The British Journal of Psychotherapy Integration

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The Integrative Project in Practice

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The British Journal Of Psychotherapy Integration

Introduction

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

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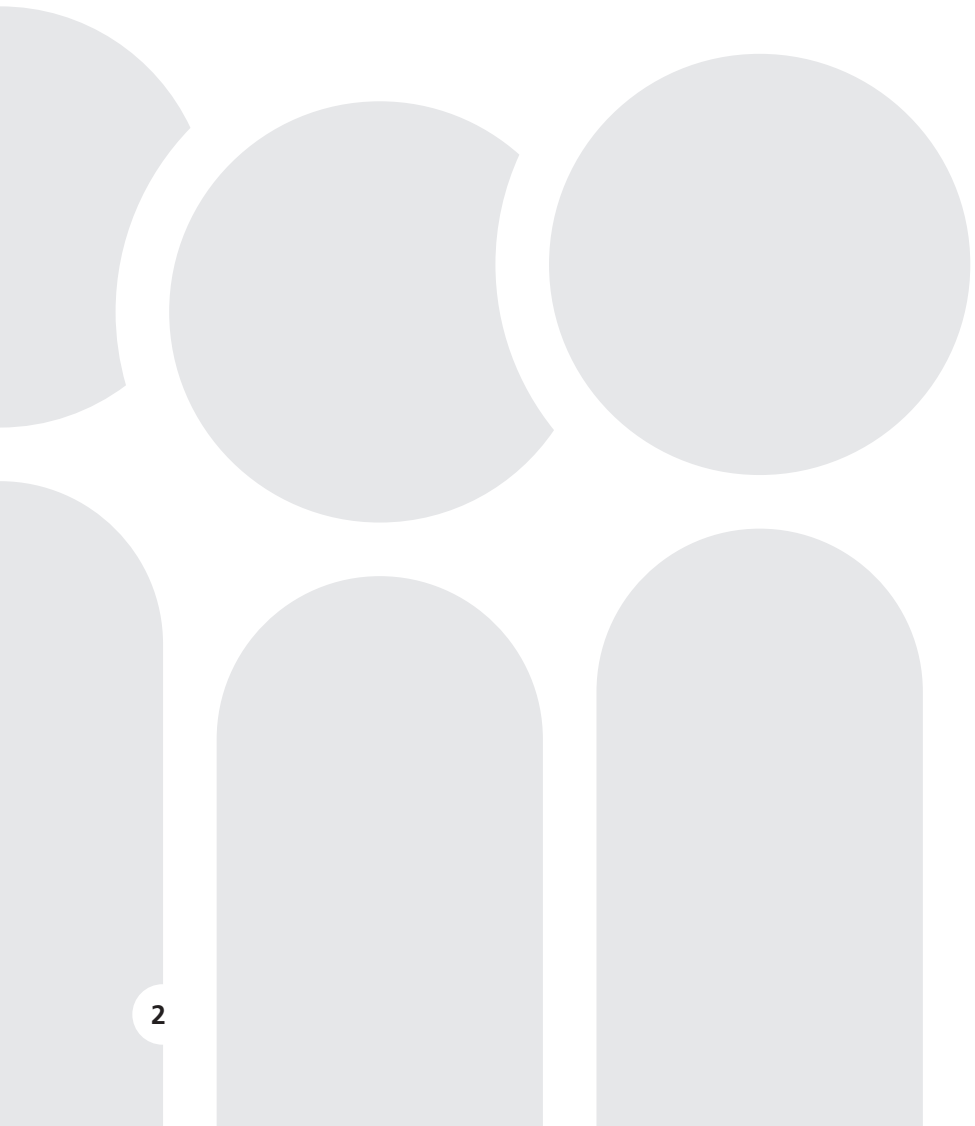

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Contents Of This Issue

Editorial

The Integrative Project In Practice

In this issue we have diverse contributions from practitioners who identify themselves as integrative psychotherapists, each reflecting on different dimensions of theory and practice. Some of these authors are more formally articulating bodies of theory that they are integrating into a coherent framework; others are more overtly practice-based with the integration more implicit in their description and assimilation of actual hands-on practice or personal life experience. What links these authors, in our view is their discussion of the movement between the lived subjective experience and their subsequent reflection on that experience in relation to their practice as integrative clinicians.

Contents Of This Issue

Evgenia Georganda introduces her concept of the DNA of the Soul as an integrating theme in her exploration of developmental stages throughout the lifespan. This article provides a fair review of classical developmental theory put alongside traditional humanistic and existential perspectives, each of which present a stage-based view of human development.

Tom Warnecke provides a comprehensive discussion of working with people with a borderline presentation from a somatic and relational perspective. Tom gives a useful overview of the borderline dilemma as outlined in the psychoanalytic literature. He integrates into this discussion the physiological aspects of the borderline structure and their implications in the transference and countertransference dynamics. Tom engages the reader in his own struggle with these dynamics in a sensitive and courageous manner. Through this exploration he shares the challenge facing practitioners of surrendering to "non separated states" whilst also being able to hold a separate stance in relation to clients. Clinical illustrations bring this account alive for the reader.

Maria Gilbert explores the concept of the relational unconscious and enactments as they present in supervision, both as part of the supervisory relationship and as direct information about the clinical relationship. She explores how these concepts are inevitably present in both domains and how their deconstruction may provide rich information to supervisor and supervisee alike. Maria draws on practice examples to elaborate her theoretical ideas and to illustrate how these concepts can contribute to an integrative framework for both supervision and practice.

Julianne Appel-Opper offers a personal exploration of her view of intercultural communication and her journey between cultures that often misunderstand one another's intentions. Her autobiographical style conveys to the reader the nuances of cultural stereotyping and assumptions and the ease with which we can misconstrue and feel misconstrued. She applies these understandings to the complexity of clinical work in a sensitive and candid manner.

Saira Bains addresses similar issues from her family's very immediate experience of racist trauma in the United Kingdom. She

explores personal narrative as a valid research methodology and as a vehicle for building intersubjective awareness and transformation.

Saira's moving account of her brother's tragic, isolated journey in the face of racial attack and their courage in providing an account of their joint experience of facing this horror is humbling and sobering for the reader. She invites practitioners to reflect on racialised subjectivities in the therapeutic relationship and to have the courage to engage in dialogue to enrich their understanding and practice.

Vanja Orlans takes the reader on an exploration of the ethical demands of practising in an era when modernist certainty has been replaced by post-modern complexity. She is discussing ethical wisdom in the context of Socratic dialogue, in the first instance located in the reflection on lived experience, rather than as inviolate rules held by authorities 'out there'. She is encouraging ethical thinking as an ongoing endeavour which is at the heart of self-reflexive practice.

Michael Randolph in his article on body psychotherapy brings the work of Wilhelm Reich into dialogue with Daniel Stern and Donald Winnicott. Borrowing from Winnicott, he highlights the image of body psychotherapy as offering both a 'holding' and a 'handling' environment. He illustrates his account with elaborated clinical vignettes that bring the work to life and provide the reader with a good sense of his way of working within an integrative body psychotherapy approach particularly within a group setting. Michael's gift with language and his integration of literary metaphor adds a richness and vitality to this article.

As is our usual tradition we publish an example of a student's final written submission for their qualification. In this edition we include a report by Lorraine Price on her research project for her Master's in Integrative Psychotherapy.

Maria Gilbert and **Katherine Murphy**.
Consulting editors and co-editors of this issue.

Evgenia Georganda

The DNA Of The Soul: Integrating Developmental Issues With Humanistic – Existential Theory

Abstract

This is a theoretical paper that describes development as a double helix leading from birth to death. Our psychological development and its basic ingredients can be visualized as an equivalent of the DNA double helix that progressively leads to a higher state of being with the ultimate goals of individuation and self-actualization. The paper is based on an integration of the developmental theories of Erikson, Freud and Piaget, as well as on the humanistic and existential theories of Maslow, Frankl and Yalom. It discusses the major developmental achievements of each stage and what constitutes the favourable and unfavourable outcome of each one of them. Our understanding of the factors that can enhance our psychological growth can help us de-mystify the process by which we can attain happiness and self-fulfillment. This paper was presented at the 4th European Conference of the European Association of Integrative Psychotherapy held in London, UK, March 2006.

Introduction

Existential theory uses a psychodynamic model of personality, which postulates that the basic conflict is between the individual and the 'givens of existence' (May & Yalom, 1995). The roots of psychopathology are to be found in the struggle of the individual with the four 'ultimate concerns' (Yalom, 1980), death, freedom, isolation and meaninglessness.

In most existential psychotherapies the focus is on the here and now. May & Yalom (1995) write: "The individual is to be understood and helped to understand himself from the perspective of a here-and-now cross section, not from the perspective of a historical longitudinal section" (p.277). However, human beings are not a-historical beings. Existential theory will profit greatly by integrating the developmental model in its understanding of the current situation. It is important to conceptualize the human being's present situation as a continuum from birth till death instead of an existence with no past or future. It is true that existence manifests itself in the now and that the here-and-now is where therapists can see the past re-enacted as well as re-formulated. Most therapists would agree, however, that dealing with the ghosts of the past plays a vital role in the healing process.

May & Yalom (1995) suggest that: "the therapist must continually keep in mind that we create our past and that our present mode of existence dictates what we choose to remember of the past" (page 278). However, it would be a mistake to underestimate the biological and psychological influences that play a role in the development of the particular individual. When we look at a newborn baby we can see the extreme vulnerability, dependence and unique idiosyncrasy. No doubt as attachment theory proposes infants are not passive in the creation of the bond with mother. Their temperament will play a critical role but there is no doubt either that the mother's temperament, psychological well being and ability to cope

with the strains of parenting will influence the infant. Human beings have the option, through heightened awareness, to change the psychological influences they have received.

Thus, a major goal of therapy is to raise awareness as to what was termed (Georganda, 2002) 'the DNA of the Soul'. The DNA of the Soul is a symbolic representation of the influences we 'inherit' from our family of origin with regards to our psychological make-up. To the extent that we remain unaware of these influences we are determined to think, feel and act in certain ways, patterns, scenarios, etc. These patterns could be changed once we become aware of them, decide to do so and use our will power. This is, in other words, what we call therapeutic change.

Humanistic and Existential theories (or the third force in psychology) disagreed with psychoanalysis and behaviorism not just because they are both deterministic theories but also because they lack a structure in their theory of personality that is responsible for change. Who changes in psychotherapy and who does the changing? The individual changes. It is the client who is responsible for change and who is changing himself or herself. We need, not only to want to change but to also put into action our decision for change. Although insight into our situation is of paramount importance it is not sufficient in itself. We need to wish and will; decide out of desire and act out of conviction. The ability to act out of will is I believe similar to other traits and characteristics of human beings. It is inborn but requires practice and cultivation in order to flourish. The early circumstances of our life play a crucial role in the opportunities they give us for training our will power. Our development also plays a significant role in the development of other properties and skills that will prove very useful for success in life and in therapy.

Development Through The Life Span

Development proceeds in stages and the attainment of different skills and capabilities can be viewed as steps in a ladder that lead us higher towards the ultimate goal of our development, individuation and self-actualization. Biology offers us a valuable schema with which we can visualize psychic development and its basic ingredients. The photograph of a DNA molecule helps us grasp the idea of development as a non-linear process. It rather takes the form of a spiral where what has been gained (or lost) in the previous stages has a cumulative effect. It is often the case that individuals in therapy realize that they are again and again working on specific themes that they believed they had already resolved. They often become discouraged and feel as if they are not progressing. It is important however to realize that such repetition, may differ from the known repetition compulsion where one seems to be stuck in a vicious circle and instead, may be viewed as a normal process by which someone is working on the same theme but on a higher level until s/he can reach full realization and thus resolution. The upward movement of the spiral suggests the unfolding and evolutionary nature of our journey in life and our struggle to ascend to a higher way of being.

Life as we know it, is a process that begins with birth and ends with death. This life long process has been divided into eight stages. Infancy, toddlerhood, early childhood, latency, adolescence, early adulthood, middle age, and old age. What happens in each stage is important for the next. Different theorists have proposed different stages but we can combine them and integrate them so as to have a more unified picture.

Erikson (1963, 1980) was the first one to introduce the idea of a positive and a negative outcome depending on the quality of our early relationships. Our parents (or parent substitutes) are responsible not only for the basic DNA material that we inherit, but for our basic psychological constitution as well. Although the knowledge of our biological structure cannot help us to change it—so if we are born with blue eyes we will have to accept that we will die with them— the understanding of our basic psychological make-up can help us to alter it. This is why the discussion of such material is valuable for psychotherapy.

As Mahler and other theorists have suggested the goal of development is separation/ individuation. In other words to reach a higher level of development where we can function as autonomous individuals; to exist

as separate unique beings. Many things can go wrong during this process of development and block our way towards individuation and actualization of our potential. The goal of individuation is attained through a process of separations that lead us from a merged and symbiotic way of being to an existence as unique beings. To be able to stand on our own, to become the best that we can be and to claim responsibility for our life are considered by many, existential and humanistic psychotherapists the ultimate goals of therapy as well.

Infancy

Birth signifies the first and most important moment in this process of separation/individuation. It is with the cutting of the umbilical cord that we become physically separate from our mother. This physical separation will be followed (or has to be followed) by a number of separations on the psychological/emotional plane, before we can reach self-actualization. The loss of the sense of security offered by the protected life in the womb can be replaced only by a very secure attachment to a mother who is always there for her child. Although the consistent care provided by a loving mother (or 'mother substitute') is absolutely essential for the development of a basic feeling of trust, it can nonetheless never be perfect. There are no perfect mothers; there are no perfect childhoods. Some feelings of mistrust and a basic fear of abandonment cannot be avoided. However, with a reasonably good mother-infant relationship we can attain the first and most basic virtue of all, the virtue of hope. Hope and optimism were shown to be important coping mechanisms, in Harvard's longitudinal study of successful graduates, as reported by George Vaillant in his book 'Adaptation to Life' (1977). Most therapists recognize from their experience that positive thinking and hope are invaluable assets for therapeutic work and believe that it is hope and trust that have to be restored by the therapeutic alliance. The creation, or recreation, of a trusting and hopeful environment is the first and foremost step in the healing process.

By the 6th month infants start to develop the ability for self-object differentiation. So, at least cognitively, the infant can begin to develop the idea of a separate existence from the surrounding world. However, whether this cognitive skill will be translated into an emotional reality will depend to a large extent on how the mother deals with separation and whether she is able to handle the loss of a dependent and dependable object; an ability, which is related to mother's process of individuation and her capacity to find a meaning in life other than her child. According to Freud (1973; 1978) our ego starts to develop in this first oral stage alongside our ability to differentiate self from object. How well it will develop and whether it will be able to deal with the pressures and the demands of the id and the superego later in life, depends on the relationship that is established with mother and the gratification (or not) of the basic instinctual drives that are associated with the different erogenous zones. The pattern of relating and the faults of this initial relationship will be re-enacted later on in the relationship with the therapist in what we call transference. The resolution of this transference can be (and has been) described as a corrective emotional experience by which the faulty patterns can be altered.

Toddlerhood

The first emotional separation is attempted during the second year of life, the period known as the 'terrible two's', when the toddler takes the first steps in life. This greater physical autonomy is coupled with the greater cognitive autonomy offered by the use of symbols and the development of language (representational thinking). The young child is able not only to move around on his/her own, but also to communicate his/her needs verbally. It slowly acquires a greater ability for self-control, both on the physical and the emotional plane. What happens in the relationship with the parents is of great importance. Will the child develop the virtue of will? Will it be able to learn how to stand on its own two feet physically as well as emotionally, or will it be led to feeling shame and doubt and, I would add, fear? Fear is a major obstacle in our development. Fearful and shy children become adults who are unable to take risks and grow. Although a certain degree of fear is useful and realistic,

most of our fears take unrealistic proportions and stop us from our struggle to attain higher and higher goals. Overprotection and authoritarianism are equally devastating both for the development of autonomy and for the creation of overwhelming feelings of fear in the two-year-old. Such negative outcomes of this early stage thwart the development of our ability to become independent and responsible adults. In addition, the way toilet training demands are handled by parents in this second anal stage can serve as a prototype for the way conflicts and general social demands are experienced and dealt with, by the child.

Childhood

Our ability to initiate activities, including sexual play, can be hindered by excessive feelings of guilt. Excessive moral demands, too much criticism, and generally a very demanding upbringing can curtail the virtue of purpose and block our ability to act and achieve goals that we set. In addition, the way the Oedipus conflict is resolved will play a crucial role in the development of both our sexual identity as well as our ability to form satisfying sexual relationships in later life. The development of a very strict superego can block our effort to fulfil our potential. A strict and unrealistic conscience is a hindrance since it moves us away from what is meant for us and towards what is desirable and approved by others. It makes us feel guilty when we do things that we like and desire, instead of what we have been taught we should do. Such a conscience is not a positive influence on our struggle to become the best that we can be since what we can do best is what we desire and is meant for us. Similarly, an extremely unrealistic ego ideal can be the cause of great pain and frustration for what we cannot be, which anyway may not be in the givens of our existence. The ability to accept who we are, with our strengths and our weaknesses, is absolutely essential in order for the healing process to take place and is hindered by any unrealistic demands and expectations that have been incorporated into our self-image from very early on.

In the next stage of our development, sexuality becomes latent and we become absorbed in our effort to learn social skills, in our effort to become competent academically and socially. The virtue of skill gives us a first good basis for building our self-esteem. We feel competent and productive. Feelings of mastery and self-control are absolutely essential not only for a positive evaluation of our self and our strengths, but also for our ability to cope with crisis and handle our fears and insecurities. The first powerful relationship outside the family is created with what Sullivan (1953) calls 'the chum', our buddy, our best friend, usually of the same sex. Learning how to relate and form intimate relationships is a skill essential for life. Living without loving leads to a bare existence. Our ability to trust is essential once more. Can we trust? Are we too scared of failure and rejection? Do we believe in our value? Do we think of ourselves as lovable? Crucial questions which will have to be addressed as we enter into adolescence and we start to form our own identity. How well prepared we are in order to face this crisis is of paramount importance. The increasing numbers of suicide attempts, of drug use and of breakdowns in adolescence lead us to believe that we are not doing a good job in preparing our children to face adult life.

Adolescence

Adolescence is a transition and thus a complex stage. A number of physical developments signal the end of childhood and the re-emergence of sexuality (genital stage). However the adolescent is not yet an adult and does not know how to handle all of the changes that take place in his body and in his mind. Cognitive changes lead to the development of hypothetical and abstract thinking. Questions around the meaning of life and one's own role in it are prominent. Existential theory can begin to take an important place in our understanding of what happens to the life of a human being. The adolescent is starting to form an identity as a unique being and has to face up to the task of claiming responsibility for his/her life. Can s/he face up to this difficult task? Does s/he feel the strength to stand up for himself/herself? We, as adults often shy away from responsibilities and prefer to claim that others are responsible for what happens in our life. How then, can we expect a teenager not to be overwhelmed by the difficulty of his/her endeavour? How much respect, acceptance and support have we

given to the teenager all along? How competent and skilful does s/he feel? How much does s/he have a sense of belonging and acceptance by peers, which is so essential for self-esteem and the process of breaking away from the family? Is the family there to provide the support and guidance that is necessary? Can the family let go of the adolescent and allow for individuation? Will s/he develop the virtue of fidelity and be ready to form commitments so necessary for success in early adulthood?

Of course, we often see in our day and age that many children and teenagers suffer more from neglect than overprotection. Our ability to give is hampered by our dissatisfaction with our life and our misguided effort to reach satisfaction by doing more and more things for ourselves rather than those around us. The teenager needs us to be there. To care and to give what is necessary, while respecting the desire to experiment by doing things on his/her own. The flexibility of the family in this aspect has been shown from the beginning, when the teenager was still a toddler. Now, the family is going to be tested again. The parents, who by now are usually facing their middle age crisis, have a very difficult role. How satisfied are they with their life? Life satisfaction depends on choices. Our ability to choose in an authentic way depends on the extent of our ability to be in touch with our true self. Ability that is hampered, as already mentioned, by a very strict upbringing, results in the development of a rigid conscience and an ego ideal that has no relationship to our true nature. Therapy can help in altering such faulty perceptions and in allowing the individual to be more in tune with who s/he really is.

Adulthood

As we enter adult life our ability to commit ourselves gains primary importance. Commitment in love and work is essential for success in either aspect of our life. Forming intimate relationships and establishing a family of our own is related to life satisfaction, as long as this is not done as another duty or as a means of proving that we are 'normal' and we can do what others do. How serious we are with our choices and the responsibility they imply relates to our level of consciousness and self-awareness. Are we just driven by life and by expectations or are we in command of our life? Our ability to be in command depends on the development of many skills. The development of the virtue of love and of self-esteem are necessary for believing that we are worthy and that we deserve to be treated well.

First and foremost we have to learn how to treat our own self well. How much we care for our well being is essential in our struggle to become the best that we can be. Self-care and self-love must not be confused with narcissism, self-centredness and egotism, but must be conceived as the basic dictate of 'love thy neighbour as thyself'. This positive attitude towards our self and others is the only remedy for alienation and isolation. Our positive outlook on life, our self and other people can improve both our intrapsychic and our interpersonal isolation. The awareness of our existential isolation, as discussed by Yalom in his book 'Existential Psychotherapy' (1980), although incurable, can help us increase our awareness of the responsibility we carry for our life and for the course it is going to take. No one else can live our life for us and no one else will die in our place. So what we do with our life is purely a personal matter. As Sartre said "we are equally responsible for the things we do and for the things we decide not to do".

The realization of the responsibility we have for our life and our choices is important for both love commitments and work commitments. It is often the case that our choices are veiled by what others (primarily our parents) desire and by what we believe will bring acceptance and recognition. Marriage that is motivated by reasons of prestige, or the pressure of social and familial demands, can have a detrimental effect on the life both of the couple and the children they may decide to bring into this life. Similarly work commitments which are motivated by reasons other than our feelings of love for what we do can lead to dissatisfaction and unhappiness. A large amount of our time and energy is devoted to work. And if the latter is not satisfying in a deeper and more personal level, it very often leaves us with a feeling of emptiness. It is this existential void that Victor Frankl describes so well in his book 'Man's Search for Meaning' (1984). Finding meaning is an essential part of our struggle in life. This quest for meaning is intimately related to

the spiritual nature of human beings, which unfolds, as Jung suggests, after our 40's. The importance and the ways with which spirituality can be integrated into treatment are beautifully illustrated in APA's seminal publication of the book 'Integrating Spirituality into Treatment', edited by William Miller (2000).

It is through the new physical changes, which signify our entrance into middle age that we usually realize that our physical, material existence is not the one that can provide for happiness or eternity and this realization can increase our quest for a spiritual path. Both happiness and eternity are much desired, by at least most human beings, but neither can be brought about by a larger bank account or by more material possessions. Our body is beginning to betray us and the concept of death can no longer be denied as much as in adolescence or early adulthood when it seemed very far away. It is actually the very idea of death that can save us, as most existential theorists would agree. Our awareness of the ultimate and unavoidable end can help us live in an authentic way and thus aid in the attainment of our ultimate goal – becoming the best that we can be. Death awareness is usually heightened in middle age. However, chronic and life threatening illnesses, accidents and other serious life threats can help us increase our awareness of the end which most often results in the realization of the value of life. Such realization leads to dramatic life changes, to an appreciation of the here and now and of what one has, rather than what one lacks

Whether we will develop a feeling of generativity instead of a feeling of stagnation depends on how well we feel in relation to our self. It is now that our struggle to be true to our self will bear its fruit. We can feel joyful and satisfied; we can care and give. In addition our desire for knowledge, beauty and order, as defined by Maslow (1970) in his hierarchy of needs, can move us to a higher way of functioning. Our quest for understanding the meaning of our life and the cultivation of our higher aesthetic needs lead us to a higher form of morality, what Kohlberg (1969) defined as the universal ethical orientation. Thus, we develop beyond what is personal to a more universal outlook. We can let go of our ego and our selfishness and understand that we are part of a greater whole.

Equipped with all the skills and virtues that we acquire throughout the journey of our development, we can truly be wise and make up for the lost physical vigour and beauty. External beauty and strength can be replaced by internal. Thus, we can reach a stage of self-fulfillment and satisfaction that are necessary for the feelings of integrity that Erikson suggests. Personally I believe that there is nothing more tragic than dying unhappy and unfulfilled. There is nothing more painful than the realization that one has not lived his/her life well. That if s/he were to live again s/he would make different choices and lead life differently. The older we get the more difficult and more painful it is to realize that we have taken a wrong path and the more strength it requires in order to decide to change it. So the sooner we begin our journey of self-awareness the better off we are. It does not have to be that something tragic happens before we realize the value and impermanence of life. It does not have to be that we lose what we have before we realize its value. Human beings are thinking beings and we can help them confront the reality of the fragility of life and the freedom we have for shaping it. Environments, which respect the individuality of each and every human being, can support and enhance this path towards individuation. Psychology and particularly psychotherapy can play a major role in advancing our understanding of this process. The de-mystification of the process by which a human being can become a satisfied, integrated, fulfilled and happy individual can prove immensely valuable for mankind.

References

Erikson, E. (1963). *Childhood and Society.* New York: Norton and Company.

Erikson, E. (1980). *Identity and the Life Cycle.* New York: Norton and Company.

Frankl, V. (1984). *Man's Search for Meaning.* New York: Touchstone.

Freud, S. (1973). *An Outline of Psychoanalysis.* London: The Hogarth Press.

Freud, S. (1976). *Introductory Lectures on Psychoanalysis.* London: Pelican Books.

Kohlberg, L. (1969). *Stage and Sequence: The Cognitive-Developmental Approach to Socialization*. In Goslin, D.A. (ed.) Handbook of Socialization Theory and Research. Chicago: Rand McNally.

May, R. and Yalom, I. (1995). *Existential Psychotherapy*. In Corsini, R. and Wedding, D. (Eds.) Current Psychotherapies. Illinois: Peacock, Inc.

Maslow, A. (1970). *Motivation and Personality*. New York: Harper and Row.

Sullivan, H. S. (1953). *The Interpersonal Theory of Psychiatry*. New York: Norton and Company.

Vaillant, G. (1977). *Adaptation to Life*. Boston: Little Brown and Company.

Yalom, I. (1980). *Existential Psychotherapy*. New York: Basic Books.

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Tom Warnecke

The Borderline Experience – A Somatic Perspective

A presentation given at the AChP
Annual General Meeting in London
on November 6th 2004

Abstract

This paper explores a therapeutic approach to BPD that integrates somatic and relational aspects. From a somatic perspective, the Borderline dynamic is characterised by chronic dysregulation of the autonomic nervous system, inadequate muscular structuring and a lack of surface boundaries. In the therapeutic relationship with BPD clients we are confronted with episodes of catastrophic anxiety which the borderline body-ego is unable to contain or defend against. Such catastrophic anxieties constitute states of unintegration which manifest at times as despair, rage, clinging or self-destructive pathologies. The therapist is frequently experienced as either 'too close' or 'too far away'. Somatic dimensions of BPD are equally evident in the transference relationship. The ruptures and dissonance typically associated with Borderline relationships reflect the extent of somatic dissonance, arousal and affect dysregulation of the fragile Borderline structure. Our bodies constitute our primary means of dialogical engagement with the world and the complexities of BPD are best met by engaging with both dimensions.

Introduction

The word "borderline", Yalom professed, "strikes terror in the heart of the middle-aged comfort-seeking psychiatrist". And we are probably all familiar with an image of borderline clients who torment and harass their therapists. But this portrait is only half the picture so far. "My first impulse was to get the hell away, far away – and nor see her again" Yalom continues. "Use an excuse, any excuse: my time all filled, leaving the country for a few years, embarking on a full-time research career. But soon I heard my voice offering her another appointment" (1989, p214).

The borderline dynamic casts a compelling shadow of turbulence across the serenity and comfort of our consulting rooms. And it is obviously capable of eliciting polarised responses and personal involvement amongst professionals who are reasonably expected to maintain some degree of neutrality and containment. And if we therapists struggle with the dynamic, what do we imagine the intrapsychic borderline experience to be like?

My interest in this subject originated first of all from a desire for self-preservation as I began to work in an environment that seemed inundated with a borderline dynamic. I was further stimulated by my experience of borderline mystification and paranoia in my initial Gestalt training. What I subsequently discovered was a confusing wealth of borderline theory which seems almost as complex and intractable as the dynamic itself.

The recognition of the body in the borderline dynamic is as old as the concept. Adolph Stern, who first introduced the term borderline to analytic literature in 1938, observed 'psychic

bleeding' and 'psychic and body-rigidity' amongst his borderline patients and included both symptoms in his definition of the borderline condition. It appears that the body then disappeared from borderline theory for nearly four decades until Robert Lewis picked up the baton in 1976 and published his paper 'Infancy and the Head'.

This paper is an attempt to formulate a perspective that is grounded in the somatic psychology of the borderline experience. The theoretical concepts and perspectives I draw on are organised around this pursuit of a somatic-integrative perspective and not always compatible. Nevertheless, I have found them helpful to make sense, connect and work with the complexity I observe and experience in myself, my borderline clients, and in the borderline relationship.

The Borderline Spectrum

The term 'borderline' refers to a continuum, ranging from what Boadella (1996) calls the 'high' borderline within the neurotic spectrum, to the 'low' borderline with psychotic or semi-psychotic episodes. I have found it helpful to think of the 'high' functioning borderline as a 'borderline structure' in comparison to the 'Borderline Personality Disorder' (BPD) diagnosis in DSM IV TR which seems heavily weighted towards the low functioning borderline dynamic epitomised by Cauvels:

"Borderlines themselves are trapped in a chaos of disturbed thoughts, distorted perceptions, raging emotions, and humiliating behaviors that seem well beyond all sense" (1992, p3).

High functioning borderline clients, however, are able to compensate the underlying dynamic to various degrees and usually hold jobs, form and maintain relationships, and outwardly lead fairly normal lives. In contrast, the day-to-day life of the 'low' borderline will appear highly disruptive and punctuated by frequent and often severe crisis states along with a history of contact with psychiatric services and hospitalisations. For the purpose of this paper however, I will apply the term borderline structure to the whole borderline spectrum.

While the actual presenting individual dynamics and symptoms may differ substantially, there are a number of indications, which, in combination, suggest a borderline dynamic to me:

an inability to regulate arousal and affect states sufficiently

difficulties in distinguishing between self and other, and between internal and external space

catastrophic anxieties and hyperarousal

blurred boundaries

indications for 'cephalic shock'

inadequate muscular armouring

lack of a self-object that is capable of a self-containing function.

Arousal and affect dysregulation is probably the most obvious presenting phenomenon of the borderline spectrum. Such self-regulation impairment also finds expression in the often intense and difficult countertransference experience of the therapist, which in turn indicates the severity of the underlying fragility and distress experienced by the borderline client. When I feel fragile, insecure, uncontained or overwhelmed in the therapeutic relationship, I need to consider that this may mirror the experience of my client.

With one client for example, it seemed that the ground beneath me had the fragility of eggshells during every single session for the first six months of our relationship. While I was only too aware how unsafe my position felt, I failed to realise for quite some time how my experience of being with this client also reflected my client's experience of our relationship.

We can expect that attachment dynamics, and the inherent quest for some effective co-regulation of distress, will constitute a central aspect of the borderline experience. But the borderline structure is also a paradoxical state of non-separateness in the sense that the precarious borderline experience of self appears largely determined by others. The word borderline – 'a line that indicates a boundary'

– incidentally names what is most lacking in the borderline structure. Masterson addressed this paradigm when he presents the borderline dynamic as a 'disorder of the self' (2000). He identified faulty separation-individuation at the core of the borderline dynamic. In Masterson's theory, the intrapsychic borderline structure develops from the internalization of mother – child interpersonal interactions. Other clinical observations should be organised around the axis of this developmental sequence he argues, as it reflects the essence of developmental arrest and provides the therapist with the most reliable guide (1981).

Catastrophic Anxiety And Hyperarousal

But the borderline experience is essentially also an uncontained state. The intensity of borderline anxiety, desperation, longing, or rage reflects experiences of engulfment, abandonment, and separation attempts which overwhelm the fragile borderline structure. The therapist is frequently experienced as either 'too close' or 'too far away' and borderline clients may oscillate quite rapidly between these polarities at times. Both are potentially the source of hyperarousal and catastrophic anxieties, another hallmark of the borderline dynamic.

Catastrophic 'too close' anxieties are likely to arise from a client's wish for closeness but also from feeling heard or seen in response to both empathic and challenging interventions and reflections of the therapist. In body psychotherapy, touch is also likely to trigger such anxieties. 'Too close' anxieties will generally express the 'fear of engulfment' which Masterson (1981) recognised. Borderline clients themselves have also described it as a fear of 'being controlled'. On occasions and particularly in regressed states, such anxieties may intensify into panic or rage fuelled by infantile devour-or-be-devoured fears. 'Too close' anxieties will also precipitate abandonment acting out.

Catastrophic 'too far away' anxieties on the other hand, manifest as despair or rage when feeling abandoned, not met, or not heard in the therapeutic relationship. They appear symptomatic of a lack of self-soothing capacity which Adler (1985) identified. He suggested an 'insufficiency of sustaining introjects' at the core of the borderline dynamic. Devoid of self-soothing images, the borderline structure depends on external sources to fill the inner void. The fear of such dependency on the support and reassurance of others however, will inevitably evoke 'too close' anxieties sooner or later.

From a somatic perspective, we can view the 'too close/too far away' phenomenon as an indication for a lack of 'surface boundaries'. Boadella (1996) employs this term to describe the experience of a dividing line between internal space and external space and between self and other. Well developed surface boundaries appear crucial for the ability to separate inner from outer and distinguish between self and other. One client for example, described her experience of being in my consulting room as a "continuous warm embrace" – that is until, without either of us moving from our chairs, I become "too close" once again.

Intrapsychic Experience – The Void

Such 'too close/too far away' catastrophic anxieties however, do not appear to represent a 'splitting' defense but rather suggest an inability to defend and protect the integrity of the fragile borderline structure. Esther Bick described such states as 'unintegration' (1968). She linked the infant's skin experience, called 'first skin formation' by Bick, to the process of introjecting a self-object that is capable of a self-containing function.

"The need for a containing object would seem, in the infantile unintegrated state, to produce a frantic search for an object – a light, a voice, a smell, or other sensual object – which can hold the attention and thereby be experienced, momentarily at least, as holding parts of the personality together. The optimal object is the nipple in the mouth, together with the holding and talking and familiar smelling mother" (Bick in Briggs Ed: 2002, p 56).

The infantile body-ego, says Bick, experiences separateness as disintegration and defends by splitting. In the absence of an internal space, however, the infant can neither contain nor

project into an external object. Adler observed that the borderline catastrophic anxiety would on occasions intensify to such a degree that borderlines experience 'annihilation panic' (1985). He described how the loss of self-cohesiveness is experienced as a lack of wholeness and crucially, as a subjective sense of being very near to disintegrating.

The notorious borderline rage will at times reflect such annihilation panic. One borderline client, I shall call her Mary, directed a torrent of rage at me which continued for about forty-five minutes. I had, so I learnt afterwards, frightened her by placing two cushions on the floor and inviting her to join me there in the first few minutes of our session without exploring this first from the safe position of our chairs as I usually did. Presented with a trigger for her worst fears by my provocation, Mary did join me on the floor albeit with a vengeance! There seemed to be absolutely nothing tolerable about me whatsoever both as person and a professional as she hurled accusation after accusation at me. Initially, I felt powerless to respond in any way but bear the excruciating onslaught and survive it somehow. Eventually I became aware of her highly charged arms and shoulders, a charge which appeared contrasted by her deflated chest. After some time, I managed to steer her awareness to her shoulders.

"That's where I am angry," she asserted.

"And what happens below?" I enquired.

"I don't exist."

Her revelation came with a heartfelt anguish that shocked both of us to the core. My earlier ordeal paled instantly in the face of her existential battle. And her realisation connected us deeply for the remainder of the session and in way that neither of us had experienced before with each other. It seemed that Mary's rage turned into anger once it became obvious that we were both surviving her rage. Paradoxically, her anger then served to separate us sufficiently in order for us to meet and connect. For the Borderline non-separateness is evenly matched by disconnectedness both within and to others. In other words, the absence of boundaries also dictates a lack of distinction between intra- and inter-personal dimensions in the therapeutic relationship, which is probably what we struggle most with as therapists. Adler and Rhine argue that projective identification, while ubiquitous in everyone, is especially manifest in interpersonal situations with an ill-defined structure and more closely linked with primitive impulses and conflicts (1992).

Ill-defined And Blurred Ego Boundaries

It is generally accepted that the borderline dynamic carries a history of unattuned and inconsistent mothering as well as incorporating experiences of smothering and cold responses. There are a number of arguments across the borderline literature that the infant's primary caretakers can be expected to display borderline aspects themselves. While theoretical models which attempt to describe the infant's intrapsychic states and development differ (Mahler; Stern; Schore), there seems to be general agreement about the devastating effects of unattuned and inconsistent mothering.

Not surprisingly, the space of the therapeutic relationship holds both a promise of rescue and a threat to the precarious autonomy of the fragile borderline structure. 'Too close' and 'too far away' anxieties determine the borderline experience of relationships and the extent of anguish and confusion in several ways:

The difficulties of distinguishing between self and other dominate the intrapsychic experience of relationships. The therapeutic relationship is anxiety provoking by itself.

At the same time and adding to the complexity, such anxieties also reflect experience and introjection of tangled and inconsistent primary relationships.

Projection and re-enactment in the therapeutic relationship, and associated borderline clinging, distancing and abandonment 'transference acting out' (Masterson, 1981).

Some borderline clients feel frightened or anxious about their behaviour on such occasions. Lewis (1976) suggests a borderline etiology where the contactlessness of the parent has been intermittent and unpredictable. He emphasised the significance of eye contact in

this context. Infants are dynamically active in self-regulating arousal by making and breaking eye contact with their caretaker. Since the parents' boundaries are blurred with the infant, says Lewis, parents relate to the child as an extension of their own organism. In self-psychology terms, such blurred boundaries would indicate that parents use the child as a receptacle or 'self-object'.

Masterson emphasizes the crucial initial therapeutic task to ascertain whether the patient's ostensible neediness is a true therapeutic need or a testing behavior (2000). This task, he argues, is facilitated by questioning and confronting the client's behaviour. And indeed, some therapeutic relationships initially resemble a walk on a tightrope as boundaries are explored, negotiated and established. Differentiating between acting out and genuine confusion, disability and distress may serve us well to contain such challenges. With such distinctions however, we may become all to easily the external arbiter and at risk of losing our participating position within the 'too far/too close' dynamic.

Boundaries are essentially the structures of relationships and thus probably as critical to the inter-personal dynamic as ego structure is to the intra-personal dynamic. They provide vital orientation in otherwise confusing relational landscapes and we depend on them for our ability to manage relationships successfully. Boundaries assert a distinction between self and other by their very existence! As such, they also determine the degree of autonomy experienced in any relationship which in turn highlights the need for boundaries to be negotiated rather then imposed. I will, for example, initially accept a short notice re-scheduling of a session if possible but spend that session exploring and negotiating a clear contract for similar occasions. The borderline challenges of boundaries in therapeutic relationships not only test robustness and dependability of boundaries but also support explorations of boundaries and form a crucial part of such negotiations.

Working With Catastrophic Anxiety

Blurred boundaries between self and other also manifest in the three-dimensional space of the consulting room. The physical proximity between therapist and client is usually either part of, or contributes to, the 'too close/too far away dynamic'. If we draw their attention to the experience of personal space and physical distance, borderline clients can learn to utilize the space of the consulting room as a resource to contain and regulate arousal and stress levels.

The concept of 'putting the brakes on' whenever arousal becomes too overwhelming for a client is well established in the work with Post Traumatic Stress. This is usually achieved by utilizing a previously established safe space and by bringing the client back into the here and now. With borderline catastrophic anxiety, we can observe autonomic nervous system activity quite similar or at least comparable to PTSD. Unlike PTSD however, the perceived threat is the therapeutic relationship itself. But we can draw upon personal space and physical proximity as a tool to bring our clients' arousal, anxiety and charge back to a tolerable level.

Trauma research has shown that motor activity and the possibility of moving is crucial in prevention and treatment of PTSD. Van der Kolk (2004) reported that very few people who ran out of the World Trade Center were permanently damaged because they ran and ran and were able to save themselves. Borderline clients will use the initial choice of position in the consulting room at the start of a session to both signal and regulate their momentary degree of arousal and self-cohesiveness.

Trauma research has also shown that arousal becomes coupled with overwhelming fear and subsequent immobilization in PTSD. Trauma survivors are often afraid of the arousal cycle itself and become stuck in a 'fear cycle' (Levin, 1997). We can observe similar fears of arousal in some borderline clients. Describing the visible sequences of embodied turmoil in detail afterwards to the client appears to be an effective way of engaging with catastrophic anxieties once a therapeutic alliance is established.

The unfolding desperation, internal pressure, hyperarousal and panic quality of 'too close' anxiety states is often quite visible and has on occasions evoked a vortex image in myself. Borderline clients have responded

with relief and appeared to take such observations as validations of their experiences. Communicating our perceptions may also open a shared space in which we can attend to the sensory details of experiences. Linehan (1993) recognised the ability to observe and describe feelings and reactions as a prime psychological resource to modulate physiological arousal. Boadella (1996) observed that the process of finding words and language is already creating containment for overwhelming experiences. One client subsequently described the tremendous charge of her inner turmoil experience quite graphically as a "hurricane".

At times, catastrophic 'too close' anxieties may also reflect borderline fears of how such states of turmoil affect others. Such fears may manifest as a need to get away or attempts to hide the catastrophic anxiety when flight is not an option. The therapist's ability to describe his observations appears to promote the capacity of the borderline client to contain such fears. Verbalisations of somatic states also signal that hyperarousal is manageable rather then too overwhelming. Another client heard a reassurance in such an intervention, namely, that I "did not want to control her".

Somatic Considerations

In body psychotherapy, some borderline clients will ask for or demand "bodywork" early on in the therapeutic process which reflects their desperate need for nurturing and soothing. We need to expect however, that touch will invariably provoke fears of invasion, engulfment and being controlled. In other words, touch will activate the too close polarity, unless of course the client is able to dissociate. Touch is likely to aggravate the volatility of both polarities and I consider it crucial to explore the 'too far away/too close' dynamic at depth before considering any work that involves touch. Once the safety of a common language is established and a contract to mutually monitor the experience of internal space and of boundaries between self and other is negotiated, touch can play an valuable role in developing and validating surface boundaries and a more secure sense of self.

The psychosomatic significance of headaches first came to my attention after a rather humbling experience. In his third session with me, Jon, a client with a high functioning borderline structure, wanted to explore an experience from a body psychotherapy workshop some years previously. He described having his head held whilst lying on a mattress but his answers to my enquiries about his experience seemed vague and disjointed. Somewhat naively, I went along with his request hoping that the experience would shed some light on what this was about. Within minutes, Jon developed a severe migraine to the extent that we had to draw the curtains to darken the room. I was left feeling profoundly confused and aware that I had obviously missed something significant.

It took another two years before the extent of his subconscious anxieties about touch surfaced: he could not distinguish whether my hand on his shoulder was inside or outside of him. Jon's history of traumatising experiences around touch continued to unfold but the initial migraine episode only began to make sense to me when I eventually learned to appreciate the fragility that such a lack of secure surface boundaries entails. Pressure and tension in head or neck as well as headaches and migraines occurring in the therapeutic space I learnt, often indicate cephalic bracing in defense against acute and overwhelming fragility elsewhere in the organism.

This would be particularly relevant and significant when headaches and migraines occur during a session. I have learned to enquire on such occasions about any sense or feeling of particular fragility. Cephalic bracing is not exclusive to the borderline dynamic, it is also common in schizoid structures. For the borderline structure however, a sudden headache may constitute an emergency distress signal and the onset of an acute crisis state and indicate the need to strengthen ego boundaries and self cohesiveness with muscular and breath work similar to PTSD.

Physiological Aspects Of The Borderline Structure

Head and neck appear to be particularly relevant to the understanding of, and working with, the borderline dynamic. The infant's neck muscles present the earliest available capacity to bind anxiety in muscular tension and brace itself against shock. Lewis (1976) refers to a state of 'cephalic shock' when such bracing becomes habitual:

"The head end is the part of the organism where the infant can best sustain a holding attitude against the dissonance it is experiencing" (Lewis 1976, p22).

He argues that the autonomic nervous system will have to be involved in such holding due to the limited muscular response possible. Breathing is also profoundly affected since diaphragmatic and cephalic spasm share a direct physiological connection (Lewis, 1976). We can assume that the borderline dynamic will continue to rely on the same resources to defend against its fragility. Neck and throat muscles are typically engaged in several contradictory and often simultaneous impulses and intentions:

holding together

keeping out

holding back or holding in.

In addition, cephalic bracing, and the fragmented cortical images associated with it, will also reflect the borderline struggle to tolerate ambivalence, both within themselves and towards others. We also need to expect that hands on explorations of holding patters in head and neck are likely to evoke some variant of primary scenario re-enactment.

The borderline structure evolves from and manifests as an embodied dissonance, Lewis concluded (1976). Experience of dissonance, disharmony and lack of attunement are structured into the physiology of the developing brain, nervous systems and muscular cells. Cauvels appears to arrive at a similar conclusion when she suggests that the analytical phrase 'arrested development' may actually reflect both neurophysiological and cognitive developmental arrest (1992).

Post traumatic stress is generally expected to dysregulate the brainstem arousal system. The usual adult regulatory system is based on cognition and operated by the neocortex as a kind of top-down processing (van der Kolk, 2002). Such higher order functions however, are entirely reliant on the basic 'house keeping' functions of the brainstem and limbic system. And coherent cognition is the first casualty of hyper-arousal and panic. The borderline chaos of disturbed thoughts and distorted perception, I propose, reflects chronic dissonance and dysregulation of brainstem, limbic system and autonomic nervous system.

Trauma alters the functioning of brain regions such as the amygdala, the hippocampus, the thalamus and the cingulate, and leads to abnormalities in the neurotransmitters that regulate arousal and attention (van der Kolk, 2002). The cerebellum, which integrates sensory input with motor output, is also damaged by trauma. Van der Kolk (2004) argues that traumatised people do not have bodies to function. They struggle to relate to themselves in a very elementary way. Perception and insight cannot influence such primary functions. There is, for example, no direct lateral connection between mind processing functions and the amygdala. Interoceptive experiences on the other hand, are at the core of brainstem behavioural change. Trauma response is a sensory response and the integration of sensory responses promotes brainstem regulation says van der Kolk (2004). In other words, the ability of borderline clients to feel themselves determines their ability to regulate their arousal states.

Interoceptive processing and sense of self are stimulated by and grounded in parasympathetic 'self care' activity. Moberg (2003) refers to parasympathetic responses as a 'calm and connection reaction'. Borderline dissonance and trauma manifest in chronic sympathetic mobilisation and a predominance of 'either/or' responses and experiences. The borderline structure has insufficient internal and surface boundaries to modulate the sympathetic over-charge and the two branches of the autonomic nervous system are failing to

regulate each other. Carroll (2001) suggested that a body in a chronic state of sympathetic activation is experienced as radically unsafe.

The borderline impasse appears to be first of all an impasse of autonomic, limbic and brainstem functioning. How do borderline clients get to inhabit their bodies when every core experience and instinct tells them not to? Children attempt to practice autonomic balancing with tears and tantrums in co-regulating relationships (Carroll, 2001). They test, explore and discover the physical and emotional limits of themselves and their caregivers.

Parasympathetic responses are activated by sound, such as tone of voice, soothing images, meditative contemplations and contactful touch. Moberg's (2003) research shows that resonant and attuned touch at the front of the body will stimulate the release of oxytocin. The hormone oxytocin fuels coordinating and modulating processes which are central to parasympathetic activity. Repeated release of oxytocin leads to significant long term effects of lower stress levels and crucial changes in the balance of neuronal receptor types (Moberg 2003, 2004). Touch, along with the development of surface boundaries, may contribute critically to the borderline capacity for self care and interoceptive experiences.

Embodied Dissonance And Sense Of Self

Any sense of self and self-cohesiveness is dependent on sensory experience, muscular proprioception and the container function of muscular ego structure. The involuntary motor system underpins the skin container with the vitality of muscular tonus. Psychotic episodes on the other hand, are characterised by a loss of muscular armouring. In the borderline structure, the lack of surface boundaries reflect a deficiency of muscular armoring. I have explored the relationship between motor systems and the sense of self in another paper (2003) but I would like to repeat Anton Lethin's striking statement in this context:

"In the absence of enough body sensation, the schizoid is not sure he exists" (1976, p43).

This would equally apply to the borderline structure. Such existential insecurity, in particular at times of acute distress, is also mirrored by the clients' experience of the therapist as Schwartz-Salant observed:

"When in acute distress, the borderline patient can never be certain if the therapist is truly present in a flesh-and-blood sense. One could also say that the patient is uncertain if the therapist is alive or dead. This state of uncertainty always exists on the patients unconscious and manifests in bewildering ways" (1989, p181).

The borderline client never had that much feeling in its infant body to begin with Lewis suggests (1976, p24). The slow, pleasureful process of developing bodily co-ordination, sensory integration and inhabitation never occurs. Such inhabitation processes, however, are inherently entwined with internalised primary relationships. For example, the 'first skin formation' process which Bick observed and identified as a process of introjecting a containing object.

At the 2004 UKCP conference, Michael Soth described two complementary ways of including the body in psychotherapy: an objectifying 'third person stance' and a 'dialogical stance' were we relate from a first and second-person perspective. This concept is particularly relevant to working with the borderline dynamic I believe. In the 'third person stance', we relate to and engage with our client's body from a potentially objectifying observer position. We utilize our understanding and techniques to explore habitual dynamics and facilitate the development of the resources and structures our borderline clients need so desperately.

But – and this is a capital BUT, we are not yet allowing ourselves to enter into the intersubjective experience of the borderline dynamic. To do so, we need to relate from the 'dialogical stance' Michael Soth describes:

"Rather than taking a position which tries to change the habitual patterns, conflicts and dissociations we find ourselves in from the outside, I am surrendering to relating from within them" (2004, p6).

Subjective And Intersubjective Sense Of Self

One borderline patient articulated her internal experience in an essay she presented to her analyst. Her essay, which epitomizes the borderline experience to me, is published as part of a case study by Adler and Rhine. This is what she had to say about the first moments of their initial meeting:

"I remember when your hand came forward, confident that when it came to rest on my arm it would touch warmth and solidness. I watched its faith extending from your body and your humanness, unaware that it would be contacting a structure that contained space itself. There was no place inside for the warmth of the sun, piercing, in the late afternoon. As your hand came closer, its warmth, like the sun, dropped behind the mountains, changing in the extended shadows from red to blue to gray, till all was cold and colorless in the stillness of the twilight. Your innocence was to be shattered by entering a void where it would be shivering for warmth, left gasping at the horror that God would allow anything as terrifying to exist. Wanting to warn you, my screams traveled, reverberating in the emptiness, becoming echos debilitated in the vastness, suspended and lifeless.

I saw the confidence crash from your hand when it touched. Jolted back into your pocket, it quivered from disgust of touching my remoteness and vileness. Without looking at your face, both of us knowing that I no longer had the right, I knew the repudiation that existed in your eyes, reflected by your hand."

If her experience is anything like her essay suggests, it cuts deep. Her perception of an inner void mirrors the absence of internalised soothing images. But so far, she is merely projecting. The last two paragraphs further down in her essay refer to the beginning of her second session. And her entanglement is already becoming frighteningly obvious:

"Today, upon your request, I entered into your house. The rooms were torn apart by the violence of life. Glass shattered against the wall, out at my feet as I approached the back of your chair. You turned to me and I saw the blood. It streamed from your eyes, onto your face, and fell from your cheeks. Your lap was a receptacle receiving each life-giving drop. Through the redness you gazed at me and I could tell by the way you pressed the injured hand down into your lap, immersing it with blood, that you had not forgotten what I was.

Then I knew why you had commanded me before you. You needed help and there wasn't a soul you could turn to. No one was to see the violent life dropping out of you. You knew my space, pleading with me to lose your pain in my gray vastness. I was the emotional vacuum swallowing your hatred and your fears, plunging deeper and deeper until they, too, would become lost and you could be at peace with yourself" (Adler et al. in Hamilton Ed., 1992, p142).

In the space of just two sessions, she identifies her analyst not only with her pain, hatred and fears but also with her tenderness and compassion. And the extent of his ability to contain her arousal, anxiety and exiled unbearable feelings will determine the nature of the self-object she is in the process of creating. Of the functions she requires from her self-object, she needs first of all a capable container for her intolerable feelings outside of herself instead of a 'grey vastness' blurred with herself. Arousal and charge have to come down first of all before she can begin a process of inhabiting herself as well as re-introjecting her self-object functions.

Self-object And Borderline Experience

The significance of the sense of self has become widely accepted in borderline theory. In his most recent book, Masterson (2000) recognised and emphasised the 'impairment in the sense of self' although his theoretical concept of self differs from 'self object' models employed by Adler and Kohut. Masterson lists self-activation, self-soothing of painful affects, continuity of self, maintenance of self-esteem, intimacy and autonomy amongst other impaired capacities of the borderline client's 'real self'. The 'real self' represents any intrapsychic self representations and associated object relations of a person (Masterson, 2000).

Such theoretical distinctions however seem of little consequence to functionality and dys-functionality of the sense of self. Masterson (2000) emphasised the establishment of physical and sensory distinctions of self and other as a necessary precondition for the development of a subjective self. But he also described the sharing of affective states – or 'affect attunement' – as the most pervasive feature of the intersubjective sense of self. And crucially, dissonant affect attunement appears to impede the development of a sense of subjective self. Resonant affect attunement on the other hand, will contribute significantly to the ability to separate between self and other. Masterson noted that the therapist is treated in the borderline transference as if he were the infantile object rather than a real object upon whom infantile feelings are displaced (1981).

Adler and Rhine advocate the "need for the therapist or analyst to function as a selfobject to bear, to contain, and, when appropriate, to analyze the experience of projective identification" (In Hamilton Ed.1992, p154). While acknowledging the basic incompatibility of the theoretical frameworks of self psychology and projective identification, they define the clinical utility of joining both frameworks. There is, they assert, a connection between the self-object function of parallel process and relational aspects such as transference, the real relationship and the therapist's capacity to resonate flexibly and empathically on the one hand and the maintenance of transitional space and the importance of ambiguity and uncertainty on the other.

Describing the 'dialogical stance', Michael Soth (2004) referred to the tension between experiencing the disembodiment from within on the one hand, and wanting to change it on the other. We could also characterise such tension as ambiguity, which in turn is one of the central aspects our borderline clients struggle to contain. Adler and Rhine argue that ambiguity exists in a therapeutic situation along a continuum and to the degree to which it is allowed to remain. The therapist's ability to contain the ambiguity experience, which may be projected by the client, with active projective identification is another aspect of the selfobject function.

> "Change that occurs in successful treatment is accompanied by the relatively constant uncertainty that is never fully clarified: how much comes from the therapist, how much from the patient, how much from the past and how much from the present, how much is transference and how much is the real relationship" (Adler et al. in Hamilton Ed.1992, p160).

With borderline clients, we can expect that the transference relationship will be characterized by somatic and relational dissonance and whatever conflicting impulses or affect states this entails. I associate an image of sitting in a soup: raw bits of intrapsychic material in various shapes floating around in the general uncertainty of what they are and whom they belong to. I attend not only to images and thoughts but also to the sensory details of my subliminal experience. Postural shifts, subtle changes in breathing or tone of voice, localised muscular tone or activity and the adoption of self-contact postures would be some obvious examples of sensorial-emotional experience.

It is a relational space where projective identification as well as re-enactments of dissonance may occur as in my earlier example of Mary's rage. On that occasion, I was able to return to a 'third person stance' eventually to observe and engage with her shoulders and chest. In the head holding and migraine episode on the other hand, I continued to relate from within – in what may well have been a successful attempt to de-structure me. I had considered myself fairly knowledgeable about and pretty comfortable with holding my clients' heads until Jon's migraine caught me out. Did he need to ascertain my ability to function in a de-structured state – or my ability to negotiate a dissonant relationship, or both? Or did he perhaps need to know what I would do with my confusion, my sense of incompetence and the loss of my comfort zone?

Re-enactments of dissonance and trauma will inevitably occur as our borderline clients test, explore and add to their repertoire of self-object functions. They will occur regardless of our theoretical modality and regardless of whether we use touch or not. An authentic impulse, grounded in ambiguity, to end the therapeutic relationship, perhaps even

prematurely, may well be one of the most significant moments in the therapeutic process of a borderline client. The therapist's main resource in the borderline relationship is, I suggest, his ability to negotiate the ambiguity between separated and non-separated states and between subjective, potentially objectifying interventions and intersubjective processes.

Conclusions

Complex levels of self organisation and relationships, said Michael Heller (2004), need to be supported by basic levels of relational and self organisation. I believe we need to apply a similar principle to an integrative perspective of the borderline relationship. It has been suggested that features common to all psychotherapeutic models may be what makes each different approach work. Re-reading Cauvels (1992) book recently, I realised that borderline theorists have perhaps more in common than their published perspectives, concepts and methods suggest. Theorists tend to emphasize aspects that most distinguish them from others after all.

Regardless of theoretical approach, therapists and analysts who work successfully with the borderline dynamic seem to share a capacity to contain their clients hyperarousal and stressful affect states as well as their own. They share a capacity for creating a holding environment and meeting the level of regression, and above all compassionately believe in the ability of their borderline clients to transform themselves.

It has also been suggested that our clients may display the symptoms we expect to see according to our theoretical modality. Be this as it may, it is all to easy to get stuck in a diagnostic or theoretical perspective and forget that we see first of all an individual in front of us, a person whose humanness we share. The question 'what do you experience' is appropriate, relevant and applicable to the most distressed and disturbed states. Unfortunately, this question is rarely ever asked in a mental health system that revolves around multiple choice diagnostic forms. While I have generally come to expect my clients to teach me how to be their therapist, this is particularly true in the work with borderline clients who taught me so initially.

The somatic experience of client and therapist in the borderline relationship provides us with an avenue into the borderline experience as well as with an opportunity to develop our ability to relate to it. The experience of another human being relating to our intrapsychic experience is tremendously powerful and in particular so the more distressing or disturbing our experience is. But psychotherapists in private practice also need to acknowledge that this may not be enough for some borderline clients who require more holding environment than one or several weekly sessions can provide.

References:

Adler, G. (1985). *Borderline Psychopathology and its Treatment.* Northvale, NJ: Aronson.

Adler, G./Rhine, M. W. (1992). *The Selfobject Function of Projective Identification.* In: Hamilton Ed., From Inner Sources – New Directions in Object Relations Psychotherapy, Northvale, NJ: Aronson.

Bick, E. (1968). *The experience of the skin in early object relations.* In: Briggs Ed., Surviving Space, London: Karnac (2002).

Boadella, D./Specht-Boadella, S. (1996). *Unpublished Biosynthesis Training Manual.*

Cauvels, J. M. (1992). *Imbroglio – Rising to the Challenges of Borderline Personality Disorder.* New York, London: Norton & Company.

Carroll, R. (2001). *The Autonomic Nervous System: Barometer of Emotional Intensity and Internal Conflict.* A lecture given for Confer, http://website.lineone.net/~thinkbody/index.html

Heller, M. (2004). *Postural Dynamics of a psychoanalytical process.* Main Lecture at the EABP Conference, Athens; http://www.aqualide.com/e/publication/textes.asp

Lethin, A. (1976). *Muscle Tone and Feeling.* In: Energy & Character Vol 8, No 1, Abbotsbury, Dorset: Abbotsbury Publications.

Levine, P. A. (1997). *Waking the Tiger: Healing Trauma.* Berkely, CA: North Atlantic Books.

Lewis, R. (1976). *Infancy and the Head.* In: Energy & Character Vol 7, No 2, Abbotsbury, Dorset: Abbotsbury Publications.

Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder.* New York: Guilford.

Masterson, J. F. (2000). *The Personality Disorders.* Phoenix, AZ: Zeig, Tucker & Co.

Masterson, J. F. (1981). *The Narcissistic and Borderline Disorders.* New York: Brunner/Mazel.

Schwartz-Salant, N. (1989). *The Borderline Personality, Vision and Healing.* Wilmette, Illinois: Chiron Publications.

Soth, M. (2006). *Towards an integrationof objectifying and (inter)subjective stances in relation to the body in psychotherapy.* In: Body, Movement and Dance in Psychotherapy, Vol 1, Number 2, Abingdon, UK: Routledge.

Uvnas Moberg, K. (2003). *The Oxytocin Factor.* Cambridge, MA: Da Capo Press.

Uvnas Moberg, K. (2004). *The role of oxytocin in touch mediated effect.* Unpublished Main Lecture at the EABP Conference, Athens.

van der Kolk, B. A. (2002). *In terror's grip: Healing the ravages of trauma.* In: Cerebrum, 4, pp. 34–50. New York: The Dana Foundation.

van der Kolk, B. A. (2004). *Trauma, Attachment and the Body.* Unpublished Main Lecture at the EABP Conference, Athens.

Warnecke, T. (2003). *Some thoughts on involuntary muscle.* In: AChP Newsletter 25, London: AChP (CABP).

Yalom, I. D.(1989). *Love's Executioner and other Tales of Psychotherapy.* London: Penguin.

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Maria C. Gilbert

Supervision And Psychotherapy As Co-created Processes: A Shared Unconscious At Work?

Abstract

In this article (recently published as a chapter in a book on supervision), I view both psychotherapy and supervison from an intersubjective perspective where the participation of two subjectivities co-construct the dialogue at both conscious and unconscious levels. I explore the concept of the co-created unconscious process as this emerges in enactments and impasses in both the psychotherapeutic and the supervisory relationships using illustrative examples. Such enactments provide rich material for reflection in supervision.

Placing supervision in an intersubjective framework:

In my framework for supervision I view the supervisory and the psychotherapeutic relationships from an intersubjective perspective (Stolorow, Atwood and Brandchaft 1994), which focuses on the interactional field created by two people. In this perspective the processes of transference and countertransference are inextricably linked and cannot be neatly separated out. In a two-person psychology there has long been an emphasis on the creation of a shared meaning between the therapist and the client in the consulting room…" the transformational processes set in motion by the analytic engagement, along with their inevitable derailments, always occur within a specific intersubjective system" (Stolorow, Brandchaft and Atwood, 1987 p9). Both participants are viewed as contributing to the co-construction of the relationship. Two people bring to the encounter their own inner experience as this is embedded in their history and in their present context "in a continual flow of reciprocal mutual influence" (Stolorow and Atwood 1992, p18). In such a model of human relationships, it is assumed that personal reality is always co-determined by the relationship and the unique meanings that each person brings to this joint encounter. Aron (1991) eloquently describes the nature of this analytic interplay "as continually established and reestablished through ongoing mutual influence in which both patient and analyst systematically affect, and are affected by, each other" (1991, p248). In such a view of intersubjectivity both the therapist and the client, the supervisor and the supervisee, will bring to their respective meetings an interplay between their current and established intrapsychic an interspersonal processes that will be influenced and changed by the interaction between them.

In viewing the therapeutic and supervisory relationships as mutual relational processes, it is important to accept that they are neither equal nor symmetrical in terms of the power base and the authority invested in therapists and supervisors alike. For example, as supervisors we have a monitoring and evaluating role which renders the relationship unequal and inevitably hierarchical. The power in the hands of the therapist is also undisputed; yet therapy remains a mutual process in which both parties

influence and impact upon the other. "The fact that the influence between patient and analyst is not equal does not mean that it is not mutual. Mutual influence does not imply equal influence, and the analytic relationship may be mutual without being symmetrical" (Aron 1991, p249). This concept of the mutuality of the therapeutic and supervisory endeavours is basic to my way of conceptualising these relationships. I believe that it is essential for therapist and supervisor alike to be sensitively aware of their influence on the relationship at the conscious (explicit), and unconscious (implicit), levels of the interaction. As a participant in the therapeutic process the therapist/analyst's very presence will inevitably influence the nature of the interaction. So too with the supervisor; for better or for worse, as supervisors we contribute in an inextricable manner to the co-creation of the supervisory relationship at both conscious and unconscious levels.

The process goals of supervision and psychotherapy

In this section I will draw on several related concepts to underpin my understanding and articulation of the primary goals of the supervisory process: these are the concepts of 'reflective function' or 'mentalization' (Fonagy et al., 2002); the concept of the 'third-person perspective' (Wright, 1991); and the concept of 'inclusion' (Buber, 1923).

When considering the main objective of supervision as a process, I focus on the importance of fostering in the supervisee a self reflective process that will enable her to evaluate and reflect upon her own work as a therapist and gradually develop a reliable "internal supervisor" (Casement 1985, p32). At first a supervisee will tend to apply to his process of learning therapeutic skills his own internalised 'shoulds' from significant others in his early environment and educational context. Gradually the person will internalize the supervisor's attitudes and knowledge base in the process of discussing case material. Casement distinguishes between the "internalized supervisor" and the "internal supervisor" (Casement, 1985 p 32). At first the supervisee will internalize the supervisor and rely on this internalized voice, working to the perceived formula, as it were. Gradually supervisees will develop and integrate their own internal supervisor, which will incorporate (alongside the influence of their supervisors and teachers) their own independent thinking, spontaneity, autonomous judgement and result in the creation of their own internal map of the therapeutic process. At this point, the clinician will in my view have a well-developed and refined reflective function and the sophistication that results from a multi-perspectival approach to the client.

A competent internal supervisor enables the supervisee to monitor both the transference and the countertransference dimensions and the dynamic interaction between these, keeping both in view without discounting the significance of either perspective in understanding the co-created relationship with the client at conscious and unconscious levels. This involves a delicate balance of awareness and entails the capacity both to be in our own experience, appreciate that of the other and stand back in order to reflect on the interaction between the two, the capacity for "critical subjectivity" (Reason, 1994). The more effectively therapists employ their own reflective function and hence sharpen their self-supervision in a constant ongoing way, the more efficiently they will be able to foster the client's developing reflective function. Educating the 'internal supervisor' in this way is consequently the primary objective of the supervision process. "I believe that the process of supervision should develop into a dialogue between the external supervisor and the internal supervisor" (Casement 1985, p32).

Fonagy et al (2002), building on Bowlby's attachment theory, focus on the development of the child's reflective function (also referred to as 'mentalization' by the authors) in the context of their early attachment relationships on the basis that the self exists and evolves only in relation to the other. They see the capacity to mentalize as intimately related to a person's capacity for self-organization and affect regulation. Essentially the development of the reflective function involves for the child the development of a theory of mind, a growing awareness that other people have minds different from their own, which enables them to 'read' the minds of others. "Reflective function, referred to in

developmental psychology as 'theory of mind', is the developmental acquisition that permits children to respond not only to another person's behaviour, but to the children's conception of others' beliefs, attitudes, desires, hopes, knowledge, imagination, prentense, deceit, intentions, plans, and so on" (Fonagy et al 2002, p24). The reflective function incorporates both self-reflective and interpersonal aspects that enable the individual "to distinguish inner from outer reality, pretend from real modes of functioning, and intra-personal mental and emotional processes from interpersonal communications" (Fongay et al 2002, p25). Essentially by the employing the reflective function, children can make meaning of others' behaviour and assess its predictability. The development of the reflective function is seen by these researchers as a critical developmental achievement.

The work of Fonagy et al (2002) was preceded by an interesting discussion of "the third person perspective" by Kenneth Wright in 1991, which maps well on to their conceptualization of the reflective function. In his interesting book on development, "Vision and Separation", Kenneth Wright, discusses the move in the child's development from a two-person to a third person perspective, that is, from the dyadic to the triadic perspective on human relationships. A co-author and I have discussed this in a previous publication (Gilbert and Evans, 2000). At first the child is dependent on the mother (primary caretaker) who reflects back to him what she sees: "The baby looks in the mother's face and sees a reflection of himself' (Wright 1991, p12). At this stage the child is totally dependent for his view of himself on this reflection back from the primary other. This may be positive, affirming and attuned to the child's needs or it may not be responsive to the child at all, and so misattuned. If the other's look is rejecting and hostile, the child will experience this as alienating or in more extreme cases as annihilating. The child at this stage is entirely dependent for feeling good or bad on one other person's perspective on himself which inevitably defines and shapes his own view of himself.

What is introduced by the father (or a second significant other) is the possibility of a further perspective, a view of the primary caretaking relationship from the outside, from a third person perspective. This third person perspective provides another view of what is happening, and another view of the 'self' of the child in relation to others and to the world. The child's experience of self with mother/primary carer is now part of a larger field in which the child is no longer the centre of attention, but part of a larger interdependent world of people and objects which affect one another reciprocally. From this position, too the absolute 'validity' of the mother's perspective can be challenged. The child is no longer dependent only on one other's view to mediate his attitude to himself and to the world, but can draw on the perspective of third 'persons' to help him develop a multi-perspectival view of reality. Wright's discussion of this third person perspective adds a helpful dimension to our view of the integrative supervisor's role: "taking the view of the third person makes possible for the first time an appreciation of the subject's position within an interactive behavioural system" (Wright 1991, p234). To gain an objective sense of self we need to see ourselves through the eyes of another person: "in order to see ourselves as an object, either in isolation or in relation to another person, we must, of necessity, first put ourselves outside of ourselves and observe ourselves from somewhere else" (Wright 1991, p229). This capacity for a perspective from outside of ourselves assists us in the process of developing an understanding and an empathy for how others may perceive us and leads to an appreciation of the multiplicity of narratives that may arise simultaneously for different observers. This description is close to that of Fonagy et al (2002) when they describe the reflective function (mentalization) as a development milestone for the child.

I consider that these processes underpin the adult's capacity for holding the other in mind both in psychotherapy and supervision. The essence of this approach to the supervisory relationship is also well expressed in Buber's elaboration of the concept of "inclusion" (Buber, 1923). Inclusion refers to the capacity to enter into the world of the other, whilst at the same time remaining grounded in one's own perspective. This concept has been taken up and expanded upon by dialogical and contemporary gestalt psychotherapy as the heart of effective dialogue. Hycner (1991) explains that "inclusion

is the back and forth movement of being able to go over to the other side and yet remain centred in my own experience" (Hycner 1991, p20). Inclusion does not exclude the need for distance between self and other. Both Hycner (1991) and Yontef (1993) insist that inclusion is different from empathy in that the therapist maintains a sense of his/her own separate self when practising inclusion. This capacity to enter into the world of another and at the same time retain a sense of one's own separateness and difference distinguishes a truly mutual relationship from one in which all the emphasis is on self and self-interest, or one which is focused exclusively on the other with little attention to the impact on oneself and to one's own responses. To this process I would add the vital importance of holding a metaperspective on the relationship, viewing self in relation to the other in context – a standing above the field, whilst also being within it. I sometimes refer to this as a meta-systems perspective. Such a multiperspectival view of the relationship will usually be held for a short time only, because of the tension of holding both these polarities in awareness at once.

In my view one of the main aims of a relationship based therapy and so of supervision, is to facilitate for the client the capacity for inclusion, which marks the goal of the therapeutic process (Buber, 1923). However, as Yontef points out, people who already exercise this capacity may sometimes come to therapy so that they can explore their own experience of a situation while the therapist practises inclusion and 'holds' the broader perspective for them. I consider that supervision serves a similar purpose (especially for experienced therapists seeking consultative supervision). The supervisee is offered the safe space in which to feel her feelings unedited and for that period not to hold the client's perspective. The supervisor holds the inclusive stance for the period of exploration and at the point of completion brings the therapist back once again to view the relationship with the client in its totality. This exploration of the supervisee's countertransference in a safe place frees the person up subsequently to resume a relational stance with the client that holds the possibility of 'inclusion'. Similarly, an opportunity to explore the intrapsychic dynamics of a client or to explore dimensions of diagnosis freely in an atmosphere of inclusion allows the supervisee to take relevant insights back into the relational work with the client.

In supervision this involves for the supervisor the capacity to retain a sensitivity to his own countertransference reactions in relation to their origins, whilst at the same time entering into the supervisee's world of experience in relation to interpersonal or intrapsychic events and in addition achieving a view that takes into account the intersubjective nature of the supervisory process. At any point in supervision, any one of these elements may be the focus of the supervision intervention. These would include the therapist's reflection upon and understanding of client dynamics or of his own countertransference, the therapist's empathic engagement with the client or sharpening his awareness of the delicate dance between them. The supervisor faces a similar challenge: she needs to shift her focus from observing the therapist's performance, to assessing the client's dynamics, to an awareness of her own reactions to the therapist/supervisee which may impinge on the process, to an appreciation of the therapist's possible countertransference reactions, to promoting the trust in the supervisory relationship. This inevitably involves a sharpened and sensitive awareness of the dance between them which will then model for the supervisee the type of contact that is possible with clients.

The supervisor needs to attend very carefully to both the conscious and unconscious communication from the therapist and the client in order to inform her meta-perspective on the therapeutic alliance and the context in which it is located. This involves reflection on the interplay between transference and counter-transference dynamics in all relationships. It is in this regard that I have come to the concept of the relational unconscious (also referred to as the 'analytic third') as a way of viewing the shared unconscious process in therapeutic and supervisory relationships.

The relational unconscious (or the analytic third) and its emergence in enactments:

The relational unconscious, referred to in much of the contemporary relational literature

as the analytic third, refers to a cocreated unconscious process that lies between therapist and client. Ogden (1994) speaks of three subjectivities in the room, the analyst's, the analysand's and the "analytic third" which he refers to as a third subjectivity in the room where two unconscious processes interact.

"The third subjectivity, the intersubjective analytic third …is a product of a unique dialectic generated by (between) the separate subjectivities of analyst and analysand within the analytic setting" (Ogden 1994 pp463–464).

So the analytic third 'belongs' to neither therapist nor client, rather to both of them simultaneously. Bollas (1992) spoke of 'the shadow of the object' to underline the idea that the unconscious is not only the receptacle of repressed material but also holds evolving experience or potential mental activity in the form of thoughts that have not yet been framed in words, and memories that have not been symbolized in language (Bollas, 1991). Bollas highlights the importance of areas of our experience that have not yet been crystallized into thought, yet exert a powerful influence on our experience of the world. This "unthought" material can emerge through reflections in the therapeutic process but may sometimes surface first in the enactments between therapist and client. "A very significant portion of our existence is predetermined by this unthought known…" (Bollas 1991, p9). In this sense, the "analytic third" may hold repressed material or material that has never been symbolized, which is waiting to be accessed.

Gerson (2004) takes the view that the relational unconscious is a fundamental part of a relationship between two people, that it is co-constructed by the interaction in the dyad, and in turn influences the evolving process of both people's subjectivities. This shared unconscious process is a subtle form of communication, as Gerson (2004) maintains:

"Intersubjectivity and the relational unconscious are better thought of as processes through which individuals communicate with each other without awareness about their wishes and fears, and in so doing, structure the relation according to both mutually regulated concealments and searches for recognition and expression of their individual subjectivities" (Gerson 2004, p83).

Attempting to separate this process out into 'what belongs to whom' will form part of a supervisory process in order to gain greater clarity and find a way forward, but it needs to be clear that this is in some ways an artificial separation as the transference and countertransference processes are inextricably intertwined in the shared unconscious process. As therapists we are co-constructing such an unconscious process with our clients moment by moment in the therapeutic endeavour and we can now also extend this concept to illuminate some facets of the supervisory process.

Perhaps the best way to conceive of the relational unconscious is as a process that occurs outside of the awareness of both participants and that usually surfaces in enactments. This shared unconscious process and its emergence in enactments allows the supervisor to gain an understanding of what may need to be addressed in the therapeutic or supervisory relationships. This may take the form of the surfacing of repressed material or may represent material that has so far not been articulated. Gerson (2004) favours the term "relational unconscious" for this shared process because it emphasizes the nature of the process between two people, "the reciprocal and reverberating influences" (p73). We can learn about the relational unconscious through enactments that arise in either the therapeutic or the supervisory relationships, and sometimes reverberate through both these relationships in the form of parallel process.

An example from a supervisory setting may help to illuminate this process and how it can reveal underlying unconscious dynamics. This example of enactment occurred in a supervision group context. One supervisee consistently arrived 10 to 15 minutes late for the beginning of the group session. Initially he explained that he had not estimated the journey time correctly; however, this did not change over several months and he continued to arrive late. The supervisor would in other circumstances have confronted this late-coming, but in this instance she did not. She made light of it and passed it off with little comment; she did not take up the invitation to become

'persecutory' either, which was very much what the supervisee seemed to be expecting from some of his veiled comments about the widespead intolerance of human weakness in the world around him ! In fact the supervisor 'condoned' this latecoming; a process she reviewed in her own supervision and identified as an unconscious enactment, a condoning of a loosening of boundaries that she would usually not have tolerated this long. She reflected on her own process here and realized that she had been drawn into condoning a behaviour that she herself had exhibited as a student in a veiled appeal to be recognized as herself. She decided to raise the issue of the enactment in the next group session as something to be curious about in terms of the process in the group. What emerged was that the supervisee had been to a very strict boarding school where the discipline had been reinforced with severe punishments. The supervisee had longed for a more accepting environment in which he could flourish; he longed to be really potent but was afraid that his success might threaten others. He appears to have been the object of envy at school where he by far surpassed the other pupils in his class and was frequently reprimanded for his perceived pride in his work. This resulted in a slightly humorous denigrating attitude towards himself which seduced others into diminishing his significance, but at the same time he avoided 'punishment' by doing this. The supervisor had unconsciously played into not taking him seriously and allowing him 'to disappear' when she did not confront his latecoming. However, the gains of surfacing this process in the group allowed for an understanding of the enactment. The supervisee's need to be potent and effective became the main focus of his supervision and he was gradually able to celebrate his competence in the group without self denigration and without drawing destructive envy from the other group members. The supervisor in her own refelctions with her consultant supervisor explored the similarity of her background with that of her supervisee; she had also beent to a strict boarding school where her experiences had a marked similarity to his! This threw some further light onto the shared enactment and her susceptibility to getting involved in the way that she did.

Enactments and therapeutic impasses

The term 'enactment' is used to emphasize the shared and co-created nature of a process to which both participants contribute. The term enactment is generally preferred to 'acting out' in the relational literature because 'acting out' refers so directly to manifest, often gross behaviours, whereas what is referred to as an 'enactment' in the relational literature may occur in fantasy, dreams or may be more subtly conveyed by gestures or even changes in posture. Many of the terms used in the literature to describe elements of the therapeutic encounter place the sole emphasis on the client's behaviour. Chused (1991) points out that terms such as 'repetition' and 'acting out' may suggest that only the client's behaviour is involved, with the therapist as an impartial observer. For this reason the term enactment has been used rather than the "somewhat pejorative" use of acting out to underline the shared nature of this relational process and its occurrence (frequently) at subtle levels of communication (McLaughlin 1991, p 599). As Chused too points out: "Even the term 'projective identification', while recognizing the analyst's responsiveness to the patient, does not acknowledge the contribution to the analytic experience which is determined by the analyst's own psychology" (1991, p 627). The point at issue here is that either the analyst or the client may initiate the process of enactment, and both are participants in generating the enactment.

What emerges in enactments often through fantasies, dreams and non-verbal channels of communication does not necessarily mean that this material is from a preverbal period of life, but rather that it reflects the many ways, often implicit and non-verbal, in which we regulate affect and convey our conflicts in a particular area to the other. Jacobs (2001) adds to the domain of discourse certain reactions of the analyst that may even occur outside of the analytic hour: "Among these are recurrent thoughts about the patient, often accompanied by feelings of depression or other mood changes, a repetitive need to talk about the sessions and the appearance of the patient in the manifest content of the analyst's dreams" (Jacobs 1984, p 291).

Thus, either the client or the therapist may unconsciously initiate an action in such a way as to evoke a familiar or desired response from the other. "Enactments occur when an attempt to actualize a transference fantasy elicits a countertransference reaction" (Chused 1991, p629) or, I would like to add, vice versa! I would like to stress here again that the initiator can be either the therapist or the client (or the supervisor). In the psychotherapeutic process, the term enactment is generally used to describe behaviours, thoughts, fantasies, gestures, even silences or any process of which we may at the time be totally unaware that arises in the therapeutic setting and interacts with the client's process. This may be in a non-productive manner, leading to an impasse or clinical stalemate in the therapeutic process. However at other times these moments of enactment can be enriching and marked by "humour, compassion, playfulness, flirtatiousness, camaraderie, charm, love, and anger" (Ogden op cit., p490).

Intersubjectivity theory sees transference (and countertransference) as resulting from a person's "unconscious organising activity" which is shaped by archaic perceptions of the nature of self and other "that unconsciously organize his subjective universe" (Stolorow et al 1994, p10). These perceptions will carry both our desires and our fears: "…whether analyst or patient, our deepest hopes for what we may find the world to be, as well as our worst fears of what it will be, reflect our transference expectancies as shaped by our developmental past" (McLaughlin 1990, p 598). Both participants in the dyad mutually act on one another in an attempt to influence and persuade the other into a particular response and both are vulnerable to falling back into past patterns. As we work as therapists, new variations of old conflicts may be re-evoked by this process in our work with particular clients so that we are challenged to relook at material that we long thought at rest. As (McLaughlin 1991, p613) so eloquently puts this:

"…the transference ghosts of the past are never entirely laid to rest. In the intensity of new work with qualities unique and not yet known, they return in fresh shape to revive shades of significance I had long forgotten I knew. Enactments are my expectable lot".

Enactments are inevitable in the therapeutic process although, of course, our commitment is to avoid them and work with the clinical material from a reflective position. Ogden (1994) points out how the third subjectivity can act in a limiting manner circumscribing the options of the patient and analyst, or be of a perverse sort that can lock "the analyst and the patient into a specific, compulsively repeated perverse scenario" (p490). However, such enactments also carry the potential for change if surfaced and worked with in the relationship. "Implicit in this perspective of enactment in the clinical situation is the expectation that close scrutiny of the interpersonal behaviors shaped between the pair will provide clues and cues leading to latent intrapsychic conflicts and residues of prior object relations which one has helped to stir into resonance in the other, and between them actualized for both" (McLaughlin 1991, p 601).

It is not the enactment itself that is therapeutic but the therapist's willingness to reflect upon it and integrate these understandings back into the therapeutic process. In this way the transferential meaning for both parties can be surfaced and used in furthering the work with the client. Slochower (1996) comments on the nature of enactments as follows: "These moments carry important historical meaning for the patient (and the analyst) and are thus pivotal analytic 'grist' that embodies potential for change. Simultaneously, however, enactments reflect the analyst's partial failure – to understand and articulate before acting" (Slochower 1996, p 370). For the therapist these enactments represent times when the therapist unconsciously behaved in a way that re-inforced the client's hopes or fears. As such they are signals of processes that need to be understood; they may result in impasses or stalemates in the therapeutic relationship or point the way to a healing process awaiting articulation. This process can as readily occur in the supervisory process!

I shall now proceed to give a further example of an enactment that a therapist brought to her supervisor where it was reflected upon and the new understandings re-integrated into the therapeutic process.

The therapist brought to supervision her tension in her relationship to a female client with whom

she was feeling 'stuck'. Uncharacteristically, in contrast to other clients, the therapist felt almost constantly tense in the room with this client. She had also noticed that before the client's arrival, she would check and double-check that everything was tidy… her normal procedure would be to see that the cushions were straight on the chairs, take out an empty glass if the previous client had taken water, and generally ensure that the room was tidy as usual. Before this client's arrival however, she behaved differently. It was as though any fleck of dust anywhere had to be cleaned, books on the shelves had to be arranged according to size etc. She did not have time to make the alterations but she was aware of her anxiety that all was not impeccable – it was as if she anticipated that the client would notice all these details and comment adversely. She began to feel apprehensive about the client's arrival and her own anxiety felt overwhelming.

In the previous session with the client, she had become particularly aware of how the client's eyes would flick around the room at the beginning of the session and then periodically throughout, as though carefully inspecting the environment. In supervision, she explored her excessive countertransference anxiety in response to this process and identified that her mother had been obsessionally tidy and that as a child she had been set to work in her room on a daily basis to make sure that all was impeccably tidy… That seemed to explain her countertransference but why with this client? More than with any other? And what about her apprehension about the client's arrival?

She felt 'stuck' with the client in that although the client had made some changes in her working life she was unhappy and anxious in her close relationship. She said that she was unsure about how acceptable her behaviour was to her partner and was very concerned about being 'too demanding'. She would crave affection and touch, but never took the initiative for fear of being rebuffed. She also felt unable to talk to her partner about this for fear that even raising the subject would anger him and 'chase him away'.

In supervision, we explored the therapist's anxiety in the room with the client and considered the possibility that she and the client had co-created a shared unconscious process which we named "hypervigilance" in the therapy room that neither of them was putting into words. The supervisor raised the possibility that the client 'sensed' that talking about this process might 'upset and anger' the therapist and 'chase her away'. Similarly, the therapist was avoiding the subject because of her own embedded memories of living with an over-anxious and obsessive mother whom she often resented and tried to ignore in her everyday activities. So too perhaps with the clinet's overvigilance! When the therapist realized that both she and the client may be feeling constrained into a position of hypervigilance about the other, of 'walking on egg shells', she felt freer to address the process in the therapy room. It is important to stress that this process was occurring at a non-verbal procedural level and emerged in the enactment of 'hypervigilant' behaviours on the part of both therapist and client…in this sense they were co-creating an escalating unconscious impasse in the relationship where they were becoming more wary of one another session by session. This growing constraint may well have sabotaged the therapy altogether as the client had also started saying that 'perhaps I have done all I can here'.

At the next session the therapist said close to the the onset of the session as the anxiety once again became palpable: "The word hypervigilance comes to my mind as we sit together; it seems that there is an anxiety in the room that we share as we take stock of one another." The client immediately responded to the word "hypervigilance" and said "that is the story of my life…in all my relationships. I am hypervigilant all the time. I never rest.". The therapist and the client were then able to explore the relational process between them. They identified that the feelings that were aroused in the client, were very similar to her feelings in relationship to her mother who had also been very demanding of tidiness and doing things right…her daughter was also clearly aware that her own arrival had been 'unexpected' and interfered with the progression of her mother's career. In that sense she feared that she had always been 'too much for her mother'. This session marked the opening up of the therapeutic process between therapist and client who were afterwards more able to speak openly about any tension or anxiety in the room.

I believe that a sensitivity to the implicit level of a relationship will allow us to work with enactments and deal with therapeutic stalemates. This could equally be true of the supervisory relationship in which enactments may surface issues that need to be dealt with between supervisor and supervisee to open up an optimal learning environment.

References

Aron, L. (1991). *The Patient's Experience of the Analyst's Subjectivity.* In Relational Psychoanalysis: The Emergence of a Tradition (1999). (Eds. Mitchell, S. and Aron, L). Hillsdale N.J: The Analytic Press.

Bollas, C. (1987). *The Shadow of the Object.* London: Free Association Books.

Buber, M. (1923; 1996). *I and Thou.* Translated by W. Kaufman. New York: Touchstone.

Casement, P. (1985). *On Learning From The Patient.* London: Routledge.

Chused, M. D. (1991). The Evocative Power of Enactments. *J. Amer. Psychoanal. Assn. 39: 615–639.*

Fonagy, P., Gergely, G., Jurist, E.L. and Target, M. (2002). *Affect Regulation, Mentalization and the Development of the Self.* New York: Other Press.

Gerson, S. (2004). The Relational Unconscious: A Core Element of Intersubjectivity, Thirdness, and Clinical Process. *Psychoanalytic Quar. LXX111: 63–98.*

Gilbert, M.C. and Evans, K.(2000). *Psychotherapy Supervision.* Buckingham U.K.: Open University Press.

Hycner, R. (1991). *Between Person and Person.* Highland N.Y: The Gestalt Journal Press.

Jacobs, J.J. (1986). On Countertransference Enactments. *J.Amer.Psychoanal. Assn. 34: 289–307.*

McLaughlin, J. T. (1991). Clinical and Theoretical Aspects of Enactment. *Journal Amer.Psychoanal.Assn. 39: 595–614.*

Ogden, T. H. (1994). *The Analytic Third: Working with Intersubjective Clinical Facts.* In Relational Psychoanalysis: The Emergence of a Tradition (1999). Eds. Mitchell, S. and Aron, L. Hillsdale N.J: The Analytic Press.

Reason, P. (1994). *Participation in Human Inquiry.* London: Sage.

Slochower, J. (1996). *Holding: Something Old and Something New.* In Aron, L. and Harris, A.(eds) (2005). Relational Psychoanalysis: Innovation and Expansion. Hillsdale N.J.: The Analytic Press.

Stolorow, R.D., Brandchaft, B. and Atwood, G.E. (1987). *Psychoanalytic Treatment: An Intersubjective Approach.* Hillsdale N.J.: The Analytic Press.

Stolorow, R.D. and Atwood, G.E. (1992). *Contexts of Being.* Hillsdale N.J.: The Analytic Press.

Stolorow, R.D. and Atwood, G.E. and Brandchaft, B.(1994). *The Intersubjective Perspective.* Northvale N.J.: Jason Aronson.

Wright, K. (1991). *Vision and Separation: Between Mother and Baby.* London: Free Association Books.

Yontef, G. (1993). *Awareness, Dialogue and Process: Essays on Gestalt Therapy.* Highland N.Y.: Gestalt Journal Press.

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Julianne Appel-opper

Intercultural Communication: My Own Personal Journey Through Culture

Abstract

In this article I share my personal journey through culture. Based on my own experience, I focus on various facets of intercultural communication. On the one hand, I explore the manifold misreadings and challenges. On the other hand, I hope to show how a growing cultural awareness may also enrich our relationships, especially in a therapeutic setting.

Introduction

When I think about culture a song comes to my mind 'Everywhere you go you always take the weather with you'. We all take our culture with us. It is like a world inside us with all the experiences, sensations, interactions, contacts we have made so far. They are all stored inside us. The voices echo in the mouth and in the ears. The gestures are written in the muscles and in the bones. All in all we carry knowledge of how to be in our world, our reality. Nine years ago I left Germany to live in the United Kingdom. Before that I had lived for some time in different countries and cultures; I had lived in France, Israel and California for about one year each. These intercultural experiences and contacts had changed the way I organized myself. In this article I would like to invite you to join me on my journey into a new culture.

First Steps: A Stranger In A Strange World

In the first years in the United Kingdom I must have looked pretty serious: a tall woman with a sound German accent who tried so hard to make sense of her surroundings. I became a bit of a stranger to myself. In theory we all know that we need the other to make sense of the world. Our identity is an ongoing life-long process depending on the context, the field we are in. In practical terms it meant that I felt lost.

I remember the following scene in a shoe shop in London. I rushed in at about a quarter to six. Lovely shoes and the shop was really busy. I thought that the shop might be closing in fifteen minutes like the German ones, so I approached a 'lady' working there, who was already serving another 'lady-like woman'. I said to excuse me and could she tell me when they were to be closing. I can still see the woman's face staring at me and telling me that she was already serving that lady. I assume now that we both thought how rudely the other was behaving. What did I do wrong? This was a question accompanying me on my inter-cultural journey. Now, years later I am sure that we both acted in an appropriate way within each of our cultures. At the time I felt the pain of frustration of being looked at like a bull in a china shop. I felt 'told off' as if I had behaved in an inadequate way. I knew that feeling too well. I grew up in a small village in Germany. At home we spoke the local dialect and at school I was expected to speak High German. I had felt embarrassed about using the 'wrong' words in the 'wrong' places.

There is one scene that sticks out in my memory. I had been shopping with my parents in the nearest bigger town. Being hungry I was given money to get myself a sandwich just a short distance away. I used the local dialect word for sandwich and the woman at the counter did not understand me at all. I did not get my sandwich, and felt humiliated and wrong.

Intercultural Communication: Could We Run With Each Other?

Imagine you and I were to meet up for jogging. Let us assume we have our own individual speed, rhythm and timing. How will we start, how will we run? In our usual tempo or slower or faster? This situation is a bit like intercultural communication in which we experience differences in speed, rhythm and timing. We are in a continuous process of tuning in to each other to make communication possible. What might we experience? Being breathless, exhausted, overwhelmed or bored, lonely, not in our flow, not being met? We all have our unique non-verbal ways of communicating, our melody of being, our rhythm of moving.

I remember these early ways of getting in touch with a different non-verbal behaviour. In the first months in the United Kingdom, I felt as though in a vacuum, not being fully met. The contact felt so different. Especially the start and the end of an encounter. I still see myself following our guests through the hall trying to come to a 'felt' ending to the visit. For me our guests seemed to disappear without really saying goodbye. I am sure that my behaviour must have been strange too. My German hands wanted to shake other hands to share their known 'hello' and 'goodbye' ritual. Indeed, conventions of greeting and meeting behaviour are culturally different. For me these 'new' conventions left me with feelings of being unworthy, untouched. In my old world I had learnt that leaving like this meant that a rupture in the communication and relationship had happened.

To tune in to each other we need to read each other. How would we read and understand signs to slow down for example? The body speaks her/his own non-verbal language depending on the culture: how we gesture and posture, how we hold our body. Within our own culture we learn to read this body language of the other. At some point I experimented in private with imitating how, for example, one of my neighbours walked. It was as if I was trying on a different body. At first I had read this walk of hers a bit like 'I am in a hurry, can't talk right now'. Imitating the walk did not feel like that. It felt more like being tense in my body and not sure what to do. This changed my perception and I started chatting to her and this helped in breaking the ice.

I also remember phoning various customer services to set up our phone, gas, and water services and so on. I was struck by the high pitched female voices which I was unable to understand. I am sure this was meant to be customer friendly. In the first years I overadapted and my voice got higher and higher. I wanted so much to belong to this new world; a world outside of my lived experience so far.

And I kept on interrupting. I just could not read the signs when it was my turn to speak. Or I was so busy answering questions that I missed a longer pause in which I could focus on the other and think about questions. And even the structure of the questions would be different as we will see in the next section.

This is the timing within communication, but there is also a timing in a wider frame. How long is the acquaintance time or the visiting time? Who gets the diary out first? Who gets up first at the end of the visit? How close will we get? Does this depend on the time we know each other? How much will we show of ourselves? Let us imagine our inner world as a house. A house with a kitchen, a living room, and so on. There is a front and a back garden. We all have different sizes of these gardens with different fences. Some doors have bells to ring, others have doors wide open. Where would we meet each other? Would you let me in, into your house? Would I let you in? What might we allow the other to see about us? How much would we hold back, in the back garden? And how much are we allowed in our culture to look, to gaze at the other? What are the cultural 'rules and regulations' of how to behave to another woman or a man?

I used to work for the NHS as a clinical psychologist and psychotherapist. I saw

my clients in a room at a centre with other colleagues working there. I smile now as I write it. I am sure that especially the male colleagues there struggled with my overtly direct way of wanting to meet and greet them. I also did not know how to flirt in the English culture. A few days ago I read in a German women's magazine how to flirt with an Italian, French or British man. I learnt that in the United Kingdom Hamlet's 'find directions by indirections' would be the motto. The author recommended that you be conscious about gazing because 'this could be violating boundaries'.

In the next section I want to add the language to the communication.

Language In Intercultural Communication: A Joint Visit To An Art Gallery

Let us assume this time that you and I are visiting an art gallery. Which experiences will we express? How will we find a way to exchange our thoughts, feelings, our reactions to what we see? How will culture come into all this? We will have our hidden individual cultural assumptions about how to do that. Like with the jogging experience we could flood each other with our experience or we could keep everything inside. Some will express their reaction in a demonstrably louder way, some will be quiet and meditating about what they have seen. Some might wait to be asked. We might feel understood or not at all.

For me intercultural communication meant not speaking in 'my mother's tongue' but in a 'foreign language'. I still change English grammar so that the melody of what I am saying fits my German style of speaking. And I remember people telling me not to worry. There must have been something in the way I chose my words that the other got the feeling I would 'worry'! Thinking about it now I realize that I get this comment less and less.

I remember sitting with a group of colleagues and friends having lunch. The friendly words inquiring after the details of my journey from a colleague sitting opposite fell on my cultural ground as 'this person cannot find anything else to talk to me about'. Now, years later, I am able to acknowledge and value her slow unfolding process of approaching me. In the past I used to distance myself, not knowing how to read the words in the other's culture. My English is and was quite fluent. However, I could not speak English in the same easy way as German. Not to mention the humour. I remember sitting with my neighbour. His wife had left the room for a few minutes and we sat in silence. I saw that it was raining, so I commented about the weather, which I thought was a good thing to do in English culture. He responded, that at least the rain was good for the garden. Was that meant to be funny? Well, I did not know what to say. I clearly did not understand the rules of this game. I remember I was relieved when his wife returned.

Intercultural Communication In The Therapeutic Relationship: Could We Dance With Each Other?

In my first work as an 'Older Age Psychologist' for the National Health Service, I offered psychotherapy to elderly clients. Because of my clients' age I did home visits finding myself in the heart of plain white middle class English culture. I told my clients that 'I am German' and asked them how they felt about that. I thought I had to, because of the age of my clients, being well over 65 years' old, because of the Second World War. The response was always that this was 'fine'. Well it had an impact, positive and negative.

I remember visiting one of my first clients, a man referred to me with 'depression' and 'chronic back pain'. My Germanness for him meant efficiency like his favourite German electrical products made by Krups and Miele. This man looked at me in the same light, he expected me to be as efficient. Psychotherapeutic work sometimes gets compared to a dance between the therapist and the client. But could I dance with him and he with me? I sat with him listening to his story, how the pain started and when, how his life had been so far. In these first years I clearly did not understand every word and every expression. I remember that I needed to slow down a lot to get an understanding of everything else his body told me. Slowly my body got a sense of his body, how he held his back, how he was breathing. In a way I understood more and

more what kind of world had been given to him and how he received and stored this in his living body. And how he organized himself when he started to feel sad. We came to understand that from early days he had learnt not to express his sadness. His lower back was the place where all those feelings were held. I told him how I felt in my body as I listened to his experiences in life. I could feel the tension in my back and sensed a movement there. I added that my body wanted/needed to move. My back felt the frustrations, traumas and the pain and wanted to 'defreeze'. He joined in and imitated my movements and was so relieved after a while.

I recall another client, a woman. She had prepared tea for me in the living room. She offered me all kinds of biscuits, I still see the fine porcelain. The whole time I was not sure, what to say, what to do. What kind of dance was this? There were many photographs everywhere in the room. She showed them to me, photographs of her dead husband, of her children, who 'would not come to visit her'. I felt with her and was touched by her loneliness. On that day, I had a tight schedule and I had to leave in time to get to my next appointment. It was as if it was hard for her to acknowledge that her tea party was part of my work. Looking back now I think that my swift exit must have been experienced as impolite and rude. She cancelled the next appointment and I never saw her again. It still leaves me with the feeling of not having passed that kind of dance, which I did not understand enough.

Is there a bridge between the cultures and our personalities we could walk on in order to relate to each other? Because we want/need to understand and meet each other?… We want to have a relationship?… Because we need to find ways of tuning in to each other?

I worked with clients, supervisees and trainees whose parents had come from a different culture to the United Kingdom. Interesting how we found each other. In this work I felt like a cultural being. My Germanness could not stay out of the room. I want to share the following scene, part of long-term work with a female trainee. At the end of our first year, the trainee tells me about a painful memory of being discriminated against because of her black skin colour. I see that her body is there in that old scene, living through it again. I am deeply touched. My body holds my breath like my trainee's body does. There is something of an atmosphere of shame in my body as I sit there. I want to disappear. I take a deep breath which comes out with a sound. It is as if my body wants to say 'I do not want to disappear'. After that sound, she moves her head up and looks at me, at my eyes first and then down to my white arms. She stops there and says "you are white" and I say "yes, I am". I feel in the spotlight being looked at. And she adds "and you are German" to which I respond again with "yes". This moment we fully saw each other. We talked about this special moment in later sessions and what it meant for our work.

On a different occasion in my work with a male black trainee I felt that my Germanness had to come out of me to invite the Jamaican side of him. I recall a session he told me about Jamaica and how he felt there during his visits. And I told him about Germany, how life is there and what I miss most in the United Kingdom. Afterwards he told me how he valued these sessions and that this had meant a lot to him.

I also did not know, whether and how I could work with touch. I had to trust my own body, that my body would know. I remember a young female client who came to see me over a period of some years. In one session she sat there in front of me crying. We had talked about her relationship with her mother, all the pain and the sadness came out of her. I noticed that her hands were holding on to each other. I was so touched by that, how she must have learnt to hold herself. Similarly to my work in Germany I held this in my mind, not sharing it yet. My hunch was that this would be too exposing and might shame her. This was what her over-controlling mother had already done to her too much. A few months later in a similar scene I had the same perception and this time I shared this with her. She listened and cried. I did not offer to hold her hand, even though I could sense that her hands wanted that so much. It was about six months later when she asked me whether I could hold her hands. At first we talked about what had happened and how that felt for her. And then my hands held her hands. We had to move a bit closer to each other. In a way her and my hands talked to each other in an universal language without words. Sometimes

I did struggle just to notice these impulses of mine and then to hold them in my mind. I so wanted to help right away, to give what needed to be given. And sometimes I saw myself in the client. I so desperately needed to be seen, to be touched in this foreign culture. I was very fortunate that I found a supervisor who did this, she saw me as a professional woman who sometimes struggled in this foreign culture.

A final scene comes to my mind. As part of a post-graduate Certificate Course in the Supervision of Counsellors we sat together in a smaller group. We shared our ongoing struggles and challenges to work inter-culturally. A colleague expressed her feelings of being overwhelmed in her work with a Greek student. Everything this client would say sounded for my colleague's ears "totally hysterical". I felt safe enough to express my doubts of being able to re-parent an English client not even knowing the usual lullabies and finding the right English tone. And then the door opened and the Course facilitator came in. We all instantly changed subject. It was as if we were not meant to have these thoughts and feelings; that they would not be acceptable.

Epilogue

A few months ago I moved back to Germany, back into my own culture. And I am a stranger again. Germany has changed in the years I have not lived here and I have changed. The adventure will start again.

Selected Literature

In the following I am including a list of books and articles which have inspired me and might be of interest to the reader:

Adams, M. V. (1996). *The Multicultural Imagination: "Race", Color, and the Unconscious.* London: Routledge.

Appel-Opper, J. (2002). *Multi-cultural Supervision: Theory and Practice. An Integrative Approach.* Düsseldorf, Hückeswagen: FPI-Publikationen. www.fpi-publikationen.de/supervision: SUPERvISION: Theorie – Praxis – Forschung. Eine interdisziplinäre Internet-Zeitschrift – 11/2002.

Appel-Opper, J. and Chidiac, M. C. (2006). Book Review of 'The Bridge: Dialogues Across Cultures' edited by Talia Levine Bar-Yoseph. *British Gestalt Journal, Vol 15, Number 1, pp51–61.*

Argyle, M. (1994). *The Psychology Of Interpersonal Behaviour.* London: Penguin Books.

Buden, B. (2005). *Der Schacht von Babel, Ist Kultur übersetzbar?* Berlin: Kulturverlag Kadmos.

Fox, K. (2004). *Watching the English, The Hidden Rules of English Behaviour.* London: Hodder and Stoughton Ltd.

Gordon, P. (1996). A fear of difference? Some reservations about intercultural therapy. *Psychodynamic Counselling 2.2 pp195–207.*

Heimannsberg, B./Schmidt-Lellek, C. (2000). *Interkulturelle Beratung und Mediation: Konzepte, Erfahrungen, Perspektiven.* Köln: Ed. Humanist. Psychologie.

Hoffmann, E. (1990). *Lost in Translation: A Life in a New Language.* New York: Penguin.

Ivey, A.E., Ivey, M. & Simek-Morgan, L. (1993). *Counselling and Psychotherapy: A Multicultural Perspective.* Boston: MA: Allyn & Bacon.

Kareem, J. & Littlewood, R. (2000). *Intercultural Therapy: Themes, Interpretations and Practice.* Oxford: Blackwell Scientific.

Lago, C. & Thompson, J. (1996, 2000). *Race, Culture and Counselling.* Buckingham: Open University Press.

Levine Bar-Yoseph, T. ed(2005). *The Bridge: Dialogues Across Cultures.* Metairie: The GestaltkInstitute Press.

Rustin, M. (1991). *The Good Society and the Inner World.* London, New York: Verso.

Samuels, A.(2005). The Hidden Politics Of Healing: Foreign Dimensions And Domestic Practice. *The British Journal of Psychotherapy Integration, Volume 2, Issue 1, pp37–50.*

Sapriel, L. & Palumbo, D (2001). Psyche and Culture: An exercise in Peer Supervision. *British Gestalt Journal. Vol. 10, No.2, 86–96.*

Straker, G. (2004) Race for Cover, Castrated Whiteness, Perverse Consequences. *Psychoanalytic Dialogues: A Journal of Relational Perspectives Vol. 14, No. 4 pp 405–422. Hillsdale: The Analytic Press.*

Strenger, C. (2005). *The designed self: psychoanalysis and contemporary identities.* (Relational perspectives book series, v.27). Hillsdale: The Analytic Press.

Sue, D. W. & Sue, D. (1990). *Counseling the Culturally Different: Theory and Practice.* 2nd Ed. New York: Wiley.

Tuckwell, G. (2002). *Culturally and Racially Speaking.* Questionaire presented at the Open Seminar Cross-Cultural Awareness in Supervision, University of Birmingham, School of Education.

Von Wogau, Eimmermacher, Lanfranchi (Hrsg.) (2004). *Therapie und Beratung von Migranten, Systemisch-interkulturell denken und handeln*. Weinheim, Basel: Beltz Verlag.

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Saira Bains

An Autoethnographic Exploration Into Transforming The Wounds Of Racism: Implications For Psychotherapy

Abstract

This paper explores the intersubjectivity of racist trauma through the narrative layering of voice and theory to attempt to integrate autoethnography and psychotherapy to produce an alternative state of intersubjective awareness. This was an effort to bring dignity, respect, and empathic understanding to unchartered territories of racism(s) to give expression to what has become sometimes indiscernible and indescribable. This experimental use of research hopes to produce dynamic and compassionate connections to racist trauma by examining felt and embodied experience for both those impacted by racist trauma and those who try to work towards the healing of this woundedness.

Introduction

This paper is based on research I have undertaken using reflexive autoethnography integrated with psychotherapy to critically apply an evocative narrative approach to describe, interpret, reconstruct, and transform the traumatic effects of colour racism on the self. I have explored the authenticity of voice and insider status to create an interweaving between my experience and my family group embedded within a physical, political, and historical context (Ellis and Flaherty, 1992). This was an attempt to produce an authentic and plural voiced representation of both the research collaborator's and the researcher's world to investigate the impact of racist trauma on one's self/identity and the relational self in the world.

I engaged in a collaborative, process orientated, creative analytic practice described by Richardson (2002) as 'non-traditional attempts to use various methods, analyses and narrative writing strategies to make links between life events'. I used these multiple processes to find the subjugated voices of racist trauma that are evocatively expressive, situated, and informative of the cultural, lived and critically edged experience (Ellis, 2002). I attempted to illustrate the method and use of autoethnography within the text to address racism(s) by giving voice to silent narratives by challenging traditional forms of representation.

This paper reveals how the integration of psychotherapy and autoethnography can be a valid form of qualitative research in researching the complexity and ambiguities of stuck places (Lather, 2001) such as racism. This was an attempt to seek out and embrace the disconnections, contradictions and the intricacies of subjectivity entangled in the discourse of racism as a source of knowledge. This work explores how therapists' life events can change practice and awareness within the field, revealing the processes of being and becoming within the research process.

I was keen not to reproduce some of my previous research pursuits in psychology and psychotherapy that ruled out the 'I' of experience and I wanted the active location of self in the text as a method of inquiry. The intention was to access both implicit and explicit complexities of racism and the effects of the splits between the oppressed and the oppressor to reveal the insider voice of trauma emerging from the wounds of racism, as these subjective inscriptions are sometimes unavailable in theoretical descriptions.

Evidently, not all racisms will be experienced traumatically but what is specific to racist trauma is the effects of possible identity abrasion, which can produce the perception that one is less then human (Bryant Davies, 2005). This acts as a kind of 'spirit killing' (Bell, 2002). The 'why me?' of this experience for the person of colour is that the potency of their skin colour means they are not just hated and persecuted because of the colour of their skin but that it is symbolic and core to what they seemingly represent.

Cheng (2001) describes the psychological injury of racism as a process of mourning and melancholy and the learnt discrimination against the self occurs by a lack of external "structure to house the painful effects of racism; its complex legacy of anger, shame and guilt can only be internalised; the 'thing', that 'gets inside'" (pg 172). This becomes both a mental, physical and psychological representation in which the self internalises the shadow of this hatred and this is what I describe as 'skin ambivalence'. The self-loathing or internalised contempt that arises from this should not be only understood as a defence but as symptomatic of living in a racist society (Dalal, 2002) and a psychic reality (Vannoy Adams, 1996).

I do not believe issues of racism are trivialized within therapy, however, I have questioned if racism is a disguised issue that struggles with expression due to the sometimes fearful, avoidant and defended nature of racism. This is compounded by the fact that our definitions and the language of race/racism are wounding, contradictory, partial, and limiting (Wellman, 1977). Racism is thus both sought out and avoided and results in White, Black, and Asian alike 'running for cover' (Straker, 2004a). Racism is then more easily located outside the therapeutic relationship and becomes further pushed into the unconscious, or projected into things that struggle to be named (Phoenix, 2004). I have therefore used autoethnography to produce a different kind of habitat or space to enhance our understandings to access the intersubjective language of trauma. As autoethnography is rarely used in psychotherapy, it is necessary for me to briefly outline its use and practice.

What Is Autoethnography?

Ethnography is rooted in anthropology, sociology, and cultural studies and is the analytic process of writing about a culture. Ethnography traditionally has not always privileged the active representation of voice and participation of the Other being studied within authoritative texts (Gottschalk, 1998). New self-reflexive ethnographies such as autoethnography have emerged from ethnographic practices in an attempt to challenge this notion of an objective observer that attempts to capture 'scientific truths'.

Autoethnography and reflexive ethnography are described as confessional tales (Van Maanen, 1988). I prefer Ellis's (1995) term 'unofficial texts' as autoethnography is a process, product and art form that focuses on how stories can be useful to express the multiplicity of lived, situated and felt meanings of an encounter and culture. Autoethnographies are produced as self-conscious, usually first person evocations of experience that can appear in a novel, fiction, poem, prose, script, performance, art and documentary forms. Autoethnography can be difficult to describe as it blends literature, science, autobiography, emotion and voice to recontextualise experience and is a blurred genre that connects the personal to the political and cultural (Ellis, 2002).

The legitimate use of self as data becomes a body of analysis that can challenge traditional knowledge and social constructs by displacing existing dominant representations of language, power and knowledge. The audience could be drawn into a participatory experience by being moved to action or by identifying

with the author and learn something new that might shift their worldview.

This is my attempt at the ethnographic Other or what has been described as the return of the represented, writing and owning their own ethnography. By reclaiming the authority within the text through collaborative activity in an attempt to improve practice, I act as both participant and observer and this offers situated knowledge, the blending of life story, history and testimony. This autoethnography, in its exploration of racist trauma uses interpretative theory that is multivoiced and dialogic (Vidich and Lyman, 2003). This provided a framework in which I could begin to describe and record the fragmented effects of trauma on some members of my family group and the visceral, symbolic and cultural effects of racism within a social and psychological framework. This paper describes my brother's story and my voice is interlaced in this collaborative restorying.

An Autoethnography Journey To Connection And Transformation: Myself As Witness

This is a story of the estrangement and the horror of racism. I was very attached to my brother and this deep attachment bond was robbed and stolen from me. I feel terrible guilt seeing someone closest to me wounded more directly by something that I escaped. I have not been traumatized by racism and if I bear any scars from racism, it is as a witness. Racism for me has been critically about an absence of connection.

This is not just a story about racist trauma it is about longing, loss and discovery.

The ache that came with this experience was my need to reclaim my deeply yearned for lost connections and I recognise that biographies often begin in mourning and come from absence (Gilmore, 2001). This has meant mourning for what has been impossibly irrecoverably lost, while being immersed in this research and simultaneously trying to make a bridge to recapture the partial aspects of the absence in the possibility of hope.

One writes, said Foucault, to become other than one is and free oneself – I recognise this need. I started writing about racism and trauma because of terrible feelings of powerlessness and shame about racism that glued my insides together. The writing of this has been coming up against this sticking and unsticking process. This work gave my shame a place to speak from and unintentionally provoked the shame of those I collaborated with. I have wrestled with the ethics of this and the effects of it being made public. Could I and should I use this shame to enhance therapeutic understandings? I directly addressed these ethical issues as I worked with the broken remains of these experiences using a methodological approach that illuminated the textual voices and brought this into view by exposition and compassionate understanding.

The ontological multiplicity of subjectivities I inhabited within the narrative were as witness, testifier, survivor and narrator and induced contradictory feelings of both failing and being privileged, at being invited into the lost worlds/memories that were recovered and lost again, as I tried to describe them. I remember sitting at my desk, feeling bewildered and paralyzed at the horror and pain of the narrative experiences that were previously unheard. How was it possible to get closer to the subjectivity of experience, as it seemed so charged, potent, and unfathomable? My brother as a collaborator in the work, actively encouraged me to be more visible and 'have the faith to speak of my experience' and this allowed for a more open voicing of my own distress at what was emerging between us. Perhaps, because I have asked this of him, in feeling heard and bearing witness to his testimonies I, too, have the right to honour mine. I realize that the more personal the more individual I could become, the more universally I could be heard (Lamb, 2004).

This is my story interwoven with the stories of significant others, where we tried to make sense of the trail of scars that made for absent and empty connections. It is a collective story using emotional recall (Ellis, 2002) distilled through our dialogue that was finally heard, spoken and reframed. This narrative could be accused of being sentimental. I am unapologetic about this. It was a story that required empathy and courage to speak and own. At times, I had to ensure I did not intervene in the story but allow it space to grow and emerge. It weaves back and forth in time.

This autoethnographic process has offered more than recovery – it speaks to the core of my being in its reshaping of this narrative of trauma.

Trauma Narrative

'I had no idea about race or colour,

When I first experienced racism at six,

I got attacked and called a paki, beaten up,

That was the first time I recall
that terrible realisation,

That just because of the colour of my skin,

I am a target.'

(My brother).

My family, ten aunts and two uncles arrived from Pakistan and India in the 1950's. They landed in England with kilos and kilos of sweating Indian sweets but were ill prepared for cold as they arrived in the dead of winter in their thin cotton shirts. They started their new life in one dilapidated caravan with little space or comprehension of their new culture or landscape.

This migratory journey had remained an untold story because it evoked shame of their struggle to find a place of belonging and of the emotional poverty of their experience. As I began to hear these narratives, I unearthed the story of racist trauma, in which significant males within my family were battered and scarred by racism. This is a narrative of how I went to find one of these males in an attempt to seek out the missing fragments and absences in our connection.

It feels impossible to express how significant my brother was to me. He was technically my older brother but I really felt like the older one. I wanted to protect him from the hurts and bruises the world threw at him. He was infected by terrible racism but never spoke of it, until we embarked on this journey. He is a disconnected soul, but as I write this I stare at his photo as a four-year child and he is full of light, spirit and his face is bathed in the sunlight, before he was touched by the sadness and anger of racism.

To me he was always so fiercely beautiful and fragile. We would wake at dawn in order to play elaborate games with secret words and nuances. We would tell each other stories late into the night until my throat got scratchy. He was my playmate; he was gentle and kind. He was my bringer of secret, sugary, pink sweets and stories that lit up fires in my mind.

As we grew up I would notice his face smeared with an unspeakable track of dirty tears when he got home. He never spoke of his terror, of the cruelty he faced and endured every day, as a child and as an adult.

Each day he wondered 'will I be safe today?' A plea that persists today. 'How will I meet the world and how will the ever-changing world meet me?' All this hurt was unravelled inside of him and he could not form the words to speak of this to our parents and to me; they would be like bullets, piercing and blistering. We were the physical representation of skin that was hated, that he wanted to wipe away. He erased himself instead, until he could not see himself anymore.

Racism took him away from me. It also helped me find a way back to him.

Ethical Considerations

'Do you think anyone would be
interested in my story?

You have no idea how it feels,

To know that someone would
want to hear my story,

And may be helped by it.'

(My brother).

I deliberated and thought repeatedly if I should speak with him about the research, would it harm him further? What are the ethics of taking this into the public world? Issues around confidentiality buzzed around my head and we talked about them incessantly. What would the research do to our relationship?

What will my peers make of me? Would I be derided and discounted by the 'therapeutic

community' for revealing not just myself but even worse my family? How would I meet the challenge of the critique that this work might be perceived as lacking scholarship, or a clearly recognisable methodology or validity? Would I be able to produce something evocative, powerful, and representative of our experiences or would I be accused of narcissism and being boundary free? Would it be safe in my hands? Would anyone be interested? There were no real answers to these uncertainties but a growing belief that this was valuable and heartfelt.

The Power Of Imagination

'I think what I have been trying to find,

In my life for a long time,

Is a reason to live'

(My brother).

The love and longing I have from him are present but he feels so indistinct, so disconnected from me and the world that I wonder if this will prove too much for him or is this too much for me? We talk about this as he sits curled in a blanket on a cold bleak day and speaks to me for the first time about his story.

The racism has stopped but it lives on inside his head. He speaks of a time when he unravelled several years ago and he saw on the wall of his bedroom the visual images and traces of racist trauma that inflicted him, the beatings, the humiliation, the gutting of his self, 'it was like watching a movie, my cigarette ash covering my bed. I was mesmerized and transfixed to the horror of the movie that was my life'.

We dare to imagine his world without racist trauma with tears pricking our eyes. It is a struggle to imagine this but it would be like having a good reason to live, he would not be bound up 'with drugs, paralysed at times with the fear of being outside and the need to escape this intolerable reality'. It would be a world of hope that he is trying hard to imagine with me.

The Terror Of Racist Trauma

'You would get a racist attack and put up with it,

I took the name-calling, hits, the humiliation,

I mean I got everything…being beaten up by thirty guys,

Whenever I won a fight, it would mean they would go off,

And bring more people, it was relentless.'

(My brother).

There was little escape from the relentless battle that was his life at school in the 1970's. He faced similar racist hate outside school. The relentless realities of perpetual violence and attack were prevalent as it was fashionable to go 'paki bashing'. The era of 'paki bashing' meant the taunts followed me too. I internalized this and would sing the chants of 'we are going paki bashing' at the top of my voice. That seemed to shut them up, for a while. Much of what is described as street racism was part of our experience in childhood. We lived on the rough side of the River, in a predominately white working class area. These highly bonded communities, white working class and poor Asian communities, met across parallel lives and divisions with watchfulness and mutual suspiciousness. Our cultural differences somehow became threatening to each other.

We would run home watching out for the skinheads whose very physical presence was terrifying to us. (It took me a while to get used to the shaved headed males, now part of everyday culture and fashion. They were a reminder of what I would look for as I scanned the horizon on my journey home). These mainly young men had very little sense of power and control in there own existences but they seemed so terrifying with their uniform of little boy clothes squeezed to fit their oversized bodies, their black bold boots with spidery laces and eyes ablaze with anger.

The National Front and Enoch Powell were part of being a child and feeling flooded by threat. They marched outside our house once and I remember anxiously drawing the blinds

down to block out their hatred and make us invisible, terrified of the idea of them and their unfathomable motives. My brother could not escape them so easily. His black peers seemed to be feared by white boys and emulated by them as being cool. Asians were seen as passive, inferior, easily intimidated. The tide of immigrants flooding this green and pleasant land needed to be stemmed. The taunt of 'go back to your country', was always confusing, where would we go where we could belong?

Assimilation As An Option

'I did not want to be brown anymore;
I used to be pretend to be white,

Being just seen with my father,
would have been bad,

I was embarrassed of their Asianness,

Even though my father was also trying,

Not to be that Asian either.'

(My brother)

Assimilation, acculturation, adaptation, absorption, melting pot were the descriptions we grew up hearing on television and the radio. What did they mean? I recognized the emphasis was that as immigrants from disparate cultures we had to do more of something and less of something else

The paradox was the 'assimilations' that my brother and I were expected to absorb, according to my family, were the vast knowledge and resources of learning and education on offer. Not the 'western sexual politics' or the perception of 'how white people did not respect their families or elders' (this was something I did not witness but was a construct we lived by). My parents were not concerned with the colour as a unifying force; it was the asserting of their values in terms of cultural wealth and the handing down of edifying cultural and religious knowledge that preoccupied them. We lived with the implicit message that our cultural wealth was superior and somehow more worthy. Our embracing of this would ensure all their sacrifices had been worthwhile. Yet we were denigrated in the outside world and this split created a challenge to authenticity, evoked guilt and the unspoken effects of racism and created a sense of further dislocation and tenuous belonging.

No Safety Anywhere

'It was like a battle you could not win,

Whenever I stood up for myself,

I got the worst of it,

I realised that being invisible
was the best strategy'.

(My brother).

Why did no teacher say that it is not acceptable to call someone a 'paki'?

There was no protection, no safety net, no recourse, and no soft landing. Those who ridiculed him were not reprimanded nor called to account. There was no shelter from the violence and contempt. Just the notion that, 'You need to stand up to bullies'. This was not just about being bullied this was more complex than that. Perhaps, it was not understood because they could not relate to it.

The journey home for him was potentially terrifying, his vulnerability and exposure made the journey feel longer than it should. After spending his bus fare on lint covered sweets that would appear for me from his deep pockets, he had to walk the treacherous route home. This revelation compounds my feelings of guilt and complicity.

Our parents could not offer the buffer; they were a visceral reminder of why we were so ashamed of our skin. How could we speak of what was unspeakable to them? He fundamentally began to believe that he would never receive support or understanding from any place; he had to withstand it alone even though it was killing his soul. He became perpetually ill; these psychosomatic symptoms followed him like a hangman into his adult life, crippled as he became by agoraphobia, anxiety and thoughts of suicide.

Splitting Of The Self

'I fell apart completely,

I am humpty dumpty,

Trying to put the pieces back together again'.

(My brother).

He made creative attempts to minimize the horror of it all.

He instituted complacency and passivity as a strategy to survive, one of many. He also attempted to fight back against the racist spew from black and white males alike. He fought one but how could he fight them all? The sealing up of his hooded blue anorak, entombing him, as he pretended to be invisible, but looking instead like a walking spaceman, made him a visible target. He made himself so unseen he disappeared inside himself. Every day, the light faded out of him.

The trauma of it all is fused with his body, mind, and spirit, like a newspaper print on his skin, exposing his shame. The humiliation has stripped him of himself. He disassociated and disconnected from his reality; the only reality he could dare to trust tentatively was inside his head, and he made the decision, at eighteen, to remake himself.

He was like a magician that believed the only possible survival strategy was through reinvention. He borrowed parts of other males. He struggled to find them in this large rambling matriarchal clan. He tried to remake himself so that he appeared bolder and brighter. Instead, he ended up feeling like Frankenstein's monster, disembodied, ill fitting and mostly 'never seeing myself'. I could not see him either then but I witnessed him wither away.

I feel less helpless now because I can see him. He looks at me as though he is seeing me for the first time.

The Search For Power

'I remember having conversations with a really good friend of mine,

I remember looking at him,

And not seeing him for a second and just seeing his colour,

It triggered a powerful memory,

And I remember feeling angry and frighteningly violent.'

(My brother)|

There was an effort to find his potency and expressive self in the retreat to Art College. The most traumatising for him was this idealised hope that brought further disappointments. His attempt to creatively make sense of the trauma caused by the racism he endured was not seen as valid, in fact he was told 'this is not real racism, not depicting the real suffering in art' by his white middle class tutor.

There are also the unspoken inexplicit racist words of the institution, that slip away when you try to get hold of them: insidious, intangible but sitting in the room like a red-faced ghost. The experience of powerlessness and helplessness, being victimised by the experience of being marked and tattooed, invalidated his voice. His racism was not up to it, not deemed good enough. He became more alienated from himself, encapsulated in the silent trauma. He decided never to paint again as he associated it with feeling powerless, his voice being decapitated, his fighting stance undermined.

I watched him peeling away and did not understand what was interrupting our contact. I remember feeling such terrible aloneness when I was with him. How much was this due to his way of being and how much to racism? This seems so entangled, interwoven and tied up into knots. I wonder how I escaped, was it my gender? Luck? Fate?

My Anger And Guilt

'I have been unable to look after myself,

See myself or be close to anyone,

It was traumatic and a tortuous existence,

I am trying to start a life,

But I am tired.

(My brother)

'I made the decision to leave my old self behind', he said after we sat revising the first draft of the research, 'I had to leave you behind too'. I feel stunned to hear this named but recognised the truth. I became lost to him and he could not recognise me. He would look through me and he could not register contact. He laughed and joked but it was all hollow. I felt his invisibility and disengagement.

Hearing this for the first time I feel like a missing piece of the picture brings recognition and understanding but this is followed by anger and guilt. I get lost in the bindings of the hierarchy of pain, is his pain not so much greater? Do I have a right to this anger? Yet I am angry at being erased and having wrestled with my right to this anger, where do I let this loss sit, a part of me wants to reconstitute this loss, repair it, offer it up to be fixed. I know I have to allow myself to feel the terrible loss and abandonment.

Healing Through The Research Process

'The trauma is still there,

It never goes away,

But this (research) has been like a process of reversing it,

And connecting to myself and you.'

(My brother).

These stories of racism were unspoken in my large, rambling and rather tribal family. Yet I have felt the oscillations of these unstoried narratives inside myself throughout my life, so racism appeared like a powerful entity outside of me that did things to my insides. The research process was like being pulled and expanded by hearing and digesting the silenced discourse, into what was knowing and not knowing (Felman and Laub, 1991). The narrative truth (Spence, 1980) of this trauma story was like a sense making process that brought relief, fury and empathy. This acts like a balm and antidote to the shame by the mutuality of recognition and validation to unclaimed complex experiences.

This autoethnography is not just autobiographical in its focus; it offered coherence while revealing the fragmentary nature of trauma that leaves one irrevocably changed. This implies the criticality of the relationship in which the other person is implicated in receiving the testimony 'to a truth that is generally unrecognized or suppressed' (Frank 1995, pg 137).

The need to speak of one's story is an important process towards healing and to reconstructing and reinhabiting life. As I transcribed the research dialogues, we colloraboratively redefined the narratives through various creative mediums such as using photographs, stories, dialogue and art as a bridge to memories and expression. My brother's role as editor allowed him to revise and review what I produced from these activities as narrator. This created stories within stories by accessing deep subjectivity within and beyond the research. This process challenged our prior notions of victim and oppressor and was an empowering connection to self and other that inspired my brother to revisit his art and reinvent a story that did not deny his experience. Rather it became a place were we could live with our trauma.

I can best illustrate the transformational aspects of this for me with a story of my own.

I slide into the taxi as I register the racist hate in the taxi driver's eyes. His taxi seems like a closed off taut world of hate and revulsion that leaves me unsettled and unsafe but reminds me that the research project means I have to be able to dwell in this place. He used no words but I am shaken by the static in the air and try to grapple with it in my research. How could my experiences act as a vehicle for meaning for others and myself? I imagine, at the time how it would be not to feel just the wrench and pain of racism but the textures and colours of the experience in a more integrated less fracturing way.

It is four years later, the research process is being revised and written up and I have been cooking rice with my mother and the aromatic Indian herbs and spices envelop me. I feel a mixture of self-consciousness and pride about this as I journey home. As I get into the taxi preoccupied with these very thoughts, I slowly recognise the same taxi driver. He recoils from me, as if I am able to pollute and invade his being. I look at him with curiosity. Where does this contempt come from? What does it do to him? I experience what I can only describe as warmth and loving compassion for him. I happily beam at him because he represents the journey that has reshaped me. I do not experience his hate as a terrible wound. I do not hurt. I feel no fear. I am not ashamed. In that moment and for a long while afterwards, I feel completely free.

Challenges To The Research

This narrative raises questions about validity, ethics, authority and voice. As Foucault says self-representation is self-construction of memory and invention. Within this intentionally self-conscious process, I grappled with how the memory and language of trauma cannot be reproduced as it is bounded by gaps and breaks (Caruth, 1996). The narrative framework and the multiplicity of selves in the account provided authority but also disrupted our voices and self-perception and was a process of recovering and identifying these lost stories and inner states of being. The reforming of this silenced discourse has highlighted the fragile nature of self-knowledge and language. The interpretations were limited by my dual position as insider and narrator and I recognise that all the narratives were partial, contradictory, and provide subjugated knowledge (Ellis, 2002).

This autoethnography embraced complexity, rawness and vulnerability of real experience and I used this as a meaning-making tool. This was risky and rich in ethical considerations, as I have wondered if these stories might constrain or liberate others and myself. I have been anxious about whether the family research might be seen as exploitative and I have wrestled with the guilt and taboo of revealing my mess and the mess of others. This demanded focussing on the ethical implications of this with fidelity, compassion and respect.

Conclusions: Autoethnography, Psychotherapy And Racist Trauma

What is the use of this autoethnography for psychotherapy? This was an attempt to produce a dialectic process between author and reader and challenge accepted views about silent authorship by using my voice as data in the presentation of findings (Mitchell and Charmaz, 1996). The research narrative was a textual place for our fears and uncertainties (Richardson, 1994) thus doing therapy on one's own life, akin to the client 'speaking back to a therapist' (Ellis 2002, pg120)

The work made explicit the multiplicity of difference in which sameness is located, which is the acknowledgement that differences are embedded within differences and that racism is an arena in which powerful feelings are expressed, enacted, denied, conflicted and enmeshed. This illustrates that it is possible to live with the ambiguous nature of the subject and hold the tension and diversity between the multiplicities of voices.

In exploring, the complexity of racism and race there is a need to take apart its construction into smaller digestible parts to identify how one becomes 'raced' (Knowles, 1991) and the inherent meanings in that process. As Carter (1995) suggests 'race is not always apparent but always present' (p227) and is a deeply problematic category. The identification and discovery of the role of race in racist trauma is thus crucial to functioning. The inherent tendencies in having racial and cultural stereotypes as a reference or starting point that we have about each other can be deconstructed by the integration of autoethnography and psychotherapy. This allows a deepening of understanding and processing of self-generated and self-defined identities (Mahmood, 2002) that is empowering and undermining of racist and racial stereotypes. It is by externalizing and describing such narratives that we can study the objectification of oppressive and difficult experiences (White, 1995), which can be unique and rich in the multiplicity of sometimes conflictual meaning and interpretation (Denzin, 2003).

As Bochner (2002) suggests, I wanted to nurture the imagination rather than stifle it to produce

something of possible meaning for the field of psychotherapy. I hoped that such evocative narratives can generate questions, conversations (Kiesinger, 2002) and dialogue about racist trauma and the racialised subjectivities in the therapeutic relationship. The intention was to produce possible identification, a resonance and vibration within the reader to contribute to a deepening of awareness not always available within traditional research methods.

This narrative tries to bring to life methods that could possibly bypass subjective prejudice by connecting individual stories to the universality of experience and seeing the personal as the political, that might evoke a heartfelt awareness and engagement. By using writing as a mode of inquiry, testimony, survivorship and subjectivity became another lens through which to view racist trauma. The embodiment of this can be a source of knowledge that can confirm and humanize experience (Ellis and Bochner, 2002).

References

Bryant-Davies, T. (2005). *Thriving in the Wake of Trauma, A Multicultural Guide.* Westport Connecticut and London: Praeger.

Boucher, A. (2002). In *The Qualitative Inquiry Reader.* Editors Denzin and Lincoln. London: Sage.

Caruth, C. (1996). *Unclaimed Experience, Trauma Narrative and History.* Baltimore and London: John Hopkins University Press.

Mitchell, R. and Charmaz, K. (1996). In *Fiction and Social Science Research; By Fire and Ice.* Eds. Banks, A. and Banks, S. (1998). Walnut Creek: Alta Mira.

Carter, R. T. (1995). *The Influence of Race and Racial Identity in Psychotherapy, Towards A Racially Inclusive Model.* New York: John Wiley and Sons.

Cheung, A. (2001). *The Melancholy of Race, Psychoanalysis, Assimilation and Hidden Grief.* Oxford: Oxford University Press.

Dalal, F. (2002). *Race, Colour and the Process of Racialization.* Hove: Routledge.

Denzin, N. and Lincoln, Y. (2003). *Handbook of Qualitative Research.* Thousand Oaks, California: Sage.

Bell, D. and Singley, B. (2004). (Editors) *When Race Becomes Real: Black and White Writers Confront Their Personal Histories.* Colorado Springs: Lawrence Hill & Co.

Ellis, C. and Flaherty, M. (1992). *Investigating Subjectivity, Research on Lived Experience.* Newbury Park California: Sage.

Ellis, C. and Bochner, A. (Editors) (2002). *Ethnographically Speaking; Autoethnography Literature and Asethics.* Walnut Creek, California: Alta Mira Press.

Felman, S. and Laub, D. (1992). *Testimony, Crisis of Witnessing in Psychoanalysis, Literature and History.* New York: Routledge.

Franks, A. (1991). *At the Will of the Body: Reflections on Illness.* Boston: Houghton Mifflin.

Gilmore, L. (2001). *The Limits of Autobiography: Trauma, Testimony, Theory.* USA: Cornell University Press.

Gottschalk, S. (1998). In Banks, A. and Banks, S. (Editors) (1998). *Fiction and Social Science Research; By Fire and Ice.* Walnut Creek, California: Alta Mira Press.

Kiesinger (1996). In Ellis, C. and Bochner, A. (Editors) (2002). *Ethnographically Speaking; Autoethnography Literature and Aesthics.* Walnut Creek, California: Alta Mira Press.

Knowles (1990). In Back, l. and Solomos, J. (Editors) (1990). *Theories of Race and Racism.* New York: A Reader Routledge.

Lather, P. (1997a). In Denzin, N.and Lincoln, Y. (Editors) (2003). *Handbook of Qualitative Research.* Thousand Oaks, California: Sage.

Lamb, W. (2004). *Could not Keep It to Myself: Testimonies from Our Imprisoned Sisters.* New York: Regan Books.

Mahmood, T. (2005). *Multicultural Politics, Racism Ethnicity and Muslims in Britain.* Edinburgh: Edinburgh University Press.

Moody, R. and Palmer, S. (2006). *Race, Culture and Psychotherapy, Critical Perspectives in Multicultural Practice.* London and New York: Routledge.

Richardson in Ellis, C. and Bochner, A. (Editors) (2002). *Ethnographically Speaking; Autoethnography Literature and Aesthetics.* Walnut Creek, California: Alta Mira Press.

Straker, G. (2004a). In White, K. (2006). *Unmasking Race, Culture and Attachment in the Psychoanalytic Space.* London: Karnac Books.

Spence (1980). In Angus l. E and McLeod J. (Editors) (2004). *The Handbook of Narrative and Psychotherapy Practice Theory and Research.* Thousand Oaks and London: Sage Publications.

Adams, V. (1996). *The Multicultural Imagination Race Colour and Unconscious.* London: Routledge.

Wellman, D. (1997). In Ellis, C. and Jennings, J. (2001). *Racism, Essential Readings.* Thousand Oaks California: Sage.

Van Mann, J. (1988). *Tales from the Field; On Writing Ethnography.* Chicago: University of Chicago Press.

Vidich and Lyman (2003). In Denzin, N and Lincoln, Y. (2003). *Handbook of Qualitative Research.* Thousand Oaks, California: Sage.

White, M. (1995). In Ellis, C. and Bochner, A. (Editors) (2002). *Ethnographically Speaking; Autoethnography Literature and Aesthics.* Walnut Creek, California: Alta Mira Press.

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From Structure To Process: Ethical Demands Of The Postmodern Era

Abstract

This article considers some of the changes that have more recently emerged concerning how ethical matters are viewed and approached within the therapeutic professions. I also seek to illuminate some of the implications of these changes for the education and support of psychological therapists. These changes are viewed in the context of a wider social movement to do with a shift from structural perspectives towards more process based formulations. This shift poses questions concerned with the way we might best approach the exploration of ethical matters in the context of the psychotherapeutic field. It raises questions about our training and accreditation systems and speaks to a much more personal and interpersonal domain of reflection. The movement towards 'experience-near' perceptions and explorations are also reflected in recent theoretical developments within the field of psychotherapy as a whole.

Introduction

It can be argued that as human beings we are constantly, if only at a tacit level, involved with ethical issues. In the clinical setting, however, a consideration of ethics has tended historically to be located in a rather fragmented position, away from any considerations of social construction or apparent interest in the development of 'live literature'. We have until relatively recently tended to frame our ethical codes as a list of things to avoid, pay attention to, note, make sure about etc. – a kind of structural run through of the rules of ethical behaviour. If I was in doubt about a boundary issue all I needed to do was to open my filing cabinet and pull out the 'guidelines' to see if the 'rule' was there. This may perhaps seem an unfair caricature in today's climate, but that is my memory of the situation some ten years ago. The placing of ethics to the side of practice issues, only to be thought about in detail if there was a 'problem', was an attitude which pulled paradoxically towards less responsibility taking and an allegiance to a hierarchically driven structure where those that 'know' make the rules for others to follow. It also meant that the subject of ethics carried with it a kind of negative connotation rather than an opportunity to reflect deeply on our own values and the individual and group management of uncertainty.

It is interesting also that the existence of 'the ethics committee', while perhaps a necessary structure for a profession, can be seen to exacerbate the sense that 'others' are responsible for working out the correct way to behave, as well as being responsible for the drawing up of a relevant 'code'. Also, as Samuels (2006) has pointed out, the structure of the traditional professional ethics committee in the field of psychotherapy has run alongside a remit which takes a somewhat narrow view of ethical matters, confining itself to a set of internal preoccupations that fail to address wider moral and social questions. Such questions

might be concerned, for example, with who gets access to therapeutic training, the skewed nature of our theoretical structures that are driven largely by white, male, western perspectives, and social discrimination in who is afforded access to therapeutic services.

The fragmentation of self and other, and its associated structural manifestations, can be seen to be a fallout of the Enlightenment which engendered such optimism for scientific advance. In distinguishing between the more general social movement of 'postmodernism' as cultural expression and 'postmodernity' Kvale (1992) states: "Postmodernity refers to an age which has lost the Enlightenment belief in emancipation and progress through more knowledge and scientific research. Postmodern society consists less of totalities to be ruled by preconceived models than by decentralization to heterogeneous local contexts characterized by flexibility and change"(p. 2). The hoped for universal truth, based on positivistic principles, and the related discovery of a 'grand narrative' have not been borne out in the field of psychology, although we can still discern pockets of continuing belief in such a possibility. Adopting a more postmodern view, however, with its emphasis on a 'local' perspective, calls into question the role of such structures as ethics committees, and the exercise of power and knowledge within the therapeutic profession. It also challenges us to think about alternative ways of moving forward in our profession in a manner that supports best practice. While the postmodern movement has brought with it a tradition of deconstruction as a valid attempt to undermine assumed truths and the imbalance of power, my own interest is in beginning to articulate how we might develop in a less fragmented way, in support of the articulation of a more practice based knowledge and inquiry (Hoshmand & Polkinghorne, 1992).

Recent Developments

The last few years have seen changes to the ways in which the subject of ethics and related codes are approached, thus creating the opportunity for more creativity, challenge and liveliness in the field of ethical reflection and decision making. The British Association for Counselling and Psychotherapy (BACP) and the British Psychological Society (BPS), in particular, have made significant contributions to the development of ethical frameworks, inviting us into more local, personal and social reflections on ways forward in our lives and our work. Both of these organisations have evolved a set of principles to guide practice and research activities and emphasize the importance of practitioners engaging in the reflective process themselves in relation to ethical challenges encountered.

This move represents a significant change in the formulation and management of ethical ideas and related practice, and moves us into an 'ethics as process' domain. As the BPS Code (2006) points out "psychologists are likely to need to make decisions in difficult, changing and unclear situations" (p.5), and "moral principles and the codes which spell out their applications can only be guidelines for thinking about the decisions individuals need to make in specific cases" (p.6). The practitioner now needs to think about the principles involved and is likely to be faced more directly with the complexity of such decision making and the fact that it is often impossible to identify a clear cut rule about a given situation. Ethical challenges will now need to be fully explored carrying the idea also that there may be no one best way to proceed in relation to a given situation. I would contend that it is the live interactive exploration itself that supports a good outcome, and that we have a long established template in the Socratic dialogue to guide us in these explorations. The demand is for individuals in conversation to locate themselves personally in the arguments, speaking with honesty and humility, and with the potential of moving towards a more embodied outcome. Indeed, the notion of a disembodied discourse, in the sense of mind/body fragmentation might itself be viewed as an important ethical concern (Sampson, 1998).

Reflection in Action

Many years ago, in a late night conversation with senior colleagues, I had a personal experience which has stayed with me as an example of the richness which may be gained from an 'ethics as process' perspective. We were considering the idea that 'a psychotherapist should not have an intimate relationship with

an ex-client'. Early in our discussions I noticed that I felt a bit irritated – surely a client was a client after all, and the transferential dynamics would be there in any case? That would instantly take any question of sexual contact out of the frame. Clearly I favoured a clear 'rule' for this as it served perhaps to manage my own anxiety and helped me feel safer professionally.

In the course of our discussions a number of questions were raised which needed more careful attention and which for the most part had no clear cut answer: Surely transference is an everyday phenomenon, so what is the special case in the therapeutic relationship? Was it not the case that we often sought out a sexual relationships in relation to transferential phenomena in our personal lives? That is, partners were chosen in order to complete unfinished unconscious issues with our parents? Long term work could be said to deal more directly with transferential issues and a special case could perhaps be made to protect such work but what about shorter term work? If a client saw me for two sessions and then left would that mean that I could not have a relationship with that person? At what point does a client become a client? What about 'visitors' to the therapeutic setting who do not want to do any therapeutic work for the moment but are there to see what a therapist looks like? How might we distinguish between a visitor and a 'real' client? And how are all of these issues viewed from the client's perspective? Would we dare to discuss them so openly? A set of fascinating issues emerged which profoundly challenged my need for a rule and the consideration of which enriched my thinking about boundaries, transference, relationship, and good practice. It was the reflective process in live discussion that proved important for me in the end.

Both the BPS and BACP now invite the practitioner into the kind of exploration outlined above. The BACP Ethical Framework (2002) states: …"practitioners will encounter circumstances in which it is impossible to reconcile all the applicable principles and choosing between principles may be required. A decision or course of action does not necessarily become unethical merely because it is contentious or other practitioners would have reached different conclusions in similar circumstances. A practitioner's obligation is to consider all the relevant circumstances with as much care as is reasonably possible and to be appropriately accountable for decisions made" (p.2). Apart from the general applicability to clinical practice, this approach to ethical understanding and decision making is now also being applied to the research setting – BACP has a separate set of guidelines for researchers (Bond, 2004) and the BPS both includes research considerations in the main Code as well as offering revised guidelines on research with human participants (BPS, 2006). I find it heartening to think that we may finally be on the path to eschewing 'technical rationality' (Schön, 1983) in favour of embracing live complexity and human uncertainty and the need for decisions in the context of incomplete data. This emphasis on reflection and exploration in the face of uncertainty has led me to think more carefully about teaching settings and ways of promoting a deeper reflective stance through open explorations in the group. In the following sections I outline some of my own experiences in three different settings: Firstly in the training of psychological therapists, secondly in the context of supervisor training, and finally in my role as facilitator of a series of seminars designed to support the development of doctoral level research projects.

Ethical Issues and the Training of Psychological Therapists

A fundamental goal in our training of therapeutic practitioners is the development of a capacity for reflection, which includes both reflections on that which is obvious as well as on that which is more hidden. My experience is that reflection of this kind requires an approach to the educational process that highlights the importance of the experiential exchange as well as a consideration of conceptual knowledge. In helping developing practitioners to consider the ethical and professional demands of their role as a therapist, significant time needs to be spent in structured conversations and personal exchange, which invite each practitioner to reflect on their own experiences and articulate specific challenges which they themselves face. These reflections often take the form of a wider focus on ethical dilemmas than those which are located in the facts of a specific case – for example, where a client reports that she has

extreme feelings of anger towards her young child and is frequently worried that she could 'lose it'. While the sharing of such practice based challenges highlight the complexities of an adequate therapeutic response, there are also the broader, and perhaps more generalizable, ethical demands that arise as a focus in the clinical teaching setting. These include: A consideration of the many dimensions of boundary management with clients; the presence or absence of personal integrity; the identification of 'the wounded healer' in the therapist; recourse to theory as a way of being absent in the room with the client; the challenge of taking a contextual frame of reference which locates the therapeutic project in a wider cultural setting; a willingness to identify, and work with, co-created phenomena in the therapeutic process; and the tendency to reify theoretical concepts and psychopathologies as, for example, in the use of the phrase 'my borderline client'.

In considering such challenges in a training setting, developing practitioners are invited to tackle issues that require a significant level of self exploration, exposure and humility, as well as learning to uncover the different layers of their therapeutic projects. It is also a way of examining the minutiae of theoretical ideas, thus leaving room for the development of personal integrity. This kind of exploration necessitates going beyond mere acceptance of the idea, for example, of 'countertransference', a technical terms that can mask a more exposing human dimension. Thankfully, we now have writers in our field, such as Karen Maroda (1998), who are willing to make transparent their own multi level and complex processes with their clients, serving as role models for a more honest approach in both theoretical and practical matters. The process of active reflection in learning groups also bears much comparison with the idea of 'mentalizing' (Allen, 2006), a human process which develops through interactive and co-regulatory experiences, and which applies both to client and therapist. The development of this reflective function that Fonagy et al. (2004) and others have highlighted as so crucial to therapeutic change, is just as crucial to the development of the therapist, and can be located within an ethical discourse, where the therapist seeks to hone their own reflective capability in the service of offering appropriate help to their client.

Allen's statement (2006), referring to implicit mentalization, highlights the learning challenge for the developing therapist: "Mentalizing implicitly in relation to oneself, then, entails an emotional state connected to the self – a pre-reflective, felt sense that is inextricable from the agentive sense of self, the initiator of purposeful action. Mentalizing implicitly, one has a sense of self as an emotionally engaged agent –'what it feels like to be me' in the process of thinking, feeling and acting" (p.11). I find that as a teacher and trainer, this kind of approach, apart from challenging me to demonstrate a willingness to engage in this process myself together with trainees, also meets the UKCP requirement for a therapeutic practitioner to "identify and manage appropriately their personal involvement in and contribution to the processes of the psychotherapies that they practice" (UKCP, 1993 & 2001).

Ethical Issues in Supervisor Training

In working with 'would be' supervisors I have found that participants in training settings are often extremely nervous, especially in the consideration of ethical issues in clinical work. There is a feeling that as a supervisor you are the person with key responsibility and 'should know' the answers for your supervisees. Such an attitude, however, serves only to perpetuate a hierarchical ideology and a set of behaviours that look for 'the right way' and 'the correct rule'. It can also hide a lurking grandiosity which, if acted out, casts the supervisee into the role of less powerful 'student' seeking answers from a 'wise' leader. My first task in supervision training has been to work against this idea – to invite supervisors to sit in the actual size of their human skin and own their own fear of uncertainty and the felt need to conclude with an outcome that puts them in the position of 'expert'. We explore the seductive nature of the expert role; the ways in which it invites the supervisee to reflect less rather than more, and to give up their drive for independence in thinking and reflecting; it also falls neatly into a frame where support is defined as being told what to do, an unfortunate mirror of many areas of the wider educational system. Making such issues explicit in the group setting takes time – we are all so socialized to look for 'the expert' or the 'wise guide' that it is exceedingly

challenging to let go into the void of uncertainty and the place of 'no clear outcome'. This kind of process is challenging also for the facilitator. I have found myself wishing that I had a good set of logical solutions to a range of emerging difficulties, thus presenting as the knowing and wise group leader and detracting attention away from my own confusion!

One of the ground rules in such groups is to notice when we (all of us that is, including me as facilitator!) feel a pull towards a conclusion that may be premature, or a need to avoid complexity by appealing to heady generalities. When the process works well, we succeed in unearthing a range of emotional and intellectual challenges such as fear of responsibility, terror at being in the firing line or being sued, anger at not being 'the expert', a lurking narcissistic need to be seen as 'wise', and a reluctance to speak openly about such matters with supervisees. We reflect on the pros and cons of an 'ostrich approach' where none of these challenges are addressed, or alternatively, on the obsessional quest for certainty and 'the right way'. We usually end these training sessions in a more humble yet more energized middle ground, recognizing ourselves as human beings who have intellectual and emotional limitations, and who need to be more willing to stay with the process of exploration rather than arriving at an ideal end, and also to discuss such matters with our supervisees. Ultimately, potential supervisors have an experience of the complexity of the ethical process, a challenge of allowing themselves to be human, and an insight into the skills which will be necessary if they are to function well in the supervisory role. I have written elsewhere about this process (Orlans & Edwards, 1987) suggesting that such an approach opens the way for the development of reflective practitioners, an on-going commitment to exploration and challenge, and ultimately a better service to clients.

Ethical Processes in the Context of Research

The research setting presents similar challenges which I have addressed in seminar groups with doctoral students. Handbooks on research (e.g. Barker, Pistrang and Elliott, 2002) usually present quite good guidelines on ethical approaches to project development but I am suggesting that reading the guidelines in a textbook is not enough – the nature of the complexities with which we are confronted benefits substantially from being tested and clarified in live interaction based on Socratic principles. To read that the major ethical principles in psychological research are 'informed consent', 'avoidance of harm' and the 'right to privacy and confidentiality' is not really helpful on its own. In seminar settings we consider, for example, how we often proceed as if these considerations were not time bound. We remind ourselves that it is only relatively recently that specific attention is paid to ethical issues in research. This greater awareness has grown out of particular criticisms of medical and psychological research including experiences in World War 2, the widespread deception techniques which were popular in psychological research in the 1950s and 1960s, and the civil rights movement which drew attention to the need for more transparent procedures and processes in the research setting. Such an historical perspective supports understanding of the socially constructed nature of the field. We consider also Kant's Categorical Imperative underlining the idea that intention is paramount and the challenge of assessing intention.

Live interaction and debate form the essence of what is useful for unravelling the complexities of ethical processes in research and presenting each person with challenges specific to their own project work. Take for example, the issue of informed consent. Ideally this means that the researcher provides comprehensive information on what is to be studied and potential participants are able freely to choose whether to get involved. What about the case, however, where a quality data set might rest on less than full information being provided? Or where there is a desire not to lead the research participants in a particular direction? At perhaps a more challenging level there is the issue of whether or not a participant is able fully to understand the information provided. This issue may not only rest on whether the researcher is dealing with children or fragile adults. There is also the question of how information is heard, what power processes are brought into play in the offer of project information, or what transferential dynamics may be played out. If we want to support more research activity

among clinical practitioners, which would include the possibility of researching one's own practice and client work, then these matters are crucial. We are trained to work with such complex dynamics in the clinical setting, yet I have found that clinical practitioners do not always use these insights in the research setting.

Let us turn to the idea of avoidance of harm. To start with, I have had interesting discussions in group settings about the focus itself – we do not often hear any reference to the creation of benefit or what we could offer research participants in the course of joining the project in a positivist world of research activity that would signal too much involvement. Then we have the problem of trade offs between individuals and the more generalizable findings which in turn raises questions about randomization, narrow inclusion criteria and the use of control groups, and the dilemmas that arise in the course of project work which cannot be worked out in advance. In one project that I carried out to implement a counselling facility in a trade union organisation and to monitor the take up rates and outcomes, I had insisted, on ethical grounds, that presenting difficulties which appeared not to be individual/psychological needed to be returned, with due regard to anonymity, to the relevant place in the organization where they could more appropriately be handled. This arose out of my experience in organisational settings of managerial level difficulties masquerading as individual level problems, and I wanted to guard against any inappropriate pathologizing of the clients. All participants in the project, including potential clients, were keen that this process should be in place and felt deeply supported by the strategy. In the course of this work I realized, however, that there were competing political groupings in the organisation and to feed back certain themes would be to put the client group as a whole at risk of being picked on in some way. I had therefore to give up my tidy ethical strategy and attempt to find other creative ways of tackling the problem.

The right to privacy and confidentiality brings similar complexities. Privacy refers to the right of the individual not to provide certain information to the researcher. Yet we know that in qualitative interviewing, for example, participants often say more than they might ideally have liked. There is also the question of what constitutes an invasion of privacy since there are significant individual differences on this matter. The confidentiality requirement comes with important challenges especially where publication of research is one of the goals. Here we can see a complex interaction between confidentiality and informed consent. Josselson (1996a) cites several examples of situations where participants initially agreed to publication but then felt exposed when the work went public. McLeod (1994) makes a further interesting point about the relationship between the quality of the data derived in the course of the project and the perceived ethicality of the researchers. A research participant who really sees that the researcher is taking care of these matters might be more willing to explore an issue in an open and completely honest way. These points place the issue of ethics deeply into the relational space between researcher and researched, yet they are not generally worked through in practice in this relational way. By the time that research participants become involved the research proposal has generally been given the go ahead by the relevant ethics committee.

A final set of questions which we consider in the context of research planning has to do with a wider moral focus. To what extent, for example, should individual projects address social responsibilities and if so in what form? Or, are there particular needs that are being met by the research which might support oppression in some form? What impact, at a social level, is dissemination of the research findings going to have? Or, at a much broader level, to what extent is the support of fragmentation in research between head and heart acceptable? Traditionally, the positivistic paradigm has sought to place the researcher in an 'objective' position and in a supposed stance of being value free – does this in itself constitute an ethical dilemma since no human being is value free and bias is a given in our social settings? Knowledge itself is a source of power. Research carries with it a set of ideological assumptions of the researcher and the research community in which the person is working. The complexities outlined here come alive in the context of group discussions and honest assessments of individual projects. These discussions raise issues and bring insights which in my view, cannot be fully appreciated

or understood through the reading of a research manual, or indeed through private reflection alone. Live contact in a setting where people are willing to make their ideas public and allow the more out of awareness processes of their project work to emerge adds significantly to ethical understanding and careful project planning. It is also deeply challenging, and often moving, at a personal level.

Concluding Comments

Our psychotherapeutic training and client work enables us to understand how much knowledge is carried at a tacit level and how the relational space in our consulting rooms facilitates the emergence of this knowledge and the resulting insights that are thus made available. The question of ethical understanding requires a similar relational space which can serve to keep us on our reflective toes and thus support on-going learning and development in our attempts to get practice and research issues more or less right.

References

Allen, J. G. (2006). *Mentalizing in Practice*. In Allen, J. G. & Fonagy, P. (Eds.) Handbook of Mentalization-Based Treatment. Chichester: John Wiley & Sons Ltd.

Barker, C., Pistrang, N. and Elliott, R. (2002). *Research Methods in Clinical Psychology*. Chichester: Wiley.

Bond, T. (2004). *Ethical guidelines for researching counselling and psychotherapy*. Rugby: British Association for Counselling and Psychotherapy (BACP).

Code of Ethics and Conduct (March 2006). Leicester: The British Psychological Society.

Ethical Framework for Good Practice in Counselling and Psychotherapy (2002). Rugby: British Association for Counselling and Psychotherapy (BACP).

Ethical Principles for Conducting Research with Human Participants (2006). Leicester: The British Psychological Society.

Fonagy, P., Gergely, G., Jurist, E. L. & Target, M. (2004). *Affect Regulation, Mentalization, and the Development of the Self*. London: Karnac.

Hoshmand, L. T. & Polkinghorne, D. E. (1992). Redefining the Science-Practice Relationship and Professional Training. *American Psychologist, Vol. 47 (1), 55–66.*

Josselson, R. (Ed.) (1996a). *Ethics and Process in the Narrative Study of Lives*. Thousand Oaks, CA: Sage.

Kvale, S. (1992). *Introduction: From the Archeology of the Psyche to the Architecture of Cultural Landscapes*. In Kvale, S. (Ed.) Psychology and Postmodernism. London: Sage.

Maroda, K. J. (1998). *Seduction, Surrender, and Transformation: Emotional Engagement in the Analytic Process*. Hillsdale, NJ: The Analytic Press.

McLeod, J. (1994). *Doing Counselling Research*. London: Sage.

Orlans, V. & Edwards, D. (1997). Focus and Process in Supervision. *British Journal of Guidance & Counselling, 25, (3), 409–415.*

Sampson, E. E. (1998). *Life as an Embodied Art: The Second Stage – Beyond Constructionism*. In Bayer, B. M. & Shotter, J. (Eds.) Reconstructing the Psychological Subject: Bodies, Practices and Technologies. London: Sage.

Samuels, A. (2006). Socially Responsible Roles of Professional Ethics: Inclusivity, Psychotherapy and the 'Protection of the Public'. *International Review of Sociology, Vol. 16, No. 2, 175–189.*

Schön, D. A. (1983). *The Reflective Practitioner: How Professionals Think in Action*. London: Temple Smith.

UK Council for Psychotherapy (1993 & 2001) Training Requirements of UKCP: The Regulatory Framework.

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Michael Randolph

Body Psychotherapy

Abstract

This article is concerned with the problem of psychotherapy's historic dis-embodiment. It explores Wilhelm Reich's work and the development of psychotherapy centred around physical as well as psychological resistance. Enrootedness and Expression are two terms which illuminate the core of Body-Psychotherapy. The esrticle focuses on Catharsis and the Reichian therapy template tension – charge – discharge – relaxation. The author introduces some variants on a potential session plan as a way of grasping some of the particular issues body psychotherapy generates and tries to deal with through organismic trajectories and the possibility of remoulding well-etched life patterns. Safety, surrender and access to re-formulation is discussed in this context (with clinical vignettes). The author discusses holding and handling and how these Winicottian terms apply to body psychotherapy as well as transference in a touching world, with comparisons with psycho-dynamic models. He explores difficulties and traps associated with the notion of reading the body. D.H. Lawrence's ethical position about the author's responsibilities is extended to the psychotherapist's position.

Introduction

The rather clumsy apposition which gives rise to this title (no one would have thought of talking of head psychotherapy) came about substantially because of a sense that psychotherapy had become dis-embodied. The talking cure developed by Sigmund Freud was opening up a world in which the body was, to all intents and purposes, reduced to a battle-field between conflicting hallucinations. Human existence became by turns a hydraulic carousel with hidden pressure gauges (Freud), a cavern of ardent, obscure tracings of indeterminate origin (Jung), a relational prostheses exchange and mart (Ferenczi), or the form which deep language had to take to propagate itself (Lacan). At each turn, the dis-embodiment became more pronounced. Some therapists might ask what a sigh meant at that moment in a session, few would ask what it felt like.

Wilhelm Reich (the original young man in a hurry, already a trainer of psychoanalysts at 27!) who was obsessed his whole life with what shied at or blocked living experience, had become by 1928 psychoanalysis' resident expert on resistance. He noticed that a particular young patient of aristocratic descent (an outmoded if tenacious distinction in imperially dismembered post-war Vienna) held his face in a disdainful rictus, emphasising a misplaced and anachronic haughtiness. He saw this, and the accompanying dismissive shoulder lift, as frozen body resistance, shadowing the man's inability to allow himself into any real contact with the plebeian world, which unfortunately now also included himself. His facial expression and chronic shoulder holding had become his prison, what Reich was soon to call his armour.

This other dimension, the one likely to be overlooked and underseen by those who mainly listened, unveiled thanks to Reich's work the mechanisms by which spontaneous

response to life difficulties became, with time, frozen patterns of behaviour, thought, perception and physiological functioning.

Live and Move and Have your Being

One of the ways an un-disembodied psychotherapy might distinguish itself is not so much in the warm, human question which nowadays peppers psychotherapy sessions, "How do you feel?" (when you say that…, when I talk to you…, when you think of…,) than, closer to the body psychotherapy point, "How does the feeling feel?" In other words, can you get deeper inside your subjective experience of yourself, as you breathe, as you move, summed up in the beautiful Jacobean biblical phrase, as you live and move and have your being?

Over the decades since the 1920's the tree of body psychotherapy approaches has ramified, some methods talk of working with energetic processes, some focus on emotional discharge or outburst, others again interpret what is going on in terms of very early childhood even foetal experiences. Some would emphasise intra-organismic freeing from deep patterns of blocks, of armouring, others might be more structured around the stammer-step of lost and found contact in the therapeutic exchange, a strobe-like dance which progressively nurtures and heals the inner waif. Some approaches have fairly clear interventionist protocols, others are disarmingly sometimes dismayingly open-ended to the extent that a therapeutic warp and weft becomes all but impossible to discern.

What probably links almost all body-psychotherapy approaches can be resumed in two terms: enrootedness and expression. Whether based on the hysterical manifestations that first put Freud (1897) on the the track of the latent or on the encounter with terrifying existential and narcissistic dead-ends, the problem of being anything from uprooted to rootless has traditionally been seen to have huge psychological and social significance. One of the underlying postulates of body psychotherapy is that your body is the root of your experience, as it is the filter through which that experience is apprehended. Feeling rooted in your own movements and awareness permits much which was twisted or stunted to straighten and grow. Lack of anywhere to feel rooted necessarily sunders the living from its matrix and drains it of sense or alignment. One might reasonably propose that enrootedness starts in the face, eyes, smell and warmth of the caretaker. As the individual becomes her own taker-care-of, the root into her own bodily experience is part of what allows her to create her own holding environment. An enhanced sensitivity to this link creates a mood of inner attunement, which fairly naturally extends to include a more rounded ability to attune to others, the root of social existence.

Expression, the other key term, is often understood to have a cathartic ring in the body-psychotherapy context. From the Primal Scream and other therapeutic meteors of the late nineteen sixties and seventies, often carriers of heavy unacknowledged debts to Reich and his disciple Alexander Lowen, the public has tended to associate intense emotional expression or discharge, to use Reich's term, with what they think of as body-psychotherapy (Oh that's the therapy where you scream and cry and throw tantrums!).

Let's go back to the sigh: Alan sits at the centre of a group of five others, half-recumbent, his back propped up with cushions, wanting and not wanting to talk of his elder brother who died last month. He has a psychologically-aware way of talking about himself which irritates him and pushes him into ironic asides about being a novice griever. Every so often he stops, turns away from us a little and sighs. I take some cushions out from under his back so he's lying a bit flatter. He can feel his chest move more now, and his hand creeps up there. He can look at the ceiling more easily too and leave us out of his picture. It's not enough, however, and he has to cover his eyes with his other forearm. You can tell he can hear his own sighs now and is perhaps torn by fear of theatricality on one hand and the pathos of the sound of his own sadness. I gently put a hand on his shoulder and it seems to tilt the balance in favour of letting the sighs turn into sobs and the sobs into deep crying. After a couple of minutes, he sits up more and talks animatedly, vehemently at times, tenderly at others, sometimes to us, sometimes just to and with himself in the presence, as it acutely feels to us, of the boy, the teenager and the man

his brother was, quite clearly holding him in his welcome as a way of bidding him farewell.

Yes, obviously, deep emotions can be intensely cathartic, or purgative of emotional stasis and its toxicity as the Ancient Greeks saw it. The question of whether emotional expression or emotional discharge as such is a liberating process, is a much more fraught issue. Reich developed a theoretical framework which he believed explained the underlying deep functioning of the life process in the organism. He called the therapeutic slope of this theory vegeto-therapy as a way of emphasising its depth and its aptitude for being generalised to all living processes. If this sounds quaint to modern ears used to fairly thick demarcation lines between the psychological and the biological it is worth remembering that at the turn of the century and up to the beginnings of Watson's behaviourist hegemony (from about 1928 on) at least in the States, the holy grail remained the search for all-encompassing bio-physical theories. Reich, for one, was determined not to disappoint an eagerly waiting world! His expressive template became tension – charge – discharge – relaxation. This was supposed to be the pattern by which all living structures from the amoeba upward recovered life alignment or the vitality of which, progressively, insults to bio-physical integrity had robbed them. The dichotomy stasis/chronicity as opposed to life-flow was thereby set up and remained the lynchpin of all his, often surprising and dramatic theoretical postulates, until his death in 1957.

The question remains unanswered, however, about the pertinence of deep emotional expression as discharge. Do emotions have to be about something to have therapeutic relevance and effectiveness? Perhaps it makes more sense to turn this around and to advance the idea that all shibboleths or received truths in this area, either refusing the value of emotions qua emotions, or positing the inevitably liberating effects of all emotional expression, are likely both to fall into reductionist traps and to render intuitive, common sense responses unavailable to the therapist just when she is most likely to need them.

A session plan

Let us take the word plan in its original sense of a laying out flat, a naming of points, to render something of what the course of a body-psychotherapy session might include and might perhaps demonstrate. Plan over the centuries has developed an anticipatory and predictive connotation which is not inherent in the following development. As framework, I will take a group session or workshop where the participants are, in the main, unknown to me. We will explore later the potential difficulties associated with ongoing individual work in the Body Psychotherapy framework.

In the beginning is the contact, which is probably given more emphasis than in most psychotherapy modalities. It is under no circumstances a preliminary, a waiting for the real stuff to emerge. Content and form are indivisible, the what and the how are permanently interwoven. In this, Body psychotherapy practice in many ways predates modern psycho-dynamic sensitivities where the position taken by the therapist and how that evolves over a session or indeed over the course of an entire therapy, is perceived as an intrinsic part of a process where the knowing is no longer the panoply of the therapist alone, the inner questioning no longer the monopoly of the other. In this beginning phase, the client is quite often, in my style of work, standing opposite me. He may cast around inside himself to evaluate how he is feeling. I may encourage this casting around, allowing its blending into a loosening up or pre-mobilisation of the body with a certain amount of shaking out and general movement. Some of this serves also to allow more focus on us whilst seeming to focus on him; the issue of distance very naturally arises in many cases combined with the question of a comfortable distance from each other (which we may never find) and the general exploration of what it is like to be in this kind of inevitably expectant connection with someone else. The exploration of this register of contact – the link between two beings, two bodies, two intentions perhaps, with all the reverberations throughout present and past life that might be fraught with, may well become the matter of this session, where it starts out and ends up. Living snared in one's imagination of what other peoples' intentions towards us consist of is common and

usually debilitating. This phase of the session often draws some of these dynamics into the light: "You seem preoccupied" the therapist might say, "Yes, there's no way I know how to be so honest about myself as Lynn has just been, when she talked about what she went through as a teenager." "Do you feel that's likely to eliminate you from being interesting to us or respected by us?" "Well, it's a bit of a handicap!" "You smiled as you said that." "Well, that's the reason I came here, because I was feeling sort of emotionally handicapped, so I suppose I'm stuck with it. That's what made me smile". "Yes, those can be frightening presumptions. Why don't you make some grimaces to loosen up those facial muscles a bit and while you're at it try rolling your shoulders a bit. Everything tends to stiffen up when we feel even subtly threatened with exclusion." Many people live almost dissolved in an acidic solution of their own anticipation of others' perception of them, writhing quietly all their lives. Exploring both the weaving of these interpretations and the spatial configurations and body reactions that accompany this, often unceasing, mental activity can open up chapters of a life story impregnated with chronic malaise. It may also, potentially, allow access to new positional possibilities, including symbolic relational ones, which the tension of fear associated with such dynamics had precluded up till now.

A therapy process which is in large part focused on tracking awareness as it lives and moves and has its being, offers a rather different experience than therapies which mainly focus on the emergence of syntheses or the insightful renaming of patterns uncovered. Daniel Stern, talking of the infant's experience uses the term vitality contours, of their being like the trajectory of a desire as it moves towards its immediate goal. Body psychotherapy typically concerns itself with organismic trajectories, both in so far as they delineate patterns whose sense and resonance may then be rendered explicit and also because the inhibitory quality of anti-expressive reflexes creates trajectory-starved or – strained lives, no impulses, or so few, ever moving to their goal. In this sense, body-psychotherapy patently offers an educational side which complements and is intertwined with its therapeutic potential. The question to the body, How are you doing that? is thus intertwined with the experience of doing something even subtly mould-breaking, something unexpected, something whose newness re-etches the habitual template. The breadth of such re-learning is surprising as is its durability.

If and when it is clear that the question of contact and distance has become one point of potential focus among many, if the person seems well enough rooted in present reality and some loosening and general body mobilisation is achieved, then his overall awareness probably is ready to leave some of its more peripheral anchors and shift into a logic of centering. This is equally to usher in a more potentially regressive phase of the session as I will have probably helped the person lie down on a mattress on the floor, propped him up a lot or a little according to my reading of the situation and his feed-back and encouraged the others to sit at a distance that will not impinge on him invasively. As the person becomes more potentially vulnerable, as the setting lends itself to a more regressive take on the present, issues touching on safety and trust come more strongly to the fore. Like me, many psychotherapists have never felt convinced by bald statements about safety or trust (you're in a safe place… it's important that you let yourself trust your therapist) nor even on contracts designed to guarantee something of that nature (so we agree that if you stop feeling safe you'll tell me) indispensable though the latter may be. It seems therapeutically essential to dare evoke mistrust as a way of shuffling towards a safe-enough space. If it does not become safe-enough as we perceive it then that will no doubt end up being the focus of the session, because moving forward organismically without safety is what happens to the coyote in Roadrunner cartoons as he overruns the canyon edge. He survives to let Tex Avery produce again. Our clients by contrast have a limited capacity to pick themselves up and start all over again. This phase of the session may be mainly physical, relayed by some gentle hand pressure on the belly as a way of mutually intimating levels of trust and mistrust, or it may be largely verbal. In contrast again to many other therapy modalities, body therapists do not necessarily see verbal understandings as the only credible anchors of an onward-moving therapy exchange.

Oceanic feelings, you say?

What might seem most natural and most pertinent in the course of this inward-directedness is to encourage a deepening of the experience into something where the whole body feels involved, where a large part of the self feels encapsulated in the sensorial and emotional process. The therapist may be fairly active here, encouraging small and larger movements to avoid stiffening and resistance against what Reich would call life flow. Breathing is, of course, at the centre both of what drives an easy rhythmicity and rocking in the trunk and pelvis and of what mobilises the nervous plexus whose feedback tells us of our emotional state.

Surrender to oneself can be the most exquisitely painful surrender known. The body and mind unceasingly beat the bounds of the organism's inner working models or underlying game plan. Going beyond these boundaries, allowing them to dissolve somewhat, is so defended against precisely because nothing seems to guarantee this step will be followed by any kind of a recognisable reformulation.

"Where has the life drained away to in this sociable, playful woman whose fleshy face and arms appear now infallen, tinted with a queasy shade of pale? In what fibre of her living might she feel touched if I slide my hand palm up under the middle of her back? Is the tilting forward of her head a shift towards contact or the mark of an even deeper, more disconsolate misery? As colour slowly washes through her, it washes her back up onto the therapy mat in a high sunny group room in an erstwhile gear factory in east London, and one can almost hear the crackling of aliveness running from cell to cell as the falling body abruptly feels caught, held, accompanied, awaited anew." I wrote a few years ago after a workshop in London.

Surrender obviously can induce the kind of oceanic feelings of universal openness that Freud famously told Reich (famous in Reichian circles, that is) that he had never experienced[1].

1. Quoted from Gustl Marloch, keynote address at conference of European Association of Body Psychotherapy, 100th year Centenary of Reich's birth, 1997, Travemünde, Germany

This peak experience in Maslow's now strangely undervalued hierarchy brings the indescribable joy of lightness and flight to some. But, as the British poetess Stevie Smith, writing in the 1960's, would no doubt have pointed out, one person's flying is another person's falling. Beyond the indisputable life-time echoes of such peak experiences, there is the powerful possibility of some real re-formulation that any such deep surrender, whether experienced as joy or even as terror, may well bring with it.

The handling

It is clear from what I have been writing, that in Winnicottian terms, from his writings of the 1950's and 1960's body psychotherapy is, potently and often concretely, both a holding but perhaps more importantly a handling environment. The man I am working with seems to be making vaguely choking sounds as he exhales. His legs seem tense and stiff with… something. I ask him to walk into the mattress, which he does tentatively to start with, then with a growing fury. I encourage him to spit out whatever words might be choking him… The choking gets worse… I suggest he just say You…! with each exhale, which soon becomes You bastard… You shit as his fists bunch up and he starts to hit down into the mat with growing power and rage. It culminates in a huge leonine yell of defiance, the outrage at humiliation bursting out at last. I massage his chest and shoulders, stiffened and reddened with blood coursing under the skin. As he softens, tears and laughter well up at the same time, vying with each other for five minutes before, gradually, words come about how his father always put him on some kind of an absurd pinnacle as another Mozart, making him play piano in front of bored neighbours and relatives, pretending to be overawed by his son's prowess, almost asphixiating the son's love of music. It was the professional musician that he had somehow managed to become talking to us at the end, talking about maybe re-dreaming his career and founding the sextet he'd never quite had the vitality and pride to get going in spite of the solid encouragement of well-known colleagues.

The interactive intensity of the handling environment was clearly seen as an essential part of the good-enough parent/child exchange

by Donald Winnicott. In what way does it make sense to transpose any of this perspective into the psychotherapy setting? Is it not self-serving to want to construct credible developmental schemes for therapy by basing them on far-away childhood dynamics which are not such close parallels after all? As with an understanding of the phenomenon of transference, those who seek perfect playbacks of past dynamics are certain to be disappointed. Whatever else the postmodern world may have taught us, the fact that we continually reinvent our history is surely part of what we have to retain. Nonetheless the dynamics of our experiences have their overtones and undertones, and a complex music is formed out of even an approximate reliving of deep early experiences. The underlying question in modern psychotherapy terms of examples such as the short clinical vignette above is: What can be authentic about such a re-experiencing when the therapist plays such a strongly interactive, sometimes suggestive role? Doesn't this invalidate the credibility of what transpires? It may well be that there is a fairly generalised bias in favour of what passes for a holding environment as good and appropriate and fostering authentic therapy. A conviction that safety and the ubiquitous therapeutic alliance is the key to good therapy. I would be inclined to propose that this is something of an illusion and that a much more intense degree of interaction (handling) is always present than is generally acknowledged. Clearly it is an exaggeration to expect brain and psychic growth to be fostered by adult interactions in therapy in the same way that the caretaker-child link functions. It is equally true however that the handling environment was not mainly a potential seat of abuse but specifically what enabled us to unfold our genetic and social potential. The reverberations of this still allow an exquisite sensitivity to those dynamics which speak to us of access to change, those changes which counteract the toxicity of stasis and immobility. Body psychotherapy rather firmly puts these questions at the heart of our reasoning, most clearly because it has never really tried to appear anything but interventionist, appropriately interventionist it is to be hoped, but interventionist nonetheless.

So what do I mean by re-formulation? As the phase of surrender, which may or may not form a central part of our session, comes to a close, the client often re-establishes contact with the therapist, with other group members. This may be a bridge too far initially or the engagement may happen of its own accord. During this time, the mind will often condense and synthesise experiences from different times in life. Patterns may become evident that were previously obscured by unacknowledged emotional charge. Choices may become apparent where once the bounding walls seemed high and narrow. Life will re-group, re-formulate if given space and support and this may emerge from experiences which in contrast to the examples above are anything but dramatic: Julie just laid down and sighed and sighed some more and then some more again. After some time she timidly sat up and said, surprised, I've survived. I told her of a photo I'd seen of a wall in Berlin in May 1945, with chalked on it in big letters: Hello Helga, I've survived. What about you? The idea that others could also live in such a logic of survival both shocked and touched her. The idea of not being the only person surreptitiously dressed in a survival suit caught her fancy and helped her laugh. As she did so a whole flood of examples of her survival tactics came to her mind. By being able both to own them and to find an implicit distance from them, something I would term reformulation got set in motion. At times, allowing clients to stay away from their own stereotyped terminology, to exist without recourse to the floss of words, may allow them gingerly to go where they never thought they could.

Transference in a touching world.

One of the three or four keystones of modern psychotherapy consists in the existence, understanding and use of transference. How can body psychotherapy, with its collapsible boundaries, make use of transferential phenomena in the same way psychodynamic methods do? I would propose that transference, at its most therapeutically usable, is essentially a phenomenon of accretion, an accumulation of slight, difficult to formulate impressions, that build up to an atmosphere redolent of prior relational dynamics. This requires both time and a certain distance between the actors involved in which such impressions can take root. The phenomenon of transference also carries the emotional charge in therapy from

session to session. It is the substrate which ensures continuity, not at an intellectual but at a feeling level, just as the postulated aether of the 19th century was supposed to permit the propagation of light in space. The transference in body psychotherapy is more of a projective phenomenon, not easy to carry usably over from one session to the next, which is the heart of the usage the psychodynamic therapies make of it. It is probably true to say that body-psychotherapy exchanges the longer-term working through or elaboration of the positional subtleties real transference presents us with for the intensity and immediacy of the encounter with the other, and the self-in-the-other.

On the whole, I am inclined to think that strongly body-centered psychotherapy is most at ease in a group setting. Individual body-psychotherapy is more often a verbal or Gestalt-type therapy modality with a much stronger commitment to bodily expression of emotions and to the permission of therapeutic touching and holding than would be normal elsewhere in psychotherapy. This framework, of course, is often particularly suitable for people with deep issues of abuse-generated shame, where body-psychotherapy offers a unique possibility to continually renegotiate space and boundaries. It is also conducive to helping some people break out of the misery of a language reflexively so far removed from visceral experience that they feel like extra-terrestrials. The weakness of certain forms of individual body-psychotherapy, especially those centered around regular recourse to visceral massage, is that the individual sessions become islands of experience, essentially separate from one another. Because this is difficult to accept in long term therapy, a transferential warp and weft is invented to supply continuity, but the same transference is submitted to the bewildering shuttle of the therapist as impalpable target of projections on the one hand and regular masseur of the chest and belly on the other. What may well emerge from this is a subtle entente to protect the framework from criticism, thereby plunging the undertaking into a space where inauthenticity becomes a real, and for psychotherapy, mortal, danger.

Read-outs

A permanent source of friction in psychotherapy concerns the respective weighting given to interpretation on the one hand and insight on the other. To some extent this stand-off has lost intensity with the rise of a more relation-centered perception of the psychotherapeutic process. Strong interpretation remains alive and well, however, in certain schools of body-psychotherapy in the form of reading the body. From Lowen's mixed bag of diagnoses, rigid – oral – psychopath – masochist – schizoid using both anatomic and psycho-dynamic designations to Stanley Keleman's rigid – dense – swollen – collapsed, to Chuck Kelley's anger-blocker – fear-blocker – pain-blocker, the body is fairly frequently used as a read-out for the discerning eye. So what might the body actually say to us and, equally if not more important, how might we use what we think we are seeing? Put in a nutshell, the interpretative faculty opens onto a striking dialectic around the issue of power. He who sees, and upgrades intelligent guesses into certainties, wields impressive power in the domain of psychotherapy. The reichian target of unearthing chronic holding patterns which betray the underlying personality make-up, can leave an impressive amount of emotional scar-tissue when they are handled without modesty and without enough enquiry into the listener's sensitivity. When Freud, Jung and Ferenczi went to America by liner in 1909, they interpreted each others' dreams at breakfast, until Freud got fed up with it and stopped coming to breakfast![2] The pro-active reichian tradition has sometimes fostered a "frank" tendency to present diagnoses as self-evident, without any counterweight, in the form of sensitivity to good timing for example, to offset this pathologising. Overweight participants are quickly labeled "swollen" in Keleman's scheme of things with the pernicious sub-text that swollen also carries with it the sense of invasive and manipulative. Many essentially genetic anatomic manifestations are seen as the results of supposedly chronic psycho-energetic leanings. We find at times a hankering for a sort

2. Personal communication from Gérard Pirlot, Société Psychanalytique de Paris, from readings in Freud/Jung correspondence and Freud/Ferenczi correspondence.

of body-phrenology supposed to help us read out someone's life experience and their ossified responses to it. The diagnosis is also of course carrier of a certain intervention plan, designed to unlock such deep patterns. I sometimes fear that constructing whole therapies around what are often no more than value judgements, can have the dramatic down-side of over-investing in or overidentifying with (and encouraging the client to do the same too) a symptom complex at the expense of something more surprising, more alive, and often also, of course, more implacably resistant to read-outs!

D.H.Lawrence, in one of his essays talked of writers who keep their thumb in the pan (a reference to the cheating of vendors with the hand-held weighing-scales of his childhood). He held that an author deeply attached to his creation does not treat his characters as so many objects to be manipulated to a predetermined end. His robust assertion of their underlying, indefinable right to a degree of independence is a reminder that life is not the domain of an omniscient cartographer with desired outcomes writ large in the margins, but something altogether more ungraspable and which, above all, does not belong to the observer. Our clients' (and our own) vitality is something therapy may enhance, but cannot appropriate.

It is difficult to conclude without quoting Dylan Thomas. He talks of "the green fuse that drives the flower", and it seems incongruous not to celebrate a certain idea of vitality which is at the heart of the reichian tradition and by extension of body psychotherapy in general. At a time when a sometimes laudable, but nonetheless massive effort of categorisation in the form of the Diagnostic and Statistical Manual sits at the centre of our psychotherapy galaxy, it is easy to forget that determinants like Henri Bergson's élan vital were once seen as the root of human existence and, as Dylan Thomas's phrase implies, what it was that linked all the different declensions of life. All psychotherapy, no matter how structured through and through it may appear, brings us in touch with what is impalpable in human existence, along with all the rest we have the hubris to imagine we know how to name or to conjugate! Body psychotherapy has a real potential to open up living trajectories of feeling, awareness and experience that bring us in some kind of contact with the green fuse that drives, that lets us dip in the crucible of the unexpected process, the enabling fluid of that drawn-out transmutation called therapy.

References

Baker, E. (1967). *Man in the Trap.* New York: Collier Books.

Eissler, K. (1967). *Reich speaks of Freud.* New York: Farrar, Strauss and Giroux.

Fonagy, P. and Target, M. (2003). *Psychoanalytic Theories.* UK: Whurr Publishers.

Sigmund Freud/Sandor Ferenczi Correspondance, Vol.1 Paris: Calmann-Lévy.

Green, A. and Stern, D. (2001). *Research in Psychoanalysis: The Green/Stern debate on the relevance of Infant Research.* Eds. Sandler, Sandler and Davies. London: Karnac books.

Keleman, S. (1985). *Emotional Anatomy.* Berkely, CA.:Center for Energetic Studies.

Lowen, A. (1974). *Bioenergetics.* Bioenergetics Press.

Reich, W. (1972). *Character Analysis.* CA: Farrar, Strauss and Giroux.

Reich, W. (1974). *The Function of the Orgasm.* New York: Simon and Schuster.

Reich, W. (1972). *W. Reich, Early Writings.* Vol 1. CA: Farrar, Strauss and Giroux.

Ed. Sandler, Michels and Fonagy (2000). *Changing Ideas in a Changing World.* London: Karnac Books.

Schore, A. (1994). *Affect Regulation and the Origin of the Self.* USA: Lawrence Earlbaum and Associates.

Stern, D. (1985). *The interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology.* New York: Basic Books.

Wilson, C. (1981). *The Quest for Wilhelm Reich*. New York: Anchor Press/Doubleday.

Winnicott D. W. (1965). *The Maturational Processes and the Facilitating Environment.* International Universities Press.

Winnicott, D. W. (1988). *Babies and their Mothers.* London: Free Association Books.

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Lorraine Price

The Dark House Of Infancy: An Exploration Of The Experience Of Regression To Primitive, Pre-verbal States For Clients In Integrative Psychotherapy

This material (somewhat abridged for the purposes of this journal) is taken from a research dissertation submitted in partial fulfillment of the degree of MA in Integrative Psychotherapy (Sherwood Psychotherapy Training Institute/Birmingham University). The student was required to relate the research to the theory and practice of Integrative Psychotherapy.

Abstract

This article is an exploration of the experience of regression to the primitive, pre-verbal emotional states of clients in Integrative Psychotherapy, looking at the aspects of regression, its manifestation within the process, and the therapeutic relationship which facilitates it. Heuristic inquiry has been used to allow an in-depth personal exploration of this process. The findings indicate the therapeutic benefits of a relational-developmental model of Integrative Psychotherapy in working with clients who need regression to developmental stages of infancy, prior to the development of personality. The implications for the practice of Integrative Psychotherapy are considered, and recommendations made as to the therapist's stance when working with this client group.

Introduction

> *"Regression is a flight backwards in search of security and a chance for a new start. But regression becomes an illness in the absence of any therapeutic person to regress with and to" (Guntrip, 1969).*

I became interested in regression as a result of studies for an M.A. in Integrative Psychotherapy at the Sherwood Institute, Nottingham. My experiences of therapy, personally and professionally had led to this research. I was first inspired by Michael Balint's book (1968) The Basic Fault in which he discusses primitive experiences, and the necessity of stepping outside the traditional therapeutic frame for some clients who regress to dependency.

I base my understanding of regression and the unconscious on the beliefs inherent in Integrative Psychotherapy, and my own beliefs about the nature of the intrapsychic structure of the person which recognizes that there are unconscious processes and parts of personality which can become split-off from awareness. My approach to Integrative Psychotherapy conceptualizes the intrapsychic as having been created interpersonally. The infant-caregiver relationship is primary, creating an organizing matrix framing the intrapsychic structure of beliefs of self, others and the world.

I have reviewed the literature from the perspectives of Human Development,

Psychoanalysis, Relational Psychotherapy and Neuroscience as the main areas impacting on my study.

The Literature

Historical perspectives

From the earliest days of Freudian psychoanalysis, some patients have not responded to the traditional, interpretive, methods. Ferenczi, a student of Freud, believed that in order to heal, some patients needed to regress to a former developmental state, considering that the traditional analytical stance was not useful to these patients who were seen as unanalyzable by other analysts. Michael Balint (1959; 1968), a student of Ferenczi, focused on the primitive area of the personality, 'the basic fault' which he encountered in his work with patients who were unable to respond to traditional psychoanalytic methods. He proposed a flexible technique recognizing the value of regression to progression, focusing on the relationship and the object relations of the patient, using the term 'regression' to denote the emergence of primitive forms of behaviour and experience. He saw it as an intrapsychic and interpersonal phenomenon, having at least two aims: ratification of instincts or drives, and the recognition of self by an object. The return to primitive features in the relationship required the analyst to be tolerant and indestructible, and willing to offer mild forms of gratification, which could include touch, and telephone contact, resembling the original relationship of primary love. Winnicott, (1954;1958) postulated that the relationship between analyst and patient could allow re-experiencing the failures of the past in a new and supportive environment. This process required the analyst to be reliable, non-defensive and aware of the risks involved (Stewart, 2003).

Therapeutic Regression

Regression in psychotherapy leads to a primal, two-person relationship with dependency and attachment to the person of the therapist. Bowlby, (1969/82; 1980; 1988); Kohut, (1971; 1977; 1984), Winnicott, (1954/1958; 1965). Stern (1985) considered that techniques developed from observations of infants and their caregivers could also be applied to regressive experience in the psychotherapeutic arena, allowing the therapeutic second chance to be offered. Gill (1982) considered that childhood traumas were acquired experientially, so must be transformed experientially through relationship with the therapist.

Van Sweden (1995) explores the nature of regression to dependence, looking at analytic interactions which impede ego integration, and the related opportunities provided by regression-to-dependence. The British Object Relations Group supported therapeutic regression as a necessary part of the therapeutic process for patients/clients with more severe problems. Bollas (1987) describes the analytic space and setting, "like being held by the mother" (p. 259). Guntrip (1969) considered that therapeutic regression offered a chance for a new start.

Steele et al. (2001), discuss the links between dependency and attachment, considering that in recovery from trauma the needs of the client must be met, including emotional and physical safety, and the attainment of a secure attachment to a consistently responsive and caring therapist.

The neuroscientific connection

Neuroscience offers new understanding of the development of psychopathology. Schore, (2001) discusses the work of Bowlby (1969) on attachment and the belief that developmental processes were best "understood as the product of interaction of a unique genetic endowment with a particular environment", directly affecting the ability to deal with stress. Clients who experienced neglect and parental failure in infancy may have a reduced capacity to adapt to new relational experiences. Their therapy will involve developmental repair through therapeutic regression and corrective emotional experiences, improving their ability to develop new attachment relationships. Schore, (1994) considers that neuroscience has confirmed that the interactions between infants and caregivers influence the developing structure of the

brain during appropriate developmental times. The adult brain is less malleable, but is still capable of evolving. Psychotherapy offers new learning and attainment of neural pathways.

Methodology

As an integrative therapist working from a relational/developmental perspective, qualitative, heuristic research was an obvious choice as it relies on researcher and participant to supply meaning, and reflects my passionate and personal involvement (Douglass and Moustakas, 1985). I intended to interact with participants, owning my values and biases.

Participants

The participants, (four women and one man between thirty-five and sixty years old), were integrative therapists who held a relational stance and had received psychotherapy. They were selected because of their theoretical understanding and experience of the subject matter, and the emotional literacy needed to describe their experience sufficiently.

My study was guided by the ethical principles of beneficence, respect and justice (Miles and Huberman, 1994). Participants were fully informed, confidentiality was protected, debriefing and support was offered.

I used set questions to form an interview guide, using supplementary questions raised as a result of the responses, enabling interaction with the participants and confirming my understanding of their descriptions, building rapport, trust and personal engagement. Interviews were tape-recorded with permission (Moustakas, 1990).

Method of data analysis

I typed transcripts of each interview, allowing re-experiencing and immersion in the material. I took the main experiential points from each interview deriving "the raw material of knowledge and experience from the empirical world" (Moustakas 1990, p. 38).

Analysis

A number of themes emerged from the interviews with the research participants:-

Regression

The participants described their regressive experiences and the physical and psychological effects in several ways.

Returning to a primitive emergent state:

> *"It's a place you mustn't at any cost go back to. It's a place of psychic death. Yet it's the place that we started from."*

> *"First of all I was stunned. I was robbed of thought…I just sat there not knowing what was wrong…"*

> *"I'm so intensely lost in something, some feeling I can't manage myself. I can't…I'm dominated by feeling."*

Disorganisation:

> *"I keep going back to that place of intimacy, that deep place, and that was kind of the beginning of em of my place of…my journey to what I would describe as madness…"*

> *"It is about losing language"…"a couple of weeks ago I was aware of a feeling that I'd left a sort of encasement at the door and as I walked into the room I immediately felt myself regressing…getting smaller, losing contact with the bit that was outside."*

Emotional vulnerability

> *"primitive, powerful…my whole physiology switches into that primitive…my whole body everything…"*

> *"First of all I was stunned. I was robbed of thought…I just sat there not knowing what was wrong…"*

Psychological re-birth:

> *"I did go into a place of what I can only describe it as nothing and it's almost*

like I went to nothing to be something. It was terrible, it was frightening."

Personal growth:

"…allowing me to be and touch that place that's been there and covered for many years, wrapped in shame, and actually know it's there and touch it. I think it's a huge gift…" "I think it was reparative."

Dependency:

The participants recognized their dependency on their therapist

"I think that if I could have actually sat in the corner of my therapist's house all that time then I would have, I would have said, 'Just ignore me'…"

"I was very resistant to feeling dependent at the beginning of my therapy and then I had an early dream where I climbed up onto my therapist's knee as a toddler and was held by her…"

The Therapeutic Relationship:

Aspects of the therapeutic relationship were acknowledged, offering, love, soothing and nurture:

"…of just lying there feeling loved and cared about, feeling I could bask in this forever."

"I had no words so I just looked at her…and she said over and over just "really!"

Touch:

Touching and being touched by their therapist was experienced by some participants as acceptance:

"I think it was about being held by a loving other…And feeling their flesh holding me, you know the way you hold and cradle babies. I think I felt adored in the way babies do"

"…if I'd got my head on her chest it was like being able to hear her heart beat, hear her breathing and feeling her chest rise and fall…"

"…it was the pure intimacy of like touch as well, and I needed to know what she smelled like and what she felt like."

Relational Needs:

Needs and expectations of therapy were identified:

"She was expressing what I couldn't express…somehow she knew what was inside of me and let me …sort of mirrored my pain and let me see what was inside of me."

Shame:

Feelings of shame were identified:

"…just feel frozen and know the sort of criticism and shame and not know where it's coming from…"

"The only sense of relationship, the predominant one at the moment being that someone else is looking on me in disapproval, that I'm wrong."

Discussion of findings

Regression

The findings indicate the potential for healing and integration in the process of regression to dependency. The process offers a chance to re-enter these developmental stages, learning new ways of relating. If an infant is neglected, physically or emotionally, or abused, the emergence of mind and relatedness is underdeveloped, and ways of relating become fixed and habitual, and therefore difficult to change. The formation of the dyadic relationship with the therapist allows regression to occur, promoting a developmental re-working of ways of relating, using the therapist as the object relation. The client experiences a former developmental state and the therapist must respond to this appropriately and with flexibility. Regression in the psychotherapy process occurs as a result of remembering and re-experiencing the past, allowing the client to experience the therapist based on early experiences which may or may not be part of linear memory, in psychoanalytic terms – regression. Most regression occurs with

clients whose therapeutic needs involve the period prior to the development of personality (Winnicott, 1958). The process of Integrative Psychotherapy involves undoing the established structural defenses which have protected the client throughout their life, but have now become a hindrance to ongoing relationship, developing conflict between these established structures and an evolving emergent process. The regressive process runs alongside the threat of chaos in the deepest area of the self. This terror has been reached originally because of the absence of an other who could provide empathic response to the infant, facilitating the formation of a positive self-object. Over time, the sharing of pre-verbal experiences with the therapist in an atmosphere of empathic responsiveness can transform the experiences into the "central organizing force in the psyche" through the process of "transmuting internalization" (Kohut 1977, page 99).

Some participants' accounts suggest a process of loss of contact with parts of self, providing protection and a defense against pain and the return to awareness of these split-off parts as a result of therapy. When they are once again known and felt by the individual, the previous self-organisation can break down and the client can experience chaotic and overwhelming feelings which bear no relation to their external circumstances. The client may also have difficulty in functioning in their everyday life and this experience can be extremely frightening. Therapists need to be aware of the neediness and dependency that may develop.

Dependency

From birth the human infant has an absolute dependence on its mother. When the therapeutic need is to return to this developmental phase, it involves changes in the therapeutic frame. Often these clients have experienced maternal failure resulting in hiding their spontaneous free selfhood and developing a compliant, adaptive false-self presentation. Entering into a dependent stage in therapy means undoing these defences, and the resulting neediness and dependency which emerges triggers feelings of shame. Developing infants need each stage of development to be accepted so that the experience can be retained and remembered. When these needs are met with rejection or derision the experience is painful for the infant and so is split off from consciousness, becoming inaccessible to memory. These split-off memory traces can be responsible for overwhelming feelings of fear or distress, but being inaccessible to memory they seem irrational. Healing these painful feelings requires integration of split-off parts by revisiting these developmental phases and creating a relationship and environment where developmental needs are accepted, and a narrative formed.

The attachment bond which was originally formed with the infant's caregiver will be manifested with the therapist who helps the client to form a new attachment bond.

Clients need their therapist to be authentic and available to them, allowing their dependency, yet remembering the adult, capable and competent part of them, to attune to their developmental states, and to be able to withstand the storms of their developmental stages, helping the client to contain their negative feelings and rejoice in their positive ones.

The Therapeutic Relationship

Clients who need to re-visit early developmental epochs will need to develop a long period of secure attachment with their therapist to create a safe, secure base from which to explore painful experiences. The disintegration resulting from undoing defences and adaptations is necessary. Therapists affect this process, providing a new holding environment which enables the client to revisit those damaged areas of development. The process of disintegration is hard for clients going from the therapeutic environment into their ordinary life. Clients need adequate therapeutic and other support whilst undergoing this experience. Therapists must recognize the consequence of the process for the client, and for themselves. The client experiencing regression-to-dependence may need frequent contact with the therapist in order to feel adequately contained. The opportunity for developmental repair and formation of new neural pathways is presented by regression to these early stages. This development, however,

is the source of the feelings of madness and chaos as the old structures in the brain still exist while the new structures are forming. Yet, Winnicott (1974) pointed out that this process of disintegration, which is most feared by the client, has already occurred in the client's infancy. It was considered that clients requiring work at this level needed to be taken care of in a unit or hospital to ensure adequate levels of support. However, it is possible to provide adequate support for most clients if the therapist has an understanding of the process and is willing to care for the infant within the adult.

Feelings of shame and pain make it difficult for clients to be in touch with the infant part of themselves. When it comes into awareness, the adult part of them gets caught up in the pain and confusion. The fact that there is a loving, understanding, empathic other who is prepared to stay with them, hold them (symbolically and/or physically), and not abandon them constitutes a new beginning. When the therapist survives this experience with them and continues to see both infant vulnerability and adult capability, the adult aspect of the client can co-operate further by holding and containing the infant, because they have finally experienced being held and contained by an other, so that they are able to begin to self-support, allowing integration of split-off and disintegrated infancy experiences. The maturational process can now proceed because the facilitating environment is adequate for the client's needs and the therapist has proved good enough, whole enough and adult enough to be able to meet those needs.

The skill of the therapist is critical in establishing the reparative relationship. An understanding of human development, and cultural and social child-rearing practices, parenting, attachment theories, de-integration and individuation is vital to correctly identify developmental injury or deficit. Clarkson (2003) recognizes the need to differentiate between the facets of the relationship in order to correctly ascertain if a reparative act is needed and likely to be effective. It must also be age appropriate, dealing with the rage of an unmet infant-need differs from dealing with a toddler's temper tantrum and must be correctly identified and appropriately responded to.

Relational Needs

Erskine et al. (1999) identify eight relational needs which must be met appropriately by the therapist with genuine affective responses of spontaneity, warmth and care. Clients have often experienced inadequate parenting and have been inappropriately responded to in their infancy, and therefore have present and past relational needs. Attunement and response appropriate for both must then be supplied.

Touch

The link between transference/countertransference and the developmentally needed relationship will affect the client's perception of touch. It is virtually impossible to know with certainty how a client is receiving touch and a client's process must be truly known before this occurs.

One of the earliest ways of experiencing is through the senses: the infant's heart rate synchronizes with its mother's heartbeat, safety and warmth is calming. Offering touch and holding when working with regression-to-dependency allows the infant part of the client an opportunity to be lovingly held, and so develop in new ways (Gerhardt, 2004).

I believe that the therapeutic use of touch can be essential for some regressed clients, but caution should be exercised, and the effects should be observed to determine whether or not touch was appropriate. Touch can enable the client to allow needs to surface which have previously been unknown because of the expectation that they will be unmet.

Current society is highly litigious and professionals from all disciplines are increasingly concerned about legal action. The use of touch and holding is a sensitive area and one open to abuse. However, I do not consider this as reason to withhold it from the therapeutic relationship. Touch is a developmental need and many clients have been starved of it. I agree with Lazarus (1994, p. 256) who says, "one of the worst professional and ethical violations is that of permitting current risk management principles to take precedence over humane intentions."

Developmental Needs

The therapist needs to be available to meet the infancy needs as they present. One participant needed to smell her therapist, and showed of the sensory nature of the infant's perception that she was experiencing in her altered state of regression. Her therapist responded in a way that was reminiscent of primary maternal preoccupation and attunement. The earliest sources of pleasure for the infant are smell, touch and sound. The infant's first experiences are sensory, not cognitive or conceptual (Tustin, 1972).

The 'original development tendency' which is reactivated in the therapy allows the client to search for the developmentally needed, reparative relationship. When the client needs to work in this developmental era it emerges in the therapy spontaneously, often developing unexpectedly because of a high degree of compensation in the client (Kohut 1977, page 178).

The therapist's failure is important, helping the client to recognize the normal failures which are a part of life and developing robustness and resilience. The verbal and non-verbal protests of the client assist the therapist to attune to their needs. When the therapist fails the client, the transgression may seem minor, yet to the client it will engender extreme rage; getting the balance right is a tightrope to be walked by the therapist during these phases. The client in this stage of development is not, and should not be expected to be, reasonable; they need the therapist to be there, and unavailability will be met by protest. When regressive experiences are split-off from awareness the therapeutic task involves helping the client to find words, so establishing narrative for their experience, providing the ability to discuss and be understood (Van Sweden, 1995).

Shame

Where dependency and a return to the former developmental state are experienced, pain and shame are generated. When clients lose words and thinking, the shame they experience comes from the belief that they are inadequate and inferior because they are unable to function in an adult way.

Intimacy is first learned in the infant/caregiver relationship and through it either lovability or shamefulness is perceived. In the developmentally needed relationship with the therapist the opportunity for intimacy is present and can contain erotic feelings as in the infant/caregiver relationship, which can add to the client's shame.

Balint (1959; 1968) believed that the process of regression to dependency offers the individual the opportunity for maternal repair. Where there is severe maternal failure the individual will seek to address infantile, dependency needs through adult intimate relationships which are unable to withstand the demand for these primitive needs. It is only through the therapeutic regressive relationship that these needs can be resolved by regression to the primitive undifferentiated form from whence a new start may be made (Van Sweden, 1995).

Implications for Practice of Integrative Psychotherapy

Michael Balint (1959; 1968) highlighted what he saw as two types of regression, benign and malignant, viewing benign as moving the client towards resolution and progression, and malignant as the request for gratification without end or resolution. He considered that clients who regress into the malignant aspect of regression will not be helped by this kind of work. Their demands will continually increase and the therapist will not be able to meet them. The client's intention in this kind of regression is not to regress in order to attain resolution but to regress in order to be gratified. Michael Balint identified some characteristics of this type of regression as belonging with a client who has difficulty in establishing a trusting relationship with their therapist which leads to 'symbiotic clinging'; an intensity of demand for satisfaction from the therapist which cannot be let go of; an aim to force the therapist to accede to demands and the presence of high drama and eroticism (Balint, 1968). It is therefore necessary to consider carefully if it is possible and advisable to work with this process with a client who presents in this way.

Winnicott (1949) described regression-to-dependency, considering it necessary to allow the regression to go as far back as necessary in order to get behind the period of ego development before ego impingements occurred and to help the patient to manage those previously unmanageable impingements through the therapeutic relationship. The participants had all had this need for ego development through regression to dependency, having achieved progression through the process, and were chosen because of this in order to explore the effectiveness and healing potential in offering integrative, relational, psychotherapy with psychological and developmental understanding. New understanding from neuroscience and child development can assist in identifying the potential needs of the inner infant and those interactions necessary to offer repair.

I have a number of caveats for those working with regression in this way:

The demands of this type of regressive work on the therapist are high. There may be a need to be available in a way that is outside the normal therapeutic arena, phone calls, texts, extra support through holidays and breaks etc. The therapist must be able to tolerate the infantile behaviour in the client which will involve pain, rage and hatred. Although this is a response to a transference relationship, it should not be interpreted, but must be tolerated by the therapist, so that the client can see that the therapist and the relationship can survive such an attack. Clients can lose functionality and this can take nerve on the part of the therapist to stay with this over long periods. An essential task at this point in the therapy is to enable the client to find a narrative and vocabulary for their experience, to enable effective communication and understanding with their therapist and within themselves (Van Sweden, 1995).

The counter-transference when working at this level of regression is for the therapist to experience the needs of the infant on a visceral level. If this has not been addressed in the therapist by personal therapy, it will be impossible to stay with the client through their experience.

Although I advocate considered and appropriate touch for clients working with developmental regression, I am aware that not all therapists agree. Some therapists may work in environments that do not allow for touch as an intervention, and some clients may have issues which indicate that touch could be counter-therapeutic. However, research into the effectiveness of differing techniques upon the process of psychotherapy has shown that regardless of the orientation of the therapist, or any particular interventions or techniques, it is the relationship itself that heals. An empathic, available and responsive therapist can still "hold" the client psychologically, becoming a transformational object, and so help them to heal (Bollas, 1987).

Conclusion

Carroll (2001) has identified the chaos of neurological changes and the acceptance of the chaotic process in psychotherapy. Psychotherapy, in a sense, is a science of chaos, the chaos of humanity, which is not linear or structured. The process of regression to dependency involves the primitive ego defenses of the client and can seem chaotic to both client and therapist. It takes patience, tolerance, conviction of the efficacy of the process and above all, love, to be able to help the client to healing through this process. The needs of the client are paramount and an Integrative Psychotherapist can adapt to these needs, living with non-linear, non-structured experience. Regression to dependency is not essentially about age regression, or about regression to an experience, it is about regression to a relationship. The work of therapy is to offer a new, reparative experience of an archaic relationship.

Regression and dependency are viewed as shameful by society generally, so I am in awe of the participants' openness in sharing and exploring these areas. I am also aware of the personal cost in exploring this area and, that in sharing this research, I also share myself and my own struggle for healing. I have no doubt that for some individuals, healing can only be fully possible when these primitive aspects of personality have been responded to and addressed.

References

Balint, M. (1959). *Thrills and Regression.* New York: International Universities Press.

Balint, M. (1968). *The Basic Fault: Therapeutic Aspects of Regression.* Illinois: Northwestern University Press.

Bollas, C. (1987). *The Shadow of the Object.* New York: Columbia University Press.

Bowlby, J. (1969/1982). *Attachment and Loss: Vol. 1. Attachment.* New York: Basic Books.

Bowlby, J. (1980). *Attachment and Loss: Vol 3. Loss: Sadness and Depression.* London: Hogarth.

Bowlby, J. (1988). *A Secure Base: Clinical Applications of Attachment Theory.* London: Routledge.

Carroll, R. (2001). *Revolutionary Connections: Psychotherapy and Neuroscience.* Paper given at 7th UKCP Professional Conference. [online]. Available from: http://www.thinkbody.co.uk/papers/between-chaos-and-order.htm. Accessed 2/5/05

Clarkson, P. (2003). *The Therapeutic Relationship.* Second Edition. London: Whurr Publishers.

Douglass, B. G. and Moustakas, C. (1985). Heuristic inquiry: the internal search to know. *Journal of Humanistic Psychology, 25(3): 39–55.*

Erskine, R. G., Moursund, J. P., Trautmann, R. L. (1999). *Beyond Empathy: A Therapy of Contact-in-Relationship.* New York: Brunner-Routledge.

Gill, M. (1982). A Re-experiencing Therapy. Cited in Kahn, M., 1991. *Between Therapist and Client: The New Relationship.* USA: W. H. Freeman and Company.

Guntrip, H. (1969). *Schizoid Phenomena, Object-Relations and the Self.* London. Hogarth.

Kohut, H. (1971). *The Analysis of the Self.* USA: International Universities Press, Inc.

Kohut, H. (1977). *The Restoration of the Self.* New York: International Universities Press.

Kohut, H. (1984). *How does analysis cure?* Chicago: University of Chicago Press.

Lazarus, A. A.(1994). How Certain Boundaries and Ethics Diminish Therapeutic Effectiveness. *Ethics and Behaviour. Vol. 4. No. 3: 255–261.*

Moustakas, C. (1990). *Heuristic Research: Design, Methodology and Applications.* Newbury Park: Sage.

Schore, A. N. (1994). *Affect Regulation and the Origin of the Self.* Hove: Lawrence Erlbaum.

Schore, A. N. (2001). The Effects of Early Relational Trauma on Right Brain Development, Affect Regulation, and Infant Mental Health. *Infant Mental Health Journal, 2001, 22, 201–269.*

Stern, D. N. (1985). *The Interpersonal World of the Infant.* New York: Basic Books.

Steele, K., van der Hart, O., and Nijenhuis, E. (2001). *Dependency in the Treatment of Complex Posttraumatic Stress Disorder and Dissociative Disorders.*

Stewart, H., 2003. *Winnicott, Balint, and the independent tradition.* [online]. Available from http:/datastarweb.com/NHS/20050531_102350_f2dd9_9/WBFORM/1005/720. Accessed 31/05/2005.

Tustin, F. (1972). *Autism and Childhood Psychosis.* London: Hogarth.

Van Sweden, R. C. (1995). *Regression to Dependence A Second Opportunity for Ego Integration and Developmental Progression.* Northvale, New Jersey: Jason Aronson Inc.

Winnicott, D. W. (1954). Mind and its Relation to the Psyche-Soma. *British Journal of Medical Psychology. 27. (Also in 1958).*

Winnicott, D. W. (1958). *Metapsychological and Clinical Aspects of Regression Within the Psychoanalytical Set-up.* In Collected Papers, Through Paediatrics to Psychoanalysis. London: Tavistock. (Original work published 1954).

Winnicott, D.W. (1965). *The Maturational Processes and the Facilitating Environment.* London: The Hogarth Press.

Winnicott, D. W. (1974). The Fear of Breakdown. *International Review of Psycho-Analysis, 1: 1.*

Book Review By Cynthia Ransley

New Approaches To Integration In Psychotherapy Edited By Eleanor O'Leary And Mike Murphy, (2006) East Sussex: Routledge

In 'New Approaches to Integration in Psychotherapy', Eleanor O'Leary and Mike Murphy bring together a range of practitioners who offer very different thoughts on what integration means to them. It is reminiscent of Dryden's Integrative and Eclectic Therapy (1992) but here they bring cultural and social factors to the centre of the integrative perspective and this theme runs throughout the book.

Of the seventeen contributions, several focus on different theoretical frameworks, others on 'special populations' ie different client groups in different settings. Issues around multi disciplinary collaboration, religion, spirituality and ethics are also discussed. My main doubt is the title of the book. The material presented covers a wide range of therapeutic interventions and certain chapters could be of great benefit to care workers, social workers, medical and nursing staff who use counselling skills but do not have a formal training. I hope the title will not narrow the readership.

O'Leary from University College Cork writes a number of the chapters. After a useful introduction on why the need for integration, she sets out with Murphy a general framework for integrative psychotherapy: a useful model for counselling and therapy trainees and trainers. The motivating force of the work is seen as the 'internal integration of clients that occurs in the context of an understanding and authentic relationship'. This involves bodily sensations, cognition, behaviour and emotion with individuals likely to have a primary mode of communication.

One of the therapist's tasks is seen as identifying which style is prominent and initially responding in that mode with a view to helping the person communicate in all four domains. I was reminded of Paul Ware's (1983) seminal work in linking personality types to the contact, target and trap 'doors to therapy'. Is it a reflection of the historical context that he did not include bodily sensations? The authors give a transcript to show how to move between modes of relating. It begins with five 'and how do you feel?' type interventions. I well remember a foster parent saying 'I will scream if someone else comes along when I'm in a crisis and asks me how I feel. What I want to talk about is what I should do!'

Integrative trainees struggling with how to begin to develop an integrative model will find the approaches of the authors largely integrating two approaches useful. These include specific chapters on the Narrative Metaphor and Integration, the integration of Psychoanalysis and Hypnotherapy, of Multi-Modal Therapy and Stress Reduction Techniques. All show clearly the theoretical and practice orientation of the authors.

O'Leary's Person-Centred Gestalt Therapy gives some indication of the way the author's thinking

has changed over the years as she has integrated these approaches. She includes the relationship emphasis of the core conditions from the person-centred tradition together with the Gestalt emphasis on support, interdependence, responsibility and present experiencing. O'Leary outlines three phases in the therapy. In the orientation phase problems are generally experienced outside of the self and presented in a story form in which clients view themselves as a victim, the middle phase where there is a growing awareness of personal responsibility and capacity for internal processing and the final phase where the individual develops this ability further as well as identifying 'areas that need closure' (p35) and say goodbye. As with so many models, this is useful and yet there is the potential for reductionism as clearly many clients arrive burdened with guilt and personal responsibility. It would have been useful to know whether they would be conceptualised as arriving in therapy at the middle phase.

I found her chapter on Gestalt Reminiscence Therapy particularly interesting partly because this reflects my background in social work with older people. For several decades, reminiscence groups have been run in residential and day care settings. This has aimed at increasing older people's self esteem and social relationships by valuing past experiences, particularly crucial for those with dementia where the grasp of the present is diminishing. The author offers a fine example of an integrative approach based on her understanding of the ageing process and ageism. She adds to the story-telling of Reminiscence Therapy, the Gestalt emphasis which includes feelings, unfinished business, contact, and present centredness. This puts loss and the finiteness of life central stage rather than potentially avoided as in pure Reminiscence work. So reflecting on the past goes hand in hand with experiencing the sense of self and facing unfinished business in the present.

Alongside Reminiscence, for people in the more advanced stages of dementia, there have been integrative approaches to Reality Orientation with the incorporation of a Person-Centred approach in Resolution Therapy (Ferguson, 1991) and more commonly with the influence of Humanist and Psychoanalytic theories in Validation Therapy (Feil, 1992 & 1999). Gestalt Reminiscence Therapy is a valuable tool. I hope it will offer trainers and those working with Reminiscence, clarity about the possibility of extending and deepening the work.

Joannis Nestoros offers a valuable perspective on Integrative Psychotherapy and Schizophrenia. This includes useful material on the evolution of the term. Apparently eighteen types of 'schizophrenia' have been set out in editions of the ICD and DSM. Nestoros offers a convincing argument that schizophrenic symptoms are not the result of a specific illness but of extreme changes in the individual's 'bio-psycho-social homeostasis' (p76). His first principle is that the symptoms are amenable to psychotherapy only if clinicians believe that this is possible so can offer hope. He sees the integration of various approaches essential in effective treatment. His 'Synthetiki' model combines medication (biological), individual/group/family therapy (psychological) and interventions to lessen the stigma of mental illness (societal/cultural).

With two others, Nestoros looks at the interdisciplinary collaboration needed and in a third chapter, with Kalaitzaki amplifies the model while focusing on improving interrelationships between families and psychotic patients with both individual and family therapy. The Greek approach integrates theory across the psychotherapy spectrum in their work with people with psychotic symptoms. It is well worth reading both in terms of theory, the imaginative range of help offered and because it is a pleasure to read an approach coming out of a different cultural tradition. This glimpse of such imaginative practice in Crete, however, left me feeling rather dispirited given the financial strictures on the mental health services in Britain.

While it is not possible to review the many contributions, other chapters focus on client groups such as cognitive-behavioural gestalt therapy with cardiac patients, integrative approaches to children's psychological services and a very useful protocol for professionals working with patients diagnosed with a severe medical condition and their families. Curiously 'Integrating spiritual and religious factors into psychological treatment' was in a section on 'Issues for Professional Consideration' rather than in the general theoretical frameworks section.

The approaches are steeped in a one person psychology tradition. I would have welcomed some critique from an Intersubjective, Relational Psychoanalytic perspective with their emphasis on the therapeutic endeavour not being located in the 'individual mind', the problem in the client, but in the "mutual interplay between the subjective worlds of the patient and analyst, or child and caregiver" Atwood and Stolorow (1999, p.178). The integration of material from the burgeoning research on neurobiology would also have been useful. However this book, with the breadth of ideas so clearly and succinctly presented, is a welcome addition to the integrative field.

Cynthia Ransley

Atwood, G. and Stolorow, R. (1999). *Faces in a Cloud: Intersubjectivity in Personality Theory.* Northvale, NJ: Jason Aronson

Dryden, W. (ed) (1992). *Integrative and Eclectic Therapy.* Buckingham: Open University Press

Feil, N. (1992). *Validation therapy with later-onset demential populations.* In Jones, G. and Miesen, B.: Care-Giving in Dementia, London and New York: Routledge

Feil, N. (1999). *The Validation Training Programme.* Baltimore: Health Professions Press.

Ferguson, L. (1991). What's New about Confusion. *Social Work Today, 31 January.*

Ware, P. (1983). Personality Adaptations (Doors to Therapy). *Transactional Analysis Journal, Vol. 13, No. 1.*

Book review by Michael Randolph

Body Psychotherapy Ed. Tree Staunton. (2002) London: Routledge

What an interesting collection of articles! They show both the strengths and the weaknesses, as it seems to me, of modern writing about psychotherapy in general, as well as offering a clear spread of attitudes present in Body Psychotherapy, with their philosophical (sometimes ideological) and clinical underpinnings well presented. A foreword by Andrew Samuels, sculpting with verve, as he knows how, the psychotherapy landscape both in its potential embodiment as in its frequent bodylessness, opens the mosaïc of reflections on body-psychotherapy this collection consists of. Samuels mentions in passing the dangers of partisanship, asserting that this peril is here held in check by the expression of commonly held assumptions. As a general comment, my feeling is that all-inclusivity has historically been and remains a greater problem for Body-Psychotherapy than any battle of methods. A voluntarily compendious world-view leads rapidly to a reification of concepts that are really just notions, potentially leading us up a good few garden paths. One of the ways this operates is through the use of quotations supposed to anchor a concept's believability. One example amongst many is when Nick Totton quotes Arnie Mindell as writing: "…if the process worker… amplifies a client's repeated tendency to stretch, yawn and groan, specific postures from ancient yoga and modern bioenergetics appear as part of a fluid flow of events." No more self-evidently than postures from speed-skating, apple-picking, tango-dancing and so on! This particular quotation was used to illustrate the existence of approaches to psychotherapy from an explicitly-labelled unified body-mind perspective. It is in the resonant but finally vapid register of such semi-revealed truths that Body Psychotherapy has tended to wander over the years, lurching back and forth between grandiosity and bathos.

In general, however, this book and most especially the outstandingly well-written and intellectually fearless contributions of Tree Staunton and Nick Totton, are a pretty good antidote to the excesses of a Reichian tradition whose ardour usually overwhelmed its potential to contain. In exemplary fashion these two authors hoist rapidly their standard: Let no nettle remain ungrasped: Touch, sexuality, the problematic weighting of theory as opposed to clinical practice, the articulation between symbolic and real, the political and social framework and what is really different about body psychotherapy as opposed to other forms of psychotherapy? Both authors elaborate on these themes in as articulate, committed but honest a fashion as one could hope for.

What of the other contributors? The one who stands out as coming from a very different world-view is Babette Rothschild who, almost single-handedly, has been introducing to the UK over the years recent American theoretical and clinical perspectives on working with trauma victims, especially those suffering from Post Traumatic Stress Disorder. She writes crisply, in almost medical language, about the steps which bodily-aware psychotherapy might and should follow after a diagnosis, or a suspicion

of a diagnosis, of PTSD. She works from the standpoint of a precautionary principle which might be enounced as until you know what you're getting into, watch out! She challenges, from a position of clinical prudence, any atavistic tendency body psychotherapists might have boldly to go where others fear to tread, and, specifically, she offers a well thought-out step by step protocol of intervention which, concretely, eschews touch as an appropriate intervention with abuse victims until such time as very solid base of confidence can be seen to have been established. It is worth pointing out that trauma and abuse victims very often need to feel held, just as they may have a freeze-response aversion to being touched. This chapter offers clinical vignettes which allow us to see just how a no-touch environment can also be a holding environment. The subtext appears to be that neuro-physiologically poorly-based, and wrongly-dosed therapeutic interventions cause uncounted ravages and it would be not too exaggerated to affirm that the sub-subtext is that, until recently, body psychotherapists have not taken these considerations sufficiently seriously and have, regularly, damaged those who came to them for help in their distress. These strictures are now being listened to much more carefully, and a whole style of gleeful experimentation previously associated with much post-reichian therapy has given way to a more pondered approach, as indeed is true of psychotherapy in general. Whether this means adopting the crypto-medical framework implicit in Babette's outline is a moot point. The debate is open. It is, at any rate, of great value to have such a forceful yet balanced proponent of this track regularly present in the British psychotherapy landscape.

Roger Woolger writes about Body Psychotherapy and Regression: The body Remembers Past Lives. "But as more and more therapists", he writes, "are discovering, there are all kinds of neurotic complaints of both an emotional and a physical nature that simply refuse to be resolved through exploring infantile stories, no matter how early we trace them back." This is an example of the seizability fallacy: If I can't grasp it, it can't exist, so I'll have to invent another framework in which it can exist. It belongs to another class of fallacy: The omnipotent therapist fallacy: Therapists exist to understand things therefore there is nothing they cannot in principle understand. Wittgenstein, on the other hand, wrote that "truth is drawn with difficulty into the realm of reality." As simple a way as it is possible to put it that inner truths do not have to be real to be true. Whether or not our lives are actually recycled through some parsimony-conscious mechanism which currently escapes most of us, is not really the point. The point is how most therapeutically to use the fascinating flashes and visions Woolger writes up elegantly and powerfully. Without any question, the encouragement he gives to experience the experience as deeply as possible is a permission to explore parts of the self which usually remain unreached, unconjugated. The difficulty comes when we force inner truth and reality into a sticky congruence that actually impedes real owning of deep sadness or a well-lodged fear of death. In one clinical example he cites a middle-aged woman who felt deeply bereft. The loneliness of her life found shape in a vision of a young English soldier being gassed in the trenches during the first world-war, choking on the grief of his own death and the loss of his comrades in arms. This beautiful story has no need to be "real" to be true. It is more than likely, in this clinician's view, that permanently mourning "her own" untimely death is just as likely to keep her out of present day interactions and attachments than to help her walk back through the door, down the steps into the brash brouhaha of people living around, next to and with each other.

Given the growing neurological understanding of how memories are actually stored and retrieved in the brain, as well as the mounting, compelling evidence about False Memory Syndrome, it seems egregious to want to find in every memory from the past an unburnished truth. It also leads many clients on a never-ending quest for the key event which will furnish a full cascading explanation of everything. This too may be one of the inherent lines of grieving in life that Freud's 1920 synthesis, in Beyond the Pleasure Principle, which he called in shorthand Thanatos – the death instinct, was all about. It has very bad press in Body Psychotherapy circles, but it allows access to a horizon of deep personal acceptance that its refusal, implicit or explicit, effectively obscures.

Some of the same kind of problems are present in the chapter about Subtle Bodywork by Rose Cameron. Much of this work with the aura or prana or the iliaster, as Paracelsus called it, relies upon the accessibility and tractability of "pure, unsymbolised energy", as Carlos Castaneda, that memorable trickster, metamorph and allegorist is approvingly quoted as calling it. Nobody doubts that the universe is full of pure energy. Can we in any useable way tap into its potential without going through any process of symbolisation? Obviously Rose Cameron believes we can, although to my way of thinking both she and Woolger set up a painful dichotomy between subtle and gross bodies, in which the language speaks for itself. On the whole helping people reclaim the gross is already hugely therapeutic and, to quote the author and literary critic Julian Barnes talking about Virginia Woolf, "I'll leave the other until after I'm dead". Tree Staunton sets out the difficulty clearly in her introduction to this volume when she cites Stein: "Ego consciousness functions largely as the observing mind's eye, which tends to increase the distance between subject and object. Body consciousness on the other hand draws an immediate or direct contact with another person or an object." Since the brain obviously equips us fully to experience both, surely what is interesting is the dynamic tension between these two poles of existence and reaction. The indispensable capacity to defer overt reaction or outreach in the complex social world we already inhabited a hundred generations ago, is now neurologically built in. Those trapped in unrelenting immediacy usually end up in psychiatry. Those whose ego functions systematically overwhelm spontaneity come to see psychotherapists or develop socially acceptable compulsions. The dynamic patterns that emerge in the interaction between the two is what gives human existence its particular quality. As Tree Staunton approvingly quotes Suzuki at the beginning of her introduction "Our body and mind are not two, and not one. If you think your body and mind are two, that is wrong; if you think they are one that is also wrong. Our body and mind are both two and one."

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