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Integrating Multiple Aspects of Experience: A Challenge for the Practitioner

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Introduction

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Consulting Editors

Maria Gilbert and Katherine Murphy

Editorial Board Members

Volume 8, Issue 1 (2011)

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Editorial

Integrating Multiple Aspects of Experience: A Challenge for the Practitioner

Over the years we have moved between having a themed edition of the journal and a journal with a more free wheeling exploration of the diversity of approaches and attitudes to Psychotherapy Integration. A specifically themed edition has a dedicated Guest Editor who attends to the overall and explicit cohesion within and between, the articles of the journal in relation to the theme. Alternatively we, the Co-Editors of the journal, have collected articles from practitioners active in the field of Psychotherapy Integration in their idiosyncratic and individual ways. At some point in the collation of these articles into a completed edition of the journal, a linking thematic thread emerges.

This edition is not a specifically themed edition, yet as is the way of these things we noticed a thematic thread as we brought the articles together. What emerged as we studied these articles in sequence and at one sitting was the focus on the rich and varied aspects of reflection and experience that feed into the concept of integration for the writers. Coming from a variety of different backgrounds and experiences, all these practitioners identify themselves as integrative and each is synthesising a particular combination of philosophy and practice; body work, trauma and practice; a transgenerational history and practice; and research issues related to the integrative practitioner. We particularly appreciated the very personal note in all these that informs thinking and practice.

Werner Prall from his wealth of experience as a trainer, supervisor and therapist, explores very effectively and fully the nuances of the process of metanoia, drawing well on its roots in ancient Greek philosophy. He stresses that the training and education of a psychotherapist is at its best a challenging transformational process. He reminds us of the centrality of the developing psychotherapist's willingness for robust introspection and reflection. Equally this presents a challenge to any trainer in the integrative field!

Morit Heitzler speaks eloquently of her own body-mind processes as an essential tool when working as a psychotherapist with any client, and particularly with traumatised clients. Her moving and courageous discussion of her clinical work in her vignettes gives the reader an in-depth view of this way of working with body process as an essential part of the relational matrix. The care and thoughtfulness with which she approaches this work with clients reminds us of the rigour required to work in a relational manner.

Gerhard Payrhuber has written a dense and well-researched article on transgenerational transferences and the transmission of transgenerational trauma in the wider historical, political and social field. He reminds us that we are all inescapably historically contextualised and that in the therapeutic dyad these forces will emerge so that the legacy of the past will be alive in the therapeutic present. Speaking as the grandson of 'ordinary Austrian Nazis' he

poignantly illustrates his point with a clinical vignette that picks up on these influences.

Claire Nelissen presents her method for researching therapeutic effectiveness which she views as offering a challenge to conventional outcome procedures. She walks the reader through her method step by step, with the aid of diagrams for researching therapeutic effectiveness in ordinary practice settings. This is a lively, if contentious, alternative to some of the current literature in this field.

As is our practice, we have included the theoretical section of a Master's dissertation presented by Maggie Morrow at the time of her completion of her MSc. This is an example of a very explicit integrative framework by a student who consciously chose this professional identity at the beginning of her psychotherapy career.

We also have two book reviews.

Peer Review

Articles for this issue of the journal have been peer reviewed using a formal peer review structure that we have drawn up from our experience as co-editors and we will be continuing with this process in future issues. We have a list of peer reviewers who have agreed to undertake this task and we would be interested in hearing from other psychotherapists who might be interested in joining this group.

We will continue having themed editions with a guest editor and then issues more generally on themes of integration. We again invite readers to contribute articles and we will also continue to invite contributions on particular themes.

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

Werner Prall

Metanoia and the Making of a Psychotherapist

Abstract

This is the slightly amended text of a talk given to students at Metanoia Institute concerning the origin and various meanings of the Greek term metanoia. (It might be worth bearing in mind that the listener, in contradistinction to the reader, would not immediately recognise which 'metanoia' is intended at various points of the talk.) This article raises a question regarding the extent to which a process of personal transformation is still viewed as a necessary element of a psychotherapy training in a radically shifting context of education.

Introduction

I would like to take the opportunity provided by this seminar to report to you on a research project that I have been engaged in over the last year or so. Whilst the title of my report is 'Metanoia and the Making of a Psychotherapist' my research question is perhaps better put like this: Has metanoia still a role to play in the training of psychotherapists?

This might be a puzzling, perhaps unsettling question to be raised in a place called Metanoia, which is after all dedicated to the training of psychotherapists. However, I am not speaking primarily about Metanoia the institution, but about metanoia with a small 'm', that is to say, I am speaking about the concept belonging to Greek philosophy. We could say that I have been doing some conceptual, including some historical research, in order to better ask some questions pertaining to the training of psychotherapists. This is ongoing work: what I am able to report here, in the time that I have, is not more than a preliminary communication. It will, I hope, open a number of possible avenues of investigation, not all of which I will be able to pursue here.

The Shifting Meaning of Metanoia

In what follows I am largely indebted to the work of three philosophers, two French, Michel Foucault (2000, 2005) and Pierre Hadot (1995, 2002), and one American, Martha Nussbaum (1986, 1994). It is in particular Foucault (2005) who shows how metanoia carries two quite distinct meanings making their appearance in different historical periods. The first meaning had currency in the era of Hellenistic philosophy, the second in Roman and early Christian thinking. The first meaning was in fact a negative one. Metanoia, translating as repentance or regret, was something to be avoided. Better do the right thing, otherwise you will experience metanoia! Perhaps some of you will recognise the feeling? Better be good, lest Metanoia will 'get me'!

It was only in early Christian thinking, which had imported via Roman thought some Greek ideas, which in the process often went through a shift in meaning, that metanoia acquired a positive valence. It was now used to refer to a radical transformation, a sudden experience of conversion to the truth of Christ (e.g. Paul's conversion on the route to Damascus). This involves a fundamental shift in the subject in relation to truth, a shift which radically

affected the whole life orientation of the person. Matthew Arnold, the 19th century cultural critic wrote: 'Of metanoia, as Jesus used the word, the lamenting one's sins was a small part; the main part was something more active and fruitful, the setting up an immense new inward movement for obtaining the rule of life. And metanoia, accordingly, is: a change of the inner man' (Lit. & Dogma, 1873, vii 196; quoted in OED).

Only last year, the German philosopher Peter Sloterdijk published a book with a rather remarkable title: 'Du musst dein Leben ändern' (2009). 'You must change your life'. The title takes a line of a Rilke poem to express what Sloterdijk calls the metanoetic imperative, which he suggests as a central term for a wholly new anthropology. Man is forever shaping, and thus changing himself through the exercise of his faculties. This always happens in the forcefield of a vertical tension - always striving higher, always in some way beyond what one is currently capable of, and therefore what one currently is. Man, and woman, are creatures always in the business of transcending themselves, always, as it were, 'self-overcoming'. This idea lends itself to the foundation not so much of a depth psychology, but of a height psychology - a shift which, whilst introducing a very different emphasis, would nevertheless re-assert the predominance of the vertical problematic for human life.

But let us come back to the idea of metanoia as a term for the conversion of the subject. For the Greeks the idea of conversion of the subject entailed a conversion to the subject - literally a turning around, away from the world and towards one's own self. It was part of what Foucault claims was most central to the whole of antique philosophy: the injunction to take care of one's self. The far better known Delphic motto 'Know thyself' was, in a sense, only a sub-set of the larger idea of care of the self.

This pre-occupation goes back to Socrates who famously accosted people in the streets of Athens and challenged them: do you take care of your self? That is to say, are you thinking about what is truly of importance in life - and do you live your life accordingly? All of Greek philosophy turned around the question of the flourishing life, eudaimonia. This is not so much a question of individual happiness, as we tend to conceive of it today, but a broader question: What is the best way for man to live? This is far from an 'academic' question (although Plato's philosophical school was called academia) - the person would demonstrate their seriousness in this most important matter by changing their life, by living according to their philosophical precepts. Philosophy for the Greeks was, as Hadot (1995) explains, 'a way of life'.

Conversion, for which, as we saw, metanoia became one of the terms, thus was a movement of re-orientation, a turning around towards one's self which affected the person's whole way of being. The various philosophical schools (the Platonists, Epicureans, Stoics, Cynics etc.) which thrived in the Hellenistic period, and which extended their influence into Roman philosophy and even Christian thought, devised different answers to the question of the flourishing life. But whilst there were important differences between them there were also significant similarities, especially as far as their methodologies were concerned. I cannot enter here into a detailed discussion of these practices, suffice it to say that what Foucault called 'techniques of the self', and what Hadot calls 'spiritual exercises' comprised, amongst others, the following practices:

1. Paying attention to the present moment;
2. Examination of one's consciousness/conscience;
3. Ascesis, i.e. exercises to limit one's desires and one's fears;
4. Melete, meditation: the learning and contemplation of true discourses;
5. Meditation on death;[1]
6. Contemplation on one's place in the cosmos.[2]

What we find in the various antique schools are the first sustained programmes in the history of Western philosophy of making one's own self an object of work with a view to overcoming or transcending one's state of being.

Greek philosophy, then, was a 'therapeutics of the passions' (Hadot, 1995, 83) or, to put

1. For Plato philosophy was a preparation for death.
2. Even for Aristotle, the most 'scientific' of the philosophers, the study of nature had as its ultimate aim the truth of man's place in the cosmic order.

the same thought differently, part of an immunology of the subject. The channeling and modification of desire and the limitation of fear - by way of a constant revision of what was truly desirable and what was ultimately to be feared, and a sustained training not to give in to irrational passions - were major foci of the philosophical life. Given that the aim was to limit one's exposure to contingency, loss and frustration one could say their programme was geared, like that of any immune system, towards anticipatory self-protection and self-repair (see also Sloterdijk, 2009; Nussbaum, 1986).

In paranthesis: some readers, maybe those versed in Freud's thought, may be thinking at this point: but isn't this how the ego operates? Others might feel inclined to consider any similarities between the Greek therapeutics and contemporary conceptions of psychotherapy. I would agree that there are indeed very interesting parallels which might be fruitfully explored. Sadly, there is not the space to do so here.

There is another interesting similarity to today's therapy training programmes which I will also only mention in passing, namely the way in which the philosophical schools organised the teaching itself through a variety of settings, including classes, individual mentors, group discussions, exercises etc. One other aspect of the history of philosophy, however, we cannot possibly pass over, even if we are in a rush, since it concerns the origins of the name of our profession.

The First 'Therapists'

The Greek therapeuein refers to medical care (a kind of therapy for the soul), but it denotes also the service provided by a servant to his master. In addition, it is related to the duties of worship rendered to a deity or divine power. Epicurus employs the term in relation to the need to take care of the self, which for him was co-terminous with practicing philosophy: 'For no-one is it ever too early or too late for ensuring the soul's health … So young and old should practice philosophy' (in Foucault, 2001, p21, n27).

Philo of Alexandria, in *On the Contemplative Life*, writes about a group of people, a tribe of philosophers, who withdrew from the city to establish a community near Alexandria pursuing a particularly rigorous form of spiritual practice: 'The choice of these philosophers is immediately revealed by their name: therapeutae (therapeutai) and therapeutrides (therapeutrides) is their true name, first of all because the therapeutics they practice (parason iatriken) is superior to that generally found in our cities - the latter only treat bodies, but the other also treats souls' (ibid., p105, n60).

The Therapeutae, the first therapists, intended to treat the soul as the doctors treated the body whilst also engaging in a practice of worship of Being (to on: therapeuousi to on). Foucault writes, 'They look after Being and they look after their soul. It is by doing these two things at once, in the correlation between care of Being and care of the soul, that they can be called "the Therapeutae"' (ibid., p99). This establishes a close connection in this particular school of philosophy between a practice of the soul and medicine which constitutes a religious or spiritual practice. To practice philosophy in this 'therapeutic' vein is to take care of the soul in such a way that a cure ensues which is at the same time physical and spiritual. The community of the Therapeutae is a philosophy school which is also a clinic. The person attending finds a cure to the extent that he undergoes a spiritual practice which involves a radical reorientation towards being.

To be a philosopher-therapist then meant to break in a number of ways with the continuity of one's lives and the life of one's community. It involved a turning away from one's social environment towards the new spiritual community and a turning away from the empirical world towards one's self (a conversion, turning around to focus on the self). It implied a critique of current practices and beliefs and a break in relation to time: the current state has to be transcended; the aimed for (i.e. future) state promises salvation from dangers to which the current state of affairs leaves one exposed. There is a break also in relation to one's past and current self: one has to change oneself (change one's self). This implies self-critique and carries with it a change in routines (repetitive practice); old habits can only be changed by the imposition of new (better) ones. Exercising thus

becomes an exercitium. The first therapeutae partook in the larger philosophical practice of conversion to the self of which the early Christian metanoia is also an example.

Reformation, Transformation, or Information?

I want to suggest now that we can broadly discern two strands of philosophical practice, which, whilst different, are by no means opposed to each other, let alone mutually exclusive. On the one hand we have ascesis, not so much in our current sense of self-denial, but that of exercise, that is, a continuous and often repetitive practice aiming at a change which is conceived as progress, i.e. a development over a long period of time. Let us call this strand formation or, if you prefer, reformation. On the other hand we have metanoia in the Christian sense, i.e. a radical break, a complete turning around, or, you could say, a revolution. Let us call this second strand transformation.

Importantly, both strands, which come from the same philosophical tradition, emphasise the strong link between the subject and truth.[3] The perception of the truth changes the subject, whilst it is only a change in the subject which can open up access to truth (further truths). It is this essential link which gets loosened, and ultimately broken, with the advent of Enlightenment and the ascendence and eventual predominance of the idea of science. A decisive figure in this development was no doubt Descartes who radically separated the subject in pursuit of knowledge from the object of his investigation. From then on truth gained status precisely to the extent that it was objectively perceived, that is, independently of the perceiving subject, and, by the same token, the subject could accumulate truth or knowledge without undergoing a change. Let us call this new strand of thinking information.

So now we have three kinds of relation between subject and truth:[4]

1. (re)formation (a gradual change on the part of the subject)
2. Transformation (radical change)
3. Information (no change)

Let us investigate these three relations a bit more in respect to ideas of training and education in general, and to the different kinds of teacher-pupil relationship in particular. (And the reader is of course encouraged to let some links to our work come to mind.)

Under the heading of (re)formation we find education as a learning process which shapes the personality of the student/pupil over time. The teachers, or masters, serve as role models and encourage identification, if not with themselves then with a certain ideal which they represent. Paradigmatic here might be the German concept of Bildung, which combines ideas of education, edification, and formation. An idea of maturation of character via the ingestion of culture (of the 'high brow' variety) is also implied. We have the literary genre of the Bildungsroman, a type of novel which has as its theme the psychological and moral development of the main character, typically from youth to adulthood. Goethe's Wilhelm Meister is a prime example[5], as is, in different ways, Flaubert's Education sentimentale. The classical idea of the university was informed by a concept of Bildung - a conception that seems to become rapidly a thing of the past, now that higher education is almost entirely geared towards the acquisition of information. Be that as it may, I suggest that for my category of formation, identification with a culturally sanctioned model of maturity is a central mechanism.

Now, as for transformation we have the promotion of a radical break with continuity, the continuity of the being of the person on the one hand, and of community or tradition on the other. The key term here is dis-identification. To the extent that there is a teacher or a master on the scene, this figure does not function to either convey propositional knowledge nor to show the way the pupil is meant to follow; rather, the teacher questions,

3. I discuss some aspects of the relation between subject and truth from the perspective of psychoanalytice work in 'The hour of truth' (Prall, 2010).
4. I acknowledge that this establishes a very stark opposition - one which we might need to revise in the light of, e.g. Lear's (2004) concept of 'subjective objectivity'.
5. Meister, by the way, is German for master.

unsettles, disturbs. Identification, to the extent that it takes place, is with the search for truth, i.e. the lack of knowledge. Figures from philosophy which point to the absent master might be Socrates or Kirkegaard; both are atopos, i.e. strange, not belonging properly, and unplaceable.[6] Equally, Zen masters might fit the bill here, the applicable motto being: If you meet Buddha on the road, kill him!

No such violence of course, when it comes to the category of information. This is the realm of 'knowledge and skills', so-called, well known to all who are exposed to a largely bureaucratic approach to questions of truth and its transmission, i.e. training or education. What is being transmitted here is the knowledge of facts and methods. The teacher functions as an expert of discipline-specific knowledge and as a guarantor of its currency. The personal attributes of neither the teacher nor the student come into this. As we said earlier, no-one is necessarily changed as a person by this process of learning. Identification, to the extent that it takes place, is typically with an ideal of knowledge as it is held to be in operation within natural science.

So, we have three very different paradigms for learning, taking place in student-teacher relationships which are very differently conceived, and with very different aimed-for effects on the student. Let us, finally, turn to the question of the training of psychotherapists which you all have a certain interest in, after all. A professional training is a training for something, a training in preparation to do a certain kind of work. What the work requires, the training needs to prepare the trainee for.

Now, when it comes to psychotherapy I think the crucial question is whether we agree that an idea which Jonathan Lear (2004) expressed in relation to psychoanalysis also holds true for psychotherapy - namely, that 'psychotherapist', like 'psychoanalyst', is a 'subjective concept', in the sense that in order to function as a therapist, or as an analyst, the person has to undergo a subjective change. If we think that this is so, i.e. that 'psychotherapist' is also a subjective concept in that sense, we need to ask the further question: What kind of change process, what kind of formation or transformation do we think the subject has to undergo, bearing in mind that this is not change for change's sake, but the kind of change that would enable the prospective therapist to assist another person to become better at being subjects themselves (if we accept this as one definition for what therapy aims to do)?

When Freud (1912) began to discuss personal analysis as a requirement for the training of analysts he was guided by the idea that the mind of the analyst might need 'psychoanalytic purification' for him to function properly, that is, to be in the right kind of state to work as a receptive tool for the unconscious communications by the patient. Whatever doubts we might have - and I am sure we have many - about the idea or ideal of a purified mind, we cannot fail to recognise that this prescription was closely linked to the kind of work that Freud thought the analyst needed to perform. The subjective state of the analyst had to change; he needed to free himself from his own repressions so that he could attune his ear to the patient's unconscious.

It has long become a standard requirement for the therapy student to undergo personal therapy, but we seem to have stopped asking ourselves what this process is meant to achieve. Training requirements tend to be very specific about the hours the students are meant to spend with their therapists, but they say nothing about the outcomes of therapy - a fact which seems all the more remarkable given the detailed descriptions of the outcomes of all the other course requirements.

Do we not know what we are looking for as a result of this process? Perhaps not. Even within psychoanalysis the aims and endpoints of analysis have been formulated in a variety of very different ways. And the three conceptions of access to truth and knowledge that I have outlined above and which it is easy enough to link with various types of therapy give rise to a very large number of possible answers to this question.

6. Hadot (2002) writes: '[Socrates] is atopos, meaning strange, extravagant, absurd, unclassifiable, disturbing. In the Theaetetus, Socrates says of himself: "I am utterly disturbing [atopos], and I create only perplexity [aporia]." The quote is from Theaetetus, 149a.

There is much that I cannot develop here. I can only attempt at this point - and I do this as a way of approaching a conclusion - to give an indication of one answer which perhaps chimes with the radicalism of the idea of metanoia conceived as a subjective conversion. It goes back once more to the beginning, that is, back to ancient Greece.

The Love of Socrates

Socrates tried to persuade his interlocutors to become philosophers, that is, lovers of wisdom, and he urged them to live according to the truth they managed to glean. That was what he understood by taking care of one's self. But the radical innovation of Socrates was the way in which love was conceived: to love is to lack. To love wisdom is to lack it and therefore to pursue it. It is to love it because you lack it. Lacking you love. Love and the relation to wisdom both change profoundly as they are joined together in the figure of Socrates.[7]

Socrates's famous dialectic method was designed to draw his interlocutors into a process of radical questioning. Talking to him meant to follow his invitation to expound one's views only to realise how tangled up and contradictory they were. In this process his interlocutors acquired no new knowledge; in fact, they lost the knowledge they thought they possessed. They learned nothing. Except, that is, to think for themselves. Socrates saw himself, like his mother, as a midwife. Except he was a midwife of the mind, or, as we say these days, of subjectivity. He was promoting the birth of mind through coming face-to-face with its lack.

Now, if we agree that all therapy is essentially a process of coming to terms with loss - whether this loss is conceived as the loss of an object, the loss of a limb (if I can put it like that), the loss of an illusion, or, perhaps more precisely, as the complex individual history of the combination of all the above - if we take it to be true, that is, that therapy is in essence a process of mourning the loss of one's omnipotence, then how can the preparation for this life of working towards mourning that we call a psychotherapy training not in important ways resemble mourning itself? In other words, should we not think of all these years spent, (depending on how you view it, working on your formation or reformation, preparing yourself for the moment of transformation, or importing into your brains these truck-loads of information) as a life in a kind of psychic gymnasium where we build up and hone our metaphorical muscles with one particular aim in mind: to acquire the strength to bear our vulnerability?

7. In my 'Transference - seduction and transcendence' (Prall, forthcoming) I discuss how the Socrates of Plato's Symposium can be understood as an early (failed?) attempt to use transference-love in the service of a transformatory intervention.

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Werner Prall, MA, MSc, PhD, UKCP Registered Psychoanalytic and Integrative Psychotherapist. Originally from a humanistic psychotherapy background with a particular emphasis on working with the body his theoretical interests and clinical experience have led him to undertake a second training in psychoanalytic psychotherapy. Whilst now positioning his work in the psychoanalytic tradition he remains interested in exploring what kinds of understanding an integrative approach to psychotherapy can open up for us. Werner maintains a private psychotherapy practice in North West London; he is a trainer and supervisor at Metanoia and a member of the training committee at the Guild of Psychotherapists. He also holds a part-time position as a senior lecturer in psychoanalysis at Middlesex University.

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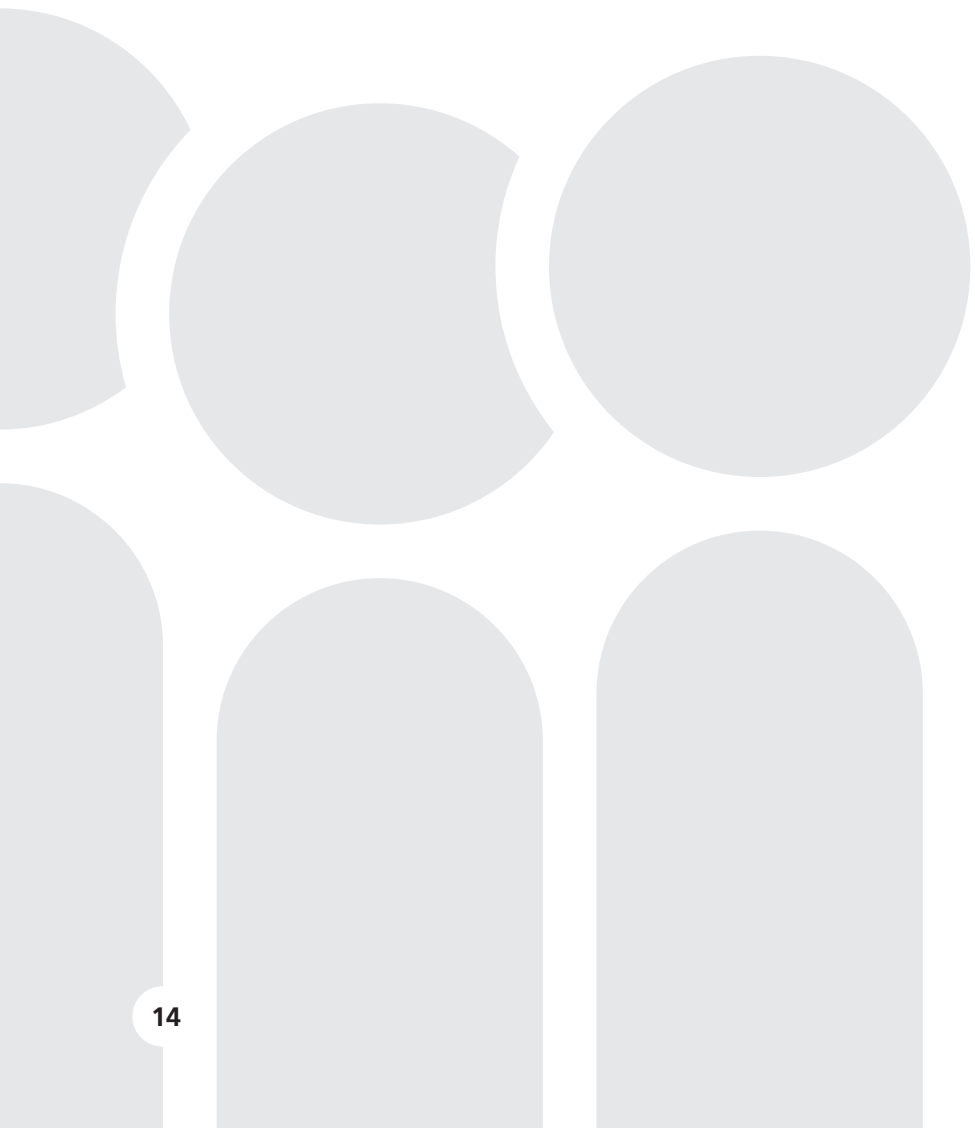

Morit Heitzler

Crowded Intimacy - Engaging Multiple Enactments in Complex Trauma Work: An Embodied Relational Approach

Abstract

Offering interactive regulation to engage with and complement the patient's disturbed auto-regulation, the therapist becomes a container for the trauma. As most of the psycho-biological stress of the trauma is communicated non-verbally, via right-brain to right-brain attunement, the process relies on the therapist's own sense of embodiment and internal body-mind regulation. This paper, based on case material, explores how Integrative Body Psychotherapy offers treatment options and techniques that are capable of reaching down into the roots of trauma in somatic experience. The paper illustrates how therapists can develop the internal resources and capacities needed to regulate the body-mind impact of traumatic relational dynamics.

Part One

Introduction

My aim in this paper is to introduce relational Body Psychotherapy and its relevance to working with trauma. The term 'relational' is now widely used; it has recently become fashionable and most practitioners accept that "it is the relationship that matters" (title of BACP conference 2006, London). However, what being 'relational' actually means in the context of trauma treatment is a more complex question than many trauma specialists have considered (see Dworkin's, 2005 book: *EMDR and the Relational Imperative*).

In the field of Body Psychotherapy there are two well-known approaches to working with trauma: *Somatic Trauma Therapy* as taught by Babette Rothschild and *Sensori-Motor* as advocated by Bessel van der Kolk and taught by Pat Ogden.

Body Psychotherapy, itself, dates back some 80 years, with a substantial history before its recent resurgence, having pioneered psychotherapeutic theories and ways of working rooted in - what today we would call - a holistic-systemic paradigm. Many of its basic principles regarding the interweaving of body, mind, feelings and psyche - at the time intuitively grasped rather than scientifically proven - are now being confirmed by modern neuroscience. The history of Body Psychotherapy also includes controversies and prejudices relating to the way it was practiced in the 1970's and 1980's by some therapists who provoked and pushed clients into cathartic abreactions with no boundaries around the way they touched them. This is not the kind of Body Psychotherapy I intend to present.

To show how both 'relational' and Body Psychotherapy perspectives can profoundly enhance trauma work, I will start by clarifying my understanding of these two terms.

What do I Mean by 'Relational'?

Bruce Perry (2006), an American psychiatrist, has developed what he considers to be a relational approach to working with traumatised children, known as Neuro-Sequential therapy. This is based on his findings and research during the 1990's when he discovered that trauma interrupts the neuro-psychological development of children and fixates the child at that point in time when the trauma happened. In working with children from neglectful and abusive families, he postulates that the interrupted development can be restored by providing - systematically and persistently - the kind of parenting responses that were missing at the time. In this way, new relational experiences in the contact with the therapist reveal the brain's underlying capacity for neuro-plasticity. Perry claims that this kind of treatment creates new neural pathways, thus providing the anatomical basis for repairing arrested development and recovering from trauma. The children's fixation at early stages of development interferes with and damages their capacity for what the neuro-psychoanalyst Schore (2003) calls 'auto-regulation', keeping them either stuck in numb dissociation or in feeling overwhelmed by unbearable intensities of feeling, or helplessly oscillating between these two extreme states.

Perry considers his approach as a relational one, because the main therapeutic agent is the caring, loving, re-parenting relationship between patient and therapist. I agree with Perry that the reparative, re-parenting, inter-subjective regulation function is an important aspect of the therapeutic relationship generally, and trauma work in particular. However, I am aware that there are other therapists and approaches in the field who would dispute the idea that Perry's method is 'relational', who would question whether being 'relational' can be reduced to the provision of a reparative relationship. There exist very different, and contradictory, ideas as to what qualifies as 'relational' and I think it is important to not gloss over these differences. So what are these differences, and what can we learn from them? And if Perry's approach cannot be considered relational, then what can? To illustrate some other forms and depths of relating that are not included in Perry's conceptualisation of 'relational,' I would like to share with you a vignette of my work.

Case Vignette 1

Sarah was struggling to free herself from the clutch of the arms that held her, but as much as she wriggled and pushed, the arms were stronger than her and did not let go. She was crying, frustration and fury mixed with her tears as her body was thrusting, fighting against the restraint. If she could, she would scream, but Sarah never screamed; she had been told very early on to be quiet, otherwise it would hurt more. So even now, 15 years later, she could not find her voice, and her distress was, as always, silent. She could feel the warmth of the body kneeling behind her, she could feel the strength of the arms holding her tightly and somewhere inside she knew she could not win. A little girl cannot win against adults. She knew that very well. This time, however, she was surprised to feel some relief in knowing that the other person was stronger than her. This time it was reassuring, and she could almost surrender. But the forces inside her were not ready to let go. She tried pleading. In a little girl's voice she was begging: "Please, please, just for a little bit, I won't do it too much …." "No", came the voice from behind her, firm and clear. "I do not want you to hurt yourself, you were hurt enough."

The arms were mine, the place was my consulting room, the year 2009. Sarah was not a little girl anymore but a 30-year-old woman, who had been in therapy with me for the past four years. We had been through this before. Sarah had a strong urge to hurt herself, especially when intense suppressed feelings were rising within her. Over the course of the first three years of therapy I had been told about her suicide attempts, all four of them - mostly by hanging - about severe self-harm and other forms of self-abuse. By now, Sarah trusted me enough to invite me into her tortured daily reality. No more talking about it; now I was offered the experience of it. And what an experience it was!

"But I have to, I have to!" she pleaded, trying again to bang her head against the wall. We were both kneeling on the carpet, near the mattress where so many times I had held her in my arms whilst she whispered to me in a little girl's voice, reliving years of sexual and physical abuse; an emotional, psychological and physical web of horror. "No," I repeated. "You

were hurt enough." I knew I was right. Sarah's whispered stories revealed an unimaginable universe, in which some adults were taking pleasure in tying, hanging and suffocating a little girl, inserting sharp objects into her vagina, raping her in every way possible and playing cruel, sadistic psychological mind-games with her. She was hurt enough, in fact, psychologically, she was barely surviving.

What was driving this compulsion to hurt herself further, I wondered? Was she trying to gain some control over the abuse by volunteering to hurt herself or was she at the mercy of an internal abuser who was continuing to use her for his purposes in the same way that the original, external abuser had used her? In the moment, I did not have the luxury of dwelling on my thoughts. The intensity of what was happening between us, what was happening to us, demanded all of me. Sarah was still struggling to free herself from my arms. I knew, from previous experience, that if I let her go, she would bang her head strongly, repeatedly, against the wall until she would bleed. I also knew that when she woke up from her 'trance', she would be overcome with guilt, shame and regret. And she would be convinced that the worst that could happen was indeed now going to happen: that I would not agree to work with her any more. That I - like so many other therapists in the past – would back away from her inner madness and leave her to face it on her own. I knew that she would plead with me to forgive her for putting me through it and beg me to give her one more chance, she would promise to control herself next time, to never do it again, and she would really mean it. The healthy part of her would really mean it. But when the internalised abuser took over again, she would be out of control, as she always is when she self-harms, as she is now, in the room with me. I knew all that because we had been through this cycle several times before. "And here we are again," I thought, "I am failing her as a therapist, I am really crap, why can't I do something helpful here? Something clever? If Pat Ogden or Babette Rothschild were here, they would know exactly what to do! In fact, I am sure it is so obvious that anybody would know what to do! I am just too stupid and ignorant. Maybe I should resign and never work as a therapist again? I am obviously not worthy to call myself one."

This harsh, judgmental voice was familiar. I had been in close partnership with my inner judge for years and, through the ups and downs of our relationship, I had learned to know, accept and sometimes even love the wound it voiced. But this time, the onslaught was harsher, pushing me to admit my absolute failure as a therapist, perhaps even as a human being. I had some fleeting images of myself standing in the city centre, naked, beating myself up, tearing my hair, confessing my crimes of pride and grandiosity whilst the crowd laughed and threw rotten tomatoes and stones in my face. I felt lower than low, worthy of nothing but scorn and punishment. My belly was churning, I felt sick, choked and sweaty. "This is how it feels," I thought to myself. "This is what it's like to be Sarah. To be sentenced to an on-going pervasive attack of a merciless, superior judge who is out there to count her sins and prove her guilty of being unworthy of belonging to the human race. No wonder she is propelled to tear her own flesh, this is unbearable!"

"You do not deserve to be hurt again; you should never have been hurt in the first place," I said.

"I am a bad naughty girl" Sarah replied in that same little voice. "I am bad, bad, bad!" She was clearly regressed, dissociated, speaking from within the abusive scenario and its long-lasting impact on her self-image. A huge wave of compassion and love arose in me as I held her tightly in my arms. I wanted to help her, to look after her and heal those deep, paralysing wounds. "No, you're not," I said. "The people who abused you are bad; they should be punished, not you!" I felt angry and protective. I was going to fight for this little girl, I was not going to let the abusers win her soul! Sarah was sobbing now, leaning against me. I rocked her in my arms and stroked her hair. The energy in the room had changed; we were cocooned together in a soft, tender womb-like space.

"I wish you were my mother," she said. "If I had a mother like you, she would not let them do that horrible stuff to me." Indeed, I felt like a mother; a loving, protective, nourishing mother. My body felt warm and expansive, my breath was synchronised with hers. Having no child of my own, I was overcome with a deep, primal need to breast-feed her, drawn into her gaze, love her, make her mine, forever

my child. I could hear the sweet hum of a familiar lullaby rising within me, a lullaby my mother used to sing to me when I was upset or frightened. My own mother and her way of mothering me was filling the room, as my urge to mother this wounded child intensified in me.

"I will do anything for you," I could hear myself thinking. "I will protect you and heal you and make up for all the atrocities you suffered." I did not say a word; I just watched my impinging impulses to become the saviour, the protector, the loving mother she never had. I felt powerful and strong, larger than life. I was not just a good mother with her wounded child in her arms; I was bigger than that. I was the archetypal good mother, the one that Sarah longed for through all those dark, scary years of her childhood and, as was becoming clear to me, was still longing for now. From early on in our work together, she constructed me as a compensatory object to her own mother, who was distanced, hysterical, self-centred and unable to bear the Oedipal competition with her daughter. Sarah was forever recruiting teachers, therapists, and mental health workers to play the role of that fantasy figure in her life. My feelings of power, omnipotence and total dedication as I held her in my arms told me of what was missing so badly in her life and of the fantasy she created in order to survive the unbearable pain of neglect and absence she had to cope with. "It was so difficult for you to go through all this on your own," I said. "You constantly longed for your mother to protect and save you. But she was not there. You survived on your own, and this in itself is amazing, don't you think?" Sarah was whimpering quietly. "You have survived," I affirmed again. "But you are forever waiting for your mother to come and take you in her arms and make it all alright. It seems to me that the pain of these longings is sometimes more excruciating than the pain and horror of the abuse." Sarah nodded silently. I was still holding her in my arms but the quality of our embrace was different. No longer the idealised, bigger-than-life maternal figure, I shrank to my human size and she, no longer a victim-child, was able to think and relate to the core of her ever-present pain. Silently, sensitively, we were holding it together, vibrating between us in the quiet room, the absence of early mothering, the unbearable pain of neglect, the defences and coping strategies, the fantasies and hope, the inevitable disappointments - all of these had been aspects of our shared experience in these last minutes. As we moved away from each other and were ending the session, Sarah looked at me and smiled, "I am so glad that you are my therapist," she said. "Thank you."

Indeed, this is who I was, after being temporarily her humiliating denigrating judge, my own never-satisfied judge, the hopeless victim, her omnipotent rescuer-mother, my good-enough mother's daughter, I was now her therapist again, the person who is called to hold and bear all these fragments of her story and mine. These were by no means the only fragments I was called to experience and hold for Sarah, However, I will now explore some aspects of this vignette in an attempt to illustrate my understanding of relational Body Psychotherapy.

Discussion

I invite you now to imagine the scenario with which the vignette opens: I am kneeling behind Sarah and am restraining her in my arms, stopping her from following her impulse to bang her head against the wall. What are the feelings rising up in you when you imagine that moment? What is happening now in your own body? Please pay attention to your body-mind reactions as we explore that scene further. Who was I at that moment? The saviour? The protector? The idealised absent-and-longed-for-mother who takes care of her child? Yes, I partly felt all that. But I also felt like a physically strong adult who is overpowering a little girl and forcing her to obey, imposing my will on her. The abusive scenario and its impact was resonating between us in more than one way, echoing on many levels of our interaction.

As therapists, how can we orient ourselves and what can we hold onto in these scary, confusing moments of intense re-enactment?

One of the ways that I have found helpful in thinking about trauma is to conceptualise it as an external event that had been internalised and now continues as an internal dynamic. This idea of internalisation has been formulated most clearly in the traditions of Object Relations and Relational Psychoanalysis. However, many other approaches have used a variety of terms

to describe the same phenomenon, among them self-state, internal(ised) objects, internal parts, ego-states or part-selves. Fairbairn (1943) talks about the impact of the internalised bad parental objects. "He (the client) is internalising objects which have wielded power over him in the external world and these objects retain their prestige for power over him in the inner world … He is possessed by them, as by evil spirits" (p. 67). Sarah's internalised abuser was compelling her to act out the abuse against her own body (Farber 2000). As with her previous suicide attempts, her ongoing self-harm and bulimia, she was now compelled to hurt herself physically in the room with me, to draw me into the ongoing battle between the abuser and the abused. As Farber (2008) puts it, "In every act of self-harm there is more than one participant and more than one self-state. There is the dissociated part of the self being abused, and then shifting abruptly and without awareness, there is the dissociated part doing the abusing. Dissociation makes possible the extraordinary feat of being both predator and prey, sadist and masochist, all at the same time" (p.26). In her excellent book *'Treating the Adult Survivors of Childhood Sexual Abuse',* Messler-Davies (1994) states, "The adult survivor, in essence, lives the original abusive experience on a continuing basis every day of her life, remaining at least in part absorbed with the cast of characters around whom the abused child's internalized system of self and object representation was organized and split off in dissociated form" (p.137).

In acting out her primal abusive scenario in the room with me, Sarah called on me to be more than a witness or a container; I was called to participate, to experience, to join in her world of dissociated part-selves. As I was restraining Sarah in my arms, I could not escape the sense of feeling like the abuser, physically forcing the little girl to obey my knowing-better will, almost saying, as he would have done, "There, there … be a good girl and do what I say." In this way, I could force her to do what I wanted, and I knew it. She was deeply attached to me, vulnerable and dependent on me, she was going to obey me, maybe with some fight, but I was going to win. Knowing this, turned our struggle into a somewhat stimulating, even arousing, game. Then, "shifting abruptly and without awareness" - to use Farber's words - I felt like the victim, frightened in the presence of the violent, cruel and destructive force which I was desperately trying to control. I might have looked and sounded mature and composed, but this was not how I felt inside. I felt helpless, at the mercy of a force much stronger than me. The impulse to give up and to split off, was overwhelming. There was a strong temptation in me to say: "This is too much, I can not cope, I do not want to be here, I do not ever want to feel this helplessness again." This gave me an immediate, embodied experience of both Sarah's torture, as well as her survival strategy.

So, within minutes I had shifted between all three poles of the 'drama/victim triangle' (Karpman, 1968) from Abuser to Victim and then to Rescuer, shifts that had occurred without me actively initiating any of them. Amongst these three positions, the Rescuer pole is certainly the most attractive pole for the therapist to inhabit, and the narcissistic gratification it holds has tempted many therapists to formulate their role – and the whole task of therapy itself - exclusively from this perspective. There is no doubt in my mind that at times I am called to embody the Rescuer pole of the triangle and that it is essential for the process that I actively want to provide this. However, as much as it is tempting to emphasise this pole at the expense of the other two, I have come to think that I need to be available to embody all three of them at different times, that all of them are - and need to be - constellated in the room (Soth, 2006).

It is often the third pole - the Abuser (Persecutor) - that is most difficult for us as therapists to contemplate, and where the line between re-enactment and re-traumatisation is most challenging. Messler-Davies (1994) explains, "The therapeutic relationship is 'where the action is'. It is the arena in which the abuse, neglect and idealized salvation are re-experienced and in which therapist and patient participate in the emergence, identification and working-through of powerful, often chaotic, transference and counter-transference paradigms" (p.5).

In working with survivors of complex trauma (Heitzler, 2009) we cannot remain a neutral observer, a form of objective doctor, nor can we remain simply and exclusively a reparative parent. We are called right in, into 'the eye

of the storm', to participate, survive and hold the re-enactment of what was before an unbearable life-threatening reality. The client's unconscious hope as she descends into the re-enactment is that this time the trauma can be survived by her and the therapist in a new life-affirming way. The hope is that all part-selves and split-off fragments of experience can be re-lived, met and integrated into a whole and robust Self, and that the trauma, once survived in its fullness by the therapeutic dyad, can be integrated and stored in the 'past file' (Rothschild 2000, p.28) of the memory cabinet.

Simultaneously, whilst this is happening, or precisely because this is finally allowed to happen, the therapeutic relationship forms the consistent holding environment (Winnicott, 1960a), where the client can explore a new model of intimate relationship, in which she is viewed and experiences herself - with all her beauties and flaws - as a subject in her own right - a worthy human being. This, hopefully, can be internalised and can support a new emerging sense of Self, as well as the ability to create healthy external relationships.

Therapy, is therefore "a constant volleying between regressive re-enactment and interpretation of that which is revived through the transference-counter-transference constellations that emerge, and the progressive unfolding of a new object relationship that takes place between patient and therapist" (Messler-Davies, p.4).

This model poses an important question regarding the difference between re-enactment and re-traumatisation, and whether there is a difference at all. My own answer to this lies with the potential of the therapeutic relationship to contain and process the re-enactment in a way that enables the client to develop a new relationship to the traumatised self. Both re-traumatisation and re-enactment can happen spontaneously and be experienced by client and therapist as a terrifying, out-of-control acting-out. However, I see re-enactment as more than a meaningless repetition of the traumatic scenario. As the therapist is able to tolerate and regulate within herself states of hyper-arousal, dissociation, splitting and despair, her energetic presence provides the container in which the trauma can be processed and survived. The therapeutic relationship, in which the therapist does not shy away from any aspect of the trauma and is willing to enter the unbearable together with her client, stands as a stark contrast to the fundamental 'aloneness' that characterises traumatic experiences. It provides a hope and a model of surviving the trauma in a completely new way. Moreover, the therapist's ability to fully engage with the re-enactment and then to "disengage sufficiently to observe, contain and process with the patient what has occurred between them" (Messler-Davies 1994, p.4) creates the space for reflection, integration and 'meaning-making,' re-vitalising all those processes of mentalisation that were distorted during the original scenario.

Summary: Re-Enactment

To summarise, I see three main therapeutic functions of re-enactment in trauma work:

1. The client can externalise and share what she carries as a consistent internal reality, not only through words, which often are unavailable, but via other, more immediate and primal means of communication. It is well-known, according to scientific research, that the cortex and the left side of the brain are largely unable to function during and after the traumatic event (Heitzler, 2009). Thus mentalisation and verbal processes are impaired and often completely blocked. This leaves the immediacy of the body and the interpersonal re-enactment of the trauma as the main channels for connecting with internal and external reality. Therapeutic approaches which rely exclusively on language and the mind's reflective capacity will, therefore, tend to view these kinds of non-verbal communications and enactments as 'acting out'. But from an embodied-relational perspective, I consider the 'felt sense' within the re-enactment as the essential realm in which client and therapist can communicate, express and work through layers of the traumatised psyche that are not available otherwise.
2. When the client senses that the therapist is willing to engage fully with all aspects of the trauma and its impact, she feels contained and fully met. She no longer has to protect the Other from the horror

and intensity of her past story, her present life, herself. She is no longer alone with it. A new model of relating, based on trust, respect and love begins to develop both internally and externally. The therapist's ability to be in the scenario and then to step back and reflect on it enables the working-through and processing of dysfunctional, trauma-based relational patterns.

3. As the therapeutic couple survives the full impact of the trauma on each of them individually and on their relationship, the client is able to verbalise, symbolise and find meaning in a way that was not possible before. The trauma can then be integrated in a healthy way and does not continue to form the main organising principle in the client's psyche.

Part Two

In order to explore another function of re-enactment and its impact on the therapist's role, I will outline a second vignette from my work with Sarah.

Case Vignette 2

Sarah and I were sitting together in a corner in my consulting room, surrounded by soft walls. Earlier on in the session Sarah had wanted to hide and I had invited her to build a hiding place for herself in the room and hide there. She had built a small cave-like enclosure, using most of the cushions I have in my therapy room and later on asked me to join her in her hiding place. It was six months since we had begun our work together; I was getting to know Sarah and she was testing me, as a way of getting to know me. I was flattered by the invitation to share with her the safe place she had created and felt that this was a sign that we were 'making progress'. Sarah had been struggling for some time to tell me about the sexual abuse she had experienced. She did not remember anything coherent, only fragments of body-parts, snap-shots of herself in different positions, words and part-sentences that kept ringing in her ears and a sharp, constant pain in her lower belly. Sometimes she was sure that she had been abused and felt very young as she re-experienced it alone in her bed at nights. Sometimes it felt like a dream. Her flashbacks were clear and depicted an ongoing brutal, sadistic, life-threatening abuse by more than one man. But what if she was making it up, she wondered? What if these were just her own mad fantasies?

I also had my doubts. I was aware of Sarah's early developmental wound and its prevailing impact. I knew by then how unloved and unlovable she felt, especially after the birth of her younger brother. He had been born with severe brain damage when Sarah was only two years old. The mother, who was struggling to fulfil her parental role with her little daughter, was tending to her disabled baby-boy with fierce determination. Sarah watched as her mother held her brother, sang to him and fed him, and she tried to be a good girl, with the hope of earning some morsels of affection. But those were very rare; hardly anything was left for the healthy, quiet little girl. Perhaps, I thought, she had learned that only the wounded and the sick received love and affection, so she needed to create a disability similar to her brother's? Or, to put it bluntly in the words of one of her previous mental-health carers: "She is chronically attention-seeking and like all borderline personalities, she creates a drama so she can get it."

But the flashbacks, the anxiety attacks, the suicide attempts and severe eating disorder had been consistent since she was 15. Surely they were there for a reason? Her acupuncturist, with whom I kept regular contact, informed me that Sarah's pelvis and thighs were completely blocked and there was an underlying current of fear creating severe imbalance in her system. She was convinced that Sarah had been sexually abused at a young age, but I, like Sarah, swayed between knowing it to be true and disbelieving the shreds of information we had. I looked at her, lying curled on her side, hugging one of the cushions. It was warm and cosy to hide together in her cave, made of soft fabric and colours. She was telling me about her cats and how they played together, and was now rolling on the carpet holding the cushion high above her, laughing and playing with it, like with her cat. Her long black hair was spread around her and her green eyes shone with the pleasure of the game. Her beautiful body was alive, her breast heaving as she twisted and wriggled about. "Here," she came closer to me, handing

me the cushion, "you can hold my cat." And she laughed, like a little girl, rolling laughter that enhanced her deep dimples. "Oh, I'd like to hold more than just your cat," I found myself thinking. "You are so… so … yummy!"

She gave me the cushion to hold and curled up to me, embracing me and her 'cat' with one arm. She was regressed, for the first time in our sessions, in a healthy way, reliving and sharing with me the one healthy relationship she had had as a young girl, the love of her cat, which enabled her to do what children do - play. And me? I was bewitched and bewildered. I could barely contain myself. The combination of the young, innocent, playful girl with the mature, beautiful body of a woman had become painfully stimulating. I looked at her full, red lips and imagined what it might feel like to kiss them. I looked at her long, tender neck and dreamt of stroking it with one finger all the way down to her collar bones and then down to …. Sarah was talking, and I pulled myself together. I must listen to her, I must STOP THIS! What IS GOING ON? Have I gone MAD? But it was really hard to concentrate on her words. I managed to respond and heard her telling me of other happy childhood memories, but I was just barely holding on to the façade of 'the therapist'. My desire for this child-woman grew and I had a vivid image of sexual intercourse, quite passionate and, actually, also quite brutal. As I surrendered to the stream of violent sexual fantasies, I could feel a cold and cruel kind of laughter inside me, and the words "You like that, don't you, you little tart?" shot through my mind. "You pretend to be an innocent little girl, but actually you are a sex slave!" I found myself thinking.

I was shocked, but before I could collect myself, the next thought emerged, now directed at myself rather than her: "You pretend to be a nice, trustworthy therapist, but actually you are a sex-maniac!"

Suddenly, it all made sense. Here I was, the trustworthy adult, pretending to care and hold her, but actually getting aroused by the innocent sensuality of the young girl. Here I was, turning in my mind a playful interaction into a violent sadistic intercourse. I was the abuser; the abuser was in me. I felt horrible, disgusted with myself. How could I? What is it in me that allowed this to happen?

I had never experienced anything like this before, and however varied and colourful my own sexual fantasy-world may be, it never included brutality or aggression and was never stimulated by young children. I looked at Sarah, she seemed so young and vulnerable. She smiled at me: "I don't know how you do it." she said. "But I feel so much better, I feel … light, almost happy. I never feel like this! As if a weight was lifted." "Yes," I responded, "it was very rare that you could play like a little girl without worrying about somebody who would turn your game into something dangerous, violent, sexual." "You believe me then!" she cried. "I knew it! You do believe me!" She hugged me tightly, relieved and grateful and I hugged her back. Nothing of those overwhelming feelings was present in me now, I was grounded in my own body again, feeling tired, washed out after this violent encounter. I knew now without a doubt that the abuse did happen, I had met the abuser, met him within me, and I had survived.

Discussion

It is now common knowledge that dissociation is a central coping mechanism during and after trauma. Van der Kolk (1996) writes, "The very nature of a traumatic memory is to be dissociated, and to be stored initially as sensory fragments that have no linguistic components" (p. 289). These "fragments" consist not only of the traumatic event itself, but also of "the traumatized individual's experience and representation of self within the abusive events, and her experience and internalization of the others in her world, as they are represented at such abusive moments" (Messler-Davies 1994, p. 64). These representations of self and others are usually split-off and in extreme cases form what we call DID - Dissociative Identity Disorder. One of the goals of therapy, therefore, is to integrate those split-off self and object representations into a coherent/unitary sense of Self.

Sarah was not able to tell me about her full experience of the abuser, as her memory was protecting her sanity by dissociating from it. But split-off fragments of her

physical, mental and emotional encounters with him were stored in her body-mind.

Understandably, like other victims of childhood trauma, Sarah had no way to verbalise this complex internal organisation, so her way of communicating it to me was via projective identification.

Projective identification is a term first coined by M. Klein (1946) to describe a defense against an intolerable, painful or dangerous idea or belief about the self that the projecting person cannot accept. Segal (1974 p. 27–28) writes, "In projective identification, parts of the self and internal objects are split off and projected into the external object, which then becomes possessed by, controlled and identified with the projected parts." Messler-Davies (1994) describes in detail the way in which this process occurs: "First, the patient projects a split-off internalized self representation onto the therapist to control good or bad aspects of the internal world. Second, the clinician identifies with the projected aspects of the patient's self, subjectively experiencing himself in a way that is ego-alien but perfectly congruent with the projected contents" (p.161).

Projective identification plays an important role in re-enacting the original abusive scenario in the therapy room. This time, the re-enactment happened within me, in my own body-mind and remained contained as such. I did feel the abuser, I identified with and embodied him and his impulses and thoughts, but I did not act them out. Via this non-verbal, unconscious form of communication, I gained an important piece of information that was not yet fully available to Sarah herself. More than confirming that some form of sexual abuse had taken place, I gained first-hand intimate access to the abuser's impulses and motivations. I learnt how he was sexually aroused by the child's innocence and playfulness, and how he had to twist precisely that and turn her into 'a slut' which he could then terrorise and humiliate.

This gave me more than an understanding of the abusive scenario; it made me feel the chill of his psychopathic presence in my own bones. I now knew about the abuse in a way no words could describe. I believe that it was this first-hand knowing that allowed Sarah to feel that I believed her. I also believe that those moments, in which I was the abuser and carried him within my system, allowed Sarah to feel lighter and more hopeful at the end of the session. I carried him for her, and somehow she sensed that she no longer had to carry him alone. More than the insight into first-hand unconscious information, I see projective identification and re-enactment as a call to the therapist to experience, contain and hold self-parts that the client is not yet ready to integrate into consciousness. An important aspect of the regulatory function of the therapeutic relationship is the therapist's capacity to integrate and contain within herself what her client is not yet able to bear. In this, the therapist is more than a mere witness or an agent of support; she is the psychic container in which all fragments of the trauma can gradually come into consciousness.

The Body

Having addressed the relational aspect of my therapeutic model, I would like to consider my understanding of the role of the body in working with trauma. The current discoveries in neuroscience confirm and explain a key principle in Body Psychotherapy, already intuited and expressed by Reich in the 1930's - that body and mind are one. Our recent attempts to formulate this systemic understanding of the body-mind as a complex whole is reflected in phrases like 'embodied mind' or the 'thinking body.' But what do we mean by this? And how does it actually manifest in practice?

Much has been written in recent trauma literature on the traumatised body. Schore, Van der Kolk, Herman, Ogden and Damasio have been voicing, from different perspectives, a singular truth: "The body keeps the score" (Van der Kolk, 1994). They all strongly believe that the therapeutic journey towards resolving the traumatic wound should be based on working with the body as the body is the carrier of the trauma and its symptoms, as well as its best hope for healing and recovery. As Farber puts it: "Infant trauma occurs before the child has the use of language to create narrative memory, and in later trauma the experience may be dissociated. But in either scenario the

experience is stored in the body as a somatic memory. That is, the body comes to know what the mind does not remember" (2008, p.30).

I have written elsewhere (Heitzler, 2009) about my integration of various trauma therapy approaches, including EMDR and Body Psychotherapy methods in working with complex PTSD, which include, amongst others, the resolution of incomplete cycles, especially ways of releasing the blocked fight-or-flight response through expressive movements and voice. I will not expand further on this now as I wish to focus on an angle less widely addressed so far: the therapist's body.

In every therapeutic encounter, there are "two bodies in the room" (Catherine Baker-Pitts, 2007). These bodies interact, exchange non-verbal messages, regulate and impact each other. As much as I do not wish to exclude the client's somatic experience from my therapeutic frame of reference, I see no good reason to exclude my own. As illustrated in the earlier case material, I used my own body as a guide in the minefield of unconscious processes that constellated between Sarah and me. By tuning into my own somatic counter-transference, I could experience Sarah's split-off part-selves in my own body, thus gaining a first-hand understanding of the internalised relational matrix. I also referred earlier to my body as a container, able to hold the fullness of the unbearable experience, whilst the client is struggling to integrate the overwhelming impact into consciousness. In order to qualify as a safe container for both the client and the trauma, it is my embodied presence that is needed to survive the test of trust.

"The client's experience of the therapist as the safe containing object is measured not by verbal cognitive exchange between them, but by the client's energetic perception of the therapist's embodied presence and the sense of congruence between the therapist's verbal and energetic messages" (Heitzler 2009, p.181).

One of the main capacities damaged during trauma is the capacity for self-regulation (Carroll, 2009); the ability to recover emotional and physical equilibrium after being knocked off balance by the traumatic event and its impact. Most people who suffer childhood trauma are struggling to regulate themselves and spend their lives oscillating between bouts of hyper-arousal and deep debilitating depression. Self-harm, bulimia and self-medication are some of the tactics by which they attempt to get relief and gain control over their overwhelming inner chaos. The ability to regulate our emotions develops in infancy via mother-baby interactions. The mother functions as the regulatory object through the use of her body, her voice, her gaze, and her energetic presence. Later on, through the use of a 'transitional object' (Winnicott, 1953) the child can learn to regulate herself. Contemporary attachment theory views mother and baby as a "mutually regulating system" (Carroll, p.97) in which the two participants mutually affect and regulate each other, creating, through the dyad, a system and an entity larger than the two, also known as 'the third'. This idea refers to the relationship itself as an entity, with its own personality, needs and capacities. One of the capacities of this 'third' is the ability to lose the system's homeostasis and to strive to gain it again, in rupture-and-repair cycles, giving the system a quality of robustness and resilience. For people who did not experience the healthy symbiosis with Mother, the task of self-regulating through their own body is almost impossible. As they do not have in their body the experience of being soothed by Mother, they cannot internalise the comforting Other and may often turn towards a harsh, persecutory transitional object, re-creating the sense of abuse and pain (Farber, 2008).

In therapy, Sarah often expressed how 'dead' or 'numb' she felt, how 'unreal' the world around her was. Splitting off from her body, involuntarily dissociating from it, led to a disembodied sense of the world and herself inside it. Lacking the capacity to regulate her intense feelings, she turned to me, asking to be held. Using my body as the transitional object, she was able to regulate her breathing, get a sense of her own skin, get back into her body. Safely cocooned in my embrace, she was able to share what she could never put into words before; the most terrifying, shameful moments of the sadistic abuse, her own hatred of herself, her regressed longing for the ideal mother. The sense of my empathic resonance transmitted through my own flesh, literally touched her in some primal layers of her

experience where she had never been touched before, and she was able, for the first time, to surrender. I strongly believe that this level of pre-verbal, animal-like experience of safety and holding could only happen through our mutual embrace. In my mind, there is no replacement for this embodied level of transforming the traumatic experience of touch as invasive and abusive into a containing, respecting, life-affirming exchange between two people.

As may have become explicit, I do place great emphasis on the reparative aspect of therapy, especially when it comes to pre-verbal layers of working with the body. However, lovely reparative experiences, as real and moving as they were, were not the only interaction we experienced through our bodies. Often, this unambiguous, down-to-the-bone sense of my love evoked in Sarah waves of primitive hate and rage, which were challenging for us both, especially as she would turn those feelings against herself. My role as the regulatory object expanded during those moments as I was called on to regulate the internalised abuser, as well as the victim. That part-self also demanded a visceral interaction with me, as the container and regulator for the sadistic impulses to humiliate and torture. These experiences of the dark side of intimacy, bordering on the edge of psychotic disintegration, were hugely demanding and often draining for me.

Intensified by our physical proximity, there were other moments when Sarah's wound would evoke my own developmental pain. There was nowhere to hide, nowhere to run to. Those moments created a different kind of intimacy, perhaps more tender, but nonetheless provoking and demanding.

What does an ordinary human being, a therapist, need in order to survive, contain and function therapeutically when the process takes us to and across these edges? What will enable us to work "at the edge of the window of tolerance" (Heitzler 2009, p.192 note 1) of ourselves as well as that of our clients? For me, the answer lies in the necessity to stay grounded in my own body, monitor my somatic counter-transference and access my own self-regulation capacities. As Carroll puts it: "If this (i.e. the therapist's) self-regulation is there, then the therapist can also allow herself to be knocked off balance, controlled or confused in the process with the client. At times her job may be to survive the intensity of her own and the client's feelings, staying with the process and with the client at the border between chaos and order" (Carroll 2009, p.102).

It is through my own process, first as a client, then as a trainee in an experiential Body Psychotherapy training and later as a therapist, teacher and supervisor, that I was able to work through layers of denial, resistance and pain dormant in my own body-mind. It is through my personal journey that I have gained the first-hand insight to madness and despair as a visceral, somatic, moment-to-moment experience. As my body learned a new language of vulnerability and trust, I was able to literally lean on my therapist and surrender to those feelings and experiences which it was - for so many years - my second nature to suppress. It is in daring to go to those scary, dark edges that I have learned to trust the nature of the healing process, the innate capacity of the body to transform darkness into light. Anchored in my own relationship with my body I can offer my embodied presence as a therapist. It is this embodied presence, I believe, that enabled Sarah and myself to lose the safe ground under our feet, to travel together to hell and back and to grow.

Summary

Working relationally with trauma in an embodied way, we, therapists, are called to walk into the fire. We cannot stay outside, gazing with horror, shouting warning, offering advice and instructions. This will not do. We need to step in and feel the fire in our own bodies and souls, be consumed, destroyed and revived. It is only by daring to embrace the trauma in our own embodied experience that we can survive it. It is only by being shaken to our core that we can truly find hope. I believe that by engaging and surviving on these levels within ourselves, we help our clients in finding their own hope and salvation.

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Gerhard Payrhuber

In the Realm of the Undead: Transgenerational Transference and its Enactments

Ó gente da minha terra
agora é que eu percebi
esta tristeza que trago
foi de vós que a recebi
Fado

Abstract

In this article I will argue that there are important relationships, part of our psychotherapeutic work, that can often get ignored, overlooked or disavowed. Those invisible relationships seem ubiquitous and are present in almost every psychotherapeutic hour and in every piece of therapeutic writing without showing their significance or vital importance. I believe that those inaudible voices are the manifestations of our ancestors and our pasts that get passed on over generations. This transgenerational relationship (invisible bond) is an important motivator in our development and will create a specific as well as a powerful force when we directly work with historical trauma or massive traumatisation. In this article I will show how this transgenerational transference manifests itself and how we might be able to transform it. I am strongly convinced that we as psychotherapists need to develop a transgenerational sensitivity and a transgenerational responsibility to be able to support our clients in their struggles with their ghosts form the past.

Introduction

In my recent work I have found myself being drawn to various 'inaudible voices' and 'invisible objects' (Faimberg 2002, p. 2) and to the realm of an 'implicit relational' (BCPSG 2006, pp. 843 – 60) life. I found myself attending to relationships that are here with me in the room almost as a shadow or ghost-like existence where their life is often not known, felt or acknowledged and even if known, felt and acknowledged then very often denied, played down, belittled or disavowed.

Jacques Derrida's (2001) unique philosophy, mindful of ghosts and relationships - that are not alive or dead - proposes a respectful attitude towards otherness whether the "other" may be corporeal or indeed a phantom or in my words undead.

In relational psychotherapy I believe we often do reveal those implicit relationships and invisible ties that have always been around but were never really seen or heard or felt before. This psychic blank screen can afflict both therapist and client. Finding interactive experiences that are vital to our ability to relate can have a powerful as well as liberating impact through those lived moment- to-moment meetings. Those relational moments are affective, interactive and full of historicity and create a pool of shared meanings that can create problems in our lives but are able to provide an opportunity for change as well.

In this article I will show that transgenerational relationships are often such implicit relational

patterns, inaudible voices and invisible ties in the psychotherapeutic work. We all try to listen carefully to what our clients communicate through their being with us in the room and through words as well as silences. I believe we can get a glimpse of the transgenerational in almost every session and every piece of psychotherapeutic writing but in ways that might not allow us to grasp its fundamental and essential presence. My hope is that I will make it more obvious and necessary in the implicit relational experience of the psychotherapeutic session. In our global world of complex interrelations I believe it is a fundamental psychotherapeutic task to develop a kind of transgenerational sensitivity that will allow practitioners and patients alike to listen to their rich, complex and often painful history whose legacies I believe can very often haunt our current life. I have therefore developed the concept of transgenerational transference that plays an important role in my clinical work.

Undead Hauntings: How the Past and the Present Mingle

Dealing with the past and how it impacts on our present life has got a long and rich tradition in psychotherapy and psychoanalysis and is closely linked to the concept of trauma. To paraphrase Desmond M. Tutu the process of involvement with the reality of how the horrors of the past keep on living within us helps us to finally deal with them and find a resolution so that we can start living our present life. If we ignore these problems then "these evil ghosts of the past" (Desmond Tutu in: Shmuel 2009, p.14) will return and create havoc in our lives. Mr Tutu welcomes any known method that will help to "silence those evil ghosts once and for all".

Although I agree with the importance of the project I cannot help but feel slightly less hopeful than Rev. Tutu and wonder if it is indeed possible to silence those ghosts once and for all or whether we need to start relating to them in a process where the outcome remains unclear. Any time I start listening to theories and stories about how to face our ghosts and that we have to work through them and then we will be freed, I start feeling uncanny and it makes me wonder if it really is that simple and above all, is it really true? Can we really heal and exorcise those evil ghosts from the past? Or is it yet again another evil ghost promising us freedom and victory while at the same time it produces dark cold prison cells where people get tortured and murdered again? Is the idea of the prison of the past (Fanon, 1967) not just another tactic to conceal and repress what is destructive and troublesome in the present? Is the past and the present just an illusion, a clever invention to shield us form the naked terrible truth that nothing has ever ended and nothing has ever really begun? Is it not better to create the myth of the past to avoid change in the present?

As a grandson of 'ordinary Austrian Nazis' (Shmuel 2009, p.186) I have been living with an implicit relational inheritance of ordinary Nazi perpetrators and with their strategies to conceal an all-pervasive affective economy of guilt, hate and shame. Perhaps that is why I do see it as my responsibility to learn to tolerate that there are no simple answers to such horrific issues. I might therefore not be able to accept and tolerate concepts that promise world peace and resolutions for us all. The shock of a reality that the most innocent sounding question can be a tool of mass murder at the same time has been "deposited deep into my bones" (Fanon, 1967). Above all the pressing 'Jewish question' just needed a final solution. I have learned to accept, against the encouragement of my family of origin who just wanted me to forget those things, that the past is still very much part of the present. The horrific atrocities committed in the Shoa and through racism as well as colonialism will create I believe powerful but undead (not alive nor dead) relationships that often have a kind of 'vampiric' and 'zombilike' grip on our life. In this sense I feel very uncomfortable about all easy and simple reductions and those attractive linear concepts that reduce and simplify the complexity and richness of human relationships with both their creative and destructive powers. In this sense is it not just "the balance between emotional toxins and nourishment" (Eigen 1999, p. XVI) that are vital for me but the reality that relationships themselves can sometimes be so deadly and toxic that it will cast out all possible life. As a grandson of ordinary Austrian Nazis I see it as my transgenerational responsibility to address and connect with my ghosts from the past in the hope that this might generate a dialogue rather than silencing and forgetting affects such as

guilt, shame, hate, disgust and their relational performativity (See Ahmed 2010, p. 93).

The generational acts of collective atrocities and their legacies can produce eerie, ghost-like relationships where people just exist and function rather then live. The transgenerational transmission of Holocaust survivors and perpetrators has produced a kind of undead relation that can neither be lived nor buried. This process of "zombification" (Mbembe 2001, p. 104) has impacted on generations and individuals alike and has made it excruciatingly difficult to differentiate between one person and the next who are nevertheless distinct. This 'vampire complex' (Wilgowicz 1999, p. 430) is "based on the disavowal of death and birth alike and on the horrific mass murders as well as infanticide and parricide in the genocidal project of the Nazi regime. The vampirised individual, whose self-experience is of timeless spacelessness, has no relational experience of the mirror" and lacks the fundamental experience of "affect attunements" (Stern 1998, pp. 138 - 154) in a mutually shared relationship. Many different writers have commented on the ghost or corpse like reality of people who have been overwhelmed and frozen into an undead position where people feel robbed of their subjectivity. In a therapeutic group for the post Holocaust generations for both victims and perpetrators which I co-facilitate, participants talk about their struggle to connect with themselves, their families and with each other. Very often people are caught in what feels like a heavy suffocating position where they cannot be alive or dead. They often talk about being confused about who they are, that they feel deeply empty and like 'a puppet' where I never know who actually pulls the invisible strings that 'I am tied to since I was born' as one group member put that.

In a one person psychology Faimberg (2005, p. 115) described this phenomenon with the help of alienating identifications and Gampel (1993–4) speaks of radioactive and primitive identifications in order to describe those experiences of undead clinical phenomena. I find concepts of a relational dynamic such as 'zombification' or 'vampire complex' more clinically meaningful than intrapsychic ideas of identities which seem to conceal the sociological and political aspect of human relationships.

As a relational psychotherapist I do understand our psychic life as an affective and interactive relational process (Rosenthal 1997, p. 11) that can only manifest in the here- and-now. In my understanding, younger generations are not just seen as passive recipients but as active agents who can only be understood through their relationships with their parents and ancestors and their respective parents and the culture they live in. The interaction between grandparents and parents with their children and grandchildren can well change how they perceive the past and how it is reconstructed in the present (Völter, 2009).

The words inter- and transgenerational are often used interchangeably but I will use the term 'intergenerational' to talk about the relationship between parents and children. When I try to point to the reality of our relationship between ancestors and the parent-child couple I will use the term 'transgenerational'. This transgenerational exchange with our ancestors, through mobility of affect and an "affective economy" (see Schwab 2010, p. 112 -114) within the family creates an important dimension that will influence who we are in the present. Affective economies are social and material as well as psychic. Affect, Ahmed writes "does not reside positively in the sign or commodity, but is produced as an effect of its circulation" (Ahmed 2004, p. 45). I think mobility of affect becomes crucial if we face the legacy and are willing to address the relational working-through of violent histories by both victims and perpetrators. I believe that a relational and integrative concept like the idea of an affective economy challenges the universal notion of oedipal conflicts or oedipal dynamics and will have an important influence on my clinical work.

I understand Shakespeare's voice as transgenerational but that of my parents as intergenerational. The transgenerational transmission in my understanding does depend on the intergenerational connection that can be full off breaks, omissions and discontinuities. Of course the inter- and transgenerational interact with each other and will produce another quality of the transgenerational phenomenon. People have spoken about 'ghosts in the nursery' (Fraiberg, 1975) where they pointed out the important influence

on infant mental health of those frightening figures – remembered or unremembered – from the parents' childhoods who become a strong presence in the nurseries of their own children and can dominate their current relationships. Those ghosts feed off the intensity of the repression of the affect accompanying traumatic experiences of the children who are now the parents and deal with their intense pain by passing them on to the next generation.

Relational Reflections: Emotions as Transgenerational Links

As a relational psychotherapist I understand my work essentially as a sensual and mostly emotional experience of relationships. When I am with a client or patient I often feel amazed by the sheer richness and complexity of unconscious and conscious relations that I have the privilege to dwell with. I often feel humbled and deeply touched by them. I feel I am not only learning from my patients but am allowed to live with them for a while. It is a great as well as an enriching privilege for me to be allowed and sometimes even invited in to cohabit a shared relational space called psychotherapy.

People often come to psychotherapy because their affects and affairs have become somewhat unbearable. Many people who come to see me talk about their experience of the wounding impacts of violent relationships. Hanna Arendt (1969) says that it is "a rather sad reflection on the present state that our language does not distinguish between key terms such as power, strength, force, might, authority, and, finally, violence -- all of which refer to distinct phenomena. To use them as synonyms not only indicates a certain deafness to linguistic meanings, which would be serious enough, but has resulted in a kind of blindness with respect to the realities they correspond to" (Ibid. p. 53).

I very often hear people talk about how they have been wounded through relational violations in the past and the present and how powerless they can feel. I am further told that they find themselves often forced into painful positions deprived of any agency or authority with no exit insight. Almost all people I see are convinced that there is something wrong with them and they usually want me to help them to change their symptoms or problems but never the condition that produces such problems in the first place. This makes sense to me because I know that the subjective experience of bodily or psychic pain which is always an intense 'sudden-ness' and 'now-ness' needs to be relieved immediately. We want to immediately move away from our painful wound, numb the pain or at least try to silence our pain. So it is no surprise that almost all of my patients and clients ask at the beginning of therapy how long it will take. But there is another side to pain. I can become aware of 'bodily limits as my bodily dwelling or dwelling place when I am in pain. Pain is hence bound up with how we inhabit the world, how we live relationships to the surfaces, bodies and objects that make up our dwelling places" (Sarah Ahmed 2004, p. 27).

In this sense pain as much as we would like to avoid it is part of who we are and how we inhabit our bodies and the world we live in. Pain is not simply a function of the amount of damage done, rather the amount and quality of pain we feel are determined by our previous experiences and how well we remember them and by our ability to understand the cause of the pain and to grasp its consequences (See Melzack and Wall, 1996, p.15).

Affective Historicity: The Transgenerational Work of Emotions

I would like to stress here that pain is an experience where soma, psyche and the social or political are already interwoven, interrelated and even constitute each other. Freud (1923) in the Ego and the Id already talks about 'the ego being first and foremost a bodily ego'. In this sense it might be important to remember that pain can define bodies, their surfaces and the sensation of pain is both biological, psychological and social at the same time. When Sarah Ahmed (2004) writes about the sociality, the politics and the contingency of pain (pp. 20–41) she tries to remind us that not all attachments are just loving even if we claim they are. We all do get touched differently by others and hence we feel different intensities of pleasure and pain. "So what attaches us, what connects us to this place or that place, to this other or that other is also what we find most touching; it is that which makes us

feel. The differentiation between attachments allows us to align ourselves with some others and against other others' (Ibid., p. 28).

In this way emotions reveal their importance as well as their power in creating and shaping relationships. In my understanding relationships are therefore not an innate capacity but a manifestation of being in contact with others over time. I do understand e-motions as transgenerational and at the same time they are the motor and creator of relationships through the intergenerational contact making. Here repetition and difference are important nodal points of experience and shape the individual and subjective self. Through repetition of the same or similar emotional movements learning and development can occur. E-motions do indeed move us to and fro, towards and against others and places. They make us get closer and attach us to people as well as places and they makes us turn away from them as well. Emotions are vital forces in our social, political and psychic life and are themselves subjective and mediated experiences. In other words the experience of 'it hurts' can become 'you hurt me' which might become 'you are hurtful' and then 'you are bad'. Historicity is a modern European philosophical concept that argues that human existence and life is essentially created through the context and Derrida calls historicity the primordial double motion forwards and backwards without which there would be no history. In short, I only have a history insofar as I both have memories and traces, conscious and unconscious, of who I was previously, and become different by new experiences. This is not a simple linear process; in fact, it is constantly zigzagging recession and procession, such that my "history", the result of the possibility of such double motion, is constantly changing, is multiple as opposed to simple, oscillating and spiraling as opposed to linear. The idea of historicity argues that there is nothing outside of context and that all existence is interdependent, interrelated as well as mediated.

I agree with Sarah Ahmed (2004) when she suggests that all affective responses not only create boundaries between selves and others "but also give others meaning and a value in the very act of apparent separation, a giving that temporarily fixes an other, through the movement engendered by the affective response itself. Such responses are clearly mediated" (p. 28). It is important to note that it is the process of being in contact that is crucial here not the subject or the object. This contact makes subjects and objects through moving closer and further away from each other and through intensification as well as expansion of feeling states. So in this light at the beginning was not the word, but movement and therefore contact or relation. Subjectivities are woven through 'being in contact with' and the historicity of such contacts.

In this sense emotions are transgenerational constructs and provide a strong link with our ancestors. This explains as well why memory and the experience of past relationships of those affective moments play such an important role in our psychic and social lives. This idea argues against an "a-historical and a-cultural" (Ellis 2010, p. 11) position of the individual subject in psychoanalysis and psychotherapy. Mary Lynne Ellis (2010) argues that we need to develop an "acute sensitivity to the specificity" (p.18) of each of our client's experience that needs to include recognition of the social contexts and the way in which discourses on gender, race, class and sexuality shape their experience. I believe that we need to start listening to transgenerational relationships as well to start to understand how those discourses have been created, transmitted and mediated to individual clients or patients.

In this article I would like to turn to one important part of contact making that I believe forms how and who we actually are or become. The intersubjective turn in psychotherapy and perhaps society at large has rightfully announced that there is no such a thing as the baby claiming the importance of the mother-infant relationship. I would now like to suggest that there is not such a thing as the mother-infant couple claiming that without the parental and familial as well cultural relationship there can be no couple. Humans have always been raised and born into groups of people, families and parents who had parents and families again. Our experience of being touched and in contact with our parents and their respective parents hints an important transgenerational relationship to which I would now like to turn. I have just recently read the interesting work within group psychoanalytic thinking where the notion of a "psychophysical matrix" seems

very closely linked to my understanding of a transgenerational relational field (Powell, 1993).

Transgenerational Relationships

In a relational philosophy we might not be thrown into the world as Heidegger says but into a family and a place where I think we experience contact making as 'going-on-being' (Winnicott, 1965). This emotional touching and withdrawing creates an emotional flow of 'going-on-being' outside our conscious awareness with specific emotional meanings. This is the preverbal realm of our subjectivity as a relational self. Stern (1998) clearly shows that we all are bathed and held in relations and communications we have no grasp of yet, and how we develop in an intersubjective matrix through various "self with other experiences" (p. 104). His concept of affect attunement highlights how emotional relations are both co-constructed and subjective and he stresses the importance of the tonality and valence of our shared emotional and verbal experiences. He sees language as yet another sense of self with other or another possibility of being with others. Language then generates "mutually negotiated we meanings" (Stern 1998, p. 170).

In a relational psychoanalytic view our psychic life happens on the local level of moment-to-moment meetings where implicit relational knowing is enacted. "Through representing these dyadic regulatory exchanges, the human infant moves from being a physiological to being a psychological being" (BCPSG 2007, p. 844). In a transgenerational view I would argue that those relational regulatory exchanges are not just dyadic but multi-personal as well as multidimensional. The role of the mother and the father play of course a prominent role in our experience long before the first word is in reach but are by far not the only ones to be taken into consideration. Those early and archaic relationships have already others in their presence mediated through their norms and values of contact making. Families always already have a whole set of laws in the form of ideas, beliefs and moral constructions ready for the newborn to be born into. These in turn are not just simple context or background issues but shape the style and quality of relating itself. So it is in this 'multi-subjective' mix, in this 'multi-subjective' realm where the subjectivity of our parents and their values and ideas (the other others) do have a huge impact on how we can experience the world. This multi-subjective mix and its historicity will set the stage and scene for what later becomes the self or the subject.

It is interesting to note that Freud (1933) in his '*New Introductory Lectures on Psychoanalysis*' is already aware of the essential connection between people within a family context. "Thus a child's super-ego is in fact constructed on the model not of its parents but of its parents' super-ego; the contents which fill it are the same and it becomes the vehicle of tradition and of all the time-resisting judgments of value which have propagated themselves in this manner from generation and generation" (p. 67). We can see that after 3 or 4 generations the intergenerational bond will become a transgenerational one because the great-great grandparents seem to disappear. But they disappear not without leaving an affective inheritance or an emotional trace that can be found, remembered and reconstructed. Memory needs to be understood, Halbwachs (1985) argues, as a function that develops through the mutual exchange between individuals and their respective groups. For memory to develop we all need a variety of "social frames" (Echterhoff/ Saar 2002, p. 23) that are constituted through the dimensions of psychological space and psychic time and a shared as well as common language of the larger group we belong to. Through interaction and communication within a large group context develops the possibility to localize individual memory traces through which we can form memories in the form of stories or pictures. Halbwachs (1985 p. 55) further argues that memory is always a reconstruction of past experiences with the help of conditions in the present time. For him memory is only possible through the togetherness of human beings in a specific situation. He writes about our "collective memory" which I believe is always an emotional memory as well. Assmann (1988) then developed his concepts further into an idea of a "communicative" and "cultural memory" (p.50) and Welzer (2010) shows how the "familial memory" (p. 18) is a function of individuals being tied together in a unique relational bond that will be with us all our life. Memory here is a

communicative practice in the family that helps to produce coherence, identity and loyalties.

The relationship with our families and its emotional experience are fundamental to our sense of self and is thus directly linked with that of our parents and ancestors through the relational exchange of that affective economy. I believe this happens through our moment-to-moment affective interaction with multiple people over time. Those lived and experienced patterns of affective relatedness are enacted throughout our life. Because we cannot see or touch these people of our past relational meetings, does not mean that they are not with us. It is those ghosts of the family not just in the nursery that play an important role in the development of the mother-infant dyad and their styles of attachments. In this sense the social and political relationships have already always been woven into the very fabric of our own selves. I think it is by far not sufficient, as revealing as it may be, to just empirically observe the exchanges between two or three generations to speak of an intergenerational phenomenon. It is important to develop a refined clinical ear for the whispers of those ghosts or we can learn to "listen to how the patient is listening" as Faimberg (2005) calls that, to be able to grasp those transgenerational bonds. Sarah Ahmed (2010) has expressed her conviction that feelings do not just originate in the individual psyche but are unconsciously given and exchanged between humans and do therefore not "reside positively in consciousness" or one body. It is those affectively relevant and relationally embedded meanings that gain fundamental relevance in a relational view of life. Boszormenyi-Nagy (2006) has developed a concept of "invisible loyalties" that tries to capture the individual sense of faith and belonging to a group and even a nation. Those implicit loyalties are woven by a multi-personal system and represent what Martin Buber calls 'the order of the human world'. They are expressed through various affective relational concepts such as trust, merit or earning, mission and compliance. They have a strong transgenerational quality and function in personal, group and national or even state dimensions and can be understood as fundamental motivators.

In a relational psychotherapy I feel we need to develop a transgenerational sensitivity to be able to grasp those implicit transgenerational patterns and meanings as they are enacted in the present therapeutic relationship. Recently one patient said that she was 'her mother's daughter' hinting that her daughter now will become a teacher as her mother and the mother's father as well as brothers had been. This invisible tie or loyalty is a strong influence in this patient's life and has been passed on to her daughter. In her family 'teacher' represents a sophisticated middle class life style and she finds herself often almost torn apart between the hateful and demeaning tensions of her working class side and her middle class part. I understand her painful emotional tension to be present in an intrapsychic, relational, social, intergenerational and a transgenerational way. This problematic transgenerational tenuous relationship still is and always has been a powerful but unspoken part of her life.

The transgenerational phenomenon is therefore a powerful but often wordless reality that exists in the intergenerational not just intersubjective world but precedes both of them at the same time. This is why the dynamics of filiation, genealogy, inheritance and reconstruction become important psychic and social realties that form subjectivities in their interpersonal dance. I often catch the impact of these emotional economies in my relationship with the person in front of me. When we get more aware of the transgenerational relationship and its transmission and when we develop a curious sensitivity about this phenomenon, the transgenerational transference becomes an important clinical consideration in our therapeutic work. I feel uncomfortable to use the word 'transmission' because it evokes an idea that something concrete gets carried over and that one is actively giving something where the other is just passively receiving that same something at the other end. We further presume that what is transmitted has an impact on the one receiving. But authors have exposed this idea as a fantasy of a hierarchical and patriarchical family structure (Stafford and Bayer,1993). They argue that there is no uni-linear transmission from the older the younger generation. It might be much better to speak about a transgenerational communication or interaction that is always reciprocal as

well as interactive. Völter (2009, p.103) has further argued that it is very problematic to invent simple causalities in life and in social histories. In her opinion this attractive causal logic represents only an attempt to reduce the complex and process-like exchanges and affairs of life. She suggests that transgenerational interaction is always a complex interactive process between multiple people "where all participants take part in a kind of relational dance" (Schlippe/Schweitzer 2002, p. 93). In my experience the idea of a transgenerational dance captures the importance of interdependent subjective positions really well but hides the gruesome and violent practices that can push and freeze people into one particular position and then fixes them there. I am thinking here of issues connected to realities such as racism, imperialism, colonialism, heterosexism, patriarchical dominance and capitalism.

There is not enough space in this article to talk about the rich history of the intergenerational work within psychotherapy and psychoanalysis. So I just want to mention the foundational works of people who influenced my understanding of the transgenerational phenomenon and helped me to develop my concept of transgenerational transference such as Freud, Sandor Ferenczi's ideas about the confusion of tongues (1932), Lacan's article on the mirror stage (1949), Winnicott's mirroring role (1967), Bion's contributions on containment and transformation (1963 – 1965) and Stern's (1998) interpersonal world of the infant. Petruska Clarkson (2003) talks about different relational modalities within the field of psychotherapy. She writes about the clinical importance of the working alliance, the person-to-person relationship, the transference and countertransferential relationship, the developmentally needed relationship and the transpersonal relationship. I feel we need to add another chapter to our understanding of clinical concepts: that of the transgenerational relationship. By doing that I suggest that we all work whether we are aware of it or not in three main relational dimensions: the interpersonal or intergenerational realm, the transgenerational and the transpersonal realm.

The Concept of Transgenerational Transference

In the early 1950's Paula Heimann posed a question that became crucial to the practice of psychotherapy: Who is actually speaking? Until then it was just presumed that a patient was talking to an analyst in a therapeutic alliance. But Heimann believed that at "any one moment in a session a patient could be speaking with the voice of the mother, or the mood of the father or some fragmented voice of a child self with either lived or withheld from life" (Bollas 1987, p. 1). In this chapter I try to make those transgenerational voices that are present in the room between the patient and the therapist as ghostly utterings or eerie silences more audible. We then need to ask, following Heimann's hunch: To whom is the person actually speaking and who is actually answering? With this I mean that psychotherapists are always caught up in a countertransferential relationship. In my understanding people are connected through their implicit relational knowledge and their implicit relational procedures that are constantly enacted out of our awareness. Language later can reflect such affective relational patterns but will not replace them (See BCPSG, 2007). I argue that it will therefore become an important clinical issue for the analyst or psychotherapist to develop an embodied sensitivity of their own subjective transgenerational positions.

The realization that the effects of the past can live on in the present through conscious and unconscious repetitions is a well known clinical phenomenon. Especially when we talk about 'massive traumatization' (Van der Kolk 1996, p. 60) or historical trauma, we can see how the social, political and personal dimensions of our lives are at stake. I think we all live with horrific histories such as slavery and genocide where "the personal is inseparable from the collective and the political" (Schwab 2010, p. 78).

Relational thinking (DeYoung 2003, pp. 106 – 116) understands trauma as a continuum consisting of core relational violations such as consistent denial of interpersonal needs (Lichtenberg, 1989), betrayal of fundamental relational needs of safety and trust and the ongoing ignorance and demeaning of an individual's personhood. People who have been wounded or psychically annihilated in early relationships and in cumulative ways

try to protect themselves from remembering and from further violations with a wide range of dissociative strategies and behaviors. Here the present becomes an important reality because for many people violations in physical, psychical and social forms continue to happen in various ways throughout their lives. If we consider massive violations of organizations such as racism, slavery, homophobia and genocide it would very hard to claim that traces and issues of those violations are not part of out present relationships and perhaps our selves as psychotherapists. Relational psychoanalysts have therefore argued for an interpersonal and contextual as well as constructed nature of the transferential phenomenon (Aron 1996, and Mitchell 2000).

Human atrocities in from of torture, genocide and mass killings leave their legacies in both the individual and the collective psyche. "Most cultures seem to share a tendency to silence traumatic histories" (Schwab 2010, p. 79). But trauma can never be completely erased or forgotten but it gets handed down unconsciously instead. Thus traumatic amnesia can become inscribed as a cultural and psychic practice. Abraham (1996) speaks of a haunting that can span generations. Alain de Mijolla (1987) writes about the genealogy of fantasies, Haidée Faimberg (1987) develops her notion of telescoping of generations and Jean-José Baranès (1993) examined the possibility of a transgenerational metapsychology. Serge Lebovici (1969) spoke of a transgenerational mandate and of writers who studied the transmission of traumas in the historical contexts of the Shoah, the NS regime and the Armenian genocide. Perel Wilgowicz (1999) developed his idea about vampire identification that "blocks the structuring of (secondary) narcissism and the process of becoming a subject" (Wilgowicz 1999, p. 430). All these ideas try to establish a formative link with our ancestors but still operate within a one-person psychology that has severe theoretical and clinical limitations as they ignore the co-constructed and deeply relational nature of those phenomena.

In discussing the Shoa and the Nazi crimes, authors have argued that we need to allow the dead to rest and the living to gain freedom from their ghostly hauntings. But in order to be able to do this we need to first reawaken the dead and revisit the trauma. This process of mourning has nowadays become a collective process as well, where communities and nations develop a culture of memory. "Recognizing the psychic life of our ancestors in our own psychic life means uncovering their unspoken suffering and secret histories, as well as their guilt, shame, their crimes – hence the importance of a family's, a community's, or a nation's secret histories" (Schwab 2010, p. 79). In my work with a middle-aged white German male we discovered how his grandmother was able to direct his whole family with her way of concealing and her encouragement to just talk about some aspects of their family life. She would turn away with a hurtful sigh and he still remembers her quiet face full of suffering if one of his uncles or aunts would mention the name of his oldest uncle who died long before he was born. When they later opened a hidden concealed box in the loft of the grandmother they discovered the documents of a Nazi trial in Munich where his uncle was convicted of crimes against humanity.

Helm Stierlin (1989) has developed a concept that tries to address the transgenerational delegation of parental demands in families of perpetrators. Especially parents and grandparents of the Nazi state have established a powerful demand or mandate for their family members to conceal and camouflage unwanted feelings states of unbearable guilt and shame. By passing their trauma on to the following generations they ask them to solve those unfinished businesses for them. The next generation is not just a passive receptor either and has answered the calling of the ancestors with forgetting and concealing their atrocities and by actively establishing what I call a kind of "screen identity" of good and nice people who did not know of any criminal acts or if they did know where not involved in them. One client of mine told me about his experience of his mother's friends visiting for coffee and cake while talking about the good old times. They often visited a well known German ex-concentration camp officer who fled after the war to Denmark which was only a few miles away from his native town. He had set up a publishing company there that only published pamphlets and brochures of Nazi ideology and propaganda until the

late 1980s. During their visit they would bring bags full of these Nazi brochures and distribute those pamphlets to various people and organizations. He remembers them talking about him as being a nice and real brave man and as someone who is not too bad after all.

Volkan (2002) argues that there is "far more to transgenerational transmission of chosen trauma than children mimicking the behavior of parents or hearing stories of the event told by the older generation" (p. 43) or through transgenerational sympathy however powerful this feeling may be. He talks about "deposited representations" (ibid., p. 36) where children's core identities are flooded with the injured self- and internalized object-images and associated affects that belong to the original victims, their caregivers or parents. The problematic question for me here is the participation of the children who seem to be understood just as passive receptor's of their parents flooding. My clinical experience shows that the next generation is always actively involved in the composition of the transgenerational relationship and people are able to take a variety of possible positions to the parental deposited representations. In my experience transgenerational bonds are always composed of various choral voices where some individual voices might be more prominent at times then others.

In their book 'The Shell and the Kernel' Nicolas Abraham and Maria Török (1994) develop a theory called cryptonymy that tries to capture the verbal process of concealing. They understood this process of concealing as manifestations of a psychic crypt often in form of fragmentations, distortions, gaps, or ellipses. They further argue that this is due to failed mourning and is a burial place inside the self for a love object that is lost but kept inside the self like a living corpse. It is a melancholic, funereal architectonic in psychic space built after traumatic or violent losses. It needs to be silenced and cut off from themselves and the world. The crypt therefore contains the secrets and silences formed in trauma. The secret conceals a trauma whose very occurrence and devastating emotional consequences become entombed and consigned to a pervasive silence by the sufferers of trauma. I understand the cryptic process as an interactive and relational phenomenon that is established through the conscious and unconscious emotional exchange between generations and provides a helpful concept when working within a relational framework. Relational crypts produce a powerful and heavy silence that seems to create the bricks of the traumatic double-wall Dan Bar-On (2006) writes about.

Transgenerational Transference: An Undead and a Relational Experience

Dan Bar-On (2006) worked with mixed Israeli and German groups to address attachments to wounds and the denial of wounds in both victims and perpetrators of the Holocaust. "To some extent some of us are still emotionally incapacitated as a result of the events that happened more than sixty years ago… This incapacitation can take different forms. One survivor might become the eternal victim 'enjoying' (or more accurately suffering from) the secondary gains of such continuous victimhood. Others might deny the victimization by emotionally distancing themselves from any sign of weakness" (Bar-On 2006, p. 46) He talks about transgenerational transference in the form of the double wall phenomenon that concerns both the survivors and the perpetrators. "They would erect a wall between their past traumatic and atrocious experiences and their present life. Their children who grew up sensing the walls built walls of their own. When, at a later stage, one side wanted to open a window in their own wall, they usually met the wall of the other" (Bar-On 2006, p. 51). I think it is this affective economy of terror and shame as well as guilt that helps erecting those walls between committed atrocities and present sense of self as well as between generations. The fear of contagion explains the secondary trauma as families and communities are indeed affected and re-traumatized by a victim's primary trauma.

In my experience mobility of affect is crucial to transgenerational transference. The mobility of affect creates a toxic deposition and disavowal of negative emotions into others and the sublimation of negative affects that are constitutive of social bonds and cultural relationships in general. The parental generation tends to disavow unbearable and overwhelming affective states such as guilt,

shame and terror only to deposit them into the unconscious and conscious processes of subject formation in the next generation through various affective relational procedures.

Kelly Oliver (2004) believes that 'relationality' needs to become primary in psychoanalysis as a social theory. "It is relationality that is primary, not one subject or the other, or two self-consciousness encountering each other and looking for mutual recognition…I maintain that drives and affects do not originate in one body or one psyche but rather are relational and transitory – they can move from one body to another. Indeed, following "Frantz Fanon, I suggest that the negative affects of the oppressors are 'deposited into the bones' of the oppressed" (p. xviii-xix).

I believe it is this affective procedure of oppressive relational practice that is implicit and gets passed on form one generation to next in both victims and perpetrators. They are consciously transmitted in the form of verbal representations of oppression and unconsciously in forms of relational experiences of how walls and fixed positions (negative others and other others) are created. I think it is not just a transgenerational object that will be handed over but implicit relational procedures. Those implicit relational patterns are created through shared affective economies that will exclude certain subjective, social and psychic positions and include as well as promote others. Althusser (1971) talks about his idea of interpellation that can hail subjects into specific cultural, political, and I would add psychic positions. I believe those 'hailings' or interpellations are powerful transgenerational relational constructs, negotiated and mediated between individuals and their respective families and bigger groups in specific historical contexts. Here I think of implicit relational and affective patterns such as gender ideas, racist ideologies, socio-economic hierarchical concepts of class, passionate antisemitism, pervasive heterosexism or intense xenophobia to name but a few.

Transgenerational transference hence has a cognitive, an emotional, a relational and an unconscious dimension. The cognitive dimension consists mainly of words, language and how language is used as well as through "communicative and cultural memory" (Assman 1988, p. 9 – 19). Memory here needs to be seen as a relational and social function in form of a practice of making past experiences present through the use of stories, knowledge transfer in schools and universities and other tools of communication such as TV, film and theatre. Memories are only possible through the mutual interconnection of people in a specific actual situation. Assman (1988) differentiates between our communicative and cultural memory. The communicative memory depends on an ordinary process of communication that happens day in day out. Communicative memory is the direct link to the stories and events that get talked about and exchanged between living members of a family. It is therefore "highly flexible, arbitrary and unorganized and lasts for about three or four generations" (Assman 1988, p.10). Cultural memory on the contrary can last for much longer and is preserved through objective cultural practices of various social bodies and institutions as well as designated individuals such as artists or historians. Assman (1988) argues that cultural memory is managed and established in social and cultural groups and that it will develop a normative and formative power for individual members of a society. It is a group function that establishes and reproduces identity formations through the induction and repetition of those cultural memories.

The emotional transgenerational transference lives in the moment-to-moment meetings between individuals and their respective groups. Here mutual affective connections and emotional undercurrents are passed on in the form, styles and modalities of how we relate or are supposed to relate. Emotional states themselves are already mediated and produce an important formative influence. The circulation of feelings and the emotional politics of families are in this sense transgenerational practices. Here ideas of what women and men are and do or how we have to be a mother or a father play an important role in the transmission and inscription of those practices in the bodies and psyches of the next generations.

The unconscious transmission of relational procedures consists of unconscious identification processes and incorporative phantasies. The process of identity formation through identifications and cross-identification

with others and their relational procedures create and influence how we develop and who we are going to become. This unconscious binding of various generations in various identity formations often produce an eerie but well observed phenomenon of silence and dissociation. Different psychoanalytic writers have developed various concepts and theories of transgenerational projective identifications. Judith Kestenberg (1989) has worked with children of Holocaust survivors and talks about 'transpositions' and an unconscious identification with the past trauma of their parents. Faimberg (1986) talks about 'telescoping' of three generation into one. Ilany Kogan (1995) develops her notion of 'total identifications' and Volkan (2002) writes about 'deposited representations' that happen in large-group historical traumas. Large-group historical traumas "are highly dynamic complexes of recollections, fantasies, affects, wishes and defenses (i.e. mental representations)…It is this complex of mental representation that is passed on to future generations who, as 'carriers', must cope with the unmastered psychological tasks given to them by their ancestors" (Volkan 2002, p. 25). The concept of identity has been challenged by many writers. I agree with Jessica Benjamin (1995) when she argues that the notion of identity produces a simplistic axis of sameness-difference that rigidifies easily into a discourse of opposites. "The term identity suggests a coherence and uniformity that is belied by the multiplicity of self-representations apparent in the exploration of unconscious processes" (Benjamin, p. 138). The process of identification should not be confused with the idea of an unambiguous and coherent identity but represents a vital dynamic in the course of development and highlights the multiple and often tenuous self-representations. Bollas (1987) argues that the self is the history of many internal relations and that "there is no one unified mental phenomenon that we can term self" (pp. 9 – 10).

In my relational understanding I would not see the mental representations or unconscious identifications as a transgenerational unconscious transmission but the implicit relational knowledge of the affective economy within families. Unconscious relational configurations such as radical freezing of affect and memory are inherited as a kind of an implicit relational manual of how to deal with unbearable feelings. Mental representations are therefore secondary as an expression of the lived relational moments within the affective economy of families and cultures. I believe it is through our relational acts within a family in the realm of the implicit relational knowledge where the affective and embodied link with our ancestors lies. This then gets enacted throughout our life span and communicated through our expectation of what forms of affective relatedness can be shared or expressed. We need to develop an affective sensitivity to how the patient is feeling and relating with us in order to grasp the transgenerational enduring relational patterns. In my work I have turned to various relational concepts of post-colonial theory that I find more helpful in addressing phenomena of unconscious transgenerational transference.

Frantz Fanon (1967) develops his relational concept of the colonized body where under the gaze of the colonizer, the black body is "sealed into that crushing object-hood" (Fanon 1967, p. 109). Kelly Oliver speaks about the colonization of psychic space (2004) and Aimé Césaire (2000) talks about the "terrific boomerang effect" where he argues that Europeans tolerated and were accomplices of Nazism "before it was inflicted on them, that they absolved it, shut their eyes to it, legitimized it, because, until then, it has been applied only to non-European peoples" (Césaire 2000, p. 36). I find these relational concepts very helpful in my clinical work as they highlight the co-construction and mutuality in the present time when we work with transgenerational transference phenomena.

Ashis Nandy (1983) developed his notion of 'isomorphic oppression' and Ashraf Rushdy (2001) writes about the impact of 'family secrets' and the powerful dynamic secrets have on individuals as well as families. They seem to tie individuals into their positions of pain and unhappiness without any chance of dying or living. Both victims and perpetrators suffer from oppressive practices. This does by no means imply that the damage done to the children of the victims are the same or equivalent to the damage of the children of the perpetrators. All too often children of the perpetrators do live in privileged social and economical conditions whereas the children of victims tend to suffer from continuous

forms of social and economic exclusion and discrimination. Here I would like to focus on the sticky dynamic of the psychic damage done to both sides of the divide and how that gets passed on to next generations. Those psychic wounds I believe will have immense political consequences and produce a kind of mutual zombification. Achille Mbembe (2001) writes about the effects of colonial oppression and he detects a depletion of vitality in both groups. "This logic has resulted in the mutual 'zombification' of both the dominant and those apparently dominated. Zombification means that each has robbed the other of vitality and left both impotent" (Mbembe, 2001, p. 104). This has been compared to the inability or refusal to mourn that can produce a similar depletion of lively energy in the post Holocaust years in Germany (Alexander and Margarete Mitscherlich, 1975) and "recalls the psychic condition of 'death in life' diagnosed in Holocaust victims" (Schwab 2010, p. 98).

I further think that those invisible and implicit loyalties towards one's partner, family and nation play an important part in the freezing of affect and bonding capacity of individuals (Boszormenyi-Nagy 2006, p. 168). It is important to see that those relational commitments and obligations to implicit loyalties work in vertical and horizontal ways. Vertical commitments are woven between past and future generations and horizontal obligations between partners, wives and husbands as well as siblings and peers. They are developed and shared in an implicit relational bond of three or four generations.

A relational view of transgenerational transference places human violence "in the context of the systemic violence we find in certain national, political, economic or religious formations" (Schwab 2010, p. 99). In my view relational concepts start to pay tribute to the reality that we live in a world of violence and destruction. Our history is indeed written in blood and through horrific annihilating acts that might explain why human beings find it so attractive to flee from this planet and from our reality in the here-and-now. We either fly to the moon or inside ourselves into 'deep' psychoanalytic constructs or romantic ideals that make us forget the painful present as well as this troublesome inbetween realm of being with others and other others over time. I therefore expect to find psychic positions in the relational self where those hauntings do create a ghost-like shadow, an undead life, through the absence of individuality, blocking of subjectivity, freezing of thinking and feeling, in a kind of relational collapse that has a timeless spacelessness. Those toxic relationships live an a-relational life where it is totally forbidden or it seems completely impossible to start linking these experiences with feelings, words or any other form of representations. But the a-relational writes itself into the body, into the flesh and biological self where it can live on (exist) without being alive. This creates a relational crypt, a relational tomb where people do incorporate and encapsulate those a-relational moments of annihilation and its overwhelming emotional responses.

Those ghosts produce the uncanny phenomenon of the undead in the subjective, intersubjective as well as somatic life. Through current experiences in the present those a-relational moments cannot only get re-activated and reenacted but even enriched and intensified. Our current world in its oppressive operations will add another layer to this relational crypt and can therefore present a big countertransferential refusal or blank screen where the psychotherapist will not be able to accept and see his or her part in co-creating a kind of intense Totentanz, a macabre dance of the dead. The concept of transference or other psychotherapeutic concepts can also become important tools in the disavowal of unbearable and toxic relationships in the present. In an unconscious defense we therapists can often flee from an unbearable present position into the past or an unconscious reality. I believe relational crypts are co-created in the implicit relational realm of moment-to-moment interactions by both the client and the psychotherapist.

Clinical Vignette

With the following clinical example I hope to show that transgenerational relationships always have a presence in my psychotherapeutic work. I have chosen an example of work with someone with no direct link to massive traumatization to show that the phenomenon of transgenerational transference and its enactment is ubiquitous

as well as fundamental. My work with individuals who are directly linked with massive historical trauma will need specific attention and perhaps an article in its own right.

Since April 2010 I have been seeing a young white English woman in one-to-one weekly psychotherapy sessions. She has been referred by her GP for psychotherapeutic help with her issues of panic attacks and depression. Early on in our relationship I became aware that I responded to her being with me with a variety of feelings. In supervision I described my relational experience of being with her like meeting a kind of Swiss clockwork. For a long time I felt confused and unable to verbalize my affective landscape in relation to her. She was always punctual for her sessions and showed a real interest in our work. She has a charming style of relating and a lively intellectual sophistication. She works as a teacher and told me before that she comes from a family of teachers and that she doesn't understand or even know why she is sometimes so 'weird'. After a while I became aware that I often felt not really in my body, that there was always something else present in the room with us. She talked about her daily struggles and how often she finds herself lost as if she was not really here. She works as a teacher and is the mother to a 3 year old son. Our implicit relational style was that of a well functioning couple with an emotional void at the same time.

After a few months I slowly became aware that my own counter-transference was hindering me to move closer to her but I did not know why I felt so stuck and imprisoned in an unreal sense of being. I started to get interested in my feelings and I started to realize slowly that I might be in contact with some layer that she was trying to communicate by awkward silences, distant smiles and friendly gestures. Then in one of our sessions Sonia started to talk about her grandfather. She talked about what an awful character he was. She said that she knows that her dad and his brothers were really damaged by him and their upbringing and that there was never any emotional closeness between them. She said "when they meet they behave as if they were strangers and my dad seemed always so stressed and anxious around his dad. That's not normal is it? My dad never dared to answer back or question my grandfather but after their visit he was always difficult, unhappy and very angry with us." While she continued to tell me about her parents and her grandparents she seemed to be just watching them from a safe distance, from behind a glass wall where everything seemed quiet and unreal. She talked about her grandfather being "a very aggressive man, that he had hit his children and his wife, that he was always very harsh, strict and mean, that he fought in the Korean war, that he hated all women and blacks and that he was a kind of Nazi." I suddenly started to remember that this was very similar to how my father always was with his mother. So I said to her: "Yeah as an Austrian I do know what Nazis feel like…" For a moment our session became alive, she looked at me and said 'it is then not just me being weird? All my life I felt that I should love and support them and not feel so different, so alien in my own family.' From then onwards she was able to share her ambivalent positions and feelings with me in our sessions. It was my own transgenerational countertransference that helped to build this double wall in our sessions. I unconsciously enacted myself watching my father and his mother locked in a deadly and unemotional relationship which was very painful and overwhelming for me so I tried to diminish and push aside my own feelings of hate, shame and pain.

Before I really understood what spell we were under, before she was able to start making sense of her absence and I of mine, we communicated to each other through various relational enactments. She would not come to her sessions, she could not remember or verbalize her struggles, everything was locked away under a thick and heavy wall of silence that created a wall between herself and her experiences and between me and her in the room as well. I often felt lost, unable to feel or think, as if caught in a waking dream. It was hard to capture this powerful presence that made itself felt but was not really here either, we were not able to name or understand and share it. There was from the beginning a kind of a-relational dance part of our work that stayed the same for all the weeks and months we met. This part of our shared life was disconnected and was kept safely away by disavowal and a kind of psychic refusal to acknowledge its presence by both parties. I sensed that this a-relational force was there to keep feelings

away, to mute and silence voices of pain and perhaps intense suffering. Was it perhaps a silent scream that was never allowed to be voiced?

We were therefore faced with the paradoxical task to verbalize something that refused to be captured in language and as soon as we were able to relate to that ghost, it started to became real for her. But that was terrifying for her because it was shut away and concealed for a reason. She had inherited a "cryptonymic style" (Abraham and Török, 1994) of talking and relating where she concealed the wound and secret of her family through an affect free speech full of fragmentations, distortions and gaps that allowed her to be with me without any emotional closeness. There was an a-relational tomb cocreated between us that had the dynamic of a psychic crypt, of a relational funereal march that was never acknowledged and therefore never mourned. The only thing I knew then was that I had to go at her pace and try to be gentle with my own feelings of helplessness and fear of not knowing. Altounian (1999) argues that we can unseal the crypt only through linguistic and psychic distancing that will allow us to assign new meaning to an originally unbearable experience. She understands that we sometimes need to make use of the language of the other to bypass our own "which had been stricken with non-existence, for the liberating work of mourning could be performed only in the shelter of the other tongue" (p. 443).

We started slowly to attend to her bodily sensations when she was with me in the room and after a few months she started to connect to many difficult feelings. She slowly found her own words about how violent, bullying and abusive her family was. She had not only witnessed her older brother being beaten and kicked but she became the target of his violence with no protection from her parents. Both her mum and dad had hit, pushed and slapped her, emotionally bullied her and left her alone in her room for hours on end. The Swiss clockwork slowly turned into a clockwork Orange where she started to remember that her mum had to ring the police in order to stop her brother's violence.

Until her psychotherapeutic work she had never allowed herself to see and feel the impact of those violent and neglectful relationships. She started to develop a thin but touching emotional and relational skin with me in our session that became and still is our guide in our work. At the beginning she talked a lot about her past and a big house in the north of England where she felt she was imprisoned and held hostage in a very painful and terrifying emotional landscape.

Our work then led us to her own enactments where she found herself violently shaking her little boy and screaming at him. On various occasions she has pushed his head on the living room table because she felt attacked by him. After such violent outbursts that happened about 4 or 5 times a year she pushes her son into his bedroom and shuts the door behind him while she stands empty and frozen in the living room. She said that she would stand there like a Zombi without any knowledge of time or why all this was happening. She felt disgusted and deeply angry with herself because she was aware that she was doing to her son what had been done to her. In one session she asked why she was doing that? Why was she so horrible to him? This time her question had become embodied and really painful for her and me. I understood that she felt captured in a horrific nightmare where there was no way out and above all no way in either. She talked about her dreams and her fascination with concealed places such as boxes or cellar departments and how often she visits houses of deceased people in her dream and how she looks through their stuff and opens many forbidden boxes, compartments and hidden containers. These dreams are terrifying for her where she experiences many people she is not able to see being around her. She said that it feels little bit like these horror movies were the creatures of the night will eventually get you.

We talked more about her violent moments with her son. She told me in one session that she really struggles with her son's feelings of hate.

> *S: It is so hard in the morning. I have noticed that when he is angry and says I hate school mummy I used to just always say no no no come on now, school is not that bad! I always just ignored him and pushed him to think about something he likes about school…and that is what my mum had always done and still does when things are hard.*

T: Again there is no space allowed and any kind of difficult feeling is cast out…

S: Yes and it happens so quickly. I feel his anger then I feel my panic rising instantly. I then react immediately to try to get away from it but that can make it all worse. The harder I push the more difficult it becomes…(sighs)

T: That sounds painful and really helpless…(sighs)

S: Yeah it is…

The implicit relational procedure she has inherited from her parents and as we will see they from their parents did not allow for any reflective space to occur. Her relational life had no symbolic reference points regarding feelings of hate, shame or guilt. She literally tried to push her feelings away and had attacked her son's feelings of anger and hate. This particular implicit relational pattern had been transmitted to her by her parents who got it from her grandparents who in turn inherited it from their parents.

In one recent session she told me about a play she went to see and that it was scary not just for her. People in the audience were seriously scared she said but that she would have liked to be even more scared. She felt a little disappointed about the play because it did not make her really scared. The play was about ghosts and how in this play a horrible secret in the past had returned and became alive again.

S: Those ghosts are not real you see but big bad secrets that come back….

T: And do you have ghosts as well?

S: Oh yeah, they sit on my chest when I wake up in the morning and make it hard for me to breathe…

T: Want to tell me more about your ghosts?

S: I know they are with me…. You know my grandparents, he was always very strict and harsh. I remember that my dad was scared a lot when his dad was around. My grandfather was a tall man and he would…he has often shouted at me for no reason. I know he hated women…. They seem to have used every little opportunity to let us know how ungrateful and what a disgrace we are. My parents could not stop him and my grand mother just pretended nothing happened or she supported him telling us off. But that is no surprise because my granddad had not had an easy life either. He was the youngest of three sons. His mother was the first woman who went to UCL where she met my great-grand father. My grandfather could not go to Cambridge like his two brothers and started to work. He fought in the Korean war but never talked about this to anyone. He just expected all of us to go on with things… they never talked about their difficulties and they were never really interested in me or my brother. He just wanted us to perform tasks like mathematical exercises or to just follow his demands as… (Pause)

T: I wonder how you feel telling me, what is this like for you?

S: I feel relieved and it all starts making sense slowly. My father told me shortly after I gave birth to my son that he had a brother and sister before him. His sister died very young and his brother was mentally handicapped and they sent him away. I was still in bed after giving birth to my son and all this was so heavy, so much to take on. His brother was brought up in a care home and his parents never mentioned a word about his two siblings. My grandfather had an older sister who died when she was only 3 weeks of age. I think this was a child out of marriage and she had a heart condition…like my grandfather and his brothers had…he had a big scar on his chest and was operated when he was little so he survived, they never mentioned his sister either, nobody ever talked about the little girl, but when my great grand-mother died they found her little shoe in her purse.

T: I can imagine that in your family there is never much space or time allowed to think or to feel…How do you feel just now I wonder?

S: Just ahmm sad…no, we are always just expected to cope and do our best, to just push on….

T: And I have just asked you here with me to push on and name your feelings…

I feel this clearly shows how in a transgenerational understanding the grip of our ancestors can still be alive as an undead undercurrent in our present relationship. Through the affective economy in our families our individual styles of relating are created and

handed down to the next generation. In Sonia's family people always had to just function and perform their tasks while their emotional life was squashed and cast out. Families create implicit relational patterns that can create dead zones or dead ends in relationships that will then create a kind of eerie silence. As we can see those transgenerational hauntings have a difficult impact and can produce loss of vitality, lack of emotional and cognitive space, collapse of any reflectivity and hence produce a zombification in our present relationship or a colonization of our psychic space.

Psychotherapy then becomes a relational paradoxical un-burial, where we have to revisit the trauma, invite all the ghosts in so to speak in order to lay them to rest. I think as psychotherapists we need to embody and learn to tolerate the zombification and those vampiric hauntings in our transgenerational countertransference in order to be able to de-colonize the psyche or exorcise this ghostly alien presence from the relational crypts in the here and now. I am convinced that psychotherapists who are not aware of their own transgenerational position might just reenact and repeat those transgenerational issues that need to be transformed. Hence in my view they can some times play an important role in therapeutic stalemates, negative transference phenomena and in empathic failures.

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Claire Nelissen

Studying and Researching Psychotherapy: the Process-structure Method

Abstract

Can we find meaningful ways of grouping what we actually do, regardless of 'school'? Can we rigorously research naturalistic practice, while preserving the blood in its veins: interaction and fundamental ambiguity? Our practitioners' viewpoint needs to be part of the Evidence Based Practice (EBP) discussion. Unfortunately, the new field of 'usual care' research tends to miss the very biotope of psychotherapy: it explicitly excludes the study of therapist-client interaction from their investigations. In this article an alternative model for analysing the psychotherapy process is discussed, illustrating things with a vignette of practice as we know it. Through addressing researchers' methodological questions, researchable process elements are identified, together with structural elements for measuring performance.

Introduction

It seems that the study of psychotherapy these days has two faces: there is the seemingly paper-'dry' rustle of quantitative analysis on the one hand, pencilling measurement and fleshing out methods of operationalization, randomization and measurement. On the other hand we have the trickle of vignettes, picturing life as it happens, colouring concepts and exchanges between therapist and client with vivid strokes. A deep rift seems to seperate these two, with on the one bank statistics with its principles of measurement and testing that seem far removed from our daily life in the consulting rooms. On the opposite side of the rift we find ourselves in our consulting room with that specific client sitting opposite us, struggling with his/her problems.

Can we combine these two? Can we find principles to study psyschotherapy, using both faces, the one of evidence and the one of daily life? Can we combine methods of testing while preserving the profoundness of case description? Preserve rigour as well as colouring, accomplish generalization as well as leaving room for spontaneity? These are the questions I will try to answer in this paper, by proposing a new model for the study of psychotherapy.

This paper is a direct answer from me as a practitioner to specific methodological issues recently brought forward by researchers developing a new field of investigation, the so-called 'usual care' research (Burnam et al., 2009; Hepner et al., 2010; Garland et al., 2010a; Garland et al., 2010b; Brookman-Frazee et al., 2010). I will explain what that is later on. Overall, I aim to correct the present characterization of treatment these researchers propose. I fear that if we do let this go unanswered, we will in the future end up with benchmarks that are off the mark of our actual practicing, just like the way controlled trials investigate something completely unrecognizable for the individual practioner.

The method of uncovering practice principles I will suggest below is an attempt to connect

evidence to life and life to evidence; I propose a method of studying psychotherapy's original biotope: interaction, including its curls, hair-pin bends and nonverbal stretches. Where, as I will show, researchers tend to exclude this actual interaction from their investigations, I suggest including it in the research of practice. My suggestion involves a systematic view of practice, enabling us to ultimately compare interventions, sessions and therapists. Where case studies are so individual that comparison and generalizability can pose a problem, I will suggest a method to uncover principles underlying vignettes.

This comparability is essential if we are to meet the present call for accountability. Psychotherapy is a professional form of care; professionalism means that the input, consumed in producing output, is taken into consideration. In the case of the therapeutic interactional process, the equipment a therapist uses for performing is a specific one. We can assess the performance of a therapist only if we couple an adequate process characterization to an adequate structure of means.

The latter is, as far as I know, up to now generally overlooked in case descriptions. These, namely, focus on theoretical means (psychology) on the one hand, and instruments, techniques, on the other. Yet, there is a third set of means in our equipment: the structure we work in. As I hope to show, it is the combination of adequate process elements with these equipment elements, that will provide us with a model for describing and generalizing therapy processes. Thus, I hope to provide a groundstructure for studying psychotherapy and make the practitioners' viewpoint part of the Evidence Based Practice (EBP) discussion.

Why would I do that? Much of my motivation will be discussed in the next paragraph. Here, it suffices to say that we as practitioners need to have a degree of organisation in the whole of Evidence Based Practice. This means, that we need to join the discussion about methodology of research and put our viewpoint forward. The notion "Evidence Based Practice" itself suggests that everyone knows what the word 'practice' entails. As I will show, however, there is a hiatus here, which we practitioners should not leave unnoticed, because our very trade is at stake.

But, as I said, this paper is not only an attempt to connect evidence to life, but also to connect life to evidence. I will therefore, try to breathe life into 'dry' methodological issues and prove my point with the help of a vignette, entitled Beloved (Haberlin, 2007). But before I turn to this case, I will first discuss shortly the situation around recent 'Usual Care reseach'.

Recent Research: Real Life Practicing

Recently, researchers realized that, in order for research to hook into actual practice, we need to know more about real-life psychotherapy: "Psychotherapy, as practiced in usual care, has long been considered a black box—a process in which the inner components and processes aren't easily known" (Burnam et al, 2009: 2).

Consequently, "… much of the variability in treatment process is explained by characteristics not examined" (Brookman-Frazee et al, 2010: 265). Usual care research endeavours to fill this gap, in trying "…to assess the range and variability in practice…" (Garland et al., 2010b: 212). This is fundamentally different from trials, which "… assess the extent to which practice meets predetermined "quality" benchmarks" (ibidem).

In attempting to characterize actual treatment, usual care research is a hopeful trend: take processes as they come and see whether we can find any patterns, any regularities. Yet, take actually one breath of usual care research, and this hope evaporates: what is being measured, namely is (intensity of) EBP-delivery… (Brookman-Frazee, et al., 2010: 261–263) and, explicitly, "…not the therapist–client interactive processes" (Garland et al., 2010b: 213).

I celebrate the candidness of the authors about their choice. Yet, as we shall see in our vignette, clinical decision making is not some 'delivery' constituting interaction, interaction co-constitutes clinical deciding. Practice is a sauce, stirred with the spoon of interaction. Deciding takes place right in the middle of it. Even if one studies primarily the therapist providing treatment (Garland et al., 2010b: 213), eliminating the therapist-client interactive process is like

taking the plug from the bath: intricacies of the actual process in vivo run to waste.

There is, however, a more grave flaw, and that is the basis of usual care research: "Most recent research characterizing psychotherapy practice assesses practice at an intermediate level of abstraction, originally defined by Goldfried (1980) as "clinical strategies"(Garland, 2010b: 211).

It speaks volumes that researchers still base their investigations more or less directly on Goldfried's concepts of 1980. So, in fact any basic methodological theory formulation on 'our' part that can serve research for naturalistic practice (Garland et al.2010b: 218), was written over 30 (sic) years ago, which means that, methodologically speaking, our input stems from before the foundation of SEPI (1984); it stems from the last century, even from the era of the last convulsions of the Cold War, when computers had the size of sturdy fridges, when the personal computer was at most a futuristic concept of two adolescents in a garage, let alone that we had only the slightest idea of search engines and the internet, such central assets if EBP is to work at all.

I propose to choose a different angle: characterizing treatment at this same intermediate level of abstraction, but then viewed as a client-therapist interactive process. I hope to elicit patterns in how we as professionals handle this interactive process, by showing that there is systematicness in client-therapist interaction, regardless of 'schools'.

To illustrate my point, I will use a case description, published in the European Journal of Psychotherapy and Counselling, entitled 'Beloved' (Haberlin, 2007). It is lovely read, for which I refer the reader to the original. For lack of space, I will only take small fragments of this text, and weave them through my argument. I need to note here that fragmenting such a process might dull its shine. I hope, however, to do it justice; the thoroughness of this work is exactly the reason why I have chosen this piece to illustrate my point.

Making Processes in Real Life Therapy Comparable

The main question to be answered here is the following. Can we find patterns, meaningful ways of grouping what we actually do and that field-wide? For reaching that we need to make some choices: an adequate focus for our investigations, a proper level of analysis and units of analysis that can make for meaningful practice description. These will be the basis for our answer to some key methodological questions researchers put forward (Garland et al, 2010b; Burnam et al., 2009).

Adequate Focus: Systematization of Interaction

Let's start with an example from our case description. The case is about a woman "…who felt haunted, both by her dead sister and by a part of herself which led a parallel life" (Haberlin, 2007: 23):

"…the first two years of her therapy essentially involved trying to make sense of how mistrustful she was of others and of how difficult she found it to make relationships" (ibid: 25).

What does this say about the therapist's decision making? We can see the therapist explicitly choose a direction for the process ('making sense of client's mistrustfulness of others' and 'making relationships').

The interaction is meant to systematically unfold in this predetermined direction. Doing this as a therapist, is not some cerebral clinical strategy, as researchers have it. Of course our therapist's interaction with her client involves goal oriented deliberation, design, and governance (control). But these take place in "the sweat and stench of real action… [in] the attending pains and joys…[and in] painstaking data collecting" (Bunge,1998: p 304). Our vignette shows what this looks like:

"As she settled in the chair, she removed her glasses, closed her eyes and began to weep

copious, thick, silent tears. She made no attempt to reach for the tissues; instead, she let the tears and the snot run down her face creating a

network of rivulets which hugged the contours of her chin and neck" (Haberlin, 2007: 23).

These are observations. Then, the therapist starts considering:

"I found myself growing increasingly uncomfortable as the minutes went by, not so much with the silence or the mess, but by a visceral response in my own body about the irritation this salty, slimy mess would cause me – especially as I watched the stream slowly disappear into her cleavage. And yet I wondered about her lack of social inhibition, that she could bear to make this mess in front of me when it was so at odds with her polished exterior" (ibid: 23–24).

Our therapist has chosen to keep silent and let things unfold, both with the client and in her own internal world. This being silent in itself is goal oriented, and therefore systematic and purposeful interacting. Theory seems at this moment to be no more than a backcloth, modality choice is still in the bud; her 'sitting with things' may be grounded in clinical theory, but (this is important:) in itself it is a social act.

This makes studying psychotherapy process from the view of considered systematization of interaction by the therapist fundamentally different from our tradition of 'schools'. Schools are identifed with psychological orientations. Orientations couple clinical decision making to therapeutic theories, based on psychological science about what constitutes normal or dysfunctional behaviour/ cognition/development of 'the' human being.

Our focus is praxeology, not theory (Bunge, 1998: 299). Praxis is not about 'the' human being. It is about deliberate action: practical activity as a product of design (ibid: 301). We act on social issues: the therapist-client interaction is in fact nothing else than a social issue; "social issues…are objective features of the social world" (ibid: 299). Scientific problems ('the' human being), however, in essence "…exist only in the brain of the curious student…" (ibidem).

What level of analysis do we need to actually find patterns in this praxis?

Level of Analysis: Design

I agree with researchers that we need a level of analysis, "…more operationally specific than the broad theoretical orientations…, yet broader than specific verbatim utterances" (Garland et al., 2010b: 211).

Our vignette can give a flavour of the actual music of change; let's listen for a while and see what it brings in terms of this intermediate level of analysis. We know the therapist works towards facilitating the client to 'make relationships'. This is how this sounds in actuality:

"It would appear at times as though there was very little I could say that interested her; she refuted any observations or parallels I drew between her history, her life outside the room and the way she and I experienced each other. Any attempts to draw attention to the difficulties we had in relating were rebutted. She was consistently resistant to any transference interpretation and found it hard to give our relationship any status, snorting if I used any construction of words that hinted at something mutual developing between us" (Haberlin, 2007: 25).

We can see how our therapist designs the process as one of resonating with the client: trying to get insight-topics on the agenda and studying what the client's reaction is.

Researchers might call this a strategy for 'providing corrective emotional experiences' (Goldfried, 1980: 994) through 'addressing client resistance' (Garland et al., 2010b: 218-Table 1). 'Providing', however, does not cover the act of creative invention performed here, nor does 'addressing'. Both cover only the social process. Invention is different from social process (Bunge, 1998: 240); social process is the bike, invention the way of paddling. We need, therefore, to typify the nature of these activities as acts.

What we see in our vignette is not even close to implementing some theoretical 'principles of change' (Goldfried, 1980: 994). Our therapist's probing might be based on knowledge of these principles, but as an act, what she does is using her experience to be able to withhold premature reacting, while taking governance of the

interaction, both in ther mind and in her talking. This is not some principle; it is facilitating.

This facilitating is potentially causal on change; that is what makes it a more adequate construct than the usually considered 'principles of change': "Unfortunately, most of …[common factors research] findings are based on correlational designs and thus offer little in terms of specifying causal mechanisms of change" (Joyce, 2006: 795; italics added, CN).

All this illustrates that we need to reframe the approach of researchers. The intermediate level between overall theories and verbatim utterances needs to be investigated at the level of (facilitative) process design and what this entails for intervening (Nelissen, 2010) not as some 'clinical strategy' level that irons out the very biotope of psychotherapy.

As we shall see below, this angle provides new units of analysis for characterizing practice.

Adequate Unit of Analysis: Decision Making

For rigour in grouping process elements, we need to have both eyes open: one on the subject matter of clinical decision making, and the other on the object of this clinical decision making, which is fundamentally different.

Our subject matter as practicing therapists is handling unique problems of this unique client sitting across us in the consulting room. For handling these, we systematically direct and pace the interaction between our clients and ourselves.

Our object for systematizing interaction, however, is something else. It is finding regularities in the constellation of the client's intrapsychic dynamics: what assets does the client have that we can make use of in helping him/her, and what needs to be worked on?

Back to our vignette. Our therapist is looking how the client's system of psychic functions might be handled to ameliorate her 'making relationships'. She inventorizes what she 'has got': according to an appraisal at her work, colleagues deemed the client as contemptuous of co-workers, yet at the same time "…a brilliant, skilled thinker, a dynamic consultant who was highly valued by clients" (Haberlin, 2007: 24). In therapy, as we have seen, the client refutes reflection, and does that in a counterproductive manner: "The tone and manner of her voice left me feeling slapped…" (ibid: 25).

Some of these properties are assets for change (her intelligence), some are blocking therapeutic work (refuting reflection). Our therapist collects evidence: the appraisal at work, the client's "…lack of social inhibition…" (ibid: 24); her own internal reaction to the client's primitive relating to her (feeling slapped).

What this therapist actually does is turning the wheel of client-change stroke by stroke. The axis on which this wheel turns is consequent reasoning, but even more consequential reasoning: a therapist takes one step at a time, reflecting on the consequences of what is being said/done (and what not) for the next building block.

An important shift in thinking about psychotherapy needs to be marked here. 'Process', namely, is too vague a term to indicate this moving forward; it is the intentional mobility we're after. Intentionally moving things forward, building block by building block, from one stage of 'therapeuticness' to the next.

Another shift in thinking about psychotherapy is considering that this intentional mobilization and motioning is not necessarily restricted to change as is often supposed; we might also seek to first empower the potential to change of the client (Nelissen, 2010), hence: from one stage of 'therapeuticness' to the next.

In our vignette this proceeding to strengthen the client's potential is shown when the therapist concludes from many forms of evidence (Haberlin, 2007: 25):

"She had limited capacity for reflection and was uninterested in seeing things from another's viewpoint" (ibidem). She adds in an endnote:

"Fonagy and Bateman posit that there is little point in attempting to attend to… the promotion of insight, until the capacity for reflective functioning and

mentalization has been instated…." [follow references MBT, CN] (ibid: 32–33).

In terms of 'units of analysis', what we are actually talking about is the following. The therapist collects evidence and looks for therapeutic agents. The intelligence of the client is potentially helpful; in other words: her intelligence is agentive in helping her move to more insight. Thus, the client's intelligence is what I would call a psychic function, which might be used as a therapeutic agent.

The client's limited capacity for reflection, on the other hand, seems to be counteracting change. In order to extend the potential of the client, the therapist starts with working on developing reflective functioning. This is done through relating directly with the client:

Ther: "I don't feel comfortable continuing with the session without acknowledging that we saw each other on Friday night in A&E [dept of hospital, CN].

She stared at me with a look of complete bemusement.

Client: No we didn't …. What do you mean?" (ibid: 27).

This tiny example of extending the client's potential (working on deficiency) by modelling contact and openness to the client, signifies a unit of analysis I would call a form of 'building therapeuticness'.

Now we have ingredients of a therapist's decision making on a level above verbatim exchanges, yet, more concrete than theoretical principles: (1) collecting evidence; (2) looking for therapeutic agents, and (3) building 'therapeuticness'.

In other words: in answering the question: Can we find patterns, meaningful ways of grouping what we actually do? These are our basic process elements.

Just a short remark on how far this angle is removed from what happens in usual care research at this moment. As I said above, at this moment, Goldfried's 1980 notion of 'clinical strategies' is being operationalized. This leads researchers in the direction of observational instruments for therapy processes, such as for instance the Therapy Process Observational Coding System-Strategies Scale (POCS-S) (Garland et al, 2010b: 211).

In the appendix of Garland et al (2010b) it shows what this entails: a dichotomy between techniques and content in an attempt, if I am getting it right, to find elements that can be aggregated on the level of items ('techniques') versus entire sessions ('content'). Techniques in the TPOCS-S, based on Goldfried (1980), are for instance: "Using positive reinforcement/rewards" with the concordant content being: "cognitive restructuring". Despite the consultation of practitioners (called "providers") (Garland et al., 2010b: 209), who were consulted for reviewing relevance to their usual care context (ibid: 211), I believe that with these categories, we plunge right in the middle of exactly those theoretical discussions the researchers try to avoid: "…characterization [of sessions, CN] at the… theoretical level has not been particularly useful in differentiating practice patterns or outcomes…" (ibidem). To prove my point, it suffices to pose a rethorical question: how 'cognitively restructuring' is the content of what our therapist in the example is doing?

What we need is a more sophisticated way of charting clinical usual care practice, with the help of the process elements I mentioned above. This will be shown in my answer to key methodological issues researchers posit.

Methodological Questions

The first methodological issue to address is defining a valid baseline (Garland et al., 2010b: 210) from which to assess work-in-progress. This means that we are looking to find elements that typify a (preferably: any) psychotherapy process, "…prior to intervention efforts to improve care…" (ibid: 208), so that we have a groundstructure for charting actual therapists' work. So, our main question is: what does a 'typical' psychotherapy process look like?

More specifically:

1. What are operationalizable and thus measurable process elements (ibid: 210)?

2. Structure elements: for improving care we need the possibility to form links (preferably in a causal way) between structure of care, process of care (treatment encounter) and outcomes (Burnam et al., 2009: 1). Structure is the equipment of the therapist. In our typifying of therapy processes, the connection between structure and process is optimal use of equipment.
3. Aggregation: the above needs to facilitate comparing items, sessions and/or therapists, so that we reach both internal (within session/process) and external consistency (between therapists) (Garland et al., 2010b: 215).

First Question: Process Elements

What is a 'typical'psychotherapy process? First, we need to define what a process in general is: "By definition, a process…is a sequence of states…a process involves a path; hence it is described by a sequence of more than two – perhaps infinitely many- states…" (Bunge, 1996: 24).

What can we distinguish as 'states' in psychotherapy processes, regardless of schools?

Considering the fact that we view psychotherapy as intentional psychic mobilization and mobility, we can identify clear process states in psychotherapy. States in psychotherapy process, namely, are in my view states in psychic functions of the client at different points in time.

Hence, as we have seen from the vignette, we already have process elements at hand at the intermediate level between 'utterances' and theoretical orientations, namely: a therapist's

(a) collecting of clinical evidence,

(b) identifying therapeutic agents, and

(c) his/her building of therapeuticness.

What these look like in vivo is directly connected to the structure elements we are seeking.

These will be discussed below.

Second Question: Links Between Process and Structure Elements

This is a subject we need to go into a bit more extensively: adequate links between equipment and process, namely, require that both our structure elements and our process elements are based on the same definition of psychotherapy.

New Definition

To turn the heads of researchers in the for us proper direction, therefore, I propose the following definition of psychotherapy, based on what has been said so far:

Psychotherapy is scientifically grounded systematization of client-therapist interaction, in which cure takes place through the considered use of the agency of the psychic functions of the sufferer him-/herself.

This view on cure as considered use of psychic functions of the client him-/herself, puts the therapist's reasoning about psychic functions of the client centre stage. This is a focus in line with EBP, in that it honours the centrality of clinical decision making, just as the EBP framework implicitly does; as we can see, clinical decision making ("CD" in Figure 1: The Framework Graph) is central to EBP:

From this definition we can turn to the methodological question: how are we to identify structure elements, given our view on cure?

To set a therapeutic process in motion, handle it consideredly, and provide a certain output, a therapist uses specific means, specific psychotherapeutic equipment.

Structure Elements: A Therapist's Means

Means are not the same as instruments. In order for means to be actual means, they need to have a clear, unambiguous relation to ends, objectives. Instruments are different. The instruments a therapist has, are manifold: lots of psychological theories, a myriad of exercises, ways of observing, talking, interacting.

The means to reach the objective of psychic movement that a therapist works with are only four: firstly, the setting as facilitative therapeutic space (the consulting room as physical place of retreat and mental place of transition); secondly, input of fundamental science about intrapsychic aspects in general; thirdly, his/her activity (design of the process and intervening in the broadest sense of the word); and fourthly: criteria as signposts along the way. All four have a specific character. I will discuss them shortly below.

Meeting Within the Setting: Ambiguity in a Shell

The first of our means is the facilitative space, here called 'Meeting' (with a capital M to signify the psychological depth of things). Its character and role is to hold and preserve ambiguity within an unequivocal structure.

In our descriptive model therefore, this specific relation between ambiguity and structure needs to be captured in the construct called 'Meeting'. What does this construct entail and what is the role of this 'Meeting' as a researchable means for therapy output?

First we need to note that ambiguity is not just a side-product of psychotherapy; due to psychotherapy's nature of transition, ambiguity is our very raw material; it is the honey for the bee; it is the blood in therapeutic veins. Without ambiguity, therapy would be no more than a talk.

To illustrate the difference, here is a flavour of this key stone of psychotherapy:

"We held each other's gaze, both understanding that something profound had occurred: what Stern…called a moment of meeting in which there is mutual understanding, mutual acceptance, mutual intentionality, mutual receiving of the other; 'I know you know I know how you feel'. Something more active had occurred than that which we traditionally refer to as containment, in which the therapist acts as a containing vessel, and it is key to working at relational depth; there are two interacting subjectivities and there is an interpersonal, mutually mentalizing space between us – we had together co-created and co-participated in a containing experience." (Haberlin, 2007: 30–31).

This is not to be romantic; it is about what psychic movement actually entails: renewed experiencing, renewed relating to oneself and the world. These words sound 'big'. Our objective, however, is not so much 'big' or romantic; it is complex. This complexity requires the practitioner to use a professional microscope on things happening in the session.

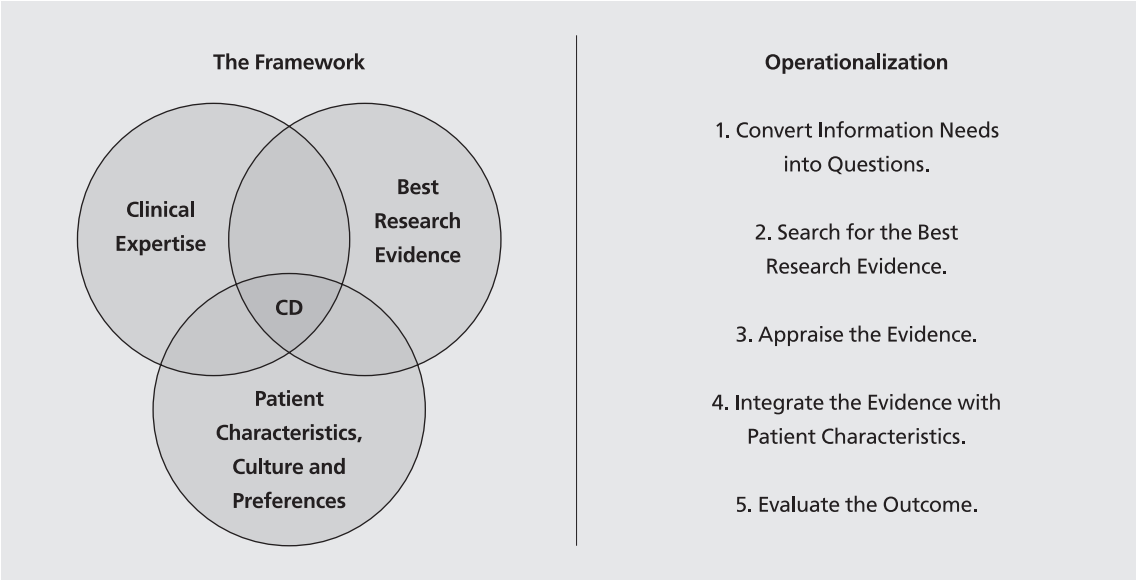

Figure 1: "Two Components of EBP" (Walker/London, 2007: 635)

If the Meeting is one of the means to process the input, how is ambiguity then being processed professionally?

In order to produce therapeutic output (work therapeutically), psychotherapy is first and foremost a process of transition. Transition is a 'crossing over' to something new and not having to 'cross over' to the new at the same time (Winnicott, 1971: 3; 17; 75–6).

This means that in the consulting room postponing action is key: therapist and client talk, in order to focus on the transition itself. The sound of the closing door marks in an absolute physical way (the philosopher Sloterdijk might say: in a geographical way) the fact that, from that moment on until the end of the session, that 'hanging'/ suspending experience between 'old' and 'new', between 'in here' en 'out there', that 'intermediate experiential space', is a fact.

Psychotherapy means that (at least) two people are working together behind a closed door. As our vignette shows, in that consulting room a specific sort of micro-cosmos is established, where therapist and client share 'interiority' (Sloterdijk, 2005: 75; 540–2). The latter is crucial, not some by-product. Whether we talk of psychoanalysis or CBT or anything in between: research shows that psychotherapy as well as its efficacy is fundamentally brought about in and through an interpersonal context (Verhaeghe, 2009: 126–7; 138; 204–207; Wampold, 2001: 137–141).

This shared interiority is nothing romantic. It can be beautiful, but in terms of therapeutic output it is not enough: this shared interiority needs to sustain psychic mobility. Therefore, what makes it into actual psychotherapy is the following.

Essential for the success of this 'intermediate experiential space' is excluding the world: here something happens between (at least) two people and between those people alone. What is important, is the fact that whatever happens is reserved for those who make it happen: the therapist and the client(s).

As I said above: ambiguity is not a by-product here; it is essential as motor of happenings.

To kick in an open door: the therapist is as much part of this togetherness as human being as (s)he is partaking professionally. Ultimately, the key of our professional activity is the fact that the inter-human and the intra-human is being explored with the help of human means and in an inter-human way. Preserving this ambiguity, this interpersonal co-creating of a fluid experiential space is key.

Hence, this ambiguity needs to be preserved. This is done through embedding the therapeutic session in a hard shell of a threefold structured context. The first structure is physical: therapist and client work in one and the same, or at least a formal consulting room. The second formalization is temporal: a session has a strict beginning- and end time (sometimes also a fixed number of sessions). The third formalization is social: therapist and client meet in clearly defined, specific roles, namely as therapist and client.

This explicit threefold structuring is traditionally one of the most striking properties of psychotherapy as form of treatment. This tough diamond with three unequivocal facets preserves something that is extremely ambiguous and fluid. The two are inseparable if therapy is to work. Only if this combination of humanness and hard shell of formalization is guaranteed, only then it is possible for therapist and client to concentrate on the experiencing and behaviour of the client and of the client alone.

While this part of our equipment is the space of intuition, of opening up the space for transition, of meeting as human beings, of betweenness and unthought known, the use of it in terms of accountability, is quite specific.

In order to facilitate mental mobility for the client, namely, the Meeting space is primarily the space where informal observation takes place (of both client presentation and of how interventions work out on the client). In other words: as part of the therapist's equipment, this is the space of collecting clinical evidence.

One could take this domain for the domain of therapeutic activity. I need to caution the reader here: we are talking about professional accountability, To gain clarity about therapeutic

performance, we need to distinguish data-collecting from a weighing of those data. Data collecting is a separate task in governing the process. In our case, it means we observe, even thought we perform at the same time.

The weighing of data (clinical manifestations) is different. This entails assessing how (mental) behaviour of both the client and ourselves can be used constructively. It is therefore an act of designing the process: conditioning the process for movement in the right direction. As such, it belongs to a different domain of equipment: therapeutic activity (see below).

Summarizing: as one of our means for the end of psychic mobility, the domain of Meeting is the domain of collecting evidence of how things are going.

Research, providing insight in the therapist's use of the domain of Meeting, will mean operationalizing what the therapist regards 'usable' psychic functions, how he or she collects relevant data, and what the observable 'evidence' is (s)he bases this on. Not so much predicting, as judgment research has it (Garb, 2005), but description and selection of data.

Using Fundamental Science

Fundamental science (psychology, neurology), our second means, is the one with which a therapist makes sense of pathology, etiology and happenings in the therapeutic space. Theoretical concepts (e.g., mentalization, basic fault, ego) are transformed into working hypotheses about therapeuticness, psychic motion for the client.

As we have seen in our vignette, the therapist refers to Fonagy and Bateman (Haberlin, 2007: 32–33) for considering the role of developing reflective functioning before promoting insight.

Science is the input a therapist uses to identify potential and actual agentic psychic functions of the client, and what therapeutic stance might be necessary to facilitate change.

Research about the therapist's use of this knowledge domain, could focus on operationalizing whether or not the therapist's choice of explanatory frame of reference is consistent with the evidence.

The Domain of Therapeutic Activity

This domain is the realm of 'what-to-do-knowledge': of designing the process and seeing what type of stance and intervening would be fitting (including non-verbal and mental activity).

What the therapist does is transforming input from the Meeting and from fundamental psychology into thinking about therapeutic agents and what is required in terms of the process to set these in motion.

The "I made a note to myself that she was able to 'split off' from her body" (Haberlin, 2007: 24) of our therapist, mentioned earlier, is an example of this.

We are inclined here to focus on the remark 'split off' as verbalizing the therapist's orientation. In terms of activity, however, we need to shift our attention to the beginning of the statement. The actual activity here is: 'I made a note to myself'. The therapist decided to keep things in mind and postpone confronting her client. Instead, she "…persisted in trying to draw her into some dyadic exploration" (ibid: 26).

How can this be made manifest in order to study it? Well, as we can see considering the extensive use of a vignette in this paper, in a way it is manifest, albeit hidden in files, case studies and in supervision reports; therapists are used to account for choices in treatments and how they organize their thinking. In fact, therapists all the time use working hypotheses, often not explicitly called 'working hypotheses', though. Much of the information, therefore, is there, yet for research sake it needs to be systematized so that it can be operationalized.

Consequently, research providing insight in the therapist's reasoning in the domain of therapeutic Activity/Mobility, will involve operationalization how (at this moment implicitly) identified therapeutic agents in the internal world of the client meet the chosen analytic frame as well as criteria.

Criteria: The Domain of Evaluation

Implicitly, or explicitly, a sophisticated therapist sets criteria; or at least he or she should do so in order to have signposts along the road. Therapeutic criteria is a separate means for the therapist to help him/her evaluate what is happening.

In our vignette, examples of criteria for change the therapist uses, are:

- (self-)object constancy: "… the sessions became linked to one another in Yvonne's mind,rather than existing as encapsulated discreet events as they had in the past…"

- relating: "She became curious about her self-with-other interactions…."

- narrative: "She began to want to own a narrative about herself…"

-mentalization: "… she was able to put words to the feelings…"

- emotionally charged insight: "…. The multiple losses of her life filled her with grief and yet she described the grieving as good."

- internal locus of control/boundaries to self: "…be in her skin, rather than suspended outside herself" (all: ibid: 29)

Of course, these evidentiary items are tailored to this particular client. Nevertheless, it is demonstrable proof of change, both in behaviour and in psychic functions.

Boundaries between these structural elements are fluid, yet each of them is a different reasoning space, with a different outlook and specific accents. Together they are our equipment in vivo in the consulting room.

Causal Links Between Process and Structure: Working Hypotheses

Let's now turn to the methodological question how these structure elements can be causally linked to the earlier identified process elements?

Connecting process elements to structure elements, means actually that we (re)view how we use the four means described above for process. The causality of for instance the 'Meeting' (as one of the means) on the quality of the therapist's collecting of evidence (as a process element) can be made manifest through a therapist's working hypotheses. In our vignette we saw how the relating of the client in the sessions leads our therapist to conclude about the client's limited capacity for reflection.

This, together with using fundamental science about mentalizing capacity (Fonagy and Bateman) leads the therapist to identify (counter-) therapeutic agents (one of our process elements) and deciding to build on the potential of the client first.

In my view, there is actual causality here, and not just correlation: the quality of the therapist's working hypotheses determines the adequateness of the process elements, hence it determines also the outcome. See Figure2.

Third Question: Aggregation

The last methodological question of the researchers is the one of aggregation. This topic merits a seperate study. At this point, I intuitively suppose that aggregation between items and/or sessions and/or therapists can be found in consistency in a therapist's set of working hypotheses, since for a sound process it seems to me these working hypotheses need to be logically consistent. What this looks like, however, will be the subject of a future article.

Conclusion

I hope to have shown here how 'usual care' research, in excluding therapist-client interaction, tends to miss the point of practice regularities in usual care. I hope also to have shown how researchers' issues can be addressed, starting form therapy as systematized interaction with the client.

Practice regularities can be found in the governance over the client-therapist interaction by the therapist (by which I mean design, management and execution of the process).

Psychotherapy treatment as cure, is here viewed as intentional mobilizing and motioning of the client's own psychic functions. The mechanism of this cure is optimizing the client's potential for change. This means that the therapist's responsibility is a continuous adequate weighing of potential of client, therapist and setting, against actual change in the client's psychic functions.

This has led to a specific view on process elements versus structure elements (therapeutic equipment).

Outcomes are to be measured in terms of use of means versus input. The latter is the different states in psychic functions of the client at any point in time.

Thus, a baseline, 'typical' psychotherapy process is the following:

a) Process elements: (1) collecting evidence, (2) identifying therapeutic agents, (3) building of therapeuticness (requirements of process and role), Operationalization of these for research might hinge on measures of psychic mobility.

b) Structure elements: (A) Meeting, (B) use of science, (C) therapeutic activity and (D) criteria to evaluate goings-on. Operationalisation of these for research might hinge on measures of consistency.

c) Aggregation: comparing items and/or sessions and/or therapists through norms for (logical) consistency in a therapist's set of working hypotheses regarding the connection of each of the process elements with each of the structure elements.

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PROCESS / MEANS	Observing & Collecting data	Identifying/Choosing Therapeutic Agents	Building of Therapeuticness
Meeting	Evidence gathering: - Observation - Listening - Self-observation	Evidence into agentive information: Data: - Narrative client - Body language &c.	Evidence into process information: Data: - Client's reaction - Therapist'sown reaction Testing of working hypotheses/empirical evidence
Fundamental Science	Selecting data/organizing information from evidence: - History taking - Life situation client - Client's presenting - Introspection	- Working hypothesis pathology/ etiology - Working hypothesis agentive/ counteragentive psychic functions client	- Working hyp. potential developments/ amelioration of pathology through process
Activity	Organizing data: - For mobilizing potential of client - For motioning agentive functions of client - For monitoring adjustment therapeutic agents	- Working hypothesis therapeutic agents process/interaction	- Working hyp. requirements of process - Working hyp. requirements of stance
Evaluation	- Criteria Meeting as evidence base* - Criteria Science for selection data from evidence Meeting**	- Criteria for validating approach - Criteria validation choice of (possible adjustments in) therapeutic agents - Criteria monitoring change	- Criteria for validating intervening - Criteria demonstrable proof/ evidence of change - Criteria prognosis further process

*e.g., content cognition client **e.g., (self)relational narrative client

Figure 2: Therapist's Means (Structure) Versus Therapeutic Process Elements

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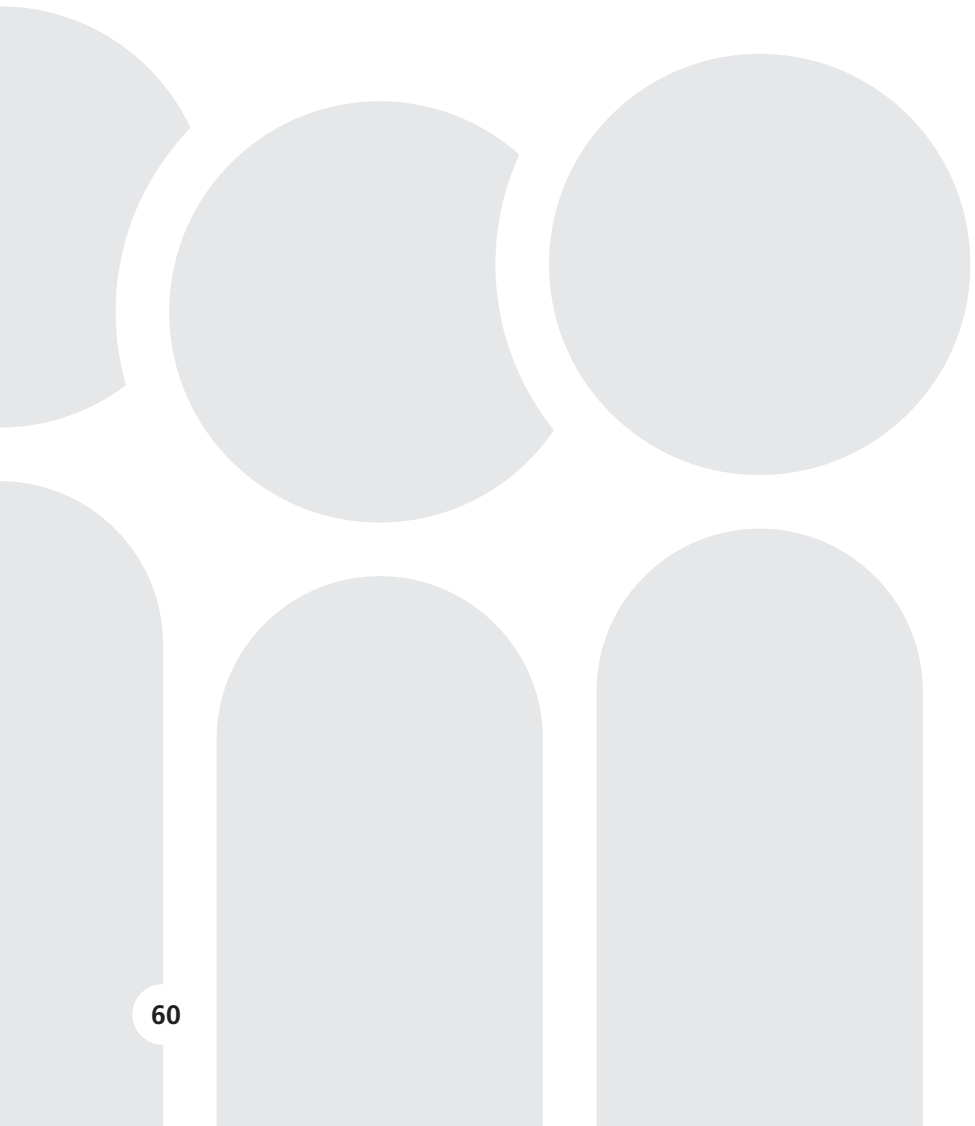

Maggie Morrow

An Integrative Psychotherapy Approach

Editors' Note

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

Section A

An Integrative Psychotherapy Approach

Introduction

In this paper I shall discuss my practice as an integrative psychotherapist. Section A below concentrates on the values, philosophies and theories which inspire my work. Section B describes the personal journey which led me to this profession. Section C describes the contexts in which I work as an integrative psychotherapist. Finally, in section D I use a case study to demonstrate how all this emerges in my integrative therapeutic practice.

The Values Which Underpin My Practice

The core values, which underpin my approach to psychotherapy, are respect, presence and partnership. Respect, for me, means putting aside judgement or personal agenda as far as I am able, in order to honour each client's inherent individuality, courage and creativity, their freedom to make their own choices and to change at their own pace. Respect also means personally valuing and communicating to the client (when appropriate) my own experiences, limits and boundaries within the therapeutic relationship. I think of presence as a willingness to meet with and be impacted by the other, in order to understand their experience through openness, honesty, compassion and self-awareness, as far as I am able. By partnership I mean, being able to view both client and therapist as equally important participants, in negotiating and creating a working relationship, whose aim is to facilitate growth for the client, which inevitably involves reciprocal learning. To prevent these values from simply becoming well-intentioned intellectual notions, I also endeavour to practice them in life outside therapy and to notice how both giving and receiving impact me.

The Philosophical Ground of My Values

Three philosophical traditions inform my practice, Buddhism, Yoga and Existentialism.

Buddhism and Yoga: Non-judgement and Self-pacing

I have had an interest in Buddhist philosophy for some time and I have been practicing Hatha Yoga for three years. I feel both traditions have deepened my own sense of physical and emotional awareness. My values of respect and presence are reflected in the Buddhist tradition (Rinpoche, 2002; Brazier, 1995), which places

a high value on compassion for self and others and suggests that we must know ourselves in order to achieve wisdom. Through observing 'what is' we learn to act according to our inner wisdom as opposed to reacting blindly to what life presents. It posits a core existential insecurity that is beyond the content of any individual story and the practice of meditation is used to learn to confront and tolerate this inherent sense of uncertainty (Epstein, 1996). The central principle of 'shikantaza' emphasises observing 'what is' without judgement, without desire to cling to or avoid experience but to simply accept that change is constant. I find this philosophy and practice sheds clarity on my internal processes thereby supporting my endeavours to be present and respectful in the therapeutic relationship.

My values of respect and presence are reflected in the tradition of Hatha Yoga. Hatha Yoga addresses our being in the world by working with the mind and body through the three practices of asanas (physical exercise), raja yoga (dialogic exploration of our desires and emotions) and karma yoga (doing work without the expectation of being rewarded). During asanas the teacher encourages pupils to notice how far their body can move into each posture and to work on the edge of growth through self-understanding and accepting personal limitations. This process strengthens the student's capacity to honour their own pace of improvement and facilitates the development of physical flexibility as opposed to 'strength' (Iyengar 1966; Vivekananda 1956/1982). Yoga practice has nourished my capacity to honour my own pace of change and increased my ability to learn from my emotional responses to life experiences. These personal changes have naturally filtered through to my client work and have enhanced my ability to attune my interventions to complement the client's pace of change.

The holistic philosophies of Hatha Yoga and Buddhism both maintain that, deeper self-awareness grows by paying equal attention to the communications of both the mind and body, with particular attention to the breath, which is seen as the life force (Epstein, 1997). I find paying attention to my own breath during the therapeutic encounter can help ground my capacity to listen to the client and take time to consider appropriate responses. Exploring the client's relationship with this aspect of themselves can potentially provide a rich source of information, and the practice of honouring personal pacing, compassion and non-judgement can complement a range of therapeutic theories.

Buddhism, Yoga and existentialism, all have a spiritual dimension. I am drawn to the Buddhist and Yogic view of 'God' being a state within us, which can be achieved through acknowledging our responsibility for the life we create, clearly an existential notion. Buddhism and Yoga link naturally with my interest in existentialism, which shares their focus on the ontological.

Existentialism: Free Choice and Responsibility

My values of partnership and respect are reflected in existential philosophy

which suggests that we are all confronted by the following existential truths.

That we are born into a world not of our choosing, which has limitations.

That in life we are free to choose, which makes us responsible for the life we lead.

That the only meaning life has is the one we give it.

That ultimately we are alone in the world, and we die (May, 1981).

I am particularly influenced by the concepts of freedom and responsibility, which are implicit elements of the therapeutic encounter for both parties.

Clients often enter therapy unaware or in denial of their free choice, what Kierkegaard termed an 'inauthentic' state of being (Yalom, 1980). Significantly, our existential choices will be mediated by the conditions into which we are 'thrown'. For instance, people can be powerfully constrained by environmental, socio-economic, political, cultural, familial, or physical limits, which impact their ability to exercise their existential choices. Ultimately decisions are anxiety provoking; they infer

personal responsibility, involve acceptance of loss and address the possibilities and limitations of life (Yalom 1980; May 1977). In therapy I aim to encourage client awareness of free choice and the accompanying responsibility. In this respect, I have found invaluable the writings of Laing (1960) who promotes respect for client choice, Frankl (1959) who observes the positive impact of meaningful choice and Fromm (1993, 1976) who expounds upon the value of accepting responsibility and the human desire to avoid the anxiety it provokes.

Negotiating Existence

Another aspect I value in existentialism is the notion that life contains three 'worlds' which each individual must negotiate. 'Umwelt'; the natural world, is the world into which we are 'thrown' and describes the biological determinism of our need for physical survival. This means we must eat, relate to others and face the limits of nature, which inevitably includes the socio-economic and political circumstances of the place and era into which we are born. 'Mitwelt' describes the world of interpersonal relationships, which we must negotiate throughout life. 'Eigenwelt' depicts our 'own world' that is, our relationship towards our self (May 1983; Yalom 1980). More recently others have proposed a transpersonal or spiritual dimension to the world, which suggests a need to relate to forces, which are beyond our self (e.g. Van Deurzen Smith 1988). I do not necessarily work with this element directly, since I see spirituality more as an implicit part of the therapeutic frame. For instance, I do not directly teach Buddhist and Yogic philosophy, but endeavour to maintain compassion and non-judgement in the relationship. I also recognise that clients may have their own view of spirituality, which underpins their way of experiencing the world and would be open to working with that.

I think exploring the client's existential 'worlds' in therapy illuminates the context and content of their historic and current relationship with life, self and others. This can facilitate self-awareness, the opportunity to acknowledge responsibility and the freedom to make meaningful choices in life.

Childhood and the Path to Individual Development

Through developmental theory I have come to understand the critical part interpersonal relationships play in moulding a person's relationship with life and the formation of their character. Abundant research supports this view and provides considerable evidence for the continuity of interpersonal experience from infancy to later development (e.g. Fonagy 1999; Stern 1988). In the following paragraphs I will discuss the developmental ideas which have influenced my thinking, beginning with early development and culminating in a depiction of the individual 'character styles' which emerge through the child's integration of early experiences (see Johnson, 1994).

Bowlby identified two styles of early relationship, secure and insecure, emanating from mother-child interactions. These evolve into three character or attachment styles: secure attachment, ambivalent attachment and avoidant attachment (Holmes 1993). More recently Ainsworth, Blehar, Waters and Wall (1978) identified a fourth, which they labelled insecure-disorganised.

The securely attached child demonstrates the capacity to self-regulate by its ability to create structure, make meaning, process affect and relate to self and others in a confident manner (Fonagy, 2001). The mother-child relationship is characterised by the mother's attuned and empathic responses to the baby's physical and emotional needs, thus providing a holding environment or what Bowlby (1988) called a 'secure base' (a phrase first coined by Ainsworth, 1982), which the baby can return to for comfort and support amidst its exploration of possibilities. Over time the baby internalises these experiences and uses them for emotional regulation and self-comfort. Part of this process is supported by the use of what Winnicott (1988) called 'transitional objects' which are inanimate objects to which the child becomes attached, such as a worn blanket or teddy bear. These are used to obtain comfort in mother's absence and enable the infant to claim magical control over external reality which is made real by the mother's support of this process. I think these ideas translate directly into the therapeutic setting and support my

view that providing a 'secure base' is essential for building trust and a safe space for client growth. This inter alia represents a powerful contribution to the process whereby the client can internalise the words or presence of the therapist as transitional objects for self-support between sessions (Winnicott, 1989). These views are also supported by neurological research which demonstrates how damaged areas of the brain, responsible for self-soothing functions such as empathy, can heal through experiencing a relationship embodying these qualities (Schore 1994; Siegel 1999).

According to Bowlby (1988) and Winnicott (1965), insecure attachment styles are rooted in failures in the child's 'holding' environment and result in neurotic and pathological patterns. For instance, the parent, often preoccupied with their own unmet needs (emanating from childhood), may experience difficulty in relating openly to the full range of their child's natural expression of instinctual needs. To manage the relationship they validate acceptable 'expression', whilst 'difficult' or 'challenging' expressions such as anger and distress are ignored, frustrated or punished. Thus what Winnicott (1988) called a 'false self' evolves as compromise formation within the child - in an attempt to create structure and meaning; in the context of the repressive limits of a parental environment that is not resilient enough to tolerate their 'falling apart' (Epstein, 1997). Severe pathological patterns may occur in cases where personal, social and/or economic difficulties result in the child being separated from the parent and placed in the care of other relatives or public institutions (Robertson, 1989). I find the Buddhist caricature of the 'hungry ghosts' - scrawny creatures with distended, red-raw stringy throats and swollen starving bellies, unable to take nourishment from the present because of their narrow throated 'craving' to be fed by unmet needs from their past - powerfully depicts the internal frustration and longing for a nurturing relationship experienced by insecure attachment styles (Epstein, 1997).

In ambivalent attachment parental relationships are characterised by inconsistency and over involvement or panic in relation to infant distress. As a result the child longs for and at the same time fears contact. This leads to an under controlled self, characterised in relation to the carer by over submissiveness, over dependence and/or adoption of premature responsibility (Holmes, 1993 p115–117). In therapy these individuals are likely to present as over compliant, transferring a terror of separation onto the therapist and inducing 'stifled' feelings in the therapist. Providing containment is the key therapeutic strategy in such cases (ibid, p163).

With avoidant attachment parental relationships are characterised by unresponsiveness to the child's feelings. Such children develop a fear of closeness and attempt to maintain a distanced contact with the caregiver; displaying an over controlled self with no overt aggression on separation (Holmes, 1993 p154,115). In adulthood these individuals often find it difficult to enter affectively into therapy, maintaining a deep fear of abandonment and using denial to avoid painful feelings. They are likely to transfer a terror of contact onto the therapist inducing bored or angry feelings in the therapist. Accepting their rage is an essential part of the therapeutic work (Ibid p163).

In disorganised attachment parental relationships are often characterised by frightening, frightened and disrupted maternal behaviour, familial violence, alcohol or other substance misuse and possible abuse (Fonagy, 2001, p136–139). These children demonstrate extraordinary controlling behaviour appearing to take control of the relationship with their caregiver. They also demonstrate dissociation, relationship violence and the inability to focus or control self behaviour. In adulthood, these individuals may demonstrate severe relationship pathologies resulting in what Kernberg (1987) termed 'borderline personality organisation'. The therapeutic relationship will be depicted by client enactment, provocation and attempts at manipulative control and the projection of inassimilable, 'alien' parts of themselves onto the therapist, inducing feelings of uselessness and incompetence in the therapist (Fonagy, 2001). Maintaining clear collaboratively defined boundaries plays a key role in therapeutic strategy (Yeomans, Selzer and Clarkin, 1992).

Winnicott's (1947) theory of hate, which outlined how identity can be forged through opposition, helps me consider the developmental roots of 'perverse structures' (for instance, a

desire to punish the other) which can evoke angry, punishing, 'nasty' feelings in the therapist. The schools of object relations and self-psychology further my understanding of the defences clients adopt to support these structures and the 'unbearable', 'un-nameable' longing, pain and rage of unmet needs buried beneath these 'defences'. For example, Kernberg (1985) provides an outline of the defences used by individuals with Borderline Personality Disorder. Other theorists, myself included, consider this premature character structure as present to a degree within us all. Features become more pronounced the more traumatic the background of the individual (Johnson, 1994). The defences described include splitting, denying or suppressing painful feelings and identifying with their opposite; projection, imagining the split off feelings are present in others who wish to inflict them back onto the projector; merger, wishing for or finding another who will mirror the self and attempting to engage in symbiotic relationships with them, and projective identification; getting the other to act out suppressed feelings which are denied by the 'false self'. (Yeomans et al, 1992; Ryle 1997; Hamilton 1993; Stone, 1986).

I also value Kohut's (1971) classification of the basic narcissistic human needs which need satisfying through early relationships. Mirroring is the need to be seen and admired, which develops healthy omnipotence; and idealization is the need to form an idealized image of the parent to experience a sense of merger, which demonstrates a healthy desire for connectedness. These ideas inform my understanding of the ways clients 'reach out' through mirroring or idealizing transference in therapy and highlight the importance of responding empathically, allowing the client to dwell in these until they grow out of them at their own pace. Inevitably as this process progresses there will be instances of what Kohut (1971) termed optimum failure on the part of the therapist in which a 'transmuting internalisation' takes place; that is, the client learns to internalise and recognise within themselves qualities previously attributed to the therapist, as valid 'strengths' and uses them independently for self-support (Cashdan, 1988).

In conjunction with these ideas developmental research helps me understand how periods of unsupported distress experienced by the child, influence their adult capacity to understand their experience and express their needs. For instance, a child who experiences abandonment at the age of one has not yet developed a verbal language to communicate their distress nor possesses the adult experience of a range of emotional states. Therefore, in adulthood such clients may not have words to express these experiences, which were felt by the body but not yet fully understood by the mind (e.g. Stern 1988, Siegel 1999). In a clinical context this concept has been cogently elucidated by Bollas (1987) via his concept of the 'unthought known'. These ideas have encouraged my interest in the value of facilitating clients' physical self-awareness as a potential route to self-understanding.

These concepts I have discussed also provide a useful model for understanding what parts of the client's presentation relate to early childhood experiences and how 'transferences' of past experience can emerge out of awareness into the present, distorting current 'reality' and the client's capacity to manage it. As discussed above they also give me ideas on how to work with these issues. The principles of 'Shikantaza', supervision and exploring similar issues in my own therapy, support my capacity to stay empathically present and notice when these aspects emerge. I also find the writings of Johnson (1994) and Erskine and colleagues (1999) help me identify the various forms of client communications which have a defensive function or aspect and provide useful suggestions for interventions to facilitate exploration and client internalisation of compassionate self-care. Additionally, Erskine et al. (1999) provide a valuable outline of eight types of human needs, which can be met through relationship - security, valuing, acceptance, mutuality, self-definition, making an impact, having the other initiate, to express love - and how to attend to these in the therapeutic relationship so that the client feels 'met' and further healing can take place. Later I will demonstrate how I integrate these ideas into action in the case study.

Returning for a moment to Winnicott's notion of the 'false self' discussed earlier. I find the transactional analysis (TA) notion of 'scripts' provides a useful model for understanding how cognitive processes affect the functioning of the

individual and the maintenance of the 'false self'. TA theory suggests that 'script' decisions are made in childhood and are part of the developmental process of making meaning and putting a structure to experience. These scripts then become the basis for managing future experience. 'Scripts' are formed in response to communications from the primary carer, which contain injunctions or attributions, which instruct the child how to be in order to remain in the carer's favour. An injunction is a prohibition or inhibition of the child's free behaviour which reflects the fears and desires of the 'Child' in the carer and is punished when disobeyed. Attributions are communications which 'define' the child's character and are reinforced with rewards (strokes in TA terms) from the carer. Either may be communicated directly or indirectly, for instance, the child may be told they are bad for not obeying orders (injunction) or they may be named after their parent with the expectation that they will follow the same course in life, for instance, become a doctor like father (attribution) (Steiner 1974; Stewart 1989; Berne 1964).

I find these ideas help me understand how the child uses thinking to deny and suppress their own needs in order to adapt to the parental environment and in doing so identify with these 'scripts' which facilitate their survival. Additionally they alert me to the possible types of communications that might suggest the presence of a 'false self' 'script': for instance, some statements prefaced by the words 'I should', like 'I should do what I'm told'. I will discuss how I use these ideas later when I describe my integrative framework and illustrate how I put them into action in the case study.

From Children to 'Characters'

Johnson's (1994) work on 'character styles' naturally integrates my interest in developmental theories, existentialism and bodily expression. Based on a number of perspectives, Johnson posits seven basic character styles which people adopt as the outgrowth of their physical and mental attempts to deal with one basic existential issue, within the limits of their developmental capacities and childhood environment.

Johnson outlines development in three phases. Stage one relates to early childhood issues of attachment and bonding (a la Bowlby) - involving the infant's exercising of initial instinctual needs in relationship - the frustration of which produce oral or schizoid structures. Stage two, relates to the child's initial attempts at individuation within dyadic relationships (drawn from research by Mahler and Stern) - involving exercises of movement away from and back to the caregiver, which underlie the development of a firm sense of self - the frustration of which produces narcissistic, symbiotic and masochistic structures. Stage three involves issues of self in the system, encompassing triadic or higher number relationships involving love, sexuality and competition, the frustration of which results in Oedipal issues in the histrionic character or obsessive-compulsive structures. Johnson then delineates seven character styles giving them human labels, the hated child (schizoid), the abandoned child (symbiotic withdrawal / oral), the owned child (symbiotic character), used child (narcissistic), defeated child (social masochism), exploited child (hysteric) and disciplined child (obsessive compulsive). He gives useful descriptions of the cognitive, behavioural, physical and emotional qualities of each character, specifies what has not been learnt or resolved and elucidates the required context and learning processes necessary for growth and resolution. In the initial stages of therapy his ideas help me to form tentative hypotheses regarding therapeutic strategies for maintaining a working partnership, which respects the client's developmental capacities.

I appreciate Johnson's (1994) suggestion that each individual may be understood as a mixture of characterological issues and levels of functioning within a context. In this respect he advocates a dimensional model which purports that at different times, in different circumstances, our functioning capacities vary along a continuum from 'high functioning' to 'low functioning'. For instance, an individual may function well most of the time and only operate on disorder (low) level when dealing with 'key issues' under stress or without enough support. I find this a valuable reminder of the importance of working with clients contextually.

Engaging the Freedom to Change

As I have outlined in the previous paragraphs, in order to negotiate repressive environments children suppress their instinctual needs and adopt a more 'acceptable' 'false self' which provides structure and meaning to their life. This 'abandonment' of the 'real self' results in an inner-conflict between impulse and will and suppressed needs persist in some manifestation of unhappiness, depression, anxiety, anger, isolation or interpersonal difficulties. These symptoms often drive people to seek psychotherapy in the hope that it can help them 'feel better'.

In the therapeutic setting, I agree with May's (1983) view that meaningful change must be rooted in our sense of 'self' otherwise, changes become adaptations or compensatory structures, which are not truly felt and cannot be maintained. I value the gestalt notion that the 'self' is not a set structure but 'a way of being', depicted as an intersubjective process, which evolves and grows through contact and assimilation of experiences with others and or the environment (Perls, Hefferline and Goodman, 1951). Therefore I am naturally influenced by the gestalt 'paradoxical theory of change' defined by Beisser, which suggests, that people change not by engaging willpower in an attempt to become who they would like to be but through awareness of their 'way of being' and 'self-acceptance' (MacKewn, 1977). I think these views are reflected in the philosophies of Buddhism, Hatha Yoga and the developmental theories I outlined earlier.

In line with humanistic and existential views, I think therapeutic change is facilitated through the provision of a relationship which contains the core values of respect, presence and partnership provided to serve client self-awareness (Cohn, 1997; Clarkson and MacKewn 1993; vanDeurzen-Smith 1988; Yalom 1980). I think this view is supported by the gestalt notion that healing takes place through therapist willingness to be available to openly meet the 'whole being' of the other, or what Buber described as an I-thou (genuine) meeting (MacKewn, 1977). As outlined in the previous paragraphs our adult 'way of being' is impacted by interpersonal relations and if these are unsupportive, our internalisation of these others (objects) can contribute to a 'self'-destructive 'character style' (Johnson, 1994). Therefore, I also think change emerges through the provision of a 'good enough' object, which the client can then internalise in order to empower a more 'self'-nurturing capacity within themselves (Hamilton 1992; Cashdan 1988).

Alongside these ideas, I think the hopeful expectation that change is possible and a personal desire to work toward change are crucial motivating factors for the client (Hubble, Duncan and Miller, 2001). I think the existential notion that we have the freedom to choose in life can provide considerable hope for an adult client whose freedom was powerfully mediated by repressive circumstances in childhood. Furthermore, I concur with the existential notion that meaningful change occurs when clients are able to accept responsibility for their freedom to choose, within the limits of their adult 'life', and can manage the anxiety this provokes (Yalom, 1980). Additionally, I believe therapeutic exercises and techniques can provide clients with additional structures to support their journey towards change (Hubble et al, 2001).

Ultimately, the above ideas help me provide the space for the client to activate what Rogers defined as our 'self actualising tendency', in other words our fundamental human motivation toward growth and development and our capacity for self-healing (Greenberg et al, 1993). Finally, these factors that I have discussed are strongly supported by research in this field (Hubble et al. 2001).

Please note that I see these factors as precursors for facilitating change with individuals who can demonstrate a capacity for some personal insight and interpersonal relationship. I am not suggesting this necessarily applies to individuals suffering from severe and enduring personality disorder, psychosis or organic conditions.

The Fundamentals of My Practice: Integration as a Pathway to Change

In the following section I shall outline my integrative framework, which is the basis for my therapeutic practice. It is drawn from an integration of the philosophies and

theories outlined previously, which underlie my core values of presence, respect and partnership and it incorporates the ideas I postulate as agents for therapeutic change. Initially, I shall describe the different aspects of my frame and how these come together to represent the client's 'characteristic' way of being in the world. Following this I will discuss how the frame works in action with clients in the therapeutic setting. In doing so I aim to illustrate how I hope to facilitate the process of client 'self' awareness.

The Basic Elements of My Integrative Frame

The diagram below (figure 1) draws on ideas outlined by Sills, Lapworth and Fish (2001) and provides a framework for the pieces, which make up my integrative view of the client's experience as a whole.

I will begin at the centre of my frame with the 'self' made up of two parts, 'Child' and 'Adult', which are roughly based on the similar notions in transactional analysis (Steiner, 1974). 'Child' characteristics represent unmet needs from the past which can result in affective experiences that confuse or overwhelm the client and also contain 'self' and 'other' directed scripts which are critical, judgemental and punitive, fostering a range of painful feelings. 'Adult' characteristics are attuned to current reality and give the client a sense of meaningful connection with 'life'.

Attached to the triangle surrounding the 'self' are the human processes of thought, feeling and behaviour which the 'self' utilizes to negotiate a way of being in the world. The world is the context or 'life' into which the 'self' is 'thrown' through birth. This is viewed from an existential perspective which consists of the three 'worlds' I mentioned earlier - 'instinctual', 'internal' and 'interpersonal' (see page 3). By its nature, 'life' exists within a time frame, which has a past, present and future, represented by the outer diamond. Past life represents the client's history, current life consists of experience outside and inside therapy during the therapeutic contract and future life represents the client's hopes

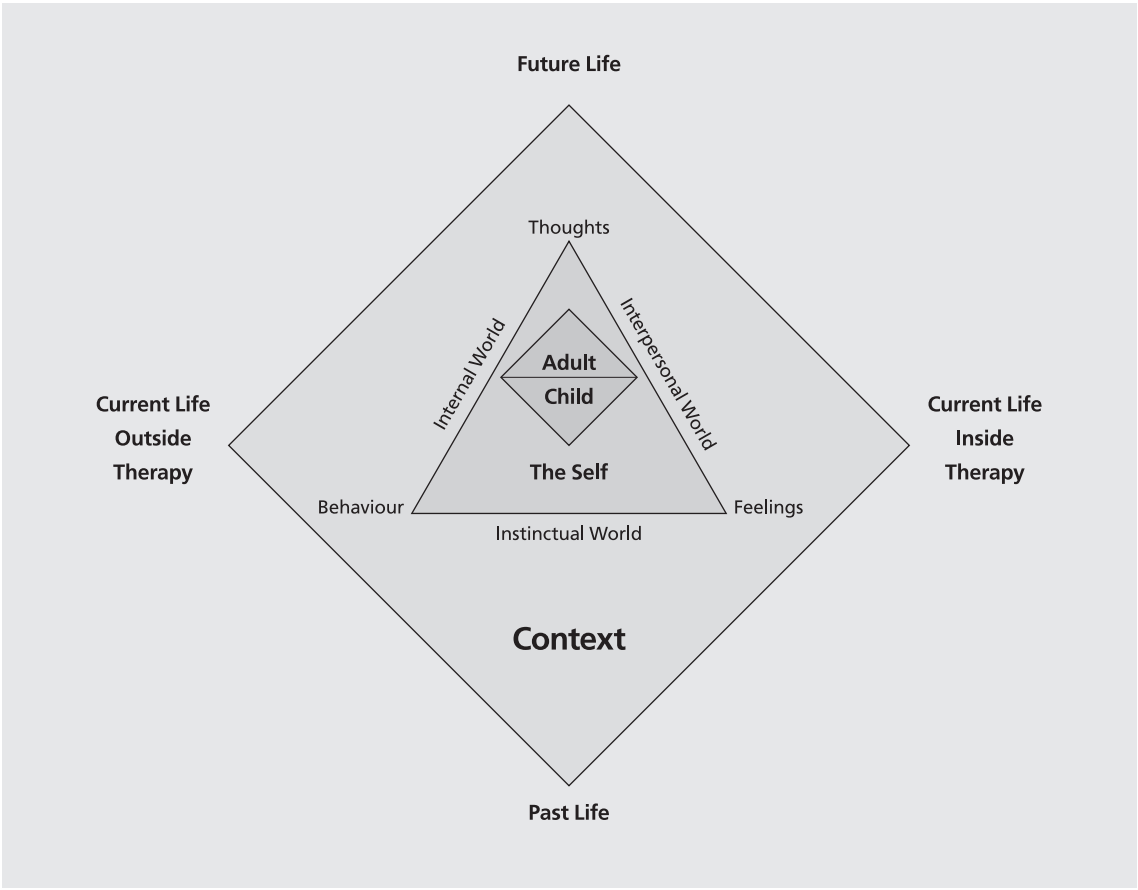

Figure 1: My Integrative Frame

and fears about their future. All the pieces of the frame come together to form the client's present 'character structure' in relationship with the context of their life (Johnson, 1994). I am aware that these parts and structures also emerge in myself and I will discuss this further in the Case Study Section.

The frame provides a 'containing' structure within which an exploration can take place, of the different pieces, which make up the client's experience within the context of their 'life', both separately and inter-connectedly as a whole. The process of integration takes place as the client becomes more aware of their way of being, how this has been influenced by past experience and how this impacts their current reality. Ideally, this process empowers client respons'ability' to make meaningful, self-affirming choices in their current life. I use the gestalt phrase respons'ability' here because, it places the existential notion of responsibility within a context which honours the client's capacity to respond to situations in accordance with their developmental abilities, as discussed earlier.

The gestalt notion of 'figure-ground' describes the flow of interaction between client and therapist within this therapeutic frame. It suggests we cannot see all that exists at once, the 'ground', and therefore we select things which interest us, 'figure', as our attention traverses the ground. Each chosen 'figure' recedes into 'ground' as a new 'figure' takes its place. Through this process we make sense of our experience (MacKewn, 1997). Adopting a humanistic view that clients are experts on their own inner experience (Perls et al. 1951) I then see the client as agent of what is figural from their view of 'ground' and my role in the partnership is to support their exploration of 'self' awareness in relation to what is 'figural'. Through this process I aim to establish a 'bond' and agree the tasks and goals of therapy, which Bordin (1979) has defined as the three essential components necessary in forming and maintaining the working partnership. In the following paragraphs I shall discuss how I aim to strengthen the therapeutic bond, later I shall outline some therapeutic tasks, which when supported by the therapeutic bond can facilitate client awareness and finally, I outline ideas which support my collaborative approach to clarifying and agreeing therapeutic goals.

My Integrative Frame in Action

I move on now to look at how my frame works in action with the client. My basic aim is to be as fully present as possible in order to respect the client's way of being and provide a secure base to facilitate self-exploration. Drawing on the Buddhist and Yoga practices outlined earlier, I try to achieve this firstly, by clearing a space in my mind and body in order to listen carefully to the client and notice their 'characteristics', by paying attention to all forms of expression, verbal; dreams, fantasies, stories and non-verbal; physical presence, whilst objectively observing the impact their story and 'way of being' has upon me. In support of this process I attempt to maintain a gestalt stance of 'creative indifference', which is similar to the Buddhist notion of Shikantaza mentioned earlier and denotes a position of being warmly involved in the whole person of the client and their dilemmas, without an investment in the 'success' of any single aspect or outcome of the working relationship (MacKewn, 1997).

I communicate my involvement in the partnership through a combination of 'empathic inquiry', 'involvement' and 'attunement', drawn from the integrative depiction of this process outlined by Erskine et al. (1999). Inquiry is a process of asking - not just with questions; a statement, a tone of voice, a gesture can all be part of inquiry - about every aspect of client awareness, whilst respecting their wisdom about what things are important and helpful to talk about and the courage with which the client has maintained their defences. 'Involvement' means being fully present to the client as another human being that is willing to be affected by the client in relationship. And to express this experience in a manner that is attuned to the client's developmental level, committed to client welfare and professionally acknowledging and addressing therapeutic limits both contractual and personal. Attunement begins with and goes beyond empathy because "it involves the deeply personal response of the hearer as well as the intent of the speaker" (ibid p46) and respects and responds to the client's developmental level. It is attunement that guides my therapeutic enquiry and shapes the nature of my therapeutic 'involvement'. In addition to these ideas I value the process, central to person centred psychotherapy, of

summarizing and reflecting back to the client my sense of their experience (and my own when appropriate) in order to clarify whether they feel understood or not (Mearns and Thorne, 1988).

To understand the unconscious interpersonal processes which take place between client and therapist, I work with the transferential, countertransferential and real relationship. I am aware that there is a range of diverse views regarding what constitutes a transference relationship (Bollas, 1989; Clarkson, 1995; Jacobs, 1988; Giovacchini 1989) and in using this terminology I do not wish to give the impression that these are clear and distinct categories. However, by separating them and using simple definitions for supervisory purposes, these concepts help me identify potential client issues and areas where I might need support, whilst also providing an opportunity for here and now experience within the therapeutic relationship.

I view transference as experiences from the client's past which are transferred, out of client awareness, onto the therapist who is then experienced as an historic 'object'. In a similar manner, the therapist is also susceptible to transferring their historic experience onto the client. I see countertransference as the responses evoked in the therapist in response to client transference (e.g. Jacobs, 1988). I find the object relations concepts of projection and projective identification clarify the transference relationship further. I like to think of projection as what happens when a client splits off unassimilable feelings onto the 'other' and projective identification is when the 'therapist' identifies these projections as their own and acts them out (Cashdan, 1988). I view the 'real' relationship as the moments of I-thou or genuine meeting when both client and therapist are truly present as themselves and open to acknowledge the 'whole being' of the other (MacKewn, 1977). Part of my commitment to being present in the relationships involves my willingness to disclose information about myself when it can serve client awareness (Yalom 2001; MacKewn 1997). I find the 'here and now' potential of the 'real' relationship creates an opportunity for 'self' healing, by providing the client with a space to affectively work through suppressed emotions, which fuel 'Child' defences, and have these witnessed and honoured empathically by the therapist (Greenberg et al, 1993). The manner in which I work with these aspects is discussed in more detail in the Case Study Section.

Whilst I do not adopt a Jungian approach, his writings have inspired my interest in aspects of the client's 'unconscious' experience, such as communications in dreams or fantasies (Jung, 1933/1961,1961/1977). I think exploration of these can provide a rich source of cognitively uncensored data. I value a gestalt approach in this area because it emphasises the primary importance of the client's view and considers each aspect of the dream as representing a part of the client. Exploration involves asking the client what sense they make of their dream and if they are interested, building 'internal' awareness by encouraging them to view or enact each aspect of the dream as part of themselves and explore what meaning this makes for them (Zinker 1977). Any interpretation I might offer is presented after the client has considered the dream first and as another view rather than the truth, which the client can choose to consider or reject.

I view ruptures in the working partnership - that is when the client feels treatment is not helpful or loses trust in the therapist - as co-created; this means I do not simply attribute them to 'client resistance' but see them as possible empathic failure on my part. I address them in a similar manner to Greenberg et al. (1993) by asking the client to describe the problem and encouraging mutual exploration of the situation, including an honest examination and disclosure of my role or responsibility for the problem. I agree with many other therapists that addressing and working through ruptures can produce powerful therapeutic movement (Dryden, 1992) and that we can learn as much from our mistakes as from the times we get it right (Casement 1985; Yalom 1989/1991).

Finally, a key aspect of my responsibility regarding the therapeutic partnership involves outlining the boundaries and limits of my practice, such as confidentiality, length of contract and availability. I discuss these issues in more detail in Section C.

Through the resulting partnership, I begin to piece together a picture of the client's

'characteristic' way of being within the context of their 'life', both past and present. I then form working hypotheses regarding their attachment and 'character style' and attempt to moderate my relating style to attune to their relational needs, respecting what is figural for them with the aim of building 'self' awareness. I will demonstrate this process in action in the Case Study Section.

Exercises for Self-awareness

To complement the relational work for developing the therapeutic bond as described above, I find a combination of gestalt, transactional analysis (TA), cognitive analytic therapy (CAT), cognitive behavioural therapy and solution focused ideas useful. I think these models offer the client more opportunity for choice and strengthen their capacity for responsibility, whilst facilitating self-awareness. By providing clients with self-supporting techniques, an opportunity to observe 'what is' and the possibility of exploring their experience in manageable 'pieces', this can help them see how to move around the frame of their experience outlined in figure 1, allow them to step back and think about their experience, use their 'Adult' and realise they are not stuck in their feelings at the internal process level. I will give one or two examples of these methods below but chiefly illustrate how I integrate them into my practice later in the case study.

Some writers use the language of energy to describe how suppressed needs and emotions get translated into rigid body structures. For example, Reich (1942/1970) outlined how clients use 'character armour' or physical rigidity, such as holding the breath, to both suppress and fight the energy flow of disallowed 'impulses'. Gestaltists talk about body energy along a continuum where at one end, held back impulses are 'retroflected' energy, which lead to bodily tensions, somatic illness, depression or even self-harm. The other polarity represents impulsiveness or unrestrained expression which can lead to dangerous behaviour towards self or others (Joyce and Sills, 2001). Gestalt exercises are then designed to facilitate the release of these repressed energies and help bring cognitively censored thinking or feeling into awareness. An example would be to ask the client to put words to a physical movement they are making. This process of learning through observing the body is also reflected in Buddhism and Yoga. Other experiments using objects to represent and explore sensation can support 'Adult' observation of experience from a distance thereby, reducing client potential to become 'overwhelmed' by painful 'Child' issues. Greenberg and colleagues (1993) provide an excellent account of when and how to use a range of different exercises effectively.

The TA notion of 'scripts' discussed earlier provides a useful model for exploring the client's 'self' described in my integrative frame. They illustrate how internal cognitive structures influence thinking, feeling and behaviour. How thoughts were formed for self-protection against the full awareness of ('Child') needs not met and then how these thoughts are reinforced by substitute feelings. For example, 'depression' may be used to replace natural impulses such as anger, which was not allowed. As clients become aware of their adaptive behaviours, I concur with Johnson's (1994) view that presenting them with a developmental reframe of the child's attempt to deal with existential issues in their environment, can prompt compassion and self understanding and reduce shame and self denigration. This honouring of 'defence' strategies born out of childhood adaptations is central to the manner in which I respect the client's way of being (see Section D).

I find CAT (e.g. Ryle, 1997) diagrams help illustrate repetitive patterns, how client's get stuck in them and options for escape. CBT can offer client's alternative coping strategies for containing symptoms of anxiety or depression and increase understanding of the cyclical processes which feed 'anxious' or 'depressive' symptoms (e.g. Padesky and Greenberger, 1995 and 1995a). Solution focused therapy gives me useful ideas regarding language that can facilitate client agency in clarifying goals and identifying hidden strengths for self support (Furman and Ahola 1992; De Shazer 1988)

I am aware that some of the exercises described in the previous paragraphs can become a way of avoiding painful processes in the therapeutic relationship by 'doing' rather than being with 'what is'. In this respect, 'context' plays a crucial part in helping me

consider when exercises will support the work. This includes my understanding of the interpersonal processes between client and therapist, the client's history and the issues which are currently figural for the client both outside of therapy and within the therapeutic relationship at the time of the session.

Through the methods outlined above, supported by the theories and philosophies discussed earlier, I hope to facilitate client awareness and strengthen their own self-healing capacity. Ideally, increasing their capacity to embrace responsibility and the freedom to choose a way of being that is meaningful to them.

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Book Review by Charlotte Sills

Tales from the Therapy Room: Shrink Wrapped

By Phil Lapworth
(SAGE Publications, 2011)

This book is a delight. It is comprised of ten fictional stories – told in the first person by a fictional therapist. The stories involve a fascinating cast of characters – from Cheryl, the sultrily beautiful romantic in search of love - to Luke, the 'spiritually wounded' 40-something - to Lee, the young offender 'wired like a whippet in a cage' Each story addresses a different aspect of the therapeutic endeavour. Some of these aspects are the challenges of any therapist's consulting room - issues like boundaries, misunderstandings, working in and with relationships, working with sexuality or spirituality. Some concern more unusual circumstances … from the transpersonal to the theatrical! Each story invites us into the usually unseen world of the therapy room to witness what goes on there between therapist and client and, particularly, what the therapist feels and thinks during and between sessions, as he endeavours to engage effectively with the situation.

A taster: In 'Holding Boundaries', the therapist faces the dilemma of what to do with his suspicion that two of his clients may be meeting outside the therapy room. 'The Carving' explores the nature of the therapy room itself and how the introduction of a wooden carving affects each client in a different way, and how one particular client employs the carving to his own ends. 'In at the Deep End' concerns trust in relation to both client and therapist. In an ironic turning of tables, the therapist (along with the reader) is left unsure as to what he can and cannot trust, while his client, having worked through her rather paranoid approach to life, goes off swimming with sharks!

But 'Who is this mysterious therapist?' readers will wonder to each other. Who can he be? He is certainly not Phil himself… Why, Phil never wears a suit! Whoever he is, the richness of the stories lies in the blend of qualities which are, without doubt, a fundamental part of the author. On the one hand, we feel Phil's loving sensitivity and understanding for the human condition and the stories are, at times, deeply moving. On the other hand, an irrepressible humour shines through the words. I love the fact that some of the situations completely take the therapist by surprise, while others – ones that I might find difficult – seem to leave him unfazed. Yet they are all written with a wry wit that is extremely amusing, while never for a moment failing to take seriously the plight of the client. I laughed out loud many times – and if you ever get the chance to hear Phil read some extracts aloud, don't miss it. His delivery is delicious.

Perhaps the cherry on the cake is Chapter 11, which is called 'Unwrapped through discussion'. Here the therapist muses and reflects on the stories, taking them seriously as real therapeutic situations. For each story, he shares how he thought clinically about the client and the situation, how each can be discussed theoretically, his clinical choice points, the options he had and why he made the decision he did. He invites the reader to think about his or her own thoughts and opinions – what would they have done in that situation? How else could the issue be addressed? Phil offers

some provocative questions to stimulate debate. It is an absolute treasure trove.

The 'lay' reader may not bother to read Chapter 11, and still get enormous pleasure from the book – particularly if they have ever been in therapy or contemplated it. The book itself does 'unwrap' the person of the therapist in an extremely delightful way. But for the therapist reader, engaging with Phil's thinking and clinical decision-making is an enormously rich learning and adds an exciting dimension to the book. I recommend it to every trainee of any approach to counselling or psychotherapy and to any qualified practitioner who would like the opportunity first to be entertained, and then to take part in a collegial debate in the comfort of their own home!

Do buy it and read it. You will be diverted, stimulated and invited to stretch your mind. What could be better?!

Book Review by Tom Warnecke

Anatomy for Psychotherapists?

A review of 'Anatomy & Physiology for Psychotherapists: Connecting Body & Soul' by Kathrin Stauffer

What could anatomy contribute to psychotherapy you may ask. Psychotherapy is typically practised as a "talking cure" after all. But looking across the proverbial fences of specialisation is becoming increasingly important at an age of compartmentalisation. Modern neuroscience would not have succeeded to unravel the mysteries of psycho-biological phenomena without interdisciplinary dialogue for instance. This book aims to build necessary bridges and explore some essential links between biological and psychological aspects of the human body.

Readers acquainted with neuroscience publications will be familiar with frequent references to the "body" and bodily experience, seen as indispensable references for subjective perception and the functions of the mind. The renowned neuroscientist Damasio argued that body states form the neural substrate of selfhood and described selfhood as a repeatedly reconstructed biological state. Neuroscientists have little to say about the particulars of psycho-biological functions outside the brain however. Stauffer's book starts at this very point and succeeds in making both our anatomy and its psycho-emotional aspects accessible in plain and simple language.

Each of the major body systems, such as the central nervous system or the respiratory system for example, has a dedicated chapter. The author selects anatomical facts for their relevance for psychotherapy and the psycho-emotional functions of each body system are illustrated by clinical case material. Case vignettes are well-developed and give a taste of how body psychotherapists achieve to integrate body and mind in clinical practice. The only letdown is the chapter on musculature which appears a bit out of date and lacks the contemporary feel of other chapters. This is disappointing since some of the most exciting recent developments in our understanding of reciprocal relationships between psychological and physiological aspects of being involve the sensory-motor system. In particular the roles played by psyche-motor skills in our self- and ego-functions, our confidence and autonomy, but also in informing mental perceptions and belief systems.

Stauffer's book is well placed to de-throne the classic 'Job's Body: A Handbook for Bodywork'. Deane Juhan's text book, considered the anatomy bible by generations of body psychotherapists, was conceived to cover the broadest range of body therapies and included much detail of limited relevance to psychotherapy. And Stauffer is contemporary: 'Anatomy & Physiology for Psychotherapists' incorporates and benefits from the neuroscience developments coming to light in the last two decades.

But is this publication clinically really relevant to psychotherapists who do not work directly with the body? I would argue it is. All body states are accessible to direct experience. We do not need to work actively with the body to utilise the insights and connections arising from observation and awareness

of the human organism. We have a broad range of tools available whether we call them self awareness or mindfulness, meditation, mentalization or free association. All these activities allow us access to direct experience of our living body. Stauffer's book provides us with essential references to think about and understand many of the phenomena we observe or experience. Whatever my clinical orientation, it may be crucial for me to see and hear when my client is in a state of sympathetic hyperarousal and have the basic knowledge to guide my responses or interventions. It may be equally important to observe how some part of my physiology becomes activated in my countertransference and to utilise my observations in the therapeutic process.

Anatomy & Physiology for Psychotherapists is essential reading not just for body psychotherapists but for all psychotherapists interested in psyche - soma relations and for anybody wishing to learn about the psycho-biological building blocks of human functioning.

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