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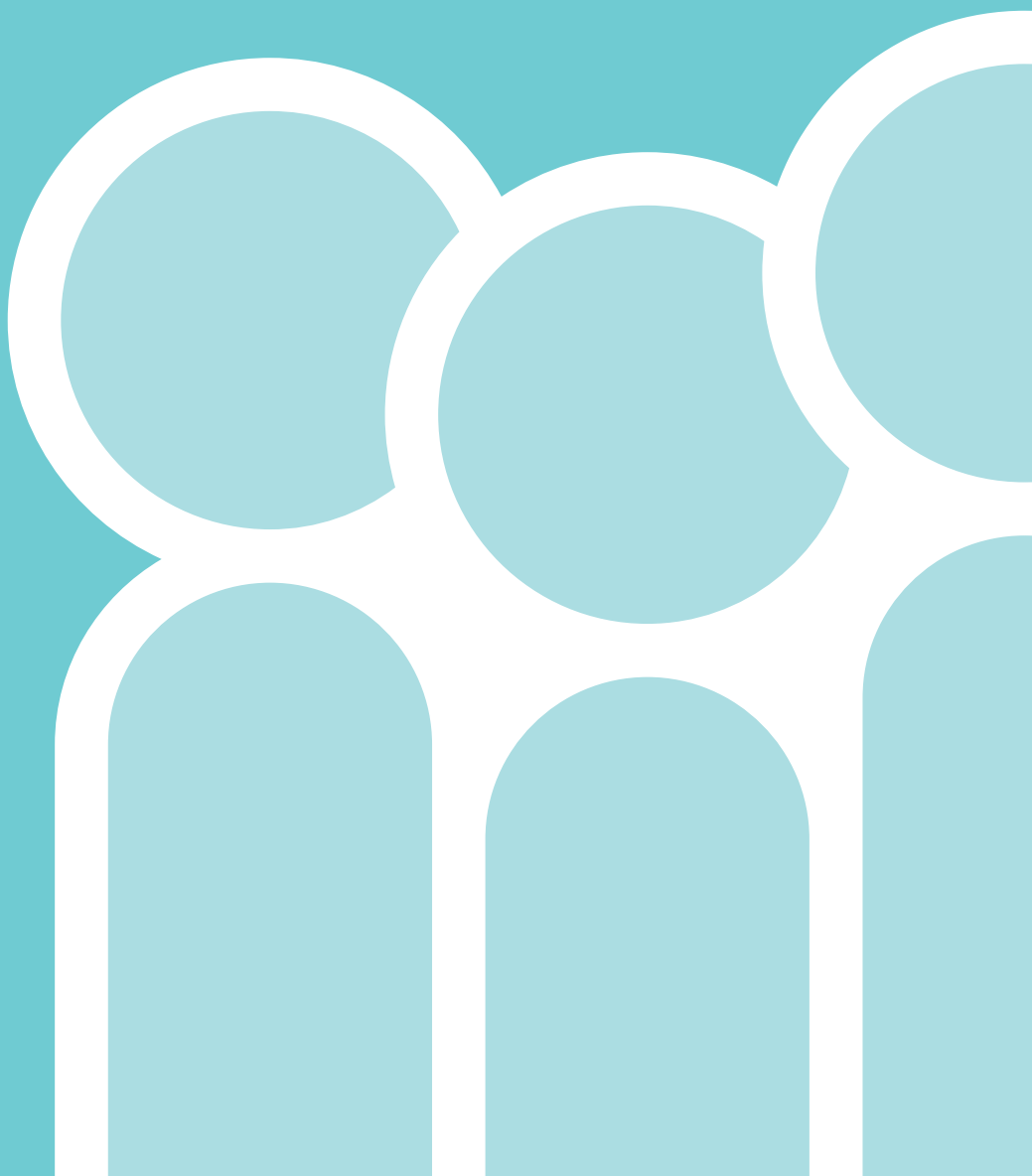
Theoretical and Clinical Reflections on Integration



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Introduction

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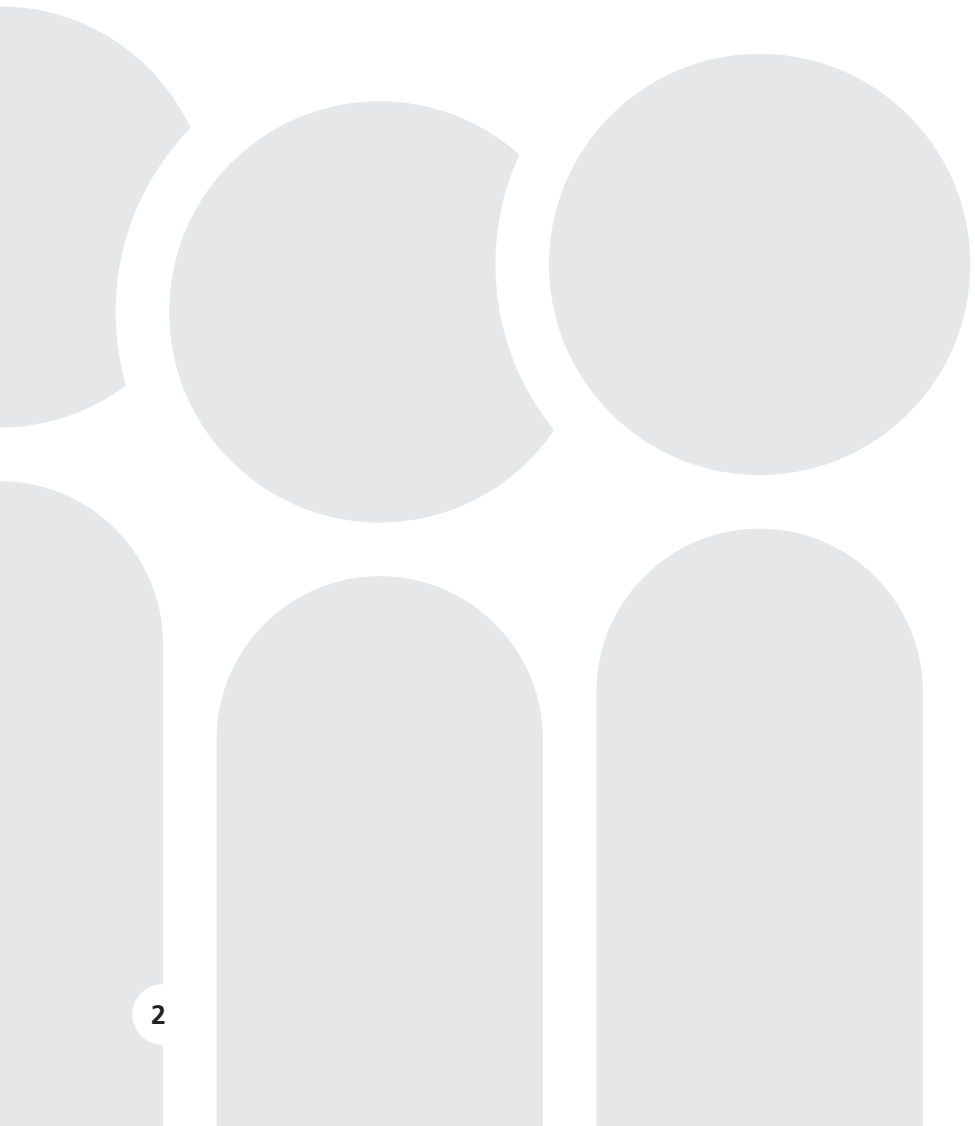

Volume 7, Issue 1 (2010)

Contents of this Issue

Editorial

Theoretical and Clinical Reflections on Integration

In this issue we have both theoretrical and clinical material on a number of interesting themes. The submissions reflect the breadth and diversity of issues with which integrative paractitioners are engaged. We are impressed by the level of engagement that these practitioners have demonstrated in their in-depth reflection on a diverse number of issues. Each author 'grapples with' a particular interest from their own integrative perspective.

In their thought-provoking article, Gillian Straker,Jacqui Winship and David Watson present their 'very integrative' approach to treating priests and men in religious orders who have perpetrated child sexual abuse/molestation. They use Fonagy's concept of the 'alien self' to support their view that these men's abusive behaviour results from a rejection of sexuality both in their original attachment environment and in their distorted interpretation of Christian Theology. Straker's concept of the 'uncanny self' picks up on the complexities of the dissociation from the self in their interpersonal process with harmful consequences in the lives of many people. They illustrate their integrative perspective with an extended case study that vividly describes the therapeutic process for the reader. We were particularly impacted by the soul-searching reflections on the part of the practitioner which gave a sensitive and moving insight into this therapeutic process.

John Boyle writes about a possible integration between psychoanalysis and parapsychology which we found both involving and challenging. He presents his experience of an apparent moment of 'telepathy' with a client which he refers to as 'uncanny intersubjectivity'. He explores this experience from his reading of Freud's little known studies in telepathy. John Boyle is to be commended on the thoroughness of his historical research into this subject which opens up the history of psychoanalysis for the reader. He looks at the many ways in which these uncanny forms of intersubjectivity have been conceptualised under other theoretical terms like 'empathy', 'projective identification', 'intuition' and 'concordant countertransference'. We enjoyed both John's academic rigour and his challenge to us to reconsider these concepts.

Jane Purkiss' poignant article shares her personal journey to find a way to integrate her own personal bereavements and losses. She shares some of the writings that brought her comfort, reassurance and hope in her darkness. Jane names her own 'inner screaming', a vivid and moving image, which characterises her struggle with her personal agony. She also engages personally with various bereavement theories and shares the findings from her own Master's research into others' experiences of living through transitions. Jane particularly engages with the postmodern theory of 'Continuing Bonds' which empathises the ongoing relationship with the 'lost one' in a way which preserves the quality of the relational experience.

Claire Nelissen engages with the issue of describing our professional identity; her immediate interest is prompted by forthcoming regulation. She argues that the expertise of psychotherapists is currently poorly described in a way that does not do justice to their/

our endeavour. She proposes a functional approach to our professional identity as experts in applying clinical reasoning based on integrative psychological theories to bring about change in the client. Her argument transcends the modality debate and looks at the expertise underlying effective practice. Her paasion for her subject and for her profession shine sthrough the writing of this article as she celebrates psychotherapeutic expertise.

As is our usual tradition, we publish an example of a student's final written submission for their qualification. In this edition we include the first section from Cheryl Keen's MSc dissertation which provides her integrative theoretical framework that underpins her practice. We also include a book review by Professor Simon du Plock of 'Relational-Centred Research for Psychotherapists' (eds Linda Finlay and Ken Evans).

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

Gillian Straker, David Watson and Jacqui Winship

Child Sexual Abuse and the Church: An Integrative Perspective and Case Study

Abstract

In recent years the church and particularly the Catholic Church has been rocked by the scandal of child sexual abuse. The outrage that this has generated has been understandable given the extent of the abuse and the institution's frequent failure to act. However one result of this is that the voice of the perpetrator has been shut down to the detriment of prevention programmes. This paper offers a theoretical understanding of perpetrators from the inside and illustrates this through a case study.

Introduction

In recent years the church and particularly the Catholic Church has been rocked by the scandal of child sexual abuse. The outrage that this has generated has been understandable given the extent of the abuse and the institution's frequent failure to act. However one result of this is that the voice of the perpetrator has been shut down to the detriment of prevention programs. We the authors of this paper have each spent at least six years working in a treatment centre that specialised in the treatment of priests and men in religious orders who had been involved in child sexual abuse. This treatment programme was very integrative, drawing on expertise from the psychodynamic, cognitive behavioural and interpersonal traditions in particular. It involved twice weekly individual psychotherapy, group therapy, psychoeducational workshops, Jungian style dream groups, art therapy and psychodrama.

It was an effective program in that recidivism, which was monitored closely over the five years that the perpetrators were followed up, was zero. We believe that the success of the program was such because it focussed not only on changing behaviour but also on the inner experience of the perpetrators.

Of course behaviour change was essential and had to be a priority, not just for the individual but also within the system. Thus the programme involved not only work with individual religious but also involved the communities within which they lived.

Beyond this, however, there was a focus on understanding the desire, psychology and ideology/theology implicated in the abusive behaviour. Thus we focussed not only on the individual's inner organsiation but also on those aspects of Christian theology that might lend themselves to distortion, thereby shoring up problematic ways of thinking about sexuality.

In this paper it is not possible to expand on all the elements in the treatment programme. Cognitive behavioural approaches are well covered in the literature (Abel et al, 1989; Finkelhor, 1994; Marshall & Barbaree, 1990; Ward, Polaschek, & Beech, 2006). There is also a great deal written about the church's systemic role in failing to intervene to prevent abuse (Camargo & Loftus, 1992;

Porter, 2003; Sipe, 1995). Thus we will focus on the psychological and theological factors that we found to be implicated in abusive behaviours of those religious with whom we worked. We will try to present a model of abuse that integrates our clinical experience with literature from psychoanalysis and attachment theory, and to illustrate this model in the case study. We will also refer to aspects of Christian theology that were distorted by those we worked with in ways that facilitated problematic fantasies and thoughts.

Nature of the Abuse

Before we begin we want to make it clear that the abuse that we predominantly worked with and will address in this paper involved molestation rather than penetration or oral sex. In other words it involved sexual contact that could more easily be disguised as affection or intimacy. It was contact where the sexual nature could often be hidden, including from the perpetrator himself. Indeed hiding the sexual nature of the act from the self seemed an important dynamic in those whom we encountered in the programme. This denial of sexuality has been noted by key researchers in the area (Marshall, 1989; Ward, 2000) and we believe that this denial is important beyond obvious self interest. Those we worked with seemed to deny the sexual nature of their acts because their own sexual nature was completely unacceptable to them.

A negative attitude to sexuality was described as a key feature of the attachment environments by the perpetrators with whom we worked. We believe that this rejection of sexuality was implicated in the formation of what Straker (2002) termed an uncanny self. In doing so she was building on the work of Fonagy, Gergely, Jurist and Target (2002) on the formation of an alien self. As far as we know Straker (2002) was the first person to apply the notion of the alien self to sexuality in a paper on paedophilia. Target was a respondent to this paper and in subsequent papers she and Fonagy also applied the alien self to the field of sexuality (Fonagy, 2008; Target, 2007).

In order to understand our application of the alien self to the area of sexual abuse it is however important to revisit the original work of Fonagy et al (2002) on attachment theory and the alien self.

Attachment Theory, the Alien Self, the Uncanny Self and Attacks on the Body

Following extensive research on mothers and their babies Fonagy et al (2002) found empirical support for Winnicott's (1962) notion that the baby's self is formed by being accurately reflected back to him in the mother's eyes. If the mother reflects the baby back inaccurately and adds too much of her own affect and fantasies to what the baby communicates, the baby will develop a false self (Winnicott, 1962).

However as Fonagy et al (2002) demonstrated, the "good enough" mother (Winnicott, 1962) frequently gets it wrong, but this does not matter as long as she gets it right often enough. In this circumstance the baby will simply cover over the gaps (Fonagy et al, 2002).

However, if the mother adds to the mix an active rejection of the baby's mind state via her experience of dislike, contempt or fear of him then this papering over will not be possible and the baby will develop an alien self that is colonised by the mother's affect (Fonagy et al, 2002). This alien self, when it is triggered in later life by body memories of the original circumstances of its formation, pushes for externalisation so it can be gotten rid of into another. When the alien self is less toxic it can be externalised through impacting the mind of the other, as in projective identification (Ogden, 1979). However when this self is very toxic it requires the literal presence of a body. Fonagy et al (2002) explain violence and attacks upon the body of self and other via this notion of the externalisation of an alien self into the body, which is then attacked as in assault and self harm. To this we have added the notion of sexual assault, including that of children.

It seemed to us from our work with perpetrators that the denial of the sexual nature of their acts reenacted the denial and rejection of sexuality that had been visited upon them both in their attachment environment and in their particular interpretation of aspects of Christian theology which can be seen to

be rejecting of sexuality. These include the virgin birth and the fact that Mary, Joseph and Jesus all eschewed expressing their sexuality.

In saying this, we are not saying that Christians reject sexuality. We are referring to the relationship to sexuality that our clients believed Christianity implied, as articulated by them both directly and indirectly in their discussion of their choice of a celibate life style. Again we are not implying that most people who choose celibacy do so for this reason. Most do so in order to be more available to the communities that they serve. Furthermore our clients also had this intention, despite their confused relationship to sexuality.

This having been said, and returning to the notion of the alien self, we believe that this externalisation of the alien self into the body is not only an attempt to get rid of the alien self and attack it, as Fonagy et al (2002) propose. We believe that it is also an attempt to see what it is that troubles the self by putting it somewhere where it can be more easily seen.

Auto-mirroring

Straker (2006) developed the notion of auto-mirroring in a paper on self harm. She posited that communication by impact and projective identification focus on communication with the other. However where the despair in regard to the other is very great, then the only communication possible seems to be with the self. In this situation, the externalisation of the alien self serves as a communication to the self as much as to the other. But it also needs the literal body to be implicated, as what is inscribed on the body can be read more easily than what is inscribed in the mind (Straker, 2006).

In the moment of auto-mirroring, the individual tries to do for the self what the caretaker failed to do. That is, they try to put what is inside out so that it can be mirrored back to them and they can know what it means. Of course the enterprise is doomed to fail as understanding the self requires the mind of the other and true intersubjectivity to be succesful. However we believe that it is important to recognise the impulse toward repair of the self in acts that are destructive, both in regard to the self, as in self-cutting (Straker, 2006) and in regard to the other, as in sexual abuse. We hope to show this in the case study we present, but first we would like to summarise the model of child sexual abuse (molestation) that we have developed in the course of our work with sexual abusers in the church.

Model of Sexual Abuse

It seemed to us that the perpetrators we worked with had experienced a reasonable attachment environment, except in regard to the expression of any sexuality. The developmental histories of the 90 child sexual offenders that we collectively worked with indicated that in their family environments there was a rejection of their sexuality. Sexuality was not only misattuned to but was also regarded with suspicion, fear and/or contempt.

However there was often a hidden sexualisation of the mother-child relationship, as we believe is reflected in the following quotes. “Mum used to bath my sister and me together in the hot tub until I was at least ten”; “Mum used to change in front of me and show me her body right through adolescence”. Another individual reported on how he was required to massage the sore limbs of his mother daily and to assist in routines including bathing and feeding. This occurred long before illness or old age would have required it. These issues will be further illustrated in our case study.

Suffice it to say at this point that we believe that all of these factors in the attachment environment predisposed the individual to a poor ability to regulate affect and to difficulty in identifying sexual feelings. These feelings came to be experienced as ‘not me’ (Bromberg, 1998), part of a false self (Winnicott, 1962) and were encapsulated in what Fonagy et al (2002) would call an alien self and what Straker (2002) termed an uncanny self in regard to sexuality.

The Uncanny Self

When it is mobilised by sexual arousal in adulthood this uncanny self is experienced as familiar, as it arises from within the body, yet also as foreign and frightening. It is experienced

as frightening because it is connected with body memories of rejection and contempt. There is thus an urgent need to get rid of it as it is so uncomfortable. But there is also a need to understand and see what it is that ails the self. There is a need to record its imprint where it can be seen, and thus the arousal and sexuality is projected into the literal body of another. As we came to understand in our work, this other is often seen as an extension of the abuser's own early boyhood self.

The uncanny self that is projected into the other is both loved and hated. It is loved because it is familiar part of the self, even as it is disowned. On the other hand it is hated because it is felt to be foreign and linked with rejection and contempt. It is an uncanny self (Straker, 2002); it is what is most familiar that is now strange (Freud, 1919; Lacan, 1966).

A boy like the self (the victim) now houses this alien uncanny self and this boy is protected and made special in conscious fantasy. However in unconscious fantasy he is attacked and punished for his sexuality.

This idea from the attachment environment that sexuality should be punished then becomes muddled in with theological notions that lend themselves to distortions by those who are already predisposed to do so. These distortions are further revealed in following case study. This case study represents an amalgam of our experiences with a number of molesters, and while all the historical details presented pertain to a child molester one of us has treated, they do not all apply to one particular molester. This format has been chosen because of the particularly sensitive nature of this work. However all the transference countertransference material and the process of therapy material pertain to the work of Watson with a client we have named Robert.

Case Study

When I first met Robert I was struck by his physical appearance. Despite being in his early 50's, Robert still had extremely boyish and youthful features which bestowed upon him a kind of 'Peter Pan' quality. His beard was carefully groomed and remained at the stage of inconspicuous stubble, creating the impression that his attempt to cross the vital threshold from adolescence to manhood had been arrested.

Robert was referred to me because of his molestation of minors. His case had been investigated, although he had not been charged as the victims did not wish to come forward and their choice was respected. Robert is a celibate religious who worked in a boarding school and who entered the church at a young age. In the course of thirty years of ministry he had molested at least twenty boys, all of whom were in their teens. However, he has not been actively molesting for a number of years.

Robert reports growing up in a highly conflicted family like a 'war zone'. His father was unfaithful and frequently became violent. His mother sought refuge in Robert's protection and he was left in no doubt about his mother's disappointment in his father. Robert remembers his mother as being highly efficient and responsible in her care for him during his early childhood, evoking a clear devotion on his part.

As he grew older, Robert recalls his mother making 'no bones' about her self-sacrifice, demanding a reciprocal relationship in which he was expected to conform to a high standard of dutiful and respectful behaviour. Within this it was clear that Robert felt he occupied a special position in his mother's imaginary world as the hero son who compensated for his father's 'fall from grace'.

I often wondered how much Robert's own Oedipal strivings amplified or coloured his view of his mother's rejection of his father and what his own wish might have been to keep his father in the position of the fallen one. Certainly in the present Robert had fallen from grace, and I wondered what identifications lay in this. However, given his preoccupation with the maternal, an exploration of paternal identifications lay far down the track. There were times, however, that I felt I too had to resist a fall from grace. For example, I felt my interest in Robert's sexuality often bordered on voyeurism and I had to resist this impulse, but more of this later.

In regard to his mother's physical affection and touch, Robert recalls that as a young child

he welcomed this and sought it out. Later as he experienced his mother's relationship with his father becoming more beleaguered, he felt repelled by her physicality. He spoke of how his bedroom was next to hers and that he needed to walk past her door in order to enter the other rooms of the house: "often she would be taking off her clothes as I walked past; I often saw her in her underwear".

In speaking of this circumstance Robert presented himself as a passive recipient of his mother's behaviour, but I often wondered if he had some part in creating opportunities to see her in her underwear. I shared these thoughts with Robert later in the work at a moment in which I felt curiously undressed by him, and that I was impinging him by my nakedness. It was a moment when he was being flirtatious and engaging and I found myself feeling unusually flattered. Whilst immersed in my narcissistic gratification I noticed what seemed to be a smirk and I felt myself moving into shame, and then anger. I felt myself blush as my inner being was revealed.

Whilst caught in my own embarrassment it was also clear that my psychological nakedness was causing Robert discomfort and that he felt impinged by it. When I asked him what had happened for him in this moment, he replied that nothing had, and I then found myself feeling further discomforted as if all the feeling in the room was mine alone. I did not pursue this further at the time, but it was a dynamic that repeated itself.

Impingement that had sexual connotations was a theme in Robert's background beyond his mother and her underwear. He recalls that his mother frequently spoke to him about her women friends and commented on their enormous breasts. She would discuss her own intimate medical details and gynaecological problems with him. When he was 14 years old she underwent surgery for the removal of a vaginal growth, and when he inquired how she was she showed him the scar. Although Robert comments on the sense of horror evoked by seeing her genitals, it seemed that there was a certain jouissance evident in his relaying of the event, a horror which encompassed excitement and fascination.

To my own dismay I felt feelings akin to this as I listened to Robert's account of this event. In pondering my feelings two different descriptions came to mind. I felt like a rabbit in the headlights, or like a mongoose confronted with a snake. I was struck by how paralysed I felt by an outside other yet I wanted to hear more about Robert's experience of his mother's sexuality. In this sense I felt collusive in the event. I wanted more exposure to maternal sexuality, yet it was exposure to such sexuality that was implicated in the problem.

Robert's story conjured an image of female genitals which evoked in me a complicated jouissance which I believe mirrored his. It was a complicated jouissance, as the image was evoked in the context of the maternal body. I wondered to myself how much our similar feelings of excitement tinged with horror were connected to each of us unconsciously revisiting Oedipal issues around castration anxiety. I felt an identification with the adolescent Robert, but did not explore this with him until much later in the work when our bond was strong enough for an exploration of the sexuality that Robert now needed so much either to leave unformulated or to disavow.

The degree to which lack of formulation of the sexual as well as its disavowal was part of Robert's way of organising himself and his world became clearer as we focused more on his abusive behaviour of the boys. This ranged from voyeurism as he watched them dress and undress to fondling them on the back and buttocks, having made excuses to sleep next to them. The abuse occurred only when he thought the boys were asleep "not wanting to arouse them but only wanting comfort". When he did touch them whilst they were awake, it was in the guise of ministering to their needs: "I touched them only while attending to sores and skin complaints".

Whilst acknowledging that he touched the boys to minister to their needs Robert always denied touching the genital area, and it seemed as though this was likely true. However, it also seemed likely that this avoidance was in the service of disavowal, as he could feel aroused while telling himself that there was nothing sexual about it.

Avoiding genital areas also allowed Robert to circumvent the issue of the existence of their genitals, and hence male sexuality. He could allow this to remain unformulated. It also allowed him to construct the boys as pristine gods in the way that it seems he experienced his mother constructing him, thus allowing a dissociated past knowledge encapsulated in an uncanny self to be externalised in the present. In speaking of his feelings toward the boys Robert often said "I saw them as godlike creatures that I needed to admire". This description was consistent with statements he made later about his sense of how his mother saw him: "my mother saw me as a saviour to her and to the world at large, this is why she encouraged me to be a priest".

Robert did not add that this would also keep him celibate and thus in a permanent allegiance with her, and that this circumstance would provide a context in which neither of them would have to confront his sexuality. They could both imagine that it did not exist, a psychological move he wished to repeat in regard to the boys he molested and whose sexuality he was invested in both stimulating and negating.

When I first shared with Robert my thoughts that his celibacy might keep him psychically fused with his mother and offer a way of managing a sexuality they both found disturbing, he rejected my ideas as somewhat far fetched. However, later in the therapy he became more curious and showed some inclination to explore these ideas following on observations he had himself made concerning his feelings toward the boys.

As Robert reflected on his relationship with these boys he identified feelings of hostility toward them, which at first he could not understand. Later he came to connect this hostility with the fact that he felt their ability to arouse him to be disgusting. In exploring with Robert his own observations of these feelings I indicated that I had noticed that he spoke in the passive tense of the boys' ability to arouse him, and wondered why this was. Robert answered that he did not know, but he invited me to speak my thoughts. It was at this time that I decided to share with him my experience of him in the room, and to explore with him whether there was any connection between my experience and his.

I then spoke to him of how I often noticed myself feeling unusually flattered by seemingly positive attention from him, and how this quite quickly turned into feeling critical. Furthermore, it felt as if he had skilfully manipulated me into feeling affirmed, but in such a way that my gratification felt like a guilty and shameful secret that I had to banish. I also suggested that when I tried to explore with him my feeling that he was trying to establish a sense of closeness to me through what felt to me to be sexual flirtation, he would quickly deny there was any element of the sexual between us. This repudiation of my experience left me feeling abandoned and confused. However what seemed significant was how I too constructed myself as passive in the interchange, as if only he was doing something to me and I had nothing to do with what transpired.

Robert was interested, and asked what I thought it might mean. I said I did not know, but it did occur to me that in seeing myself as a victim I could disown responsibility for my part in what happened between us. I then took the risk of speculating on whether this might in some way reflect Robert's own stance in regard to the boys that he molested.

Robert found this confronting. He was reluctant to accept that giving away his agency facilitated disowning responsibility for placing himself in the circumstances that occasioned his own arousal. He retreated to the position that the situation was not sexual, either between us or between himself and the boys, that all this was a figment of my fantasy. I felt my anger rising again, but this time I was able to contain my feelings and remain in the interchange.

As I persisted with communicating my own thoughts and experiences I felt a rising pressure to get Robert to admit he had disowned his agency in the situation. I felt the weight of my dual responsibility to his victims and to him, and felt exasperated. We seemed at an impasse, as I also knew that to attempt to coerce him to accept my views would be fruitless. In pondering my dilemma I felt that we would remain stuck unless I could find a way out of Robert's need to see what had happened

between him and the boys as something that was done to him. I also needed to find a way out of my own need for Robert to see that he was the "doer and not the done to" in Benjamin's (2004) terms. Eventually I decided the best approach was to explore with Robert the losses for himself implicated in disowning his own agency. I therefore suggested that not owning his own agency allowed him to feel not culpable for his own arousal and that it also, paradoxically, kept him impotent.

He became angry when I suggested this, as it created a dilemma for him. The idea of being potent was terrifying, perhaps because of his father's violence. Furthermore, potency, as it implicated the sexual, was 'sinful', but on the other hand in a general sense to be a man who was impotent was also unpalatable. Having articulated his feeling that I had put him in a no-win situation, which in one sense I had, he reflected further on the moment of abuse and how in the moment he felt all that existed in the world was himself and his young victim. It was as if they were not separate and thus a sense that he was 'doing' something to them was hard to grasp.

Robert did not know how to describe his feelings. They were familiar and somehow comforting, but also strange. There was something familiar in the feeling that he and the boy were one, and were in perfect accord. However, when he became aroused, and became aware of this arousal, it was as if a chasm opened up between him and the other, and they were on different sides of an abyss, and the whole world felt strange.

Robert spoke of his relationship to his own arousal and to the boys that were implicated in it in the following terms: "I was attracted by how young and innocent the boys were, but then it all got spoiled and I felt hostility to them when they aroused me. When I looked at them I felt such tenderness and sadness that I did not understand. I felt muddled, as I also felt sad for myself and I wanted to reach out to comfort them, but then they would arouse me and I would feel disgust, and suddenly I would feel a great distance opening up where once there was closeness. But all of it seemed to happen in a kind of bubble. I knew there was a world out there, but it seemed strangely distant. It was as if I was cushioned from it".

This description of Robert's experience seemed to me to be a description of a dissociated state. In this state there was an initial fusion with a perfect other in a state of harmony, as occurs between a mother and a baby in certain moments, but this was disrupted by the intrusion of arousal that Robert felt was thrust upon him and which led to a sense of profound alienation. It appeared to me from this description that Robert was in a dissociated state during his molestation of the boys in his care, as if he was enacting some traumatic memory encapsulated in an alien self split off from the rest of him. Given he felt that his victims were part of himself, it also seemed that Robert's actions were addressed to himself and not to another. Thus psychically, it was as if one part of the self was the recipient of the actions of another part of the self. In this sense it was an address to the self, a form of auto-mirroring so that what was inside could be put outside for the self to see. Thus it was an attempt by the self to do for the self what the other had not done for it.

As Robert became more able to elaborate his experience I became braver in sharing some of these ideas. I shared with him that I experienced him in two modalities. In one sense he was active in creating circumstances that led to his abuse of others, but it was as if this active part of himself had no concern about the consequences for him or for the boys he abused. It was as if he himself was abused at the hands of this more active part of himself.

Robert did not respond to this directly, but instead he associated back to the memory of his mother in her underwear. He began to consider the possibility that he had not only been passively impinged by her, but that he had actively created opportunities to walk past her door. He mused that there were perhaps times when he did walk past her door to see what she was doing. Thus he could begin to see that he was often in thrall to the awful jouissance of the voyeurism her exhibitionism evoked, just as I had felt in thrall to my own voyeurism in regard to his mother and the boys he abused. I once again shared my thoughts with Robert and my idea that neither of us was without agency.

This enabled Robert to see that he indeed had been implicated in his own actions and to begin to come to terms with what had been dissociated. New possibilities opened concerning what choices Robert now had. He became intensely anxious and shame-filled, as with agency comes responsibility.

Robert became more able to own that his encounters with the boys had indeed been sexual, although his capacity to acknowledge this fluctuated. This acknowledgement was a large step forward from the previous denial of the sexual implications of his actions and which had led him to deny that his actions had damaged or harmed the boys. Previously he could hear in the boys' complaints against him that they felt they had been damaged, but he believed it was the boys' construction of his actions and the response of those around them which was damaging, not the nature of his acts per se. However, as he became able to acknowledge his own history, Robert became better able to understand his feelings of identification with the boys and also to see the impact of his actions upon them. He was better able to own his sexuality and to see that he needed to explore this in its own terms, and not within the repetition of a sexual trauma to which he felt he had been subjected.

At this point in the therapy an event occurred in the external world which facilitated Robert's sexual exploration in a less damaging way, but also showed that the effects of Robert's sexual history were still very alive. About two years into the therapy Robert was stripped of his right to practice as a priest. This provoked intense rage and he felt he had been given a 'raw deal'. These events and his feelings about them had an interesting effect as Robert began at this time to make excursions into the adult gay world. He embarked upon a series of short-lived sexual relationships which began as anonymous encounters. In speaking of these he said that he "was not driven by a desire for anonymous sex as some gay men may be". This was not his economy of desire. He said that what he desired was a "real relationship with sex', a strangely ambiguous statement although it was not meant to be.

Robert's accounts of the "relationship with sex" that he engaged in set in motion complex relational forces between us. I initially felt very positive about Robert's forays into adult sexuality. I felt there was some progress in our work together and that this was reflected in his confidence in approaching sex in the adult world. As time went by and these forays intensified, and given that Robert was determined to stay in the priesthood, my feelings became more complex and vexed.

As Robert seemed more and more inclined to flaunt his sexuality outside of the priesthood whilst remaining in it, I felt more and more judgemental, believing in regard to his fellow priests that he was leading a secret and clandestine life. I thought of Robert as dishonest as he was deliberately violating his commitment to celibacy while remaining under the protective umbrella of the church. He was extremely hostile toward the church but felt entitled to its protection and nurturance. He wanted to exploit and 'milk it for all it was worth'.

I felt in a double bind. Sharing my feelings that he was being duplicitous and biting the hand that fed him would hurt and injure him and could negatively impact his newly emergent sexual self. At the same time I felt that to say nothing was to collude in a pattern that was destructive and fuelled by hatred and anger. The situation came to a head when, after again expressing intense anger with the church, Robert went on to describe his weekend with a man from a gay bar. The sequence of disclosure was not unusual; first would be his anger with the church, and then the story of a sexual exploit. On this occasion I felt irritated in the same way I had felt when we were dealing with his molestation of the boys. It had to do with Robert's inability to see anything problematic in what he was doing.

My irritation may also have been fuelled by envy that Robert seemed to be having his cake and eating it, and perhaps I felt that I too would like to stay in the safety of my relationship whilst engaging in other sexual delights. However, I felt my irritation was not solely fuelled by envy, but there was a contribution from Robert. I do not think I had sufficiently processed my own contribution when I shared my observation that his complaints about the church were usually followed by stories

of sexual contacts, and wondered how much his sexuality was imbricated with hatred.

Robert's response was that while he intellectually could see what I meant, he experienced my comments as reflecting my own conservatism and narrow-mindedness about gay sexuality. I found myself stung by Robert and misunderstood, as it was not his adult sexuality that bothered me but his duplicity. I pondered aloud whether Robert's creation of me as critical of sexuality was perhaps mirroring the feeling in his family that sexuality was always at the centre of the problem. Robert dismissed this, persisting in his focus on my narrow-mindedness, ignoring the issue of his duplicity in living two separate lives with his sexual life split off from the rest of his life. I continued to feel irritated by this, and knew we were at an impasse.

I am not sure how this impasse would have resolved were it not for professional supervision that assisted me to think beyond the dyad of Robert and myself to the context of his referral. Robert was referred to me by the church. As he had now lost his rights it would seem logical that he saw me as shouldering some of the blame for this. This was in fact not the case, as this decision was inevitable and I was not reporting on my treatment of Robert to anyone. However, as we explored this it became evident that Robert had hope that his entering treatment would stave off the loss of his rights of priesthood.

In Robert's mind I had become the impotent one who could not protect him. In the light of this revelation the question arose concerning how much of Robert's current behaviour was an attack on me through his sexuality, and I was struck by the parallels in regard to how his father had used sexuality to humiliate his mother. His father was also unfaithful and duplicitous. I have not as yet explored these thoughts with Robert, but hope to do so in depth. I feel confident this will take us forward, but no doubt there will be other impasses ahead as this complex work continues.

Conclusion

We wish to conclude our discussion of Robert at this point in the hope that it has gone some way to illustrating the dynamics that we the authors believe are implicated in the disturbing phenomenon of child molestation as it has occurred in the Catholic Church. These include the enactment of an embodied trauma, generated initially in the process of becoming sexualised, and later sustained by certain aspects of Christian Theology. It is an enactment in the service of auto-mirroring and doing for the self what has not been done for it. Unfortunately, in this process the child molester does to the other what he felt was done to the self. In asserting this, we focus on the victim in the perpetrator, but not to the exclusion of the perpetrator's acts and his generation thereby of more victims. And thus it is with a return to a focus on the victims of the child molester that we draw this paper to a close.

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From Telepathy to Projective Transidentification: Casting a Beam of Intense Darkness Upon the Role of Uncanny Intersubjectivity in Psychotherapy

Abstract

In this paper, Freud's studies into telepathy are used as the locus for a mainly historical and theoretical exploration into the neglected parapsychological origins that may underlie a range of non-verbal forms of intersubjective communication referred to as 'uncanny intersubjectivity'. A case is then put forward for adopting an interdisciplinary approach for enhancing our understanding of uncanny intersubjectivity in clinical practice. A Brief clinical and supervisory vignette is provided to illustrate both the nature of this phenomenon and to assist in the formulation of some potential difficulties commonly encountered in its conceptualisation. The paper goes on to look at Freud's studies on telepathy as a prelude to embarking upon some speculations concerning the subsequent fate of the telepathy concept in psychoanalysis. An historical framework is then provided to assist in thinking about the possible reasons for the comparative neglect of uncanny intersubjectivity in more recent times. The paper also makes some suggestions as to how it might be reconceptualised as a means for potentially enhancing our awareness of uncanny intersubjectivity in clinical practice.

Introduction

"Telepathy would be the name of an ongoing and groping research that-at the moment of its emergence and in the area of its relevance-had not yet grasped either the true scope of its own enquiry or the conceptual rigour necessary for its elaboration" (Maria Torok, 1986, in Totton, 2003, p. 187).

"If the aim of a system is to create an outside where you can put the things you don't want, then we have to look at what that system disposes of-its rubbish-to understand it, to get a picture of how it sees itself and wants to be seen. The proscribed vocabulary in anybody's theory is as telling as the recommended vocabulary" (Adam Phillips, 1995, p. 19).

"If I had my life to live over again I should devote myself to psychical research rather than to psychoanalysis" (Sigmund Freud to Hereward Carrington, 1921, in: Jones, 1957, p. 419).

Setting the Context and Defining the Problem

In this paper Freud's studies into telepathy are used as the locus for reflecting upon a particular category of non-verbal intersubjective communication, the precise nature of which will be explored throughout the remainder of this paper under the overarching rubric of uncanny intersubjectivity (Major & Miller, 1981, p. 449). In the course of these reflections, it is suggested that these uncanny forms of intersubjectivity may have come in more recent times to be redefined and refracted from the

pure white light of their parapsychological origins into the rainbow-hued spectrum of object and self psychologies. As a consequence, their underlying strangeness has become occluded beneath the conceptual 'glare' created by the object and self psychologies, within whose frameworks they are most commonly articulated in the course of everyday clinical practice. This paper seeks to 'defamiliarise' these 'homely' paradigms, through disinterring the *unheimlich* qualities that it is suggested may lie buried beneath the more *heimlich* 'glare' of familiarity generated by the language of contemporary intersubjectivity (Freud, 1919/1987). To some extent, this process of occlusion can be likened to a conceptual variant of the clinical phenomenon known as negative hallucination, whereby something that is actually there can no longer be 'seen' by its intended percipient due to defensive psychodynamic processes resulting in repression and disavowal.

The term uncanny intersubjectivity is used as a convenient term of reference throughout this paper for denoting a series of oblique-yet-familiar phenomena, whose nature may, at times, overlap with a range of more frequently utilised clinical concepts, such as those of 'unconscious communication', 'projective identification', 'empathy', 'intuition' and 'concordant countertransference' (Mayer, 1996a; Eisold, 2002). While the specific theoretical origins that are unique to each of these terms is to be acknowledged from the outset[1], the central theme of this paper is focused upon the possibility that certain clinical manifestations of each of these distinct-yet-related concepts may also provide clues that point towards a linked thematic convergence, whose nature may serve the paradoxical purpose of both articulating and obscuring an underlying 'implicate' (Bohm, 1980) order that could be of potential significance for the development of psychotherapeutic theory and practice (Godwin, 1991).

While these concepts may carry in their wake the penumbra of the everyday 'familiar', it is possible that they may also (through their very familiarity) blind us to the dark luminosity of their uncanny undertow. Freud articulates the polarities of this tension between penumbra and undertow by means of a striking metaphor, whose nature hints also at an associated methodology underpinned by paradox:

> "When conducting an analysis, one must cast a beam of intense darkness so that something which has hitherto been obscured by the glare of the illumination can glitter all the more in the darkness" (Freud to Lou Andreas-Salome, in Grotstein, 2007, p. 1).

This paper seeks to consider some of the historical reasons why we may have scotomised (Lonergan, 1983) these *unheimlich* qualities originally associated with uncanny intersubjectivity in order to make its clinical manifestations more palatable to the requirements of "normal science" (Kuhn, 1970). It goes on to suggest that certain anomalous findings concerning our understanding of

1. In order to clarify the scope and the limitations of this paper from the outset, it may be worth stating clearly what it is specifically not about. To facilitate this, some additional references have been provided in the bibliography that address certain definitional and conceptual questions touched on, but not directly dealt with, in the course of this paper. Consequently, it should be understood that the paper does not seek to provide either a summary or evaluation of the evidence for anomalous phenomena such as telepathy (Lazar, 2001; Beloff, 1993; Mayer, 1996a). Nor does it offer an account of the historical evolution and clinical vicissitudes of concepts such as projective identification (Finell, 1986; Hinshelwood, 1991, 1994; Ogden, 1992; Sandler, 1988; Schore, 2003; Steiner, 1999); unconscious communication (Frayn, 1998; Langs, 1992); countertransference (Racker, 1982; Heimann, 1950/2003); empathy (Basch, 1983; Szalita, 1981, 2001); or intuition (Roazen, 1975; Moore & Fine, 1990; Grotstein, 2007). Finally, since the paper focuses primarily upon the psychoanalytic contribution to this topic, it does not provide an account of Jungian (Jung, 1985, 2008; Bair, 2004; Reiner, 2004), humanistic/integrative (Frank & Frank, 1993), existential-phenomenological (Spinelli, 2001; Blackmore, 1996), or indeed group perspectives (Schneider, 2003) relevant to uncanny intersubjectivity.

uncanny intersubjectivity may have been (until recent times) effectively discarded due to a complex dynamic created by multiple psycho-social factors that can also be viewed as providing the possible precursors to a process of paradigm shift in the field of psychotherapy. However, recent evidence suggestive of an interdisciplinary cross-fertilisation between certain convergent themes in psychoanalysis, analytic psychology, parapsychology, quantum physics and chaos theory that are referenced in the course of this paper suggests that it may now be time to review the significance of these findings with respect to their synergistic potential for informing the future development of psychotherapeutic theory and practice.

Making the Case for an Interdisciplinary Approach

In terms of making the case for adopting an interdisciplinary approach advocating a dialogue (or, perhaps more accurately, a colloquium) between the potentially incommensurable 'worlds' of psychoanalysis, analytic psychology, parapsychology, quantum physics and chaos theory, it may be worth starting off with a remark made by the cultural critic George Steiner, in which he argues that "…even the illicit metaphor, the term borrowed though misunderstood may be an essential part of a process of reunification' pursued across disciplines (in Zabriskie, 1995, p. 542). In a similar vein, the physicist Frank Oppenheimer (in Mayer, 1996b) has suggested that the impulse to play freely across disciplines should not be equated with theoretical incoherence; and that by employing such an approach contributors may actually enhance their creativity within their respective 'core' disciplines. With respect to the historical-conceptual exigencies influencing the development of psychotherapeutic theory, it has been observed how:

"History has shown that many theories previously associated with the physical sciences have been influential to theorists in psychology…Freud, for example, applied the biological principle of the reflex arc in his work; Erikson used the epigenic principle to describe psychosocial development; and family therapy used cybernetic theory and general systems theory to illustrate communication" (Butz, 1997, p. 4).

In particular, Mayer (1996a) offers an exemplary account of the potential for synergy created by adopting an interdisciplinary approach to the kinds of questions raised in this paper, as evidenced in her lucid account of the empirical basis for evaluating the significance of "explicitly anomalous processes of information transfer" (Meyer, 1996a, p. 717) through applying the empirical findings of parapsychological research to psychoanalytic practice. In a similar vein, Godwin (1991) has offered an intriguing account of the partly unconscious "theoretical recursivity between psychoanalysis and science…" that he associates with our "…persistent tendency to project our tacit understanding of physical reality onto the otherwise amorphous mind" (ibid, 1991, p. 653).

While it is true that the adoption of an interdisciplinary approach may entail certain concomitant risks, such as those of category errors, the establishment of false parities between incommensurables, and the potential for confusion arising between levels of inference, it does not automatically follow that it is therefore misguided in its intent or otherwise doomed to failure (Mayer, 1996b). Although it is an important principle in any interdisciplinary dialogue to resist the temptation to derail meaning through conceptual elision and the ad hoc synthesis of superficially similar yet fundamentally dissimilar concepts, it is arguably of equal importance to ensure that the pursuit of conceptual integrity does not come at the cost of an over-zealous regard for inherited theoretical shibboleths whose 'initial conditions' (Butz, 1997, p. 6) may have owed more to the historical exigencies and shifting allegiances of psychoanalytic politics than to the findings of clinical observation. The following two related anecdotes might help to briefly illustrate both the phenomenon of uncanny intersubjectivity, and also its likely reception, within the field of clinical practice.

A Clinical Vignette and a Supervisory Interlude

A few years ago when I was in training as an integrative psychotherapist, I worked with a female client in her mid-twenties

I shall refer to as 'Tina' whom I saw on a weekly basis over a period of about 1-year. It was in the course of our work together that the following incident occurred.

To set the scene, since the therapy room was located on the second floor and the waiting room was on the ground floor, each session began with my collecting Tina from the waiting room in order to escort her to the second floor. Over the time that we worked together, I had observed that Tina often liked to make small-talk on the way up to the room; however, when there was something particularly troubling her, I had also noticed that she tended to fall silent. On this occasion, Tina was silent, which alerted me to the possibility that something might be wrong. As I was mulling over what this could possibly be, I was suddenly gripped by an absolute sense of certainty that she was pregnant. I have to emphasise that this awareness came to me not in the form of rumination or speculation, but in the form of a 'sure and certain' knowledge. Once we entered the room, Tina sat down, burst into tears, and informed me she was indeed pregnant.

I remember having to hold back a spontaneous urge to respond to this disclosure by saying "I know", as I felt that such a response would make me sound too disconcertingly omniscient. Moreover, my ostensible 'omniscience' was in fact underpinned by the equally disconcerting awareness that I actually had no idea how I had known this, only that I had; and that, consciously at least, I could discern in Tina's appearance no visible signs of pregnancy. More importantly from a clinical perspective, my initial response to this experience of uncanny intersubjectivity was guided by the fact that Tina was deeply distressed by the implications of her pregnancy, which meant that her need for me to help her address her situation obviated any diversion into the more esoteric realms of epistemological speculation[2].

As I reviewed this session subsequently, my sense of the 'uncanny' nature of this exchange deepened. Although Tina was in the early stages of a relationship, neither the desire for, nor the fear of, pregnancy had been figural as content, symbol or metaphor in our work (at least insofar as I could consciously discern) either centrally or tangentially.

It has been observed that the kind of non-verbal communication illustrated in this vignette are very common in psychotherapy, but that they are more usually attributed to such ostensibly familiar processes as empathy or attunement (Totton, 2003). Over time, as I mulled over this incident both in supervision and in private reflection, I arrived gradually at an admittedly heterogeneous list of hypotheses that included (but did not exhaust) the following possibilities: subliminal cueing; communicative countertransference; projective identification; empathic resonance; telepathy. I eventually concluded that none of these alternatives really offered a wholly satisfactory explanation for what I had experienced, and that consequently I would simply have to accept the sense of not-knowing-yet-experiencing that is so evocatively articulated in the work of Christopher Bollas (1987). In essence, it seemed to me as though while each of these concepts appeared to offer equally valid descriptive accounts, they nevertheless failed to provide an adequate explanatory account of what had taken place between us.

Some years later, in the course of a conversation I had about this episode with a supervisor from a Contemporary Freudian background, I was struck by the prompt and peremptory manner in which he informed me that any ostensibly 'mysterious' communication that I imagined might have occurred could be wholly attributed to 'unconscious communication' that was operative below the threshold of my awareness. The possibility that Tina might have 'unconsciously communicated' knowledge of her pregnancy to me, or that I might have failed to consciously register my awareness of her doing so, is of course unanswerable; for as Robert Stoller has observed in a similar context, "It is the perfect philosophic theory: untestable, irrefutable" (in Mayer, 2001, p. 637).

2. More clinically-oriented accounts of uncanny intersubjectivity can be found in Devereux (1953); Lazar (2001); Mayer(2001); Farrell (1983); Bass (2001); Silverman (1988); Balint (1955) and also other sources detailed in the bibliography.

However, I suspect that what this anecdote really serves to illustrate is the extent to which we all exist within the idiosyncratic parameters of our unique internal worlds:

"…the world we ordinarily know is confined by our imaginations, phantasies, perceptions, and conceptions… we live in a veritable bell jar of our epistemic limitations, a bell jar that is suspended and surrounded by mystery" (Grotstein, 1996, pp. 48-49).

Nevertheless, while it may be true that we are indeed 'surrounded by mystery', we still have a shared human tendency to see only that which we are equipped to see, and whose nature we happen to regard as being a part of the fabric of whatever it is that we happen to believe lies within the parameters of what might be described as the 'possible real' (Ricoeur). Freud had his own thoughts on these matters, some of which are discussed below in the context of his papers on telepathy.

Freud on Telepathy

The context to the epigraph from Freud given at the start of this paper provides a pithy encapsulation of the complex and fluctuating attitudes that typified Freud's investigations into telepathy (Freud, 1899, 1904, 1921, 1922, 1925, 1933). When Freud was questioned eight years later regarding the accuracy of this assertion, he initially denied its veracity, only to have his denial disproved by a Photostat provided by Mr Carrington, the recipient of the original letter from which the epigraph was taken (Jones, 1957, pp. 419-420).

Freud's forgetfulness in this instance is a salutary reminder of the exceptional difficulties entailed in the activity of bringing into awareness the underlying motivations that influence our unconscious attitudes towards parapsychological phenomena. A propensity to 'believe' in telepathy may be attributable to the activities of 'the paraconscious' (Donovan, 1989) originating in early infantile experience, or to the vestiges of infantile omnipotence, in which our thoughts were considered as equivalent to the deed (Devereux, 1974). Freud's own motivations in this regard have themselves been subject to a reductive reading of their psychodynamic determinants (Wallace, 1980). Alternatively, it has also been suggested that paranormal effects (psi) may be inhibited by our unacknowledged fears of psi (Tart, 1984). This fear can contribute to what has come to be known in the literature as the 'sheep-goat' effect, whereby the attitude of the percipient influences the eventual outcome (Beloff, 1993, p. 143). Either way, both advocates and opponents of psi need to take cognisance of their potential for cognitive bias and its effects upon the evidence when arriving at their respective conclusions regarding the existence, or otherwise, of psi effects (Kennedy, 2005).

It is beyond the remit of this paper to provide an in-depth account of Freud's views on the role of telepathy in psychoanalysis (see Devereux, 1953/1974). For my present purposes, it is sufficient to begin with a brief preamble on the origins of the telepathy concept, before embarking upon a highly compressed examination of Freud's complex and (at times) difficult-to-determine views on this subject.

The term telepathy was coined in December 1882 in the first volume of the Proceedings for the Society for Psychical Research: "we venture to introduce the words Telaesthesia and Telepathy to cover all cases of impressions received at a distance" (in Luckhurst, 2002, p. 60). It is notable that Freud was himself a 'corresponding member' of the Society for Psychical Research (SPR) in London (his work on hysteria having first been brought to the attention of the British public by the SPR in 1893) and had honorary membership with the American and Greek Societies for Psychical Research (Jones, 1957, p.425; Hinshelwood, 1995). In 1912 he also published a paper entitled "A Note on the Unconscious in Psycho-Analysis" in the Proceedings of the Society for Psychical Research (Keeley, 2001). Moreover, he conducted his own experiments into telepathy with his colleague Sandor Ferenczi and his daughter Anna, the success of which were to have a "persuasive power" sufficient to relegate "diplomatic considerations…to…a back seat", much to Ernest Jones' chagrin (Gay, 1988, p. 445). He also participated in at least one telepathic séance (Roazen, 1975). Intriguingly, the ostensibly 'Kleinian' concept of projective identification has itself been traced back to its 'pre-Kleinian' roots in the work of

Eduardo Weiss (1925), who corresponded with Freud on the topic of their shared interest in telepathy and the unconscious transmission of thoughts (Steiner, 1999; Simmonds, 2006).

Despite these experiences, Freud was nevertheless keen to promote an idea of psychoanalysis that made it look more like a medical procedure than a séance (Phillips, 1995; Bass, 2001; Widlocher, 2004). Freud himself was highly conscious of both the potential implications of the accusations of 'occultism' that were regularly made against psychoanalysis, as well as the tensional and synergistic links that existed between psychoanalysis and psychical research. Both disciplines were frequently perceived as having disreputable origins, and both shared in common an aspiration towards establishing their respective scientific credentials (Jones, 1957; Phillips, 1995). Regarding their potential for synergy, Freud (to give but one example) was of the opinion that dream-analysis could be of particular value to research on telepathy, insofar as it provided the tools for unearthing latent telepathic communications from the distracting Babel of the manifest dream content (Freud, 1925, in Devereux, 1953/1974).

Freud offers his own pithy definition of telepathy, or "thought-transference", as "…the reception of a mental process by one person from another by means other than sensory perception", before going on to argue that "it provides the kernel of truth in many other hypotheses that would otherwise be incredible (Freud, 1925, in Devereux, 1953/1974, p. 88). More recent commentators have argued that the term 'thought induction' (with all the theoretical ramifications that this shift in terminology might potentially entail) constitutes a more accurate translation of Freud's original German (Widlocher, 2004). Freud subsequently speculated (1933) that this constituted the original archaic method of communication between individuals that, in the course of phylogenetic evolution, was replaced by sensory communication; but he also suggested that this older method of communication could still persist in the background, and might still under certain conditions become active again (Silverman, 1988).

Freud could be intriguingly (and at times frustratingly) equivocal regarding his attitude towards telepathy, concluding one paper in which the topic is discussed at some length with the disingenuous disclaimer: "I have no opinion; I know nothing about it" (Freud, 1922, in Devereux, 1953/1974, p. 86). While Freud's equivocations on the topic are suggestive of a sensitivity to political nuances coupled with an undertow of psychological conflict, he otherwise evidenced in all his writing on the topic a highly sophisticated understanding of the 'psychopathology' of paranormal phenomena (infantile omnipotence, hallucination, subliminal perception, fraud etc) alongside a judicious and nuanced appreciation of the evidence that might be adduced in its favour (Devereux, 1953/1974; Gay, 1995; Jones, 1957; Totton, 2003).

Farrell (1983) has argued that Freud's telepathy papers constitute a neglected 'major paradigm' (ibid, p. 71) that has been subject to those forms of forgetfulness commonly associated with repression; while Roazen (2002) has similarly regretted the neglect of these papers, observing that "it is no tribute to [Freud's] memory to narrow him down to what might be plausibly acceptable today" (ibid, p. 77). This marginalization of Freud's work on telepathy is particularly curious, bearing in mind that it was as a consequence of his revision of that most central of psychoanalytic texts, *The Interpretation of Dreams*, that acted as a spur to his reconsideration of the problem of telepathy, and within whose contents the burning child dream in particular (Freud, 1900/1991) notably admits of a 'telepathic reading' (Roazen, 1975; Major & Miller, 1981).

In contrast to this viewpoint, Calvesi has argued that for "over half a century there has existed, in psychoanalysis, a direction of study and research that uses the parapsychological approach" (Calvesi, 1983, p. 389). Since evidence can be adduced in favour of supporting both sides of this debate, the remainder of this paper will be devoted to suggesting some reasons why Calvesi's assertion may in fact be closer to the mark. However, it also suggests why it doesn't thereby follow from this that the evidence in support of Calvesi's viewpoint necessarily undermines the validity of the remarks made by Farrell and Roazen,

the contexts to which are briefly reviewed below from an historical perspective.

The Repressed and its Return–The Fate of Uncanny Intersubjectivity After Freud

It is notable that some commentators have associated the decline from the 1970s onwards in discussions about telepathy with the simultaneous rise in psychoanalytic thinking of intersubjectivity as illustrated, for instance, in the gradual dissemination and development of the work of theorists such as Paula Heimann and Heinrich Racker on communicative forms of countertransference, and in Wilfred Bion's model of projective identification as a means of communication (Eshel, 2006). While the discovery in recent years of mirror neurons (Greatrex, 2002; Marshall, 2006; Gallese et al, 2007; Meissner, 2009) has inspired research into the neurobiological mechanisms for understanding the non-verbal aspects of empathic intersubjectivity, it is debateable whether such mechanisms can in themselves be said to provide an adequate explanation for the totality of some the more mysterious forms of intersubjective communication occasionally encountered in clinical practice (Mayer, 1996a; Lazar, 2001; Allik, 2003; Eshel, 2006; Grotstein, 2009b).

Be that as it may, the suggestion that there could be processes at play that cannot be comprehensively explained by the current findings of neuropsychology, still appears to raise a degree of peripheral anxiety in the minds of some commentators. This has meant that the identification of "the neurological correlates of emotional communication" has additionally come to acquire the additional burden of providing reassurance, so that "those who question the seemingly mystical concepts of induced countertransference and projective identification can breathe easier and feel on more solid ground" (Marshall, 2006, p. 303).

Perhaps somewhat ironically, it has been suggested that certain ostensible 'developments' in intersubjective theorising may have inadvertently contributed to what has been pointedly described as "…the fuzzy and muddleheaded nature of much discussion and thinking about concepts such as projective identification and countertransference in contemporary psychoanalysis" (Eagle, 2000, p. 35). Moreover, it appears that the implications of these 'developments', and their ensuing confusions and resulting problems, may have already been discussed in utero in the Freud-Ferenczi correspondence. For instance, in their correspondence of 1910, we can see the nascent beginnings of both the dangers and the enticements offered to clinicians by concepts such as projective identification and countertransference-as-communication:

"Interesting news in the transference story. Imagine, I am a great soothsayer, that is to say, a reader of thoughts! I am reading my patients' thoughts [in my free associations]. The future methodology of psychoanalysis must make use of this" (Ferenczi [1910] to Freud, in Widlocher, 2004).

In a case of what might perhaps constitute yet an additional ironic 'reversal' of the terms of this debate (in which metaphors of 'rigour' and 'fuzziness' are deployed as putative accolades or terms of abuse, depending upon the viewpoint taken) it has been suggested that "in a quantum worldview the structure of mental life becomes a fuzzy entity whose essential nature will always elude our grasp" (Sucharov, 1992, p. 209). If such a viewpoint is accepted, then perhaps some degree of 'fuzziness' in our concepts might also be congruent with both the epistemological qualities of the subject under investigation, as well as with the ontological nature of the human investigator. However, in order to do so, it would be important not to confuse and conflate this epistemological 'fuzziness' with our deep-seated and perennial tendencies to deal in confused thinking. Nearly two and a half thousand years ago, the philosopher Aristotle had already warned against the dangers attendant upon our seeking to impose a higher degree of precision upon the subject of an inquiry than was appropriate to the nature of the subject under investigation.

However, putting these fundamental (and possibly irresolvable) epistemological questions to one side, it seems likely that our clinical awareness of uncanny intersubjectivity will remain limited in the absence of an appropriate theoretical framework within which to understand it since, as the original Gestalt

psychologists have demonstrated, we do not see in the absence of a framework for seeing (Mayer, 1996b, p. 187). As a consequence of this, it is suggested in this paper that our understanding of uncanny intersubjectivity could be deepened and enhanced through the cross-fertilisation of psychoanalysis with analytical psychology, as well as other more notionally disparate disciplines such as quantum physics, chaos theory and parapsychology that may appear at first glance to offer little of relevance to the advancement of psychotherapeutic understanding (Godwin, 1991; Mayer, 1996a; Kakar, 2003). The deployment of this kind of approach constitutes not so much an attempt to arrive at the demystification of uncanny intersubjectivity as an attempt to provide an account as to why there might be a need to reconceptualise the nature of its mysteriousness (Allik, 2003).

Unfortunately, it is beyond the remit of the current paper to provide a detailed overview of current attempts to revitalise psychoanalytic theory through a dialogue with Jungian perspectives (see Eisold, 2002; Field, 1991; Grotstein, 1996,1997; Kakar, 2003; Mayer, 2002; Wolman, 1984; Reiner, 2004); or by updating and harmonizing its "outmoded classical world view" (Godwin, 1991, p. 626) with more recent scientific findings, such as those taken from quantum physics, chaos theory (see Bass, 2001; Godwin, 1991; Field, 1991; Mayer, 1996a, 1996b, 2002; Sucharov, 1992) and parapsychology (see Mayer, 1996a, 1996b; Lazar, 2001; Calvesi, 1983). However, notable potential synergies spanning these domains include the concept of the radically connected mind (congruent with contemporary ideas in physics regarding a participatory universe) as a dialectically-related corrective to the perspectives offered by the more boundaried mind of traditional Freudian discourse (Mayer, 2002). Moreover, robust evidence (in the form of studies undertaken by the Princeton Engineering Anomalies Research Programme) has been adduced in support of the idea that research into areas such as parapsychology could be of future relevance in determining our understanding of what constitutes a "clinical fact" (Mayer, 1996a, p. 723) in psychotherapy-

> "The physical and psychological relationships between consciousness and its physical world entail subtle effects and processes that in some cases appear to violate the most fundamental scientific premises of space, time, and causality… various subjective and aesthetic factors not normally accommodated by traditional scientific methodology seem crucially relevant" (Jahn & Dunne, in Mayer, 2002, p. 96).

It is evident from a review of the literature that a range of concepts originating in disciplines as diverse as quantum physics and chaos theory have begun to be extended, and their implications creatively applied, to psychotherapeutic theory and practice (Butz, 1997; Chamberlain & Butz, 1998: Godwin, 1991; Sucharov, 1992). Quantum theory in particular has been invoked as having the potential to provide a theoretical resource for enhancing our understanding of telepathy (Beloff, 1993; Shan, 2004). While it is beyond the scope of the current paper (and also the abilities of the writer) to summarise the relevance of these disciplines to clinical practice, three concepts taken from quantum theory (complementarity; implicate and explicate orders; Bell's theorem), will be referred to very briefly in order to give some indication of their potential value for helping us to reconceptualise the nature of uncanny intersubjectivity.

Sucharov (1992) has provided a lucid account of the application of Bohr's theory of complementarity to self-psychology that has relevance to psychotherapeutic epistemology in general:

> "Bohr introduced the term complementarity to denote a novel logical relation between two descriptions that cannot in principle be visualised simultaneously, that may appear to be contradictory, and that together form a complete picture of reality…Neither the expression either/or nor the expression both/and describes the meaning of complementarity. In fact, the term was introduced by Bohr as a novel logical relation for which we did not have a linguistic term" (ibid, p. 201,207).

Sucharov's account is of particular value in terms of the account it provides of the potential uses and abuses of the concept of complementarity with respect to theory-formation:

"Complementarity is itself an epistemological framework for specifying the relationship between mutually exclusive descriptions. It cannot define a relationship between epistemological systems. Complementarity should not be used as a panacea to resolve all contradictions" (ibid, p. 208).

Bohm's theory of implicate and explicate order (Bohm, 1980) has been lucidly summarised by Godwin (1991) in the following terms:

"Perhaps the most significant discovery of quantum physics is the disclosure of a fundamental realm of unbroken wholeness underlying our perceived world of apparent separateness and fragmentation. Instead of analysing the universe into parts and then trying additively to make a 'whole' out of how they interact, Bohm therefore begins with this notion of an underlying, undivided wholeness, and then attempts to show how amidst this wholeness there may exist the 'relatively enduring subtotalities' available to our senses and scientific instruments. Language becomes problematic at this point, because the deeply dualistic basis in its subject-verb-object structure presupposes a universe of individual parts in external relationship to one another. This outward order described by conventional language is what Bohm refers to as the 'explicate', or 'unfolded' order. But underlying this explicate order is the vast multidimensional sea of quantum potential which forms the constantly unfolding ground of the manifest universe. This prior and fundamental order of the universe Bohm calls the 'implicate' (or enfolded) order" (ibid, p. 628).

Godwin goes on to observe how the ostensible familiarity of words such as 'unconscious' can "…delude us into thinking that we know what we are talking about simply because we have a word for it" (ibid, p. 631). In order to avoid this kind of reification, and to promote a state of defamiliarisation in the reader, he notes how in his later writings Bion came to eschew the more familiar distinctions commonly made between conscious and unconscious processes, choosing instead to refer to the finite (explicate) and the infinite (implicate) orders of the mind. It has been observed that the theories of Bion (1977/2004) and Ignacio Matte Blanco (1998) in particular, may possess an especial resonance with a quantum world-view (Godwin, 1991; Grotstein, 1998).

Finally, with respect to the potential implications of the Bell's theorem interpretation of the Einstein-Podolsky-Rosen experiment (Godwin, 1991; Mayer, 1996b) for our understanding of uncanny intersubjectivity, Mayer asks us to consider the following germane question:

"…how will we start to come to terms with its shockingly counterintuitive implications regarding causality: the fact that atomic particles which were once contiguous and are then separated over great distances, continue to remain in apparently instantaneous contact, capable of mutual influence?" (Mayer, 1996b, p.186).

Albert Einstein referred to this non-local effect as "spooky actions at a distance" (in Lazar, 2001, p. 126) and it has subsequently received significant empirical experimental support (ibid). With respect to the themes outlined in this paper, it is notable that quantum hologram theory has challenged an earlier assumption whereby it was thought that quantum properties did not apply to macroscopic objects, thereby opening the way to a conceptualisation of human consciousness as something that extends beyond the individual and that shares the characteristics of a quantum field in terms of its ability to affect the probabilities of macroscopic events (Mayer, 1996b; Lazar, 2001, Bohm, 1980).

Telepathy and its Discontents

It has been argued that one of the reasons why the topic of telepathy proved to be so contentious within the history of psychoanalysis (as illustrated, for instance in the Freud-Jung, Freud-Jones and Freud-Ferenczi correspondence) was because it fundamentally challenged the nature of the power relationship existing between analyst and patient as embodied in the concept of transference (Major & Miller, 1981). However, it is also possible that these disputes might be related to more fundamental questions concerning the extent to which psychoanalysis has continued to remain embedded within an outmoded classical Newtonian world-view, "…with

the result that its investigations have…been hampered by its own preconceptions about the nature of the mind" (Godwin, 1991, p. 626).

Freud's attitude towards telepathy charted a complex path over the course of nearly a quarter of a century, oscillating between an enthusiastic advocacy in support of the views propounded by its most vocal supporters, Jung and Ferenczi; the persistent antipathy displayed by Abraham and Jones towards the phenomenon; and the middle ground in this debate, which was inhabited by figures such as Eitingon, Rank and Sachs (Roazen, 1975; Eshel, 2006). In the course of these discussions, 'associated' concepts, such as that of 'empathy', became the subject of ambivalent inquiry, due in part to what Freud described in his correspondence with Ferenczi as its "mystical character", and the absence of satisfactory criteria to distinguish it from telepathy (Kakar 2003, pp.667–669).

Nevertheless, what is clear is that at this time it was still possible within the psychoanalytic community to engage openly in debate (albeit of an often heated nature) regarding the existence or otherwise of telepathy; and that determining its scientific status was seen to be of relevance to the practice of psychoanalysis. In 1953 for instance, eminent analysts such as Helene Deutsch and Dorothy Burlingham were to publish papers in an anthology (Devereux, 1953/1974) devoted specifically to examining the role of telepathy in psychoanalysis (an endeavour that was to remain singular until the publication of Totton's more theoretically pluralistic anthology in 2003). As late as 1955, Michael Balint published a paper in which he speculated upon the preconditions for the production of parapsychological phenomenon in therapy and upon the possibilities for parapsychological phenomena to be repressed, or 'scotomised', in the course of psychoanalytic treatment (Balint, 1955, p. 33).

In contrast, by the time that Robert Stoller was putting together his thoughts on telepathy (1973), the political climate in psychoanalysis had changed to the extent whereby his supervisor Ralph Greenson strongly advised him to curtail publishing on this topic lest it damage his career prospects. Stoller took Greenson's advice, and while the topic of telepathy was one that he returned to towards the end of his life, his paper on telepathic dreams was only published posthumously (Mayer, 2001). Read in this context, it is perhaps a matter of some poignancy to note how, in the course of his posthumous paper, Stoller makes a heartfelt plea for the open-minded examination of data, even if it has as yet "no respectable explanation" (ibid, p. 631).

While some theorists, such as Sandler (1983), have advocated for the happy co-existence of divergent public and private theories, others such as Mayer (1996) have argued that the contradictions inherent within such a state of mind can have a corrosive and destructive effect upon both the individuals concerned and the discipline as a whole. It is notable that in an effort to practically address the more problematic implications issuing from this divergence, Mayer and some of her colleagues set up in 1997 a study group entitled "intuition, unconscious communication, and 'thought-transference'" under the auspices of the American Psychoanalytic Association (Mayer, 1996a, 2001).

Mayer illustrates the kinds of political pressures that researchers on telepathy have occasionally been subjected to in the form of a detailed exposition of what appears to have been an instance of scientific bias in the work of the National Research Council of the National Academy of Sciences (NRC) in 1988. In this incident, a favourable report corroborating the sound experimental design of a series of Ganzfield ESP studies was unaccountably omitted from the final version of the NRC report; prior to which exclusion overtures were made towards the original reviewers to engage in 'self-censorship'. This resulted in the Congressional Office of Technology Assessment recommending another investigation, "so that emotionality does not impede the objective assessment of experimental results" (in Mayer, 1996a, p. 735).

Conclusion

Psychoanalysis has been described as an activity that is "…set on swallowing and simultaneously rejecting the foreign body named Telepathy, for assimilating and vomiting it without being able to make up its mind to do one or the other"

(Derrida, in Luckhurst, 2002, p. 273). From such a vantage point, it is possible to discern in the history of psychoanalysis a dual-track process of transmutation and mystification in the course of this metaphorical regurgitation, whereby the earlier 'parapsychological' influences on psychoanalytic thinking have been either jettisoned or glossed over with the patina of the less contentious nomenclature of object and self psychologies, in order to assist in their absorption into more a 'digestible' version of psychoanalysis corresponding more closely to a prevailing materialist metaphysics and the requirements of what has been termed 'normal science' (Kuhn, 1970, pp. 23-34).

However, in the course of this process of jettisoning and occlusion, it is suggested that that the baby has, so to speak, been thrown out with the bathwater; with the resulting consequence that those findings commonly described as 'anomalous' with respect to their relation to 'normal science' (and which in themselves constitute the necessary precursors to paradigm shift in science) can be seen historically to have suffered the fate of what amounts to repression. However, there are signs that these anomalous findings may now be ripe for reappraisal. Moreover, it is also possible that the processes of interdisciplinary convergence outlined in this paper could potentially offer a meaningful contribution to the process of paradigm-shift in the development of contemporary psychotherapeutic theory and practice. By way of conclusion, the following anecdote is offered as a brief illustration of how this kind of process of paradigm-shift can evolve in practice.

Some time ago, I had the opportunity to briefly discuss with James Grotstein his work on projective transidentification (Grotstein, 2007), a concept he developed to articulate a particular form of 'communicative' projective identification (based upon the work of Bion) that may be partly dependent upon 'extra-sensory perception' (ibid, p. 188) as part of its modus operandi. When I questioned Professor Grotstein on his views regarding the existence or otherwise of telepathy in this context, he informed me that he kept an "open mind" on the subject, before proceeding to anecdotally illustrate why this was so (Grotstein, personal communication, 2008).

It is notable that Professor Grotstein's work on this topic appears to have struck a resonant note amongst the wider psychoanalytic community. In a highly laudatory review of Grotstein's study on Bion (2007), Antonino Ferro makes the following highly apposite comments relevant to the arguments outlined in this paper:

"I believe the concept of projective transidentification allows us to clarify and enrich our understanding, but I also think that there is still a lot of work to be done on the theme of projective identifications. I think that many more things than we currently know and recognise actually occur between one mind and another. As far as the analytic session is concerned, I believe that emotional upsets really can pass from one mind to the other, especially if we consider that the patient and analyst form a field of emotional forces which belongs to both of them" (Ferro, 2008, p. 878).

It is notable that in his two most recent book-length publications, Grotstein (2009a, 2009b) has continued to develop and elaborate upon these views, going so far as to state that he has "…both analysed analysands as well as supervised analysts who have analysed analysts who, to my mind, unequivocally demonstrated telepathic capacities" (Grotstein, 2009a, p. 298). Viewed from such a perspective, it may not be too much of an exaggeration to suggest that it may even constitute a form of clinical wisdom to mindfully cultivate a capacity to experience the uncanny so that new things might be discovered about the world (Allik, 2003).

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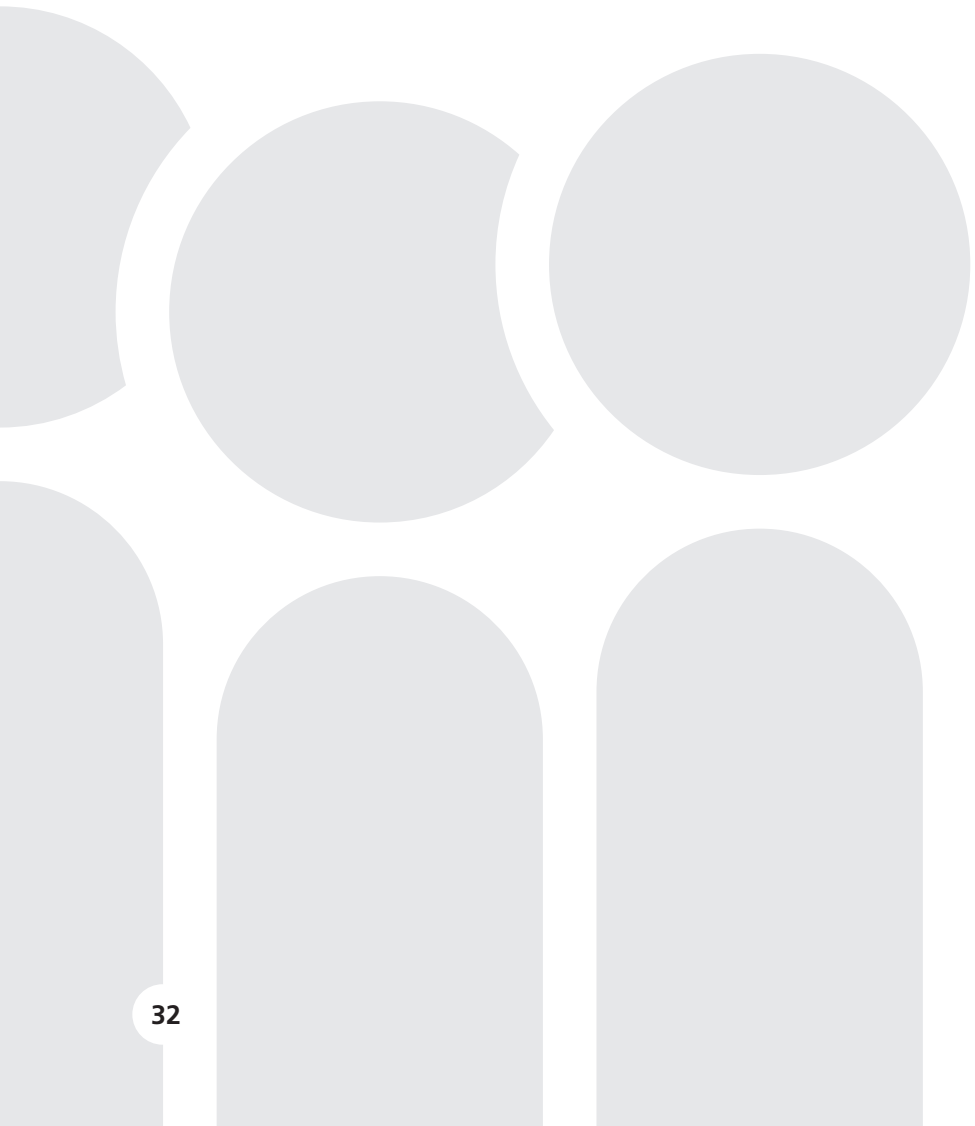

Jane Purkiss

Working with Loss and Separation: Postmodern Perspectives

Abstract

I was stimulated to write this article after reading Sharon Cornford's excellent paper 'After the Death of a Selfobject: Understanding and Working with the Impact of a Major Bereavement on the Self' published in this journal series in 2008. In her work I found many resonances between her approach and my own, as described in my Post-Qualifying MA 'Inner Screaming: Explorations in Loss and Separation' (Middlesex University 2006). In this paper I intend to bring further contributions to this important subject from personal and theoretical perspectives. I will also draw on the results of interviews with research participants about loss and separation that can be directly applied to clinical work.

Preamble

"When we grieve for someone we love we are broken into pieces, and some of those pieces go missing, never to be replaced. We want to scream our pain and confusion to the heavens" (Rowe 2004, p.ix).

These words from Dorothy Rowe provide a way of introducing my theme of loss and separation. During the years 2001 – 2004 I lived through many experiences of loss – due to actual deaths, and due to much transition and change. My grief was huge and prolonged. I began to describe the pain and despair that I was experiencing as a kind of 'inner screaming', and at times I did indeed scream out loud in the way Rowe describes. Despite years of psychotherapy training, involving access to a whole range of theories and understanding about loss, and years of my own personal therapy, I kept coming up against severe limits in integrating my grief. My usual ways of making meaning out of my experience were just not helping me heal the pain with which I was living.

The accumulated knowledge that was already available to me during this time was as follows: I had various bereavement maps and models for healing and recovery at my fingertips (Kübler-Ross 1969; Colin Murray Parkes 1972; William Worden 1983; C S Lewis 1961). I had perspectives from Attachment Theory that could help me account for the level of anxiety I was experiencing in relation to separation (Bowlby 1969, 1973, 1980, 1988). I had in-depth understanding of psychoanalytic theory providing me with insight into unconscious phantasy stirred up by loss (Klein, 1940). I had made extensive links between some of my early primitive experience and my present distress of feeling left and abandoned (Winnicott 1963; 1988). Somehow all of this understanding was just not enough. And so began a journey of searching and looking for more. Using heuristic research methods (Moustakas,1990) I immersed myself in exploring my experience - by reading, journal writing, note taking, gathering information from all kinds of obscure places, discussing loss and separation with anyone who would give me the time of day.

Initial Signposts

"Tears are a river that takes you somewhere. Weeping creates a river around the boat that carries your soul life. Tears lift your boat off the rocks, off dry ground, carrying it down river to someplace new" (Pinkola Estés 1992, p.374).

During my initial "endless hours of sustained immersion and focused concentration" (Moustakas 1990, p.14) on my subject I found various pieces of writing, ideas and perspectives which were soothing and nourishing to me in my grief. I will gather some of them here in the belief that they will hold value for others. As Moustakas says "heuristic inquiry is a process that begins with a question or problem which the researcher seeks to illuminate or answer. The heuristic approach is autobiographic, yet with virtually every question that matters personally there is also a social – and perhaps universal – significance" (Moustakas 1990, p15).

Furthermore, in his descriptions of the processes of heuristic research Moustakas describes a kind of readiness that is needed "to risk the opening of wounds and passionate concerns and to undergo the personal transformation that exists as a possibility in every heuristic journey" (Moustakas 1990, p14). My explorations did indeed feel risky and they were taking me to places of great darkness and despair. This in itself feels like an important contribution to the work sometimes needed in relation to loss, grief and separation – time to allow oneself to be with "the deepest darkest smokiest experiences in a life" (Moore 2004, pIX). From his Jungian perspective Moore also says the following: "If your main interest in life is health, you may quickly try to overcome the darkness. But if you are looking for meaning, character, and personal substance, you may discover that a dark night has many important gifts for you" (Moore 2004, pXIII).

As I slowly found that I could stop resisting my darkness and simply allow it to have its time and its place I discovered many gifts, often initially in the form of resonating with the experiences and writings of others. These brought comfort and reassurance. In his chronicle of grief following the death of his wife C.S. Lewis writes "No one ever told me that grief felt so much like fear" (Lewis 1961, p5). He later expresses a simple idea: "there is nothing we can do with suffering except to suffer it" (Lewis 1961, p29). Alongside this I found the writings of journalist Lindsay Nicholson very moving. In her memoir of loss and survival she describes how she stopped pretending that grief was "pretty or decent or sensible or civilised". She allowed it to be as she was feeling it – "horrible, painful, jagged and dangerous" (Nicholson 2005, p4).

Other writings offered significant hope about the darkness. I found the following from the contemplative psychotherapist Nigel Wellings – "At the point of greatest darkness things change" (Wellings 2005, p 120). The process of simply being present with pain can allow discovery and renewal. As the little prince in the well-known French parable says to the pilot (who has had to make a forced landing in the middle of the Sahara) "Ce qui embellit le désert, c'est qu'il cache un puits quelque part – What makes the desert beautiful is that somewhere it hides a well" (Saint-Exupéry 1945, p89). Life can slowly or suddenly subject us to forced landings in lonely dark or desert places that we were not expecting at all. Staying there and searching can lead us to new places, new discoveries.

From my own personal darkness and desert I found various 'wells' from which to drink. I discovered the work of neuroscience researcher Jaak Panksepp (2004) to be particularly helpful in relation to separation. In his view coming off a needed person feels the same as coming off heroin. Attachment to a needed person is like an opiod addiction and so separation from that person involves all the agony of opiod withdrawal, with the hormone acetylcholine washing over the brain, creating internal chemical havoc. This is particularly so if grief is not fully recognised. Without appropriate soothing attention we are left in states of misery and despair with the pain of separation remaining uncomforted. In extreme cases where the experience of loss is not acknowledged at all (either by society or by the individual) then the griever, the relationship or the loss itself can remain painfully hidden –'disenfranchised' (Doka, 2001). Some of my own losses came into this category – transitions that were complex and thus hard to embrace. They involved more hurt and pain because their impact and significance were not straightforward. The work of Pauline Boss (2006) about ambiguous

loss was also very informative for this context. As I began to integrate these perspectives – of separation as being like an opiod withdrawal, of uncomforted disenfranchised grief, and of ambiguous loss, I could begin to make more sense of my inner screaming. My longing, waiting, wanting and 'hunger' in connection with all my experiences could be more deeply acknowledged. I could find a place within me in which to store and hold the pain more easily.

These perspectives led me into a deep exploration of the notion of Family Constellations (Hellinger, 1998) and in particular the idea of generational grief. Hellinger's 'Order of Love' work became widely known in Germany during the early 1990s and spread onto the wider international scene following the translation into English of *Love's Hidden Symmetry* (Hellinger et al, 1998). His approach is phenomenological, seeking to show the truth of 'what is' within a family system by setting up a spatial representation of the family and working with what emerges. This may include hidden dynamics – loyalties and unconscious identifications transmitted through the generations that contribute to an unconscious family conscience. In Hellinger's view, when the system is affected by trauma then family members suffer and the flow of love and nourishment can be interrupted down through several generations. With the help of a Constellations Therapist I set up my family system and explored the layers of trauma and loss through the generations – and in particular a possible personal identification with my paternal grandmother. The losses of her life were huge and I believe largely uncomforted due to the emotional limits of her generation and her class where a 'stiff upper lip' attitude mostly prevailed. In this supportive therapeutic context I experienced relief and release in honouring my grandmother's pain whilst firmly seeing it as hers and not mine, bringing our different situations and contexts fully into consciousness.

Following on from the signposts of my initial explorations I uncovered various different theoretical perspectives on loss and separation and I will now bring them into my discussion.

Theoretical Perspectives: New Understandings of Working with Loss and Postmodern Bereavement Theory

"Grief is a process…of moving from losing what we have, to having what we lost" (Fleming and Belanger 2001, p314).

The quotation above serves to introduce the essence of my feeling about the theoretical perspectives I found during my heuristic inquiry. These are Dual Process Theory (Stroebe and Schut, 1995), Meaning Reconstruction Theory (Neimeyer 2001, 2002) and the postmodern Theory of Continuing Bonds (Klass Silverman and Nickman, 1996). I found these theories illuminating and exciting in terms of my process of integrating my inner screaming.

Dual Process Theory

Firstly, I came across an approach to loss outlined by Margaret Stroebe and Henk Schut, researchers in collaboration at the Department of Health Psychology at the University of Utrecht. In 1995 they introduced their Dual Process Model of Coping with Grief at a conference in Oxford (Stroebe and Schut, 1995) in which they described two concurrent processes or 'orientations' as a way of explaining reactions to grief. Loss orientation is the traditional realm of sadness, anger and so on. Restoration orientation is by contrast very much characterised by attempts to reconstruct life and get on with things.

The Model presents a fluid picture of the grieving process in which it is possible to experience the two orientations within the same timescale - times of deep pain alongside attempts to rebuild life. This oscillation between the two opposing modes is the key feature of the theory, rather than a gradual chronological transition from one orientation to the other. Stroebe and Schut argue strongly that most bereaved people will move between these two strategies for managing their grief - at times adopting a loss orientation while at other times becoming immersed in new activities which provide relief from the sheer pain of loss. So, times of momentary forgetfulness or distractions of any kind, rather than being signs of denial, enable daily routines to re-emerge and

create a chance to rebuild a stable sense of self. Moments of extreme distress and focus on loss, rather than being signs of an inability to let go, provide a helpful ongoing opportunity for full expression of feelings associated with the loss.

Dual Process Theory puts forward some very useful perspectives, helpful in themselves and also suggesting a new way forward from other approaches. Grief is not seen as a linear pathway of letting go and moving on, in contrast to the stages approaches of Kübler-Ross (1969) and Parkes (1972). According to Stroebe and Schut it is a very complex process, one that is characterised by tension between the opposing tendencies of the two different orientations.

Meaning Reconstruction Theory

Alongside the above, I also came across Robert Neimeyer's Meaning Reconstruction Theory (2001; 2002). He is currently a Professor in Psychology at the University of Memphis and his ideas are based on the premise that when we experience loss of any kind we also experience a disruption of our lifestory. This represents a loss of meaning - a deep disturbance to our taken-for-granted beliefs about who we are and where we 'fit' in to life. We can no longer rely on ideas like a predictable life or a benign universe. The process of grieving is deeply concerned with attempting to make sense of the loss and to reconstruct what our life now means. This involves integrating not only the loss itself but also possibly a wide range of circumstances, linked to the loss, that are now disrupted. According to Neimeyer "meaning reconstruction in response to loss is the central feature of grieving" (Neimeyer 2002, p47).

In his theory Neimeyer suggests three contexts in which this reconstruction occurs: sense-making regarding the loss, benefit-finding in the experience, and identity reconstruction in its aftermath (Neimeyer 2002, pp 48-51). He then describes the ways in which this meaning can be achieved: "The losses of central people, places and projects that anchor our sense of self force a reordering of the story of our lives, triggering the re-authorship of a new life narrative that integrates the loss into the plot structure of our biography" (Neimeyer 2002, p51). He describes three kinds of narrative process, distinctive styles of storytelling that help to make meaning. External narratives focus on concrete descriptions of events, internal narratives focus on emotional responses, and reflexive narratives include our attempts to analyse our reactions to events (Neimeyer 2002, pp52-54).

I found this notion of the power of narrative in assisting in the transcendence of the pain of loss very illuminating. During the summer and autumn of 2005 as I began to write up my research in more detail I could feel the benefit of the narrative exploration helping me find deeper significance in my various losses. My understanding expanded in the actual process of narrative. As part of what Neimeyer would call a reflexive narrative process I began to distinguish more fully between grief connected to loss through death, and grief connected to the changes and transitions of life. This process certainly helped towards soothing my inner screaming: it was a further way of making meaning of the various disruptions of my lifestory.

Postmodern Bereavement Theory: Continuing Bonds

My most important discovery was the Theory of Continuing Bonds developed by Dennis Klass, Phyllis Silverman and Steven Nickman who are currently connected through the Department of Psychiatry at Harvard. It was this notion that provided me with what I had perhaps been instinctively looking for, and it now feels like the key that opened the door into a deeply significant understanding of my inner screaming. Klass and his colleagues discuss the importance not so much of letting go, but of actually holding onto the lost relationship - being able to feel that there is still something ongoing even after the loss has occurred. So grieving is a process of maintaining ties rather than severing them. Klass explains: "We are not talking about living in the past, but rather recognizing how bonds formed in the past can inform our present and our future" (Klass et al 1996, p17). He describes the creation of inner representations of significant lost people, processes of adaptation, and the construction and reconstruction of new connections.

Drawing on Piaget's cognitive theory, Klass and his colleagues propose the notion of "accommodation" as a more appropriate term than recovery or closure. They see this as a dynamic, interactive activity, different from "psychoanalytic internalisation" (Klass et al 1996, p16). According to Klass and his colleagues, accommodation does not disregard past relationships but incorporates them into a larger whole. "People are changed by the experience; they do not get over it, and part of the change is a transformed but continuing relationship with the lost one" (Klass et al. 1996, p19). Rather than letting go, the emphasis is on negotiating and renegotiating the loss over time.

These ideas were like an explosion in my mind and heart. I could now fully see that so much of my inner screaming had been about my resistance to separations that I did not want to embrace. The notion of Continuing Bonds provided me with another way through the pain of my various losses - rebuilding life with a reorganised, but not relinquished, link with my lost ones. I could hold on, incorporate and integrate them into my ongoing story. It was this paradox - of letting go AND remaining involved - that ultimately soothed my inner screaming.

Continuing Bonds in Context

In my view, the beauty of the Theory of Continuing Bonds lies in the way in which it points overwhelmingly to a different kind of knowledge about loss – that it is possible to feel a strong sense of ongoing connection, even though nothing will ever be the same again. Klass and his colleagues argue passionately that the twentieth century prevailing models of bereavement, which focus on 'letting go', are based on the cultural values of Western modernity with its emphasis on autonomy and separateness.

As Klass says, the models of grief that began with Freud are based on a world view that stresses how separate people are from each other. He firmly rejects these perspectives. Freud saw the work of mourning as involving the mourner introjecting the lost actual person. This is achieved by means of a process that he called hypercathexis – the ties to the loved object are severed by gradual detachment and the process is complete when libininal energy is withdrawn from the lost person: "Mourning has quite a precise psychical task to perform: its function is to detach the survivors' memories and hopes from the dead" (Freud 1913/1961, p65).

I have already mentioned the various bereavement maps and models for healing and recovery that were very familiar to me at the outset of my research, and all are based on the Freudian notion of detachment and re-investment in new relationship.

By contrast, Klass prizes interdependence over autonomy: living in a web of relationships, ongoing involvement with others even in their absence. This is not seen as pathological – on the contrary interdependence is much needed to support healthy living. There is no sense of having to 'move on' or 'let go'.

The theory of Continuing Bonds links very directly with new paradigms in Psychoanalysis: Self Psychology and Intersubjective Systems Theory. The Theory of Self Psychology developed by Heinz Kohut in the 1970s has its roots in traditional psychoanalysis (Kohut was President of the American Psychoanalytic Association in 1964-1965). The significant new paradigm developed by Kohut indicates a conceptual shift from the primacy of instinctual drives towards the primacy of self experience. The most crucial concept in self psychology is probably that of the 'selfobject' – the idea introduced by Kohut that an object, a separate person, can be experienced as a functional part of the subject's inner psychic organization (Kohut 1984, p 49). The selfobject is another person whose responsive presence is required during healthy development to regulate the child's experiencing self.

Alongside this, Intersubjective Systems Theory (principally developed by Robert Stolorow and George Atwood also in the 1970s in the United States) grew in parallel with Self Psychology and became greatly enriched by its framework (Stolorow et al, 1994: Ch 3). The central metaphor of Intersubjective Systems Theory is the larger relational system or field in which psychological development takes place and in which experience is continually and mutually shaped (Stolorow et al, 2002).

These new paradigms are extremely helpful in terms of thinking about the impact of loss and separation. Self Psychology sees the individual as embedded in selfobjects throughout life. Kohut drew attention to the continuing need for responsive others in adult life as well as in childhood. Alongside this, Intersubjective Systems Theory defines the self as a psychological structure that gains cohesion shape and coherence within an intersubjective field of sustained relationships. These are not just needed for early growth and development but are necessary throughout the entire lifespan.

The Death of a Selfobject or the Loss of the Intersubjective Mutually Regulatory System

As Cornford (2008) has described, when someone who sustained and repaired our self-experience dies or is missing (in one way or another), we can be plunged into a serious crisis. Our actual sense of self may be threatened as our self experience becomes disorganised. She elaborates various ways in which we may be profoundly affected by the loss of such a significant person:

If their selfobject function was to sustain our sense of identity, we may fragment

If they maintained our self-esteem, we may lose our confidence

If they helped us regulate our feelings, we may find ourselves overwhelmed

If our self-experience was dependent on the presence of the lost one for its cohesion, then our very survival may be under threat (see Cornford 2008 for a full discussion of this perspective).

Results from Research Interviews: Clinical Application

:…becoming stronger and being devastated at the same time" (Burkeman, 2008).

As my research project developed I became very interested in discovering how others had lived through periods of major transition. I decided to recruit people willing to discuss the losses of their lives and their reactions to the separations involved and I was keen to find others who might feel a connection with my phrase 'inner screaming'. Consequently I set up a series of semi-structured interviews, drawing on two different groups of people. Some of my research participants came from within my Training Organisation (BCPC) and others were from the local branch of a social activities group. The focus of my inquiry was ways of healing the pain of loss (of any kind). What had others found to be helpful?

The results that emerged from my interviews were rich and varied and many of the ideas below can be integrated into clinical practice when working with clients who have experienced loss of any kind. My interviewees gave in-depth descriptions of the kinds of processes that they had lived through: giving way to uncontrollable tears; defensively fending off the pain of loss and keeping feelings firmly at bay; surrendering to darkness and despair; embracing collapse or illness; allowing bitterness, resentment and rage to surface in a very full way.

Following on from their narratives of loss, my interviewees talked about their ways of healing and coming through the hurt of such separations. There is not enough room here for great detail and I will summarise the main findings from my interviews. The place of physical activity emerged very strongly as a helpful resource in providing an outlet for pain. Alongside this, and in stark contrast to it, a theme developed of taking time out from all activity – just sitting, being, especially in some secluded place. This often enabled a healing sense of 'letting it be' to grow. Many of my interviewees arrived at a place where they found themselves able to somehow say 'Enough'. They wanted and needed to stop trying so hard to understand their feelings or work everything out. Within the heart of this idea of 'letting it be' many of my interviewees found the capacity for acceptance, the ability not to blame the other, whoever he or she may be, for the losses, changes and transitions often painfully endured. Another important theme that emerged was about finding a place to accept help in a significant way from many different sources. This was often the start of a deep healing process, a fuller recognition of need and dependency.

The over-riding theme throughout all my various discussions was indeed the significance of maintaining some kind of ongoing link with the loved person, now lost by whatever means.

This emerged in stories from my interviewees of, for example, talking to their lost loved ones, dreaming about them, imagining their comforting presence, and carrying out various rituals that created a sense of ongoing relationship as life continued. For example, BC carried on the shopping and cooking routines that she had had with her partner; C continued to go sailing on a regular basis on Sundays and found himself feeling the ongoing presence of his father on the boat they had shared; HG spent hours walking in forests and on coastal paths as he had done with his sister, sometimes returning to favourite old haunts, sometimes exploring new places and telling her about them as he walked.

Other stories from my interviewees reflecting a continuing bond are as follows: N and W created special quiet places in their homes with photographs and other treasures belonging to their lost ones; B and F found healing just sitting for long periods in the gardens they had shared with their lost relatives. Many of my research participants turned to writing during these quiet times, finding that this process enabled an ongoing sense of connection. TR found release 'just getting my pain down on paper, writing to P and letting him know how I was feeling'; for BC writing two novels was a way of both 'saying goodbye and making our relationship visible'.

Some of my research participants had experienced sudden traumatic loss, as indeed I had myself. They described life suddenly going 'out of shape', feeling 'pole-axed', events being 'incomprehensible', feeling in the grip of 'total mess and total need', suddenly 'life caving in'. In the words of Robert Stolorow we move from living in the world of the "normals" to suddenly belonging in the world of the "traumatized". (Stolorow 2002, p2). Stolorow is however strongly of the belief that trauma can be integrated if it finds a hospitable relational home in which it can be held. His recent work *Trauma and Human Existence* (Stolorow, 2007) contains reflections on the sudden death of his wife and of how he found comfort for his overwhelming grief in the presence of his colleague George Atwood whose own world had been shattered by loss as a small boy: "He really grasped my devastation… small wonder that George and I began calling each other 'my-brother-in-darkness"…' (Stolorow 2007, pp 50-51). Klass (1996) suggests that the emotional work of integrating loss is significantly helped when it can take place in conversation, and particularly in conversation with others who know the same (or similar) darkness.

Conclusions

"We accept our lack of control over almost everything…we accept our vulnerability and finitude in the face of illness and losses and death…we accept our own past, even those parts we regret. We come to terms" (Orange 2008, p 9).

The pain of loss and separation is one of life's great givens, an inevitable consequence of the loves and attachments of our lives. I embarked on my research project with intense puzzlement and pain about my inner screaming state. As my various explorations bore fruit I feel as if I found ways in which to make a deep and meaningful relationship with my suffering. This has inevitably had an impact on all aspects of my work – with clients and supervisees, and in the teaching programmes at BCPC.

I resonate very fully with the words of Donna Orange above – in our own lives, and in our work with others and their lives, we try to "make sense together: (Orange 1995, pp 6-7), we come to terms with mess, misunderstandings, incompleteness and contradiction. Perhaps we can also see how "loss sheds its light on what remains" (Bywater 2005, p 267). Perhaps we can appreciate the 'tent pegs' that are still firmly there in our lives. Hopefully we find that staying in some form of relationship with lost loved ones enables us to function in the present in an enriched way.

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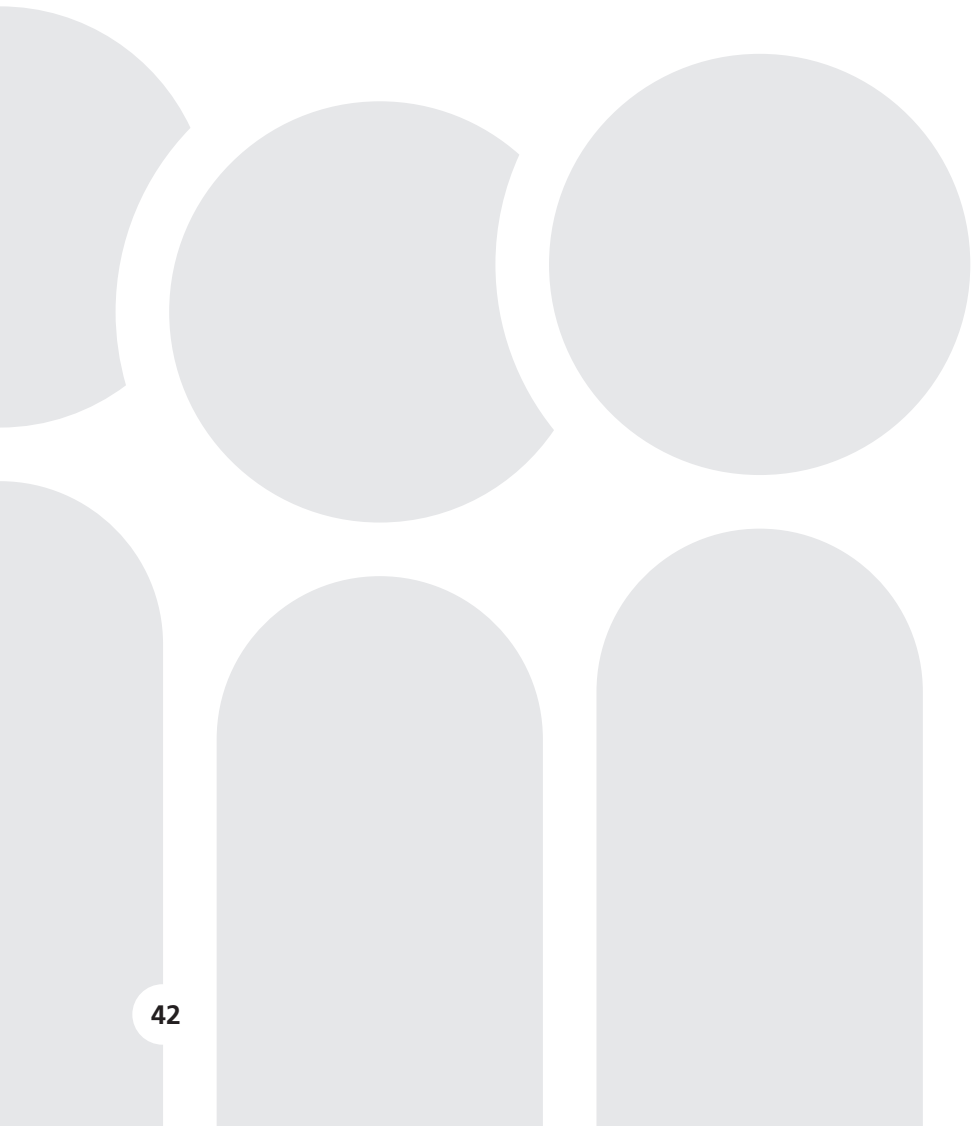

Claire Nelissen

The Professional Identity of Psychotherapy

Abstract

As psychotherapists we need to raise a united voice in the statutory regulation debate. At this moment our unique contribution as professionals tends to get drowned in the turmoil of regulation and manualization of treatments. In this article Claire Nelissen connects this risk to problems in our professional identity. A shift in focus is proposed, away from the so-called modality wars, to identifying our clinical reasoning across the field: what are we uniquely accountable for and what unites us as psychotherapists? An attempt is made at laying the groundwork for defining the fundamental principle of our expertise, by bringing consulting room common sense into focus. Regardless of modality, this expertise consists of a unique form of clinical reasoning, consisting of weighing the potential of client and setting against actual change in the consulting room.

Introduction

There seems to be something truly amiss with our professional identity: how much unified professional identity is there, if "Multi-modality…is one of our unique identifiers", as the Chair of UKCP states in the 2009 Summer issue of the Psychotherapist (Antrican, 2009 p 1)? Stressing multi-modality is understandable as a reaction to protocollarisation, which seems to define away our creativity. Yet, 'multi-modality' and 'unique identifier' do seem to contradict one another. What could be our professional identity, our specific expertise, if it is not a pluralistic one?

There is no easy answer to that question, especially at this moment. Statutory regulation is in fact one big pressure to explicitly define our collective expertise. A well defined professional identity, therefore, would be a safe rudder in the stormy weather of statutory regulation. At this moment, however, we seem to lack that rudder. I hope to make clear that our professional identity is insufficiently established, because our expertise is poorly described. And by 'poor' I do not just mean that it is defined only in the most general terms. The implicit definitions used in our clinical dialogue at this moment seem inadequate as well to reach transparency about what we do. Consequently, we run the risk of being out of control in turbulent seas of financial and political forces, of external parties with only a crude understanding of the subtleties of our trade, and of trends of contesting that we even have a specific expertise (Erwin, 1997 pp 158-160; Pollard, 2009 p 18; see for a discussion: Verhaeghe, 2009).

Illustrating how poorly described our expertise is at the moment, and proposing what course to take instead, requires a journey of what philosophers call 'slow thinking'. As psychotherapists, we are a reflective species, used to resisting pressures to act at the moment, and we often postpone any defining. I propose to use that quality here, and see what emerges if we manage to withstand pressures to define, and first take a closer look at what it is that we are trying to define.

Regarding professional identity, therefore, I propose to take a step back and think about how we can actually look at professional identity as such. From there, we will turn to how our expertise at this moment is viewed in the clinical dialogue. As I will show, views of clinical scientists generally seem to lack consulting room common sense (in the philosophical sense of the word). I hope to illustrate this by explicating some positions regarding our expertise, as they are implicitly held in the present debate. Next, I hope to construct, step by step, a rudder for our vessel, by bringing in consulting room activity and thinking through what, from that perspective, the fundamentals of our expertise might be. I will end with an illustration, based on these fundamentals, of our specific expertise on change itself. This might provide us with ideas about how we can describe and study our unique psychotherapy expertise in the future, but now on our own terms.

Professional Identity

Professional identity is a notion that indicates how we view ourselves as professionals. A shared, yet unique professional identity for psychotherapists addresses two dimensions simultaneously. Firstly, there is the issue of commonality: what is it, that unites us? What is the professional task of any psychotherapist, regardless of school? Secondly, there is the issue of uniqueness: what is it that distinguishes psychotherapy from other therapies and from non-therapy? In other words: What makes psychotherapists as professionals distinctively qualified to perform the identified task?

Here we immediately slow down our thinking by not answering these questions right away. First we need to look at how to approach identity as such, so that we can compare different views on professional identity.

In a recent article about clinical approaches to identity, Vanheule and Verhaeghe (2009) propose to distinguish two viewpoints: a categorical one (what category do I belong to), and one which stresses the functional, process-like viewpoint of identity. My starting point is to borrow this distinction and use it for viewing our professional identity. This means that I propose to look at our professional identity from two angles: categorical (what category do I belong to), but also functional (in our case: how do I do what I do?), so in terms of process.

This makes it possible to compare different approaches to our professional identity. From my perspective, namely, psychotherapeutic, professionalism is generally viewed in categorical terms: our allegiance to a clinical school, be it a 'single' approach, or an integrative/eclectic one. I will argue that this approach does not bring us much with which to identify ourselves professionally. It provides no insight into our specific task; we therefore lack criteria for our competence, which in turn, as I will show, can lead parties to even disqualify our expertise.

Hence, for finding our professional identity, we do need a change of course. Below, I will propose a different, functional approach to our professionalism. This view starts from the question: how do we do what we do? (instead of: what is it that we do?) Thus, in answering the two intertwined questions about our shared, yet distinctive qualities, I will put 'the how' of psychotherapy centre stage. This way we can describe a task we all share: pacing and fostering, or, more generally: influencing a therapeutic process. The change of course in acknowledging this, is the fact that our focus shifts from asking 'what is it that we do?' to 'how do we what we do?' This change is crucial: it brings to the fore our specific handling, in the consulting room, of a therapeutic process as a process, both in total and from moment to moment.

Before we discuss the task which we as psychotherapists share in our own unique way, we need to further gear down our thinking again. Exploring our task, namely, requires me to introduce a few terms: design, execution and clinical reasoning. I will discuss these shortly below.

As psychotherapists we gradually develop a therapy process. Let us zoom in on this process and view it as a trajectory. Design is an overarching notion for our intentional efforts in gradually developing that trajectory in the consulting room. This means that 'design' entails all our continuous considerations, from assessing what might be the problem of the client and how the therapeutic space

can be employed, through developing a therapy strategy, to evaluating our stance and accommodating, from moment to moment, how what we do can actually help the client.

What we thus continuously design and reflect on, needs also to be effected in the consulting room. For that, I use the term 'execution'. Executing, in other words, is intervening as we see fit. Yet, I need to add at the risk of elaborating the obvious here: intervening refers to both behavioural and mental activity.

This addition is essential for our purpose: it brings to the fore that our key activity is a mental one. In other words: our key activity in the consulting room is clinical reasoning. Clinical reasoning refers to our reasoning process in the consulting room: our exploring before we act, our reflecting on our own intervening while acting, and our thinking through what actually happens in the consulting room and how this might help the client.

Summarising: I view our task as designing and executing a therapy process in the consulting room with the help of specific clinical reasoning. This process is aimed at facilitating change, leading to amelioration for the client. What it is, that exclusively identifies psychotherapeutic competence, is in my view the specific nature of this clinical reasoning, which we use in order to adequately facilitate change. I will discuss this to some more extent later on.

At this point it suffices to note that our change of course to a functional approach to our profession implies that we put clinical reasoning centre stage. This choice seems to be in line with research findings. Specific competence, research shows, is the core of therapy effectiveness (Wampold 2001, pp 184-202). Besides, therapists appear to be the crucial factor of variance in efficacy (ibid, 2001, p 202). Studying our specific clinical reasoning, therefore, might give us a clear idea of core standards for our professionalism.

The Present Lacking of the Rudder: Problems in Describing Our Expertise

At this moment a clear understanding of our expertise seems to be lacking, as much within the psychotherapy field as in the outer world: "There are no agreed criteria, except in the most general terms, as to what qualifies any of us to practice psychotherapy" (Pollard, 2009 p 18).

Although, as I said above, our expertise can be viewed as a specific, unique way of clinical reasoning in the consulting room, regardless of schools, we do not view ourselves as unique 'reasoners'. In fact, we are like that cabinet-maker, who can endlessly talk about the exquisite furniture (s)he makes, but who can only explain how (s)he smoothes the wood by telling us which shave to use and showing how to do it. Thus, we discuss what we reason with, a multitude of psychological views (modalities), much less so how we actually 'smoothe' our working hypotheses.

Hence, our self-definition as experts is dispersed and amorphous (Prochaska/ Norcross, 2007 p xiv; Wampold, 2001 p 1). This in itself contributes to the myth that there is no such things as specific psychotherapeutic reasoning, that treatments therefore can be manualised, resulting in the psychotherapist as expert being a chronically underrated species (Verhaeghe 2009, p 157).

Yet, clinical scientists do try to find more clarity about what the core of psychotherapy is. There seem to be several ways of proceeding in finding this core, of which I will mention three here. Firstly, there are efforts at defining our exclusiveness, namely in branding the therapist a master of some unique creativity. Secondly, there are efforts at integration. And thirdly, there are efforts at unifying client-change. I will discuss these three shortly and illustrate how they miss the mark in identifying our expertise.

Firstly, the uniqueness of the therapist's creativity. This strand of thought stresses the fact that actual therapeutic reasoning is so refined, that it is viewed as a very personal form of artistry, creativity, or wisdom. One could say, for instance, that when James Antrican stresses the fact that multi-modality "…provides a playground for creativity" (2009 p 1), he is in passing suggesting, as many of us do, that such vague notions as creativity, 'art' (Yalom, 1970: x; Lazarus, 2005 p 106), 'clinical wisdom' (Erwin, 1997: 159; Norcross/Halgin, 2005 p 440) 'adopting a mind-set' (Edelson,

1994 p 82) or even 'methodical unconcern' (Nieweg, 2008 p 111) identify our expertise.

Calling our expertise the 'art' of psychotherapy, has a somewhat romantic sound to it. In reality, however, it throws a mystifying veil over our very own professionalism by turning our reasoning into a 'black box', better not be opened because mastering psychotherapy is so personal (Levenson 1983, p5). The result is not preservation of the true character of psychotherapy; instead, this kind of argument suggests that psychotherapeutic clinical reasoning cannot be studied. Hence, our expertise tends to disappear in the mist.

Secondly, efforts at integration. Of course it is true that plurality, not only of thought, but also of practice, is a "…rich resource, from which we all benefit" (Pollard 2009, p19). Yet, as I said in the introduction, as identifier for our expertise, 'multi-modality' lacks unification. Our expertise, it is suggested, is a function of how we handle a multitude of clinical approaches. Thus, we either belong to a 'mono-school', or to an 'integrative/eclectic' one. Schools, approaches, however, are in my view inappropriate for identifying our professionalism. They do exactly what the term says they do: they are no more than approaches to, lenses on our profession. Handling a multitude of clinical approaches, even when these are taken together in a small number of strategies for integration (eclecticism, and translation or assimilation of theories - Goldfried, 1980), refers to a (meta-)rationale: how we all appear to undergird our choices through (now integrative) psychological theories.

Undergirding choices is different from actually making them. The actual clinical reasoning as it takes place in the consulting room tends to get hidden behind reasoning about undergirding those choices.

Thirdly, efforts at unifying client-change. This is the realm of the common factors approach, an integrative approach that claims both unification and exclusiveness around: "…a central and recognizable core of psychotherapy" (Prochaska/Norcross, 2007 p 6). This core of psychotherapy, adherents of the common factors approach state, consists of phases of (intrapsychic) change of the client, that can be found throughout psychotherapeutic processes in the consulting room (Prochaska/Norcross, 2007 p 480). To find unification in psychotherapy practice, therefore, this approach seeks to generalise this core, i.e. the change process of the client (ibid: pp 526-532; Beitman et al., 2005 pp 72-80; Miller et al., 2005 pp 85-95).

Handling phases of (intrapsychic) change of the client in the consulting room is indeed unique for psychotherapy. The common factors approach, however, lacks a unified description of how professionals actually work with identified phases of client change. For fleshing out 'the how' of psychotherapy, namely, authors generally leave the unifying path and turn to the particularity of case descriptions (Prochaska/Norcross, 2007 p 538; Beitman et al., 2005 pp 80-82; Miller et al., 2005 pp 95-98). Case studies, however thorough, are in fact anecdotal (in the philosophical sense of the word) descriptions of the application of tools: the activity, the changing itself, so as component of our reasoning, is not generalised. Hence, our clinical reasoning in the consulting room gets fragmented into a range of case studies.

All three approaches to psychotherapy fall short in identifying our professionalism: both commonalities and the uniqueness of our expertise are mystified, invisible or dispersed.

Consequences of a Poorly Identified Expertise

One of the main consequences of the above is the fact that our professional task, design and execution of proper treatment, has disappeared out of sight. The centrality of this task for our entire professional field seems at this moment not to be recognised, snowed under as it is in multiple modalities.

By this I mean that the how of designing and executing proper treatment, seems at this moment to be scattered over more than 400 'schools'. However, the fact that implementing treatment is our task, can be found throughout the field. Because of the actual execution being scattered in all directions, we have forgotten that the task of design, in total and from moment to moment, is in fact what all schools share. Hence, we seem to have given up on viewing professionalism in terms of design and

execution: as a pointer to our expertise it is at this moment at most implicit, 'hidden' as it were in over 400 'schools' and their training institutes.

Yet, the aspect of design and execution of the therapy process itself, the fact that it needs to be sound in a specific way (however scattered the understanding of the word 'sound' may be), is what in my view unites us; the expert reasoning required to flesh out that soundness might distinguish psychotherapy from other therapies as well as from non-therapy.

What does overlooking this fact mean for our professional identity as we see it ourselves? Let us take the position that multi-modality is one of our unique identifiers. Rachel Pollard, in the summer 2009 issue of "the Psychotherapist", formulates the weakness of this position beautifully by connecting it to an ethical issue. She raises the question "…whether as a 'profession' we can continue to value our own trainings, whilst granting an equal value to those of others; to acknowledge that our theoretical orientation is a matter of personal preference or serendipity" (Pollard, 2009 p 18).

The quotation marks ('profession') used by Pollard, speaks volumes for the fact that we do have an identity problem. Unfortunately, Pollard goes on to answer her own question again on the 'modality-track' by adding a kind of meta-modality in stressing the dialogical nature of psychotherapy. This proposing of yet another modality, another category, is a trend that can be found throughout the clinical literature. It is illustrative for the endless proliferation of views that the categorical viewpoint brings on essentially one task (be it a complex one).

The consequential lack of agreed criteria as to what qualifies any of us to practice psychotherapy has led Pollard to toss in the towel: "Even the designation of psychotherapy as a profession or professional activity is highly questionable" (Pollard, 2009 p 18). That position contradicts the entire consulting room experience of every practitioner who tries to practice as professionally as (s)he can. The fact that psychotherapy as a discipline is at the moment 'amorphous', fragmented and confused (Prochaska/Norcross, 2007 p xiv, 1), does not necessarily mean that psychotherapeutic professionalism does not exist at all as a specific homogenous class of activity.

Towards a Different Perspective on Our Professionalism

Let us now turn to identifying our expertise from a functional perspective. Our expertise, one could say, is engrained in our handling of the client. In order to make this expertise visible, we need to slow down again, and ask ourselves: how do we design proper treatment and set it in motion?

As I illustrated earlier, our expertise is to be found in our clinical thinking. This clinical thinking is not random; it is systematically organized thought. Implementing change strategies, therefore, can be understood as movement of expert thought. Hence, I propose to look at psychotherapy from a standpoint of how we organise our thinking in the consulting room. Or, better still: from a standpoint of movement of our expert thought.

There remains the question how this can be made manifest, in order to study it. In fact, implementing change strategies, understood as movement of expert thought, boils down to a considered use of working hypotheses (e.g. about pathology/problems of the client, about possible therapeutic agents, about our required role in the process). These working hypotheses are therefore, as it were, evidential stepping stones that show how we reason to get a useful result.

Philosophically speaking this entails that clinical reasoning needs to be approached as an act in itself in order for us to study psychotherapy design. As an act we might be able to generalise it and find what it is that we share across the therapeutic field.

Skipping the details of the enormous field of philosophy of science about theory versus hypothesis, probability, confirmation, mechanisms and determinants (Bunge p 2005; Rubinstein, 1997a; Rubinstein 1997b), let us, with clinical reasoning as an act in mind, now return to our core question: what are we all uniquely accountable for, and can we generalise psychotherapeutic clinical reasoning?

I do think we can, to a certain extent. It is the sophistication with how we do reason while making therapeutic choices, that delineates our specific expertise. The fact that, and the point at which we choose is as technological as an architect who plans to work on an initial drawing or a detailed design.

But first we need to find a common foundation for identifying the characteristics of our clinical reasoning. This will be discussed below.

Finding a Fundamental Principle for our Reasoning

Here we take a step back again and look at how to go about finding that fundamental principle of our expert reasoning. We turn to the philosopher Mario Bunge, who suggests two steps for a rational analysis. First, one needs to discriminate relevant components at some level; after that we can find our fundamental principle by trying to identify the relations among these components (Bunge, 2005 p 33).

Discriminating Groups of Components of our Expertise

As said above, our chosen level of analysis here is therapeutic reasoning, hypothesizing about change as such in the consulting room. That is where we seek components of professional expertise. Given this level, we can now turn to the components.

Two components of our expert reasoning are already identified above: psychological explanation (modalities and integration) for understanding a person (the client) on the one hand, and design and execution of the process, based on this understanding, on the other. These two components center around one core task: facilitating change.

On the level of therapeutic hypothesizing, therefore, there are three groups of components:

a) psychological explanatory theories
b) design and execution of the therapy process
c) change.

From a viewpoint of clinical reasoning, these three components are mutually exclusive, in that their character is essentially different from one another. There is, for instance, an essential difference between a psychological theory of change and psychotherapeutic clinical reasoning about change as it is understood here. I will discuss the components below. For lack of space, this discussion will be rather sketchy, and not doing any justice to the complexity of things. I choose to be just clear enough to shed more light on our expertise.

Psychological Explanatory Theories as Component of Our Expertise

Firstly, I will attend to the specific character of psychological explanatory theories as part of our clinical reasoning. In that light, psychological theories are in essence explanatory pictures. Thus, psychological theories are (important) resources, input. Psychology as science entails theorising about the social reality, the design of psychotherapy entails theorising about how to use the psychological body of knowledge. They are, therefore, essentially different.

Formulating psychological theories is not the core of psychotherapeutic expert reasoning. Our methodical reasoning consists of hypothesising. There is an essential difference between explanatory theories and our hypothesising in the consulting room in the service of implementation.

It is important to note this difference, since both the social reality and the reality of design are generally discussed in terms of psychology: many an author uses the term 'psychotherapy' interchangeably with 'psychology' (Eagle/Wolitzky, 1992; Taylor, 2000; Goldfried et al., 2005 p 24; Fishman, 2005 p 1; Prochaska/Norcross/, 2007 p 513), thus suggesting that the realities are the same.

Yet, from a standpoint of our clinical reasoning they may look alike, they even may be similar, or even more, they may overlap: they are not the same. Thus, from the viewpoint of clinical reasoning, taking psychotherapy as interchangeable with psychology would be a flawed approach, that can be referred to as, what Casement, using Matte Blanco,

calls: similarity being misunderstood as sameness (Casement, 1999 p 7).

Given the habit in clinical literature of using the terms 'psychotherapy' and 'psychology' interchangeably, I need to elaborate a bit more on the essential difference between the two from a viewpoint of psychotherapeutic clinical reasoning as act in itself.

Psychological approaches view the therapeutic space as a social reality, in which we as professionals are subjects, part of the interaction between client and therapist, while trying to explain this interaction in terms of psychology. Whether one calls it transferential, co-constructed, co-created, cognition correcting, behavioural instructive or interactional: all of these perspectives view both the therapeutic space, and change taking place within it, as in essence a social, psychological reality.

The therapeutic space, however, is more than a social reality. As we have seen above, it is also the realm of designing and executing a process as such. For this systematising of our treatments we use more than psychological concepts: we also continuously perform a task.

The difference between explanatory theory and performing a task is analogous to the difference between content (psychology) and process, acts, verbs (therapist). Psychology may be the substance of our therapeutic goals, and psychological considerations may be the substance of our working hypotheses, they are not the act of hypothesizing itself. They may be the substance of reasons why we temporise a process a certain way, they are not the temporising itself. They may be the substance of why we should work thoughtfully, while respecting the unique inner experiencing of the client. They are not the being thoughtful itself. In other words: psychological concepts formulate why our task should be interpreted a certain way (e.g., working on defect or on deficit), performing the task itself is of a different logical order.

Design/Execution of the Therapy Process as Component of Our Expertise

Secondly, I will attend to the specific character of design/execution, viewed as part of our clinical reasoning. As I said earlier, what in my view characterizes specifically psychotherapy-design and -execution, is the fact that both designing and executing psychotherapy are mental acts. Analysis of psychotherapy-design/execution, therefore, needs to be an exploration of our clinical reasoning, understood as movement in therapeutic thought.

Let me illustrate what I mean by the latter with an example. A therapist writes about the intake of a client, whose reason for contact is migraine: "I experience M as a hard person, hard for herself and harsh in her judgements of others. She's very 'tight' in her body and in her mind. I experience resistance when I inquire further or try to explore certain themes further. "

The therapist states how she thinks along lines of bodily expressions of psychic 'tightness'. All this is social, psychological content: how the client's presenting is experienced by the therapist.

In the next sentence, however, we find the content of design: "…I inquire further or try to explore…further". The therapist inquires further, looks for an appropriate line of working, before developing a hypothesis about what therapy-agents might help the client change. She postpones assessment: she first explores what is underlying the migraine and what this says about the kind of interaction needed in order to make it work as a therapeutic agent with this client: is shared inquiry the way to go? Or maybe Psycho-eductation? Excercises? Medication? In other words: she is hypothesizing about possibilities for facilitating change.

In clinical theory, if discussed, authors generally use verbs like 'inquiring' and 'exploring', in terms of their psychological merit: the empathic stance it brings, the merit of "staying with the client", etc. (Ornstein, 1978 p 218; Erskine, 1997 pp 37-45; Hargaden/Sills, 2001 p 172). Yet, for one school the merit is introspection and/or empathy, for another it is developing the client's observing ego; or trying to trace any dysfunctional cognition; or modelling psychological thinking and/or facilitating

mentalisation. The commonality between these in terms of professionalism, however, is that they all are an act of design: developing a line of working with the client. Explanation and design/execution go together. However, they are related yet separated: if the substance of explanation (psychology) is the handle, the substance of hypothesizing (the act of, in our example, inquiry) is the opening of the door.

One more example. In the therapist's remark "I experience resistance…" above, the social and design-dimension meet even more closely. The reaction of the client to the therapist's exploring is for the therapist part of the nature of the client's problems. Next to this however, implicitly, the therapist also scans possibilities for a process of working together. Both the psychological picture and the design of psychotherapy are involved.

Change as Component of our Expertise

Thirdly, I will attend to the specific character of change, viewed in the light of our clinical reasoning. What characterizes change in this respect, is in my view, that change, as it unfolds in the consulting room, is an interplay between potential for change and actual change. What does this mean?

In order for a therapy objective to be attainable in the consulting room, practitioners continuously look at the potential of the client. For managing the therapy process adequately, they need a thorough understanding of possibilities of both setting and the client, versus what actually changes for the client in due process.

Specific clinical reasoning about change in the consulting room, therefore, is not restricted to reviewing actual behavioural or even merely actual intrapsychic change. It is in my view a continuous considering of (changes in) the client's potential, versus actual change. In other words: our clinical reasoning is, regardless of school, in essence about potential and actuality: what is possible and what actually happens in the consulting room for the client? Subtleties of our expertise reside in my view in this relation between the potential for change and actual change.

This means that we are experts in viewing pre-manifest change: how both potential and actual change manifest themselves in the way the client interacts with us. What we consider as therapists can be so subtle, that a lay person cannot identify it as significant. Take for instance changes that take place in the 'as-if'-functioning-mode of a client (Fonagy et al., 2005 pp 265-310). By whichever approach we try to reach it, we do know that mentalized psychic reality (by client and therapist) is important to ultimately change affect regulation. Thus, we can choose to interact in such a way that it builds the 'pretend mode' of the client; or the boundary to self; or a differentiated self; or a strengthened Adult; or corrected cognitions. I am not suggesting that these approaches are interchangeable. My point here is, that in all these approaches we work on the client's potential for change in experiencing and ultimately in behaviour. In all these cases we review any changes in the client, sometimes long before it manifests itself in behaviour. It is this refined body of knowledge about (pre-)manifest intrapsychic goings-on that discriminates the entire field of psychotherapy in my view from other trades, even from for instance from counselling.

The Interrelationship Between Psychology, Design/Execution and Change

We have by now identified the main groups of components of our expert clinical reasoning. A specific interrelationship between psychology, design/execution, and change brings the fundamental principle of our clinical reasoning into sight. I will discuss this below.

In designing and executing psychotherapy in the consulting room, we as psychotherapists focus on a therapeutic time span, called 'process'. Firstly, therefore, we need to view treatment in the consulting room as a function of time, related to intrapsychic change (figure 1, x- and y- axes respectively). For identifying aspects/stages of intrapsychic change (C1 to C8), we use psychological concepts (e.g., establishing basic trust, changes in the client's sense of self, development of mentalisation).

Therapy design and execution are based on a continued weighing of changes in a certain

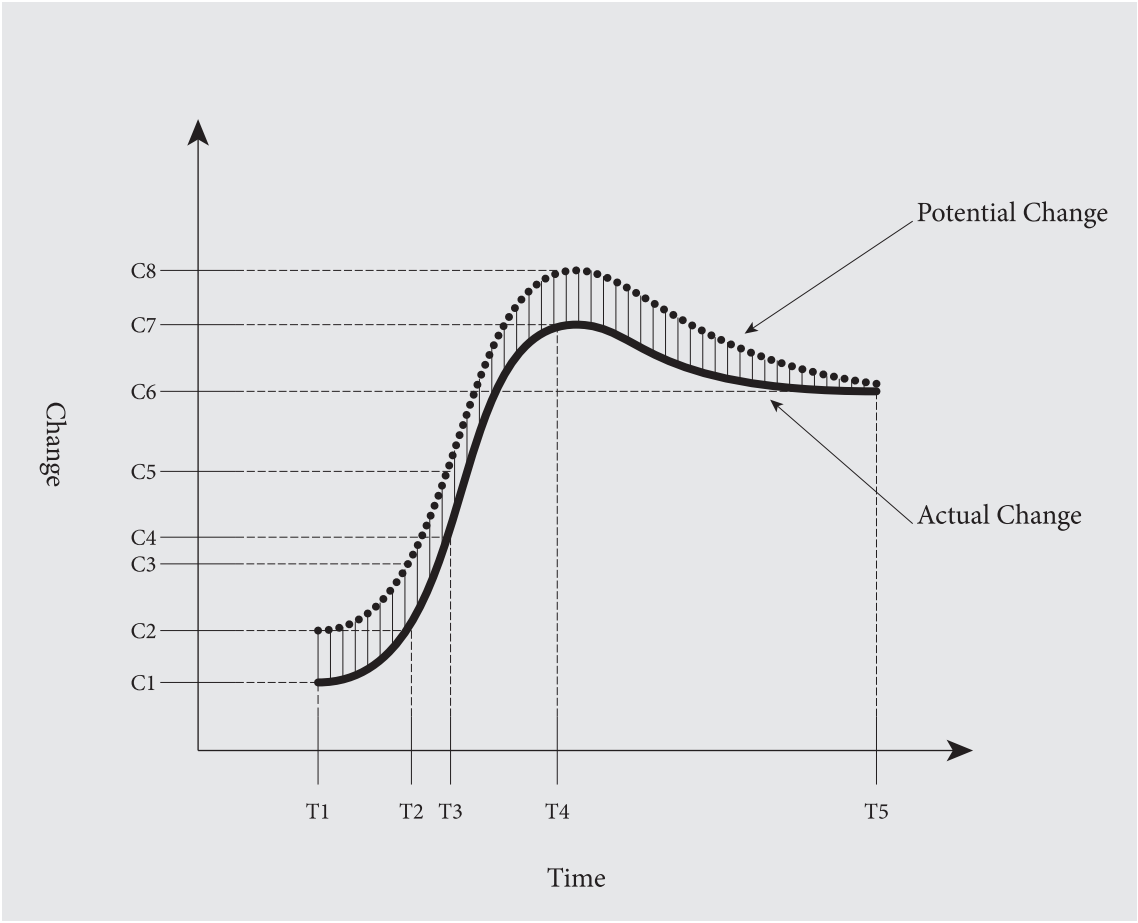

Figure 1: Actual Versus Potential Change

respect (C1 to C8), at many points in time (T1 to T5). This professional weighing entails that we reason about the relation between the client's potential for change (see dotted curve in figure 1) and the client's actual change (soild curve):

The curves for potential and actual change are separated for the following reasons. It is part of our practice to respect the client's freedom and autonomy; this requires that (s) he is entitled to choose how far (s)he will go. We therefore reason essentially from a difference between potential and actual change.

The therapist is in my view accountable for optimising as much as possible the use of the client's potential. The client's potential for change needs to be in principle higher than what is actually achieved; starting therapy from an assumed potential of the client that would be lower than actual change, would mean that the therapist overstresses the client and is therefore practicing in an unethical and unprofessional manner.

The bends of the curves are based on the following. At the start (T1,C1) there already is some change assumed (C1), change connected to the very coming to therapy. Already at this point we might assume more potential than actual change (T1, C2 - see above). In the beginning there is possibly relatively much change (T1 to T4), hence a steep climbing of the solid curve. The dotted curve, however, climbs as much; this is based on the assumption that also the client's potential to change might grow initially, because for instance extended psychological insight for the client might increase his/her potential as well. Usually, after some point change might slow down (after T4). At the end of the process (T5), ideally all potential of the client is actually realised: hence, the soild and dotted curve coming together there. This is of course a very simplified version of a change process. It is in no way intended to be an extensive graph of every therapeutic process. It serves to illustrate my point here.

As I said before, it is specifically the interrelation between actual (solid curve) and potential

change (dotted curve) that is the unique expertise of the psychotherapist. This means that (s)he extrapolates potential, given the process so far (T1 to T5), and evaluates actual change against potential change at each point in time (T1 to T5). Our grounded decision-makinbg is in my view aimed at trying to provide ways for potentional and actuality to converge in the end (T5).

Thus defined, our expertise is not actual change in the client alone (solid curve) as thinking in terms of psychological objectives (including the common factors approach) has it. Nor is it 'just' judgment and prediction of change in the client (dotted curve), as judgement research has it (Tversky/Kahneman, 1974; Garb, 2005; Norman, 2005). It is the area between both curves (shading) as it develops in due process.

Conclusion: The Fundamental Principle of our Expertise

As may be clear by now, I do view psychotherapeutic expertise as a refined weighing, in the consulting room, of potential for, and against the actuality of change. The thorough psychotherapist is able to recognise the client's potential; for the seasoned therapist the potential change is 'manifest' in aspects of the ongoing process, even when there is no specific change observable (yet) in the client's behaviour 'out there'.

Our expert weighing is done through specific handling of working hypotheses. Thus, these working hypotheses are in my view constituents of psychotherapeutic clinical reasoning, and not cognition per se, nor psychological theories: these are input for (and maybe output of) the therapist's thinking. Consequently, we need a deeper understanding of our unique psychotherapeutic clinical reasoning; what we all share is movement of thought, directly related to goings on in the process.

Hence, I hope to have made clear that pluralism is not necessary as a denominator for sophisticated psychotherapy expertise. It is the creative thinking that counts, but in a different way: it is our clinical reasoning that counts, as methodical reasoning, not as creativity per se. I do think that this might be a foundation for the "…designation of psychotherapy as a profession or professional activity…" (Pollard 2009, p 18) that Pollard misses. We need not toss in the towel. We need to explore and describe adequately.

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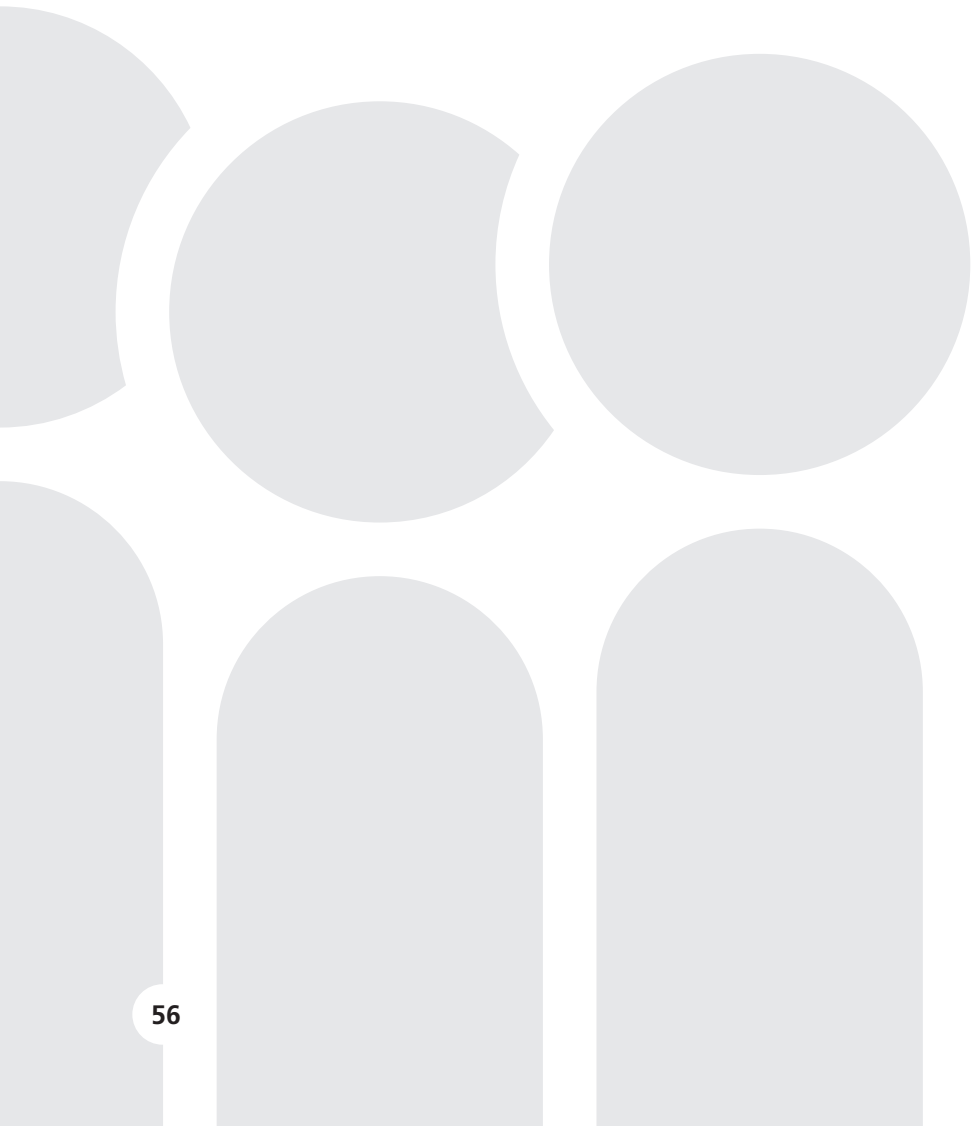

Cheryl Keen

Myself as a Practising Integrative Psychotherapist

Editors' Note

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

Introduction

> *In the wide ocean upon which we venture, the possible ways and direction are many; and the same studies which have served for this work might easily, in other hands, not only receive a wholly different treatment and application, but lead also to essentially different conclusions.*
>
> *(Burckhardt, Civilisation of the Renaissance in Italy, (1860), quoted in Tosh, 1991, p.141).*

As this opening quotation indicates, my model of integration is a reflection of my views at this point in time. For me, an integrative stance means that my model will change. Although I doubt my framework will be "wholly" different in the future, nevertheless I remain open to influences not yet known or fully integrated.

As I discuss in detail below, I start from a basis of existential philosophy (Van Deurzen & Arnold-Baker, 2005; Spinelli, 2005; Yalom 1980), which underpins my belief that psychotherapy is essentially about making meaning and grappling with existential anxieties. My own meaning is derived from relational theories that emphasise how human beings naturally seek relationship, underpinned by the confirming evidence of neuroscience regarding the importance of human relating. Self-concept and dysfunction, in my view, arise directly from relational experience and the individual's inner felt-sense of cohesion. I am drawn particularly to theories on shame and an expanded view of attachment theory which includes the whole of the familial, social and environmental network.

My psychotherapy practice arises out of these beliefs and assumptions. I come from a humanistic position which emphasises empathy and acceptance of the client. I focus on the nature of the relationship between myself and the client, as well as working intersubjectively with transference and countertransference. My problem formulation utilises holistic and dynamic models such as Johnson (1994), Lapworth et al (2001) and Kearns (2005) and my practice draws on a range of techniques and ideas which suit the client in his particular developmental and temperamental need.

Philosophical Roots Underpinning My Integrative Practice

Existential philosophy provides a foundation and guiding principles for my psychotherapeutic work. For me, human beings simply 'are'. There is no great purpose, no God, no external meaning. There is no particular reason for our existence other than we are part of the many life forms which populate our planet. As a species we are no more special or superior than any other, except in our own imagination.

In the absence of any external truth, I believe we make our own meaning. As Viktor Frankl (2004, p.105) says:

> *Man's search for meaning is the primary motivation in his life… This meaning is unique and specific in that it must and can be fulfilled by him alone; only then does it achieve a significance which will satisfy his own will to meaning.*

Psychotherapy, as I see it, is an exercise in making meaning on behalf of the client, in which both of us are engaged.

Psychotherapy is a means for the client to experiment with his meaning, examine his assumptions, beliefs and values. My job, as a therapist, is to support him in this. Mostly I do this by attempting to attune with his world view, attending to him and ensuring that he is heard. However, as another human being in this relationship, I am able to suggest perspectives, be curious and wondering. This I offer to my client as material to use in his journey towards self-insight and meaning. By examining, clarifying and assessing his presently held meaning, the client is offered the opportunity to refine his view and thus embrace growth and change (Spinelli, 2005; Yalom, 1980; Mearns & Cooper, 2005).

Human Beings, Function and Dysfunction

Social Beings and Attachment

We human beings are social animals. I believe we are born ready for connection (Fairbairn, 1952; Mearns & Cooper, 2005) and our sophisticated emotional and cognitive development, as well as our physical survival, relies on other human beings who relate with us. Recent research and thinking is convincing in its emphasis on the importance to healthy psychic development of very early intersubjective experience (Siegel, 1999; Schore, 2003; Stern, 1985; Gerhardt, 2004; Rothschild, 2000).

The infant is usually born into an existing familial and social network and her hard-wiring for relationship is surely toward all those she encounters. From the beginning of life, many babies are held by their fathers. They have early and direct contact with siblings, grandparents, extended family members, friends of the family and child carers. Some relationships – particularly those with the primary caregiver and others in the inner web of relationships – more strongly influence representational processes by reinforcing neuronal patterns associated with these experiences (Siegel, 1999; Schore, 2003). Schore (2003) argues that by eighteen months the infant will have developed a bias toward certain emotional responses shaped by the early care giving relationship. Attachment literature (Goldberg et al, 1995; Bowlby, 1979; Siegel, 1999) goes some way to map the relationship between early intersubjective experience and likely future patterns of relating.

For me, however, the limitation of attachment literature is in its heavy focus on only the primary care-giving relationships. True, for the first few years of life the infant is pretty much stuck with the network that she is born into and her early patterns of relating are being established according to the attachment style of the inner web of significant others. Yet even within this network, the infant is able to develop and maintain a range of attachment styles with different people, thus allowing from an early age for the development of different relational styles (Zimmerman & McDonald, 1995; Zeahan, 1996; Siegel, 1999; McElwain & Volling, 2005; Belsky, 1996; Braungart-Rieker et al, 1999; Volling, 2005). Beyond toddlerhood, as she starts to acquire new experience in the external network of contacts and the environment, she may be able to seek what she needs elsewhere. Kohut (Kohut & Wolf, 1978; Kohut, 1984; Mollon, 2001) argued that a deficit in relation to one dimension of narcissistic development could be compensated for by good enough development along one of the other dimensions.

It seems likely that relationships with various and diverse people, both close and more distant, form the building blocks of the individual's developing sense of self and other. It is this that becomes integrated into the self as 'internal working models' (Bowlby, 1979; Holmes, 1993) of our expectation of how interrelationships will pan out. I believe that self-concept arises from the relationship of our self with those important to us, and that parents, family and

reference groups are "central influences on the developing self-concept" (Spinelli, 2005, p.79). Clearly this process continues throughout life, as the individual acquires a wider personal network than the inner web. A crucial time for development is adolescence (Harter et al, 1997; Gerhardt, 2004; Erikson, 1998) when a second period of brain reorganisation takes place, with what Schore (2003, p.297) calls "extensive re-pruning" of the neuronal pathways.

The implication for my psychotherapy practice is that whilst I may support the client in looking at deficit and misatunement in his relational history, I am also observing and working with other more positive attachment experiences, building the areas of personality strength and success. As the work progresses, the client will introduce me to various aspects of his multi-faceted self. At first, stuck with the pain of the deficient aspects of relating, a client might show only that which is wounded. Other clients, frightened of their pain, or unconscious of it, might reveal only their positive, competent selves until sufficient trust is built to reveal the hurt parts. My integrative model allows for all of these selves to be 'real'. My job is to track the self that is being presented, attune to it in the moment whilst holding in mind those other selves that wait in the wings.

Imagination and Shame

Our capacity for imagination distinguishes human beings as a species and allows us uniquely to contemplate 'being' and existential concerns – death, freedom, isolation and meaninglessness (Spinelli, 2005; Yalom, 1980). Existential anxiety includes ontological insecurity which may be manifested internally – a sense of unrelatedness within – and externally – a sense of unrelatedness with others and objects (Spinelli, 2005; Laing, 1990). I believe we are motivated to create an internal sense of cohesion. Human beings cleverly develop all manner of strategies to prevent fragmentation of the self. We will blame others, internalise the other's badness, dissociate, develop addictions, depression and obsessions, fantasise and forget in order to hold onto the thread of cohesion. When we can no longer do so, I believe we may move into psychosis – the ultimate strategy for carrying the unbearable threat of our fragmentation.

Siegel (1999) and others (Schore, 2003; Gerhardt, 2004) have demonstrated that human development involves a complex interaction between the self and other so that, over time, the individual develops the capacity to know, or at least to imagine, the mind of another. Healthy development occurs when what is imagined is attuned to what is experienced. When there is misattunement, either because we did not get the other right or they did not get us right, we create meaning through internalising the experience (it is my fault that happened) or externalising (it was the other's fault). Either way, a structure is set up to manage the shame of misattunement and failing to be connected emotionally (Siegel, 1999; Erskine, 1994).

I concur with Schore (2003) who proposes that shame first emerges at 14-16 months and is used by caregivers for socialisation. Shame teaches us "how to adapt ourselves to social roles and how to influence others to adapt to us" (Pines, 1990, p.3). To be shamed is to risk being cast out by those we rely on for psychic survival. With shame comes a sense of a rupture in the attachment system, the loss of loving connection and empathic failure (Mollon, 1984). If the other (adult) is able to maintain affective engagement with the infant and reconnect, not much harm is done. However, sustained experiences of being shamed, the caregiver's failure to differentiate between the infant's unacceptable behaviour and the infant's self (Spinelli, 2005), and failure to repair the rupture can lead to the infant's adoption of an inner sense of badness and loss of agency. As Miller (1997, p.84) puts it: "It is not the frustration of his wish that is humiliating to the child, but the contempt shown for his person". In order to remain cohesive therefore, the shame-full child conforms to the misattuned demands of his social network – "the narcissism of the object has prevailed over the narcissism of the subject" (Pines, 1990, p.3).

Function and Dysfunction

My existential (Spinelli, 2005; Yalom, 1980) and intersubjective (Stolorow & Atwood, 1992) principles mean that I prefer to focus on the experiential character of psychological

dysfunction. I remain open on the question of why one person may develop dysfunction whilst another with similar experience may be diagnosed with psychopathic illness or even move into psychosis. I am drawn to Johnson's (1994) character-development theory as a theoretical model. He sees personality and dysfunction developing out of the complex interaction of the expression of instinctual need, how that need is met or frustrated by others and how the individual responds to that frustration. The individual's response is dependent on her structural capacity at her current level of development, or maturity. Johnson (1994) and others (Sieff, 2006; Herman, 2001) point out that a child has limited capacity and options to develop strategies to deal with frustrations. The strategies that are developed early on, and those that are developed in response to relational deficit, "tend to become rigid and resistant to change" (Johnson, 1994, p.4).

Therefore I locate dysfunction within the individual's relational experience. When a person encounters difficulty in her web of relationships it is likely that her capacity to relate becomes disrupted and she will develop strategies to continue to function in the world (Mearns & Cooper, 2005). Such strategies might include projecting the unbearable feelings into another, splitting them off into the unconscious to make them manageable, developing compulsions in an attempt to control anxiety, developing addictions to either allow the experience of the pain or to avoid it.

Dysfunction is also a manifestation of a sense of internal unrelatedness. Mearns and Cooper (2005) distinguish an 'I – I' mode of relating which emphasises internal empathic and affirming communication. This form of relating allows for the emergence and impact of unknown parts of the self. The 'I – Me' mode of relating, on the other hand, is objectified and critical. There is a wish to disown this part of the self. It is characterised by low self worth, a high level of internal conflict and subjugated or disowned ways of being, which constantly demand repatriation but have no way of communicating with the more adult self.

From clinical experience I observe that clients with the most entrenched psychological problems have not only experienced severe and/or prolonged deficit in their early attachment experiences, but also found no-one in the network, early or later, who provided a different sort of relational experience. No grandmother to find twinship with, no teacher to be grandiose with, no friend to be affectionate with. In addition, these are the clients that often internalised the fault for this deficit to be their own. Rigid strategies to deal with the deficit get laid down early on. The strategies are reinforced by there being no alternative experience. They are further reinforced because the individual's behaviours, which develop as a result of the strategies, make them a 'more difficult' human being to relate to. The child internalises the fault for this to be his own. So, the child who has experienced (say) critical parenting develops grandiose, narcissistic behaviours as a strategy to defend against the message that he is fundamentally flawed. The family rejects that type of behaviour as being 'not like us'. In school he's regarded as a show-off and attention seeker. He is shamed for his exuberance. And so the cycle continues (Wachtel & McKinney, 1992).

For some clients, the extent of the relational deficit can be regarded as relational trauma. This includes specific traumatic experience, such as sexual, verbal or physical abuse as well as chronic relational injury. Kalsched (1996) describes a process by which the child develops mechanisms to cope not only with the traumatic experience itself, but also the failure of care that went alongside it. He argues that a defensive splitting occurs whereby the child's creative, relational, 'core' self goes into hiding deep in the unconscious and is protected by a rigid, psychological defence system. In turn, this protector system becomes self-traumatising, a defence against self-expression in case of further wounding. It is an understandable, sophisticated system designed to protect, but, I believe, at great internal and developmental cost.

For the traumatised child, basic feelings of trust and safety may never develop leaving the client believing that she cannot "be herself" in relation to others. Indeed she may lose any sense of self at all. The experience of being harmed by the very people expected to care for her leaves the client fluctuating between yearning for care and dependency and dread of intimacy (Herman, 2001).

My Practice of Psychotherapy

In this section I discuss how I believe psychotherapy works, how change comes about and give a flavour of how I practice. I see psychotherapy as falling into overlapping stages, with the work and the therapeutic relationship developing as therapy progresses, and hope to give a sense of this in the sections that follow.

Growth and Change

Clients enter therapy with a combination of awareness that there is something 'wrong' and with hope that things could be different. I believe that things become different as the client uses psychotherapy over time to develop meaning of his experience which he can then integrate into himself. Gradually this provides him with a narrative about himself and his life – how he came to be where he is and where he might like to go next. Self awareness and self acceptance is my focus in the early stages of therapy. The gestalt concept of the paradoxical theory of change appeals to me which suggests that growth and change occur naturally as a result of the self-awareness that comes from immersion in all aspects of our experience (Joyce & Sills, 2001).

I find it useful to remind myself that, in a typical year, I will spend about forty hours working with a client. It is in his life 'out there' – the other 5000 or more waking hours – that learning and insight mainly takes place. Tallman and Bohart (1999) remind us of the central importance of the client's role in the outcomes of therapy and his capacity for self-healing. As I discuss below, this capacity is enhanced and encouraged through the experience of being in relationship with a therapist who is largely attuned, empathic and non-judgemental and, when this is not the case, is willing to recognise and repair rupture. A relationship that is reparative, but not regressive.

My Part in the Process

I enter the relationship with the intention to be non-judgemental, empathic and genuine. From the therapeutic relationship the client has the experience of being listened to fully. My understanding of the client's world develops over time, moving from knowledge of the 'content' of the client's life to knowing more about his internal processing. I strive to stand beside my client, wholly on his side. I seek to understand what the client needs our relationship to be – reparative, twinship, advocacy, empathically attending to narcissistic needs and so on. Lynne Jacobs (1991, pp.8-9) captures the importance of the therapist attending to what is needed at particular points in the development of the relationship:

> *"If the therapist can provide the ground by being available for various kinds of 'meeting' as new developmental sequences emerge, then the fullbodied turning-toward-the-other will emerge … For one's presence to be part of what heals the other, it must be delicately balanced against the patient's readiness to encounter an 'other'…We also come to understand what kind of otherness the patient seeks. We can adapt our presence to be relevant to the patient's emergent developmental needs".*

Intersubjectivity, Transference and Countertransference

I work from an intersubjective perspective, believing that each of us influences the other simultaneously, leading to insight, understanding and changes in both the client and myself (Orange et al., 2008; DeYoung, 2003; Beebe & Lachman, 1998; Gerson, 2004). The intersubjective expansion of consciousness that occurs in therapy is built not only from verbal exchanges but also, and very importantly, from shifts in tone, bodily posture and non-verbal communication (Beebe & Lachman, 1998). Much of it is out of immediate awareness and usually I can only process what has been created outside of the session.

Although I hold an intersubjective stance, I do not regard the therapeutic relationship as mutually dialogic, but rather as one of "one-sided inclusion" (Jacobs L., 1991, p.5). As therapist, I am there to do a job: to be in service of the client and to be used by the client. It is part of my job to be curious about the relationship between us. I am attentive to all of the feelings aroused in me by the client, viewing them as an attempt to tell me something of

his story (Miller, 1997). My processing of this in supervision contributes to the therapy.

Transference clearly operates within the psychotherapy relationship, as it does in everyday interactions with others (Andersen & Berk, 1998). Because of the way we encode and retrieve memory, and utilise the ensuing mental models, we filter our interactions with others through the lens of patterns of past experiences (Siegel, 1999). Since the process of transference is natural, inevitably both client and therapist bring it into therapy. I believe that appropriate use of transference within the therapeutic relationship can enrich the client's experience. Patterns of behaviour in relationships might be revealed, which then informs the client's self-insight. Working with the transference, I might unconsciously offer a new type of response, in which the client finds a reparative experience (Casement, 1990; Mollon, 2001). This, together with revealing past patterns, can increase the client's emotional insight. It has been shown by Gelso et al (1997) that a high level of transference combined with a high level of client self-insight leads to positive outcomes in therapy. Likewise, I might work to "confront and unhook" (Lapworth et al, 2001, p.102) the transference in order to broaden the client's options and introduce new experiences. On the basis of the client's developmental need, I may work either within the transference (ie. the developmentally needed relationship) or on the transference in the 'real' relationship (Clarkson, 1990, 1995).

However, I am cautious neither to over-interpret nor over-use transference. There is a danger of the 'real' relationship between the client and myself being missed in favour of a convoluted interpretation of links with earlier, less satisfactory relationships (Arachtingi & Lichtenberg, 1998). Casement (1985) reminds us that the client could become irritated by all of his material being constantly related back to the therapist. I believe that transference interpretations should be straightforward and of certain therapeutic value before being used overtly with the client.

Countertransference gives invaluable insight into the client's unconscious communication. By tracking my countertransferential responses, I come to a deeper understanding of the client's patterns of relationships with significant others (Jacobs M., 1999; Casement, 1985, 1990) Like Kearns (2005) I think about countertransference operating in two ways. First is the process, which happens at a deeply unconscious level, by which the client induces me to know what it is like to be him, by subjecting me to his early experience. Second, the client may induce in me the feelings and responses of a significant other, by projecting this individual onto me. By effective use of supervision to work through what responses are from my own experience and what do not seem to belong to me, I can come to a greater understanding of what the client is trying to tell me.

The Working Alliance

Creating a working alliance early on is key. This is the collaborative engagement of therapist and client in the therapeutic endeavour, identified as a key ingredient in a therapeutic positive outcome (Bachelor & Hovarth, 1999; Hovarth & Greenberg, 1995). In the early stages of therapy the client has to be convinced of my genuine commitment to helping which I convey by taking the client seriously and holding therapeutic boundaries. Later, the working alliance supports the continuation of therapy, especially when it has become difficult and the client perhaps feels he no longer wishes to continue (Clarkson, 1990). By this time, the client has also engaged fully in the working alliance and is able to use me in the joint endeavour.

Rupture and Repair

Inevitably there will be ruptures in the therapeutic relationship (Kohut & Wolf, 1978; Gerson, 2004; Chused, 2003). Some of these will be slight misatunements, which, if infrequent, might be withstood by the client. However, repeatedly missing a client, particularly in ways that re-activate earlier relational deficit, can create rupture and enactment in the relationship which becomes the focus of the therapeutic endeavour.

Rupture can occur as a result of my faulty relating – making a mistake, going too fast, offering an unwanted interpretation, missing a

cue and so on – all aspects of being misatuned in that moment. However, transferentially I may be induced by the client into a particular stance – the client trying to show me something of what it is like to be him (Chused, 2003). As Messler Davies (2002) describes, in the most difficult of enactments the client may be projecting his sense of inner badness onto me whilst I, because of my own history, am defending against it in order to maintain my own sense of cohesion.

I scan the therapeutic environment for signs of rupture and will become aware of such when tuning into what Chused (2003) calls the "internal 'oops'". As a number of practitioners have argued (Aron, 2003; Chused, 2003; Gerson 2004), ruptures can be a rich source for therapeutic insight, particularly in the middle and later stages of therapy when the client really starts to use our relationship in the work:

> *"the therapist's sensitivity to the ups and downs of the relationship and her or his ability to attend to relational stressors could directly influence the client's willingness to confront their own dysfunctional relational patterns, as well as increase their confidence in asserting their psychological needs within a relational context" (Bachelor & Hovarth, 1999, p.151).*

If ruptures are caught, my own part accepted, the experience overtly worked through and the client's reality honoured I believe that the shame associated with rupture can be averted. As I have become more robust as a therapist, I have learned to risk being more authentic with the self-disclosure demanded to repair rupture. Therapeutically repairing rupture can keep open the possibility of relationship.

Diagnostic Tools

I am wary of labelling, and of attaching rigid diagnostic formulations to my clients. I believe individuals are too complex, and how they have arrived at where they are to be so unique, as to defy categorisation. I am wary too about the use of labelling becoming pejorative – 'borderline', 'narcissistic', 'highly defended' can carry a tone of judgement (Miller, 1997).

Yet the expertise, observations and research of the many practitioners in the field have mapped 'typical' characteristics of personality styles and disorders of the self. My clinical experience tells me that clients with similar backgrounds and relational experience will present in a similar way. So I use Johnson (1994) and Kearns (2005) particularly to signpost ways of thinking about my clients on the basis of how they present. This 'getting the general direction' provides suggestions on how I might work with a particular client.

Johnson's model fits with my integrative framework because whilst it provides a set of sign-posts which point to the likely characteristics of a person who has experienced a particular type of environmental frustration, it is not a linear or causal model. Johnson allows for a multi-dimensional understanding of the client which fits with my belief that the client's broad, lifelong experience will have led to the development of multi-faceted selves which operate at different levels of functioning under different circumstances.

I take a holistic view of the client and find Lapworth et al's (2001) framework useful, after a few sessions, in providing a structure to think about the interplay between what is enacted within the therapy space and the client's world outside, the links between present experience and affect and relational patterns built up in the past, together with my own observations of the client and information about her social context.

Kearns (2005) has developed a useful map based on an integration of the object relations categorisations of narcissistic, borderline and schizoid with DSM personality disorder categories. She tracks these categories in terms of the existential issues preoccupying the individual, his relational (or 'contact') style and the therapist's typical countertransferential responses. I find this particularly useful as therapy gets past the initial stages in helping me to use my countertransferential responses to flag up possible personality categorisations.

Finally, I use the DSM-IV (2000) as a reference to contextualise the client and to check out my initial theories and considerations. For instance I might consider whether a client is showing signs of a clinical disorder (Axis I) and requires onward referral. I find Axis II useful for thinking about whether the

client is presenting personality traits and characteristics or is sufficient to be considered a disorder of the self. Again, in such a case I might consider onward referral or consider the level of support I require from supervision.

Techniques

Whilst I hold to an integrative framework in terms of my understanding of clients and problem formulation, I tend to be more eclectic in my choice of techniques when working with clients. Underlying all of my clinical work is the belief that change comes about through the client-therapist relationship and the client's self-agency. However, there are ways of working I favour. The choice of technique depends to a great extent on the client's own temperament and personality style, the 'door to therapy' (Ware, 1983) that seems appropriate and the stage of the therapeutic journey.

I view psychotherapy as a developmental process and part of that is encouraging the client to develop his internal empathy. A useful technique for this is the development of the concept of the "compassionate mind" (Gilbert, 2007). This is achieved first by modelling compassionate and empathic responses towards the client and gradually encouraging him to internalise such responses. As Kalsched remarked (Sieff, 2006, p.9)

> *"This vital shift [towards a place where we take responsibility for our own pain] is only possible if we are able to look at ourselves with deep compassion and forgiveness, realising that our collusion with the self-traumatising system was the only way that we could ensure our psychological survival and the only way we could protect the animating spark of life at our core".*

For some clients, 'talking therapy' can be very difficult, particularly if their developmental deficit was pre-verbal. In this case I encourage the use of objects – particularly stones and shells – to help the client express his emotional experience. Clients occasionally need to shift away for a while from self-insight work to 'just do something' that will explicitly help functioning in the external world. In such a case I might introduce cognitive behavioural techniques, whilst not losing sight of the importance of our relating in the work.

As a therapist I am a keen observer, believing that much unconscious process is revealed in body language, seemingly innocuous stories and events. I pay attention to pre-transferential issues as potentially indicating something about the client's being in the world. I note the way in which the client comes into the room and particularly to the first words in the session. Often this provides the theme of the session, and the content that I track. I do not ask many questions, preferring to observe how and when the various characters that populate the client's life are introduced into the space, and to wonder about what is being revealed about self and other regulation.

As therapy progresses I move into a more overt phenomenological method, relating the client's material explicitly to the here and now experience in the room. Many clients are indirect in their messages to me, so I might wonder aloud whether the theme of their content today is something also about our relationship. My supervisor often reminds me that the work is 'nothing about me and all about me' at the same time.

Once trust has been established I might also decide to self-disclose, if I am sure that it is in the interests of the client and is not likely to damage the relationship. So, I might share a physical or emotional feeling that I had in response to something that was said, or my perception of the quality of a silence. I am always careful to relate to the client that my response could be just my own, and have nothing to do with him, but most times it provides a catalyst for further exploration.

Concluding Remarks

Two interrelated threads run through my integrative framework - relationship and the wish to create meaning. I hypothesise it is relationship that we seek from birth and which carves our sense of self with others and objects, and with our inner self. It is deficit in relationship that creates dysfunction and forms the basis of most psychotherapy. Throughout life we are making meaning through our

experience of relationship. It is relationship between the client and myself that enables the creation of new meaning and learning.

My hope is that my client goes away from therapy with a knowledge, if not an acceptance, that there are alternatives to old patterns of believing, functioning and relating which sustain the original hurt. Resistance to change may remain strong, but the edges of the rigid old patterns will have been softened. I am not convinced that old patterns are ever eradicated completely. In times of distress, I believe we go back to them, but as a result of growth in therapy that catapulting back is less frequent, less automatic and we stay in the old pattern for a shorter time.

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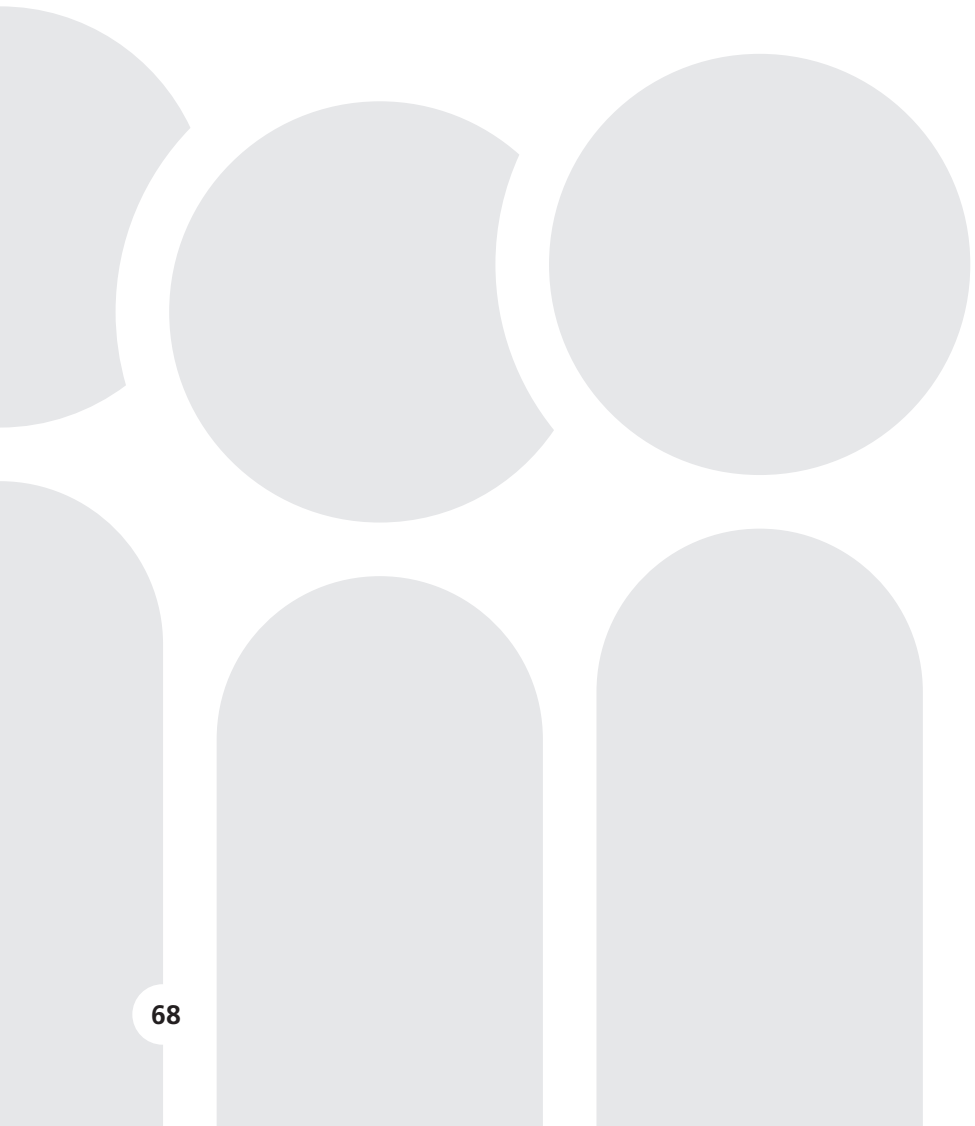

Book review by Professor Simon du Plock

Review of Relational-centred Research for Psychotherapists. Exploring meanings and experience. (2009) Wiley-Blackwell

by Dr Linda Finlay (Editor), Ken Evans (Editor)
Publisher: Wiley-Blackwell

I am grateful for the invitation to write a review of Relational-centred Research for Psychotherapists because it gives me the opportunity to expand upon my really very brief recommendation on the back cover of the book. It is always a little flattering when an author asks you to contribute a few words in this way, but in this case I was delighted to agree because I found the manuscript managed to strike that rather challenging balance of being not only theoretically rigorous and intellectually stimulating, but also an accessible and practical companion to research for the growing audience of practitioner-researchers. This is a breath of fresh air in a field where there is a premium on truly user-friendly texts. As I wrote in my recommendation:

'This book is essential reading for seasoned and novice researchers alike; Finlay and Evans put relational-centred research on the map and offer a much-needed bridge across the gulf between academic theory/research and clinical practice'.

Leading a research-based doctorate in psychotherapy, I am frequently made aware of the paucity of non-reductive but accessible and appealing texts designed to assist students and candidates to undertake rigorous qualitative research congruent with their existing expertise. All too often books on setting up and conducting research are written in a 'top-down' style which fails to capitalize on the knowledge and insights of therapy professionals. We can probably all remember, too, investing in books which promised to equip us with research skills, but which failed in reality to demystify the topic and even left us feeling deskilled. With a handful of honourable exceptions, (recent texts by Paul Barber, Kim Etherington, Darren Langridge and John MacCloud spring to mind), offerings on research methodology set out to instruct the practitioner in one or a range of approaches. This can lead to a sense of disconnection between their individual focus of inquiry for the practitioner, and, at its worst, encourages practitioners to use a methodology with relatively little sense of enthusiasm or ownership. In my work as an external examiner I have noticed, as an example of this, that a high proportion of counselling and clinical doctorate students use Jonathan Smith's Interpretive Phenomenological Analysis (IPA) simply because it offers a relatively clear step-by-step route. In some respects it may be that the lack of confidence which this evidences is due to the twin factors of the professionalisation of psychotherapy, and growing demand for evidence-based practice – both of which have meant that trainees, recent graduates and seasoned practitioners all find themselves engaged in reading, thinking about, and undertaking research to a degree previously unforeseen.

In contrast, it is refeshing to find in the work of Finlay and Evans, two well-respected humanistic practitioners, a more holistic philosophy which invites therapists to accompany them on a journey of exploration. This journey has, as its guiding principle, an appreciation of relational dimensions between researcher, participants, and their wider social fields. In this, they are informed throughout by the values of humanistic therapy, and this serves them well since it leads them to remain focussed throughout on the needs of their readers. Because of this the reader feels that the book speaks directly to them, and recognizes the value and validity in their special position as therapists undertaking research. The result is a text which emerges from the needs of practitioner-researchers. At no stage does the reader feel that this text is The text is written in a remarkably clear language, and adopts a pragmatic style which reminds readers that they are already, as therapists, exponents of a range of skills, attitudes and insights which can be transferred to the research domain. Finlay and Evans say they hope to impart their own commitment, passion and enthusiasm for qualitiative relational-centred research, and I believe that they have succeeded in this. They suggest that qualitative research can be seen as a 'voyage of discovery', and that qualitative methodologies provide maps and guides for a number of different routes. The book is structured as three sections. In the first Finlay and Evans give a rationale for qualitative relational-centred research and make a convincing case for its validity and relevance to therapist researchers. It quickly becomes evident that an approach which foregrounds the relational-dialogic context and the need for reflexivity fits remarkably well with both the skills and needs of humanistic therapists. They provide a map contextualising relational-centred research within competing qualititive research traditions. Each of the five chapters in this section contains helpful research vignettes. This hands-on approach continues in the second section, where they take the reader through what they aptly term the 'being and doing' of relational research – once again with numerous clear practical examples.

In the third and final section, individual chapters by Virginia Eatough, Darren Langridge, Anna Madhill and Susan Morrow follow this notion of voyaging, and describe a number of possible routes the researcher might take. Their accounts of using relational work across a range of methodologies are useful for the way they show how relational-centred research, foregrounding as it does the relational aspects of the research enterprise, can generate rich and compelling findings.

I would have found a concluding chapter useful to draw the themes of the book together; as it stands the third section feels rather brief and as though it is not as coherently woven into the text as it might have been. This section does not, perhaps, make so strong a case as it might for what is explicitly relational in each piece of research. Eatough, in her study of the lived experience of anger, provides, as she says, 'a flavour of how a hermeneutic phenomenological approach such as IPA engages research as a human science endeavour'. It is clear that she goes beyond the 'how-to-do IPA' guidelines, but I was left wondering whether this alone is sufficient to enable other researchers to be similarly reflexive. I found Langdridge's chapter on Critical Narrative Analysis more helpful, perhaps because it includes a critique of IPA. These, though, are relatively minor quibbles which do not detract from the significance of this book for practitioner researchers, and I would recommend it to any therapist wishing to embark on meaningful practice-based research.

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