long I had been there, and I certainly didn't know.

I was frequently tested, for all manner of things, with different kinds of scan; heart echo, MRI, X-ray, C-T scan and whatever else. And my blood was tested daily. This blood was usually taken through the multiple line in my arm. But sometimes this became blocked, so the nurses had to put a cannula into a vein. Unfortunately they had to use my veins so frequently, for one thing or another that they began to have difficulty in finding any vein that would work. I was told that this was because the chemo had the effect of shrinking my veins, making it increasingly difficult to take blood in that way. And sometimes a nurse ended up digging into my veins trying to get blood. This was the only thing that was really painful, throughout my time in hospital. Strangely, there were some nurses who were still expertly able to find blood at the first attempt, and yet others regularly had problems over this.

Several times I was found to be in need of a blood transfusion. Altogether, as I recall, I received at different times a total of 14 units. It was extraordinary knowing how many people had donated blood towards my treatment. What a gift.

For most of the first two months, looking back I now realize, I had been mostly in a kind of hibernation. I was sort of suspended this side of sleep but only fully awake and alert when I had visitors. And one of the many things Margaret was doing for me, throughout, was to handle the frequent requests from people wishing to visit me. It was a huge help knowing that I would be visited, but also knowing that I was being protected from too many visits on any one day. I often had just one or two in a day, each person knowing that I might only manage about half an hour or so. Quite often it was so good to see these people that I would manage longer, but then I would find myself slipping back into being drowsy or falling asleep while they were there. Amazingly, Margaret never missed a single day during the time I was in hospital, in coming to visit me.

Some days I was caught into such a deep lethargy that it felt as if there might not be sufficient energy available to sustain life. On one such occasion the sense of being drained of all energy was so complete that I could not dare to sleep until I had made sure that Margaret would be able to find my wedding ring, which had to be taken off. I had lost so much weight it was falling off. Only then could I give in to sleep, feeling that I might not wake.

There were several periods of time when I was faced with the real possibility that I might die. In fact, during those times when I felt able to concentrate enough to write on my iPad, I worked out details for my funeral: mainly the music. But I was in no way afraid of dying. I felt completely accepting of it. The only thing that really mattered was that I should live long enough to see our grandchildren again, and they were not due to come to England until July. In the end I didn't leave hospital until 23rd April. But that still gave me time before they came, for me to adjust to being on my feet again and being back at home, all of which took adjusting to.

Our daughter, Bella, was in Australia with our four grandchildren. The youngest, Iona, was three when I was in hospital and she

had no memory of me, so Bella brought her (along with Arthur the eldest) so that she could have at least some memory of me -- in case I died. They were in London for about ten days, which was wonderful.

For the first six or seven days, when Iona came to visit she just stood at the end of my bed. Mostly she was staring at the strange sight of her grandfather in bed, already with very little hair, with tubes into his arm, a tube up his nose and sometimes with oxygen as well. She was silent and shy. But about a week into the visit, she came to stand beside me (un-prompted by anyone) and she put both of her hands on top of mine, which was on the bedside rail. She then stood there, gazing into my eyes, unblinking and silent. It was like a healing, a laying on of hands. At the time it really felt as if she was willing me to live, and maybe she was. It was a magical moment that I have treasured ever since.

One of the things that had most preoccupied Bella when I first went into hospital was: "Will they know who Dad is?" She kept asking this, which began to worry me. Not knowing what we could do about that, I suggested to Margaret that she bring in a copy of my last book, Learning from Life, which could be put on my bedside table. If anyone showed interest in that, they could get some sense of me as having been someone before I became a hospital number.

Unexpectedly, that book came to be very useful to me later on. For the first two months, or more, I was so low in energy that I felt completely unable to concentrate on anything: no books, no papers, no TV and no radio or CD player. As mentioned already, I was mostly in a state of hibernation. But a time came when I began to remember Bella's concern, and I found myself thinking: "It is not just do they know who I am; do I know who I am?" It felt as if I had completely lost touch with my former self, feeling now reduced to this sick person in hospital, fighting to stay alive.

One day, when I was again wondering who I was, I saw the copy of my own book beside my bed. I remembered that I had loved writing it. Just maybe I might begin to get back to reading if I could read some of my own book. This may sound very self-preoccupied but it did the trick. It helped me to get me back in touch with having a self, and who I used to be before my cancer.

We were not yet through the wood with my treatment. I used to be visited most days by the physiotherapists, trying to help me recover strength in my arms and legs. Some days, when I woke early, I would lie in bed doing such exercises as I could manage. But there were some days when I had to ask them to leave my exercises for another day. I just didn't have the energy to exercise anything.

One day I woke early to find that my left arm was causing me great pain, but the strange thing was that this arm was in spasm -- sticking straight up -- but I could not release it, to bring it down. Nor could I move anything. I found that I was completely paralysed, unable to move anything except for my eyes; and I could not make a sound.

I lay like this for about two hours until a nurse came in with my morning pills. "Sit up", she said, "it's time for your pills." I could not make any response. After repeating her command several times, and not noticing that I was in crisis, the nurse proceeded to push all the pills into my mouth and then pushed a bottle in to make me swallow them. Fortunately I still had a swallowing response.

Although I experienced this pushing of pills into me as a terrible assault, it was strangely helpful in one particular way. I was so angry about this I struggled to protest, and that struggle somehow began to join me up again. After beginning to be able to make a few groaning sounds I found that my nerve connections slowly spread to my head and then to my arm. At last I could lower it and begin to get the blood back into my hand. The pain began to subside.

No one seemed to understand what had happened and neither did I. And this same paralysis happened again a few days later, again for about two hours, but I was then not so alarmed as I knew I had come out of it before. But the first time was an extraordinary opportunity to experience, first hand, the terrors that locked-in patients must go through. I subsequently begged the doctors to note that if I ever got stuck in that state I wished to have DNR (do not resuscitate) recorded on my notes.

One day, when the physiotherapists were again trying to help me to recover use of my legs, I was standing at a zimmer while trying to walk on the spot. I then found that I began to feel dizzy; very dizzy; very, very dizzy. I told the physio of this, as it increased, and then I remembered no more.

I learned later that the physio got me seated and then found that I had stopped breathing, and "showed no vital signs." It seems that I had gone into 'arrest'. She immediately called the crash team which, I was told, were there within two minutes. Meanwhile, Margaret was telephoned and it was suggested she came to the hospital as soon as possible. When she arrived she found the crash team still working on me. I don't know what they did, but they got me back. I later learned that the physiotherapist who had been with me had undoubtedly saved my life by acting so promptly.

I continued to have problems in recovering the use of my legs. This had presented a regular problem when it came to weighing me. The nurses didn't always have time to find the weighing chair, so they made do by holding me onto floor scales, while I bounced up and down unable to stand properly, and they would note the swings on the scales -- estimating my weight as being mid-way between the extremes.

We then came to the moment of decision about whether to continue with the chemo treatment or to discontinue it. Until then I had been accepting that a lot of people learn to live with cancer, so I surely could do the same. I therefore told my consultant (Kate) I was prepared for the possibility that I might have to return, from time to time, for more chemo. Why should I expect it to be any different from how it is for most cancer people? However Kate was very direct with me -- as always. She explained that, with my cancer, there is only one chance to 'get' it. Either we eliminate the cancer or the cancer would eliminate me. She also explained that I should not think of coming back for more chemo treatments in future. As I understood it, she would not be able to give me any more chemo treatment after the course I was on. I think this may have been because of the risks to my heart. So, when we were coming up to the point of my having the last of the four chemos in my treatment sequence, Kate came to see me along with Margaret to explain the options. From the last scan it was evident that my cancer was still active. So the choice was as follows: either we let the cancer have its way, which should give us some weeks or months to prepare for my dying. Or, if we went for the final chemo, I might be dead in a matter of days. "So, don't be greedy for life," she said. She had presented the clinical picture to a group of consultants and they were apparently completely split between a definite "don't go there" and "give it a try."

Margaret and I thought carefully about the options and decided to let the family know we were going for the slow route to death, with the advantage of having time to prepare for it.

However, the following day, Kate came to let us know that the latest echo test on my heart had come back with a slightly more encouraging reading. This might give us a chance of risking the fourth chemo. We therefore decided to go for it, and we had to go through the process of letting the family know we were no longer preparing for my possible death in a few months. But, I might still be dead in a few days! We went for it and I didn't die!

There came a time, towards the end of my five months in hospital, when I was beginning to make progress on the zimmer. Having needed two people to hold me, at first, I had got to the stage where one was enough. Then I was told that I could have a go on my own, next day, as long as there was someone in the room with me.

A lovely Irish nurse was there when I tried my first solo attempt with the zimmer. He watched me, no doubt seeing the eagerness in my eye as I began my first steps towards getting out of hospital, and he remarked: "Look at you with that zimmer. You are going along like a snail with a 'hard' on." I nearly fell over I laughed so much.

Mostly I was treated extremely well. But there was one relief consultant, who was dreadful. He twice visited me without giving me a chance to speak to him. The first time was when I was cleaning my teeth. He just spoke to my back and disappeared. The second time I was sitting down and he again spoke to the back of my head. This time I protested, saying I didn't want him to say another word until I could see

his face. He claimed that there was no way he could get to where I could see his face, but a registrar took charge and moved the bedside table so that he could stand in front of me.

I later complained about this to my lovely Kate. She said I could either write a formal complaint or I could ask to speak to him. I chose to see him face to face. In the meantime I had learned that this consultant used to have a good reputation for his bedside manner. So, when we met, I said to him that, as an analyst, I had been interested to hear he had once been particularly well thought of for his bedside manner. But I had been told that about two years ago he seemed to have lost that skill. "I don't want to know what has happened to you, but I do think you owe it to yourself, and to your patients, to think on that change -- you giving up on such an important skill." I was pleased to find that this consultant did not retreat into being defensive. He listened to what I was saying and he assured me he would think carefully about it. I was glad we were able to part on an amicable basis.

Towards the end of my time at the Royal Free I was sent to the Marie Curie Hospice (Eden Hall) for rehabilitation, mainly to help me get to the point of being able to manage the stairs. This wasn't really as helpful as it might have been. For some reason I didn't get any access to the gym. By this time I was almost through my hospital time, but not quite. One day, in Eden Hall, I was (a second time) found unconscious on the floor. I had passed out once more and my pulse was again found to be 220.

This led to my being referred back to the RFH, once more in the heart unit, where I was eventually given "cardioversion." This was amazing. I came too after the anesthetic and my head had become completely clear -- such as it hadn't been for all the time I was in hospital. It seems that my cancer had affected my heart and my central nervous system, but at least the arrhythmia had been cleared. However, I had learned that the chemo had somewhat reduced my heart function. And I was later to find that I had also lost proper control of my legs, needing always to have a walking stick to catch me when I begin to stumble. I now regard my legs as having become adolescent. "They won't always do what I tell them to do." But all of that is but a small price to pay for life.

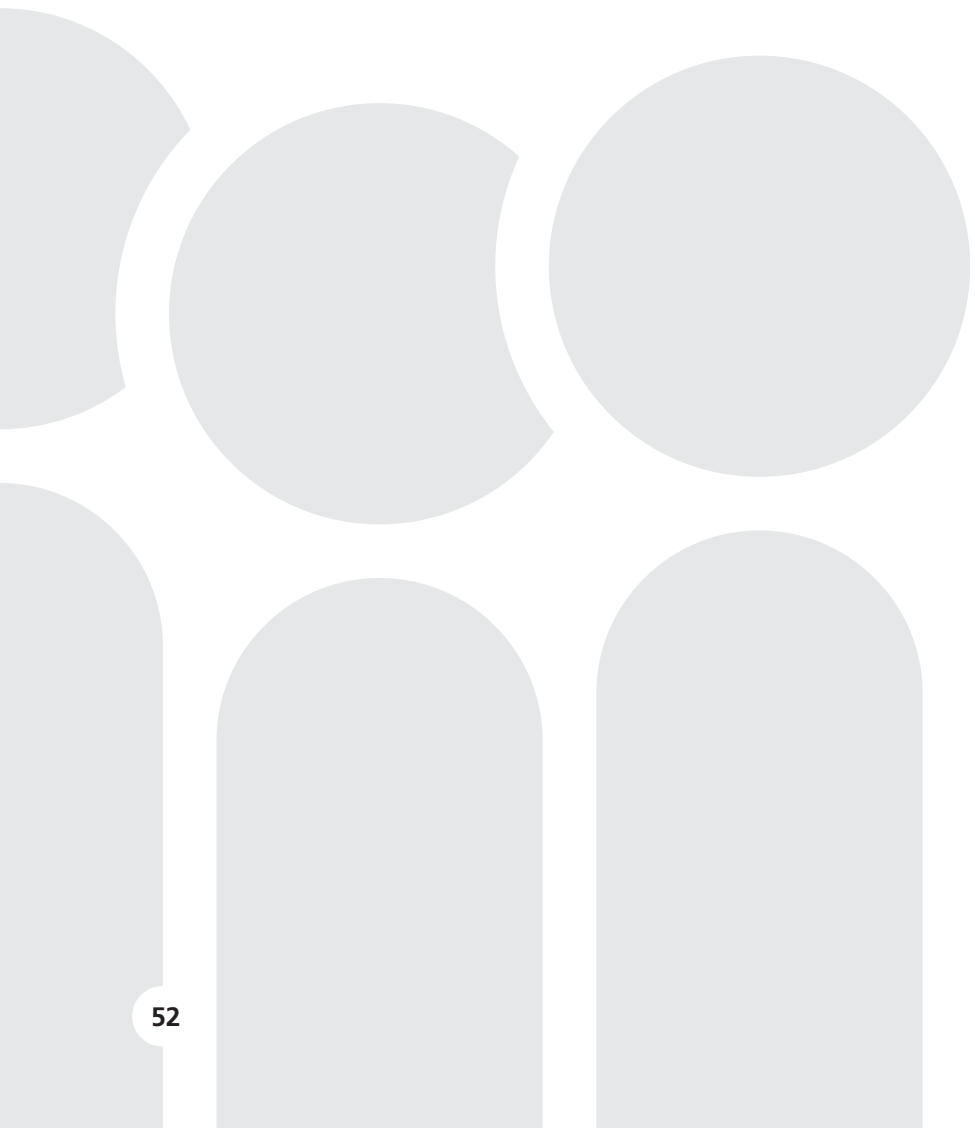
I was finally sent for a further CT scan, again at UCH where they have that most advanced scanner. This would tell us if my cancer was still active or, maybe, that it had been eliminated.

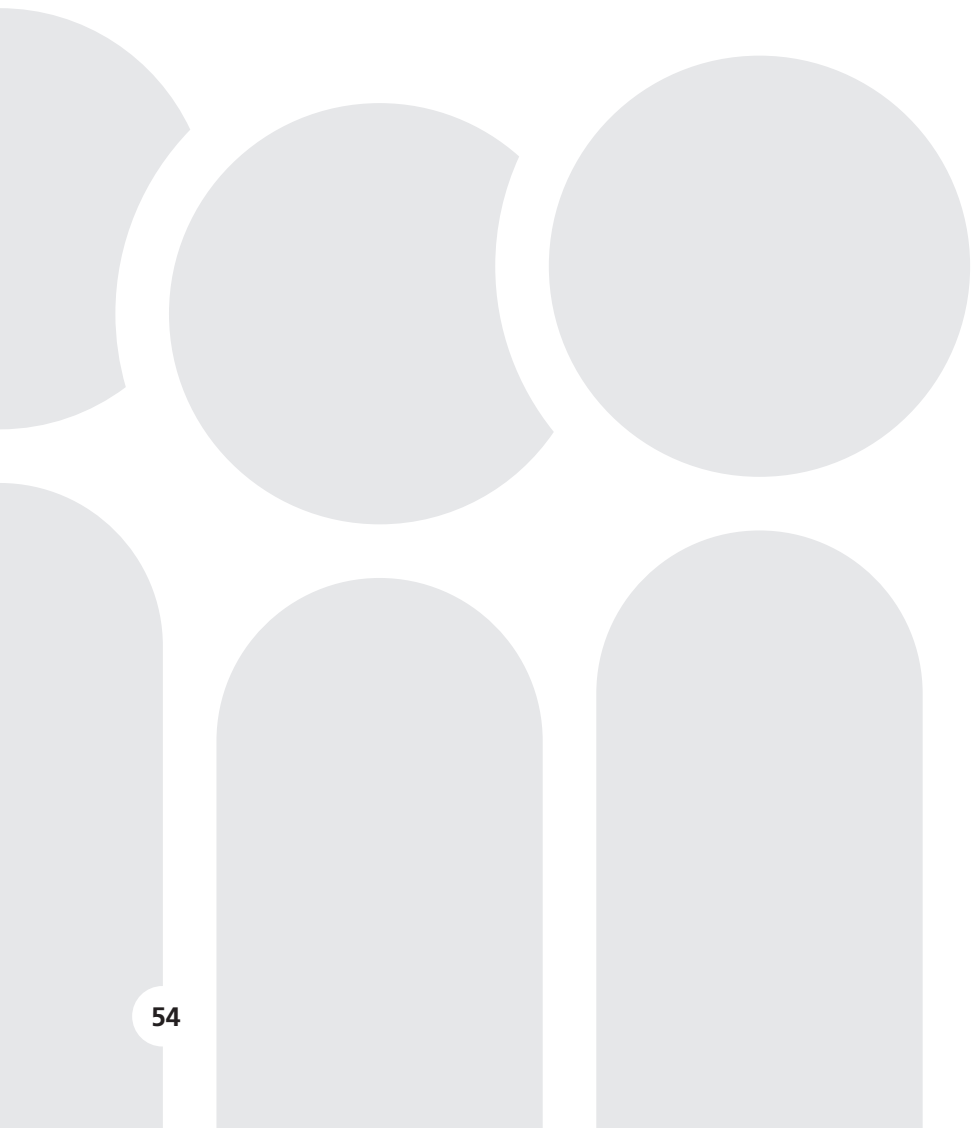
We had to wait for a further consultation with Kate. The results she would be giving us could not have been more totally "life or death", as it had been made clear to us that, if the cancer was still active, I could not be given any more chemo -- then or ever.

Margaret and I went for the consultation to be told these results. Of course we were both very anxious, so it was not surprising that we arrived an hour early for our appointment. We then saw Kate come out to collect her next patient. But, when she saw us sitting at the back of the waiting room, she didn't turn away from us -- as some doctors might have done. She came straight over with a broad smile on her face. She said she didn't want us to have to wait until the time of our appointment, so she was telling us straight away that the scan was completely clear! Wasn't that just the best doctoring possible? Just imagine the hell we might have gone through if Kate had turned her back on us, it not yet being our time to see her!

When we eventually saw Kate she said that I had made another patient very unhappy. How was that? She then told us that she had another patient who, previously, had been the oldest person she had known to survive their most aggressive chemo. He had been 72 at the time. She had just been seeing him and he had told her how proud he was to have achieved that special place in medicine. "Unfortunately," she had to tell him, "that place has now been taken by another." I was then 77. Kate also spelled out to us, something she had chosen not to tell us before, that I had initially been deemed to have "less than a 3% chance of survival," because of the advanced state of my cancer when we first knew of it and because of the other complications that came to be involved -- my heart and the clots in my lungs.

So, how good it is to be still alive!





Megan Rose Stafford

My Integrative Approach to the Practice of Psychotherapy

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

1.0 Introduction

This paper outlines my integrative approach to the practice of psychotherapy. I begin with an overview of my theoretical integrative framework and the different philosophical assumptions, as well as personal values, underpinning this. I draw on the key writers at the core of my approach to address my understanding of the person, human motivation and human function. Finally, I apply insights from traumatology, personality specialists, DSM-5 and neuroscience to address the key concepts that inform my problem formulation, before reflecting upon the nature of psychotherapeutic change.

2.0 An Overview of My Integrative Framework

Central to my framework for integration is both the co-created nature of relationship, and its healing potential. My model of integration is developmental, relational and transpersonal in nature and hence, draws upon Object Relations, Self-Psychology, Intersubjectivity theory, Relational Psychoanalysis, Rogerian and Jungian schools of psychotherapy.

My developmental-psychoanalytic lens provides me with an important maturational map to consider the key life stages and needs of the emerging child, and what is required from the environment to support optimal growth. Hence, through the transferential domain of relating and experiencing, and observation of my clients' phenomenological embodiment moment-by-moment, I am looking out for early, archaic wounds that will arise in the therapeutic dyad. Here, my aim is to step into the transferential aspect of the relationship as a new object (object usage), or new self-object, to resuscitate the developmentally arrested client. I acknowledge the tension between Kohut's (1959) postulation that it is the function of a therapist (i.e. their provision of empathically couched interpretations) that slowly restructures a fragile and enfeebled self, and Object Relations writers who offer themselves in terms of 'half-a-person' (Stark, 2000). However, while I find Kohut's ideas useful to think about the archaic child in moments of regression, I do not believe I can split off who I am in my response to my clients, serving as simply a function. Thus, while Object Relations and Self-Psychology help me understand transference as 'organizing principle', I believe it is the person of the therapist who serves in this capacity. Therefore, both schools help me understand the psychotherapeutic relationship as a developmentally nuanced, oftentimes reparative, exploration and experience; and

as the regressed child emerges, to work with that child and their developmental wounds.

Equally, my humanistic-relational lens informs my relational presence and the quality of my responsiveness to address clients' current relational struggles. These writers prize a 'two-person psychology' (Stark, 2000) which values authentic, interactive engagement. The term 'relational' has been adopted and used in different ways throughout the psychotherapeutic community (Aron, 2013) and it therefore seems expedient to define how I use this concept. Working relationally for me, acknowledges the psychotherapeutic relationship as unfolding in a co-created space, as the subjective experiences of both therapist and client meet and relate in a pattern of 'reciprocal, mutual influence' (Stolorow & Atwood,1992). I believe this promotes personal ownership and responsibility enabling us to become more engaged authors of our own happiness. Intersubjectivity theory and Relational Psychoanalysis guide my understanding and acknowledgement of relational phenomena and perspectival realism (Ringstrom, 2010), but offer different emphasises on issues of vulnerability and responsibility within the therapeutic encounter. The Intersubjective approach places particular significance on clients' vulnerability within the intersubjective field, to the "pro forma belief in the [therapist]'s 'goodness' and correctness at the expense of the [client's subjective] self" (Stolorow et al., 2000:115). Conversely, Relational Psychoanalysts emphasize the potential for neglecting the client's agency, a view that necessitates discussion of the argument put forth by Aron (1996) that mutuality does not equate to equality. Maintaining the tensions between these different positions, enables me to hold multiple possibilities regarding "what is impacting what and who is impacting whom" (Ringstrom, 2010:206), and approach this endeavour with sensitivity to my clients' vulnerability and awareness of my own. This enables me to work developmentally, but also relationally, at the level of authentic person-to-person exchange, facilitating my clients in experiencing relational flexibility in the here-and-now. To further assist me in this aim, I utilize Rogers' (1957) core conditions of congruence, empathy and unconditional positive regard. This approach acknowledges the different evocations of each therapeutic dyad (Lietaer, 1993) and values the therapeutic power of the authentic, intersubjective 'between' (Sperry & Shafranske, 2013). A position resonant of Intersubjective and Relational Psychoanalytic writers.

Finally, my transpersonal lens is informed by Jungian psychology which sheds light upon the client's relationship with the sacred, or 'transpersonal Self', and may be purposefully used within the therapeutic relationship to further aid the client's psychotherapeutic process of change. Edinger (1972) has elaborated what he calls the 'Ego-Self axis'. Here, the sacred is understood to reveal itself through dreams, imagery, altered states of consciousness and synchronistic events, with the aim of 'speaking' to the conscious developing Ego which may be wounded, over-inflated, or lopsided in its psychic equilibrium. I also draw on such phenomena to describe my belief that we are joined at some deeper level of profound union. Rogers' (1980) complementary ideas regarding intuition and a meeting of inner spirits within the psychotherapeutic relationship resonates with this perspective. Drawing on Rogers and Jung enables me to use my clients' experiences of the sacred to support them in their spiritual hopes for greater cohesion and development, promoting psychotherapeutic change.

3.0 My Philosophical Assumptions and Personal Values

Psychotherapeutic schools of thought are highly dependent on the philosophical presuppositions and underlying belief systems of their age (Schapiro, 1994). As Evans & Gilbert (2005) argue, understanding the philosophical basis of a psychotherapy model makes possible an adequate critique, and recognises the contribution of epistemological assumptions and personal values regarding the implicit or explicit conveyance of power in the therapy room. I therefore believe it important to address the philosophical assumptions that underpin each domain of my integrative framework, the inherent tensions between them, and how these translate into my personal values.

Object Relations and Self-Psychology, are steeped in Newtonian physics (Issac Newton: 1642-1727) and are deterministic

in nature. Namely, they have a cause and effect understanding of human dysfunction. Equally, they are informed by Rene Descartes' (1596-1650) philosophical postulation that the only certain foundation of knowledge is one's own existence and that reality can be defined in terms of the thinking self, encapsulated by the assertion: 'I think therefore I am'. At this point the human mind and body are split into isolated components, hence the dichotomous language of Object Relations and Self-Psychology, such as the Winnicottian 'True Self' versus 'False Self', or the Kohutian 'Enfeebled Self' versus 'Grandiose Self'.

Conversely, my relational writers are influenced by Maurice Merleau-Ponty's (1908-1961) contention that we are not dichotomous creatures, but holistic creatures whose bodies are the conduit to communication. In other words, we are embedded in a web of relatedness. As Aron (1996, chapter 1) writes, "relational theory is linked philosophically to the position that man is a social animal and that human satisfactions are realizable only within a social community". Here, Martin Buber's (1878-1965) 'I-Thou' philosophy marked by dialogue, is where the therapeutic leverage is moored. Additionally, Intersubjectivity theory and Relational Psychoanalysis draw upon post-modern ideas regarding power, social constructivism and feminism (Aron, 1996). This standpoint emphasises the nature and role of the perceiver, viewing reality as co-constructed between the observer and the observed (Gilbert & Orlans, 2011). These theorists collectively argue reality is relative and the therapist needs to be challenged in their belief of absolute power and authority (Stolorow et al., 2000).

From a transpersonal perspective, Jungian psychology is informed by quantum physics which also subverts the idea of cause and effect casting doubt on the notion of objective reality. The phenomena of 'entanglement' proposed by Albert Einstein (1879-1955), that quantum objects are not independent of one another, influences the Jungian idea that we are all deeply connected to each other and at the level of the collective unconscious, communicate with one another by tuning into a wider reality about the sacred and divine.

Post-modernism, a reaction against assumptive certainty and objectivity, offers a way to manage these diverse philosophical assumptions. Evolving out of Friedrich Nietzsche's (1844-1900) thinking that objective truth is an illusion, post-modern philosophy assumes a position of 'no one truth', permitting and facilitating truth as "perspectival, plural, fragmentary, discontinuous, kaleidoscopic and ever-changing" (Aron, 1996, chapter 1). While I believe that there is no such thing as 'absolute truth', its polarity, that truth is tantamount to opinion, is equally untenable as it leaves no solid ground on which to judge or make decisions (Evans & Gilbert, 2005). I therefore aim to hold the tension between these polarities and acknowledge the significant contribution of our personal narratives to our understanding of reality. In the therapy room this translates into an appreciation for clients' shifting experiences of past, present and future. At times they may have a sense of being hostage to the past and early wounds. Equally, the power of the here-and-now dialogue can shift them into different ways of experiencing and relating. At other times, they may be affected by transpersonal experience in their dreams or synchronistic events that ultimately speak to their sense of lop-sidedness.

My personal values and principles are deeply embedded in the diverse religious and spiritual influences of my early life and are nested within the landscape of post-modernism. The Protestant-Christian teachings of my early childhood, compassion, forgiveness, acceptance, honesty and equality are echoed in the psychotherapeutic principles I aim to embody: empathic attunement, congruence, respect and anti-oppressive practice. The exemplification of the Calvinistic work ethic in my family life, which introduced me to the significance of commitment, personal responsibility and freedom are key concepts in understanding and working with the co-created nature of reality, which pays important attention to the mutual contribution of my clients and myself. Furthermore, the exposition of diversity in itself, through the contrasting religious and philosophical views of my parents, illustrates the intrinsic value of difference and the complexity of multiple truths. A piece of prose introduced to me many years ago epitomizes many of these personal values and to my mind, also

includes a respect for the client's spiritual sense of themselves, encapsulating a post-modern focus on relative truth and denial of absolute authority: "Out beyond ideas of wrongdoing and right doing there is a field. I will meet you there" (Jalal ad-Din Mohammed Rumi, 1207-1273).

4.0 My Integrative View of the Person

I believe human beings are born as healthy, meaning making, spiritual creatures, primed to relate, grow and actualise. I view relationship as the crux of what is means to be human, and our most fundamental motivational force. We are social creatures and relationships provide us with essential psychological and physiological regulatory capacities, a sense of belonging, love and meaning. I believe our environment is critical to our capacity to function relationally and spiritually and, while our genetic code establishes a basic set of features, our diversity as human beings is environmental in origin. Embedded within a cultural context, the self is forged through our interactions with others and the way we make meaning from our external world.

4.1 Human Motivation

From a developmental perspective, Object Relations and Self-Psychology view the individual as inherently social and relationship seeking, regarding our relational urge as a primary motivational principle. Mitchell & Greenberg (1983) delineate two different relational positions within these theories: those that reject classical Freudian drive theory ('the strategy of radical alternative'), and those that attempt to incorporate it ('the strategy of accommodation'). Proposing a radical alternative to drive theory, Bowlby (1997) argues we are born primed to relate with an instinctual system designed to enhance our chances of survival by facilitating emotional maturation through proximity to our primary caregiver. Conversely, Winnicott, Balint and Kohut attempt to accommodate drive theory by keeping instinctual and relational issues separate, and limiting relational issues to the earliest developmental phases (Mitchell, 1984). Hence, Winnicott (1950) distinguishes between early relational 'needs' and later instinctual 'wishes', conceptualizing innate developmental energies, such as creativity, spontaneity and aggression, as characterizing our earliest states of mind in our first attempts towards relating. Similarly, Balint (1968) depicts relational need as a search for unconditional, 'primary love', originating in the most formative phase of development; arguing the infant is born in a state of relatedness experienced as a 'harmonious inter-penetrating mix-up'. Specifically, it is the need to establish a state of unconditional love which motivates us, not the gratification of base urges. Kohut also views early relationship as the central motivation of the self. Narcissistic libido mobilizes specific self-object needs which establish and maintain a healthy and coherent sense of self, and aggression is viewed as a reaction to frustration (Kohut & Wolfe, 1978). I recognize the tension between the strategies of 'radical alternative' and 'accommodation'. However, while I acknowledge that we may be hardwired for sex and aggression, I believe the nature of these instincts enables us to get us into relationship and make contact with others and we resort to impulsiveness only when the environment fails us in our need of the other.

From a relational perspective, Intersubjectivity theory mirrors Kohutian thinking but also proposes that the need to maintain our unique and subjective psychological experience according to 'organizing principles', is central to human motivation (Atwood & Stolorow, 1984). These are unconscious and, for the individual, suggestive of objective reality (Atwood & Stolorow, 1984), such as Kohut's self-object transferences (Trop, 1994). Mitchell (1988) also rejects drive theory, proposing instead a relational-conflict model. Here, conflict is conceptualised as taking place between opposing relational configurations rather than between drives and defences. Accordingly, and echoing Atwood & Stolorow (1984), from a Relational Psychoanalytic perspective, we are motivated to maintain coherence in our intra-psychic and interpersonal life.

Conversely, Rogers' approach emphasizes the individual's inherent drive towards self-actualization, a motivation towards psychological enhancement, personal growth and fulfilment. Rogers (1946) asserts that within us all there resides an 'ego-integrative',

constructive force, capacity and strength to move in the direction of this personal goal. For me, this essentially outlines the motivational dynamism impelling the transpersonal Self forward, and aligns to Jungian 'individuation'.

From a Jungian perspective, we are innately driven towards spiritual health, to discover and fulfil our potential, to become 'whole', and consciously realize our unique being (Jung, 1995). These ideas prize a sense of 'wholeness', or self-awareness, over perfection (Neumann, 1969). Spiritual experience has the potential to meet the deepest needs of the Self, in the same way that responsive self-objects support the cohesiveness and vitality of the relational self (Sperry & Shafranske, 2013). A soul-searching process of 'individuation' facilitates a lifelong, non-linear, integrating process of opposites, including the conscious Ego and the personal and collective unconscious realms of the psyche (Jung, 1995). Although opposites are apparent in us all, our individuality is based on their imbalance and our human motivation to individuate therefore involves the pursuit of our own distinctiveness (Jung, 1971).

4.2 Human Function

From a starting point in which I advocate the developmental self as highly reliant on the quality of its immediate, early environment, I view a 'secure base' (Main, 2008), as critical to cultivating 'secure attachment' and healthy 'internal working models' (Bowlby, 1997). These foster social and emotional behaviours that invite mutually nourishing relationships (Bowlby, 1997). That is, functioning adults view the other as trustworthy, and the self as valuable and relationally capable. Correspondingly, Winnicott (1970) asserts that 'True Self-expression' develops through 'primary maternal preoccupation' in a 'holding' environment, a collaboratively creative process at the earliest stages of development which promotes the infant's primeval sense of rightfully existing in the world. Accordingly, the infant becomes the primary focus of unimpinging attention. Together with 'maternal failures' affording responsive opposition (Philips, 2007) and gradual disillusionment of 'omnipotent subjectivity', this environment is pivotal to optimal development (Winnicott, 1970). Having successfully transitioned from absolute dependency to independency, the fully functioning 'True Self' is creative, communicative and spontaneous. Personal responsibility and a capacity for guilt have developed in response to restitutive gestures provisioned by the 'good enough mother', facilitating the capacity to love and be loved in both 'excited' and 'quiet' forms (Schore, 2013). The 'True Self' fluctuates between fused and individuated positions but does not rigidly adhere either way (Mitchell & Black, 1995). Similarly, Balint (1968) believed the 'harmonious interpenetrating mix-up' must be gradually relinquished for the sake of a more autonomous sense of self. Balint proposed human function to arise from successful negotiation with other as indistinct from self, to other as a discrete, whole object. Balint's experience-near relationship, further complements the aforementioned ideas regarding the significance of a responsive environment. For these Object Relations writers, the functioning human being is able to engage in active object love, based on reciprocity.

Kohut's Self-Psychology is equally interested in early formative experiences between the emerging infant and caregiver: "the essence of the healthy matrix for the growing self of the child is a mature, cohesive parental self that is in tune with the changing needs of the child" (Kohut & Wolfe,1978:417). 'Transmuting internalizations' and 'optimal frustrations' foster the development of a cohesive and consistent self structure, marked by self-esteem and self-worth, supported by, and developed through, mirroring, idealizing and twinship (Kohut, 1959). The healthy individual has been afforded opportunities to internalize good self-object experiences and grow into an autonomous, mature individual. Thus, the 'self in harmony' (Kohut, 1984) seeks maturely chosen self-objects which support the individual's sense of self-value, trust and belonging.

Further elaborating on the aforementioned writers, Intersubjectivity and Relational Psychoanalysis elucidate human function within an intersubjective matrix. Intersubjectivity theory posits the inseparable, integral nature of self and world, asserting human function is a product of good self-object experiences, apparent in a cohesive self structure (Stolorow

et al., 2002). For Relational Psychoanalysts, in a mutually regulating, interactional field, the healthy self emerges as one who fully recognizes the subjectivity of the other, and learns to "contain in dialectical tensions different mutually enriching forms of relatedness" (Mitchell, 2000:101). Rogers' (1961) belief that early relational experience and environmental conditions of worth shape, and may derail, the self-actualizing tendency and organization of self chimes with these theories. The functioning human being is one who embodies 'openness to awareness', 'existential living' and trust in himself (Rogers, 1946).

From a Jungian perspective, the individuation process has a holistic healing effect on the individual's being (Jung, 1995). In a well-functioning human being, true and unique potential and personality enables a sense of harmony, calm, maturity and responsibility. The developing Ego that is open and 'in-tune' with the transpersonal Self, is healthily connected with all living things like a sacred tapestry. This awareness is the ground from which spiritual moments of profound connection, meaning and action arise.

5.0 The Concepts that Support My Process of Problem Formulation

In this section I utilize insights from DSM-5, personality specialists, traumatology, and neuroscience, alongside the key writers within my model, to address the key concepts that inform my problem formulation.

5.1 Developmental Considerations

My developmental writers alert me to my client's levels of relational availability, security, and self-esteem. Hence, at the implicit level of exchange, I am gently noting their attachment pattern and sense of self structure. For example, a client presenting with a closed down body style, unengaging eye contact, and a demonstrable aversion to closeness, necessitates consideration of an insecure-avoidant attachment (Bowlby, 1997). Equally, a client who is overly guarded, in terms of how they express their immediacy and cognitive, emotional and behavioural spontaneity, entails consideration of Winnicott's (1970) idea of a lack of 'True Self-expression' to inform my understanding of why they are overly adaptive, manifesting primitive forms of self-reliance. Likewise, in a client who appears consistently withdrawn or expresses indifference towards others, I would consider Balint's (1968) concept of 'philobatism'. Here, the natural expectation to be loved has been stymied, resulting in a 'basic fault', based on a sudden rupture of the 'interpenetrating mix-up' (Balint, 1968). Similarly, I find Kohut's (1984) 'enfeebled self' and 'inflated narcissistic self' useful in deepening my understanding of how a client uses the latter self in a defensive manner to distance their deeply embedded shame, depression and sense of worthlessness, inherent in the former self. This presentation may be viewed as compensatory wherein a, "weakened and defective self" (Kohut & Wolfe, 1978:414), has been abandoned - to gain, "borrowed cohesion at the price of genuine initiative and creative participation in life" - and depressed, "hopelessly caught within the psychic organization of the self-object" (Kohut, 1959:17).

5.2 Relational considerations

I draw on Intersubjectivity and Relational Psychoanalysis to deepen my understanding of my client's relational capacity, guiding my appreciation for their issues as intersubjective phenomena. I sit with the premise that early relational turmoil significantly influences my client's ensuing relational capacity (Mitchell, 1984). Furthermore, as Shane & Shane (1993:779) note, "every diagnosis and every course of treatment can only be comprehended in the field comprised of the two individual subjectivities in interaction with one another, joined together by an exclusive intersubjective empathic-introspective stance". A client with self-object needs around safety, for example, may perceive my relational presence as frightening. Moreover, the presence of defences like avoidance or dissociation; and responses such as panic attack, will be significantly codetermined by my relational style. I add to this Rogers' (1947) complementary contention that pathology arises out of negative, environmental 'conditions of worth'. Pathogenic beliefs of self-worthlessness such as, 'I am acceptable if I show no emotion' or even, 'I have no right to exist', sabotage the inherent goodness and

creativity within the individual, resulting in destructive or maladaptive behaviours.

5.2 Transpersonal Considerations

My transpersonal writers help me consider my client's presentation in terms of "the something more than the sum of the parts" (Maguire, 2001:126). Consequently, I am alert to my clients' sense of their transpersonal Self as it relates to their developing Ego, the core archetype embedded in their unconscious; and their spiritual hungers and hidden angst communicated in transpersonal phenomena such as dreams, imagery, altered states of consciousness, symptoms and synchronistic events. A client presenting with a schizoid style and depressive and anxious symptomatology, may at a profound, unconscious level be struggling with split off anger and rage which may be more easily accessible through the imagery and metaphor they use to describe their experience. Jung's (1995) concept of the 'shadow' elucidates such emotions as buried and unintegrated. I am mindful this client is looking for 'The One' who should have been present and comforting in their early developmental years, but was experienced as absent or harmful (Sperry & Shafranske, 2013). Therefore, the transpersonal Self has been blocked or stifled in its attempt to humanize and transform, remaining archaic, and formed of uncompromising, conflicted opposites (Kalsched, 1996). Transpersonal phenomena are not considered pathological, rather they communicate important messages regarding my client's sense making, and connection or disconnection, with the sacred.

5.4 DSM-5 Considerations

The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [APA], 2013) edition five (DMS-5) provides a comprehensive classification and diagnostic tool for problem formulation. I draw on this system because it has the advantage of providing me with a commonly used, clinical framework and an interdisciplinary language. For some of my clients, medical concepts have been valuable in aiding the provision of necessary medication or normalizing experience (Boyle, 2007). However, blind adherence to this system would ignore important cultural and socio-economic contextual issues (Boyle, 2007). For example, symptoms of Major Depression require consideration of the complex interplay between class, gender and employment; acknowledging the potential socio-political biases in the system's construction (Pilgrim, 2000, Boyle, 2007, Kutchins & Kirk, 1999). Additionally, a simple dichotomy of 'sick' and 'well' reduces ordinary human experience to a pathology, neglecting large areas of our knowledge and understanding of what it means to be human (Pilgrim, 2000; Boyle, 2007). I aim to balance these arguments against the utility of system which aids me in navigating cases of extreme mental distress.

5.5 Personality Considerations

I draw on Johnson's (1994) taxonomy of character constellations within his characterological-developmental model to aid my problem formulation. I appreciate Johnson's acknowledgement that character formation is ever evolving, iterative and culturally determined, and a system of personality classification must therefore strike a balance between generality and specificity. Johnson (1994) proposes that infantile, 'adaptive' solutions to existential issues often achieve "an imperfect escape" (1994:4) from adversity or non-optimal environments. Character is seen to correlate with the degree of psychic disturbance regarding each respective existential issue. Psychopathology, as it manifests in an individual's personality, is defined as "the suppression, in the exaggeration, or most often, in the individual's natural reaction to….habitual, unnatural accommodation to avoid pain while maintaining contact" (Johnson, 1994:10 [italics inserted]) and hence considered at the developmental-relational interface. A schizoid personality, for example, is seen as being rooted in traumatic frustration to safety. As such, defensive object relations are adopted in order to survive perceived or imagined threat and may include dissociation, or becoming absent in moments of meeting. Here, I appreciate I am working with the 'hated child', which supports my empathic understanding for why they struggle to be present and contactful. However, sometimes my well-intentioned

attempts to understand highly complex and often painful aspects of my clients' personality, leave me susceptible to trying to 'fit' experience into theory. I aim to manage this tension by holding an awareness of these issues, and acknowledging the contention that disorders of the self, refer to "phenomena arising in an intersubjective field" and not "a pathological condition located solely in the [client]" (Stolorow et al., 2000:116). Specifically, I aim to be continuously mindful of the co-construction of reality as it pertains to personality diagnosis.

5.6 Traumatology Considerations

The psychological, biological and neurological aspects of trauma are key components in my problem formulation. I understand trauma as an event or repetitious experience "that overwhelms people's existing coping mechanisms" (van der Kolk, 1996:279) and "fear in its most primal form" (Gerhardt, 2004:134). Trauma does not arise solely from extreme experiences or result in Post-Traumatic Stress Disorder (PTSD). It may be viewed on a continuum, with 'milder' or periodic trauma, resulting in insecure-avoidant or ambivalent attachment types at one end; and intense, sustained forms of abuse and/or neglect associated with insecure-disorganized attachment, and possibly PTSD at the other (Gerhardt, 2004). Hence, I consider the interface of development and intensity of traumatic experience, mindful this correlates with the nature and severity of symptomatology. Furthermore, I acknowledge the range of related neurobiological abnormalities indicated in traumatized individuals, particularly within the amygdala and hippocampus. Additionally, underlying belief systems about self, other and 'The Other' will have been negatively shaped, so that the individual is left feeling uncertain about their self-worth or right to exist, anticipating attack or criticism from others (Gerhardt, 2004).

5.6 Neuroscience Considerations

Neuroscientific research supports the contention that we are hardwired to relate (Schore, 2000), and for spiritual experience (Smith, 2006). Furthermore, work in neurotheology demonstrates neural underpinnings of spiritual experience and, as Smith (2006) suggests, may attest to Jung's idea of the 'within-ness' of God (Jung, 1995). Given this strong research base, I believe it important to consider the neurological underpinnings of my clients' presentation. Human brain development has been shown to be 'experience dependent', with secure relationships providing attuned, 'synchronized' interactions for optimal growth (Schore, 2001) and early affect dysregulation impeding the structural growth of neuroanatomical areas known to be responsible for our emotional and social lives. In particular, those areas located within the right hemisphere, the prefrontal, orbitofrontal, hippocampus, amygdala and anterior cingulate (Schore, 2005). These areas mature almost entirely post-natally (Gerhardt, 2004), with their critical stage of development occurring at the same time that internal working models of attachment have first been measured (Schore, 2001). Early negative experiencing adversely impacts development through expression in these right-brain structures. For example, high levels of stress results in increased levels of corticotrophin-releasing factor in the amygdala, known to mediate autonomic and behavioural stress responses, leading to fearful and anxious behaviours (Heim & Nemeroff, 2001). Babies of depressed mothers become sensitized to low level stimulation and lack of positive affect influencing how and what they learn to communicate and impacting the adult client's interpersonal relationships and ability to recognize and modulate feeling states (Schore, 2003). Impeded self-regulatory efficiency may be evidenced in the adult client through explicit visual cues, such as blushing or physical rigidity, or at an implicit, visceral level. Minimal affective expression and relational remoteness, may suggest a client with early experiences of aversion or withdrawal who, left to inexpertly self-regulate, has suppressed feelings they now have difficulty recognizing.

6.0 Psychotherapeutic Process of Change

6.1 What Engenders Change?

In considering what engenders change, growth and healing, in the co-created, therapeutic space, I am drawn to recapitulate the central,

neuroscientific research findings demonstrating that we are hardwired for relationship. This evidence demonstrates that when the emerging child is neglected or traumatized, their capacity to relate with self, another, and 'The Other' is severely impaired or derailed. Thus, just as relationships can harm, so they can heal. More specifically, my developmental writers postulate that my own developmental capability and availability to work with transferential dynamics, as the much needed parental figure working through developmental deficits, traumas and conflicts, is pivotal in its power to resuscitate the dormant child at the heart of the adult, realigning them on their trajectory of maturational growth. Equally, my capacity to be present and responsive to the adult in the room, is essential in embodying and modelling authenticity, spontaneity, immediacy and flexibility. Namely, to be human at the psychotherapeutic interface, capable of deep contact with self and other. Finally, I believe that the transpersonal Self will also be present in its communications through dreams, synchronistic events, and altered states of consciousness, and will draw the troubled and unsteady developing Ego into a greater state of homeostasis and wholeness. In summary, whether the focus is on the developmental self, relational self or transpersonal Self, it is relationship that is instrumental for good therapeutic outcomes (Asay & Lambert, 1999; Glass & Arnkoff, 2000; Martin, 2000; Jones et al., 2003; Schore, 2003, 2013).

6.2 The Five Aspects of the Therapeutic Relationship

I draw on Clarkson's (1995) 'Five Relationship Model' to support my consideration of what affects change in a multi-faceted, psychotherapeutic relationship. This includes: the working alliance, the transferential, the developmentally needed, the real person-to-person, and the transpersonal levels of relationship.

The working alliance is an implicit or explicit endeavour to establish mutuality of commitment and responsibility within the therapeutic dyad (Clarkson, 1995). Research has demonstrated that the working alliance significantly contributes to psychotherapeutic change, drop-out rates and therapeutic outcomes (Cooper, 2008). Bordin's (1979) conceptualization of the working alliance postulates the degree of agreement between therapist and client regarding the tasks and goals of the work which is co-mediated by the quality of their bond. I believe the bonding aspect of the working alliance develops the most slowly (Gelso & Carter, 1985) and can often constitute the task of therapy and the pinnacle of change.

I view transference and countertransference as natural and necessary components of learning (Clarkson, 1995) and therefore at the heart of psychotherapeutic change. I believe, as postulated by Stolorow et al. (2000:37) that transference is an, "expression of a universal psychological striving to….construct meaning", presenting us with rich data illuminating our early relational experiences which shape and organize our internal and external worlds. In the intersubjective field, and as discussed by Gilbert & Orlans (2001:79), 'organizing principles' predispose us to take a particular view, however, "it is the particular context or relationship that determines which among the array of these principles will be called upon to organize the experience". Transference and countertransference, as mutually influential phenomena, cannot therefore, be understood without the other (Gilbert & Orlans, 2001).

For me, a key element of psychotherapeutic change involves employing a 'one-and-a-half-person psychology' (Stark 2000), or a 'developmentally needed relationship' (Clarkson, 1995). This involves the intentional use of self as a secure base, an empathic self-object, or good-mother-good-therapist. Ultimately the goal of this therapeutic position is on, "filling in the [client's] structural deficits and consolidating the [client's] self" (Stark, 2000:4) offering new opportunities for socio-emotional functioning of right brain growth and adaptation (Schore, 2000). As the work of Schore (2000) demonstrates, 'right-brain-to-right-brain' communication in the therapeutic relationship provides a 'growth facilitating environment' in which insecure attachment patterns can be updated. Ultimately I believe this 'corrective experience', facilitates psychotherapeutic change because it enables previously unbearable

experiences to be managed and encourages the development of autonomy and personal resource.

Not all material the client (or therapist) brings is transference phenomena. Our motivation towards relationship also engenders clients to seek a restorative and real, person-to-person relationship which is, "one of the most potent factors for cure" (Clarkson, 1995:149), and is supported by research (Cooper, 2008). The therapeutic relationship has been described as, "a microcosm of the [client's] world wherein he can explore the conscious and unconscious expectations and meanings which he brings to his life experiences" (Stolorow et al.,1978:249). I believe, the here-and-now, person-to-person exchange therefore has the potential to deepen the client's understanding of personal responsibility and their part in the co-creation of their relationships, providing a safe environment to experiment with personal change. For Stark (2000), this 'two-person psychology' offers the possibility of resolution of relational difficulties and the ability to engage healthily in relationship.

Within the humanistic and Jungian traditions there is a recognition and ever growing acceptance of a sublime and unique quality in the therapeutic relationship that moves beyond the rational, exceeding the limits of our understanding. The term 'transpersonal' has often been used to refer to the existence of this arguably matchless quality within the healing relationship (Clarkson, 1995). For me, it attends to and expresses not just that which is in mind and body, but also in spirit. It is highly relevant to consider as fertile ground for psychotherapeutic change and growth because without it the 'whole' human experience, in its health, subjectivity and sense of balance, is not truly appreciated or deeply understood for its potentiality. As Jung (1995) purported, spiritual elements of individual experience are fundamental to our psychic health. The transpersonal level of relationship is about "daring to open up to what is inside" (Rowan, 2005:3), uncovering and bringing into awareness hidden, darker aspects of the psyche as essentials elements of the truly integrated Self. Working from this perspective requires a capacity to work at the meta-level, holding a complexity regarding the boundaries between self and other (Rowan & Jacobs, 2002) in which client and therapist "are not lost in the other, as in fusion, but found" (Field, 1996:71).

6.3 Treatment Planning

My treatment plan does not adhere to a linear, prescriptive, phase orientated approach because I don't believe clients process their material in this manner. Rather, one moment they bring issues of developmental injury, or unprocessed traumatic experiences; the next they may bring current personal or work relationship struggles; while the next they may experience thoughtful concern or angst about their spiritual growth and development. These issues are not experienced or presented consecutively, rather they ebb and flow becoming figure and ground moment-by-moment, session by session. This thinking chimes with the Jungian idea that the psyche operates outsides the Ego's time-bound reality, and healing unfurls according to the soul's own rhythm. I value Johnson's (1994) three treatment considerations, which are not held in any linear sense, but rather provide key aspects to consider. However, my critique is that Johnson (1994) doesn't hold a spiritual lens with which to understand his clients, and so to this I add Sperry & Shafranske's (2013) model of spiritually orientated psychotherapy. Using this model, I consider a client's relationship with the sacred as similar to their relationships with other significant psychological objects; and view spirituality as it exists within a wider, relational matrix. Thus, in planning my work with my clients I incorporate affective, cognitive, and behavioural-social therapeutic objectives and abilities (Johnson, 1994); as well as holding a space for my clients' spiritual yearnings and hopes (Sperry & Shafranske, 2013).

7.0 Conclusion

In this paper I have outlined my integrative approach to the practice of psychotherapy. This approach integrates developmental, relational and transpersonal perspectives, and considers insights from traumatology, personality specialists, DSM-5 and neuroscience. Central to my model, is the co-created nature of relationship and an acknowledgement that, just as relationships can harm, so they can heal. Thus, whether the focus is

on the developmental self, relational self or transpersonal Self, it is relationship that is instrumental for good therapeutic outcomes.

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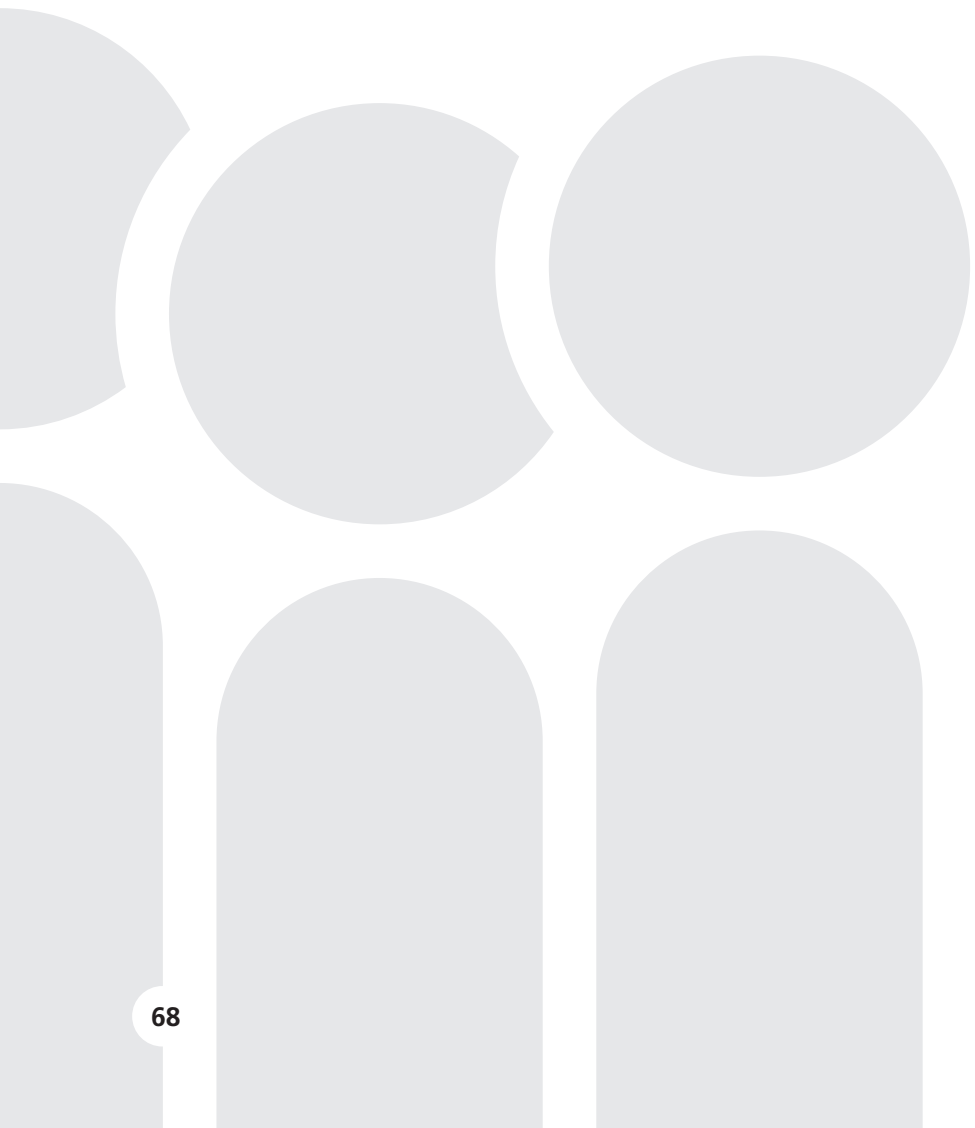

Book review by Megan Rose Stafford

'Forced Endings in Psychotherapy and Psychoanalysis. Attachment and Loss in Retirement.'

By Anne Power (2016). New York: Routledge

In this book, the author presents her qualitative research investigating what the process of retirement involves, specifically how hard retirement may be for both therapists and their patients, and how they manage the challenges inherent in ending their work. Power draws on a sample of 13 therapists who end their work for a variety of reasons – including, retirement, relocation, maternity leave, taking a sabbatical – and who all have to manage issues such as how much notice to provide, how to pace the ending, self-disclosure and the individual responses from each of their clients.

I was struck by the negativity of the front cover, which seemed to symbolize fragility, awkwardness and isolation. Equally I wondered about the word 'forced' in the title of her work, which for me, suggests a process which is essentially disempowered and lacking in hope. This was in strong contrast to the opening of the book – an engaging, loving and analogous description of her cat who required her to trust in his capacity to judge the trajectory of his journey as he leaps from windowsill to pavement, at the grand old age of 12 years. In fact, while Power provides a thorough and thoughtful account of the intrinsic difficulties of ending with clients, she also highlights how positive endings can be if handled well.

Power begins by examining the reasons why we might retire and how we may begin to do this. In doing so, she highlights the complex emotional and intellectual challenges that face the retiring therapist as well as intricate issues around legislation and policy in relation to retirement in our profession. Here Power, raises interesting points regarding how we prepare for retirement in the absence of regulation. This includes an appreciation for how we currently trust in the ethical morality of our peers and colleagues who need to judge their own capacity to work, sometimes beyond an age which is standard in most other professions, as well as the risks that may be associated with this.

Throughout the book Power expertly weaves attachment theory into each topic that she addresses – why and how we retire, how patients respond to the therapist's decision to retire, how we manage our own endings, supervision, loss and the future beyond retirement. Ethical issues are considered throughout, as are issues relating to major themes such as the transferential relationship, possible feelings of guilt, and an existential awareness of our own mortality.

This invites potentially uncomfortable self-reflection. However, this may be essential reading on the ethics of ending with our clients, self-care, and the awareness and theoretical knowledge needed to make decisions about closing a practice. Power raises a good point here, about accessing personal therapy in order to guide the decision making process.

Power also clearly and usefully details the practical issues to be considered when retiring, such as room hire, insurance and financial

implications. She also provides an excellent chapter on supervision which includes a discussion on saying goodbye to the supervisory relationship. The appendices provided, are in a helpful check-list format to aid the reader in thinking and preparing for endings.

This book is thorough and well researched. Power has written an accessible, comprehensive and thought provoking exploration of the process of retirement in the psychotherapy profession. However its relevancy and applicability may have a broader reach than the title suggests – I believe this book could be of interest to therapists of all ages: how do you manage endings with your clients? How often do you reflect on the importance of self-care? How do you manage significant breaks in the work? Overall, this book is particularly pertinent to therapists approaching retirement age, however it may also speak to therapists at various other stages of their careers who are grappling with these issues.

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