Volume 1, Issue 2

The British Journal Of Psychotherapy Integration

Integration: The Exploration Continues

Introduction

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

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Submissions

Future volumes of this journal will be on theme issues based in an integrative perspective. Two members of the editorial board will act as co-editors with the support of the two consulting editors. If you are interested in a particular theme, please contact the consulting editors and discuss your interest with them.

Editorial structure

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Editorial

Different Understandings Of The integrative Project: The Exploration Continues

We welcome our increasing number of readers to this second issue of The British Journal of Psychotherapy Integration. From the informal responses to the first issue of the journal, it is clear to us that many people would welcome an opportunity for an integrative discourse in reference to the ideas presented in this journal. We, therefore, want to experiment with inviting our readers to contribute brief written responses to the articles in the form of letters to the editors. We will publish these as and when space allows, in the next edition if possible. (E-mail letter to maria@fluffy.dircon.co.uk).

Contents of Volume 1, Issue 2

Jane Speedy has offered a very personal account of the narrative metaphor as a basis for psychotherapy integration. Her article is an interesting combination of relevant theoretical concepts which she links to her integrative clinical practice. The vividness of her clinical examples conveys a narrative sense at the heart of her Integrative framework.

Maggie Senior gives us an insight into her own particular understanding of the challenge of working with clients presenting with dissociative symptoms. Maggie provides a good overview of current thinking in the area of dissociative disorders of the self. She weaves together these different theoretical strands which she grounds in an experience-near manner in her clinical vignettes.

Pauline Rennie-Peyton has drawn on the wealth of her experience of working with the victims and the perpretators of bullying in the workplace. She provides the practising clinician with a way of approaching these dilemmas as they arise in the workplace. She has chosen to focus her discussion on bullying in the workplace, as this is an area in which she has extensive experience, but clearly these are transferable ideas.

Werner Prall has, as promised in Volume 1, Issue 1, provided a clinical case example that exemplifies his approach to integrative practice. He gives a comprehensive analysis of his work with a client over time showing how he uses his integrative understanding to both make sense of the client-psychotherapist experience and to illustrate his choice of response.

Harbrinder Dhillon-Stevens has supplied us with a scholarly account of her own 'multiple oppression model' of anti-oppressive practice. Her paper is firmly based in the relevant literature, her own research, her personal background and her clinical experience. Harbrinder challenges us as practitioners to think about issues that are often uncomfortable or avoided altogether.

In line with our commitment to include a student's written submission for their qualification, we have Morit Heitzler's account of her integrative approach to psychotherapy which has been edited and shortened for the purposes of this publication.

Finally, we include in this issue two book reviews. We intend to continue with this, and invite our readers to send us copies of their own books or those of their colleagues which they believe will be of interest to our readers. (Send copies to The Journal Editors, P.O.Box 2512, Ealing, London W5 2QG).

Maria Gilbert and **Katherine Murphy**
Consulting editors and co-editors
of volume one.

Jane Speedy

Stepping Into The Space: The Narrative Metaphor As An Invitation Towards Therapy Integration

Abstract

This paper situates narrative therapy practice alongside other 'post-psychological' therapeutic traditions and invites readers to consider the ways in which the narrative metaphor invites them into 'the space between stories' in therapeutic conversations. It offers a brief overview of narrative practice and considers the ways in which certain elements of this approach, such as the position of the therapist as co-researcher, the transparency of consultation processes, the use of re-membering conversations, outsider witness practices and therapeutic documents might sustain the integration of therapy into everyday lives.

Introduction

The stories I want to tell you will light up part of my life and leave the rest in darkness. You don't need to know everything. There is no everything. The stories themselves make the meaning. The continuous narrative of existence is a lie. There is no continuous narrative, there are lit up moments and the rest is dark (Winterson, 2004:134).

I am sitting at the kitchen table constructing myself as a writer, an identity claim that is not entirely privileged in this context. The kitchen windows are casting a pool of light into the fern-fringed darkness of the garden beyond. There is a large dog at my feet and in the next room; door ajar, my twelve-year-old daughter is watching 'Bend it like Beckham' on a flickering television screen in the half-light of the living room. It is nearly suppertime. Under the pretext of spending time 'in the kitchen', I have begun to write this paper. A multitude of alternative identity claims (dog walker, parent, partner and meal provider to name but a few) are tugging away at the edges of my mind's eye and disrupting my focus and sense of purpose. This space will be short lived. This 'lit up' moment will soon retreat back into the darkness. This opening paragraph is being fitted in 'in-between' and will soon unravel between my fingers as other threads of my life encroach and tighten their grip.

This is one of the ways that I may begin to write this piece. I may well come up with others and, indeed, as we speak, there are at least seven moments that I might 'light up', seven perfectly acceptable alternatives, absent but implicit in the current text, scrunched up on the floor. Not to mention the myriad versions that are becoming apparent to you, the readers, as you are re-telling these stories to yourselves within the conversational space that is opening up between us. (I am also forming a picture of you, the critical, questioning readers of this new journal, scanning the pages, looking for places to belong and the spaces to engage in conversation and debate).

Returning to my paper, I imagine your curious, critical questions about this 'storied world' that I inhabit and am attempting to describe. If I could begin anywhere, why not choose

somewhere a little more esoteric than my kitchen table? Is there some purpose? Have these beginnings been constructed by chance associations in the 'mind's eyes' of tellers and audiences? Might they be changed at random at any given moment? How will we know which stories and identities are 'authentic'? Where is all this leading? In what ways has this domestic detail concerning (for example) the writer's kitchen table got anything whatsoever to do with therapy integration?

Perhaps some of these questions can be answered by taking a quick metaphorical scan inside this my mind's eye as the story unfolds. If this story was represented by a thin line travelling across a slice of my 'mind's eye', there might be clear signs of agency, of my making choices about the stories that I prefer from those that are culturally and personally available to me.

I was, for example, drinking a glass of Chianti as I was writing, but I did not mention that, lest it demonstrate a lack of gravitas on my part. I also chose not to include any mention of my partner who was upstairs filling in her tax returns at the time. Does the gender of the partner, I wonder, trouble the original image of the daughter or of the author or re-design the kitchen in the eye of the reader? (Several readers of earlier drafts of this paper, for instance, perceived a fall in house prices and a shift from rural 'Aga saga' to urban Victoriana, in tandem with the onset of the partner's gender).

A great deal of open space is also evident in this quick mind's eye excavation. Space that perhaps sustains many possible ways of linking the traces and fragments and aspects of stories that have not yet been told, may never be told, or are unsayable and unavailable for the telling. It is the liminal or 'threshold' space that particularly interests me as a narrative therapist. This space is the integrative 'substance' of this paper. This is the space that I am inviting us all to step into. It is a space that is very familiar within a more 'literary genre', as Pullman (2003: i) eloquently demonstrates in the frontispiece of 'Lyra's story':

"This... contains a story and several other things. The other things might be connected with the story, or they might not; they might be connected to stories that haven't appeared yet. It's not easy to tell. It's easy to imagine how they might have turned up though. The world is full of things like that: old post cards, theatre programmes, leaflets about bomb-proofing your cellar, greetings cards, photograph albums, holiday brochures, instruction booklets for machine tools, maps... All these tattered old bits and pieces have a history and a meaning. A group of them together can seem like traces..."

Thus, I hope, by way of introduction, to have described some of the key ideas that sustain narrative therapy practice, specifically the notion that human identity is a social achievement, contingent on audience, culture, history, memory and agency (that which is available to us and what we make of all this at any one moment), and that the stories we tell ourselves and each other in our day to day lives and in therapeutic exchanges both constitute and are constitutive of our lives. I do not have time to do justice in this paper, other than in passing, to the burgeoning literatures of the narrative therapies, but if aspects of this paper capture your imagination, I recommend White and Epston, 1991; Freeman and Combs, 1996; Monk, et al, 1997; Morgan, 2000; Payne, 2000; Bird, 2000, 2004; Carey and Russell, 2004; and Speedy, 2000, 2000a, as good introductory texts.

Situating the narrative therapies

To give a quick and incomplete overview, narrative therapists are perhaps the most well known contingent amongst a burgeoning new wave of discursive, relational or 'post-psychological' therapists. As such, they are interested in how people have come to make unique sense of their lives and of how people make and remake sense of this experience through the construction of narratives: that is to say,through the unfolding of sequences of events, through time, to form a plot. Narrative practitioners are perpetually curious about the kinds of stories that people tell: the habitual well-rehearsed personal stories, the dominant discourses of the day, the myriad opportunities for more local discourses and the continuous possibility of alternative or preferred stories.

They are not in the somewhat grander business of 'reframing' people's life stories (replacing one story with another). They are interested in thickening people's descriptions so that lives become multi- rather than single- storied texts and in noticing the spaces that open up between the stories. These open spaces, in turn, might yield yet more stories and lend yet more shape to people's lives.

These narrative practices have a post-modern, post-psychological flavour and are sustained, to some extent, by post-structuralist thinkers and literary theorists such as Foucault (1980) and Derrida (1978 and 1981). These practices privilege post-colonial, anthropological, cultural, historical, sociological, literary and philosophical theories every bit as much as psychological and psychotherapeutic understandings. At the same time, these ideas are not new and have many linguistic and literary antecedents within the 'folk' (Bruner 2000) or 'intentional state' psychologies (White 2004) that preceded modern 'psychologised' times. These are age-old traditions, as Pinkola-Estes (1993:I), a Mexican-American 'cantadora' or traditional storyteller, points out:

"Among my people, questions are often answered with stories. The first story almost always evokes another, which summons another, until the answer to the question has become several stories long. A sequence of tales is thought to offer broader and deeper insight than a single story alone."

Narrative practice as 'therapy integration'

This paper is not primarily an introduction to the narrative therapies, but rather, is an exploration of narrative practices as a form of 'therapy integration'. That is to say, the integration of therapy into the everyday lives of therapists and of the people who consult them. The narrative metaphor can, of course, become both descriptive and integrative of the diversity of stories that we tell ourselves as therapists about the work that we do. There have been some interesting 'post-psychological' critiques of the traditional discourses of therapy and their support for the 'cult of the individual' within advanced western capitalist societies (see; McLeod, 1999; Cushman, 1996). There is also a growing trend towards constructing narrative ideas not as 'local' metaphors or invitations, but as 'grand' integrating therapeutic frameworks. Angus and McLeod (2004: 373) for instance, believe the concept of narrative to be "so fundamental to human psychological and social life, [that it] carries with it such a rich set of meanings, that it provides a genuine meeting point between theoretical schools of therapy that have previously stood apart from each other". I am wary of 'fundamental' claims, particularly those currently made by the west for the rest of the world. There are some powerful commentaries on these claims. Speaking for indigenous and colonised peoples, for instance, Linda Tuhiwai-Smith (1999:1) comments:

"It galls us that Western researchers and intellectuals can assume to know all that it is possible to know of us. It appals us that the west can desire, extract and claim ownership of our ways of knowing".

I would want to make more modest claims for narrative therapy practice as an uncertain, more locally generated practice. A practice that is context-dependent; integrates literary, philosophical, anthropological, cultural and political ideas within therapeutic domains and that privileges 'living experience' and local knowledge over expert interpretations or professional expertise. I am engaged with this practice as a way of integrating 'therapy' into everyday life. I am also interested in therapy integration in terms of identifying, reinforcing celebrating and re-membering the therapeutic relationships (with people, animals, landscapes, artefacts, etc) that are available, or might become available, in people's day-to-day lives.

For Alice Morgan (2002) the most striking feature of narrative therapy practices when she first encountered it was the position taken up by the therapist. This de-centred, influential position placed neither the 'client', nor the therapist's 'expertise', nor the 'therapeutic relationship' centrally. It placed the therapist alongside the person consulting them. The focus of their endeavour was not the person, but rather the issue or concern that they were co-researching in that moment, together with

their relationship with that issue over time. I am most struck by the reciprocity of this positioning and by the mutual climate of curiosity and engagement. This positioning (see: Davies and Harré, 1990, on the 'discursive production of 'selves') situates them both as curious co-researchers and allows therapist and client alike to question and re-search the problems, issues or concerns that have been brought. It also invites therapist and client alike into:

"stretch[ing] their minds and imagination; think[ing] beyond what they would otherwise be thinking; connect[ing] with their histories in new ways and rais[ing] possibilities for action in the world that would not otherwise have occurred to them" (White, 2004:55).

Taking up this position of collaborative investigator, supporting people in interrogating and excavating life's puzzling or troubling aspects is quite significantly 'other' than the positions held in many therapeutic traditions and stances and might be seen as a means of 'integrating' the skill and knowledge of both participants in the conversation into the business of 'doing therapy'. The use of the term 'co-researcher' was first coined by David Epston, in relation to narrative practice and speaks to the mutual development of 'ethnographic imagination' on the part of therapists and people consulting them (see; Epston, 2001, 2004).

One of my own clients, reflecting back on her experiences of narrative therapy practice and comparing these with her (extensive) familiarity with other traditions, commented that narrative therapy was very different from 'proper' therapy. She went on to describe us as:

"Detectives!! It was more like I had hired myself a private detective. No, that's not quite right. It was more like we were detectives together in the CID, on the trail, looking for clues, partners on the trail. So that's the image, quite fast moving, not messing about, both researching issues in my life. I had the 'local archive' as you put it, but you had more questions. No, more practice at asking interesting questions, and the archives of other people's experience to draw on, even other people to e-mail or bring along (Gina, quoted in Speedy, et al, 2004).

Integrating everyday life and 'local' knowledge into therapeutic conversations (and vice-versa)

The discourses of therapy and of 'professional expertise' generate power relations that can sometimes mitigate against our clients fully appreciating their own agency. Given the space to step into and tell their stories, clients frequently come up with all kinds of ideas that they wouldn't have expected to come up with. This doesn't necessarily mean that such stories will be sustained, or will make a difference outside the therapeutic domain. One way of ensuring that the narratives that have been shaped over the course of the client's life and experiences or in co-research conversations are not attributed to the 'insight' of the therapist is to make the 'social construction' of professional knowledge as transparent as possible. Constructing therapy as co-research does not prevent the co-researchers from getting stuck, or from not knowing where to look or what it might be useful to explore next. When people get stuck in everyday life one course of action is to ask for help and get another person's take on things.

The co-founders of narrative practice were family therapists who already had a tradition of 'live supervision' and professional reflecting teamwork (see: Denborough, 2001) and the practice of transparently consulting other people for their suggestions has continued and developed within the narrative therapies. A therapist and client from New Zealand have documented the ways in which they consulted David Epston several times during "Mad Fax Sunday" (Lane, et al, 1998). I have often e-mailed my online peer-vision group during the course of therapeutic conversations with people, sometimes receiving the reply by return and sometimes not (hence Gina's comment, above, about e-mail). Consulting other professionals about your work is integral to all therapies, but the transparency with which this takes place within narrative practice situates 'therapeutic skills and knowledge' more relationally and socially: alongside the co-researchers rather than embodied in the person of the therapist.

Re-membering conversations

Conversations that link our lives to those of others through 'shared values and commitments' (White, 1997:23) are common narrative therapy practices that also 'bring other people along' into therapeutic conversations. The terms 're-membering' and 'definitional ceremony' have been extended into the therapeutic domain from the work of Barbara Myerhoff (1982, 1986) a cultural anthropologist whose studies of elderly Jewish people were particularly concerned with the social achievement and social maintenance of identity. Re-membering conversations are conversations that bring other people into the story and into the 'club of life' sustaining the storyteller. Barbara Myerhoff was interested in the flexibility and ingenuity demonstrated by the elderly in 'peopling' their lives and these ideas can be used to stand against individualistic, isolated or 'single-storied' notions of 'self' in a range of contexts. Such conversations can be particularly useful in bereavement contexts and Lorraine Hedtke's work (2001, 2004) has been very influential in this respect.

Margie, for instance, was a person who had consulted me about her life. Margie had been grieving for her mother for several years (see: Speedy 2005, in press). She had become determined to 'take a stand against contemporary throw away attitudes towards families and places' and resolved, with the support of her daughters, to renew her commitments to 'continue to miss Fay [her mother] every day' and to continue to have both 'out loud' and 'in her head' conversations with Fay. She also reminded us that this was something of a 'family tradition' in that Fay had 'continued to chat to Jack', her husband, for at least forty years after his death.

Margie's daughters had been initially concerned about her 'spending too much time with dead people' but this became something of a re-membering conversation for the whole family as many of the stories that they began to tell each other linked their lives with Fay's life, Jack's life and each other. Thus, what had begun as individual therapy for Margie in order that she 'sort herself out' about her mother's death, shifted out of the therapy room into a linking of lives between (in this case) family members.

Definitional ceremonies

Definitional ceremonies "deal with problems of invisibility and marginality: they are strategies that provide opportunities for being seen in one's own terms, garnering witness to one's worth, vitality and being" (Myerhoff, 1986). These ideas have been taken up by narrative therapists to create opportunities for the witnessing and re-telling of stories and re-membering of lives. Re-tellings within definitional ceremonies offer the opportunity to engage with others in the re-telling, re-shaping and performing of life stories. Outsider witnesses who have been invited to take part by the principal storyteller (and/or co-researcher at their request) are then invited to re-tell the stories that they have heard, noticing what struck a chord for them, and what expressions and images from the story resonated with events or images from their own life. It is in these rich re-tellings that a thicker description emerges, as the story is re-retold in response and (to quote Pinkola Estes 1993:I) "each re-telling offering a broader and deeper insight than a single story alone".

The narrative practitioner acts as the facilitator of the ceremony, including the careful preparation and questioning of the witnesses (see: White, 1995, 2000) who may need considerable support in maintaining focus on the particularities and expressions of the person at the centre, but it is in the telling and re-telling of the stories (the construction of a multi-storied context) and not through the interventions of the 'therapist' that therapeutic endeavour occurs. There are numerous examples of engagement with outsider witness practices in a variety of contexts (see, for example, Behan, 1999; Andrews, 2001) all of which illustrate the metaphor of 'multi-storied living' as a vehicle for constructing identities as social and relational achievements.

To give a brief example from my own practice, Marie (see; Speedy, 2003) was a North African student at the University of Bristol, struggling with homesickness and the incomprehensible

'cultural mores' of her British flatmates. An outsider witness group of students from Japan and China, as well as young British women, provided her with a rich multi-storied resource of stories of cultural and gender practices and experiences to draw on. In her re-re-telling of her story after hearing from her witnesses, she commented:

"I realised listening to Jenny that I don't know how to tell what 'social class' people are here. It is immediately clear to me at home, where it is more tribal; I do not understand the English tribal system. I did not think the English had a tribal system, but of course they do, and white male medical students probably come from the top tribe..."

There was a sense that this whole group, client and witnesses alike, had gained much from Marie's ceremony, as I had. Marie's original story of her stand, as an African woman, against her flatmates had not only been witnessed, but had also become a thicker description, far less 'on the margins' and she emerged from the ceremony with the beginnings of further stories and possibilities for her future: the possibility, for instance, of standing with her flatmates as a member of her own top tribe, was beginning to emerge in quite delicious ways:

"I have been trying to fit with democratic English ways, everybody equal and so on... but perhaps I should get a little more regal with them. I can 'do regal', I've had a lot more practice at that ".

This was not a place that Marie could have predicted getting to at the beginning of the ceremony, nor would these ideas have obviously emerged in conversation with this therapist (my take on 'posh' white men has yet to include the performance of regality). The witnesses provided a multiplicity of resonances and possible places to stand. The ceremony gave Marie access to a richer and broader range of stories and generated a far more imaginative space than a conversation with one person.

Writing practices

As outlined above, narrative therapy presents quite a challenge to therapeutic practices that focus primarily on individual history, potential or 'inner state' psychology (see: White 2004, for a discussion of these differences). Narrative ideas position personal agency firmly within social and political discourses and the cultural and historical traditions and stories that are available to people. In this way the construction of preferred stories in therapeutic conversations, however fleeting or tentative, may be seen as something of an extraordinary achievement that warrants a written record in order to be more firmly captured and embraced. In this way documentary accounts of therapeutic conversations often follow on from the more ephemeral and transitory 'talk' that has taken place, in my case often through e-mail exchanges. They are also more integrated into people's daily lives than 'therapy talk', if only by virtue of popping through the letter box or computer 'inbox'.

Narrative therapy frequently makes use of writing and the production of therapeutic documents and books on the part of therapists, the people that consult them, and on the part of many of the 'outsider witnesses' to these endeavours. More recently, poetic writing strategies that have emerged from the field of narrative research, are also being used within therapeutic encounters.

Narrative practitioners also tend to subvert some of the taken-for-granted assumptions about the execution and ownership of note-taking and record keeping that have become part of the professional writing culture of therapy (see: White, 1995, for a description of ethical priorities in giving notes to clients). These therapy notes, or reflections, are usually considered to have distinctly more therapeutic than professional purposes.

David Epston, who first developed many of these ideas with Michael White, suggested that the use of therapeutic documents increased the impact of 'talking therapy' fourfold (see, White, 1995). Many narrative therapists send documents to clients as a supplement to face-to face sessions, reiterating and providing a

permanent expression of what might have been key moments, asking supplementary questions that might be useful and, particularly with children, presenting certificates that acknowledge achievements. Such documents are usually tentative rather than prescriptive in tone:

'What stood out for me, and you may have seen things differently...'

'Your words have stayed with me and perhaps...'

'After our session I realised that there were a couple of other questions that I might have asked and I just wanted to capture them in case you would have found then helpful...'

These documents capture words and stories from the more ephemeral, spoken, therapeutic conversations and put them into writing. In this way people can remind themselves about the ways in which their stories change over time and the ways in which they position themselves differently than they might have done at the beginning of therapy (Payne, 2000:127-157, explores this process extensively). Clients may also regularly engage in letter and other writing practices in between face-to-face sessions, as a reference point and a way of 'capturing' conversations.

One such client observed:

"I began writing regular letters to Tim [a narrative therapist] about people and issues we were discussing, not letters to mail, but simply to hold onto and refer to..." (Farmer, forthcoming, p55).

In all the examples, above, the therapeutic documents can be seen to consolidate and to thicken stories that are only faintly held on to. Putting these traces and glimmers and threads into writing not only seizes the fleeting moments and gives them some permanency, but, given the power differential between spoken and written languages (and the higher status afforded to written text, outside of therapeutic exchanges, in modern society) it may also lend more authority to the stories being told.

Neither prose letters nor poetry can ever completely represent verbatim the words, nuances and meanings expressed in therapeutic conversations (and even if they could the meaning would still change in the re-telling), but perhaps the meaning-rich writing traditions of poetry allow for more powerful re-presentations by therapists and those who consult them and thence also allow more open, liminal space for storying (see: Broadhurst, 1999 for an exposition of 'liminality' as a site for meaning-making). In my experience people invariably find the poetry easier to read, more meaningful, and often surprise themselves by responding in kind. Consider the differences between two versions of the same conversation (Speedy, 2004a). The first I might have sent as a letter and the second is part of a therapeutic document that I did send to Hyatt, a young woman with concerns about her histories and relationships with her extended family.

Prose:

(At first summarising the concerns)

"Your story suggested that it was the cruel inroads that 'patriarchy and other animals' (as you put it) made into your friendship, companionship and 'secret alliances' with your much-loved brothers and that had brought you vividly back in touch with that earlier time of being so lonely: lonely down to the whites of your bones".....

(And also touching on an account of alternative versions)

"and yet as you look at this all now, although this loneliness was seen as something troubling by others, particularly by those in 'authority' over you, it seems that for you, both then and now, being alone in your bones has been a way of keeping yourself safe and calm and in touch with your own ways"...

Poetic stanzas:

The cruel inroads
of patriarchy
(and other animals)
into friendships,
companionships
and secret alliances with much-loved brothers

brought you vividly
back in touch with that time
of being so lonely
lonely down to the whites of
your bones

yet now it
seems those bones
those same authority-troubling bones
those 'alone bones'

were the very bones that kept you
safe and calm
and in touch with your ways.

Endnotes

This is not a definitive account of narrative therapy practice and, indeed, it has not even alluded to the most well-known and colonised narrative practice of externalising or to most of the narrative technologies of conversation. Each one of the narrative therapy practices outlined above, (whether it is about positioning ourselves as co-researchers or about engaging in collaborative consultations, or taking part in definitional ceremonies, or conducting re-membering conversations or co-writing therapeutic documents), illustrates an integration of therapy into everyday lives. With the same breath that narrative practitioners speak of commitments to the integration of therapy into everyday lives they also speak of positioning themselves as curious questioners whose purposes include 'exoticising the domestic' (Bourdieu quoted in White, 2004a). In other words, making the familiar and taken-for –granted stories of our lives into archaeological sites, rich with unfamiliar possibilities that await our attention. These aims seem both modest and enormously difficult to accomplish in comparison with some of the claims made for, and cultures inhabited by, psychotherapy and its bedfellows as we enter the 21st century. Perhaps some of the conversations above have resonated with, or even transgressed, the professional territories and values of some of the readers of this Journal. What I have tried to do here is portray some of the ways in which the narrative metaphor invites therapists and those consulting them to inhabit particular spaces in relation to 'therapy integration'.

I shall not neatly return to the confines of my kitchen and further attempt to 'exoticise' my own domestic life, as I end this text. For one thing I am writing this ending some months after the evening in my kitchen and for another, in chronological time (as opposed to 'narrative time') I did not write this last paragraph last. The order of the text, like life itself, has changed in the re-telling. I nevertheless hope that this incomplete account has gone some way towards depicting the value of harnessing various narrative practices as a means of integrating, or making some sense of 'the profusion of tangled events' (Foucault, 1984) that make up our lives, in order to generate some preferred places to stand, in the moment, in this world.

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Pauline Rennie Peyton

Harassment, Bullying And The Integrative Practitioner

Abstract

This article addresses the issue of bullying in the workplace and the implications of this process for the integrative practitioner. The author provides definitions of the process of bullying in the workplace, some brief theoretical reflections and references to research, followed by a detailed discussion of bullying as it occurs and provides detailed guidelines for the practising clinician in working with the victims of workplace bullying.

Introduction

Amongst psychotherapeutic practitioners, those using an integrative way of working are likely to have the least difficulty transferring their skills from a clinical to an organisational context. And, because I deal with workplace bullying, this organisational context is relevant to my integrative view.

Bullying is of course not exclusive to work situations. Indeed, we have only to wander around the supermarket, drive in a car, or be in any place where there are crowds of people, to become inadvertent witness to abusive or bullying behaviours. Similarly, we are all only too aware of domestic violence and other forms of bullying. Although these could all be brought into any therapy, they are beyond the scope of this article, which concentrates on institutional bullying.

Whether or not practitioners ever work within an organisational setting, the probability is that at some time or another—be it in private practice, clinic settings or the National Health Service—they will find themselves having to deal with harassment/bullying in one or more of its many guises. The aim of this article is to answer some of the questions practitioners may get from clients presenting with workplace-bullying issues such as "What can I do?" and "How do I deal with this situation ?"

The working definition I use for bullying is the one used by the Manufacturing Science and Finance (MSF) Union:

"Persistent, offensive, abusive, intimidating, malicious or insulting behaviour; abuse of power or unfair penal sanctions, which makes the recipient feel upset, threatened, humiliated or vulnerable, and which undermines their self confidence and may cause them to suffer stress".

Bullying behaviours are unlikely to be isolated incidents; the first one to take place invariably serves as a signal that there is more to come. A single incident is rarely seen as bullying, except in extreme circumstances. This is not necessarily prejudicial to the therapeutic interests of the victim for the very reason that the incident usually marks the beginning of an emerging pattern.

Another important point to be made about bullying is that it is measured in terms of its impact upon the recipient and not in terms of the intention of the perpetrator.

The perpetrator may or may not be consciously aware of the impact of his/her behaviour on the victim and may, in fact, be reproducing behaviours that the person was on the receiving end of in earlier years.

From an integrative viewpoint, Ferenczi's "identification with the aggressor" (1933) may serve as a useful concept for understanding this process. He writes of children who have been abused and who reach a state where they are "completely oblivious of themselves and identify with the aggressor" (Ferenczi 1933 p 162).The aggressor then becomes part of the child's intrapsychic world and the arbiter of his/her behaviour. In this way the child takes on the values and attitudes of the aggressor towards herself/himself and perpetuates internally the abuse and punishment. In order to control situations in adulthood, these victims may turn persecutor by assuming the stance and values of the original aggressor in order to maintain control of relationships and avoid re-experiencing the original pain and humiliation. In Transactional Analysis terms, we may describe this process as the bully's operating from an introjected Parent ego state and putting the other person in the Child position (Berne 1961), a position reminiscent of his/her own original situation. In other words, the bully identifies with the Parent ego state and projects onto others his/her own hurt Child. While I certainly do not maintain that all persecutors have been victims in the past, it may be true in many cases where it serves as a possible psychological explanation. Nevertheless, this in no way mitigates or justifies the behaviour.

Research into bullying

No discussion on bullying can be complete without looking at the research in the last 10 – 15 years, starting with Leyman (1990) who recognised the symptoms suffered by victims ranging from mild depression to suicide. This work was reinforced by Bjorkqvist et al (1994), and many others subsequently. Cooper, the co-author of a study in 2000 for the University of Manchester Institute of Science and Technology, concluded that with better management training and awareness, bullying is avoidable (Hoel and Cooper, 2000). (For readers interested in details of the research, please see Rennie Peyton (2003), Dignity at Work: Eliminate Bullying and Create a Positive Working Environment, Ch 3.)

Bullying behaviour can take myriad forms, and so I will add to the definitions and descriptions above by quoting synthesised examples (i.e., combining typical elements from many cases) derived from my own practice and those of my supervisees. To ensure anonymity I have disguised the names, genders and details of the individuals involved.

Gross behaviours

First are examples of what I classify as gross bullying behaviours. Of course, in this category we have shouting, screaming and actual threatening behaviours that are easy to identify. However, a list of gross bullying behaviours is lengthy indeed and for the purposes of this article I will give only a few. A recent example was that of a woman who was facing charges of bullying from a member of her team and could not understand why. She rang the victim and said "I don't know why you don't just leave, your partner earns a good salary so it's not as if you need the money..."

Using personal information against people is another example, and one that comes up time and time again. One man, whose partner had died from an AIDS-related illness and who himself is known to be HIV positive, was told in a heated argument with a colleague that he "killed" his partner. A subtler, yet still distressing, example was that of a line manager who said to one of team member in public "No wonder your boyfriend left you when you dress like that."

Other extreme examples are when people believe that they have a right to impose their own religious beliefs onto other people — for instance, "You will never find happiness because you divorced your husband", or "Your disabled child is a punishment from God for your behaviour in the past."

Electronic harassment is not uncommon. People can switch on their phones and be bombarded with voice mails and texts, or they can log in to their computers and be faced with dozens of abusive e-mails. An interesting point is that people often believe that abuse sent electronically cannot be used as evidence of their inappropriate behaviour. Fortunately for the recipient, it is more and more frequently being used as proof.

Sexual harassment by e-mail has become widespread. Some years ago a client reported receiving a dozen red roses every hour on the hour from a colleague who would not "take no for an answer"; today's version of this scenario takes the form of electronic invitations, text messages and e-mails bombarding the recipient at regular intervals. This method of sexual harassment is used by both males and females, who send lewd messages while they are out drinking with their friends or — clearly when alone and awake in the early hours of the morning — it seems a good idea to them to pour their heart out or to vent their anger via e-mail. It has even happened that the recipient has had to endure the added humiliation of being called before Management to explain why they are receiving these messages on the office e-mail system.

I have seen instances where people have used someone else's password, or hacked into a corporate server, to download unwelcome images to their victim's computer. One woman found child pornography on hers. Fortunately, she went straight to the police and had the matter dealt with before there could be any comeback on her. However, though she dealt swiftly and efficiently in reporting the matter, the psychological trauma took longer to heal. We read in the papers of people being vindictive by posting unflattering photographs of others on the Internet; this too can happen on internal messaging systems and intranets.

Sometimes inappropriate texts, e-mails and voice mail messages are used under the guise of "good natured fun." Many organisations have put a stop to the personal use of company systems; others have built-in monitoring systems that can recognise, and prevent the distribution of, certain materials.

This type of "humour" is rarely funny to the recipients. People with unusual names neither need nor want this to be pointed out or joked about. People who carry more weight than is probably healthy for them know that they are overweight and their lives are not enhanced by comments about their size or their appetite. As a client explained: "Imagine every time you walked into the office someone started to hum the theme tune from Jaws or make unwelcome comments to the great amusement of others in the room." Funny? Good fun? No, this is bullying.

More subtle bullying behaviours

Bullying behaviours in the workplace can also be expressed in much milder forms – though this does not mean their effect is any less harmful or damaging. For example, giving someone a job to do for which they are unqualified or untrained could be a way of making them fail and providing an excuse to give them a poor performance rating.

Other examples are:

a) Bogus scheduling—arranging meetings and leaving someone who should/would be expected to be present off the list.

b) Setting unrealistic deadlines—this is done to ensure the person will either have great difficulty in meeting it or else fail to meet it.

c) Turning down requests for leave—a variation of this is cancelling previously approved leave at the last minute for no good reason.

d) Removing someone's responsibility and dealing with them only through a third party or electronically—also, ignoring someone and encouraging others in the department to do the same. This latter technique was repeatedly used in a particular company to push people into leaving, allowing it to maintain its so-called "culture of no conflict".

e) Excluding someone from training courses—especially when allowing new members coming into the team to attend them.

f) Criticising a member of a team behind their back—e.g., "I told Jim to do it but he didn't get around to it."

g) Lying—bullies often manipulate the truth to serve their needs, for instance refusing to acknowledge that they did, or said, something that affected someone else's work. Or, deliberately lying such as saying "I did not take the file" even if it is found in their office.

h) Taking someone else's work or ideas and presenting it as their own—cases of this come up time and again and it is especially common in academic institutions or with junior members of staff who work under a more senior person's direction.

i) Rumour mongering and jokes—because bullying is about impact and not intention, "it was only a joke" is never funny.

j) Undermining someone's authority—such as where a supervisor encourages team members to report issues directly to her and thus cuts out the line manager who previously, and routinely, would deal with them.

k) Giving only negative feedback and withholding praise for a job well done—this type of behaviour often takes place when someone is "micro managing" and constantly looking for mistakes. The inevitable outcome is that the person being victimised feels the pressure and fears the anxiety – and ends up making even more errors.

l) Performance reviews, holiday rotas, overtime rotas can all be used to undermine and bully people.

What to do

People who are being bullied at work turn up in the clinical practitioner's office presenting with anxiety, their self esteem is low and they show many of the symptoms of extreme stress. They feel demeaned and devalued and frequently believe that there is "something wrong" with them.

People who are bullied at work often develop both physiological and psychological symptoms. Those of a physiological nature include headaches, migraine, nausea, skin rashes, irritable bowel syndrome, elevated blood pressure, frequent colds, sweating and churning stomach. The short-term psychological symptoms include anxiety, panic attacks, tearfulness, a constant feeling of dread and depression.

One man who was being severely bullied at work eventually took to his bed, stayed under the covers, and refused to answer the phone. He would venture from his bedroom only after office hours when he felt it was safe. This is an extreme case, yet people arrive at the therapist's consulting room for many other reasons: they may be having tense relationships at home resulting in rows, anger and withdrawal, followed by feelings of isolation and guilt about upsetting the people they love. They may also feel isolated from their colleagues and believe that they are pushing people away.

The first role of the therapist as they listen to the story unfold is to identify that the person sitting in their office is a victim of bullying. For many victims, this is the first time they have ever been explicitly told about the precise nature of what is happening to them. For all their pain and suffering, they may not have understood that they are being bullied. Others, of course, will come directly to the point and inform you that they are being bullied at work. In fact, some clients may have a history of being bullied (in their families, by a parent or sibling, at school or in a previous place of employment). They may see themselves as a perpetual victim – but this does not detract in any way from the fact that they are being bullied in the present situation.

On the other hand, a client may feel that they are being bullied in circumstances where you cannot find any evidence to support this contention. Here, it is the practitioner's role to help the client come to terms with the reality of the situation. For instance, they might not be comfortable with the behaviour of someone at work in situations where their behaviour does not necessarily constitute harassment or bullying. Or, they might be angry with someone

and, in their anger, misreading (intentionally or otherwise) that person's responses to them. Finally, perhaps they are simply being challenged on performance-related issues; the mere fact that the client does not like to be reproached for their under-achievement does not mean that they are being bullied.

Make sure you are up to date with the story ; find out whether the client has already tried to do something about the other person's behaviour and whether the accused has acknowledged it as being bullying or not. Sometimes, the incidents can be so severe that the client is traumatised and a debriefing is necessary. In this connection, note that it may be a good idea to be prepared to take this material to supervision to prevent you yourself from carrying it.

Our role is to help clients to help themselves; they are feeling powerless and we can assist them to regain some power. First, invite them to find out if their employer has an Equal Opportunities Policy or a Dignity at Work Policy, both of which cover harassment and bullying. Many larger companies post copies of such policies on their intranet site or include them in employee handbooks; encourage the client to get hold of a copy and to bring it to their next session. On this issue you may be surprised at the number of people who do not know whether their organisation even has formal policies in place or if they are entitled to approach a Human Resources (HR) officer or a personnel department in connection with these.

On the other hand, some companies are so aware of harassment and bullying that they have set up mentoring or buddy systems as a first line of defence in dealing with these issues. These services are likely to be advertised either electronically or on the notice boards. Other organisations may be unionised and the client, if a member, will have access to their advice and support.

This first step, ascertaining whether policies are in place to protect them, is often difficult for the client because they fear that if they are seen to be asking HR about company policies they will be regarded as "trouble makers". Added to this, some HR personnel are reluctant to deal with bullying especially if they themselves are wary of the individual concerned, or if the accused is a senior member of staff. This problem arises because all too frequently HR departments are staffed by young people who have little life experience and this work is out of their depth. They have been known to make situations for victims of bullying worse by saying things—meant to be comforting—such as , "It's just the way she is; It must be a personality clash; I find him OK; She gets good results," or, ominously, "We know, but what can we do about it?" In these circumstances encourage the client not to give up but to escalate the problem higher up in the department or the organisation.

Second, encourage the client to keep a diary of dates, names and incidents; also, to record the names of anyone who may have been a witness to the event. It is usually a good idea that these diaries or notes are kept at home and not on the company's computer system (including laptops) or on the work premises (I have had to deal with more than one case where computers were tampered with and papers had disappeared from desks). It is also advisable to keep hard copies of any e-mails and to preserve text messages and voice-mail messages if possible.

Third, clients may benefit from writing the story of their relationship with the particular person (or group of people) involved. Questions such as the following could be a source of valuable information:

Have there been relationships between the parties outside of work?

Have the client and the bully competed against one another for a promotion or position?

Has there been a change in the parties corporate status vis-à-vis one another?

Has the client ever confided in the bully and given them information that they are now using against them?

Encouraging the client to write their story and share it with you has an additional purpose beyond allowing them to investigate the

history; it very often aids them in coming to terms with it. This can be a painful process for the client especially where the bully once was, as frequently turns out to be the case, someone who was a close friend and confidante.

Other cases of bullying arise out of punitive motives, for instance, revenge: a client was being bullied by a manager after she passed a promotion board's examination while his girlfriend did not. In another case, a woman was bullied by her ex-brother-in-law at a time when a child-access battle between him and her sister was being contested in the courts. Clearly, people do not necessarily leave their private life out of the work environment and this can cause others to suffer.

People who are being bullied often undergo behavioural changes that their family and friends do not understand or recognise. Examples are heavier smoking, drinking to excess, or taking street drugs. They can eat more, or less, than they need to keep healthy. They can be difficult to be around and show signs of unreliability. Often, they also show signs of not taking care of themselves as they used to; a person who always presented himself or herself well can lose interest in their appearance or cleanliness.

When working with someone who is being bullied at work, find out about the support systems they have both at, and outside, work. In some cases, people are bullied both at work and at home – which further reinforces their sense of worthlessness. In these cases it would be important to work with both sets of relationships simultaneously.

Once you have an idea about the facilities and policies their employer has in place for dealing with bullying at work, you can take them through a decision making process.

What do they want to do about it?

The reality is that most people who are being bullied at work merely want it to stop. They don't want revenge; they just want to be able to get on with the job that they are paid to do. Often, policies suggest that in the first instance the person who is being bullied should approach the perpetrator, clearly tell them about the effect of their behaviour, and ask them to stop. I always suggest that they should not attempt this alone; they should make sure they are accompanied by a trusted colleague. The reason is simple: the victim is in a highly vulnerable position and I have come across too many instances where the bully has manipulated the situation so that the victim ends up feeling even worse, having been convinced that it is either all their fault or, even worse, in their imagination.

If the situation is untenable or they are too afraid to approach the person directly (even accompanied by a colleague), they need to write down what happened in as much detail as possible (including dates, times, names of witnesses, etc) and take the matter directly to the HR department. Often, HR departments will have laid down the format for two ways of dealing with these issues. The first is the informal route, in terms of which someone from HR or Management talks to the individual or individuals concerned, explains the situation that has arisen, and asks them to stop behaving in this way – making sure, at the same time, that they explain that such behaviour not only contravenes company policy but also exposes the perpetrator to the risk of disciplinary or other consequences.

The second alternative is the formal procedure. This takes the form of a thorough investigation in which the victim, the accused and the witnesses are interviewed. The investigator then makes a decision on whether the behaviours in question contravened the company's Dignity at Work policy. The victim has no control over what will happen to the accused; in fact most policies respect confidentiality and do not give the victim the right to know what punishments or treatments the accused has been subjected to. Victims in these situations are often afraid. As we've seen, in most cases they don't want the perpetrator to lose their job; they just want the bullying behaviour to stop.

It is often a good idea for the therapist working with a person going through one of the above processes to pose the question "How do you think I can help you through this process?"

Sometimes it is just being there for them that is sufficient, others times it is helpful to work with their anxiety before an interview. It can even involve finding ways of enabling them to work with the accused again once the investigation is over.

Working with the accused

Practitioners who work as internal or external Employee Assistance Providers (EAPs) may be asked by management to work with a person who has been accused of harassment or bullying. The same process applies; first listen to their story. Even if they are guilty of gross bullying behaviours, they are human beings who deserve to be treated with dignity and respect.

Considerable progress can be made with these people if they have the ability to self reflect and begin to understand the impact of their behaviour on others. I can recall the case of a woman who had always modelled herself at work on her father and who was genuinely shocked when a bullying charge was brought against her by her entire team. "My father always ruled with a rod of iron, and was greatly respected by his staff," she said. "All I wanted to do was use his successful methods of management." It was a real breakthrough for her when she realised that her father was probably "respected" out of fear. She also realised that she had spent her whole childhood in fear; in her thoughts and memories she had always placed him on a pedestal and moreover felt that she must have been a model child to have pleased him as she did. In reality, she had been too scared to be a child.

In another case, the client, charged with bullying, realised that it was not only the members of his staff who were afraid of his unpredictable behaviour, but his wife and his children too. They felt the same fears and anxieties as the people at work did. In this situation he was able to change his behaviours and save his marriage, his relationship with his children and his professional life.

Witnesses

Other people who will have their stories to tell on workplace bullying are the witnesses. These people often feel ashamed of themselves and guilty for keeping their heads down and getting on with their work while others around them are being abused. Sometimes they convince themselves that there is something wrong with the victim and that they have "invited" the treatment they are receiving.

At other times people may feel guilty because they are afraid – they fear being the next victim. Interestingly, those who are especially afraid are usually those who are the current favourites of the bully. One of the characteristics of bullies' modus operandi is their tendency to create a set of "favourites" who, based on their own past observations, understand all too well that the status quo could suddenly change, turning them into the next victim.

One way of working with witnesses is to explore the process of whistle blowing: how they feel about reporting the behaviours that they have witnessed. Many who have thought about this course of action are afraid of making the situation worse for the victim. Some company policies now have a section on whistle blowing, which encourages people to report inappropriate behaviours to management without prejudice.

Sometimes you may find yourself helping the family members of those being bullied at work. They will have come to you seeking therapy because they feel so impotent about – and can't get through to – their friend's or loved one's plight that they want to find a way of doing something about it.

Encourage them to talk to the person they are concerned about or, if this feels difficult or awkward, even write them a letter. A note from a caring/loving stance can often get through to someone who is devaluing themselves and allowing others to treat them in this way without doing anything about it. The client in front of you may also benefit from working through any part they may believe—rightly or wrongly—they have had in their loved one's distress.

Yet another group of people who might seek the services of the integrative practitioner are managers or HR personnel who are experiencing stress and difficulty in dealing with these behaviours – especially if they have carefully turned a blind eye to what has been going on for some time. Sometimes they turn up because a formal complaint is being brought against a perpetrator and it is their job to deal with it. By listening to their story, and helping them to make plans and strategies within the remit of the company policy, we can make a big difference to the way in which these people, who often work unsupervised but with access to work-based counselling, operate.

An important part of carrying out this work is being non-judgmental and a role model. It is easy to identify with all of the parties in cases of harassment or bullying because many of us have, at some time in our past, behaved in ways that would now be considered unacceptable

Conclusion

Working in this field can be challenging; some clients who present themselves as being bullied know how to behave only as victims and it is therefore rewarding to work with them in learning to do something about their situation, reclaiming their own power, and letting go of the role of victim. Similarly, with clients accused of bullying – people who do not behave in a way that allows us easily to like or respect them – watching them change in a positive way can be hugely rewarding.

Unfortunately, however, there will always be those recalcitrant people who try to rubbish you as a practitioner and lump you with all the other "little stupid people who try to do good" rather than try to look into their own motivations for causing so much unhappiness to their victims. In my experience, though, these cases are rare because most people do want to be accepted and liked by others, and so are ultimately willing to change their behaviour.

For the therapist, supervision is vital for carrying out work in this field; they need to debrief, explore their own processes, and be able to know that they have support in this challenging and rewarding work. In addition, an integrative training allows the practitioner in these sometimes unfamiliar contexts to think and work "outside the box" in transferring their skills to an organisational environment.

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Maggie Senior

Dissociation: Concepts and Practice Issues

"We don't forget, thought Mma Ramotswe. Our heads may be small, but they are as full of memories as the sky may be full of swarming bees, thousands and thousands of memories, of smells, of places, of little things that happened to us and which come back, unexpectedly, to remind us who we are." From: *The No.1 Ladies Detective Agency,* Alexander McCall Smith (1998).

Abstract

This paper offers an overview of the field of dissociation, illustrating how it may be seen as a complex continuum of trauma-related clinical presentations, some of which have specific features. The paper discusses particular practice issues which the contemporary integrative psychotherapist may face when working with dissociative clients.

Introduction

Once thought to be the sole province of the priesthood and God (Ellenburger, 1970), dissociation became a subject of study in its own right in the nineteenth century, through the work of Charcot, Breuer, Freud and especially of Pierre Janet. Since that time a range of practitioners have explored the field and this paper is an attempt to alert the contemporary integrative practitioner to some key concepts and important practice issues involved in working within the field.

The term 'dissociation' is really a general term for the presentation of fragmentations within the personality. How dissociation appears in the life of the client depends therefore upon the extent and severity of the clinical processes involved. The ancient Greeks may have known something of these processes for in the Temple of Apollo at the ancient ruins of Delphi there used to be the inscription, 'Know thyself.' This journey of self-discovery may be difficult for most of us, but how is it possible for those whose lives are affected by the psychological processes of dissociation?

These processes, sometimes seen as one of 'severing connections' (Davies and Frawley,1994) lead to gaps in memory, discontinuity in the sense of self experience, strange bodily sensations which are experienced as having no narrative meaning, intrusive memories, amnesias, and numbing.

Other symptoms can include losing time, fugue states, persistent episodes of feeling detached from parts of the body or emotions, sometimes known as 'depersonalisation' and episodes of feeling that your own environment and people in it are unfamiliar or unreal, also known as 'derealization' (Steinberg and Schnall, 2000). Perhaps most bizarre of all is the sense of many selves in the one body vying for expression, even to the point of believing that the differing self-experiences (the experiencing of alters), are actually different people with separate bodies (Chu,1998; Putnam, 1989; Krakauer, 2001).

So the landscape of dissociation is broad and complicated. Those who experience the

effects of dissociation sometimes find that past memories burst upon their consciousness, reminding them of the 'big things' that happened to them, and so the whole process of dissociation begins again; the memories are too painful and traumatic,so they have to be dismissed from conscious memory yet again.

Judith Herman (1992) reminds us that the processes of dissociation have 'a prodigious array of symptoms' (p.96); furthermore these manifestations very often evoke powerful responses within the psychotherapy practitioner, within the psychiatric community and also within society at large, in the forms of denial, criticism, fascination, confusion, compassion, rescue and also blame, misunderstanding, and professional disagreement. Furthermore these contemporary processes have been echoed in the historical development of the fields of psychotherapy and psychiatry, in the acknowledgement and then the forgetting of what happens when people, regardless of gender, are traumatized (Breuer and Freud,1991; Ellenburger,1970; Herman,1992; Janet,1907; van der Kolk et al., 1996).

Blizard (2003) suggests that Freud's abandonment of the seduction theory and the development of the Oedipal theory, may be a defense against his own history. Whatever the origin, the net result historically, was that many students of psychoanalysis disregarded "the psychopathological consequences of interpersonal trauma" , which in turn, led them "to dissociate the existence of dissociation" (p.2).

Blizard (2003) and Tarnopolsky (2003) both believe that psychoanalytic concepts are crucial to the understanding of dissociative processes and that contemporary work on trauma and dissociation are illustrative of and develop from early psychoanalytic formulations on the organization of personality, in spite of the differences of language between models.

The Contemporary Integrative Practitioner

Even though there is a renewed interest in the concept of dissociation within the current literature, the contemporary integrative psychotherapy practitioner still has to find a way to receive, understand, process and work with the material that the client, perforce, has had to dissociate. Furthermore, the practitioner also needs to have a clear conceptualisation of what dissociation is, its aetiology and also its likely effects on the practitioner.

Straker (2002) and Eagle (1998) both suggest that a multi-faceted, integrative approach to treatment is necessary to successful outcome of working with trauma and disconnection; moreover all contemporary writers on dissociation highlight the therapeutic task as integrating the material that has been dis-integrated. An integrative approach then, with its stress on the relational aspects of therapeutic work and with its understanding of developmental processes, is well-placed when working with this type of presentation.

My own experience of working with people who dissociate, especially early on in my psychotherapy practice when the bizarre array of presentations felt at times almost overwhelming, was to ponder, Pooh Bear-like, 'Who is what and what is who?' And I shall never forget the stillness in my therapy room and the fear I allowed myself to feel as the room seemed to come alive and fill with watchful presences, at the end of the first session with a particular client. This, I stoically reminded myself, is what Patrick Casement calls the 'therapeutic pas de deux' (Casement 1985). But just who and how many was I dancing with?

For me, working as I do mostly with clients who have experienced early histories of abuse, it is essential to consider the processes of dissociation within the dialectic of trauma, with special reference to the developmental and relational contexts in which dissociation arises. Phil Mollon (2001) writes that dissociation is a 'core feature' of responses to trauma and it seems that dissociation at the moment of trauma is the single most important predictor for the development of chronic PTSD, which is essentially a dissociative presentation (van der Kolk et al., 1996). Children are less neurologically well-equipped to process trauma and therefore will dissociate trauma memories (van der Kolk and Fisler,1995).

Judith Herman (1992) suggests that a traumatized child trapped in an abusive environment "is faced with formidable tasks of adaptation. She must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable..."(p96). In other words,to live in an environment created by caretakers who are consistently inconsistent, the child's creative answer to the problem of how to do this and still maintain the relationship is to dissociate from their own experience.

So dissociation may be seen, not so much as a process of 'severing connections' (Davies and Frawley 1994), but as a failure of the integration of self-experience (Putnam,1997) and as a disruption in the domain of core relatedness (Stern, 1985).

The Phenomenology of Dissociation

It follows that the very contradictory relational and environmental conditions which create the dissociation are also expressed in the experiencing of dissociation itself.

In my research into the phenomenology of dissociation (Senior, 2003) I demonstrated that the experience of dissociation is essentially paradoxical. Here are just a few examples of how the adult interviewees described their experiences. These are paradoxical both in the direct experiencing of the dissociative processes and also in the individual's way of dealing with them.

Two said that they could not empathise with anyone else when they dissociated. They went 'numb' and one said that she 'just needed to get through this little bit of living.' Paradoxically they also spoke of an incredible sense of 'connection' as part of the experience. Yet others spoke of dissociation as being the 'safest place', even though they knew that it might actually put them in danger. One interviewee described how she sought safety on the roof of a particularly high building when she dissociated. She knew that for others, it would be a place of danger, yet for her it was 'safe.' She also gave a graphic image for the physical sensation of dissociating - that she felt like 'a tape winding backwards,' yet she still knew she was going 'forwards' physically.

Another participant shared with me the feedback from a friend who had seen her in a dissociative collapse. She looked as though she was trying to swim across the room but without moving. Yet another said that the experience of healing from dissociation is also paradoxical, that it is like dying: 'the journey back is awful – it is like dying, dying in reverse....now I know that when I feel that I'm dying, I'm healing.'

The point that all participants noted was that dissociation is a bodily as well as a psychological experience which leaves the person feeling disconnected or disembodied in some way or other, but also connected in other ways. Most noted the distortion in time; time is elongated or condensed very rapidly.

Another wider aspect of the experience of dissociation reported by the interviewees was how the environment somehow picked up the process and acted it out. Places which were supposed to be places of safety and healing, such as psychiatric wards, became for some of them, places to withstand and escape from, thus echoing aspects of the person's earlier traumatic childhood.

Several spoke on the theme of having to manage and control the psychiatric system in order to get 'back into the world' to safety, even to the point of secretly managing their own drugs (by giving them to plants!) and also in refusing to wash. Bath-time for one particular interviewee had been a time when her 'bath-time mother' had been out of control (either scrubbing her with bleach or trying to drown her) and so bathing in hospital, which smelt of bleach and where the bathroom door had a spy-hole, was quite simply impossible.

Unconscious Replication and the Paradoxical Nature of Dissociation.

Dissociation may be seen then as an expression of the inner split the child has had to make within the environmental context of the parent who

is also the child's protector,turned persecutor. The child's self therefore becomes constellated around self and self-object representations based on themes of the protector/ persecutor, which like binary stars revolve around one-another.

Donald Kalsched (1996) in writing about these 'tandem inner images' of the protector/ persecutor, reminds us that 'splitting is a violent affair - like the splitting of an atom' and as Freud reminds us, in writing about 'psychical fixation' that 'the unconscious is quite timeless' (Freud, 1975 p 339). Matte Blanco (1975) takes this further in his book, The Unconscious as Infinite Sets, in which he uses concepts from the mathematics of set theory to elaborate aspects of unconscious process. The unconscious he suggests has no sense of asymmetry, but possesses a logic basic to primary process thinking (Casement, 1985) that is, that the "system unconscious tends to treat any relation as if it were symmetrical" (Matte Blanco1975,p38). Therefore aspects of 'self' and 'other' may become interchangeable; this is true also within the clinical setting and has important implications for transference reactions. As Casement suggests, it is important to develop ways of listening to the paradoxical logic of the unconscious.

So what happens if the original relationship(s) with mother and father are formed around protector/persecutor inner images? It follows that the timeless unconscious will project those inner images onto succeeding relationships, so that they become endlessly replicated in present experience. A therapeutic relationship in Matte Blanco's terms offers the opportunity to experience the relationship both as symmetrical - replicating other earlier ones, and also as asymmetrical - as offering the opportunity to experience the therapeutic relationship as new, different, consistent, and therefore with the potential for healing.

From a neuro-psychological point of view, "cells that fire together, wire together" (Hebb, 1949) and in the positive experience of therapy, new neural pathways will be established through the developmentally needed empathically attuned and kinaesthetically resonant relationship (Erskine,1998,2004; Schore,1994; Siegel,1999; Solms and Turnbull,2002; and Stern,1985).

Recent Developments in Thinking: Structural Dissociation

It is interesting to note that DSM categorization has identified Post-Traumatic Stress Disorder as an Anxiety Disorder (DSM IV 1994; Rothschild, 2000). This reflects perhaps something of the confusion of terminology and thinking about clinical presentations which are trauma-based. Judith Herman (1992) tried to redress this in calling these presentations, Complex Post-Traumatic Stress Disorder, but DSM still scatters these across a multiplicity of descriptors.

The complex nature of dissociative, trauma-based symptomatology is clearly evidenced by Nijenhuis, van der Hart and Steele (2004). In an attempt to understand how dissociation affects a number of clinical presentations, they have re-visited the original concept of dissociation, particularly in the work of the Frenchman, Pierre Janet and Charles Myers, an English psychiatrist working in the 1940's. Nijenhuis et al. (2004) have developed the concept of trauma-related structural dissociation which involves primary, secondary and tertiary levels of dissociation, which in DSM terms have been represented firstly by Post Traumatic Stress Disorder, secondly, presentations such as the Borderline and Dissociative Disorder Not Otherwise Specified and thirdly, the presentation of the former Multiple Personality Disorder now known as Dissociative Identity Disorder.

I find it helpful to visualize this concept of structural dissociation as a three dimensional continuum, beginning with what I call 'ordinary dissociation,' which might be experienced as being absorbed in something so deeply that when your door-bell rings, it goes unheard, or, perhaps, as driving down the M.1.using all the driving skills you can muster, but thinking about what is in the fridge for supper; then suddenly coming upon your exit and wondering how you got there! These are the psychological skills of everyday life; dissociation which comes from trauma goes deeper and is more complex.

Now leaving the ground level of 'ordinary dissociation', imagine an elevator going down to three sets of basements. Level one is primary dissociation and opens onto a space where you will find clients who still have clear narrative memories of a recent train crash and can function reasonably well cognitively, but they cannot process the emotional memories of the crash. They may, after a time become depressed, and they certainly find it difficult to concentrate sometimes on the present, because they experience being overwhelmed by flashbacks and nightmares about the train crash. When this happens it sometimes feels as though the crash is happening again. This is the experience of Post-Traumatic Stress Disorder.

Go down now to level two, secondary dissociation, and you find clients who are inexplicably triggered into states of overwhelming feeling, often of terror, rage or neediness, which seem to others to be out of proportion to the present event. Sometimes the clients may also numb emotionally or even anaesthetize parts of their bodies, they may also experience out-of body sensations, or seem to act-out compulsively and destructively, events which you, as the therapist, suspect are from past history, but for which the clients have no narrative memory. At this level, clients may also experience mysterious bodily pains and sensations, which are detached from meaning. This might be seen as the territory of the borderline experience with its 'all or nothing' quality.

Down to basement level three and we arrive at a strange place where the elevator has doors which open on all sides, but at separate times. Go through the first and you a meet a character called Miranda. She claims she holds an overview of all the rooms down here, but she may not be entirely convincing, because you have seen someone arrive for therapy who looks too young to go to work. But Miranda goes to work, earns money, does not feel too much and possibly knows a little about what happens behind the other doors, but not in great detail.

As this door closes, you enter the world of Dawn, an adult who caretakes children of different ages, who have different memories of the past and many of whom experience terror which is so frightening, it is totally overwhelming and utterly unforgettable at the time. Right at the back of the room is a very small child who is too terrified to show herself and whose answer to the experience of early trauma is to believe that she died; she died so that she could live.

As this door of the elevator closes, another door opens into a room which contains an adult who is a female bouncer, called Madge. She is a kind of adult protector, but behind Madge are a number of rageful young adults and teenagers, one of whom is a lad called Billy. He was taken into care at the age of fourteen, he has not forgotten the experience, is fiercely independent and predictably, refuses to trust anyone ever again. He suspects that there might be some little ones in the other rooms; sometimes he has heard their voices, but he loathes their vulnerability and hates their neediness.

Finally, there is the door which opens into Doreen's world. She is a cleaner and is especially good at taking care of the environment. She cleans her room daily and she knows about a few people down here, some of whom are older children. They are also very good at taking care of the environment; this is the way they gained recognition in the past.

What is interesting to note is that clients at level three may appear to function better than those at level two, in that they have developed greater cognitive capacities and functions within certain parts of their personalities. Miranda, for example is an excellent worker, and knows how to organize her staff, but if one of the children from Doreen's small group of cleaners goes to work accidentally, the work rotas get very mixed up. So at level three there may be parts of the fragmented personality which present as extremely competent, but others which present as irrational, chaotic, and overwhelmed by emotion. This level is the territory of Dissociative Identity Disorder where characters sometimes appear as separate, disconnected personalities.

Unlike primary dissociation, which is really a 'simple' post-traumatic presentation, secondary and tertiary forms of structural

dissociation are seen by Nijenhuis et al. (2004) as ones ensuing from childhood experiences of chronic interpersonal violence and neglect, when children are the victims and their caretakers are perpetrators. They emphasize the importance of dissociation as a failure of integration in the face of threat and set their understanding within the context of the inborn evolutionary systems that are evoked by threat with particular reference to the integrity of the body.

Drawing on the work of Charles Myers, these authors believe that the failure to integrate trauma memories leads to a structural dissociation, splitting the personality into two mental systems, which they call the Emotional Personality (EP) and the Apparently Normal Personality (ANP). The ANP they argue has failed to integrate the traumatic experience, but through numbing is able to engage in matters of daily life, whereas the EP is a manifestation of a more or less complex system that essentially involves the memories of trauma. Trauma memories are, they point out, different from processed narratives of trauma, in that they have an overwhelming 'here and now' quality, they engross the entire perceptual field and upon their re-activation access to many other memories is obstructed. The ANP on the other hand may experience a degree of amnesia for the trauma and also anaesthesia for sensory modalities.

Whether or not we like the terminology ANP and EP, (I personally do not) the importance of Nijenhuis et al.'s thinking is that they put dissociation as a central mechanism operating in those presentations which as psychotherapy practitioners we recognize as widely diverse aspects of relational trauma. Nijenhuis et al. (2004) also consider the psychobiological implications of their findings and additionally explore them from an attachment perspective, locating their findings within the framework of dysregulated attachment. An attachment experience which is healthy is seen to be assisting in the psychobiological development of the child, guiding interpersonal behaviour and assisting in the processing of affect (Schore, 1994). In contrast, an experience grounded in interpersonal trauma leaves the growing child abandoned at the mercy of conflicting, overwhelming emotion, without relational support or the neurological capacity to process the experience. It is the expression of this dynamic which lies at the core of the diverse presentations of dissociation.

Practice Issues
Diagnosis In Dissociative Identity Disorder

Dissociative Identity Disorder (Steinberg,1994; Steinberg and Schnall,2000) can be dramatic in its presentation and prove both bewildering and fascinating for the clinician. An accurate diagnostic picture is important with all presentations of dissociation in order to develop a suitable treatment plan. I refer the reader to Chu (1998) for two versions of the Dissociative Experiences Scale by Carlson and Putnam. The DES has 28 items and is a useful screening tool which reflects dissociative amnesia, de-personalization, de-realization and also dissociative absorption. Other extremely useful sources are Steinberg and Schnall (2000); Steinberg (1994) and Nijenhuis (2000) for detailed information on the differing presentations of dissociation and their accurate diagnosis, most especially of DID. The International Society for the Study of Dissociation also has a web-site which has information for the practitioner and also a members' only site.

There are, however, a number of potential indicators which may suggest a dissociative presentation that the reader may find helpful, before considering using any of the other research-based screening tools mentioned above.

The following list is not intended to be exhaustive, but is one built up by myself through direct clinical experience or from other sources over time:

The client has difficulty remembering any of his/her childhood, can remember nothing before a rather late age, or has a gap of several years between clear memories.

The client has an abuse history and memories have been accessed some time after the traumatic incident, or the client suspects that

the abuse may be more extensive than she had thought previously.

History of difficult, failed relationships and failed or prolonged psychiatric or therapeutic interventions with little improvement.

Flashbacks, nightmares, intrusive images, generally without awareness of 'triggers.'

Losing possessions abnormally often /Evidence of activities outside of awareness/ Forgetting then covering up quickly.

Things do not 'add up' - e.g. your client functions well in certain circumstances, but collapses in others.

Somatic signs such as averted gaze; eyes hidden behind hair; peeping out; constant scanning of the environment; staring at something intensely; drooping or fluttering of eye-lids; jumpiness; numbness in parts of the body; client complains of being to one side of themselves; feeling 'floaty;' not hearing you; not seeing you; frequent / sudden headaches/ bodily ailments which have been investigated and have no apparent physical cause; high threshold of pain/self-anaesthesia.

Inappropriate childlike speech, behaviour, feelings, body language.

Thinking and behaviour which is out of character with person's usual level of functioning; sudden change of mood without awareness of 'triggers.'

Chronic depression; chronic sense of being stuck in life in general, or in relationships.

Chronic ambivalence about making decisions, sabotaging them or failing to carry them out.

Chronic physically self-destructive behaviour e.g. drink, drugs, self-harm, eating disorders and attempted suicides.

Signs of identity confusion.

Signs of identity alteration.

Obviously, clients do not need to present all of these indicators, but a cluster of several might lead the practitioner to think in terms of a dissociative presentation and lead the therapist to make further enquiry both within herself and with the client.

My own approach to diagnosis is that it is an ongoing process, rather than a one-off event and that it needs to be relationally approached and explored, rather than 'administered.' Some of the subtle differences between levels of dissociation may only appear over time as the integrative psychotherapist works towards building and maintaining the therapeutic alliance, observing the client's phenomenology and monitoring transference and countertransference responses.

Relational Enactment Dramas: Transference And Countertransference Issues

The therapist working with presentations of dissociation will inevitably be drawn into a variety of relational positions which reflect aspects of the original trauma. Because they are representations of self and other, which are lost from consciousness (i.e. dissociated), the therapist needs to pay careful attention to her countertransference responses.

These complex therapeutic responses to the processes of dissociation, Judith Herman (1992) calls 'traumatic countertransference'. Davies and Frawley (1994) see them as a form of projective identification. Racker (1982) has written about concordant countertransference, when the therapist picks up what the client has disowned, and complementary countertransference, when the therapist enters a role that the client has transferred. But these technical words do no justice to the intensities of feelings and sensations that we, as integrative practitioners, are likely to experience emotionally, psychologically and also physically.

Davies and Frawley (1994) suggest a number of possible relational enactments which may be useful to bear in mind when trying to remain centred in the face of therapeutic challenges. These include the uninvolved parent, who may

not be directly engaged in overt abuse, but who nonetheless neglects and fails to protect the child; the pairing of the sadistic abuser and the helpless, but furious child who was the victim; the rescuer and the entitled demanding child, who does not want to grow up; and sexual aspects of the past relationship - the seducer and the seduced.

All of the above or some specific aspects may be replayed within the therapeutic relationship, through feelings, bodily sensations, behaviours and thoughts. Bob Shaw (2003) reminds us that the idea of a therapist's body being affected by a client is not a new one, but one which featured in ancient Babylonian and Brahmin rites. Van der Hart et al. (2000) and Nijenhuis et al. (2004) have suggested that dissociation is not simply a mental event, but is also a physically embodied one.

Such experiences might be feelings of nausea, physical pain, dizziness or palpable feelings of intrusion; emotionally the therapist may experience intense rage, grief or nothing at all. I have been induced to a deep sleepiness in sessions with a particular client, whose mother it later turned out used to get drunk every afternoon before the abuse began, and a colleague has shared with me that she found herself drawn to looking out of the window with one particular client, which was precisely the client's coping strategy during abuse.

With yet another person I was troubled by what I can only describe as a kind of intense lack of feeling. This is not my normal way of being, but the intensity of the experience alerted me to question whether or not this was part of the early relational dynamics and whether I was called in to occupy the role of the unseeing, uncaring parent. The situation became clearer when the client showed signs of adopting similar attitudes with regard to her own needs and feelings and became silently withholding in sessions with me.

Dorry Lake (1998) suggests that it is impossible to engage in trauma work without being permanently impacted and changed by the experience. This is inevitable since we need to maintain our openness and also our empathic engagement with the client. The cost may however be, when projective identifications and traumatic counter-transference responses cease to be seen and worked with as communications from the client, and tip over into vicarious traumatization. McCann and Pearlman (1990), Wilson and Lindy (1994) and van der Kolk (1994) suggest that vicarious traumatization can affect the therapist in a number of ways such as workaholism, relational disruption, distressing emotions, intrusive imagery and somatic experiencing. A feeling of powerlessness may also affect the therapist and when that happens the therapy cannot productively proceed without knowledgeable help from a supervisor.

Some Caveats:

I need at this point to flag up a few caveats about working with clients who dissociate. Firstly, on the theme of therapist self-care and case management, it is really important to have a supervisor who is clinically very experienced and who is familiar with the kinds of impact that working with this presentation can have.

An excessive fascination with dissociation may be experienced and, especially with Dissociative Identity Disorder, may prove to have hidden difficulties both for the clinician and also the client (Chu,1998). Overt fascination about such phenomenology may lead to 'considerable secondary gain for patients in terms of maintaining the attention of the therapist' (p.159). For example, there might be a client who feels they can only command the attention of the therapist by being unable to self-care during breaks. Conversely, if a therapist is fascinated by an excitingly difficult client, this may be feeding the therapist's narcissism and also serve as a distancing defense to protect the therapist from the pain of a real relationship with the client and her inner world.

Sometimes too much fascination may put the clinician into the position of 'buying into' an aspect of countertransference which may be a voyeuristic re-enactment of the original abuse scenario. (Who was watching what, how and what was the pay-off ? Too little interest may mean a distancing from the client by the therapist as a response to difficult unmanaged

countertransference) (Brand 2001; Chu,1998), leaving the client abandoned as she was in her early history. (Who maintained a by-stander position and did not intervene?) Brand suggests that 'empathic strain'(p.135) experienced by the therapist may be a response to the client's chronic suicidality and/or self-mutilation which in turn compromises the therapist's capacity for the sustained empathic inquiry so necessary in this therapeutic work (Erskine,1998). Lake (1998) emphasises that the therapist needs the emotional capacity and therapeutic resources to protect against and also work with the twin pulls of invasion and disconnection experienced in this kind of in-depth work.

Clients who dissociate are often psychologically under-resourced and a further problem is that positive resources may be lost or avoided in favour of more primitive coping strategies. Sometimes the therapist may be drawn in to a rescuer position.

With DID, alter personalities sometimes fear that eventual integration of the personalities, which have been so vital to earlier survival, will mean that they will be 'killed off' (Steinberg and Schnall, 2000) and therefore resist the idea, believing that if they 'kill off' the one who wants to integrate, all will be well. As my interviewee remarked, 'healing feels like dying', because of the pain of re-connection. Such difficulties need to be worked with by developing system co-operation and also through negotiation with the therapist, which is usually an important developmental learning, for those whose earliest and most enduring of experiences have been coercive.

Suggestions For Developing Co-operation.

George Fraser (2003) has evolved a technique called the 'Dissociative Table Technique' which draws on principles of Gestalt therapy, combined with hypnosis and visualization, to help gain access to the client's inner system. Basically it allows for dialogue to evolve between the differing parts. Members of the inner cast are encouraged to come forward and sit around an imagined table. Some clients like to develop a 'conference room atmosphere,'(p.12) where negotiations can take place during the therapy. Fraser writes that one of the most amazing parts of the 'Dissociative Table Technique' is that the presenting personality may actually visualize the other parts. If the client is DID, often the inner cast has only been experienced as inner voices. The presenting personality is often surprised by the physical appearance of the others, for example, that the gruff voice 'so feared actually belongs to a young child ego state' (p.14).

One of my clients decided to do something similar but using art-work. First she decided to have a conference table for everyone to sit round or at least for everyone to have their representative present to talk. What evolved around the conference table was a conference room. Then a whole mansion grew organically during therapy for everyone to live in. Everyone had their own room, but all rooms were interconnected through corridors and those who were too little and frightened to have rooms on their own, shared and also had a safe wood to play in.

Each week, over a period of several months, she brought her drawings, sometimes a new room was added between sessions and sometimes a room was added during a session, but all of it developed organically at the client's pace. What this particular client gained was, not only the development of co-operative strategies, but also a growing capacity to regulate affect, to tolerate different feeling states without experiencing total overwhelm and an important inner sense of safety.

Safety

Clinicians working with dissociative clients need to be adept at coping with safety problems, especially when dealing with those who are at risk of self-harm or suicide. A recent front page article in *The Independent* (27th July 2004) highlighted self-harm as 'the hidden epidemic' with 170,000 young people a year being hospitalized, because of self-harm and attempted suicide. The article also linked this directly to abuse and neglect. Dissociative clients may be highly reactive to triggers and engage in self-harming behaviours as

re-enactments of past traumas (Brand,2001) and therefore complete resolution may not be possible until the client has worked through the trauma history (Kluft, 1993).

However, therapeutic tasks to establish a good enough safety are basic to building up client awareness of their own process. Empathic inquiry into feelings just before the act of self-harm and enquiry into the coping mechanism that is involved in the behaviour may encourage the dissociative client to self-reflect on their actions and allow development of mutually evolved strategies which are an advance on the more primitive, self-destructive ones they have historically relied upon. Understanding the trigger and the function is vital for the client and the therapist.

Some writers negotiate a truce on self-harm (Chu,1998; Kluft, 1993; Putnam,1989) which may only last for a limited period (Brand,2001), but which can serve to strengthen the therapeutic alliance. However, this may also lull the therapist into a false sense of security.

Nonetheless safety is paramount and one of the most useful strategies I have developed over time is to have discussions with clients about their experience of their own special safe place. The range for clients has been wide, from a mountain top in Scotland, an East Anglian beach, to the colour orange. With each client I have then, with their agreement, developed a visualization designed to enhance and amplify the positive feelings associated with the special safe place, using the client's own words about their sensory experiences associated with it.

Safety is not simply a concept; it needs to be felt in the client's body. For example, a client may say in response to an enquiry about the different sensations experienced on the mountain in Scotland, "I can see the sheep on the mountain top (sight), I can smell the sea from the hill-top (smell), I can hear the sheep nibbling the grass and hear the wind blowing (hearing) and feel the gravel crunch under my feet as I walk on the path, hold my hands out and feel the wind touch my fingers(touch)." In response to the question, "and how do you feel when you are there?" - the client might reply, "I feel at ease with the world." This then is the beginning of the resources to be used within the therapy room to remind the client of the feeling of safety and to be given back to them in the form of a visualization, with either open or closed eyes, when ready.

Some clients like to practise in between sessions. The "Safe Place" will be unlikely to work best when the client is feeling stressed or is experiencing a lot of triggers, so it is useful to encourage its usage when the client is feeling ' good enough.'

Finally, I should like to emphasize the importance of building the 'good enough' middle ground, with clients who dissociate. The anticipation is sometimes that life is a kind of snakes and ladders game, in which they will always get on the big snake at ninety – nine and land back at square one! A gentle reminder, given with warmth and compassion, that there are numbers in between, can prove effective and normalizing. One person came to me recently alarmed at the changes in her internal system. "Some of them seem to be growing up!" she said. "Yes – that's what children do!" I said in reply. She smiled and seemed relieved.

Herman (1992) says that the processes of dissociation have protean manifestations and that trauma forms and deforms the personality. Rollo May (1991) reminds us that whenever the Greek god, Proteus was in any danger, he could change himself into some new form which promised safety. Homer describes the forms:

First he took on a whiskered
Lions'shape,
A serpent then; a leopard; a
Great boar;

Rollo May p.104-105

The therapeutic task for the client who dissociates and the therapist who works with her is to hold on, 'by hook or crook, through everything,'(May,1991: 105) until the process of self-discovery is complete, self-narrative is re-established and a commonality with others is achieved. 'All that remains before her is her life' (1992, Herman:236).

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Werner Prall [1]

One Patient, One Therapist, Multiple Perspectives

Abstract

This paper addresses the question how multiple theoretical perspectives operate in clinical practice. I present a case example, the main feature of which I take to be a narcissistic psychic organisation, and discuss it from phenomenological-existentialist and psychoanalytic perspectives. I suggest that, for the purpose of the therapeutic work, the necessity for a coherent clinical strategy outweighs the importance of theoretical integration.

Introduction

Quite possibly I am biting off more than I can chew with this article. I am going to present a case of mine for discussion; but at the same time I am trying to meet an undertaking I gave at the end of a paper published in the first issue of the BJPI ('Failing Better', Prall, 2004), that is, to give a case example that will serve to illustrate the rather abstract argument I was putting forward there. In that paper I proposed, as an alternative to integration as system building activity, something I called an integrative process, which I characterised as the working-itself-out of a process of engagement with difference. I should state at the outset of this present paper that here I am not primarily concerned with what happens to theory in this process. Instead, I would like to show how different perspectives on clinical material can work together, whilst being incompatible in other important respects - something for which the term 'integration' might perhaps be a misnomer. We will have to see about that.

In the integrative field we seem to take it as a given that a) no one theory explains all the facts of observation, and b) different theories can account for the same observations.[2] This is interesting, and difficult enough, if the task is to come to a view on the proper explanation or (if one is, as I am, of a hermeneutic persuasion) the adequate understanding of what we are presented with in our work. However, as therapists, that is as practitioners concerned with ameliorating human suffering, we seek to do more than observe and explain or understand, we seek to be effective in relation to the suffering of our patients. In order to have an effect we need to gain something which we might call therapeutic leverage. In order to gain leverage we need to take up a position from which to intervene, that is, to act, in a sustained manner over a period of time. It is this need to act which complicates, and limits the shifts in perspective open to the therapist in practice. Ignoring this limitation, the therapist runs the risk of undermining the potential therapeutic power of his interventions.

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[1] This article is the slightly amended text of a presentation made to the UKAPI conference in March 2004.

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[2] In the philosophy of science a) is referred to as indeterminacy of meaning, and b) the competition of theory (see e.g. Davidson, 1984).

The need to take up a position, whilst viewing the clinical material from more than one perspective, can come into conflict with the wish to be integrative, particularly where integration is understood to demand coherence and consistency. Any particular therapeutic perspective leads to a certain intervention strategy which needs to be sustained to give it a chance to have an effect. A therapist who shifts about too much ends up acting - shiftily.

Thus, multiplicity of perspective, therapeutic power and theoretical coherence make demands on the integrative therapist which are, to some extent, conflicting.[3] Something seems to have to give. But what?

I am now going to present, in the first part, some clinical material concerning the man I am dubbing here 'the coma patient' (using an image by the patient of himself). In the second part I will lay out some of my 'conceptual wares', diverse as they are, and I will say something about the kind of practice which ensues from my thinking. Clearly, there are tensions inherent in this approach giving rise, I hope, to thoughts about the gains and losses in proceeding in this way. The reader might wish to decide whether this kind of work ought to be called integrative.

The Patient

My patient - I shall call him Adam - is a man in his mid 40's who has a well paid job in the television industry. He is handsome, youthful, fashionably dressed, articulate, softly spoken and very polite. He came to see me some three years ago, after the break-up of a relationship which had lasted, in spite of the unhappiness it had generated on both sides, for over eight years. Whilst there had been a period of intense excitement in the beginning, for much of the time he felt taken for granted and exploited by Karen. He portrayed her as an attractive but rather troubled woman, who as time went by became ever more demanding and agoraphobic. Adam felt he expended more and more of his money and time looking after her, showering her with expensive gifts and acting as her chauffeur. Although he felt he gave up so much for her, and in spite of her neediness and demands, Adam never felt sure of her love and her commitment to him. After numerous crises they finally split up, just after he had bought a house for the two of them. In this house, a family house much too big for him alone, he now camped rather than lived, since it contained no furniture to speak of. From the beginning he spoke of his intention to have it extensively refurbished in accordance with his own designer ideas.

Adam said he wanted to know why he had persisted for such a long time with a relationship he felt was wrong and which part of him always seemed to want to get out of. Also, he said, he was troubled by the rage and viciousness which had occasionally welled up in him during their fights. By the time he started therapy with me he had already made contact again with Anna, his previous partner whom, by his own admission, he had rather coldly ditched to be with Karen. Anna now lived abroad. Driven by what he saw as his anxiety to repair the hurt and damage he felt he had caused Anna he visited her repeatedly and had already re-established a sexual relationship with her. He said one of his aims in coming to therapy was to enable him to have a family - children he said were very important to him. He was not sure at all, however, whether Anna was the right woman for him and he said he was afraid that, far from undoing an act of callousness, he might in fact repeat a destructive pattern with her. He added that in his early 20's he had been engaged to a girl but broke off the relationship after the invitations to the wedding had gone out.

Adam's background remained somewhat opaque in the early sessions and was only 'filled in' in the course of time. He was born and raised in Scotland, the oldest of two children (his sister is 3 years younger); both his parents were devout Christians. His mother he described

[3] I have come to the view that there are approaches which, whilst disagreeing fundamentally on the metapsychological and philosophical level, can be put together on the level of clinical practice, whilst some approaches which share more of a common theoretical heritage pull in different directions as far as the treatment is concerned.

as a kind and rather unsophisticated woman, who was primarily preoccupied with the local church and Jesus. She would float through the house humming hymns and would refuse to let register anything that might spoil her image of her children as perfectly good and wholesome. His father, who died of a stroke 8 years ago, was a teacher of children with learning difficulties; for much of Adam's childhood the family lived on the estate of residential schools. In spite of this physical proximity, father remained rather remote and much more involved with his pupils than his own children.

Later in the therapy it emerged that his father had become sexually involved with some of the girls in his care, a fact which, when it came to light, lost him his job and almost broke up the parents' marriage. Adam was 15 at the time. Understandably, he was shocked and outraged by the behaviour of his father who had betrayed his family and brought shame on them all. He felt driven into a closer alliance with his mother on whose side he now went to church twice every Sunday. He was more than ever the 'goody-two-shoes mother's boy' who was making up to her for the terrible hurt their father had caused her, himself losing all contact with his peers whom he saw, with barely acknowledged envy, smoking and playing football and getting involved with the girls. Whilst being a regular churchgoer for years, he was not yet baptised. His parents had wanted their children to choose the church for themselves. Adam now felt the pressure of his mother's expectations that he should take the leap and join. Again and again he thought he was about to step forward to the altar - but he could not bring himself to do it. Neither rebelling nor ultimately complying, he gradually drifted away from home.

His father's evident failure has caused my patient enormous shame and anger, and persists as a nagging problem in terms of his identification with him. Is he like him, or has something of his father rubbed off on him? Can this guilty secret explain his own difficulties with relationships? In his adult dealings with his parents he liked to keep a regular but emotionally minimal contact and, on the rare occasions when he went to visit them took up the position of the happy, bountiful son who helped his parents in their material hardship. He described his father as emotionally inaccessible and charged him with faking his Christian demeanour. About his mother he complained that she was intrusively needy and that she kissed him on the lips when they met. He recoiled from these intimacies but was unable to stop them.

The therapy

The initial agreement was for twice weekly sessions. About three months after the start of his therapy, as a result of changes in my clinical practice, I introduced a couch into my consulting room which he has used ever since. A few months later I suggested a third weekly session, a proposition which he initially resisted but after considerable to-ing and fro-ing agreed to.

Adam attends his sessions regularly and punctually, and he appears, for the most part, very engaged and engaging. He would hardly ever show any difficulty in filling the sessions, producing ample relevant material, exploring his day-to-day experiences as well as his past in considerable detail. He appeared to reflect quite hard on his patterns of thought and behaviour, getting to know, with the help of my interventions, the strategies he tendend to use in order to avoid anxiety. Thus he seemed to be using the sessions very well; except, after some time it became clear, both to him and to me, that nothing was making any marked difference in the area he said mattered most, that is, the quality of his engagement with life, particularly with the woman at his side who could, or perhaps should, be a partner or wife. This peculiar quality of 'engaged non-engagement' became more graspable when he spoke of his habit of 'doodling', something he has been doing since childhood, filling pages and pages with intricate drawings, which he would then throw away. Doodling was the way in which he nursed his preoccupation with designing his perfect space. 'Doodling', I found, was not the worst way to describe the use he made of the therapy sessions. He brought material, played with it, elaborated on it, sometimes quite exquisitely - and then, after the session, threw it all out.

Whilst he seemed to be very interested in what I was saying to him about his experience, his anxiety and his defensive operations, it gradually became clearer that he used these insights in quite a peculiar way. For a long time they had no other effect than to enhance and, I want to say, adorn his verbal production. He weaved the insights gained in therapy into his narrative, doing away with the fact that he had received something from me. Whilst I had for quite some time the narcissistically rather gratifying illusion that this patient was involved in rather an important dialogue with me, as far as his own experience was concerned he was really talking to himself.

When finally I managed to say something to him about this he replied he had the following fantasy: the therapy room was an intensive care unit, and he was a patient in a state of coma. I was the doctor caring for him and I did my utmost to tune into all his bodily functions, attending to the highly sophisticated machinery which was humming away in the background fulfilling their purpose of keeping him alive whilst he was enjoying this deep and utterly mindless slumber. In fact I was so attuned to every minute change in him that in truth I did not exist as a separate person. 'Dr. Werner' was really an aspect of him, 'Dr. Adam', who was looking after and at the same time maintaining the patient's comatose state. So there he was, alone really in his perfect space, with me fulfilling some auxiliary function which kept him physiologically alive, but psychically dead.

The coma patient fantasy expresses perfectly the quiet aspect of his way of being - perched precariously between life and death, in a retreat from relationship with others, denying the existence and hence, of course, the importance to him of the other person, the other mind. But 'underneath' this deadly quiet which is afforded him by the space in which only one mind, his, exists there rages a more violent battle. When challenged by me in the earlier stages of his therapy (particularly around the issue of the third session) he occasionally erupted to life and a very different fantasy burst forth: him ripping down my bookshelves and challenging me to a fight at the end of which there would only be one man left standing. There is no way for him that a space can be occupied by two people, with separate minds. But the fight to death which erupts in relationship with the other is a fight which he essentially fights with himself. Here is another picture of him: An asthmatic and a heavy smoker, who is being urged by his friends and his doctor to quit, he tells me, not without perverse pride in his recklessness, how even on the verge of a chest infection he would insist on carrying on. There he is, in his kitchen, on his own, still standing, still smoking, cigarette in one hand, inhaler in the other - undecided, you might say, between life and death.

I also want to say something about his dreams, since dreams open up another important, less consciously controlled view into the psychic life of the patient. Adam doesn't dream much - at any rate, he does not bring many dreams to therapy. The first dream, about one year into the process, was not a dream properly speaking, but a nightmare which hit him with the power of an hallucination. He found himself leaping out of his bed utterly convinced there was a big spider in his bed. He searched his bed and his room, but found none.

A few months later he brings his first 'proper' dream. He was in a big white modern space, like an art gallery. A human figure was suspended from the ceiling, its limbs strangely underdeveloped and swaddled in bandages which tied the arms to the body, reminding him of a mummy. There was a mask-like contraption where the face should have been, with lace work covering what might have been just a hollow. He tried to pull off the laces in order to reach through to the face, but he was very frightened that there might be nothing. He was in two minds whether to really attempt to find out if there was anybody in there.

In a more recent dream he is in the house of his parents. There are people in the other room, but he goes into the kitchen where he finds a very old and very sick dog on the floor looking at him imploringly. He thinks the dog might be dying and is pleading with him for help and human contact. Then he notices something odd about the dog, some slight but nevertheless rather bizarre discontinuity in its movements, which makes him think that this is not a real live animal, but a computer-generated, virtual

dog. He picks it up nevertheless; the dog then starts to convulse and shudder and dies in his arms whilst shitting and vomiting all over him. He awakes shocked and repulsed and saddened. (I will return to his dreams and their possible significance further down.)

Some developments

Adam pursued (or perhaps better: went along with) his relationship with Anna right up to the point where she was about to move to London to be with him. He remained intensely ambivalent, but when issued with an ultimatum by her ('either we move together or end') he finally decided he could not say yes. This relationship ended. Within two months he 'stumbled into' a liaison with a woman half his age which continues to date. This new woman is presented as entirely exchangeable and almost devoid of personality (she is, he tells me, very nice and young and pretty). The relationship is restricted to weekends; it is part-time and temporary. Adam constantly repeats this is only 'for the time being', and he says he knows he should end it; but, so far, he hasn't.

There was a major change regarding his work, too. About a year ago he was made redundant and, in spite of his initial confidence that he would find a new, perhaps even better job, he remained unemployed for some months. This has seriously undermined his view of himself as independent and limitlessly resourceful. The anxiety regarding finding work again has exposed him much more to his need for others, including his therapist. He has since found work on a freelance basis with a firm which keeps holding out to him the possibility of permanent employment, but he feels they are 'stringing him along.' Thus in relation to work his situation is also, but here against his wishes, part-time and temporary.

In the meantime he has fulfilled his ambition to refurbish his house in his own design. He converted what was a family house into a largely open-plan luxury bachelor pad. This was a costly process not only in monetary terms. Having to rely not only on architects and builders, but also on the hospitality of his friends who offered him temporary accommodation, exposed him to a great deal of anxiety. Now, having moved in to his new house, which to his great disappointment is not perfect (and, he fears, never will be), he wonders whether he has made a big mistake. His 'dream home', designed to be strictly single-occupier, now confronts him with the bleakness of his relational life. He finds himself in an empty space which he can't bring to life by himself. He now realises more than ever the lack of a meaningful relationship, but wonders still whether he can ever overcome his fear of letting anyone in.

How to think about this patient and his problem?

In a necessarily very condensed fashion I will now try to indicate what strands of theory I draw on to assist my thinking about Adam and the problems he presents. Each of these strands of thinking reveals the clinical material in a certain light, highlighting various aspects of the material in such a way that one is perhaps tempted to believe that they all add to each other creating an ever fuller picture of what is the case. It is important however to keep in mind that each of these approaches is founded on certain presuppositions - and leads to certain clinical consequences as far as the intervention strategy is concerned, if the therapist truly embraces the approach in question. I wish to make it very clear that there are many and far-reaching differences between the different strands brought into play here, and I am not suggesting that I integrate them, neither on the level of theory nor on the level of clinical practice. The different theories and their contradictions rather constitute a dynamic force field in which I operate and where the decisions I have to take seem to come about not unlike the vector of movement in a parallelogram of forces. Another, equally imprecise, way of putting this is to say that I see my presence and my interventions as an action (or a series of actions) based on the sum of my best convictions. In what follows I will try to show what these consist of.

In presenting my patient I have tried to give as full an impression as possible in this context of the 'life-world' of this man. The 'fullness' of this

account is of course severely limited by (quite apart from my own limitations) the constraints of space and the contradictory demands of a presentation like this, i.e. to show and to hide this person, for the obvious need to protect his true identity. The intention, nevertheless, in giving a reasonably 'full description' is to let the patient and his world become visible, an intention guided by a phenomenologically informed conception of truth. Truth, according at least to Heidegger's phenomenology, reveals itself if what is inquired into can be allowed to come forward in its own being (Heidegger, 1930).

Phenomenology in my mind is where all clinical thinking has to begin and end - and it is the base that has to be touched again and again. We have to start with what is presented to us, that is, we have to clear a space where our patients can present themselves to us as they are. (Now there is a problematic proposition if ever there was one! We can hardly get our head around what that could possibly mean, yet we cannot get away from from such a notion - it is too important; much of the endeavour of therapy hinges on it.) Also, we must not forget that in thinking about what is presented to us we are likely to have to draw on theories, i.e. systems of thought which are just, well, theories.

So to begin with, I would like to organise the clinical material around the central themes of an existential-phenomenological analysis as it was developed by Heidegger and applied to psychotherapeutic practice by the early existentialist analysts Binswanger (1946) and Boss (1980).[4] Existentialist analysis raises the question of the openness of the person to dimensions of being which 'come with' being human - the conditia humana, as this 'package' is also known. It investigates the mode of being-in-the-world of the patient pursuing understanding through the analysis of the person's particular way of relating to the existential dimensions of time, the lived-in-world, the being-with-others, and the inevitability of choice. Binswanger writes: '[...] spatialisation and temporalization of existence play an important part in existential analysis. [...] at least some insight into the respective variations of the structure of our patients' time' has to be gained as part of such an analysis' (1946, p.194).

In relation to time we find my patient, a self-confessed 'Peter Pan', caught up in a dream of eternal youth, a fantasy of a never-decreasing reservoir of future opportunities and eventual choices, a life constituted by repetitions and postponements, which, taken together, amount to a strenuous denial of the fact of his ageing and ultimate death. This denial of the passage of time itself supports in a precarious fashion his peculiarly suspended life of part-time commitments and temporary arrangements.

The space which he seeks to create for himself is strictly self-designed and 'single-occupier', almost systematically excluding possibilities for a life shared with an other person. He cannot bear it when his 'girlfriend' makes a suggestion how to furnish his house. In fact, he safeguards his space by obsessively removing any traces of the presence of her or others. Problematically for him the space thus emptied of the other is then experienced as lifeless and bleak. He seeks to circumvent this problem by putting in place a look-a-like partner, who whilst helping him against his fear of loneliness and depression does not confront him with the problem of a separate mind.

Seemingly paradoxically, given his need to be in sole control, he feels he has never chosen his partners; he feels he was always rather passive when they made their choice for him. He had to know he was desired; to be the one to feel and show desire would have exposed him too painfully to a lack in him and thus would have given too much importance to the other. It had to be him who had what was missing; he was the resourceful one, he paid the bills. In this way he could keep the awareness of any lack or

[4] The exploration of existentialist-phenomenological ideas presented in this paper is perhaps more in line with Binswanger's than with Boss's clinical application of Heidegger's thoughts. Binswanger (1946) uses Heidegger's philosophical analysis of Dasein as being-in-the-world and applies it to the individual person and their 'world design' - an 'application of' Heidegger's philosophy criticised as 'too ontic' by Boss (1980).

limitation firmly lodged in the other whom he took care of - but held at a distance.

Returning to the theme of death, the material he presents seems replete with it. Not however in terms of the death of another person, or even the end of his own life - which he claims to be looking forward to as an end to suffering and which he sometimes seems to be almost actively, recklessly pursuing. What we find in the material is a whole host of unavoidable indications that he is stuck in something deadly, that what ought to be alive is being deadened. He is obviously not dead, but he is not alive either. He is the 'coma patient'. The question which presents itself can perhaps be put in this way: Can he be alive? Is there life before death? - or, more fully, Can he let himself come to life with an alive other?

The question arises how to think about the very powerful tendency of this man to retreat into his self-designed and strictly single-occupier space, a tendency which obviously deadens any possibility of creating any sort of life with another person, let alone a family, the desire for which was after all his stated reason for seeking therapy.

From an existential-phenomenological perspective Adam has closed himself off to essential dimensions of his being. He has retreated to a considerable degree from an alive interaction with others, reduced his living space to a bleak, unpopulated, if no doubt very well designed bubble. The position of 'temporary accommodation' which characterises both his interpersonal and his work life could be called 'permanently temporary', to mark his refusal, for the most part, to acknowledge the passage of time - an acknowledgement which might force him to take his own situation seriously. This analysis gives rise to a therapeutic practice which aims to help this man in what is undoubtedly a difficult and painful confrontation with precisely those aspects of his life from which he has closed himself off.

I will go on to show that this therapeutic trajectory is largely compatible with an intervention strategy based on psychoanalytic thinking, although it draws its strength from different philosophical foundations.

A pure existential-phenomenological approach disallows explanations in terms of metaphysical constructs not given to us qua phenomena, that is, as data of our immediate experience. Consequently, notions like 'the unconscious' or 'the drives' are considered as quasi-objective reifications running counter this philosophy. Whilst I would agree that such notions need to be subjected to critical questioning, I do draw on these ideas for the sheer richness they can give rise to in clinical thinking.

Psychoanalytic perspectives

From a psychoanalytic perspective (which, as we will see in a moment, does not really exist in the singular) this patient's presentation seems to demand to be thought about in terms of the concept of narcissism.[5]

What is narcissism? For reasons of space I can only give the briefest of surveys over this vast area. For Freud, secondary narcissism, which is what we are thinking about here, is a withdrawal from object love due to a failure to confront the Oedipal scenario; it involves the investment of the person's own ego with the love which is withdrawn from the other (Freud, 1914).[6] Narcissism thus is a defense against anxieties stirred up by love for the other. This became evident in my patient's therapy when his narcissistic organisation weakened and he became more aware of my presence as a separate person, and especially when he started to acknowledge his need for me as his therapist.

[5] I will not enter into the debate whether narcissism should be thought of as a psychic structure in its own right, or as a defence mechanism which can be found in a variety of psychic organisations.

[6] This redirection of libidinal investment onto the self rather than the world meant for Freud that the narcissistic patient is unavailable for psychoanalytic treatment since the lack/denial of the desire for the other precludes the establishment of the transference, which, as we know, is the force on which psychoanalysis relies for its transformative action.

This shift provoked considerable homosexual anxiety in him. One of us, more likely me than him, was going to overstep a line and make a sexual advance. It is possible of course to think of this development as 'just' a variation of a narcissistic object choice - to love and/or be loved by someone like himself. Quite possibly, he was identifying me - and/or himself - with his unboundaried and aberrant father. Either way, in the absence of a parent who is secure in their own couple (me in the transference in my relation to my own private partner/wife or to my profession) he is left with an overpowering anxiety of being taken over by the desire of the other (mother/partner/me). (I come back to this point when I talk about Lacan.)

From within the Kleinian tradition, I wish to highlight the work of both Rosenfeld and Steiner. Rosenfeld (1964) stresses the narcissistic patient's denial of separateness and the heavy reliance on projective identification in his defence against dependence and envy.

> *"In narcissistic object relations defences against the recognition of separateness between self and object play a predominant part. Awareness of separation would lead to feelings of dependence on an object and therefore to anxiety. Dependence on an object implies love for, and recognition of, the value of the object, which leads to aggression, anxiety and pain because of the inevitable frustrations and their consequences. In addition dependence stimulates envy, when the goodness of the object is recognised. The omnipotent narcissistic object relations therefore obviate both the aggressive feelings caused by frustration and any awareness of envy. When the infant omnipotently possesses the mother's breast, the breast cannot frustrate him or arouse his envy " (1964, 171-2).*

In his 1971 essay Rosenfeld links the narcissistic defense to the death drive, understood in the Kleinian sense as the innate destructive tendency directed against the object. Steiner (1993) describes how in narcissism various aspects of the psyche work together as a highly complex and deeply entrenched organisation so as to provide what he terms a psychic retreat, that is a state in which denial of separateness is maintained through the projection of need, denigration and destruction of the needed object and an idealisation of one's own omnipotent organisation.

I believe my patient provided me with ample evidence to support this kind of reading. The 'coma patient' fantasy illustrates some of the important aspects - the denial of separateness, the possession of me as the doctor, that is, the possession of the therapy, and the idealisation of this state of affairs. To the extent that I was useful to him the importance of the sessions had to be 'shredded': after sessions he would habitually return to his car and blast away any thoughts and feelings related to the sessions with the help of loud music; over the weekends he would return to his 'independent', 'self-sufficient' state by 'blowing his mind' indulging in excessive drinking, drugs, parties. When he had to cancel sessions, he apologised profusely - so much so that it became clear he felt that those missed sessions were my loss rather than his. It transpired that, like his girlfriends, I was the receptacle of his projected need. For a long time he had convinced himself he came to the sessions so I would not be too lonely and depressed. He imagined me sitting in my consulting room all week waiting for his visits; he had to keep me alive.

When this organisation became more permeable he had to acknowledge that ends of sessions, weekends, and holidays became more problematic to him. He started talking about not wanting to leave, lingering in the hall after the sessions, stroking one or the other of my cats. He talked about his curiosity about what was going on behind the doors which were shut to him, he wanted to 'nose around', then fantasised about being invited to my dinner table where he would be welcomed (or rejected) by my family. This made things easier, but also more difficult for him: he realised that, in letting himself think about my 'outside' life, my private couple, that he became very envious. He expressed a wish to destroy my separate life, my couple - 'I can't bear seeing that you have what I haven't got.'

Symington (1993) places narcissism at the core of every neurotic organisation. His description

of narcissism, which echoes all of the themes so far developed, emphasises the obliteration of self-knowledge as well as the denial of the importance of relationship. In a move which might be strictly speaking called existentialist rather than psychoanalytic he stresses the element of decision/choice the person has in responding to life's traumata by opting either to give in to the 'narcissistic pull' or to choose what he, somewhat mystically, calls 'the life giver'.

For Lacan too narcissism is a central problematic, inextricably linked to the development of the ego. The child-subject receives his or her identity via the identification with the mirror image, an image that is always more unified, more integrated, more 'perfect' than the chaotic and conflictual psychic reality of the child. Importantly, the mirror image comes from the outside, it is tied to the image of the other person who speaks the language of 'the Other'.[7] Identification with the mirror image is therefore not, as some object relations theory suggests, a route to the realisation and/or recognition of one's ('real') self but, on the contrary, leads to a mis-recognition which, whilst providing a sense of unity, is ultimately self-alienating. The narcissistic person remains caught up in this imaginary identification (i.e. the identification with an image) evading the confrontation with the Oedipal scenario. It is only through the intervention of a 'third object' that the subject gains entry into what Lacan calls the symbolic order, where he finds his bearings by taking up his position in the system of social bonds and language. The narcissistic person, however, defends their imaginary omnipotence tooth and nail, refusing to acknowledge the existence of difference - a move which would entail the acknowledgement of loss, dependence and limitations. He thus remains caught up in the imaginary (dual) relation; a third object (a 'father', who acts as the symbolic 'Father') has not entered into the relation as a limiting factor - hence the anxiety that desire, if given into, is limitless, and therefore necessarily destructive. (What is limitless is destructive to the subject.)

After the breakdown of his father as father and the consequent breakdown, in effect, of the parental couple, Adam ends up on his mother's side, the place vacated (if it was ever fully occupied) by father. The absence of the actual father by his mother's side, but also the lack of the symbolic father as a limiting factor regulating his relation to mother (including his mother's desire for him) leaves him with terrible anxiety at the prospect of entering into any couple relationship - including the therapeutic couple.[8]

I think this is all I can present here in terms of the theoretical ideas guiding my practice. This account is far from complete; it represents perhaps the main strands of my conceptual thinking, with other ideas operating in their various ways (not all of them conscious) in the background of my mind.[9] I wish to stress again that the theoretical ideas are not integrated (and in all likelihood not capable of such an integration), since they are based on very different fundamental presuppositions. There is no space here to show what these differences consist of and to discuss the relative merits of these views. What I hope to have at least indicated are the different clinical insights these different perspectives can give rise to. For the remainder of this paper I wish to concentrate on the direction of my interventions - my

[7] The 'big O' Other of Lacanian theory is - in a doubtless crude over-simplification - the system of symbolic meanings (first and foremost: language) existing prior to and outside of us and confronting us with 'The Law', i.e. symbolic castration.

[8] This analysis in effect rests on Lacan's re-interpretation of Freud's concept of castration. The problem here is not, as Freud thought, the threat of (actual) castration by the father, but, on the contrary, the absence of a limiting (that is, symbolically castrating) father intervening in the libidinal relation between mother and child. Verhaeghe (1997) demonstrates how in the famous case of Little Hans the threat of castration was uttered by the mother; and it needed the background intervention of symbolic 'Father' Freud (who was supervising the 'analytic treatment' of the boy by his father, who had been in analysis with Freud) to persuade the father to intervene by acknowledging at last what Hans knew, but had to repress: the fact of parental sexual intercourse.

therapeutic strategy, if you like - resulting from these theoretical considerations.

The direction of the work

To begin with, two important, if somewhat general comments on my intervention style. Whilst I draw here on two 'founding fathers' and one 'founding mother' of psychoanalysis not famous for their relational style, I seek to enter into a dialogue with the patient which can allow the joint exploration of his experience, an important aspect of which is his experience of the therapeutic relationship (i.e. the transference as understood in British psychoanalysis). This very brief comment on how I position myself in the therapeutic process leads on to my use of interpretation. Interpretation should not, in my mind, be explanatory (furnishing the patient with answers, of which we could say he already has too many - or, at any rate, too definite ones), but instead allusive and exploratory (raising important questions which are thought to belong to him).

These comments on technique (if that is the right word) are not incidental to my thoughts about the overall directedness of my interventions. As I hope I have shown, the question whether there is one mind or two minds present in the therapeutic space is important in any therapy, but never more so than when we are working in the area of narcissistic organisations. I believe that the question whether it is at all possible for two minds to coexist and to enter into a constructive exchange is at the very heart of my patient's problems; it is therefore vital that the therapist's interventions, which are always interventions in a relationship, hold open this possibility. Like much of contemporary psychoanalytic practice my intervention style is probably considerably more 'relational' and 'intersubjective' than the bulk of my theoretical references (much of which I would gladly recognise to be 'Old Europe') would appear to suggest.

We have seen how powerful a hold Adam's conviction, that he must be the sole designer and sole occupant of his space, has over all aspects of his life. This is perhaps most evidently manifested in his 'coma patient' fantasy, a fantasy which rather shows up that 'one mind' in reality amounts to 'no mind' at all, to the 'never mind' of him shrugging off his investment in life. The therapeutic frame creates a space for this fantasy to come forward but to my mind it is vital that the therapist does not join in. The goal becomes instead to explore the fantasy and, in thinking about it together, to unsettle it and undermine it. Ultimately, the narcissistic slumber afforded by this kind of psychic retreat has to be disturbed. A doctor has to appear at this patient's bedside and to start talking to him in such a manner that he realises he is indeed being addressed by someone existing outside of his own mind.

This exploring, unsettling and undermining of his narcissistic retreat, bit by bit, and again and again, is the central task of his therapy as I see it. We do this always in relation to the material he brings, with the focus of his preoccupations shifting between the lack of perfection of his designer home, his awareness of the non-relationship he keeps going with his girlfriend, the temporary state of his work situation, his refusal to face his health problems or his real

[9] One could introduce here a distinction in terms of the usage made of certain theoretical ideas between 'core concepts' and 'regulative concepts'. Core concepts have a major influence on clinical thinking and would, in more or less intentional fashion, guide many of the therapeutic interventions. I think it is important that the core concepts add up to a relatively coherent intervention stategy, i.e.that they pull in one overall direction. 'Regulative ideas' function more in the background, but can occasionally be used in order question one's overall stance and to think through potential problems with particular cases. Naturally, this is of special importance when therapy processes get stuck. An example of such a 'regulative concept' in my case is Kohut's theory of narcissism as a result of deficient self-objects. Its emphasis on empathy no doubt gives rise to an important and interesting clinical perspective and without doubt offers a substantial challenge to my 'core concepts'. It does however demand a type of clinical practice which runs counter to the trajectory suggested by my core concepts and would therefore serve to undermine their therapeutic leverage rather than enhance it.

age, the lack of his own desire for the other and the compulsion to look after the need in the other, his prevarications and postponements,

his fear of being on his own at one moment and of being invaded the next - and so on.

We have over the years assembled a rich arsenal of metaphors with which to address his struggle. There is a lot of talk of doors, open and shut, people turning up on one's doorstep with their suitcases, burglars, invaders; we talk about shared or single spaces, dialogues v. monologues, intercourse v. masturbation etc. The tendency has to be always watched however that a useful, creative exploration degenerates into an obsessive and ultimately solitary inspection of every nook and cranny of his mind, primarily with the purpose of postponing a real engagement with me. Recently Adam got quite excited when he heard me say something about how little sense he had of this therapy possibly being a space where we could work something out together. He thought my 'we' opened up hopeful possibilities he had never really thought about and elaborated in some detail what he now thought such a 'we' might be capable of. After a while I said to him I thought he had 'highjacked' the 'we' and scuttled off with it back into his own, single-occupier space to have sole ownership of it. He would agree with such an intervention - which can be part of the problem, because for him to agree can amount to neutralising my contribution.

Whilst there persists a tendency to retreat into his self-designed space, I believe that nevertheless his attitude towards his therapy and me has undergone a significant shift. He is much more ready to acknowledge his wish for/need of the sessions and has become much more likely to be affected by any breaks or cancellations. His idea that it is me in bad need of his sessions has taken rather a knock, and he is much less likely to engage in any prolonged idealisation of his disengaged state. He has become increasingly interested in the fact of my separate existence, my house, my family. Whilst, as I have already mentioned, this initially triggered significant envy in him and a wish to attack 'my couple', it has also forced him to confront in different ways his own wish to be in a creative, life-giving couple. In fact, I believe that his realisation of my couple, which excludes him, can now serve him as a safeguard against his otherwise overwhelming anxiety of getting caught up in the desire of the other. He has recently discovered the thought that if he has a therapist who is a separate person, then perhaps he could talk to him and ask him questions!

As a different way of thinking about his struggle with 'the other' and any development through therapy I want to come back to his three dreams. Inevitably, the richness of the associative material and the various ways in which we spoke about the dreams can hardly be touched upon in this very brief discussion. The sudden, shocking appearance of the spider in his bed was not, I thought, a dream proper, but more like a hallucination or a nightmare which acted on him with the force of a traumatic event.[10] The other here is presented (rather than re-presented) by the image of the spider, it is the other as the wholly other whose intrusion is unthinkable, undreamable even.

Regarding the two other dreams what struck me was their emphasis on strangeness and artificiality. The question seems to be posed whether there can be a real object - in the first dream we have the uncanny hollowness of the mummy-like figure with its laced-up face, in the second the virtuality of the suffering dog. Interestingly, and encouragingly, the artificiality breaks down in the second dream, the dog is suddenly very real - at which point there is a very disturbing confrontation with death and the 'shitty' aspects of life which seriously spoil his always perfectly turned-out self image. With the penetration of the narcissistic psychic organisation, which turns life and the alive other

[10] Following Verhaeghe (2001) I think of nightmares as 'failed dreams'; something arises in the psyche which pierces its 'protective shield' (Freud 1920) the stimulus intrudes, but cannot be properly worked over and re-presented in a dream. Dreamwork fails in its function to safeguard sleep (Freud 1900); instead the person awakes, disturbed psychically and physiologically, 'in a cold sweat.'

being into an artefact, which in his fantasy is in his omnipotent control, he is confronted with a seemingly overwhelming array of problems: ageing, suffering, need for the other, loss, death, shit, hostility, guilt etc. - in other words the whole gamut of issues which narcissism, as I characterised it earlier, is designed to defend against.

I hope this will suffice to give an indication of the overall direction of the therapy. I believe its trajectory is in line with and supported by the different strands of conceptual thinking which I outlined above. Despite their considerable disagreement on many substantial questions these theories point clinically in a similar direction. This is what allows their different perspectives to add to, rather than subtract from, each other as far as the much needed therapeutic leverage is concerned.

In conclusion: 'Call this integrative?'

The way of operating with multiple theoretical perspectives presented here conforms with none of the definitions of integrative strategies given in the literature (Norcross and Newman 1992; Goldfried 1995), nor is it eclectic. Perhaps this paper will be seen to serve the aim of illustrating the kind of integrative process outlined in my paper 'Failing Better' (Prall, 2004), which emphasises the ongoing development of clinical thinking resulting from the engagement with the differences between the different theories rather than their combination into a new system.

In this clinically focussed paper I have concentrated on the point that the therapist whilst being informed by different theories, must commit him/herself to a fairly defined therapeutic position. Too much shifting between intervention strategies weakens therapeutic leverage rather than enhancing it.

The commitment to a cause of therapeutic action has to be carried by a degree of conviction which must not be allowed to be undermined by a more intellectual commitment to an ideal of multiplicity of understanding, let alone an ideal of a coherent integration of what are after all different theories. This in my mind constitutes a limit to what can be 'integrated' in clinical practice. Whether or not this way of operating with different approaches is rightfully and most appropriately characterised as 'integrative' I would like to leave to you to decide.

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Harbrinder Dhillon-Stevens

Personal And Professional Integration Of Anti-oppressive Practice And The Multiple Oppression Model in Psychotherapeutic Education.

Abstract

This article examines issues of anti-oppressive practice (AOP) within the British counselling and psychotherapy professions. It explores what AOP is and introduces a model of multiple oppression to understand the interconnected and yet the specific nature of oppressions whilst considering structural dimensions to oppressions. It challenges the existing training of therapists in relation to such issues and attempts to provide a platform for considering a more political and socially aware debate on the subject and moving away from the current 'cultural / multi -cultural perspective' usually adopted by the professions of counselling and psychotherapy.

Introduction

The areas of difference, discrimination and oppression are complex, multi-dimensional, emotive and psychologically challenging and the potential for ruptures are enormous. However, I would argue that if we can get beyond the shame, hurt, anger and rage the potential for healing and better understanding of self and other through dialogue is rewarding and liberating.

I would like to define the term black as I use it. For me it is a political term and encompasses people from Africa, the Caribbean, Asia and ethnic minority groups who experience racism. I recognise that not everyone will identify with or even share this definition. I am aware that all sorts of reactions take place when I define myself as a 'black woman born in the Indian sub-continent'.

My own history and arrival to this country are embedded in the roots of oppression and discrimination – present day as well as intergenerational. There are many incidents I could cite but the one that springs to mind and reminds me of the specific nature of the British context is as follows. I remember being brought up in Southall, London, a very large 'black' population. At the age of 7 years old I was bussed out of Southall to attend school in Northolt National Front terrority. It was decided that "there were too many Asians around". This policy caused me shame, hurt and humiliation as I faced overt racism and violence in the playground. This experience is still very raw but reminds me that multicultural approaches are limited: all the festivals and cultural differences can be cited in the classroom with an attempt to embrace 'difference' but racism is still present and perpetuated in the playground. From such experiences I have come to be critical of 'multi-cultural' approaches within the UK. Multi-culturalism which attempts to superficially embrace difference through targeting differences such as food, clothes, festivals and so on, but ignores issues of race, racism and power dynamics, remains unchanged.

Multi-culturalism is the main approach I would argue that the counselling and psychotherapy professions have adopted

in working with issues of difference. This approach is concerning and adhering to this philosophy in 'working with difference' has caused a lack of forward movement in this area within the psychotherapy and counselling professions. Working with 'difference' is an important subject within the counselling and psychotherapy professions. However, the theoretical and practice dimensions have focused largely on 'culture' and 'diversity'. It is my belief that these are limiting frameworks. The cultural dimension either incorporates or ignores race and ethnicity. The diversity dimension embraces difference but the norm is not challenged or examined, which again means diversity is accepted at a superficial level. Furthermore, issues of power and socio-political factors are often ignored and separate oppressions such as gender or disability are not considered. My work in this field seeks to provide an alternative theoretical framework. An exploration of the interconnectedness of oppressions to the self and consideration of a multiple oppression model offers new ways of working with difference (Dhillon, 1997; Dhillon Stevens, 2001).

In an article on this subject, how I attune or misattune to the reader will be through the terms used. The use of terms such as 'difference' as opposed to 'oppression' will have different impacts on different people. You might at this point wish to consider how these words are impacting on you?

In undertaking this article I was asked to consider 'what is your model'. I began thinking about this and realised 'my model' has developed and been enhanced by various experiences as a practitioner, educator and researcher that have led to the adoption of various principles that inform my theoretical knowledge base, my attitudes and values and practice as a clinician. I will outline some of these principles before considering AOP and the multiple oppression model.

Issues Of Oppression And Ethical Professional Practice

Before considering AOP within counselling and psychotherapy, it is worth reflecting on the development of difference and oppression within the British context.

Historically, in the 1940's and 1950's the oppression that was central to the discussion of difference was 'class'. This was followed by addressing in the 1960's and early 1970's the discourse of gender and gender equality for women, promoting feminism. Basically in the British context class and gender discrimination were more prominent and this was reflected in equality legislation with the introduction of the Sex Equality Legislation consisting of the Equal pay Act 1970 (1983;2003) and the Sex Discrimination Act 1975 (2003). Later in the 1970's the focus developed into 'race' and Race Awareness Training (RAT) was promoted in the UK. This developed the introduction of concepts such as 'racial equality' and the introduction of the Race Relations Act 1976 (2003). It is interesting to note that 'racial grounds' (S.3) as defined in the legislation includes: colour, race, nationality (including citizenship) and ethnic or national origins. It is a misnomer that the Race Relations Act 1976 is to do with 'race'. A white Irish teacher successfully utilised the legislation in his claim that Irish jokes in the staff room were discriminatory.

The confusion between race and ethnicity has continued. In the 1980's there was the promotion of such concepts as 'Anti-racist practice' (ARP) and 'Anti-discriminatory practice' (ADP). These concepts were developed in the helping professions, initially within social work. This was a move to improve practice and to integrate the philosophy of race equality with the practice, especially in delivering services to individuals from marginalised groups. It is interesting to note that such concepts were linked to political discourse between the political left and political right within the UK. The backlash to justice and equality issues came with Virginia Bottemley MP and her attack on 'political correctness'. This term has since been used to undermine all principles and discourses relating to justice and equality. The term is a reaction to equality issues and seeks to ridicule and undermine equality strategies. This term is used in a sweeping way and has become an obstacle in developing critical reflective practice. This backlash introduced

the way for 'embracing difference and diversity' discourses where values around oppression and discrimination were watered down. AOP emerged as a reaction to this and is significant currently due to the recognition of structural oppression in British society and the notion of institutionalised racism evidenced by the Macpherson Report (1999) into the death of Stephen Lawrence.

It is now interesting to follow the historical emergence of such concepts through counselling and psychotherapy. The professions in the main have advocated for multicultural and cross-cultural approaches (most of the literature developing from the USA experiences). In the British context transcultural approaches developed which were still rooted in working with cultural differences (D' Ardenee & Mahtani, 1989) and then the notion of Equal opportunities. Lago and Thompson (1996) promoted 'Race and Culture' in an attempt to emphasise 'race' and later discourses included Intercultural Therapy (Kareem and Littlewood, 1992) and Gay & Lesbian Affirmative Therapy (Maylon, 1982). ARP and ADP have had little exposure in the profession and so too has AOP.

In examining the very brief historical sketch above it becomes clear that there is a legal as well as moral context to such debates. Psychotherapists as providers of goods and services need to be particularly aware of the legal issues and implications of service provision to clients, especially in terms of the Race Relations Act 1976; Disability Discrimination Act (1995); Employment Equality (Sexual Orientation) Regulations 2003 and the Employment Equality (Religion or Belief) Regulations 2003. The legal and moral perspectives require therapists to critically evaluate their own values, attitudes, prejudices and experiences towards oppressed groups and to consider the philosophical and epistemological values of the different approaches and consider their own political consciousness. The latter I feel is a crucial ingredient in adopting an AOP stance. However, it seems to me we have removed politics from psychotherapy and this is reflected in our trainings. The teaching of philosophy and political thought seems central to this debate, to raise socially conscientious practitioners.

The above debate reflects the current need for us to consider AOP in counselling and psychotherapy and the importance of these issues to be embedded in psychotherapy at all levels.

Issues of AOP need to be considered as good ethical professional practice and therefore integrated within all aspects of therapists' and supervisors' work (training, research, theory, and clinical practice). Often these issues are seen as 'extra' or 'special' issues and given little more than a cursory mention. Therapists need to be aware that 'we live in the world' and that structural issues (social, economic, political, cultural) impact on our work in the therapeutic space and in the lives of our clients. These structural issues can put constraints on people's lives and they exist and are perpetuated by our desires - whether conscious or unconscious – to maintain them (Proctor, 2002).

As individuals and as therapists, we do have an impact on such structures; we either accept them or we challenge them. This raises the question of how therapists understand and work with contextual issues. Do we hold the different oppressions in a hierarchical framework, dependent on the way in which in our own schema (Beitman, 1992) we have experienced and constructed them? How do these issues enter the therapeutic space and relationship? And how do therapists demonstrate that they have addressed these issues and are aware of their prejudices / discriminatory attitudes, as well as the potential these have to impact on their work?

In my doctoral research: Healing Inside And Out: An examination of dialogic encounters in the area of anti-oppressive practice in counselling and psychotherapy (Dhillon-Stevens, 2004) a questionnaire was distributed to counsellors and therapists. Therapists were asked, "As a client have you ever explored any prejudice you have in your own therapy in terms of race, ethnicity, gender, sexual orientation, disability, age, class, religion, language and culture?". The majority of responses indicated that therapists did not tend to explore AOP issues

in their personal therapy. This lack of personal exploration in terms of our own schema (Beitman, 1992) must raise questions about our ability as therapists to deal with these issues professionally. Where respondents stated they often explored these issues, the attributes they explored often related to aspects of their own personal identity which they had disclosed at the beginning of the questionnaire. For example if the respondent identified themselves as gay / lesbian, these attributes received a high score in relation to this question. Only one respondent explored all of the attributes in personal therapy often. This respondent identified herself as "female, from a marginalised ethnic group, heterosexual, working class and disabled". The AOP attributes identified are central to the formation of our identity development and at different times they will be in the foreground or in the background. How can we separate such aspects as gender from race? Which is the primary aspect for the client? Which is primary for the therapist? How does the therapist understand this?

If we have not explored our attitudes to these issues, including our own internalised views, we will not be conscious of them in our work and there is a potential for them to enter the therapeutic space. As Lago & Thompson (1996) state, "all human beings – counsellors included – do respond to and judge others, initially, on the basis of their own prejudices" (Lago & Thompson, 1996: 33). The point raises a serious question about how psychotherapists can explore these issues. Such explorations are limited in training and as a result the therapist is likely to have limited knowledge and personal experience (skills and attitudes). The personal is the professional. If these issues are not being dealt with, there will be no modelling of engaging with them in therapy or in the wider profession. This is interesting in terms of the personal growth and development of therapists. We are encouraged to explore our history, developmental deficits, and our relationship patterns, to become aware of our transferential material. However, we are

not encouraged to explore our own racism, homophobia, ablism, sexism etc.

The Personal Versus The Professional

As stated, any discussion of AOP must begin with an examination of one's own values and influences, and an honest appraisal of how these influence and impact upon one's work as a professional.

I am conscious of the need to own the history, experiences and values that have contributed to my interest in this subject. Many of the influences on my professional development are grounded in my racial, cultural and linguistic upbringing. Psychotherapists need to be explicit regarding the principle of personal values and beliefs, especially if these are oppressive or discriminatory and how these impact or the potential for them to impact in their work with clients. It is interesting to note in the 'BACP Ethical framework for good practice in counselling and psychotherapy' (BACP, 2001) under 'Values of counselling and psychotherapy' this principle is omitted. Furthermore, as regards 'values, ethical principles and personal moral qualities' I would argue these are open to interpretation by each individual practitioner and where issues of discrimination and oppression are paramount there is the potential for practitioners to be oppressive. For example, my understanding of 'Autonomy' is very different being brought up in a Sikh family / community and as a member of an oppressed group. Given psychotherapy and counselling are white middle class professions values such as 'appreciating the variety of human experience and culture' again emphasise a cultural approach to working with clients rather than an anti-racist or anti-discriminatory approach. Such outcomes need to be far more explicit so practitioners, supervisors, and trainers all understand the specific issues rather than the generalisation and therefore the potential marginalisation of such issues.

There is a need to consider such issues in training as ongoing, life long learning issues. However most trainings incorporate a one off training consisting of 2 – 3 days a year or for the entire training. This gives the message to trainees that these issues are not that important or that this is sufficient to understand such a complex subject. In my research, white trainees

commented on the attitude of such training as 'done and dusted'. In discussing issues of oppression with black and disabled members and hearing their experience of everyday oppression, the white able-bodied members reflected that this attitude of 'done and dusted' was perhaps a way of avoiding dealing with the gravity of experiences of oppression and the ongoing nature of oppressions.

Specific Learning Outcomes In Relation To Issues Of Oppression

The research questionnaire, already mentioned, raised another important theme – the need for a competency framework. Of those therapists who responded, 73% stated that they felt the need for a framework to support them to consider and direct their work in this area. They questioned the way in which these issues were addressed in training and supervision and believed it needed examining. If therapists feel they need a framework, it is likely that this may also be useful for supervisors.

AOP issues need to be incorporated throughout the curriculum and for this to be reflected in the teaching and assessment criteria. In the research the inquirers used the terms "therapists who have socio-political awareness and those who are non-aware". This developed because black members felt they had encountered experiences with other black therapists who had no awareness of oppression. This highlights the need for training for all trainees in all areas of oppression. For example, how are black trainees helped to explore their homophobia or internalised racism or how are all able-bodied trainees to explore their attitudes to clients / people with a disability? What are the training needs of black gay men?

A framework for psychotherapy and counselling could consider three distinct areas for professionals to engage with:

1. To demonstrate an understanding of discrimination and oppression in terms of a knowledge base.

2. To critically demonstrate that they can examine the impact of their values and beliefs (attitudes) on their work and be clear about moral and ethical principles and the management of ethical dilemmas.

3. To demonstrate concrete skills to work with a range of oppressed clients (individual / group).

Therapists need to have an understanding of how the past historical / ideological legacy of counselling and psychotherapy may impact on issues of oppression. These values are assimilated into the profession of psychotherapy in terms of training, supervision, research and clinical practice. Therapists need to be aware of racism, sexism and homophobia in the early literature of psychoanalysis (critiqued by Dalal, 1988; Littlewood & Lipsedge, 1989) and how these issues have seeped into psychotherapy from psychiatry – rooted as it is in colonialism and theories of racial differentiation. It is no wonder that a single approach to working with issues of race / oppression has been seen to be problematic, for the origin of that approach is located at a particular point within European culture (Lago & Thompson, 1996). This raises the question as to what approach or orientation is more suited to the delivery of AOP teaching in training ?

The Impact Of Language

Language in the arena of AOP is crucial; it has the potential to disempower or empower others. Furthermore, language coupled with professional jargon has even greater potential to disempower others. Language used relates to personal awareness, understanding the theoretical discourses of oppression and a conscious commitment to understanding power dynamics, how these operate, and are maintained by use of certain terms by those in the majority.

Defining terms to describe people and intricate aspects of their life experiences is always very difficult and often unsatisfactory. Language in the arena of AOP is constantly changing and the reader is asked to critically reflect on the

use of terms rather than adopt them as definite or prescriptive constructs.

It is also worth noting that some oppressed groups are currently reclaiming language for their own use: e.g. disabled people calling themselves and others 'crips' or gay men using 'queer'. It is considered offensive for able-bodied people or heterosexual people to use such terms.

My doctoral research (Dhillon Stevens, 2004) evidenced the impact of language in the therapeutic space. A white therapist in the role-play of being a client was asked what her experience would have been if the therapist had used words like 'discrimination' and 'oppression' to talk about her experience. She replied that 'discrimination' was a word that she accepted and that it validated her experience. However, 'oppression' she said evoked a very different reaction. She said, " I think I would have reeled against that word". In exploring this further, she felt 'oppression' was a strong word and implied a 'victim'. This she said was "way too strong... I couldn't go there." 'Discrimination' implied that she would have been "really unlucky". She said " It just has a totally different emotional feel for me".

The construct of oppression was something associated with being a victim and as a white person she did not feel this nor that she had a right to own or connect with this word. Interestingly enough the words resonated differently with black and disabled members. They said that 'discrimination' would alienate them from the therapist and give them a sense that the person did not really understand their experience, whereas 'oppression' would create a sense of feeling heard and understood.

This exchange demonstrated the importance of these words for different groups and, I would argue, that the client as a white person, has internalised the idea that she is not oppressed but that other groups are, so projecting out that they are victims (how does this unconscious value impact on her work with clients from oppressed groups?). In this way, members of the norm may experience discrimination, but members of groups not of the norm - black or disabled - experience oppression, which is a more systematic experience. This for me evidences the difference between discrimination and oppression not just theoretically but in practice.

The British Context And The Discourse Of Oppression

Although there is a considerable amount of literature in the USA, it is important to consider literature within the British context. Issues of oppressions do have commonalties globally. However, I would argue they are differently constructed due to historical, cultural, social, political and economic differences. My work has focused on issues relating to the British context.

The reader needs to be aware of two issues (1) that the discussions around difference, discrimination or AOP all have a theoretical base and (2) that AOP is just one discourse within this vast subject. Psychotherapists have not really understood that there are different discourses from multiculturalism, cross cultural, transcultural counselling, valuing difference and diversity, inter-cultural therapy, gay and lesbian affirmitive therapy, race & culture, equal opportunities, anti-racist and anti-discriminatory practice to AOP. These have evolved at different times within the British context and result from different values and ideologies regarding oppression within the British Context. In understanding the above, the practitioner will become aware of benefits as well as the limitations of each approach (Dhillon-Stevens, 2003). This understanding is crucial in locating therapists' practice. Unfortunately, I do not think psychotherapists and psychotherapy trainings are clear of the distinctions between such approaches and how these affect practice.

I am always disappointed and confused when words like 'multi-cultural' and 'anti-oppressive practice' are put together in the same sentence as if interchangeable. These are two separate discourses with different philosophical bases that do not, for me at least, co-exist.

As a model that works in terms of empowerment and liberation (Phillipson, 1992), it considers power dynamics as central to the relationship and considers both the internal and external world of the client.

It requires a fundamental re-thinking of values, institutions and relationships: therapists are seen as change agents and are proactive in considering these issues, rather than reactive. Therapists accept that they can have influence at the individual-to-individual level but are also aware of their contribution at the structural level in terms of institutional levels and the cultural norm. The therapist is aware of all these levels, as demonstrated in Fig. 1, and can operate from each of the levels at different points of contact in the therapeutic relationship.

An integrative relational model would consider the following levels:

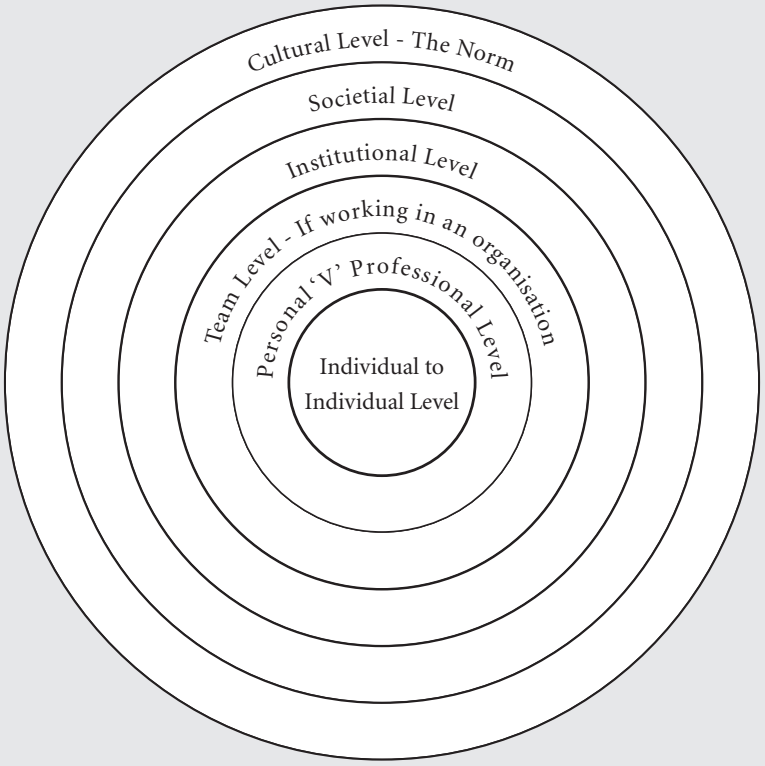
Individual to Individual Level: The relationship in the here and now encounter between the client and therapist. This level considers personal and individual values, prejudice and experiences of discrimination.

Personal versus Professional Level: An understanding by the therapist of her own values, that have the possibility to be discriminatory and the potential of these to impact on the therapeutic space and work with clients, especially in relation to AOP and the potential for these to impact on her work with clients.

Organisational Level: understandings of AOP in terms of how systems, policies are set up that promote the 'norm' or are oppressive to

Fig.1

The AOP Levels at which psychotherapists / counsellors need to work



oppressed groups. For example the way lack of disability access, assumes all individuals are able bodied. A trainee who is a wheel chair user reported that he had to phone 35 therapists before he could arrange to meet one that was wheelchair accessible. His choice of therapist is reflected by his ability to find one that he can actually meet face to face and this impacts on his ability to make an informed choice in finding a therapist he feels he can work with.

Institutional and Societal Level: This encompasses the social, political, economic aspects of society. An understanding and appreciation of how these levels impact clients from oppressed and marginalised groups (the above example is also applicable at this level).

The Cultural Level: The Norm: recognition that this is so powerful it encompasses and embeds all the other levels. Therapists to critically consider this. The fact that counselling and psychotherapy in the UK are practised along this continuum.

Furthermore, power and power dynamics (formal and informal) needed to be considered at each of the levels.

Various authors has emphasised these dimensions and considered them important in developing practitioner AOP: Thompson (1997) and Dominelli (1997). However, the levels represented in Fig. 1 are too 'neat and tidy' and do not demonstrate the complexity, the multi-layered and multi-dimensional nature of these issues in the therapeutic relationship and clinical practice. This is represented in Fig.2

Thus therapists need to have an understanding of structural inequalities of oppression (social, economic, historical, political, cultural, and psychological) and how these dimensions impact on clients from specific oppressed groups.

Therapists are aware of the differences between prejudice, discrimination and oppression and consider how systematic oppression works at an individual and structural level for clients of certain groups, thus raising awareness of differences between discriminated and oppressed groups. For example, As a black, heterosexual, female therapist being aware in working with a white, heterosexual male that in the therapeutic space at the individual to individual level I hold power (as the therapist) and being conscious of this whilst recognising at the structural and cultural level my client holds more power and being aware that somewhere in my history he represents an oppressor for me. However, in working with a white gay man, I need to be aware of my power as therapist but also as a heterosexual person who at an individual and structural level has the potential to oppress my client, whilst holding in my awareness issues of race and how my client might be more powerful at a structural level in terms of his whiteness. As a therapist I draw on my experiences of 'race' to understand commonalties as well as differences between the oppressions of race and sexual orientation.

An important question regarding power is whether therapists have an automatic understanding of what to do with power and how to empower another, raising the question of whether it may be to do with knowing what it feels like to be disempowered or oppressed. In my research, factors such as who the therapist is and what their own personal experience of oppression is, impacts on the way they work. My own hypothesis is that an understanding of power and powerlessness in a RIG (Stern,1985) informs a therapist how to work with such concepts in the therapeutic space.

So what is it about the experience of being either powerful of powerless that can aide a counsellor or therapist? The research group spoke about the capacity to demonstrate empathy without words and attune to issues of power that might not be explicitly named.

A black therapist demonstrated very skilfully how she worked with issues of power and powerlessness with a white client. In reflecting on her work, the therapist felt that, having been able to develop in her personal therapy from feeling powerless to being powerful was an experience she drew on. The movement back and forwards of being powerful and powerless in different contexts aided her in understanding the client. She was able to transfer this personal learning into having a sense of what the client

might need to do for themselves, or how to assist them in working it out for themselves.

So, having an experience, drawing out the knowledge base from that experience and developing a construct that then can be applied therapeutically seemed to be important learning from the above discussion. This also demonstrated the relationship between knowledge, skills and experience. The interweaving back and forth of knowledge and experience appeared to develop into a therapeutic stance.

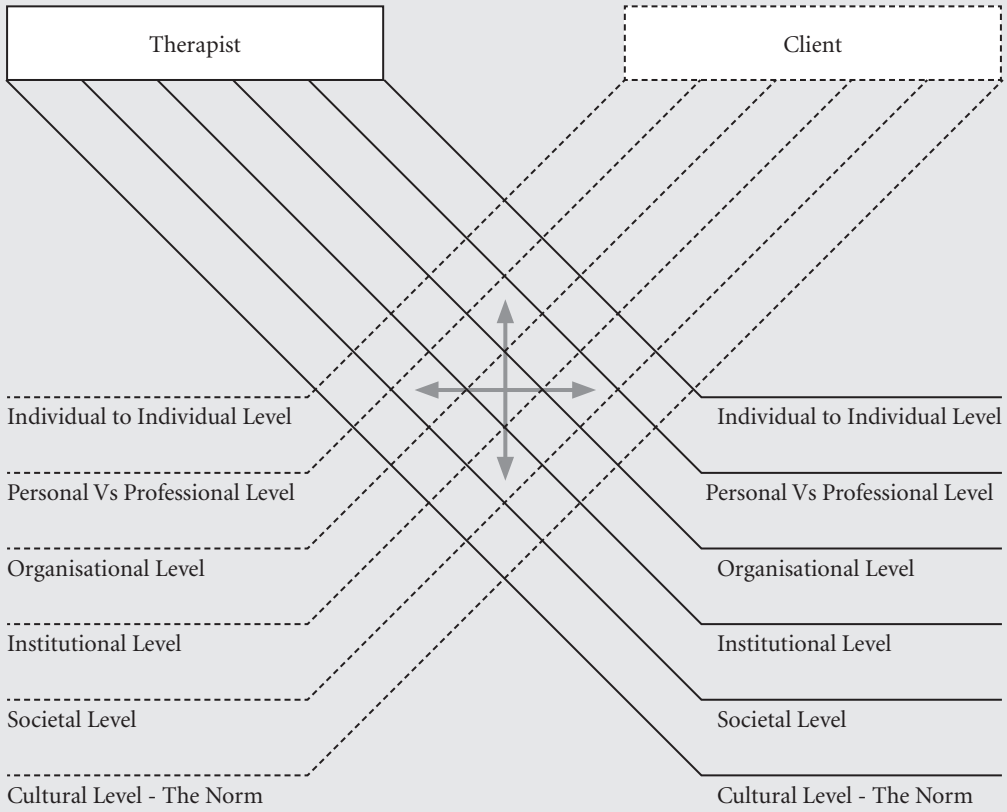
The client reported that it never occurred to her that the therapist might have had experiences of being powerless. The therapist did not disclose her experiences of powerlessness in her attempt to demonstrate empathy / identification with the client. She used her experiences in a very skilful manner; one which the client felt "didn't interfere with my stuff."

The Multiple Oppression Model

The multiple oppression model (Dhillon, 1997; Dhillon-Stevens 2001) has arisen out of my ongoing academic and clinical work with issues of oppression and working within an Anti-Oppressive Practice (AOP) framework. The ideology of such a model has existed in the combined works of authors such as Friere (1990); Lorde (1984); Begum (1994). My understanding of this model has arisen out of the synthesis of my knowledge base and clinical practice and research as a social worker and integrative psychotherapist and senior lecturer in both professions. I have taught this model for 12 years as an academic working with students from different oppressed groups. This model is

Fig.2

Multi-dimensional Nature of AOP in the Therapeutic Relationship



an integrative relational model focusing on the active use of the dialogic relationship in working with issues of oppression in psychotherapy and counselling.

In this framework I focus on oppressions of race, ethnicity, gender, disability, sexual orientation, age, class, religion, language and culture, though I am fully aware that other oppressions exist. I accept that in naming certain oppressions others are excluded but my intention in naming these oppressions is to provide a platform for understanding the complexities involved and transferring the knowledge gained to other areas of discrimination or oppression.

Working in an AOP framework promotes a Multiple Oppression Model (Dhillon, 1997) which is embedded in such an approach. This model considers the interconnectedness of oppressions, but also acknowledges the differences and this is the area that is highlighted in the therapeutic relationship and dialogued with (Fig.3 page 60). This model does not accept that all oppressions are the same. Neither does it promote a hierarchical view of oppressions. The idea that some oppressions are visible (race) and others invisible (sexual orientation) is explicit and understood in terms of power between oppressions (Fig.4 page 61 & Fig.5 page 62 see appendix) and the potential to be oppressed as well as be an oppressor is central to the model. For example, in a training group I encountered a white man in his late 60's who spoke with a very upper class English accent and talked of how he spent most of his life in India. I found it really hard to connect with him. I was aware of a powerful response in me: he evoked my historical and collective experiences of colonisation, imperialism and racism. This man's being embodied various experiences that belonged to me and my ancestors. I realised he powerfully represented an oppressor in my history and my emotional, thinking and behavioural responses towards him were based on these reactions. I was surprised by my reactions. In reflecting and critically examining my responses I was able to approach this man and share with him my reactions. Our dialogue and his empathy and resonance helped me move out of my position as being oppressed which had the potential to distance myself from him and to accept my experience of him as oppressor in my history but to also to see myself as oppressing him and potentially recreating the same experiences. This for me is not just a countertransferential response, as the structural and political dimensions of power in my historical experiences are a reality of the experiences of colonialism, imperialism and racism.

Thus therapists need to understand the specific discourse of each oppression e.g. 'race' but also its interconnectedness to other oppressions such as sexual orientation (this is demonstrated in Fig.4 p61 and Fig.5 p62 which was produced in working with a group of trainee therapists). Through the commitment to dialogue, an analysis of each oppression needs to be named and understood in terms of various levels (see Fig.3 p60). This process can inform therapist's theoretical and practice frameworks in working with clients.

In practice the Multiple Oppression Model operates from certain principles. In working with groups who are systematically oppressed, therapists need to understand the centrality of the following:

Self Disclosure And The Therapist's Role

The notion of self-disclosure appears to be different, I would argue, in this arena. Self-disclosure is more within a spectrum that aids the therapeutic relationship when issues of oppression are present. Self-disclosure is a way that clients of oppressed groups may test the therapist and her awareness of issues of oppression. For example, in working with a client with a disability, I named my awareness of being able-bodied and my potential to oppress my client and how I may do that in the therapeutic space. The client informed me that raising this issue demonstrated that these issues could be named and openly discussed. She felt we had a platform for working together and a commitment on my part to own my own fear of disability.

Responsibility Of The Therapist In AOP Issues With Clients

From my experience of being a trainer I am aware that most white therapists working with a black client will say something like " I am aware I am white and you are black and I wonder how you feel about that". Although this may be an attempt to 'own whiteness' unfortunately it puts the onus and responsibility onto the client to say something about the difference. Taking responsibility is an important principle in AOP and, if therapists are naming the difference they need to be clear what that is about. What do they want to say about the difference and how do they feel it will impact the therapeutic space ? What is it that they want to say about whiteness as a white person to a black client ? What do they want to communicate about their values in the context of historical oppression ?

A black client reported that she was pleased that the white therapist drew attention to her difference in being white, but added, "it wasn't enough." The client wanted the therapist "to show me that she had an appreciation of difference. And it was so important because I think for me it's about myself and if she could show me herself... I wanted her to show me her awareness of herself because I felt if she could do that for herself then she could help me do that for myself." The therapist needed to talk more directly to the client. The client wanted her "not just to say - I'm wondering how it is for you - I wanted her to own the fact that she has a position as a white woman. That she is the oppressor. She could be perceived as the oppressor by me. That there are dynamics that could happen in our work together and I wanted her to talk about them, and I wanted her to say that, if and when they come up, how we might manage them. I didn't feel that she set any clear boundaries around how we were going to go forward." In asking the therapist if she perceived her whiteness to be a problem, the client wanted the therapist to acknowledge it might be a problem. "I kind of want her to own something... I was increasingly becoming aware that that's what I needed....I wanted her just to take some, take some responsibility about it."

The same is true in black / black dynamics, regarding issues of prejudice: a client whose father was Muslim and mother was Sikh came to see me. Part of the aim for her therapy was to explore her identity and self-concept. I actively named that as a Sikh born in the Indian sub-continent I was mindful how her background represented the historical split between Sikhs and Muslims and I was conscious of how that might impact on our work and her identification with me as well as her possible dislike of me from the Muslim polarity. The client reported that in naming this she felt I would be able to hold both aspects of her identity, historically and present day ; and indeed this split is something she has lived with at an individual level but been oppressed by at a structural level from both Sikh and Muslim communities.

Explicit Verbalisation Of Such Issues By The Therapist

The need for therapists to be explicit in the arena of AOP is essential. Clients reported that when clients wanted to know something explicit about the therapist, the therapist often deflected, taking the stance - this is about you and not me. A white therapist in working with a black client reported "To be in the situation where the client's really demanding me to say something and really coming back and back and back and saying - tell me something. And I don't know what to do...I had no words to give her an answer. I've never experienced that (referring to her whiteness) before and I didn't know quite what to say. I can't even remember what I did say actually".

This demonstrates that therapists frequently do not have the concrete skills in naming such issues and do not know how to engage in dialogue with such issues with clients.

The Use Of Language And Possible Oppression By The Therapist

Language, as stated previously, is enormously important in this area. Words used can have the effect of either attuning to the client or misattuning resulting in possible ruptures.

A white therapist working with a black client continually used the word 'explore'. The therapist was unaware of the impact of this word and how it linked to the client's narrative of oppression. The use of the word 'explore' evoked all sorts of historical, namely colonial, feelings that were not safe for the client. The client reported that it was as if "we're going to explore you, the white therapists are going to explore me. These feelings were exploring 'me' in a sort of taking over rampaging, what do you call it plundering kind of way." (This may demonstrate the client's narrative of oppression). Furthermore, when the therapist started exploring, this did not feel safe enough for the client.

In theoretical and ideological terms therapists can comprehend and aspire to a multiple oppression model. Philosophically therapists accept the concept that the oppressed can become an oppressor. However, my research (Dhillon-Stevens, 2004) has demonstrated that the emotional and psychological investment in understanding and more importantly sustaining our constructs of being oppressed override the theoretical aspirations. In practice it is far more difficult to move out of being oppressed and step into the frame of reference of (or even identification with) the other in their oppression, especially if the other is perceived as the oppressor (present day and historical). The investment in sustaining the construction of oppression is central to identity formation and sense of self. This leads to staying emotionally separate. The complexity of really being available for the other person in that moment is multi-layered. Dialoguing in this area provides potential for personal growth and development. Through my research in the inquiry group I have learned to understand and know my constructs and am able to bracket them or use them to understand and connect with the other. I can connect with another and myself – these constructs can be used in a complementary way rather than a competitive and 'either or' way. This appears to be the tension that has to be managed in an integrative relational approach.

A possible limitation of AOP is that it may become a generalised concept for all oppressions and that practitioners lose sight and do not name the specific oppressions.

Conclusion

Acknowledging individual oppressions are important but how these can affect identity development in terms of several oppressions existing and the interlocking nature of oppressions in each individual (race, gender, class, and sexual orientation) need to be considered. This area of the multiple oppression model is the challenge to current literature where one oppression is adopted in a hierarchical framework at the expense of others. Current literature in psychotherapy and counselling reinforces the separateness of oppressions e.g. how to work with gay men and lesbians or people with a disability. In considering the whole being of clients we need to consider all dimensions of oppression and understand these may be in the foreground or background at different points of relational contact.

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Fig.3

The Multiple Opression Model: An Integrative relational model focusing on the intentional use of the dialogic relationship. © DhillonStevens Ltd.

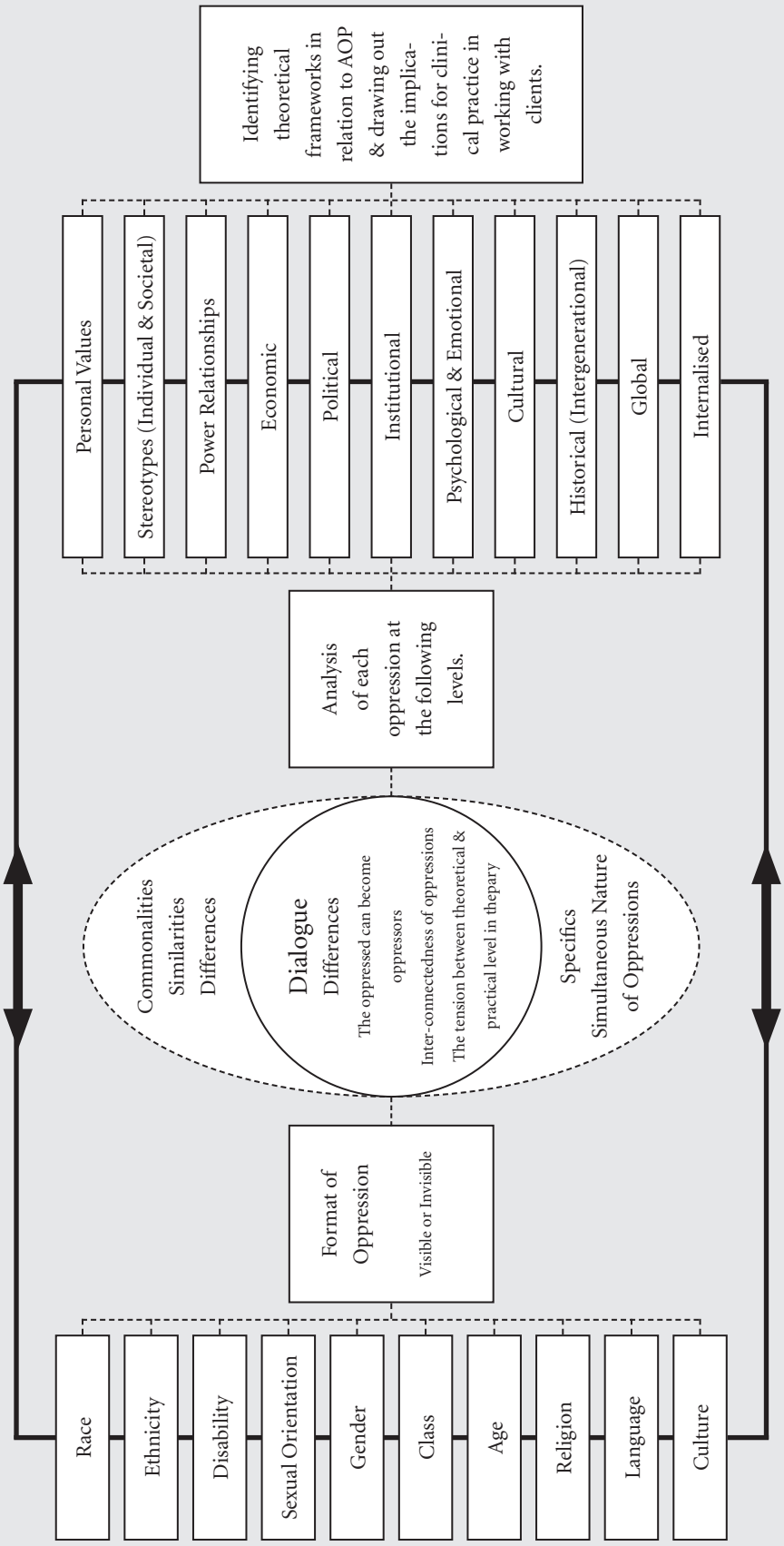

Fig.4

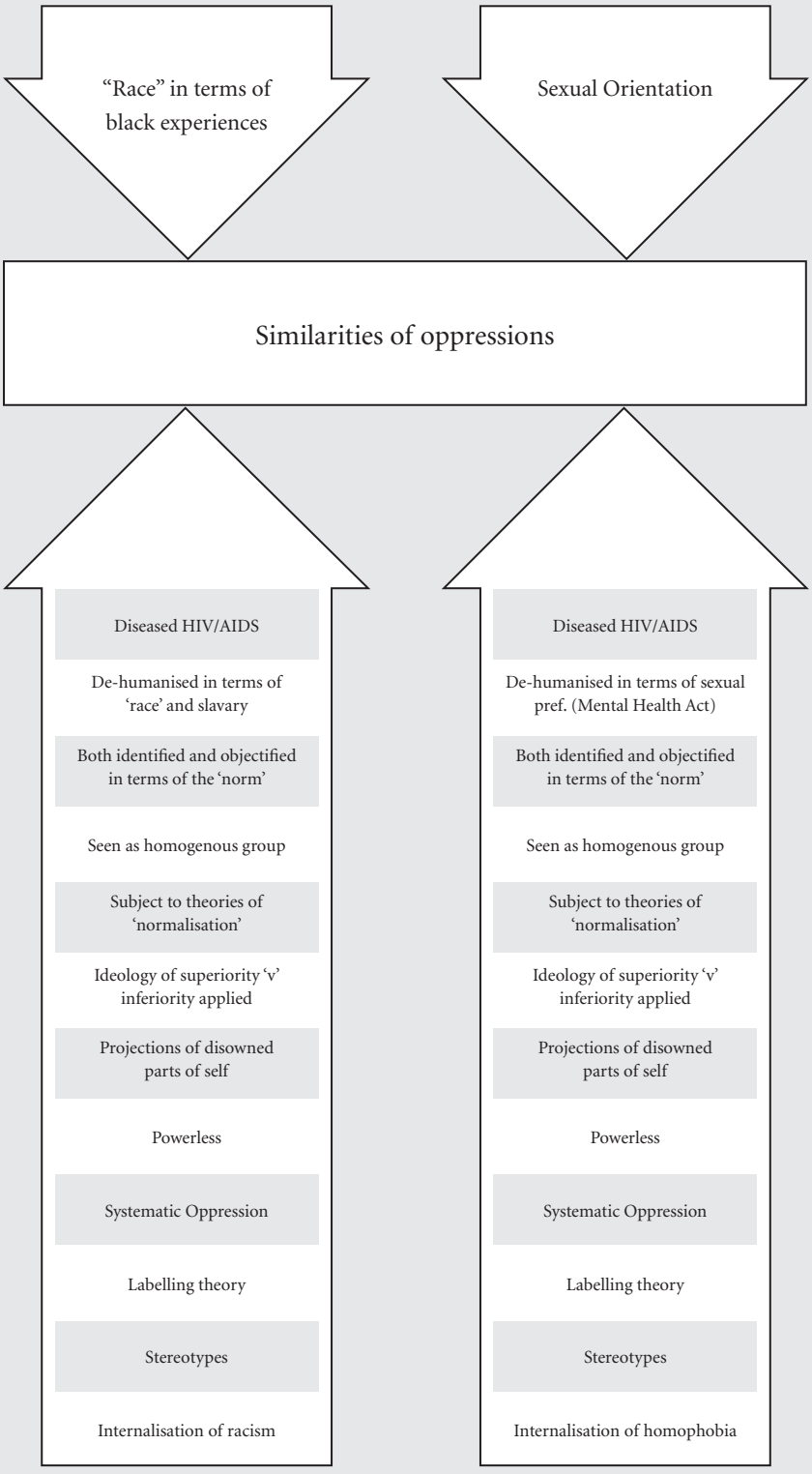
"Race" in terms of black experiences
Sexual Orientation
Similarities of oppressions
Diseased HIV/AIDS
De-humanised in terms of 'race' and slavary
Both identified and objectified in terms of the 'norm'
Seen as homogenous group
Subject to theories of 'normalisation'
Ideology of superiority 'v' inferiority applied
Projections of disowned parts of self
Powerless
Systematic Oppression
Labelling theory
Stereotypes
Internalisation of racism
Diseased HIV/AIDS
De-humanised in terms of sexual pref. (Mental Health Act)
Both identified and objectified in terms of the 'norm'
Seen as homogenous group
Subject to theories of 'normalisation'
Ideology of superiority 'v' inferiority applied
Projections of disowned parts of self
Powerless
Systematic Oppression
Labelling theory
Stereotypes
Internalisation of homophobia

Fig.5


Differences
Historical discourse in terms of slavery & colonisation
Visible oppression
seen as 'no choice due to skin colour'
African / Caribbean seen as lazy Asians seen as hard working
Racism is legislated against
Socially constructed
Relationships accepted
Sexually seen as exotic
Race is fixed
Pathologised for being 'sick'
Invisible Oppression (demonstrated through USA Immigration policies on HIV/AIDS)
seen as having 'choice' (feeds pathology) Societal blame
Seen as 'professionals' – Economic weight of Pink Pound
No legislation in terms of discrimination (recent legislation in terms of employment rights)
Differently constructed 'reality of experience'
Marriage / co-habiting not accepted
Gay men seen as 'sensitive Lesbians as 'butch' Bisexuals ignored too threatening Sexually seen as exotic
Sexuality is fixed or fluid

Morit Heitzler

My Personal Approach To The Theory And Practice Of Integrative Psychotherapy

Editors' note

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

Introduction

Having grown up in a culture and a social atmosphere of conflict in which the tension between fundamentalism and orthodoxy on the one hand and plurality and appreciation of difference on the other was a matter of life and death, the project of psychotherapy integration makes eminent sense to me individually. Whilst on a personal level it has taken considerable pain and effort, I am aware of the argument that in some ways this process of psychotherapy integration is not just a deliberate endeavour and luxury, but is a rather unavoidable necessity.

In my own development as a psychotherapist, I started out with an intuitive sense that the pain we carry is a body/mind phenomenon, and that psychotherapy cannot just be an intellectual procedure, a cognitive reframe. I understood from my own process that my pain and my defenses and protections against it run right through emotional and mental levels, and that therapy could not just be a left-brain manouvre, or a mere technique. All of this led me to a psychotherapeutic approach which was implicitly sceptical of the haphazard use of eclectic techniques, of defensive and inauthentic role manouvres on the part of the therapist, and of any possible reductionism in terms of its conception of the psyche and human suffering.

In my view, an integrative attitude requires a commitment to conflict, tension, diversity. It arises out of prioritising relationship in the face of the all-to-frequent dynamics of dualism, antagonism, dis-integration and splitting. I take this integrative attitude to be consistent with the notion of the 'wounded healer' (Nouwen, 1990) which was an important influence in my initial training. As a 'wounded healer' I engage in the painful and difficult dynamics which the client brings to therapy, and, resting in an awareness of the client's and my own woundedness, I think of myself as bringing relational commitment to the pain rather than expertise, techniques, skills, promises or cures. To me, practising as a psychotherapist means offering myself to the client, knowing that in the psychotherapeutic relationship my own wounds will be touched and activated, leading to a sense of dis-integration. Surviving this dis-integration, understanding the connection between the client's inner world and the internal and self-objects activated within me, can eventually lead to a sense of integration not only in me, but also in the relationship and in the client.

From my own experience as a person and as a therapist I have faith, that, given the right environment, integrative processes can happen which leave me with a sense of a larger identity,

or able to embrace a wider range of experience and feeling. This more inclusive sense of self, with greater flexibility, is what 'integration' feels like. In the moment, I rely on the experience of the spontaneous nature of the 'integrative process', not so much as something I 'believe', but as something that has been put to the test and experientially re-confirmed again and again.

My Theory of Integration

My own theoretical frame, therefore, reflects the fragmentation and conflictedness of the psychotherapeutic field, but also insists on the possibility of shifts towards integration and resolution of contradictions and conflicts. In this sense I do, and I do not have an overall theoretical model, and I think it is in the nature of the integrative endeavour to sustain that paradox. There are, however, bodies of theory that inform my practice. I think of these different therapeutic theories as lenses through which I reflect on the complexities of the therapeutic relationship. To me, therefore, each paradigm and theory has some usefulness, in that it does justice to certain aspects of these complexities. I was trained in a body-oriented holistic approach, with humanistic principles informing the training. This is what I would call my 'host theory', my foundation. Over the years of my practice I discovered many shortcomings and blindspots in the Body Psychotherapy tradition, starting all the way back with Reich, and I will try to sketch my development later on. But throughout I have appreciated and relied on some of the aspects which drew me to this approach initially.

I will now summarize briefly the concepts I draw on from four different theoretical traditions and I will then expand on these concepts in terms of my own integrative understanding.

The Reichian tradition has an intricate grasp of these complexities on an energetic and physical level both in terms of the body's resistance to change as well as its wisdom and potential for transformation. Together with Gestalt it provides me with an appreciation of inter-subjective contact, immediacy and emotional expression as vehicles for change. From psycho-analysis I gain an insight into the complexities of the transference-countertransference relationship and from object relations an appreciation of the intricacies of the 'inner world' of emotional and mental subjectivity. Self Psychology underpins all this with a focus on the subjectivity of the client's experience, the fundamental sense of self, which is at the root of any process of change, if it is to hold meaning and subjective significance for the client.

These are some of the principles I take from the Reichian tradition:

*that therapeutic change requires more than interpretation, more than insight i.e. for an interaction to have therapeutic effect, reflective insight and spontaneous physical-emotional experience need to come together, need to be connected;

*that certain developmental injuries in childhood will tend to result in physical, emotional, mental armouring (= character), determined by the stage of development, the severity and nature of the environmental response, the frequency of the injury, etc;

*that - according to Reich's notion of 'functionalism' and 'functional identity' - the physical manifestations on the one hand (chronic muscular contraction, restricted breathing pattern, hormonal hyper- or hypo-arousal, etc.) and the psychological (emotional and mental) are but two complementary, albeit antagonistic and opposed, expressions of the same energetic, functional pattern;

*the idea of the pulsatory cycle of expansion - contraction, pleasure and pain which Boyesen later extended into the 'vasomotoric cycle', and its link with the autonomic nervous system;

*that therapy needs to address character rather than symptom, and that it needs to do so 'systematically' rather than haphazardly, i.e. that the timing

of an interpretation, its 'ripeness' is as important as its 'correctness';

*that negative transference to therapy and the therapist is inevitable, and indeed fruitful, productive and necessary; that it is pointless to interpret 'underneath the resistance' the whole set of bodywork techniques developed by the Reichian tradition.

The key ideas I take from Gestalt:

*the dialogic attitude and phenomenological inquiry;

*the notion of working in the 'here and now';

*the idea of the field as an extension of the notion of the whole which is a Gestalt;

*a wide variety of techniques including dialogue (two-chair work).

From object relations I derive, amongst many others, the following emphases:

*the recognition of 'internalisation', together with primitive mechanisms including fusion, projective identification;

*the idea of splitting in general, and specifically Fairbairn's splitting of the ego;

*an appreciation of the containing function of the mind (and therefore of interpretation as a technique);

*that containment is not just something the analyst 'does' through interpretation, but that it has to do with the analyst's presence and 'being' (Winnicott, 1971);

*the power of the unconscious process, the unfolding of the transference;

*and the importance of the countertransference as a carrier of information.

Some of the key principles I take from Self Psychology:

*the notion of 'self' as an integrative concept between classical drive theory and object relations, which also provides possible overlaps with Jungian notions of 'Self';

*the distinction between the internalised object and the self-object;

*Kohut's understanding of the narcissistic wound and the transferences arising from it, as well as his notion of 'introspective-empathic' attunement and mirroring.

From Jung and Hillman I derive the following ideas:

*the notion of 'archetypes' and their autonomous functioning within complexes;

*the ego-Self axis, the tension between ego and psyche, and the de-construction of the ego by autonomous and spontaneous forces within the 'unconscious';

*Jung's notion of the transcendent function of the psyche and individuation process.

How do I integrate these theories?

The humanistic bias towards catharsis and optimism, shared by Reich and Gestalt, is contrasted by analytic ideas of containment. Reich's narcissism and belief in the 'core' is balanced by Klein's 'depressive position' and respect for primitive processes of fusion and hostility. Reich's 'medical model' stance in relationship and his quite Freudian focus on sexuality (in spite of his holistic ideas) needs balancing by a focus on human relating and 'object-seeking' as proposed by object relations. Reich's literalistic style and his focus on undercutting the client's ego call for

analytic appreciation of symbolisation (Freud, Jung, Hillman) and cognition; his obsession with libido needs the containing capacity of the mind.

In terms of therapeutic intervention, I rely quite happily on the humanistic tradition, but in terms of my perception and my understanding of the relationship I feel I need the solidity of analytic reflection. As Reich is quite close to the analytic drive theorists, my main inspiration here comes from object relations and self psychology, augmented by attachment theory.

My Theory of Human Motivation and Development

In trying to understand human development, I use Johnson (1994) and Wilber (1995) to provide a basic frame, as both of them are integrationists themselves, whose models encompass a wide variety of other theories. Johnson provides a comprehensive outline for the stages of childhood development, whereas Wilber puts early development into the wider frame of overall psycho-spiritual development. Following his terminology, I distinguish broadly pre-personal from transpersonal development. What both these theorists do not emphasise enough, however, is the relational context of development.

I believe that even in utero a profound and subtle intercommunication between fetus and mother exists on an emotional and energetic level which is punctuated by the cataclysm of birth, but ideally persists for the first few years of the child's life until, through age-appropriate disappointments and separations, initiated by both mother, child and significant others, the nucleus of a self-sustaining identity has formed. I believe that some sort of identity is there from the beginning, but takes time to unfold and manifest on physical, emotional and mental levels, given a 'good-enough' emotional environment. If this happens, the child will come to experience and identify with increasingly integrated self-structures. Whereas at first the sense of self will be rooted mainly in physical-energetic experience, with the development of emotional and cognitive capacities, new territories of experience will become new sources of identity. Ideally, this results in the child feeling that it is safe and possible to exist, to need, to be emotionally mirrored and contained, to have autonomous interests and desires, to be a sexual being, i.e. an underlying sense that the fullness of its potential is loved and appreciated. Whilst most parents would consciously subscribe to these aims, the vicissitudes of the parents' own emotional wounding and unconscious communication result in a mixture of systematic messages which are conflicted and less than ideal. The child is an object in the parents' psyche, and enters a family atmosphere replete with largely unconscious conflicts, conditions, rules and impossible dilemmas. Both its instinctual and its 'object-seeking' needs, as well as later on, its personal and social development, are to some extent frustrated beyond the possibilities of healthy accommodation to the environment.

An internalisation of these conflicts lays the foundation for chronic conflict within the developing character. Johnson (1994) outlines the steps of character formation as:

1) self-affirmation rooted in an instinctual (including 'object-seeking') need

2) negative environmental response (from the 'object')

3) organismic reaction to frustration

4) self-negation (turning against self, i.e. against both the original self-affirmation and the organismic reaction)

5) adjustment process (compromise), which is an habitual 'unnatural' accomodation in order to avoid pain, whilst maintaining contact, and which involves a compensation.

Depending on the timing, frequency, severity, traumatic nature of the developmental injury, stage-specific characteristics can be described which Reich called 'character structures'. Reich distinguished schizoid, oral, masochistic, psychopathic and rigid structures. Johnson had

to add the symbiotic and narcissistic structures, as the major crisis in child development as formulated by Melanie Klein, between symbiosis and rapprochement, had been 'overlooked' by Reich. This gives us broadly seven types, or styles, each with their own physical, emotional, cognitive and relational symptomatology. Johnson, wanting to avoid the pathologising labels of the Reichian tradition and the DSM IV, calls them the hated, the abandoned, the owned, the used, the defeated, the exploited and the disciplined child.

The Process of Therapy: working through the wounds of childhood

The process of therapy provides a relational container where these early wounds are constellated again, ideally to be worked through and brought towards a more satisfactory, integrated resolution. This process hinges largely on the therapist being available to be constructed as an object by the client's unconscious. The therapist's commitment, underpinned by their actual relational capacity to be available for the client, touches the client's experience of failure in parental holding and re-stimulates the unmet needs, unfulfilled longings and repressed desires which had to be abandoned in the 'turning against the self' and the 'adjustment process'. Because of the emotional pain involved, it is the nature and function of these processes that the client's ego is rendered largely unaware both of the repressive / dissociative processes as well as the repressed pain and conflict. The therapist needs to be attuned to both the defenses and the underlying impulses and conflicts, i.e. to all the steps of character formation which are now present simultaneously in the client's communication and which the therapist is confronted with as a complex matrix of contradictory messages. This multitude of messages, both non-verbal and verbal, communicated on physical, emotional and mental levels, contains clues as to what early relationship is constellated and 'active'. The intensity of archaic pain experienced between the two relational poles constellated (e.g. child and adult, child and sibling) inevitably leads to some degree of projection and projective identification between client and therapist. In surviving the intensity of the projected feeling, as well as mirroring and interpreting those emotional currents which the client is unconscious of, the therapist attempts to provide an experience of containment of precisely those feelings which the client's ego is chronically incapable of containing.

The therapist thus offers herself as an 'auxiliary ego', allowing awareness, sensation and expression of previously unconscious and chronically held feelings. Through this process the client's sense of self changes, to take account of and integrate the now larger available and survivable territories of relational experience.

The Process of Change

In my thinking I distinguish concepts which help me understand and work with therapeutic change in relation to early developmental arrest (mainly self psychology, object relations and character analysis) from those which see therapeutic change only as one instance or as part of an ongoing journey of human change (e.g. Jung's individuation process; and Wilber).

It is my experience that most clients tend to apprehend the transpersonal aspects of their being through the lens of idealisations, denials and compensations arising from an underlying pathological self-structure. I think that - generally speaking - these disturbances of the self need to be worked through before transpersonal perspectives can be integrated in a sustainable fashion. The bulk of my clients' presenting problems can be effectively conceptualised in terms of the effects of 'past hurt', as developmental injuries within 'the primary scenario' which become perpetuated and internalised as neurosis, character, scripts, repetitive patterns. In the words of T.S. Eliot 'The Cocktail Party' (1976): "People are a set of obsolete responses." The client's presenting problems and subjective symptomatology reflect a disturbance in the underlying sense of self, the self structure. Addressing this self-structure, and the internal relationships which constitute it, is in my view the central task and objective of therapy.

Developmental Injuries within the 'Primary Scenario'

From a psychodynamic perspective, the assumption underlying therapeutic change is that the person's development was arrested at some stage through a 'not-good-enough' environmental response, usually early on by the primary caretakers, but in principle throughout the life cycle (Erikson, 1980).

I am accustomed to using Rosenberg's (1984) notion of the 'primary scenario' as the overall landscape of these environmental responses, the whole biopsychosocial context of early development. His definition of the 'primary scenario' is sometimes in danger of being taken somewhat literally as merely the client's conscious perception of the significant others in his childhood. I therefore want to be explicit about my use of the term 'primary scenario': I use it to refer to the sum total of conscious and unconscious processes, the whole set of object relations over time throughout the formative years, the relational matrix in which a person's psyche is born, develops and finds and defines itself.

The conceptualisation of the 'primary scenario' as implying developmental arrest immediately also constitutes a framing of the goal of therapy: Rosenberg conceives of the process of change as a working-through and shedding of the restrictive armourings developed within in the 'primary scenario' which occlude the Self on physical, emotional, mental and spiritual levels. There is an important tension here between Rosenberg who clearly subscribes to a Jungian notion of 'Self', and a more object relations idea of the 'self': for Rosenberg the 'Self' is occluded by internalised objects, for modern psychoanalytic theory the self is constituted by internalised objects. Rather than trying to resolve this question philosophically and generally, I tend to approach the dilemma phenomenologically, with each client anew.

Gestalt conceptualises the process of change primarily in terms of 'unfinished cycles' from the past which may find completion in the here-and-now interaction between client and therapist. But by focussing on the phenomenology of the present rather than inference and interpretation of the past, Gestalt reminds me that all change always happens in the present moment, and that the past is only significant in as much it still lives on and determines the present. With its stress on immediacy and experiential experimentation, Gestalt is in danger of over-emphasising the interpersonal at the expense of the intra-personal dimension and encouraging the therapist into a too directive, active and pro-active mode. However, I think it provides me with a necessary and challenging polarity to the possible 'over-containment' of an overly receptive and reflective stance favoured by analytic theorists, operating mainly from within the mother-infant metaphor of the therapist-client relationship.

In terms of my 'host' model, Reich's contribution is essential: his "Character Analysis" (1934) constituted a fundamental shift in the way psychoanalysis framed both the task of therapy and the therapeutic process of change. Rather than being oriented mainly by the presenting symptomatology and 'the material as it surfaced', Reich recognised that the presenting problems which patients brought to him were only a rather haphazard manifestation of a deeper, chronic and habitual dynamic. He took it upon himself to engage more systematically with the underlying 'character armour', and he formulated explicit principles for the diagnosis and the 'working-through' of character resistances.

The problems I encountered when working within the Reichian tradition have made me question not only the quasi-medical and quite un-relational application of body-oriented techniques, but also certain theoretical assumptions. I am thinking of Reich's emphasis on sexuality, his rather literal formulation of repression and his one-sided therapeutic objective of liberating the energetic core, his under-valuing of the mind and hence the containing function of symbolisation. But in perceiving and formulating holistically the developmental injuries in people I work with, Reich's work is of fundamental significance in my therapeutic model.

Johnson ("Character Styles", 1994) has done important work in integrating the

Reichian conception of character formation with complementary ideas from object relations, ego and self psychology. In his book "Characterological Transformation - the Hard Work Miracle" (1985) he describes the stages of 'working through' the wounds of the 'hated and the abandoned child' from an integrative perspective. From a similar therapeutic perspective, Kepner has described the 'Healing Tasks" (1995) in the process of change, and categorised them in different phases according to the therapist's focus on feelings, memories and the therapist's use of Self. Along with Rosenberg, Keleman, Kurtz and Boadella, these are the main recent writers who have addressed the process of change from within the tradition I initially trained in. They all share an emphasis on the integration of working with body, feelings and mind in relationship, although what they mean by 'in relationship' is partly vague, and certainly quite diverse.

To understand the significance of the relationship more fully, I look to object relations and self psychology where I also find a stronger sense of the internalisation of the other, both in its damaging and healing potential. There is considerable overlap between the Reichian and the analytic traditions regarding their conception of the aetiology and effects of developmental injury. What Bollas (1987) calls the "unthought known" is not dissimilar to what the modern Body Psychotherapy tradition considers the somatic aspect of the unconscious, including 'body memory'.

The divergence between the traditions is greatest in their different perceptions of the therapist's response to developmental injury. In Bollas' view, change occurs through the therapist as a 'transformational object', providing a similar emotional function as the mother to the infant: to perceive the inner stirrings, movements, impulses of the infant and to mirror, contain, soothe and eventually translate them both behaviourally and cognitively. The infant subjectively experiences this as the mother 'transforming' the experience, for example from a possibly frightening to a pleasurable one.

In terms of the therapist's task, I find a conceptualisation of this interactive process in a variety of object relations theorists (see Gomez "Introduction to Object Relations", 1997) from Winnicott (1971) to Cashdan (1988). Bion (1962) might think of this in terms of 'projective identification' and the therapist internally processing the projected material before attempting to give it back in more palatable, bitesize and digested form.

Stern (1985) has challenged traditional assumptions about the subjective world of the infant and the nature of the mother-infant dyad. Through gathering research on infant observation he has expanded earlier notions of the infant's autistic and narcissistic state (which tend to lead us toward the assumption that the child needs input - socialising - in order to become a social, relational being) to an appreciation of the intricacy and reciprocity of the early mother-child bond. It had always made sense to me that the infant is a 'self-and-other-aware' being from the first moment, and an active co-creator of the relationship rather than a narcissistically self-absorbed, passive recipient of the mother's care. But what I took from Stern's writings, both as a woman and as a therapist, is that the mother is not only a libidinal, gratifying instinctual object, but also a subject which has significance as a particular individual in the creation of a unique human interdependent relationship. This new understanding of the mother-infant dyad has immensely relevant parallels for my practice: the notion of the therapist as the containing affect-regulator is a foundation of my therapeutic presence, ever-present in my background awareness. My responses to my client cannot be standard, rule-bound or predictable because it is evident to me that my function of affect-containment and regulation is a subtle and sensitive spontaneous process which depends on the intricate attunement of two individuals in reciprocal relationship.

I have found similar confirmation in attachment theory, based on the pioneering work of Bowlby (Holmes, "Bowlby and Attachment Theory", 1994) which has deepened my recognition of the relational roots of emotional pain and psychological difficulty, and has added further weight to the pivotal importance of the relationship in the process of change.

In many ways my development as a therapist can be charted in terms of my focus on increasingly deeper and subtler, more unconscious levels of injury and developmental arrest. In this I have been greatly influenced by modern psychoanalysis. One significant shift for me was from the libido-oriented Reichian paradigm to a more relational, intersubjective conception of the therapeutic relationship. This parallels developments within psychoanalysis, i.e. the tension between the 'drive model' and 'object relations' (see Greenberg & Mitchell "Object Relations in Psychoanalytic Theory", 1986). Over the last year of my training at Metanoia I have increasingly realised that my ideas of 'internal objects' were too simplistic. Self Psychology has taken a significant further step in the recognition that the internalisation of objects is facilitated, mediated and also complicated by self-objects. I am now trying to distinguish in my practice between objects and self-objects, and this is helping me in further understanding the subtleties of my countertransference.

Developmental injuries: a conclusion to the discussion

Through my early years of practice, which were within an integrative frame from a body-oriented, humanistic bias, I have come to appreciate the client's resistance. Invariably, my clients would have intense and profound experiences which no doubt had an impact on their life. But inspite of apparent behavioural change, I learned to appreciate that deeply engrained patterns of relating often persisted. The more I have learned about the subtleties of internalisation which sabotage, reverse and undermine the work of therapy, the more I have come to assume that the process of change needs to include deep layers of early 'programming', of internal habits of relating to self and other, if it is not going to get side-tracked into superficial behaviour modification. So whilst I am not trained to work as a psychoanalyst, I realise that these deep layers, without which change remains superficial, are best and most usefully described by modern psychoanalytic theory.

Change moments in therapy: my integrative perspective

The integrative model I have developed over the last few years and which I am currently using, focusses on moments of change in the therapeutic relationship in which an established relational pattern is being re-experienced and also challenged. I aim to bring both the client's and my own awareness to the 're-enactment' of the client's relational pattern in the 'here-and-now' of the interaction between us. I am assuming and attending to three aspects of the relational pattern: the past, the internalised one and the re-externalisation in the transference. Both the original as well as the internalised scenario is phenomenologically present in the body/mind experience in the moment. To the extent that this body/mind experience is painful, conflicted, restricted, limited, self-negating, I see it as an experience of 'dis-integration' which always already implies a sense and maybe an image or fantasy of 'integration'.

Here I am implicitly drawing on ideas from a psychodynamic and Reichian as well as a Gestalt background, which all agree on the idea of 'unfinished cycles' from the past, but have different emphases in terms of the therapist's response to it.

My attention as a therapist in terms of perception focusses on a Gestalt notion of phenomenological enquiry, which in turn is based on an holistic Reichian notion of the client's (and therapist's) dis-integration, i.e. the way psychological pain and conflict manifests on all levels in the client-therapist relationship: physical, emotional, mental and also transpersonal. This spectrum includes the feeling states, unconscious fantasies, mental representations and processes of projective identification which are essential ingredients of a modern object relations and self psychology conception of the client-therapist relationship. I find the conceptualisation of the process of change offered by these theories helpful in focussing me on the countertransference, the 'transformational object' and the idea of a "mutative interpretation" which addresses the various aspects of the transference experience in the 'here and now' (Sandler, Dare, Holder, 1979).

By including both my own and the client's body/mind, however, as aspects of that experience, I find that my range of responses and interventions dramatically increases because I do not feel restricted to verbal interaction or, more specifically, interpretation. In general terms I could describe my way of working as using a wide variety of body-oriented, humanistic and holistic techniques, including interpretation, within a framework of reflection which is consistently analytic. Whatever the 'technique' or mode of relating currently in the foreground between us, I reflect on the interaction between the client and me in terms of transference and countertransference:

*What object am I being not just in terms of the client's conscious perception of me as a 'professional helper', but more importantly in terms of the unconscious fantasy ?

*What, specifically, are the relational patterns being re-enacted ?

*What are the turning points, tangents and reversals, the interruptions in the build-up of intensity and intimcay in the contact ?

*What aspects of the client's experience are being denied or kept at bay through our interaction and my way of thinking about it ?

In contemplating these questions, I pay particular attention to possible conflicting messages between the client's unconscious and spontaneous communication (non-verbal, including gestures, movements, mannerisms, voice tone, recurrent themes in terms of metaphors and images) and their more deliberate, voluntary and reflected expression (both bodily and verbal).

I have in mind the steps of character formation as described by Johnson (1994) and wonder which aspects of the energetic-emotional-psychological conflict are being carried and communicated by the different aspects of the client's 'here-and-now' experience:

*Where is the primary impulse ?

*Where in the room is there a sense of the 'negative environmental response' ?

*How do I perceive the 'organismic reaction' ?

*Is there - in me or the client - a sense of 'turning against the self' - on a physical, emotional or mental level ?

In the more accessible terms of Transactional Analysis (Berne,1964), I could phrase this as me looking for manifestations of the 'free', the 'hurt', the 'angry' and the 'adapted' child as well as the corresponding set of parental states, both in myself and the client. I am open, however, to the possibility that these states are not coherent, but appear in a fragmented and conflicted way throughout the body/mind system, i.e. that the various states are anchored, felt and communicated simultaneously in various parts of the body/mind (for example, that the 'hurt child' may be contained in the client's throat, the 'angry child' in their legs, the punishing parent in my voice, etc). Considering the ubiquity and strength of projective identification processes, I am open to the possibility that any of these aspects can manifest both in the client's and/or my own body/mind experience. Here I draw on Cashdan (1988) who sees projective identification as the pivotal point in therapy in that the therapist is affected by and then uses projectively identified material.

Whatever the significant emergent relational dynamic in the foreground of our interaction, I assume that both the traumatic, frozen, chronic, dysfunctional and dis-integrated pattern of relating and the potential for a more integrated, flexible and inclusive way of being are present in the therapeutic space. There is a tension between the established, familiar structure and the emergent process, and I see my task as holding that tension in myself until integration can take place spontaneously. This implies that I am deeply, inextricably involved in the process, but try to not abort or foreclose the emergent process by reverting to my own bias, prejudice or favoured agenda. Rather I try to contain the tension, both the urgency for transformation and change as well as the attachment to the 'habitual mode' and status quo. Change, in my view, happens at that edge

of chaos, when the client is exposed to and in touch with the unbearable pain they so far had not been able to face, and experiences its power for transformation in the container of the relationship. A succinct way of formulating this is to describe the habitual, established relational structure as a dis-integrated state which already has the seeds and impulses toward integration within its phenomenology.

By attending to the dis-integration as it is, by being drawn into it through projective identification, by gathering in awareness the fragments of the dis-integrated experience in the present moment, we constellate its origins and history, as well as its emergent tendencies towards the future. Holding the tension between the urgency for transformation and change on the one hand, as well as the attachment to the 'habitual mode' and status quo on the other, can then be formulated also as holding the tension between integration and dis-integration. For me being able to hold that tension, implies, of course, an inner activity both in relation to the client and to myself. My own internal sense of conflict, uncertainty, failure, unknowing, ambivalence both in terms of my own wound and pain and in terms of possible responses to the client is an essential ingredient in several respects: working as a 'wounded healer', being available to be constructed as an object by the client's unconscious and in functioning as the 'transformational object' in terms of affect regulation and containment.

Integration of analytic and holistic notions of change

My formulation of the process of change draws mainly on analytic ideas of change (Casement 1985; Bollas 1987; Cashdan 1988; and Winnicott 1971), and is in many ways consistent with them, but differs from their theories in terms of underlying paradigm and technique. For me, the transformational experience inevitably includes a body/mind experience (and usually re-experience) of the 'bad' and 'good' objects, both as external and externalised and as self-objects. Once the physiological-emotional upheaval of that re-lived trauma has been survived (by both client and therapist), integration on a mental level seems to occur quite naturally. Interpretation then becomes a step in the organic process of integration. Cognitive reflection helps to integrate a more 'complete' experience rather than describe and possibly re-inforce the 'incompleteness' of the conflict.

I strongly believe that both the habitual interpersonal relational pattern and the corresponding internal self-object relationship are rooted and maintained also on a physical level. Transformation of these relational patterns both interpersonally and intra-psychically, resolution of the transference, cognitive re-framing and re-scripting, the transition from an old to a new sense of self - all these processes also involve change on a bodily level. Unless the therapeutic interaction touches the visceral, the vegetative and the autonomic nervous system, transformation remains incomplete.

Neuroscientific Perspectives

This holistic body/mind perspective has recently been strengthened and complemented by neuroscience. The assumption is that early developmental damage on an emotional-relational level corresponds to anatomical damage in the development of the brain, for example in terms of right and left hemispheres and their co-ordination, or in terms of the complex interrelating between the various brains from the more primitive limbic system to the cortex. Affect arousal and containment, as experienced during the early stages of development in relation to the caregiver, is reflected in the relationship between the different levels of the brain, i.e. we could imagine this as the 'transformative object' being internalised and anatomically structured into the containment of the limbic system by the cortex. Similarly, the corpus callosum could be seen as the biological focus for the internalisation of masculine-feminine relating, facilitating or interrupting the communication between right and left sides of the brain. These subliminal processes form the foundation for our sense of self. Damasio (1994) has collated neurobiological evidence for one of the basic principles of Body Psychotherapy: the assumption that thought and reflection

arise out of and follow feeling and sensation. Damasio suggests that any idea or concept of self, including self-image, is a translation of a moment-to-moment scanning of body states. Within the Western scientific paradigm, this implies a new understanding of the connection between affect and cognition, and transcends dualistic assumptions, especially around the relationship between body and mind.

Conclusion

In terms of technique my work belongs in the humanistic tradition, as I am liable to use a wide and 'eclectic' range of interventions, exercises, and suggestions like gestalt experiments, bodywork techniques, visualisations, with the client sitting and talking, lying on a mattress and breathing and a whole host of verbal and non-verbal contacts in between. However, I think about the relationship, and the function and effect of all these techniques on the relationship, mostly in analytic terms of transference and countertransference. It is the relationship, and my attempt to monitor the unconscious process within it, which is the 'integrating factor' and which gives the techniques their purpose and meaning. The paradoxical nature of the process is that therapeutic and countertherapeutic effects are usually intricately interwoven, and - as Casement (1985) describes - the therapist's "mistakes" can become important learning and turning points both for client and therapist. In summary and inevitably, the process of change affects both people involved, as Jung (1970) clearly stated throughout his writing.

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Book Review by Gillian Straker

Learning From Our Mistakes: Beyond Dogma in Psychoanalysis and Psychotherapy by Patrick Casement.

Published by Brunner-Routledge, Hove and New York ,2002 Paperback: 144 pages; £15.99 ISBN 1-58391 -281- 9. "Learning from Our Mistakes" has just been given a 2004 Gradiva award for "its contribution to critical analysis and interpretation" by the National Association for the Advancement of Psychoanalysis (USA).

In 'Learning from our Mistakes', Casement has written a book which contains riches for both experienced and inexperienced clinicians alike. Essentially the book comprises detailed analysis of interventions that Casement felt were mistakes. Using examples from both his clinical work and supervision of training analysts, he gives us a rare insight into an analyst's own self reflective processes. Whilst never shirking from taking responsibility for his mistakes, he reflects both on the factors informing their recurrence as well as on the factors implicated in their resolution.

Casement involves theory in his analysis, but only in the service of emphasising an experience-near perspective concerning the patient's unconscious communications and his own reverie. This provides a nuanced context for learning, not only in regard to the content of the book, but also in regard to the processes it encourages in the reader.

Casement's own commitment to transparency, openness and authenticity, together with a certain simplicity in his style of communication, encourages a reciprocal engagement in the reader. Indeed, in the face of the disarmingly open self disclosures of Casement, it is almost impossible to remain complacent in relation to one's own mistakes. Certainly Casement's lack of defensiveness in examining his mistakes encouraged me to enter a parallel process and examine some of my own mistakes, and it is this aspect of the book I consider to be one of its most valuable contributions.

In addition to the non-defensiveness required to examine one's own mistakes, Casement also brings to bear a number of perspectives from which one may view them. The one that appealed to me most originated with Winnicott, who said "in every analysis there will come a moment where the analyst may be manoeuvred into a failure that repeats an earlier one from the patient's past and (that) in the end we succeed by failing, but failing the patient's way" (Winnicott, 1963). Casement brings this statement alive by offering numerous clinical examples in which he shows how he became embroiled in this process of failing the patient's way. However, he does not simply leave one at this point of learning from one's mistakes, inevitable as these may be. He also shows a way forward and indicates how we may move beyond such mistakes. What is of particular interest is that he addresses these issues both in regard to therapy, and to supervision.

Referring to therapy, Casement speaks of developing "two heads, one which may be involved in the patient's dynamic, and the other which is able to observe and monitor and reflect with enough detachment to gain

an understanding of what is going on". He speaks of developing a stance of both optimum abstinence, and optimum responsiveness. Beyond this he speaks too, of the difference between the patient's wants, and the patient's needs.

In speaking of supervision, Casement comments on the importance for the supervisee of not only thinking of what a supervisor may say, but also of thinking autonomously, thus again emphasising the notion of 'two heads'. In his chapter on supervision, Casement shows a particular sensitivity to the context of supervision, and how presenting training cases may influence the counter-transference. He integrates multiple perspectives within himself as he approaches both therapy and supervision, but nevertheless retains a central anchor in the patient's experience and viewpoint as he tries to understand unconscious communication.

This capacity for integration within the self, a capacity clearly communicated in the book, is one that many readers of this journal will wish to develop. With reference to the issue of integration on a meta level, Casement's work fits in well with that of the relational analysts, although its differences from them should not be obscured. Casement clearly indicates that his work has grown out of his own clinical experience, and, whilst it may fit in well with the relational school, it is not his starting point. However, given this journal's focus on integration, it is important to mention how Casement's experience-near approach resonates with the conceptual language of empathic attunement, vicarious introspection (Kohut, 1971), the intersubjective space (Stolorow, Atwood & Brandchaft, 1994), and the co-created hermeneutic circle (Orange, 1994), and so on. Nevertheless, Casement emphasises that his own work was not initially informed by the writings of these analysts, and thus its resonances with them are all the more noteworthy as they underline the consistencies that emerge when work is experience-near.

One final comment in regard to integration pertains to Casement's chapter which presents further reflections on "to hold or not to hold a patient's hand?". In this chapter he offers us the complement to learning from our mistakes when he focuses on what he has learnt from what he believes are others' mistakes in what he sees as their mistaken readings of his work. He shows, again from an experience-near perspective, how one may undefensively defend one's own thought and how one may survive sustained criticism with dignity, yet use it to take one's own ideas further.

In summary then, Casement's new book is very much in the mould of his very successful earlier ones. The learning one derives from this book is as much from Casement's style as from its content, although the detailed case studies in and of themselves are invaluable. Whilst reading these case studies, beginning therapists might feel some anxiety as they delve into the myriad of ways in which practitioners may make mistakes, with all the ensuing consequences. Experienced therapists and analysts might experience discomfort as they recognise their own mistakes in those described by Casement. However, for all, he offers a way out of the impasse, both in terms of his double headed approach and his encouragement to move beyond the shame that mistakes might evoke. For these reasons alone, and there are others, the Casement book is certainly well worth reading.

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Book Review by Noreen Tehrani

Dignity At Work – Eliminate Bullying And Create A Positive Working Environment. By Pauline Rennie Peyton.

Published by Brunner-Routledge, Hove and New York, 2003. Paperback: £15.99. Pages: 190. ISBN 1-58391-238-X.

This book was written as a manual for people with a responsibility for employees. It has been written in two inter-related parts. The first part focuses on information and is of primary interest to organisations and those managers who have a responsibility for developing the policies, procedures and support for the workforce. The second part of the book has been written for counsellors and others who work in organisations to help the organisation and employees deal with the impact of bad behaviours. Clearly, the book is intended to be read in its entirety by both groups as a way of creating a common awareness of the context and interventions that may be available.

Part One is comprised of nine chapters and looks at such issues as:

Why bullying is an important issue.
What constitutes bullying, victims.
The law relating to bullying.
Policies and processes for dealing with bullying.
The advantages of mediation.

These areas are likely to be of interest to Human Resources and management. Unfortunately, this part of the book fell between two stools. It was written in an academic format with a liberal sprinkling of references, for which the author did not provide the essential framework that is vital to the non-academic reader. Without the framework, it is difficult to understand why specific references are included, particularly when the reference is not taken up or expanded upon in the body of the book. If, as is suggested, the book has been designed to be used as a manual, it would have been helpful to have made the structure much clearer. For example, it would have helped to have separated the causes from the outcomes of bullying in the workplace, rather than presenting the literature as a list of references with no obvious rationale for why particular findings had been included. However, the author's own experiences of dealing with victims of bullying provided a refreshing break from what was at times a rather difficult and sometimes confusing read.

The section on creating an alternative to a bullying culture was rather short and tended to focus on what organisations and workers should not do rather that how they might create a more positive working environment. However, there were some good points including the need for respect, openness and clarity of roles and responsibilities. It might have been useful to have illustrated the need for an organisational approach to bullying with some of the important research that has been undertaken in this country and in Europe during recent years.

The chapter on bullying and the law covered much of the current legislation but missed mentioning the Management of Health & Safety legislation that requires organisations

to undertake risk assessments. This legislation provides the backbone to the recent Health and Safety Executive initiative on workplace stress. Under the Management of Health and Safety at Work legislation, organisations are required to undertake risk assessments of the workplace relationships. This is an important starting point for any organisation wishing to take the reduction of bullying and harassment seriously.

The chapter on harassment investigations focussed on formal processes, although mention was made of the need for advisors who can help employees to gain an understanding of the organisation's policies and procedures for dealing with bullying. The informal process was presented as providing the employee with four options for handling their concerns. These were 1) to ask the person to stop the upsetting behaviour, 2) to put the complaint in writing, 3) to ask a colleague to speak to the person exhibiting the upsetting behaviour and 4) to discuss the situation with a member of HR, a supervisor or line manager. Whilst this is one type of informal process, there are other approaches which are rather more proactive in identifying inappropriate behaviours at a much earlier stage. These approaches then lead to working with all the employees involved to adopt a more appropriate and respectful set of behaviours.

Part Two of the book deals with the role of the counsellor/psychologist in organisations. However, the emphasis is on counsellors, therapists and counselling psychologists. The book fails to recognise the significant role that has been played by occupational psychologists with their specialist skills for dealing with the organisational issues that lead to workplace bullying.The chapter on useful theories looked at the benefits of training in systemic approaches, which is important when dealing with the complexity of the workplace. There is also a brief description of the way that the author uses transactional analysis, gestalt therapy and emotional intelligence in her work. It was perhaps rather surprising, given the emphasis in the book on the possibility of Post Traumatic Stress as an outcome of bullying, that there was no mention of the tried and tested traumatic stress therapies such as debriefing, cognitive behavioural therapy, eye movement desensitisation and reprogramming and trauma incident reduction.

The short chapter on counselling in organisations looks at the benefits of integrating counsellors into the organisation. The importance of the three cornered contract is discussed together with some practical advice and pitfalls that may befall the unwary. The author suggests a number of other roles as being suitable areas for counsellors/psychologists. These include training, investigating claims of the perceived victims, bullies and witnesses, mediating, coaching and mentoring. Whilst it is possible that some counsellors will be able to fulfil these roles, it is important that any counsellor wishing to broaden his or her practice undergoes training to ensure a level of competence commensurate with the work to be undertaken. These are special skills and need specialist training.

Perhaps the most important part of any book on working with bullying and harassment is the need for the practitioner to take care of their own health and well-being. It might have been useful to discuss the possibility of compassion fatigue or secondary trauma, which is particularly relevant to anyone working with victims of bullying and harassment. The impact of working with bullying on the practitioner's own values, beliefs and assumptions, or mental schema cannot be over-emphasised. The danger of psychological injury is very real. The feelings of distress, shame, frustration and helplessness encountered in this type of work can be strong and taking care of oneself is essential if burnout and compassion fatigue are to be avoided.

It is possible that I am reviewing the book from a different point of view than that of the target audience and this colours my view; and perhaps it would be more appropriate to ask someone will less knowledge of the field to give another opinon on how helpful it might be to them.

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