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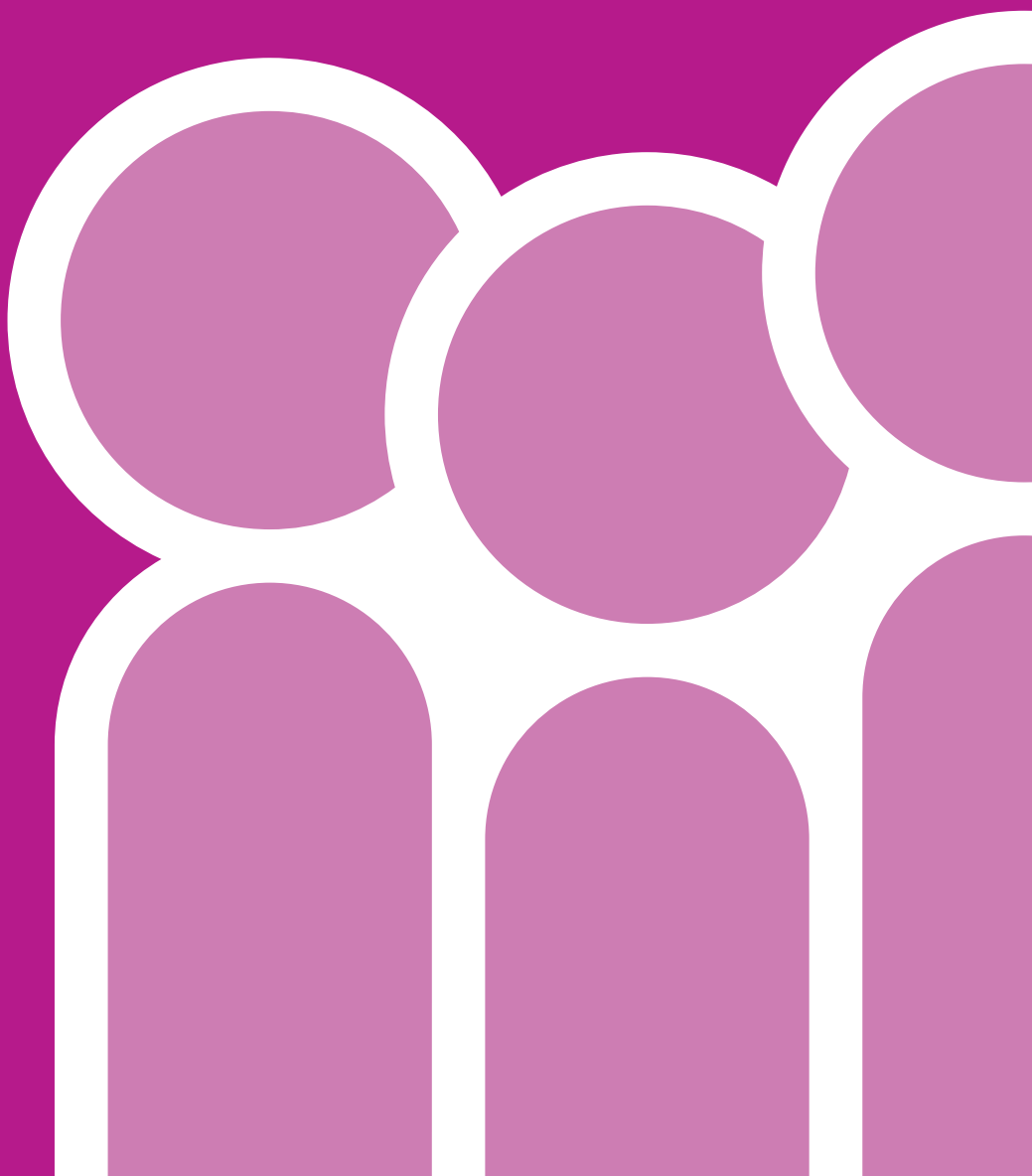
On Being An Integrative Psychotherapist



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Introduction

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

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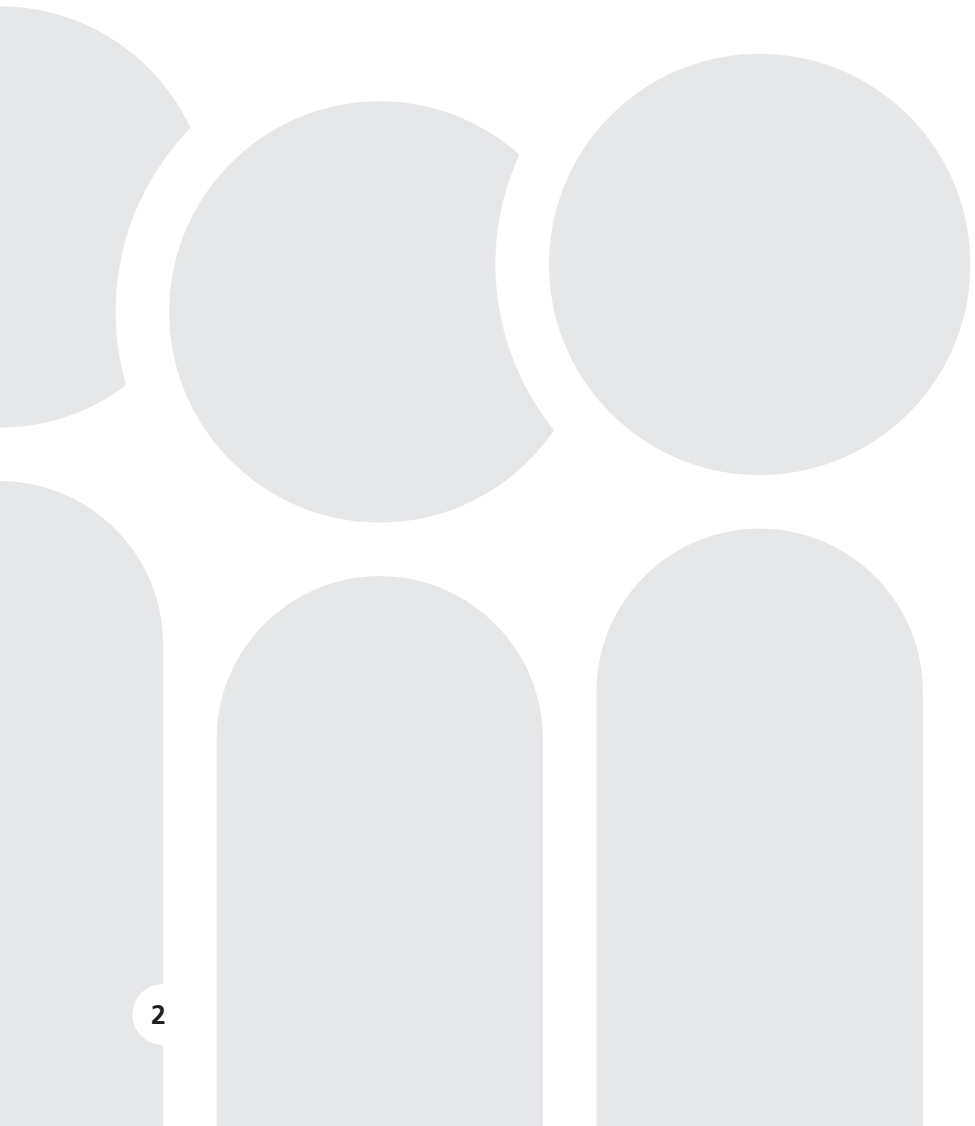

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Contents Of This Issue

Editorial

On Being An Integrative Psychotherapist

For the purposes of this edition of the journal, the editor of this issue Katherine Murphy invited practitioners and trainers who are active in the integrative field to submit a brief paper on their current personal perspective on integration and integrative practice. The brief was intentionally very broad and what we hoped is that each contributor would speak personally to this project. As you will see each contributor has engaged with the task in an individual and often passionate way. There is a mixture of the personal and the professional, of philosophy and practice, and there are certain common themes that emerge. We are choosing not to comment on each contribution in this editorial to leave you free to relate to each in turn with freshness and curiosity.

We wish to thank the contributors for their willingness to speak both personally and professionally keeping to the brief about their individual views of integration. These were varied and people chose the emphasis they wished to give to this endeavour.

As is our tradition we have included an example of a student theoretical discussion of her integrative framework taken from her final dissertation for her MSc in Integrative Psychotherapy.

We have also included two book reviews.

We are planning some more editions on particular themes. Some possible themes are "Sexuality, Gender Identity and Sexual Orientation"; "An Integrative Approach to Working with Children and Adolescents"; and an edition on the political and social contributions of Integrative Psychotherapy in the wider field.

We invite readers who may be interested in these themes to come forward as co-editors of a special edition. We also invite you all to consider contributing an article to the journal on any of the above themes or any other theme related to Psychotherapy Integration.

These can be forwarded to the editor@ukapi.com. Please view our submission guidelines on our web site. www.ukapi.com/journal/

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

Marvin R. Goldfried

How I View Psychotherapy Integration

As I was trained in the 1950s, it should come as little surprise that my original orientation was psychodynamic. However, at the same time I was receiving my doctoral training in clinical psychology, I was also involved in studying learning theory and research. In trying to put these two threads to my education together, I was attracted to the classic volume by Dollard and Miller (1950) Personality and Psychotherapy, in which they attempted to translate psychoanalytic concepts into learning theory. But the real change in my thinking came when I joined the faculty at Stony Brook University in 1964.

The clinical program at Stony Brook had not yet been developed and, just three years after having received my doctorate, I was provided with the exciting—and somewhat intimidating--opportunity to collaborate in creating a clinical training program. The guideline we received was that the underlying approach to clinical work had to reflect learning theory and research.

It was around this time that behavior therapy was beginning to gain some recognition in the United States, presenting itself as an approach completely different from psychodynamic therapy. After having formed a clinical faculty that made use of behavioral methods in working with various clinical problems, it soon became apparent that there were instances where this approach fell short. As we moved into the 1970s, many of us practicing behavior therapy came to recognize that cognitive factors needed to be introduced into what we were doing clinically, resulting in the approach that eventually became called "cognitive-behavior therapy."

The introduction of cognition into the practice of behavior therapy also led many of us to consider how a psychodynamic approach was dealing with similar aspects of clients' thinking processes. Thus in our book Clinical Behavior Therapy, Davison and I (Goldfried & Davison, 1976) maintained that behavior therapy need no longer assume an antagonistic stance vis-à-vis other orientations. Acknowledging that there is much that clinicians of different orientations have to say to each other, we suggested: "It is time for behavior therapists to stop regarding themselves as an outgroup and instead to enter into serious and hopefully mutually fruitful dialogues with their nonbehavioral colleagues" (p. 15). That many clinicians were in effect already doing this was reflected in Garfield and Kurtz's (1976) findings that approximately 55% of clinical psychologists in the United States considered themselves eclectic. Most frequently used in combination were the psychodynamic and learning orientations, a combination that was based on the pragmatics of doing clinical work.

Moving from Cognitive-Behavior Therapy to Psychotherapy Integration

In an article published in 1980, I suggested that a fruitful way to find commonalities across therapy orientations would be to look at a level of abstraction somewhere between the specific technique and theoretical explanation for the potential effectiveness of that technique (Goldfried, 1980). I maintained that it was at this intermediate level of abstraction -- at the level of clinical principle -- that potential

commonalities might exist. An example of a clinical principle that cuts across orientations entails providing the client with "corrective experiences," particularly encouraging actions that are inhibited by anxiety. For example, the psychoanalyst Otto Fenichel (1941), on the topic of fear reduction, noted that:

> *when a person is afraid but experiences a situation in which what was feared occurs without any harm resulting, he will not immediately trust the outcome of his new experience; however, the second time he will have a little less fear, the third time still less (p. 83)..*

This very same conclusion was reached by the behavior therapist Albert Bandura (1969), who observed:

> *Extinction of avoidance behavior is achieved by repeated exposure to subjectively threatening stimuli under conditions designed to ensure that neither the avoidance responses nor the anticipated adverse consequences occur (p. 414).*

In looking at the middle level of abstraction to find principles of change that appear to underlie different approaches to therapy, we can find the five following principles:

1. Promoting client motivation to change and belief that therapy can help.
2. Establishing an optimal therapeutic alliance.
3. Facilitating client awareness of the factors associated with his or her difficulties.
4. Encouraging the client to engage in corrective experiences.
5. Emphasizing ongoing reality testing in the client's life.

In considering the first principle—ensuring that the client is motivated and believes that therapy can help—it is hard to imagine any successful approach to therapy that can produce change without this initial and ongoing client state. At times the client will enter therapy with such positive readiness in place. In other instances, it is up to the therapist to move the client from a pessimistic and unmotivated state to one more in line with what is needed for therapy to progress. As Prochaska and DiClemente (2005) have demonstrated, clients who have not yet contemplated the necessity of change are unlikely to respond well to therapy. Thus successful therapists of all orientations, using a variety of techniques, recognize the importance of first increasing precontemplative clients' motivation for change and, later, offering therapy to produce such change.

As any practicing clinician well knows, it is not always easy to motivate a client who is resistant to change. In working with unmotivated substance abusers, Miller and Rollnick (2002) came to the realization that direct attempts to persuade these clients that change was important typically failed miserably. Their clients resisted this attempt at influence, and the therapy typically went no where. From this clinical experience, they developed a motivational interviewing procedure, in which the therapist empathically follows and validates the clients' feelings, thoughts, and intentions, and then gradually leads them to realize for themselves the negative consequences of not changing. They have found motivational interviewing to be successful not only with substance abusers, but with other unmotivated clinical populations as well.

It is also difficult to image a successful therapeutic intervention in the absence of a good therapeutic alliance. In a landmark article by Bordin (1979), the therapy alliance was conceptualized as being comprised of three factors: 1) There exists a good interpersonal bond between therapist and clients, where clients feel there is genuine concern for and understanding on the part of the therapist. 2) Both client and therapist are in agreement about the goals toward which they are both working (e.g., symptom reduction, improvement in relationship with a significant other). 3) Both client and therapist agree on the methods that will be used in therapy to reach these agreed-upon goals (e.g., becoming aware of and changing one's thinking, learning better ways of expressing one's needs toward others). Clinical and research work has been carried out to help therapists repair alliances that have been weakened (Safran & Muran, 2000), using such methods as attuning to a client's own experience of the interventions, having the therapist accept his or her own contributions to the therapeutic interactions, and identifying markers of problematic interpersonal functioning.

Another over-riding principle of change common to all theoretical orientations involves the facilitation of client awareness. Even though the actual therapeutic technique used to encourage such awareness may differ across theoretical orientations, all therapists strive to help clients become better aware of those factors that are contributing to their problems. Thus such diverse interventions as providing feedback regarding the interpersonal effectiveness of a role-play interaction, as well as making an interpretation about the cyclical themes that guide clients' relationships, both facilitate client awareness. Even though these may represent different clinical procedures, they nonetheless help clients become better aware of possible factors that may be maintaining their unsatisfactory relationships. As is the case with all principles of change, it is important to look beyond the specific method used and instead attend to the function of that method.

The principle of encouraging clients to engage in corrective experiences was first highlighted by Alexander and French (1946), when they proposed that the manner in which the therapist responded to clients provided them with "corrective emotional experiences" that served to disconfirm previously held negative expectations and feelings about interpersonal interactions. Their suggestion was quite controversial at the time they proposed it, as it implied that change could be possible without resolving underlying historical conflicts.

As the principle is currently manifested, therapists can facilitate a corrective experience by encouraging clients to take the risk and behave more assertively to others, or by responding to the therapist in a manner that serves to challenge clients' previous expectations of others' reactions. What is common to both is that they promote a corrective experience that helps clients update their inaccurate expectations and associated negative emotions that have prevented them from behaving in more effective ways. The importance of the corrective experience as core principle of change was acknowledged by a diverse group of well-known therapists of different orientations who presented their views in a special edition of the journal Cognitive Therapy and Research (Brady et al., 1980). Such therapists as Brady, Davison, Dewald, Egan, Frank, Gill, Kempler, Lazarus, Raimy, Rotter and Strupp categorized the importance of new experiences from within their orientation as being "essential," "basic," "crucial," and "critical."

As important as the corrective experience is to the therapy change process, one such experience is unlikely to lead to long-lasting change. Instead, therapists need to encourage clients to engage in ongoing reality testing, which is comprised of a synergistic interaction between the two last change principles described above—increased awareness and corrective experiences. Thus as clients become aware of those factors that are creating problems in their lives, they begin to take risks by functioning differently and providing them with corrective experiences which, in turn, serves to further increase their awareness of aspects of their functioning (e.g., thoughts, feelings, actions) that do and do not get them what they want. This synergistic interplay between awareness and action is what serves to make inroads in changing the cognitive-affective-behavioral patterns that have created problems in their lives.

The Clinical Implementation of Change Principles

When deciding how to intervene with clients at any point in time, I first think in terms of principles, not methods. Not only is thinking in terms of principles easier to do—there are only a handful of principles as compared with an almost infinite number of therapy procedures—but it helps me to think functionally: What do I want to accomplish clinically? Once this question is answered, I then move on to the next question: What method or technique can I use to best accomplish this in the case of this particular client?

Depending on one's theoretical orientation, the typical way of implementing these principles may vary. Thus corrective experiences are often seen to occur in the context of the therapy relationship within psychodynamic therapy, but are highlighted as between-session homework in cognitive-behavioral approaches. One of the advantages of being integrative is that one is not limited to a specific orientation in selecting a method or technique for implementing a principle. Thus in

fostering corrective interpersonal experiences (e.g., having a client become more effective in dealing with others), I make use of in-session feedback about the therapy interaction as well as between-session homework.

Although I practice integratively, I consider my primary orientation to be cognitive-behavioral—an orientation that has long argued that insight into the past is not needed to bring about change. However, the integrative part of me recognizes that there are instances where a review of early childhood experiences can prove to be invaluable in implementing the principle of facilitating client awareness. In the case of a client that blames him- or herself for having a given problem, a review of the early experiences that that may have created this problem—often experiences the client could not have avoided—can help the person develop a more self-accepting explanation for the cause of the difficulty.

Conclusion

Over a quarter of a century ago, I described my fantasy of the psychotherapy "textbook of the future" (Goldfried, 1980). Instead of being divided up into different schools of therapy. The table of contents would deal with agreed-upon principles of therapeutic change as well as the effectiveness of various techniques and methods for implementing each principle, taking into account the relevant client, therapist and relationship variables. An important step in this direction is the recent volume by Castonguay and Beutler (2006), which identifies principles that work in therapy--regardless of one's theoretical orientation. With further clinical and research input, it is hoped that the field will eventually see a clinician-friendly, empirically informed text as wished-for several generations ago.

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Heward Wilkinson

Poetic Integration: The Muse As Therapist

We need another language that does not exist (outside poetry), a language that is steeped in temporal dynamics. (Daniel Stern, The Present Moment).

To begin in slogan mode: Poetry is Therapy; Therapy is Poetry.

First Example

I have a client who, like me, regards Dostoeivsky as the ne pus ultra of novelists, and as perhaps the single human being who has most endured the sight and feeling of the terribleness and sheer brutal horror of human existence. My client does idealise him, and me, and his tendency to idealisation is linked to his predicament. This is the background to what transpired. In the course of conversation which had touched upon creativity, and dramatic art and experience, including Shakespeare, we reached Dostoeivsky, and he remarked, very earnestly and shyly, with a pause in the middle, as if whispering a secret: "But I have realised that, in Dostoievsky – there are some cracks…" I chuckled and paused, and then said, "But, - you know, - no one's perfect!"

We both fell about laughing. What was the joke? Very hard to explain! Something about the extreme contrast between Dostoievsky's supreme greatness and the hyperbolic perfectionism that would find fault even with him – and, in a sense, thus, even with life itself! Such a moment is impossible to capture (even for myself in retrospect), virtually impossible to explain, because it depends on the ramifications and idiosyncrasy of persons, and context, it depends on the total enactment of it, depends on enactivity. In its accessing universal themes, and in its participation in language, in iterability, the enactment transcends the moment, as a poem transcends the moment.

Second Example

There is a very accessible, and teasingly funny, example, and type of example, that of graffito paradox: in this case the graffito which reads, 'Do not read this!'.

What happens here is that to understand the graffito, of course, we have to disobey it.

And that is also what makes us chuckle!

Intrinsically, of its essence, we cannot attempt to obey it without ipso facto disobeying it. It is a classic double bind, enacted, essentially enacted, as what it is, and so also it is a classic self-reference. In the terms of Aristotle's Poetics (Aristotle, no date) or Girard's (Girard, 1987) terms, we cannot avoid the enactive mimesis/intentionality required to grasp this.

Relation to Integration in the ordinary sense

To begin with: I am an orthodox Integrative Psychotherapist. The conception of Poetic Integration is my own meta-analysis of what I do, which I have been developing for some years now, and which is now the theme of my book in press, The Muse as Therapist: a New Poetic Paradigm for Psychotherapy.

It is not a new name for Integration or a new mode of Psychotherapy, but an elucidation of what I found I was doing. And at the same time of course it does impact on practice; it opens up new possibilities if one is explicitly aware of this way of thinking about things. Even though, in a sense, it is actually primarily offering an analysis of everyone's praxis, it makes a significant difference if one can assimilate this way of looking at things into one's own praxis. I have perhaps highlighted it more emphatically than anyone else, but this is an incremental process, and there are many precursors; Joyce MacDougall, Robert Hobson, Miller Mair, and Don Coleman are significant names in this connection.

I shall begin by explaining what it is as a conceptualisation, and then look at its potential to change practice.

As I have said, in the simplest, indeed most oversimplified, terms, the model says: Poetry is Therapy; Therapy is Poetry. Mythologically speaking, as I discovered after I had written my book, Asclepios, (the Greek god of healing, in the sense of healing of the whole person), is the son of the god of poetry, Apollo.

The concept relates to, and to some extent takes off from, a lot of things that Daniel Stern has been saying in his books and articles, about implicit knowledge, present moments, and moments of meeting (e.g., Stern, 2004, Stern, et al, 2002/2004, Wilkinson, 2003).

The core Psychodynamic discovery

The core idea is that we are all intrinsically engaged in a temporal process, which gets itself structured in ways which relate to patterns which are all-pervasive in our process. This happens in therapy and in 'real life' and also in other frame-based contexts (indeed there is no 'absolute' 'real life', everything is in some frame or another, which is why enactment is universal process). The acceptance of this is common ground amongst the psychotherapies, though there are many labels for it.

Arguably this is the great psychodynamic discovery, more primary than the unconscious and less restricted in its scope (Stern, 2004, Wilkinson, 2003). If this is accepted, then the whole of experience, - rather than a split off part, which is seen as the 'real' meaning of an expressed part, as in much psychoanalysis, and some elements in integrative and humanistic approaches - becomes the vehicle of therapeutic process.

Then also therapeutic work can take a whole variety of forms, experimentally and creatively and according to individual style and skill, without the obsession with 'the one right way'.

Taking a difference in emphasis to an extreme, one might say that in traditional psychoanalysis the patterned temporal psychodynamic process is channelled into the narrowest channel, so as to intensify the process of dissolution of illusion. By contrast, in an integrative-humanistic, poetic-integrative, framework, the aim, rather, of the use of the psychodynamic process is to increase connection with inner and outer reality by emphasising unitive congruences and relationship.

Even Person-Centred approaches are psychodynamic, in this broad sense, with their inner-outer dialectic, their movement from other-directedness to Self-directedness; and the overlaps with Kohut and Jung have been oft-noted (e.g., Rowan, 1998)!

So the difference between psychoanalytic approaches and integrative-humanistic ones is not in the general acceptance or rejection of the psychodynamic hypothesis, but in what they do with it, and the scope that they give it. Perhaps paradoxically, therefore, integrative-humanistic approaches do indeed normalise the psychodynamic hypothesis itself more comprehensively than psychoanalytic ones do. The latter stop half way and keep it at the pathological or reductive end of the spectrum (corresponding to Freud's original hypothesis splitting conscious and unconscious, primary process and secondary process, reality principle and pleasure principle, and so on).

Developing the recognition of the core psychodynamic hypothesis, Stern writes:

> *I was prepared to see present behaviour as an instantiation of larger behavioural and psychological patterns. That is the essence of*

> *the psychodynamic hypothesis. However, I was surprised to see larger psychodynamic patterns reflected in units as small as present moments. This realisation opened up the way to consider the present moment, like a dream [my italics], as a phenomenon worthy of exploration for therapeutic purposes. (Stern, 2004, p. 18, Wilkinson, 2003, p. 240)*

This, when I read it, immediately reminded me of Freud's similarly radical and universal recognition (Wilkinson, 2003, p. 240)

> *And even when it happened that the text of the dream as we had it was meaningless and inadequate—as though the effort to give a correct account of it had been unsuccessful—we have taken this defect into account as well. In short, we have regarded as Holy Writ what previous writers have regarded as an arbitrary improvisation [my italics], hurriedly patched together in the embarrassment of the moment. (Freud, 1900/1991)*

So in this sense Stern, with his concept of the implicit, is applying the psychodynamic hypothesis to the most ordinary experiences, as Freud applied it to the lowly fragmentariness of dreams, jokes, and slippages, and in a way which does not see psychodynamic patterning in reductive terms.

Grounds for the Poetic Paradigm

This now paves the way to the recognition of the poetic understanding of psychotherapeutic process.

If the whole of experience is patterned in a widened psychodynamic sense, then the whole of experience interacts.Thus every level of meaning and experience and developmental causality interacts in a totalising, holistic, non-compartmentalised way, which we can then simply be open to- likewise with the whole of ourselves in relationship (and who are 'we' then?!)- and so inherently cannot be pinned down theoretically and ideologically (let alone express it linearly in 'evidence-based' terms).

This has been long recognised in the integrative-humanistic community, but it has lacked a paradigm expressive of the totality one which would go beyond negations, beyond definitions in terms of what it is not. It has tended,therefore to move back into split and normative notions, which do not express the whole as a whole, and start us on the slippery slope which leads to 'one right way' dogmatism in psychotherapy. These normative notions include: the true or authentic self, the concept of the true developmental pathway, attachment norms, contact as a paradigm, reciprocal transactions, and so on (unless these are construed in a meta-conceptual way which includes their opposites or contrasts – so that, for instance, in that sense of contact, there would indeed be nothing which was not contact; this would be nearer to the poetic paradigm).

What we need is a comparative paradigm, an active positive analogy, which expresses that totality. I have come to believe that poetry is that paradigm (in a wider sense all the arts, but poetry, combining both the semantic and the musical-expressive elements, is the most apt). In a poem, as Aristotle (The Poetics, no date) already grasped, the mimetic (participatory-imitative) capacity of the human mind is employed to evoke an embodied totality (c.f., also e.g., Stern, 2004, on mirror neurons).

The great Shakespeare producer, Peter Brook, who produced Paul Scofield's performance of King Lear, the greatest Lear of our age in my view, states this poignantly (it is not, as he claims, unique to Shakespeare, but shared by all poetic understanding, - including psychotherapy):

> *…Now if one takes [Shakespeare's] thirty-seven plays with all the radar lines of the different viewpoints of the different characters, one comes out with a field of incredible density and complexity; and eventually one goes a step further, and one finds that what happened… is something quite different from any other author's work. It's not Shakespeare's view of the world, it's something which actually resembles reality. A sign of this is that any single word, line, character or event has not only a large number of interpretations, but an unlimited number. Which is the characteristic of reality, (Brook, 1977).*

This is also what Freud evokes, as what he labels as the 'overdetermination' of the meaning of dreams (Freud, 1900/1991). I shall

pursue this analogy in particular relation to examples which evoke temporality.

In the greatest poetry, this multiplicity of the radar lines and the enactments, is everywhere to be found. One of the greatest and most famous examples is Andrew Marvell's *To His Coy Mistress*. It is not an accident Marvell focuses upon time, in three modes: the endless time of paradisal happiness and utopian exchatological anticipation of the future; the truncated time which death imposes upon us; and the urgent immediate time of the emerging present moment, which he claims is all which is left to us. As in all Marvell, the endless ambiguities of the embodiment of spirit are enacted in profound forms of wit and double meaning (for example, the double meaning of 'no more' as both 'not any more', and as 'no more than (mere physical beauty)', in the line, *Thy beauty shall no more be found*). Here, in the second part of the poem, is the truncated time of death, with its astonishing hammer blow sense of surprise and shock, following the expansiveness of the first part (Marvell, 1681/1984):

> *But at my back I always hear*
> *Time's wingèd chariot hurrying near;*
> *And yonder all before us lie*
> *Deserts of vast eternity.*
> *Thy beauty shall no more be found,*
> *Nor, in thy marble vault, shall sound*
> *My echoing song: then worms shall try*
> *That long preserved virginity,*
> *And your quaint honour turn to dust,*
> *And into ashes all my lust:*
> *The grave 's a fine and private place,*
> *But none, I think, do there embrace.*

A related sense of temporal arrest, in a stunningly unexpected enactive succession of images, is expressed in Macbeth's speech following his wife's death (Shakespeare, 1623/2005):

> *She should have died hereafter;*
> *There would have been a time for such a word.*
> *To-morrow, and to-morrow, and to-morrow,*
> *Creeps in this petty pace from day to day*
> *To the last syllable of recorded time,*
> *And all our yesterdays have lighted fools*
> *The way to dusty death. Out, out, brief candle!*
> *Life's but a walking shadow, a poor player*
> *That struts and frets his hour upon the stage*
> *And then is heard no more: it is a tale*
> *Told by an idiot, full of sound and fury,*
> *Signifying nothing.*

In psychotherapy, Freud introduced us to the experience of primary process, when the work is stuck in glue, and there seems to be no movement, only paralysis and repetition ('tomorrow and tomorrow and tomorrow'). He talks of it as outside of time, but we can see it rather has the particular character of suspended temporality. We are all familiar with this, and with its excruciating quality. Our omnipotent impulse to prematurely solve the problem is intense, but if we can hold the existential uncertainty then the truth of John Keats's words (which Bion found so compelling, Bion, 1970) comes home to us:

> *I had not a dispute but a disquisition, with Dilke on various subjects; several things dove-tailed in my mind, and at once it struck me what quality went to form a Man of Achievement, especially in Literature, and which Shakespeare possessed so enormously - I mean Negative Capability, that is, when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason - Coleridge, for instance, would let go by a fine isolated verisimilitude caught from the Penetralium of mystery, from being incapable of remaining content with half-knowledge. This pursued through volumes would perhaps take us no further than this, that with a great poet the sense of Beauty overcomes every other consideration, or rather obliterates all consideration. (John Keats Letter to George and Tom Keats, 21 Dec. 1817, Keats, Ed. MB Forman, 1947, my italics)*

If we sustain our capacity to think, with however great difficulty, in the midst of the paralysis, in the midst of the process-impasse and temporal arrest, then discovery emerges, and thinking and feeling return. It is trust, and, in my language, awaiting the visitation of the Muse, the experience of grace and epiphany, which enables us to do this. What we discover is that in the impasse itself are all the materials required to resolve it.

This connects with, in a broadened sense, the 'free association' method. For what we have to do is to sit down before the totality, and allow ourselves to follow the track of associations

and intuitions of the blindingly obvious, to allow what is needed to unpack. This is the method of poetry; poems compose themselves by allowing words to come, in the same way as words and intuitions come to us and our clients in the dialogue, if we can permit it. Within the process of psychotherapy, as within poetry in another way, in psychotherapies which are process-based, there is an intensification of this, due to a focus on process 'for its own sake'. For instance, aspects of Gestalt, Core Process Psychotherapy, Symbolic Psychodrama, Focusing, and Transpersonal and Jungian approaches have much affinity to what I have tried, all too briefly, to evoke here.

The background to the profound belly laughter which my client and I shared in our first example is this shared and emergent totality of experience, which gives an elusive infinite depth to the words we use, and to the intuitions which pass between us.

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Tom Warnecke

The Well Tempered Therapist: Psychotherapy Integration And The Personality Of The Therapist

"Every explicit duality is an implicit unity." – Alan Watts

Integration is inherent to the art and science of psychotherapy and constitutes a core function of the psychotherapeutic process. But integrative processes not only facilitate our clients' process of change but also crucially contribute to the development of psychotherapists. This paper is about the integration of the therapist's personality with his or her clinical approach as a necessary aspect of professional individuation and maturation.

The term integration refers to a process of bringing something into unrestricted and equal association, to an act of making whole or combining into an integral whole, and to describing the organisation of psychological or social traits and tendencies of a personality into a harmonious whole. As such, integrative processes would seem an essential aspect of any psychological therapy that strives to contain and integrate a client's distress, dissociated experiences and fragmented personality aspects. As a therapist, I attempt to integrate aspects of clients' presenting material with my transferential experience and with the real relationship that always exists side by side with transference.

Integration is also central to the evolving development of ideas and constructs. In the terminology of evolution research, integration is seen to alternate with differentiation both being agents of development. Psychological theories aim to conceptualise the unruly emotional life dwelling within the human organism. They are abstracts created to think about, and communicate, aspects of psychological dynamics but remain approximations of what they seek to describe. We strive to improve our approximations, usually by expanding constructs and integrating new conceptions into a theory. Psychological theories, like all concepts and ideas, are subject to evolutionary dynamics. They either develop and evolve or become discarded.

Theoretical constructs and the personality of the theorist

Theoretical constructs are permeated by a range of subjective variants. The confirmation bias phenomenon describes a tendency of researchers in a variety of settings to notice more, assign more weight to, and actively seek out information that confirms their hypothesis. Psychological theories are also influenced by differences in the clinical environment that inform them, such as a particular client/patient population for instance. They also reflect and are informed by the personalities of their architects. The work of Reich and his contemporary Winnicott, for example, show a common fascination with the body. They both developed theories that aimed to conceptualise psychic dimensions and functions of physiology. Reich and Winnicott recognised and emphasised the centrality of a psyche - soma relationship

that is unitary as well as conditioning one another. But here the similarities end.

Reich's ground-breaking theories on character, muscular armouring and sexuality led him to develop an emotional, deeply charged psychotherapy approach. While Reich argued for nurture versus nature and insisted that people should be present and in contact, his clinical approach remained remarkably non-relational. Winnicott's equally eminent theories of self development explicitly recognised the significance of bodily experiences within resonant attachment relationships to achieve an adequate development of self. He saw the crucial importance of kinesthetic awareness of self and other in attachment relationships and yet displayed a notable hesitation to recognise and engage with the awareness and embodiment of erotic charge in the therapeutic relationship (Phillips, 1988).

It is tempting to argue that Reich's and Winnicott's personalities and their respective degree of discomfort around sexuality and attachment not only contributed to but also benefited the theoretical constructs they formulated. More specifically how Reich's reluctance to engage with co-regulation and relational dynamics may have facilitated his focus on interventions aimed to energetically explore and unlock the self-regulating potential of the body. It is equally tempting to consider Winnicott's evasion of erotic tension in the context of his attention to, and availability for, embodied mutuality as a way to facilitate resonant relationships.

The work of Fonagy and Schore raise similarly intriguing questions. Both Schore and Fonagy have been at the forefront of attempts to integrate attachment theory with neurobiology and the development of the self. Their respective research on self-development and affect regulation brings together observations, research data, and concepts from the developmental branches of psychoanalysis and neurobiology. Both identify and recognise the central role of affect regulation within early attachment relationships in facilitating successful structural development of the brain and an individual's later complex affective and cognitive abilities.

Schore (1994, 2003), approaching the biological functions of emotions from a two person psychology perspective, proposes a psycho-neurobiological model of 'implicit self' development and makes a compelling case for a brain/mind/body system as the dynamic core of the implicit self, mediated largely by the brain's right hemisphere implicit regulatory functions. Fonagy and colleagues (2002) on the other hand, develop a psychoanalytic construct of mentalization. Mentalization is defined as the ability to make and use mental representations of one's own and other people's emotional states. Fonagy and colleagues propose that the individual's capacities to mentalize contribute crucially to the depth of abilities for mediating self-functions and relationships with others.

Such divergence in terminology is not just linguistic but reflects significant differences in their respective perspectives of self- and co- regulating functions. I cannot help wondering if the term mentalization indicates an inclination to keep the messy world of limbic communication and relatedness in the safe realm of abstract mental activities. On the other hand, only Fonagy and his colleagues (2002) have developed a clinical approach based on their construct. Would that suggest that Schore might feel more comfortable with a body of theory?

Arguably, the above four examples have all benefited from the personalities of their architects. They present profound and inspiring endeavours to integrate psychoanalytic theory with observed phenomena and research.

A personal journey

"…and every attempt is a wholly new start, and a different kind of failure." – T S Eliot

My integrative journey is a story of paradoxes, which is probably not uncommon. I received a Gestalt initiation to psychotherapy which stimulated my curiosity about the reciprocal relationships between physiology and psychology. I continued my studies through training in Biosynthesis, a somatic and psychodynamic oriented approach which combines pre- and perinatal psychology with body psychotherapy and transpersonal

psychology. As my own understanding of psyche – soma dynamics in the therapeutic relationship evolved, my focus began to shift away from looking at organismic structures, defenses and embodied polarities. I learned to watch and listen to the symphonies of mutual exchange in the therapeutic alliance and to observe the internal adaptations, psychic and bodily, in myself and in my clients. I became curious about clients' particular styles and patterns of relatedness, their embodied rhythms and intricacies, and how they impact my psyche and soma.

Body psychotherapy had taught me about the body and embodied process work. Neuroscience, Object Relations and Self Psychology theory invited me to attend to the rich tapestry of my somato-sensory experience in the therapeutic relationship and encouraged me to explore the intricacies of psyche - soma relationship as an agency for development and continuity of the self. I learnt to attend to my struggles and failures of psyche dwelling in soma in the therapeutic relationship. I became curious about how I experience my clients' struggles through my own failures, for example when my psychic or bodily counter-transference interferes with the effectiveness of my interventions. I attempt to engage with excess or lack of defensive muscular armouring as disruption of relational vitality within a two person system. I have come to rely on my psyche and soma to invite a client's body and psyche into relatedness, both with each other and in our relationship. Today, I describe my approach as relational body psychotherapy. These two paradigms sit comfortably with one another and between them address what draws me most about psychotherapy - the intricacies of psyche and soma dynamics in the therapeutic relationship.

Integration as professional individuation and maturation

"In the middle, not only in the middle of the way
But all the way, in a dark wood, in a bramble
On the edge of a grimpen, where there is no secure foothold,
And menaced by monsters, fancy lights
– Risking enchantment." T.S Eliot

Limbic communication is increasingly seen as the central factor in the transformative capacity of psychotherapy (Lewis et al, 2000). Humans beings, in line with most mammals, are relation seeking creatures. They rely on the limbic systems of others for co-regulation. Our open loop physiology is designed to answer to the call for limbic regulation by another. Limbic resonance and regulation connect therapist and client in somatic states of relatedness facilitated by a continuous exchange of signals which influence and modulate the embodied states and nervous systems of both participants. Regulatory information is required to tolerate, balance and integrate affect and emotional states and any associated physiological parameters such as heart rate or blood pressure for example. Who we are, our personalities, and how we manage ourselves in the therapeutic relationship is as important as what we do, our interventions, our professional identities and the theoretical constructs that support us. This is a far cry from from the current attempts to define psychotherapy in mechanistic frameworks of treatment manuals. The qualitative and quantitative dimensions of the art and science of psychotherapy are deeply entwined.

The personality of the therapist is a catalyst for change in the therapeutic relationship. He (I use the masculine pronoun for convenience sake) is not only a resonant co-regulator but also required to act as a character in the client's internal drama who, in Vaughan's (1997) evocative metaphor, collaboratively rearranges the furniture from a position within the client's internal world. To be a resonant agent of change, he must risk enchantment by tuning into the limbic melodies of his clients' inner world, yielding to their gravitational tug to apprehend the internal reality and yet remain sufficiently anchored within his own personality. And it is necessarily a tangled place – if clients knew how to self- and co- regulate and manage good relationships successfully they wouldn't come to therapy.

Winnicott (1971) emphasised the overlapping capacity to play in both patient and therapist in psychotherapy and suggested that development and continuity of self rely on the playful creativity of transitional phenomena. Transitional phenomena, like play and poetry, provide permissible ways of saying or doing

one thing and meaning another. They require a shared simultaneous holding of two paradoxical realities, the pretend and the actual, and allow us to both own and disown vulnerable aspects such as threatening internal states, feelings, thoughts and intentions while testing out the responses of others. As such, transitional phenomena provide a shared metaphorical space to playfully try out new identifications and to explore different ways of being in the world and relating to others. The creative dynamics of transitional phenomena are equally available for the development of the therapist.

Professional identity, initially modelled on templates provided by mentors, is being constructed, reflected back and deconstructed in relationships with clients, peers and supervisors. 'Tempering' describes a process of achieving a requisite combination of strength and flexibility through exposure to alternating temperatures. In musical terms, tempered means 'tuned to temperament', which is another apt description of the therapists' integrative process. His professional self is tempered by the fierce heat of subjective and intersubjective experience in his relationships on the one hand and by the calming immersion into observation and reflection on the other. This interplay of formless experience and transitional phenomena with rigorous review of therapeutic procedure in clinical theory and supervision invites a multiplicity of questions and perspectives. It is one of the main arguments for integrative psychotherapy: that the complexities of our clients' experiences and problems require a plurality of perspectives to facilitate their integration.

Jung coined the term individuation to describe a process of differentiation of the individual from collective and archetypical material. Interestingly, this theorising coincided with his personal development of differentiating himself from the dominantly mechanistic thinking of the nineteenth century with its outright rejection of subjectivity and the entire emotional experience. Jung achieved some integration of the feminine within himself in this process and later viewed this phase as the most profound turning point in his career which formed the foundation for his later theoretical endeavours (Conger, 2005). Our conceptualisations and clinical practice seem inextricably entwined with our personalities. There is a parallel, I suggest, between the complexity and the many layers of a client's personality, between the plurality of theoretical perspectives, and between the complexity of the therapists multi-layered self-organization that supports him in the therapeutic relationship.

Integration is not a quest for unification. Therapy does not aim to unify the multitude of personality aspects but rather facilitate their differentiation, mutual acknowledgment and negotiated co-existence. However, theoretical perspectives, much like personal belief systems, need to be continuously questioned and examined from the perspectives of alternative constructs. And we can apply this equally to the construct of the therapist's identity and the theoretical perspectives he identifies with. Identity, personal and professional, is forever under review and concomitantly constructed and deconstructed in the process.

The therapist's integrative journey is a journey towards integrity, towards functioning from somewhere closer to our core, towards finding the theoretical tools that suit our personality and cultural context. Our personalities are the flesh and blood on the bones of our clinical constructs. Integration is a journey towards becoming more conscious of who we are by participating in the dynamic forces that shape us. It is a passage of finding ways to exist and work which support our unrestricted engagement in the therapeutic relationship and which best facilitate the flow of transitional phenomena and somatic states of relatedness which may transform our client's inner world.

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Tree Staunton

Finding A Relational Home For The Body

Abstract

In this paper I will discuss current debates and attitudes regarding the body in the process of psychotherapy. Drawing on my own research, I will introduce the notion of Somatic Consciousness. I am suggesting here that whilst somatically trained psychotherapists have developed special skills in this area, we are all tasked to neither limit nor exclude somatic reality, and to embrace our client's body alongside our own, with a conscious welcome.

> *A woman enters the consulting room. A smile flickers across her face. She apologizes for being late. I greet her, smile, and invite her in. She admires the room as she sits down. She cups one hand gently with the other, as though it might be a wounded animal. I notice my response to seeing this. Noticing that my breath is held, I deliberately take a deeper breath… our eyes meet. What happens in this moment is crucial. There are two bodies in the room. One is more anxious than the other. One is more familiar with the setting and is prepared, knowing the significance of this first meeting, alert to detail. The woman in the chair does not speak….*

In my title I am referring to intersubjective thinking that 'our being is embodied from the start in experiential worlds' (Orange, 2008) and that ongoingly, throughout life, we search for our experiences to be validated by others – to find a 'relational home' – thus enabling us to process and metabolise them, as well as to feel that we are not alone. What does it mean for a therapist to provide a relational home for the body?

It has been my experience that to introduce or invite the body to become part of the therapeutic encounter – whether with students, colleagues or clients – often produces an anxious response. What would we 'do' if the body were included? a client might ask. How do we 'create' an experiential encounter with the body? a supervisee wants to know. How is this integrated into a normal 'talking' psychotherapy? asks a colleague, and Isn't the therapist introducing something artificial, and directing the process? It seems we need to make a conscious decision to relate to the body, it is not self-evident. Is it not always and forever present? Have we lost access to the spontaneous unfolding of our lived experience? We know of course that relationship with the body is not suddenly introduced by the therapist, it is there all along whether we attend to it or not.

Borrowing from Symington I want to consider the notion of the body as the lifegiver (Symington 1993:34) which we can 'turn towards' (or turn away from) as a source of nourishment and emotional connection. What has interested me for some time clinically, and more recently as a researcher (Staunton, 2007) is the phenomenology of what I am calling 'body consciousness' – the subjective experience of being in a body, and the way this is hidden, obscured, and often remains 'unvalidated' and 'unconscious' (Stolorow & Atwood, 1987). By using this term, I am distinguishing it from Reich's unconscious body – the binding of energy in 'character armour' (Reich, 1972/1990) – which fits more closely with Freud's 'structural' notion of a repressed unconscious.

I find the notion of a dynamic body process which explores consciousness more helpful, both in the clinical setting, and in developing a set of attitudes and approaches which are pro-actively inclusive of the body in psychological processes and relationship. This is counter cultural. One can ask a person 'What's on your mind today?' without causing too much of a stir, but asking 'What's with your body today?' would almost certainly meet with strong resistance – or at best produce a list of symptoms. We come up against a barrier when we acknowledge the experiencing body.

Cultural taboos and attitudes to the body have been mirrored in psychotherapeutic literature. The psychoanalytic body is either medicalized – treated as 'the patient' – or symbolized – treated as an object of the mind. There has been a tendency to infantilise the body in psychoanalytic thought; viewed as somehow less evolved than the mind, it is primitive and pathological; we are somatising when we should be symbolising (McDougall 1995, Sidoli 2000) and there is a 'constant risk' of 'somatic explosion' (McDougall 1995:159) which must be guarded against in the analytic process.

There is validity in the developmental view that in psychosomatic symptomology the body is carrying early affects which have been split off from consciousness. However, Sidoli's suggestion that it is the analyst's job to 'translate' the patient's body by interpretation – to 'mend the broken links between body and affects' (Sidoli 2000:116) – is alien to the practice of listening to the body's own voice adopted in body psychotherapy practices and Humanistic methodologies, where there is a belief that understanding follows experience – a 'bottom up' rather than 'top down' approach. A discipline cultivated in the methodology of body psychotherapy is that our reflections with the client remain experience close, and that words do not come too soon, truncating or bypassing a deeper process. One of the values for me of being grounded in a body-based approach is that metaphors that arise are always set within the context of a relationship that is founded in a somatic connection, a resonance with the client's embodied experience – their felt sense (Gendlin, 1982) – and my own instinctual response to them.

These apparently opposite approaches seem to meet in intersubjective theory, where analytic understanding roots itself in the emotional experience. Defining emotional memory, Orange says that 'tacit knowledge continues to be the core of our knowing, not the precursor of representational, or symbolic, cognition' [italics mine] and she values an 'emphasis on such knowledge as the core of selfhood.' (Orange 1995:116)

I agree with Orange's view that 'the psychoanalytic emphasis on verbalization reflects a Cartesian mind body dualism' (Orange 1995:121) and that these reifications of 'body' and 'mind' are themselves symptoms of trauma and splitting. Orange calls this a 'traumatically generated dualism' (personal communication) and some theorists have attempted to circumvent this with use of terms such as Bodymind (Dychtwald 1977) Organismic Self (Rogers 1951) and Psyche-soma (Winnicott 1984).

Work in the field of trauma (Van der Kolk, 1994; Herman 1992; Levine 1997) has demonstrated the ways in which dissociation splits consciousness from the body and Levine describes how complex symptoms which comprise the core of a traumatic reaction can be 'thawed' through active imagination and somatic processing, (Levine 1997:109).

Humanistic practitioners will be familiar with Primal therapies (Orr, 1983; Swartley, 1962; 1977; Janov, 1973, 1977, 1983) which discuss birth trauma in terms of a primal split where body and consciousness split from one another due to the overwhelming organismic pain which the individual cannot defend herself against. Rowan suggests that splitting from the body happens 'maybe pre-birth, maybe during birth, maybe some while after birth' (Rowan in Feltham, 1999) and a primary aim of these approaches is to re-unite consciousness with the body through regression and breathwork.

As so much of our understanding about somatic aspects of psychological processes emerges from work with trauma and extreme states, a theory of 'splits' is generated– supporting Orange's notion of a 'traumatically generated dualism' – rather than a dynamic interplay between body and mind, or a more integrated

view which considers a spectrum of somatic – emotional – cognitive experiencing. This more process-oriented attitude allows for theorizing that moves away from reifications and towards a kind of 'unity' consciousness. Jungian writer Robin Van-Loben Sels holds that 'When we establish a rapport with the emotional experience ceaselessly taking place in our bodies, we do not need to think as much, or in the same way' (Sels 2000:234). Dualisms cease, or at least diminish.

This touches my own experience of a 'somatic consciousness' which reaches more 'global' dimensions of awareness, and has the ability to unite opposites, and to rest in the present. I want to add the voices of my research participants, to whom I am continuously grateful for their willingness to enter into the experiential world of the body, and allow me to report these findings. Their reports include feeling a 'strange dreamlike quality' and 'feeling unfocussed and at the same time clear headed'…'a unifying feeling…bits of me brought together….I felt something opening up in my back, and now when I start to tighten up I am breathing into it automatically'…. 'a great sensation of lightness and ease in my chest and ribcage that made me wonder that I don't recognise how restricted and tightthey normally feel' and 'for a very brief while after that I felt a huge surge of what seemed to be immense physical strength, so that I imagined what itfelt like to be able to run a marathon effortlessly or push over a lorry… a good feeling while it lasted!'

This experience of being more somatically connected was also described as a more 'spiritual' state of being: 'it made me acutely aware of other dimensions, and opened me up…' 'I felt more 'in' me or 'at one'…yes…I felt more connected, and more open to others… these are the things that are important to me, spiritual connection is not solitary for me, it is also about feeling more intimately connected to others…I felt I had a more permeable boundary.' Another participant described it as being 'present in eternity….not limited by time and space.'…Horizons were more expansive…I felt more accessible to other people, to my environment…more open, expansive..'…'I felt spatially aware…there was no edge between me and my environment..' and 'It was a pleasure to just feel…to feel that the body could tell its own story…something to do with me that I didn't recognize….strange and frightening…but pleasurable.' All the participants in my research were able to connect to the aliveness of their dreams, a broadening of their perception, the appreciation of their senses and appetite, and in becoming aware of their body as a resource, many felt gratitude.

What phenomenological body based methodologies share is their capacity to facilitate an experience of 'being in the present' and the qualities of the 'present moment' have recently been studied more closely (Stern, 2004). The intentional focus on the phenomenological experience of being, and witnessing the body's breath, movement, sensation and 'nowness' combined with the presence of an attuned witness provides a prime opportunity for heightened awareness to change into consciousness. In his detailed study Stern says of present moments that they are '…unbelievably rich. Much happens, even though they last only a short time (Stern 2004:14) and 'present moments are holistic happenings' that '[have] psychological work to do' (Stern 2004:35). They are important for the process of therapy because of their potential to change our experience. When we can meet each other in the present moment, it opens up a sense of space and new possibility in the relationship, for a new experience to become possible. We have a breakthrough; Stern tells us that 'the present moment changes the functional past' [the past that influences our present behaviour] and can 'rewrite the neural circuitry and phenomenal expression of a previously written and remembered experience' (Stern 2004:222). This is news! We must all have heard and repeated 'you can't change the past'. However, Stern warns, strengthening the neural basis for change is a slow process that must be repeated over and over again.

Intentional focus on the body, then, offers access to other dimensions of experience. The process itself of entering 'somatic consciousness' can be restorative and transformative, and even when it brings with it painful and difficult experiences, there is a feeling of 'arriving' and being in the 'now'. It follows that when we as therapists become more attuned to our own somatic responses, we become more present. Through 'somatic resonance' we attune to our

client; we develop an 'energetic perception' which draws our attention to the withheld gesture, the tense jaw, the hardened mouth. Our verbal responses connect to the client's process at a somatic level, and this means that the dialogue becomes an increasingly embodied one. Our skill lies in whether and when to share our observations, and how we convey our connection with, rather than looking at our client – beautifully described by Van Loben Sels as 'beholding'. (Sels 2005:221)

As we know, each individual client is unique, and integrative theories have helped us to understand the centrality of relationship as the primary agent for change in psychotherapy, taking precedence over interventions or applied techniques. The psychotherapist who is somatically trained has at her disposal myriad ways of helping her client to 'tune in' and follow the inner direction of the body, and she is challenged to use her skills wisely, relationally and subtly, with a deep respect for the interpersonal boundary. Working somatically can be intimate and intense, and relies on a solid therapeutic alliance. In my experience it is often the client who actively seeks a body psychotherapist who is least ready to engage with their body process.

Finally, we must awaken from the illusion of dualism. Whilst somatically trained psychotherapists have developed special skills in this area, we are all tasked to neither limit nor exclude somatic reality and to embrace our client's body alongside our own, with a conscious welcome. Establishing a rapport with our bodies, and cultivating an interest in the experience of bodily aliveness brings with it the possibility of a body meeting a body in the consulting room.

"Our body and mind are not two, and not one. If you think your body and mind are two, that is wrong; if you think that they are one, that is also wrong. Our body and mind are both two and one." – Zen Mind, Beginner's Mind, Shunryu Suzuki.

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Phil Lapworth and Charlotte Sills

To Skin A Cat… A Personal Approach To Psychotherapy Integration

It is said that there is more than one way to skin a cat. We imagine, paradoxically, that people skin cats very similarly. It seems to us that integrative psychotherapy holds these two perspectives (if not cats) in mind in relation to working with clients. We see a richness and benefit in discovering 'more than one way' by exploring the diversity of viewpoints, theories and concepts in psychotherapeutic and other disciplines that may help to widen our understanding and practice. Paradoxically, we believe that within many of these various approaches there are similarities and common elements. This reassures us that maybe we're on to something useful, or at least on the right track. Both these views form part of our integrative stance.

In our book (Lapworth, Sills & Fish, 2001/ 2nd Edition, 2009, in press) we suggest a process for evolving a personal integrative approach. Essentially, this begins with identifying the beliefs and values that inform the practitioner's view of what it is to be human. From these fundamentals, key elements are extrapolated to create a descriptive framework into which psychotherapy theories that are compatible with this overarching theory of human beings may be integrated. We stress that this is a uniquely individual process influenced by each practitioner's personal, relational, cultural, educational, political and spiritual experiences, which continue to evolve over time. There will be as many integrative psychotherapy approaches as there are integrative psychotherapists and their integration is always a work in progress. We also emphasise that an integrative therapist is not simply someone who decides upon and then applies her framework of chosen theories and methods by rote but one who sees the client as the main factor that guides her in what and how to integrate, according to that client's own particular needs and circumstances.

In following this process in our book, we explore our own theory of human beings, extrapolate the key elements and develop our own multidimensional framework for integration (see Fig.1). As the resulting model contains the thoughts of all three authors, it is necessarily quite complex. Though each of us may emphasise different parts of the framework and integrate different theories according to our knowledge, experience and preferences, we have found it helpful both as a diagnostic and descriptive tool as well as a framework for theoretical integration. It encompasses both structure and function (enduring over time as well as dynamic in time); the intrapsychic as well as the interpersonal; the focus on the individual alongside the acknowledgement of the relational.

It is not possible here to discuss each aspect and build the model step by step as we have done in the book but we offer a quick run through of the whole before illustrating the use of one part in theoretical integration when working with a client.

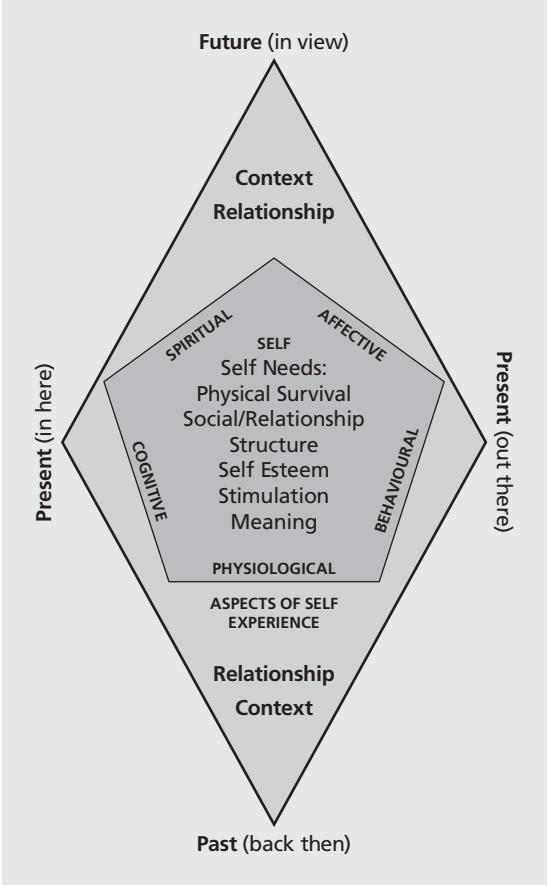

Figure 1: The Multidimensional Integrative Framework

At the centre of our framework we place the core structure and the here and now, dynamic function of the Self. The Self structure, for our purposes here, we view as the part of the personality that is cohesive in space, enduring in time, the centre of initiative and the recipient of impressions (Kohut, 1971). We see the Self as having the following needs and being motivated by them: physical survival, social/relationship, structure (of time and space), self esteem, stimulation/rest and meaning. It is the fulfilment of these needs (or aspects of them according to what the client presents) which psychotherapy is seeking to facilitate. These Self needs are experienced and expressed through what we have called Aspects of Self Experience: physiological, behavioural, affective, cognitive and spiritual which, in our framework diagram, form a pentagon around the Self and Self needs.

All of these – Self, Self needs and Aspects of Experience – are neither experienced nor addressed in a vacuum. They are contained in our framework by the environmental factors of relationship and context. The whole is then located within a temporal frame which takes into account the Present 'in here' and 'out there', the Past 'back then' and the Future 'in view' (Menninger, 1958; Elton Wilson, 1999). This dimension allows a focus both on the individual and his patterns and also the continuing relational mutuality of the therapeutic encounter.

Using this framework descriptively and diagnostically helps to highlight those interconnected areas which may need particular attention in working with a particular client. For example, within the initial interview and the following early sessions, the therapist noted that Sheila's sense of Self sometimes lacked cohesion - which Sheila described as 'occasionally losing the pieces'. In relation to her Self needs, at such times, her physical survival could be under threat as her disorientation and lack of coordination endangered her, particularly when driving. A single, thirty year old sales assistant, Sheila's social/relationship needs seemed to be met to a small degree by her working life. This also provided some structure. However, in the evenings and at weekends she tended to isolate herself in her flat finding it hard to occupy herself or motivate herself to meet other people. Her self-esteem was low and her experience of any satisfying level of stimulation and meaning in her life was limited.

The therapist considered the Self needs in relation to Sheila's Aspects of Self Experience. Responding to the client's account of herself as well as his own assessment, he started by making self-esteem the centre of his focus at that time as being the key to the other areas. It became apparent that Sheila's low self-esteem was both maintained by and manifested in her cognitive aspect through her beliefs that she was 'not good enough' and that 'other people disapprove' of her. In her affective aspect, she presented as sad (but without tears), her feelings seeming hidden and 'depressed'. The therapist noted that in her physiological aspect Sheila's body was thin, her skin-tone pale and her posture slouched. This appearance of a 'collapsed', energy-less body was reflected too in her behavioural aspect - she moved slowly, almost lay in the chair rather than sat, and spoke quietly and slowly as if it was an effort to find enough breath. Not being someone who perceives or experiences a

spiritual aspect to life (see Lapworth et al, 2001, pp 61–62), the therapist did not determine what was going on 'spiritually' for Sheila, preferring to see what might later emerge as her understanding and experience of this area.

Widening the perspective on Sheila's lack of self-esteem to further consider relationship and context within the temporal frame, the therapist was mindful of what Sheila had already said of her current situation regarding her work and home life (Present out there) and was also aware of his own response to her in the consulting room (Present in here). He thought she looked like a rag doll who wanted to be ignored and who expected disapproval if she was noticed. Whilst empathically responding to her, he also noted in himself some critical thoughts and feelings of impatience in response to her passivity. He was able to hold these lightly and continue to listen empathically as she gradually provided some clues as to the origins of her low self esteem as the youngest, unwanted and 'accidental' child in a large family and a childhood in which she had 'given up' competing for love and attention (Past back then). In exploring what Sheila wanted from her therapy, she said she longed to be accepted by others and to feel she belonged in the world. She hoped for a close, intimate relationship with a man whom she could trust (Future in view).

In this single, selected area of self-esteem, as in all the others, the therapist was, inevitably, simultaneously meeting the client and thinking theoretically. His attention to Sheila's aspects of self experience in various contexts and relationships (back then, out there, in here and in view - in themselves suggesting a theoretical view of inter-related and influential experiences over time) informed his theoretical considerations regarding Sheila's self esteem in the area of the therapeutic relationship. Sheila's early lack of attention from an empathically attuned attachment figure (Stern, 1985; Bowlby, 1969, 1973, 1980) suggested her need of what Kohut refers to as selfobject transferences (which Hargaden and Sills (2002) refer to as introjective transference) to provide a corrective emotional experience (Alexander and French, 1946) both to develop a more cohesive sense of self and increase her self esteem. He was, however, also aware of his countertransferential feelings of impatience and criticism towards her passivity. He held these in mind as a possible identification with the 'bad object' (Fairbairn, 1954; Guntrip, 1971; Winnicott, 1965) or Sheila's internalised Structural Parent Ego State (Berne, 1961/80) (an example of similar ways of 'skinning a cat' though from different schools of thought) which maintained her Child beliefs that she was not good enough and, therefore, deserving of disapproval. The therapist believed that with him and with other people, Sheila was likely to 'induce' (Wachtel, 2008 p.105) or 'elicit' (Stark, 1999 p.305) a reinforcing repetition of the past in the present in the intersubjective (Stolorow et al, 1994) matrix of her relationships and thus maintain her low self esteem. The possibility of a 'game' (Berne, 1964) or an 'enactment' (Maroda, 1998; Aron, 2003) of this repetition in the therapeutic relationship (back then enacted in here) was likely at some point. However, the therapist believed this would not be therapeutically beneficial until Sheila's earlier introjective transference needs had been met and a strong working alliance (Horvath and Greenberg, 1994) developed over time. He was interested that his counter transference was so strong at such an early stage in the therapy and his assessment was that the potential for re-traumatisation was high if her wish for 'a close intimate relationship with a man whom she could trust' was not first established in the working alliance. The therapist, therefore, saw his role in the early stages of the therapy as to contain and sit with his irritation while also practicing 'inclusion' (Buber, 1965). In other words he held his antipathy alongside his willingness and capacity to empathise and recognise Sheila's full experience as well as his own. During this period, he addressed Sheila's low self esteem from a cognitive and behavioural perspective (Beck and Greenberg, 1974; Beck et al, 1979) by working with her self-defeating patterns of cognition and behaviour. He gently drew her attention to, and also challenged, the negative beliefs she held about herself and the ways in which she isolated herself in the structure of her life and in her passive, collapsed and withdrawn behaviour with him and with others. She recognised how her early internal experience of 'giving up' in the competition for love and attention was manifested in the present and how this was probably perceived by others as a lack of interest, even as an "I can't be bothered with you' message. In response to

this, others might respond with criticism of her 'rag doll' passivity (the therapist eventually shared with her his own countertransferential feelings) or by ignoring her (as she both wanted and did not want). She would then feel 'unwanted' and the negative cycle be continued.

There was a time, inevitably, when the dynamic between the two (in here) became the specific focus of the work. The therapist's approaching holiday break was the trigger for Sheila's experiencing him as not wanting her, not having time for her, never really caring. The therapist's (genuinely aggrieved!) response to this co-created the enactment which was the vehicle for exploring a richer level of dynamic process as Sheila retrieved the painful feelings of her outraged sense of entitlement and found herself heard and received even while having to accept that her therapist was 'human'.

Over time, the therapist's integrative approach provided Sheila with insight into her cognitive and behavioural patterns (with the opportunity to change and practice new thinking and alternative behaviours with him and, crucially, with others outside the consulting room), a different affective and emotional experience of being empathically attuned to, mirrored and affirmed and a different authentic relationship, a safe but challenging intimacy developed intersubjectively between her and her therapist. In other words, specifically and appropriately attending to Sheila's low self esteem, the process of the therapy provided the knowledge, experience and relationship themes outlined by Stark (1999).

As can be seen even in this necessarily brief vignette, it is not possible to isolate the focus on Sheila's self esteem from the other inter-related and mutually influencing aspects of the multidimensional framework as well as the theories suggested by these several aspects. That is the point. We hope that it has illustrated some of the ways in which such a framework can assist a practitioner to widely consider, thoughtfully contain, accurately describe and theoretically conceptualise in an integrative way the unique stories brought by our clients. We believe that such a multi-facetted perspective allows for both the differences and the similarities of a range of theoretical approaches to find a place in the process of psychotherapy. As with cats, the more so with human beings.

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Tricia Scott

Magic In The Consulting Room

Some years ago when I was involved with a pilot project to introduce counselling in a number of General Practices, a GP circulated widely a pamphlet he called 'Magic in the Surgery'. The pamphlet was designed to oppose and discredit counselling and psychotherapy in general practice settings by saying that there was no scientific evidence that we did any good – and that it was akin to witchcraft. Plus ca change! He had lots of media attention and it fed into the Bernard Manning incident at the same time – when the comedian set himself up as a BAC member and a counsellor – to prove the point that anyone could be a counsellor and that we were all charlatans. Nowadays of course there are counsellors of some sort or another in every GP practice.

However – I also realise that this GP had a point. Not the point he thought he was making – because of course there is plenty of evidence that psychotherapy and counselling do good – and people have known that and been voting with their feet for many years. But actually that psychotherapy and counselling do work magically.

At the time I was also doing my masters research. Because I had been so shocked by the attitudes that I found amongst many of my GP colleagues, I wanted to understand them more and set about researching the underlying causes for these attitudes. I had not long previously been asked to organise an 'All Wales Conference for GPs' about counselling in General Practice. The day was packed with all kinds of keynote addresses, workshops and discussions that focussed on the issues, such as why there was the need for supervision, or a protected confidential space and so on. At the end of the day there was a plenary session. At this a general cry went up from a large number of the GPs – 'we want supervision' – 'we want counselling ourselves' – 'we are stressed out of our minds' – 'what about us?' Clearly, I thought, these feelings must play some part in the contemptuous and negative attitudes I was encountering in many GPs to the emotional vulnerability of their patients and the idea that counselling might have something to offer.

I interviewed on tape twelve GPs and transcribed these interviews, as was required by the research model. Using qualitative analysis (Miles and Huberman's system of grounded theory), I extracted sentences and statements from the verbatim transcripts. I cut them up into units of meaning, coloured them in different colours and spread them around me on the floor, moving them around like pieces of jigsaw. I clustered them together in themes to make some sense to myself of what they were saying. Along with my own process diary it was a deeply phenomenological and creative process. One of the main things that this work was commended for was the quality of these interviews. How did I (a mere counsellor in GP's surgery) manage to get so many illustrious GPs to speak to me so openly about their attitudes and feelings! What could I say? It is what I do and had at the time even been doing for many years. Creating – even in one interview – a trusting and open relationship in which a person feels properly heard, respected, attuned to, understood and able to articulate their experience in depth. This was clearly

part of a research project and all the ethical guidelines were followed. These were not meant as therapy sessions – nor were they. But the GPs involved did say that they had enjoyed the opportunity to say what they felt including those who were profoundly suspicious and negative about counselling – and of course there were a fair number of those. It doesn't really matter what I found through this research and in any case what I found was shaped by my own way of viewing the world and the meagre tools I had at the time for making sense of my world. What mattered was the richness and authenticity of the data of these interviews. It isn't and wasn't a technique – it is magic.

So what is this magic? Can I say something more about it? Can it be taught? What are the ingredients?

What strikes me, first of all, as the most important ingredient is faith in the innate creativity of human beings and the world. Is this God? I really don't know – but I do know that I have gained over the years a large capacity for this faith. It has been central to my training from the beginning. It has been demonstrated to me time and time again – hold the space open for people and a wonderful creativity will eventually emerge, even in the most damaged and numbed people. Even in the most conflictual and negative circumstances.

Translated into psychotherapeutic process it underpins the ability to let things go, to 'hang out with the process' as my colleagues at Bath Centre for Psychotherapy and Counselling call it. There are many theoreticians from different schools who write about this process in detail. Rogers describes the ways in which we can create a 'facilitating environment', Winnicott refers to the 'transitional space'. I think it was Bion who stressed the importance of two people, therapist and client, stepping into the unknown in the therapy room. I think there are many more theoreticians who have articulated this in different ways. It involves the capacity to just 'be' with clients in their emptiness and despair, in their pain or in their joy - to witness and attend to it. Not to interpret it; not to impose change on it.

Recently I have been involved in a working group in a Department of Health funded project called 'Skills for Health'. We are trying to extend the range of 'competences' that are intended to break down into descriptive components what we do as psychotherapists and counsellors. We have been trying to extend these competences to encompass more of the depth and breadth of what we do. So for example we have suggested that the statement "the ability to clarify the client's primary therapeutic goals in a collaborative manner" should be extended to say "including where appropriate the possibility of holding an open space for goals to unfold". These small steps, amongst others like them, are hopefully a way of introducing a bit of this particular magic into the system.

Key to this is the knowledge that change happens when we are fully 'in' the moment. This to me means being fully accepting of our embodied experience in the moment – integrated emotionally, cognitively, physically and spiritually. This acceptance enables experience to transform – to change. We have probably all experienced allowing ourselves to let go and cry deeply – and how somehow magically we gain peace – and usually another feeling, perhaps laughter or anger, follows. The same with anger – accepting it, is at the same time letting it go. I remember on a particular occasion feeling overwhelmed with murderous rage for my mother. It was the culmination of many years of experience. I moved away from her to another room. I sat and shook from head to toe with it. I was conscious that I really could have taken a knife and stabbed her at that moment, but also that I was not going to do that. I was able to be fully present with this feeling and contain it. Following that experience, I was able to feel my love for her again and I have never again lost it. Something transformed in me. This has profound meaning. It is not an easy or simple process. It is multi-layered and complex. But I know that it works. It also makes a difference in how we approach someone experiencing depression for example. How we think about how to heal any emotional pain – not strategies to avoid or manage it – but ways to embrace it so that it can transform us.

It seems that sometimes to have another person who is also fully present in the moment and in contact with us – helps the transformative process. Buber referred to these moments of psychological and spiritual contact as healing.

Or at least that is how I understand what Buber was saying. Going back to Plato one of the fundamental principles of life that is universally accepted is that the world is chaotic and meaningless, and that we human beings seek to make sense of it – referred to as 'intentionality' in existential thought. So perhaps another important ingredient in this magic is the willingness of another person, in this case the psychotherapist or counsellor, to fully engage with making sense of another's experience.

Over the years I have learned and been enthused by many theories about human development and change, designed to help us in this sense-making process. But actually my own experience is that these are secondary. They form part of the creation of a common language between therapist and client. They are useful to put things into words. We now learn from neuroscience that putting experience into words is healing. It can heal the split that occurs in consciousness when unspeakable, intolerable pain is held out of awareness in implicit memory. In helping this experience to be verbalised it can become contained, manageable, and bearable - and even an enriching part of consciousness. It is not insignificant. But I wonder if the more important ingredient here is the attending to the other, the witnessing of their experience that enables it to be contemplated, articulated and eventually embraced? The other's presence inspires the hope that our vulnerable, unspeakable humanity is of value, that our life has meaning – that we have meaning and value.

But also theories form the basis of a language for psychotherapists and counsellors to speak to each other. Sometimes they are used in the jostle for power over each other – and over their clients. Sometimes I feel angry and de-skilled by theories – intimidated by the cleverness of the interpretation or apt metaphor, or beautifully judged literary quote. My mind empties – it's as if I know and remember nothing, I have never heard or read a poem in my life. I become culturally bereft. This can work like that for clients too – that our cleverness intimidates and reduces them. So the magic is to create a common cultural forum between you – not to be clever yourself, but to attend to the richness of the culture that shapes the other's internal world. It seems unimportant to me if it is the BeeGees or Dostoeivsky. I want to celebrate whatever it is and what it means to the individual concerned. I do also love and admire my colleague's cleverness when they expound their theories from the heart. It can be a joy to and make me feel better, and proud, and as if there really is some order in the world – where someone knows what is going on here. It is this process which engenders the magic of hope I think – not the actual theory.

Is there any other ingredient that is important? I wonder about using the word 'love'. I saw (magically) last night a programme presented by Alan Yentob about the love story. The psychoanalyst Adam Phillips was amongst the authors and film makers who were interviewed on the subject. He said something about our parents being our first loves – and that falling in love with someone outside the family was a way of leaving home. That we found someone enough like our first loves and at the same time different enough for them to re-awaken the familiar love feelings and to contain our projections, dreams and hopes to enable us to move on. That's a nice love story! I thought how magical it would have been had it happened in that way for me. I recognise it as a dream that I was brought up with. However, I wonder about its middleclass, Eurocentric origins and how relevant it is to other cultural constructs of love and family. Later on I noticed there was a programme about polygamy. I wondered how Phillip's theory would work with that construct. I was too tired to watch and find out. But one thing that really struck me was what someone else said about the difference between love and romance. He talked about love as something which existed beyond time and space and even contact. This is a different kind of love, perhaps more akin to spiritual love. I am reminded that even thirty years on many of my past clients still write to me. Not often – maybe just at Christmas – maybe once in ten years when there is something special happening. Maybe when some painful process has re-emerged that we worked on and the person is struggling to come to grips with it in a new way – even unsure if my contribution could possibly be still of any use – but nevertheless sharing with me the dilemma. This, to my mind, demonstrates the love that existed between us in the therapeutic space. I did love them. They did feel loved. I still love them even though in some cases they have not written – and even

if I never see them again. They are there in my psyche and held in love. Sorry to be so ---what? Slushy? Sentimental? No! I want to stand up for it. As Adam Phillips also said last night in this programme 'love is the only game in town'!

Re-reading this article I have just realised that I have written about 'faith, hope and charity'. Charity is the word for spiritual love in the Christian tradition! And – so the Bible says – 'the greatest of these is love'. I did not set out to write this article. I am not a regular churchgoer or particularly a member of the Christian church. It was how I was brought up in a girls' boarding school. It is astounding how deeply these lessons become embedded in us. But I did open myself up to writing what came to me – and this is what emerged. I am rather amazed at the magic of it myself – even as I write.

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Vanja Orlans

The Interplay Of The Intrapsychic, The Intersubjective And The Contextual: Integration In Action

In this paper I set out my current thinking about integration in the psychological therapies. The emphasis on 'current' is important; the integrative path is an evolving one across the life span, involving openness to ideas and experiences which are constantly being formed into states of 'temporary totalizations'. There are, however, a number of core philosophical and broad theoretical perspectives that offer a containing boundary for such a developmental project. I am aware also as I write that we are in the middle of changing political times, where there is in many ways a pull back towards 'schoolism' and away from the integrative project, at least as expressed through the current development of 'competencies' and 'national occupational standards' for different so-called 'modalities'. My involvement in this political process has given me some new insights into the reductionist nature of a modality focus and its links with positivistic methods of inquiry. It has considerably strengthened my interest in the contextual elements of what I do and my awareness of the ways in which knowledge is socially constructed and maintained by a range of power processes involving social control, the structure of the professions, the dominance of positivism, and the packaging and marketing of psychological help. The latter perspective is cogently outlined in Darian Leader's ideas about the current search for 'a quick fix for the soul' and the emphasis on a market-driven view of the human psyche (Leader, 2008).

My commitment to integration in the context of the psychological therapies is deeply informed by my own development. The requirement for reflexivity as a support for the articulation of an on-going coherent frame for psychotherapeutic work is also a key principle for the integrative project. I was born in Ireland, to an Irish mother and a Swedish father. At the age of six months we moved to Sweden where I lived for the first 5 ½ years of my life. We then moved back to Ireland where my father took issue with the protestant-catholic divide in terms of educational choices; I was thus sent to a school outside of this system, a small German school created originally for the children of visiting German diplomats. Learning everything through an initially foreign language, dealing with two different kinds of currencies in maths classes, tackling the, at times, skewed nature of inputs on modern history, and noticing that there were no Jewish children in the school, set me thinking at an early age about how to locate myself in different kinds of systems, places and traditions, and both make sense of, and hold, some of the significant tensions which I became aware of in the course of growing up. In the context of family experiences and attachment patterns, my mother was loving but often invasively close, while my father was extremely eccentric and in his own world most of the time. As a result of these developmental experiences I found myself to some extent on the outside looking in, at languages, cultural activities, different forms of knowledge, different

kinds of social groupings and different patterns of intimate relating. I became interested in the construction of meanings way before I understood anything about phenomenology as a philosophical system. I also became aware of the internal organization of 'personality' and the way that the person both constructs and is constructed by their social setting.

In my study of psychology I dealt at undergraduate level with 'rats and stats', spurring me into a search for 'persons' and their potential location within mainstream psychological theory and practice. I first met Freud briefly in the context of 'abnormal psychology', neatly contained within the medical model yet with a marginal feel to his location. Even so, Freud's ideas made an impact on me, highlighting the vast array of human activity that is not immediately available to the conscious mind, and pointing to deeper intersubjective matters that had a resonance for me in my own family context and my relational life. I also began to consider the links between the intrapsychic and the social realm, expressed through a number of sociological and philosophical writings (e.g. Berger & Luckmann, 1966; Gergen, 1982) and the inextricable link between the person and their social context (e.g. Goffman, 1961; Macmurray, 1961; Miller, 1982). Anthony Giddens, in his explication of the idea of 'practical consciousness', offered a conceptual link between the 'not known' and the 'known' (Giddens, 1987). Other educational opportunities gave me a grounding in developmental psychology, as well as a greater knowledge of systemic and contextual factors in human development. My decision to train as a Gestalt psychotherapist was a further reflection of my interest in the links between the individual and the social.

In the course of training as a Gestalt psychotherapist I also learned about the somewhat perplexing behaviours of schoolism. In the training that I undertook, we had to limit the extent to which we drew on references or ideas that were not recognized as part of the Gestalt approach! This involved me in several debates as to what the boundaries of this approach might be in terms of 'acceptable' literature or 'acceptable' practice. Luckily for me, Gestalt psychotherapy is located within a strong anarchic tradition, supporting the permission not to follow the rigidities of these directives, and providing me with the opportunity to reflect on how I might need to extend my learning so as to offer a reasonable service to my clients. This approach, however, did offer important perspectives on the body, and on the relevance of action and experimentation as a means of gaining a greater understanding of mutual knowledge production in practice, either between therapist and client, or involving other persons in both the client's and the therapist's life. The Gestalt idea of the self being continuously formed at the contact boundary with the environment involves not just the complex interplay between a one-person and a two-person psychology but also focuses on the presence of social and other forces in the wider 'field' (Lewin, 1997) as they are expressed in the therapeutic setting. Apart from the multi-level nature of social exchange I am thinking also about the structural impact of war, famine, colonization and oppression, factors which are not normally addressed in any detail in mainstream psychotherapeutic theory.

Currently, the complexity of knowledge production and the processes that contribute to this, have been well explicated within the context of the postmodern turn, even if, at times, the verbosity of postmodern writings appears to outweigh the learnings gained. Nevertheless, the postmodern movement has created a culture of questioning and deconstruction of existing ideas which has posited itself as a new philosophy. For example, Parker et al. (1995) focus on mental health and psychopathology, highlighting the role of language as structuring both reason and unreason. Foucault (2001) has brought out the hidden power processes operating in our mental health systems, while Parker (1999) offers us a systematic deconstruction of theory and practice in psychotherapy. Writers such as these present a powerful case for holding truth lightly, and for not accepting the dogma of one particular way of construing either knowledge or practice. This is not to say that 'anything goes', a fact brought out also in the context of postmodernist writings. There is currently much heated debate in this field, with many writers setting up a modernist monster to be radically deconstructed, and others wanting to accept the critical turn without throwing the baby out with the bathwater. Perhaps, as suggested by Feyerabend (1987), what is necessary is

that we aim to 'go beyond empty slogans and {to} start thinking (italics in the original, 1987, p.161). As Bekerman and Tatar (2005) point out, '… telling the counsellee that his/her pathological personality/identity is constructed and that the world that surrounds him/her (cultural context) is equally constructed will not deliver the goods of recovery' (p. 416).

As I hope to have brought out in what I have written so far, integration in the psychological therapies is not just a question of a 'pan modality' focus with the emphasis placed on a set of ideas outside of the individual practitioner or of a particular professional grouping; nor is it the unthinking accumulation of techniques to be thrown at the unsuspecting or distressed client. The process of integrating, and the actual activity of facing a particular patient in the consulting room, is done by a person with a particular psychological and social history; furthermore it can only, in my view, be successfully achieved in its most useful form through a careful articulation of a philosophical position. Apart from the requirement for relativity embedded in such a perspective, there is also a moral dimension which has to do with the therapist's values and attitude to the client. From this perspective we are concerned with personal integrity, an issue highlighted also by David Pilgrim in his reflections on professionalism (Pilgrim, 2005). In a discussion concerned with the relationship between competence and effectiveness Pilgrim makes the point that 'given the centrality of the relationship to the success or failure of therapy, technique is worth nothing unless it is underpinned consistently with a positive, respectful and non-abusive stance towards the client. Personal integrity, not just technical competence, must be reliably present in the therapy trade' (p. 172). This is a position that I think is essential to an integrative approach, highlighting also the deeply human and relational nature of therapeutic work.

The demands of holding truth lightly, and of paying attention to different elements of the intrapsychic, the intersubjective and the wider context place a significant demand on the therapist since there is no one neat way of construing the task at hand. It is important also for the therapist to have access to a meta framework which serves to hold the complexities embedded in these different levels of experience. While there is clearly a need for a deep understanding of developmental processes, reflections on the nature of human motivation, and a consideration of relevant research and inquiry, it is often the holistic nature of the person in their social context that needs to take priority over a more fragmented system of psychotherapeutic thought. This perspective calls on the therapist's willingness and capability to manage ambiguity and uncertainty, and the tensions that ensue from tracking and holding different perspectives in the course of this work. These are ambitious requirements; however, with a commitment to creative indifference, critical subjectivity, phenomenological noticing, personal reflexive awareness, the present moment as the focus, and an eye to 'the obvious', my view is that much can emerge that is interesting and important to the client, to the therapist, and to the developing process as it unfolds in the room. At any point in the work particular factors may be a focus of interest. Intrapsychic aspects involving the development of and adherence to a 'system of meanings' might be important from an individual perspective; there might be a focus on the ways that these manifest in the room with the therapist offering a live opportunity for revised experimentation; or there might be a more considered possibility that both therapist and client are tied up in wider intersubjective and co-created social processes, involving, for example, the rupture and repair of relationship. Exploration of such processes can offer some different possibilities and an alternative to fixed patterns of relating, perhaps on either side. However, in the course of this journey certain theoretical ideas will emerge whose relevance needs to be checked against a range of possible directions that the work might take. I am thinking, for example, about the notions of transference and countertransference and the manifestation of early relationships with significant others which play themselves out in the context of the therapeutic space. It may be, for example, that these theoretical notions distract away from broader issues which could be more important to the outcome of the work.

To illustrate these ideas I shall draw on the case of a young Jewish man who came to see me with the desire to understand aspects of his relationship with his father, and his

experience of his father as 'distant'. In the course of exploring and understanding this issue there were developmental experiences that were relevant as a focus; there was also the material that emerged between us when I was experienced as the distant father, a predictable possibility since I also knew about such an experience and carried this 'father' as a part of me. However, focusing solely on the relational between or the potential for 'corrective emotional experience' (Alexander & French, 1946) in the therapy room would have been to 'psychologise' something that had an essential and relevant social component. It transpired that this young man's grandfather had been captured by the Nazis along with his five siblings and sent to Auschwitz; the grandfather was the only surviving sibling of this experience and from a generation which bore the burden of this trauma in a silent way. As our work unfolded, and trust in our joint creativity developed, we began to move from a position of facing each other as therapist and client, and instead looked together, almost side by side, at the grandfather and his five siblings. We invited these siblings into the room, recalled their names, reconstructed the 'shape' of this family, and created the conditions for historicity where the lost context became thinkable. As we worked through the family stories and the memories that had had very little space to emerge, so the father of this young man became noticeably less distant with his son – a curious and moving set of developments which reflected experiences at a number of different levels, and which made space for impact and experience to be expressed for the first time. In this case, some key material that needed attention appeared to be carried across the generations and it was this focus that allowed a different relational freedom to emerge.

A number of different factors were at play here which could not be contained within a single modality focus. We have an important intrapsychic dimension in the internal experience of the young man and in his early relational development. There is also the intersubjective dimension which played itself out in his story, as well as through the dyadic nature of the work. Intergenerational developmental issues were important, as were the embodied experiences within the family and within the experimentation in which we creatively engaged in the therapy room. The interface between self and system, with the potential of a reconstellation of the field, was facilitated in part by an intergenerational contextual focus, and by the freedom to bring this context directly into the room. In this way a number of different threads were brought together in the 'here and now', creating a different experience of the 'there and then'. The creativity of working in this way lies, for me, at the heart of the integrative project.

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Keith Silvester

On Being An Integrative Psychosynthesis Therapist

Introduction

The professional label I apply to myself is 'integrative psychosynthesis', which means that although the basic assumptions and principles informing my model of working are psychosynthetic, I see the value and usefulness of almost any other theoretical model when used in an appropriate context. So, in recent years I have coined the term 'contextual psychosynthesis' to describe my particular way of putting all this together.

The psychosynthesis approach

Psychosynthesis itself began with an Italian psychiatrist and analyst, Roberto Assagioli. His main contribution to the psychotherapeutic field can be summarised very briefly as follows.

First, he recognised that we all have a personal 'self' or 'I' which is the centre of awareness and agent of 'will' in the world. This 'I' is a reflection of a greater or more universal 'Self', of which we all emanate, which some would call the cosmic, the divine or the great unmanifest. The degree of psychological and spiritual maturity of a person relates to the degree to which I-awareness is developed and connected to Self. This connection is sometimes referred to as the transpersonal, because it goes beyond the separate-self sense. This connection can be facilitated by the therapist, but is essentially an intra-personal and inter-personal process.

Second, the 'I' or personal self achieves self-awareness through a process of integrating the many complex parts or subpersonalities. These parts have a semi-autonomous life, reflected both in our day to day behaviour patterns, and as a vehicle for transpersonal qualities. This 'bifocal' view of subpersonalities is very important in the practice of therapy because we recognise that our personal character styles are double-edged – they are our gifts as well as our limitations – our angels as well as our devils, in the terms of the poet Rilke.

Third, there are two types of unconscious process within the psyche. This was perhaps the major departure from Freud, though not necessarily from Jung. Assagioli identified the lower unconscious, which carries our complexes, primitive drives, neuroses and ego-formation trauma – familiar ground when working psychodynamically. But we are also affected by the higher unconscious, which informs the self of qualities such as beauty, compassion and inspiration. In contrast to conventional psychoanalytic views about the unconscious, where the integration of the self is stimulated and promoted by analysis and resolution of the lower unconscious, in psychosynthesis, we are ultimately compelled by the influence and effect of the higher unconscious. This is what makes us human, and what makes the integration process both a spiritual as well as a psychological one. All this was put together in what became the classic 'egg diagram' model which Assagioli put into his writings. Diagram 1 presents a simplified form of this.

Earlier psychosynthesis generations made the mistake of believing that the development of the higher unconscious was more important

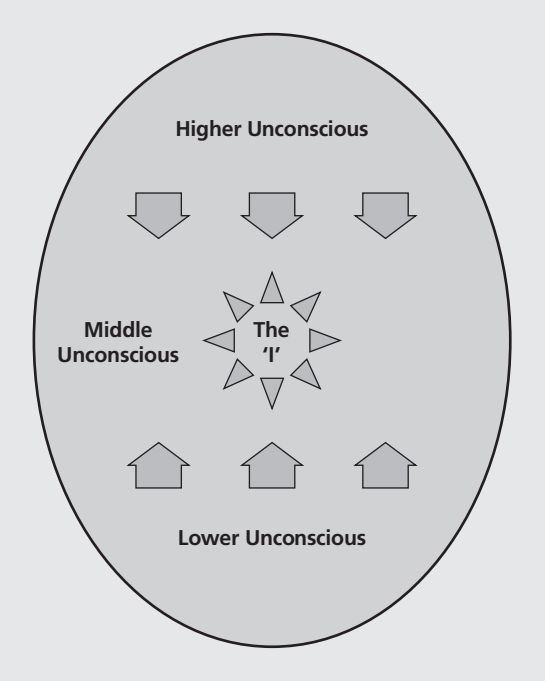

Figure 1: Simplified Assagioli 'Egg'

than deepening the experience of the lower unconscious. This led to much denial and spiritual hubris. Contemporary psychosynthesis recognises the importance of working with both higher and lower in equal measure. For some clients (and trainees), there is possibly more work to be done on the lower, for others it is the higher that has been neglected - what is called 'the repression of the sublime', where transpersonal qualities and gifts are denied. This feature is very relevant particularly when working with crises of meaning and life change, where creative impulses might be very valuable in facilitating healing and growth.

So much for psychosynthesis theory itself. What also gives psychosynthesis a distinctive identity might be described by a further set of factors – our methods of working. Although this cannot be conveyed in full here, there are three features which could be mentioned.

The first is the equal attention paid to body, feelings and mind. It is recognised that we are embodied beings, which means that the symptoms of change or distress manifest in a variety of ways which need to be taken both literally, and as metaphor. So, for example, someone exhibiting back pain, might speak in terms of 'being unable to take the weight of life'. In western culture, it is a particular struggle to counterbalance the privileged position of the mind over the feelings and the body. This means great attention is paid to the whole-organism experience of the self. For example, when we work with subpersonalities, we might work as much with body energies such as demonstrated through posture and expression, as with ideas. In this respect we may work similarly to Gestaltists. However, perhaps unlike Gestalt, we see the process of change as being explicitly guided by the desire to create meaning, value and direction in life, with the symptoms and crises being our teachers along the way. If we do not value them they become 'shadow', and eventually manifest in further pathology.

The second feature is to be found in our understanding of the wisdom of resistance. We take very small and precise steps with our clients, recognising the value of the defences they have so far used to preserve the existing sense of self. It is not our role as therapists to remove or override such defences, as they are functional. Rather we look at them in terms of how they facilitate and limit the self, and assist the client to release or transcend these defences in service of a greater whole. This makes our work very subtle and respectful of the value of psychopathology. For example, someone who has been abused might have had to shut off from very painful feelings for many years, developing what we call a 'survival self'. With help, this can be let go of in favour of what we call the 'authentic self'.

The third factor concerns the nature of relationship. In many ways we work psychodynamically with the transference, but with the added factor of the higher unconscious. In this respect we have been influenced by the self-psychology of Kohut. In other ways, we may be said to work phenomenologically, opening to a co-creative narrative between client and therapist. In this, we hold a model of 'right relating', a term used by both Rogers and Assagioli. By this, we mean that the process of integration and synthesis is as much to do with the influence of the wider interpersonal and relational field, and conversely, the individual's impact on that field too. This is as much applied to the global context as the immediate personal one. Thus, a person who is, say, acting in a way which is contributing to ecological harm of the planet, is also harming themselves, and vice versa.

My working model of contextual psychosynthesis

In recent years, I designed a working model that goes beyond the classical 'egg diagram' of Assagioli – although I am certainly not the only person who has attempted to do so. One of the difficulties of the classical model, however, elegant, is that it tends to be rather static and is a map of individual consciousness rather than therapeutic change. So, my model, (thought out during some years working in a drama school!) turns the egg diagram sort of inside out, and starts with how the person might look from the outside. I have called this the contextual, or at times the incarnational model. See diagram 2.

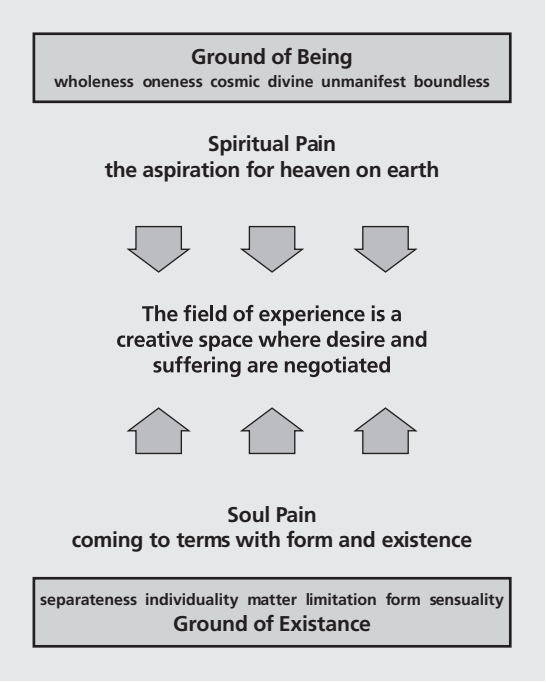

Figure 2: Model of the Human Condition

I have designed my own template with which to look at the dilemmas and contradictions facing human existence. Each person lives within a field contained between two planes: The first I call the ground of being, which is the equivalent of Self described earlier. This is a fact of life that says we are all connected to the same source, emanate from there and return there - call it cosmic or divine. At this polarity, there is an experience of oneness. The second plane I call the ground of existence, which is about being a physical flesh-and blood organism, engaging with matter, and experiencing the separateness of being in form as an individual. This we all endure, suffer or enjoy as the case may be. I see the nature of the human condition as having to come to terms with the tensions and contradictions of living with these planes as principles of being alive in the world. In practical work with clients I often find it useful to identify and name such dilemmas explicitly.

It is within this 'field of existence' that the self, along with the subpersonalities, manifest and evolve. See diagram 3. In my dynamic model each subpersonality undertakes a broadly two-part journey: the first part is about coming into form; the second part is about transcending form. The sequence is not necessarily linear (subpersonalities can regress), and each part of us (ie. each subpersonality) is a different place in this journey. For example, someone may have a very evolved artist subpersonality, able to produce many good paintings and make a living, yet be very adolescent and immature around issues of personal relationships and love. This accords with Ken Wilber's ideas of various lines of development being at different stages of consciousness, from what he calls the pre-conventional to the post-conventional. Sticking with Wilber here, the fact that a subpersonality may be close to an experience of oneness, may not say whether it is the beginning or the end of its incarnational journey - what he refers to as the 'pre-trans fallacy' - a useful teaching tool in psychosynthesis.

Now, what the classical egg diagram does not make clear, but which is important to my model, is that each subpersonality has a 'higher' and a 'lower' unconscious. Each is a mini-egg, with its own authentic centre. The 'I' or self, actually is contentless, or is in fact a 'no-self self' - similar to some Buddhist notions. The work of what we call 'the journey of the soul' takes place in the constellation and development of the subpersonalities. Now, it is important to stress here, in this dynamic model, that there is not a fixed number of subpersonalities. There may be many many more than we know. We discover them when they get constellated into existence, which depends on the context. This means that each new life situation brings up a possibly untried and untested aspect of ourselves. For example, a sudden life-or-death emergency situation may constellate the inner hero or heroine, which may be a part of ourselves that we never knew existed.

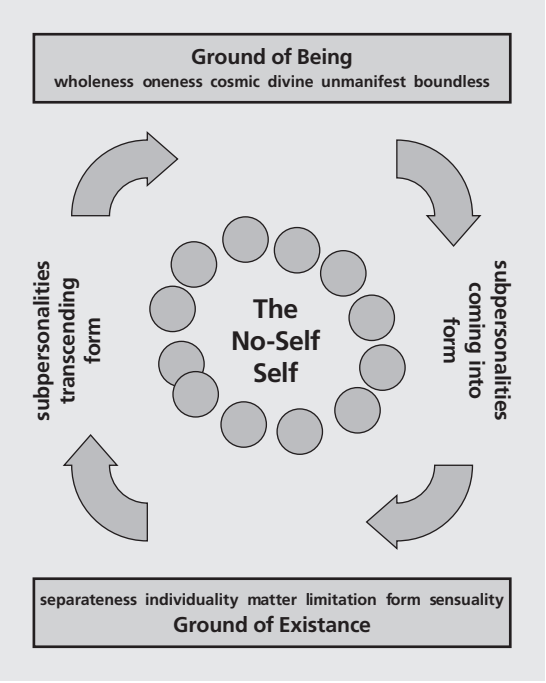

Figure 3: Simple Model of the Person

The implication of this is very 'postmodern' in the sense that our personal narratives are context-dependent. In the therapy room, this means that some part of us may emerge that has never been experienced before. This might be a product of the therapeutic relationship itself, and in that sense is truly phenomenological. In practice, this means that in the early stages, my intervention style is very much one of what I call 'apprehending' the client - allowing space for something to emerge into the space which might not have been named explcitly before as the presenting issue or symptom. Then, when it does emerge, I form this into a working hypothesis which I sometimes choose to share with the client. This is typically (but not always) the naming of a subpersonality that has not been recognised before or which may be emergent. For example, where a client describes a chronic stuckness or a restlessness in a hitherto stable partnership, I might point to an energetic countertransferential experience of an adolescent who has never been allowed to develop. I will then check this against the actual lived history and experience of the client. In this way, a newly-constellated, emergent subpersonality can be given a life and worked with therapeutically and explored practically in the everyday here and now life of the client.

This ever-moving 'wheel' of subpersonality systems, with the 'I' at the centre, exists within the wider field of existence, of which I wish to say something too, as it is also dynamic and (arguably) evolving. In my model, the drama of the self takes place within, and interacts with four zones of influence shown in diagram 4. The first is the proximal. This consists of actual people - past or present - who have shaped or iimpacted the client's life. Here we include family, friends, partners, mentors, abusers, etc. The second zone of influence, is the distal. This consists of the culture and wider society within which the client has lived. For example, the influence of feminism or attitudes to race and colour belong to this zone of influence. The third zone of influence is the abstract. This represents the impact of systems which are neither reducible to identifiable people or to any one culture. By this, the principal example is the impact of computer technology on the way we live our lives - the way it gets us to think and structure our communication patterns and relationships. An example of this would be the collective manifestation of certain types of stress-based states such as road rage. The fourth zone is the zeitgeist - the spirit of the age. For example, world views in the post-war boom of the 1960s differ markedly from the global, ecological, terror-fearing realism of the 2000s, giving rise to background anxieties about future survival, mainifesting as symptoms in the therapy space.

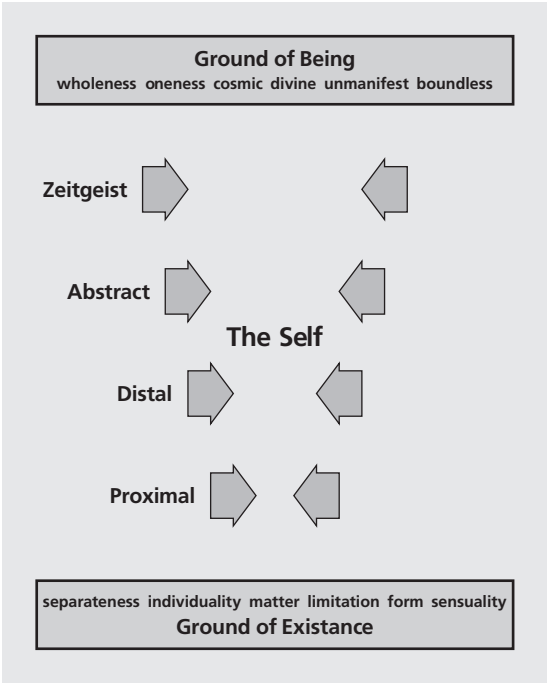

Figure 4: Zones of Influence on the Self

It is crucial, in my view to take seriously these four zones of influence, because they all impact the self, and invite a response to life from the self. For example, whereas someone suffering from depression might be interpreted one way when looked at from the standpoint of the proximal (eg. "your mother didn't love you"), might also be acutely aware and distressed about the destruction of the environment. As these four zones interpenetrate, it is not always clear in the therapeutic setting which is the most appropriate zone to address first. Certainly I would argue against a crude reductionism which collapses all the zones into the proximal. ("It's nothing to do with the planet, it's your mother"). This could be a cruel distortion of the symptom and a grave misunderstanding of the client.

Concluding remarks

Of principal importance in my style of therapy is to increase the field of awareness of the client, as this facilitates greater choice and furthers the 'I' or self as a centre of agency in the world. I would be in agreement with James Hillman that to 'see' the client is as important, if not more so than 'loving' the client, for if we do not see the life-predicament of the client, who are we loving? In my view, the core condition of respect for the client comes about through what I have called the apprehending process - creating the conditions for the full possibility for all the relevant narratives to manifest in the room without foreclosure. Yet, it is also important to me to be able to think about the client, and to form workable operating hypotheses which are fluid and to which I am only lightly attached. Hypotheses yield strategies, and every therapist needs a strategy - even if it is an intuitive one.

In writing this piece, I would like to name some key influences on my thinking, some of whom have been directly mentioned: Roberto Assagioli, Zygmunt Bauman, Martin Buber, James Hillman, Heinz Kohut, Rainer Maria Rilke, David Smail, Ken Wilber. I would also like to thank some of my trainers over the years who taught me how to think about these things - particularly Jarlath Benson, Joan and Roger Evans, John Firman, Nick Hedley, Chris Robertson and Danielle Roex.

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Katherine Murphy

On Being An Integrative Practitioner: Principles Of Integrative Psychotherapy In Practice

Introduction:

In one of his writings Nietzsche suggested that all choices of profession are autobiographical. What draws me to this developing tradition of psychotherapy integratio is a longstanding interest in multidisciplinary perspectives both in my personal and professional life,which I no longer see as a problem with attachment. Some of this interest emerges out of my own struggles to embrace the best of a childhood in rural, multicultural, New Zealand with the best of an adulthood in heterogeneous London: the energetic "Can do" freshness of the new world with the nuanced wisdom of the old world. It also draws on my experiences as a primary school teacher in a multicultural context, as a residential social worker with troubled adolescents and as a qualified social worker educated in a psychosocial perspective working with families and with groups. All of this at a time when the personal was the political and the personal was the professional. Although I did not formally plan my career path the integrating thread is summed up by my passionate interest in the freedom to learn what that means to me, what that might mean for others and how can I create for, and the cocreate with others the conditions of freedom so that learning, in the widest sense of that word, can take flight, and growth continue. This inspired my work as a teacher, as a social worker and it inspires my work as a psychotherapist and as an educator of psychotherapists. It is from this very personal place, perhaps from the very heart of myself that I think about the principles that shape my identity as an integrative psychotherapist.

My initial training was in an integrative approach to Transactional Analysis psychotherapy, augmented by workshops in psychodrama, bioenergetics, gestalt and individual and group psychotherapy with an integrative psychotherapist. We were encouraged to follow our interests, to read widely, to think robustly, to experience deeply and to bring all this to bear in our reflecting on our psychotherapeutic work. We learned the science of thinking clinically and how to make a multi-axial diagnosis and the art of putting that to the back of our minds as we opened our hearts and minds to meeting the very human being in front of us. I experienced this for myself, and was continually reminded by clients, that being listened to, being witnessed in all the aspects of our being, having someone deeply committed to engaging with us and trying to understand our ways of making sense of ourselves, others, and the world, is a profound and often transformative experience.

There have been many years of personal and professional development since then. I experienced other forms of personal psychotherapy – two differing forms of psychoanalytic psychotherapy and an existential psychotherapy. On the one hand I went,and continue to go, to conferences and lectures that explore new ways of thinking about relationships and therapeutic relating - contemporary object relations, self-psychology,

attachment, intersubjectivity theory and relational approaches to psychotherapy. As much as I think that it is the quality of the encounter that is necessary to change and at the heart of therapeutic work I do not think it is sufficient. So on another hand I sought out more practical and technical knowledge and skills in working with post traumatic experiences, cultural identities and issues of diversity in practice and on sexuality and being engendered. In a very different vein learning ceroc dancing gave me much cause to think about the necessity of both partners holding their own space in relation to each other so that they could create a frame between them that allowed creative partnered dancing to happen. What a wonderful metaphor for practice. I have come to think that psychotherapy is a kind of contact improvisation-ultimately both client and therapist have to entrust themselves to the process of being together and there are skills, techniques and exercises that may be useful to this process.

Bearing this in heart what follows is a brief synopsis of how I think about Integrative Psychotherapy and the component parts that I integrate to form the framework that guides my clinical decisions. This is in two parts. The first is a brief overview of psychotherapy integration as a dedicated activity and the second is an introduction to how I am finding my expression of this dedicated activity.

Part One: An overview

At its most essential, and poetic, I see psychotherapy as care for the soul (Moore, 1992). Deriving from the ancient Greek words psyche, meaning breathe or soul, and therapeia, meaning to tend or cure, the service of psychotherapy in its contemporary incarnation builds, in my view, on ancient traditions of the tending to the emotional aspects of life and to the essence of being human. In its modern idiom it is a profound form of collaborative endeavor that addresses, and seeks to redress, the suffering that arises when the core organizing principles of being human with other human beings have been disrupted and damaged in some way. Such disruption and damage compromises the fundamental coherence, cohesion, flexibility, adaptability and resilience of a sense of myself with other(s) and thus compromises a person's capacity to navigate the vicissitudes of living, existential givens and the vagaries of fate.

In a more practical sense I share the view that psychotherapy is primarily an interpersonal activity, a form of dialogue between two persons, client and psychotherapist, dedicated to bringing about changes in the essentials of the personality, in the dynamic interrelationship between the client's affective capability, cognitive capability and the manner of their relating to the other/s.

In discussing the evolution of psychotherapy integration Norcross and Arkowitz (in Dryden, (1992) state:

"Psychotherapy integration is characterized by a dissatisfaction with single school approaches and a co-committment desire to look across and beyond school boundaries to see what can be learned from other ways of thinking about psychotherapy and behavior change. "

Necessary to an Integrative approach, though not specific to it, is in my view a commitment to informed pluralism, intellectual relativism, open minded curiosity, pluralistic tolerance of different perspectives, an interest in bridge building or rapprochement, and an interest in commonalities between different approaches. It involves an interest in being multilingual and being able to move elegantly between languages as well as speak Esperanto. Sometimes this can be derided by detractors as unbridled freedom and undisciplined eclecticism. At worst having opened one's mind so much that one's brains have fallen out. To the contrary, I share the view that this is a highly disciplined way of working which Clarkson (1992 p.48) summarized as:

"… it involves an inclusivity (that) necessitates a responsibility that is no longer about what is right or wrong, what is the truth and what is not the truth, but a responsibility to be able to explain why, when and how we select the theoretical constructs or operational procedures that we do."

In general, terms informal integration as the natural and inevitable assimilation of new knowledge /experience into existing bodies of

knowledge is as old as philosophy itself. The emergence of a formal and coherent tradition called Psychotherapy Integration or Integrative Psychotherapy can be dated back to the late 1970's (Norcross and Arkowitz, 1992). Earlier in the twentieth century there were several intimations of this cross disciplinary way of thinking about practice. These can be seen particularly in the work of, for example, French (1933) and Fiedler (1950), both of whom were interested in factors common to different psychotherapy traditions and in the Jerome Frank's work (1961) on factors common to forms of persuasion and healing. There has been a lot written in the ensuing forty years about psychotherapy integration and integrative approaches to psychotherapy (see for example: Norcross and Goldfried, 1992; Mahrer, 1989; Dryden, 1992; Evans and Gilbert, 2005) as a way of synthesizing differing bodies of theories and diverse concepts into a coherent trans-theoretical framework for organizing ethical and responsible practice. Whatever the specific ingredients, it provides the integrative practitioner with a necessary structure which is powerful but flexible and malleable, generative rather than deductive, with which to go on building coherent and comprehensive theories of practice. There is therefore no monolithic entity called The Integrative Approach. It is about individually tailored practice within a conceptual framework that in inclusive. I locate myself formally in this way of approaching practice.

Part two: My View-for-now:

My framework is made up of the following six strands. I see these as oscillating together in states of ongoing mutual and reciprocal influence, to adapt a phrase from Robert Stolorow.

These strands are:

A psycho/social/somatic perspective where the interpersonally developed brain/mind/sense of self and with other(s) is both embodied and socially embedded where the inner and outer worlds of the person are inextricably interrelated and interrelating. What I think of is involved in the interpersonally developed sense of sense with other/s, the disruptions to this development across the lifespan and ways of working with this therapeutically. I am particularly blending ideas from neuropsychology, intersubjectivity, body oriented psychotherapies and intercultural psychotherapies. This places me in traditions that see working with the dynamics of the many relationships that are involved in the umbrella phrase "therapeutic relationship" as being at the heart of therapeutic work. Core to this is what Daniel Stern describes as: `This new view assumes that the mind is always embodied and made possible by the sensorimotor activity of the person, that is interwoven and cocreated by the physical environment that immediately surrounds it, and that it is constituted by way of its interactions with other minds. The mind takes on and maintains its form and nature from this open traffic. The mind emerges and exists, from intrinsic self organizing processes, interacting with other minds, without these constant interactions there would be no recognizable mind. "(2004. p65). Further …." The existence of an intersubjective matrix defines the psychological context in which the therapeutic relationship takes form." (op.cit).

As I see it this intersubjective matrix defines the psychological, the physiological and the sociocultural context in which the therapeutic relationship takes form. I see both client and psychotherapist as observing participants engaged in a mutual and authentic collaboration, exploring experiences of being together in this context, and attending to the many levels of communication between them both implicit and explicit such that this present centred relationship might allow for the client to both re-experience and explore this existing processes without shame or blame and for change to emerge out of this new experiencing.

Information about common factors across different psychotherapy approaches. In particular, I draw on Frank's work (1961; 1982) and the need for there to be congruence between my therapeutic rationale, therapeutic rituals and my form of healing setting and how all these contribute to the (co) creating of a confiding, emotionally charged relationship. I take heart from common factors research that indicate that it is a combination of the qualities of the therapist, the self of the therapist the qualities of the client and the quality of

the relationship between them, that are the fundamental contributors to sustainable change.

Issues of time: the existential given of the finiteness of our lives, and, in microcosm, the therapeutic encounter; the plasticity of time – how the past and the future colour the present and working with the past and the future in the present; and the immediacy of the present times – how current events are influencing our sense of ourselves, our identities and our concerns.

Generic occupational standards for sound,ethical,autonomous professional psychotherapy practice from the moment of initial meeting to the closure of a therapy, (See 2006, Law and Leipper report for UKCP). Our therapeutic relating is contained within the framework of a professional service with all the proficiencies associated with this.

The values stance of an integrative approach as outlined previously.

All this distilled through the unique particularity and sensibility of me, the person, who steps into the role of integrative psychotherapist.

Although this provides a comprehensive and multidisciplinary map for practice, it is not the territory and I share the view that each client calls forth, with me, their own unique form of psychotherapy although each psychotherapy is embedded in the framework I hold.

A vignette:

Hesther phones to discuss the possibility of psychotherapy. Her voice is firm, though with a feeling of sharpness and urgency. We talk briefly to arrange an initial meeting to see what might be possible between us, my usual practice; I begin to feel some prickling irritation. I like the seeming ease with which we could find a mutual time and make the beginning arrangements and yet I feel itching and afterwards find myself preoccupied with "I don't know why but I watch this". Hesther arrives 15 minutes early for our appointment and I realize that I have been pre-occupied with her coming and that I am not surprised I also feel flustered and wrongfooted. I am finishing a supervision session. I don't have a waiting room and the other room in my practice is busy. I am mindful Esther has come a long way and that all of this is new – I want to re-assure her she has the right place but we can't meet yet. I choose to interrupt the closing minutes of the supervision to answer the doorbell. I am full with a mixture of feelings as I open the door. I don't feel quite composed. Esther looks at me in shock as if she has been struck – "I am so sorry", she gasps." I am so sorry I am early. I am so sorry I will come back at the proper time". I clumsily apologize too and say I will be ready to see her then as arranged. She slinks down the path and out onto the pavement. I close the door feeling shocked, rude, and ungenerous as if I'm doing something wrong and casting her out into the wilderness. My supervisee and I manage a good enough ending and I wait to remeet Hesther after what already feels a charged and aborted beginning. I wonder what we have already cocreated and how we will now meet and who will now be meeting whom on this autumn afternoon in 2005. Will I be able to stay open to all possibilities? In the years that Hesther and I subsequently worked together we came to realize that this doorstep drama between us contained the core ingredients of her story-issues of being wanted, of being welcome, of nearly being aborted, terror of getting it wrong and being abandoned, not feeling able to have her own feelings. It tapped into my own story about getting it right. The present had become over shadowed by the past and yet the present moment was all we actually had. We cautiously explored together the experiences we both had of that moment: the thoughts and feelings it evoked in both of us. I was pained to hear what happened for her when she saw my face and what this evoked for her whilst holding lightly to my own version of my process. I agreed that I could have been clearer about my practice situation and that I had assumed she knew how it worked. This resonated for her and it also had resonance in my own story. We made the links to her family story and gradually my way of being with her became not just a momentary repeat but a new experience and a fresh sense of herself with others took shape.

I come back to Daniel Stern again (2004,p227):

"In talking therapies, the work to interpret, to make meaning, and to narrativize can be seen

as an almost nonspecific, convenient vehicle by which patient and therapist 'do something together'. It is the doing – together that enriches experience and brings about change in ways-of-being-with-others through the implicit processes discussed. Complementary to this, verbal meaning making and narrativizing as forms of explicating can be viewed as also bringing about therapeutic change. Here the implicit doing together and altered implicit knowing frames the flow of explicit understanding and locks it home".

Finally, I take counsel from two different sources when I think about any theory based practice. Firstly, from Shakespeare's Hamlet where Hamlet says to Horatio;

"There is more to heaven and earth than is dreamed of in your philosophy Horatio"

Secondly, from Jung who said something along the lines of learn your theories and learn them well and then leave them behind when you encounter the mystery of the human soul.

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Ros Guthrie

Integrative Psychotherapy MSc Dissertation

Editors' Note

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

A Discussion Of The Influences That Have Contributed To My Development As An Integrative Psychotherapist At This Stage.

1. Oppression and difference

I believe that the most painful events in my life have not only influenced my becoming a psychotherapist, but also have informed my integrative model of psychotherapy.

My parents were economic migrants from Jamaica, West Indies who found work within the British nationalised industries in 1950s. When I was two, our family was re-housed, from a black neighbourhood to a white working class community. Being the only black family in the neighbourhood, we became targets for racial abuse; the type that was prevalent in 1970s Britain. In spite of constant racial abuse in its many forms I was desperate to fit in, and to belong, and I somehow learnt to "dissociate" from my blackness to create an illusion of internal safety within a hostile environment.

Growing up different and hated meant that while other girls were playing with dolls, as a child I was already busy with existential enquiry, "Who am I? Why am I treated differently? What is the purpose of my experience?" It seemed that society had already begun to deconstruct me by asking about my hair, nose, skin, and even the colour of my blood. Consistently changing definitions such as "African Caribbean", "ethnic minority", or "minority ethnic"add to the sense of having a shifting sense of self where the locus of evaluation is held firmly in the oppressor's hand.

The potential impact on one's self esteem is powerfully described in Hugel – Marshall's (2001, p33) autobiography "Growing up Black in Post War Germany, when she asks: "How can I recognise that I am loathed for my blackness and that I will not be afforded an equal chance in life without also giving up completely? How can I manage to be human when I am neither loved nor wanted? … How can I prevent whites from building themselves up on the basis of my oppression?"

Through my personal experience as a client in psychotherapy and through psychotherapy training I learnt to reclaim my black identity and transform my introjected perception of "ugliness" into one of beauty. Feelings of anger and hurt have been gradually transformed to that of compassion for victims and perpetrators alike.

My own experience of being oppressed for my difference means I particularly empathise with those who had also abandoned aspects of themselves in order to survive. I endeavour to bring into my practice an attitude of compassion

and an awareness of the guilt and shame that often accompanies this process of realisation of the high price paid in order to maintain attachments to those in positions of power.

As a black practitioner I am also conscious of how discrimination, poor housing, and the stigma of poverty not only erode self-esteem but also arrest its development and I work to identify and challenge the negative messages that have been unconsciously introjected.

Through challenging internalised oppressive structures I believe we make small contributions to social change.

A Brief Summary Of The Main Themes In My Framework For Integration

1. Introduction

My experience of difference has informed me that the social impacts on the personal, as the personal, impacts on the social. I believe there is a strong connection between societal oppression and family disintegration and subsequent susceptibility towards psychic fragmentation and mental illness. I pay attention therefore to the effects of the wider context. Within my therapeutic practice I endeavour to create a sense of relatedness between internal and external worlds through the provision of a relationship that focuses on containment, curiosity and compassionate communication.

2. My Personal Values and Principles

Racial injustice has cultivated a commitment to equality; and having lived within the suffocation of a hostile environment I now value growth, learning and play. authenticity and integrity are also very important.

2.1 Equality

I believe basic human survival instincts direct us to fear those who are different and we can sometimes create the other as an "it" instead of seeing the sacred, or the "thou" inherent in their nature (Buber, 1970). This dehumanising process cultivates misinformed perceptions that lack empathy. With this, internal conflicts become externalised as we defend what we find familiar. However, by maintaining awareness of the other's humanity, we maintain an "inclusive sense of I", or interconnectedness (Wang in Gilbert 2005, p143). The Buddhist concept of cultivating compassion, or metta invites us to realize the deeper reality; that we are all connected, we are all one; thus the space between us is no longer solid, but fluid.

2.2 Integrity

Because of my own experience of overadaptation, I now value wholeness, cohesion and integrity. I believe that in hiding our true nature, or our "True Self "(Winnicott, 1979) we negotiate away our integrity for the illusion of wholeness and only reveal what he calls our "False Self". I prefer to use the terms: "Visible Self" and "Hidden Self" respectively. These definitions seem less polarised or judgmental. Without judgment we can become curious about what remains hidden; like the crescent moon, our shape is defined by what catches the light and we forget that the moon is round. If we search out what is hidden in the shadow there is a chance to remove past negative introjects, and find true connection with self and universe.

Out of this sense of relatedness we can experience true holding that supports our growth, as "once this type of integration occurs, then the tendency towards growth can become fully operative…(Rogers 1951, p514). Psychotherapy, therefore, is a place where the unlikeable aspects of self can be contained and integrated within a containing and non-judgmental realtionship.

2.3 Growth, learning, and transformation.

Our sense of curiosity needs encouragement in order for us to learn about ourselves, each other and the world. My previous studies in the sciences have led me to value playful curiosity and experimentation. Like play, it involves the imagination, and testing out of reality. In mirroring, modelling and validating another's sense of play and curiosity, we are both validating their growth potential, and

also communicating our interest in that person's inherent nature, as Winnicott (1979, p146) writes: "The True Self has a spontaneity, and this has been joined up with the world's events. The infant can now begin to enjoy the illusion of omnipotent creating and controlling, and gradually come to recognise the illusory element, the fact of playing and imagining."

If when we make a mistake, we do not receive a mirroring response but instead receive a critical and shaming response, we can begin to believe that we are the mistake and through our lack of self esteem, we learn to adapt.

3. Human Motivation

3.1 Self Actualisation

To me, human motivation fluctuates and changes with each life stage, however I believe that throughout life we are motivated towards self knowledge and actualisation (Maslow, 1954; Rogers, 1951). The paradox therefore is that when we seek self actualisation we inspire connection on many levels; it is not at all selfish. I believe that a full relationship with our self leads to satisfying connections with others and with the world. Being loved and expressing love is central therefore in a quest for a sense of wholeness, and it follows that a sense of wholeness and security can only be achieved through relationship.

3.2 The need for security

Bowlby's (1988) attachment studies demonstrated that from birth, we make strong affectional bonds with our primary caregivers in order to achieve a sense of security or "secure base". As Holmes (1993, p.67) states," to feel attached is to feel safe and secure". With an "internal working model" (Holmes 2001, p.14) of a secure relationship; we attain a healthy self esteem that supports growth and exploration.

3.3 The need to belong

Throughout life we continue to seek secure bases, or objects as "self -regulating others" to leave from and return to, (Stern 1985, p.269); in other words, we are primarily object seeking, and are motivated towards making relationships (Fairbairn, 1952). However our attachment needs evolve as we mature. Our need for affiliation and belonging is confirmed by Bowlby (1969, p207) who states" a school or college, a work group, religious group or political group can come to constitute for many people, a subordinate attachment figure."

Buddhism and other spiritual practices often include a perception and treatment of others as familiar and are based on a more "inclusive sense of self "(Wang 2005, p 89). In my view, the need to belong comes from this need to feel connected, as Kaufman (1996, p44) states "A bond is forged out of experiences of identification, and a sense of belonging grows."

3.4 The need for power and mastery

As we form new attachments or "object relationships "(Gomez, 1997) we test out our own potency. This "power motive" (Kaufman 1996, p 80) is an outgrowth from our early experience of powerlessness; which includes our initial need to be in control of our bodily functions, and our later need to differentiate and be separate. Without choice, or autonomy or a continued "sense of self agency "(Stern, 1985) we can feel powerless, which can then lead to depression, and despair, as Kaufman (1996, p80) states: "Power is also the fulcrum upon which hope and despair delicately balance."

4. What makes us Human?

We are, I believe, "a holistic combination of psychological and physical factors in a particular context" (Kepner1996, p3). Essentially I see humans as energetic systems constantly responding and organising internal and external stimuli; and the self acts as," a centre of initiative and a recipient of impressions" (Kohut, 1977, p99). However, artificial divisions of the person such as Ego, Id and Superego (Freud, 1923) or Parent, Adult, Child (Berne, 1972) can help to understand our internal mechanisms and Kleinian (1946) concepts such as splitting, projection and projective identification, help us to understand where affects are located.

4.1 The self

The self develops robust and cohesive psychic structures, primarily through significant early relationships with our primary caregivers or Objects, (Klein, 1946; Kohut, 1977; Stern, 1985; Fairbairn, 1952). These early relationships act as "selfobjects" (Kohut, 1978) in that they provide us with much needed functions such as empathic attunement, misattunement, mirroring and handling which Kohut referred to as "selfobject needs" (op cit). He explains (p72): "psychological structures … are internalisations of the soothing, tension regulating and adaptive functions that have previously been performed by the self-objects."

If the self experiences an empathic, responsive human milieu, or a "good enough" holding environment (Winnicott, 1979), they form healthy relationships with self and other. I also hold that a predictable and benign community provides a "facilitative inter-subjective matrix" (Stolorow 1992, p. 27) that modulates affect through echoing and mirroring, which in turn helps the baby to organise and tolerate the chaos of reality.

5. Normal Development

5.1 The Developing Self

Within the first three months, the human baby attempts to negotiate and tolerate the chaos of new experience and stimuli. I believe the baby splits good and bad experiences by projecting total good or total bad onto the Object and through a process of "projection" and "projective identification" early tensions and polarities of affect are regulated in order to maintain trust and love in the good object (Klein, 1946). In my opinion these concepts form a bridge to the more relational theories.

Like Bion (1970), I view the carer's role as that of container; functioning as an external object receiving the baby's uncontrollable anxieties and transforming them and then making them tolerable to the baby; this he called the container-contained relationship.

Kohut (1984) described another anxiety-transforming function; that of "optimal frustration." He explained how the "narcissistic self" has three selfobject needs; that of mirroring, twinship and idealisation, which provide a framework within which repeated experiences of disappointments or "optimal frustration" (Kohut, 1984) become manageable, and tensions between the "ego-ideal" (Kohut & Seitz in Siegal 1960 p.42–43), and our real ego self is reconciled. These disappointments are tempered by the repeated validations, acknowledgements and empathic attunement received from the primary caregiver.

5.2 The Developing Personality

The infant learns to regulate affect through attunements and manageable misattunements from the caregiver. Repeated episodes of these experiences are internalised to form "Representations of Interactions that have been Generalised," or RIGS, (Stern, 1985). These internal models of the world provide structure, constancy and a sense of security. What we believe about self, other and our world forms our personality as well as our internalised beliefs about relationship or what Bowlby (1969, p. 79–84) called "the internal working model".

5.3 The Space between Us

Caregivers have a vital role in helping modulate children's physiological arousal by "affect attunement" (Stern, 1985). This regulates normal play and exploratory activity and in turn develops a predictable sense of self. Memories are synthesised into "internal working models" of attachment which shape our expectations of future attachments (Bowlby 1988, p.129–133). Mahler et al. (1975), and Main et al. (1985) provide clinical evidence to support that when we are provided with a "secure base" (a good and predictable enough environment that supports our individuation as well as our appropriate dependency), we are able to undergo the developmental task of "separation – individuation" (Mahler et al. 1975). This process supports our capacity to live interdependently without compromising the self.

5.4 The Impact of Context

Although I concur with the above I would stress, like Bowlby (1988), that communities and cultures can offer a diverse range of environments that can influence the attachment pattern and in turn the separation process. Therefore, interpretations of attachment must be viewed contextually.

Minority groups are particularly susceptible to containing negative aspects of society. By a process of projective identification, the minority member maintains attachment with the majority group by identifying with negative projections (Shivanath in Sills, 2003).

Black people in Britain experience further lack, as Shivanath (2003) states "for black people who grow up as a racial minority, the lack of their own race being mirrored or reflected back to them is profound". This confirms my view that the secure base must include the community; without this the world is viewed as Wolf (1980, p128) posits: "but if by some adversity of events this person would find himself transported into a strange environment, it will be experienced as alien and even hostile, no matter how friendly it might be disposed toward him. Even strong selves tend to fragment under such circumstances. One can feel loneliest in a crowd. Solitude, psychological solitude, is the mother of anxiety."

6. Abnormal development

Disruption of attachment bonds at the very early stages of life can lead to regulatory failure because the child does not have a mental representation of a responsive caregiver in times of need and therefore is not able to regulate his arousal and emotional reactions (Van der Kolk, 1989). It is this "affect dysregulation" (Schore, 2005) that is at the heart of dysfunction, and indeed he goes on to state that this dysregulation is the root of all Axis 1 and Axis 2 anxiety disorders as described by the American Psychiatric Association's Diagnosis and Statistical Manual of Mental Disorders, or DSM1V (2000).

Ainsworth et al, (1978) classified the resulting attachment patterns as "avoidant," (overregulation of arousal), "ambivalent" (underregulation of arousal) and "disorganised" (where both under and overregulation of arousal exist). All of which utilise maladaptive strategies to gain proximity to the caregiver in order to survive.

6.1 Effects of trauma

When faced with events that we perceive as life threatening or severely dangerous, we may undergo a prolonged psycho-physiological alarm response, or "trauma response," (Schauer, 2005). Here, the survival decision is either to flee, fight or freeze.

In psycho-physiological terms, the overloaded right hemisphere of the brain is unable to transmit the sensory information to the left hemisphere, the language centre, hence the accompanying "speechless terror "(Van der Kolk 2004, p11). A prolonged and extreme physiological response to trauma is classified as Post Traumatic Stress Disorder (P.T.S.D.) where symptoms such as sweating, flashbacks and sleeplessness are accompanied by feelings of shame, and powerless.

Potential physiological damage includes an altering of the brain function which can result in maladaptive mental health in later life including problems in forming trust in self, other and environment, (Sapolsky, 1997). The body's ability to maintain homeostasis or "allostasis" (Schauer 2005, p.5) is disrupted by prolonged stress, which can damage organs including the brain. Further brain damage can occur due to stress induced unregulated glucocortoid and neurotransmitter secretions leading to dysregulated states (Zulueta 2006, p7).

Self medication through drugs or alcohol can serve to cut oneself off from the overwhelming experience and manage the chronic affect dysregulation (Chilcoat & Breslaus, 1998). Dissociation, or "inward flight" (Zulueta, 2006), is utilised under extreme stress. Here the body, the container of affect and physical experience, is perceived as dangerous in its vulnerability.

In cases of developmental trauma, chronic abuse, or neglect, the brain's right hemisphere together with part of the supra orbital area

are impacted, and therefore the empathic perception of others is dysregulated, leading to "pervasive problems with attachment, attention and with managing psycho-physiological arousal "(Van der Kolk 2004, p. 9). Emotionally, the loss or lack of self – regulatory processes in abused, neglected, or otherwise traumatised children leads to problems with self- definition with a poor sense of separateness and body image disturbance as well as problems with intimacy (Van der Kolk, 2004).

Unconscious denial or "defensive exclusion" (Bowlby, 1988) as well as taking the blame for the abuse, known as the "moral defence "(Fairbairn, 1952) act as defence strategies used by the victim to maintain a positive internal representation of the abusive attachment figure. As Schore (2001, p240) states" the resulting working model are those of an idealised attachment relation and that of a dysregulated self in interaction with a mis-attuning and frightening other." In other words these defences act as defence against experiencing the pain of traumatic loss of a good object.

6.2 Psychosis and traumatic loss

Along with Winnicott (1963) I believe that traumatic loss, together with other contributing factors such as chronic isolation can elicit a psychotic episode. There is a lack of interest in the meaning of psychosis; instead, psychiatrists focus on diagnosis and physical treatment and hospitalisation (Kareem, 1993). I believe the fundamental flaw in the medical model is that it often exacerbates the very factors that contribute to the mental disturbance, such as stigmatisation and isolation due to the side effects of medication, feeling pathologised and increasing helplessness and dependency on mental health services.

Therefore I support a collaborative systemic approach that includes symptom management, community and family support and access to talking therapies to explore their experience of relationships. This could reduce the "revolving door "experience of repeated hospital admissions and increase the sense of relatedness for the client.

6.3 Personality disorders

Personality is "the relatively predictable ways in which a person functions at the contact boundary "(Gilbert & Evans 2005 p.96) Contact here, means the interface between the internal and external world. If the person is unable to organise the environment at that time, personal pathology arises in the form of personality disorders (Gilbert & Evans 2005 p.96). As Johnson (1994, p14) states, "all personality disorders are characterized by a very low tolerance for and difficulty in containing any increase in a number of affective states: anxiety, frustration, aggression, grief and loss, love or intimacy, etc."

7. Diagnosis and Client Formulation

My experience of supporting those within the mental health system has reinforced my belief that although diagnoses can serve to distance the client, used sensitively, they can be used to distance the problem from the client and thus empower the client.

The DSM 1V (2000) provides a description and classification of such clinical and personality disorders in terms of behaviour. In my practice I find it valuable to see how the client fulfils the criteria listed for each disorder. However, Johnson (1994) provides me with an integrative and sensitive frame to identify, understand and treat psychopathology through relationship. Having a framework of behaviours, attitudes, affective responses etc…helps me to therapeutically "reframe" the client's problem which in turn "promotes compassion and understanding in place of self denigration" (Johnson 1994, p. 6).

I hold in mind that various factors can be at the root of mental disorders, such as genetics and external events; however I do believe that developmental and environmental factors should be explored when diagnosing someone with depression, anxiety or personality disorder, as this can support appropriate treatment direction. For example, if the schizoid personality is considered in terms of internalising an unattained and harsh parent (Johnson 1994, p.19), then a relationship with an

attuned therapist can help build self structures that can support their tolerance to affect.

In my practice, phenomenological observations, the client's reported behaviour together with their affect, and cognition are gathered to build a picture of my client which I compare with the characters and personalities as described in the previously mentioned references. Initial guesses, intuitions or responses can then be held in mind and either integrated, reformulated throughout the developing therapeutic relationship.

The Therapeutic Relationship And The Process Of Change

1. The process of change

Fundamental change involves loss, and confrontation with the unknown. T. S. Elliot's (1989) poem illustrates beautifully the uncomfortable tensions we feel when faced with inevitable change, thus:

> *April is the cruellest month, breeding*
> *Lilacs out of the dead land, mixing*
> *Memory with desire, stirring*
> *Dull roots with spring rain*
> *Winter kept us warm, covering*
> *Earth in forgetful snow, feeding*
> *A little life with dried tubers.*

I perceive therapy as a place to stir dull roots and become conscious of the "little life" we have created. Many factors contribute towards the process of change. A therapeutic relationship that includes a motivated client, together with an involved, warm and empathic therapist will normally effect significant change (Strupp, 1994).

My holistic approach supports Kohut's (1979) view that insight alone is insufficient for long term change to take place, and what is needed is empathic attunement that acknowledges sensory, cognition, emotional and physiological experience. I see the process as one where the client and therapist create a robust and flexible frame where old object relationships can be rerun and disavowed parts of self can be identified, evaluated and retrieved. Internalisation of the flexible containing frame of relationship can be reparative in that it provides a different emotional experience.

2. The three phases of therapeutic relationship

Like Clarkson (1995), Bordin (1979), Dryden (1992), I see the therapeutic relationship as having a beginning, middle and an end phase, each requiring stage specific interventions. Firstly, the containment phase is predominantly focussed on building a flexible container ready for the client to feel safe enough to begin exploratory work. This exploration marks the beginning of the middle phase. Within this phase, both client and therapist shed light onto the "hidden self" by being curious and questioning. Finally, the compassionate phase begins when the client makes for reconciliation with the "hidden self" and mourns the loss of archaic but unreal attachments.

3. The beginning phase – containment

I consider containment as an essential aspect of the therapeutic process. This containment includes the loving holding, routine care, visual and auditory sensitivity, and temperature, as defined by Winnicott, (1979) as well as the aspect of the transference relationship where the client needs the other to contain the disavowed aspects of self until the client can bear for it to be returned, (Bion 1988, p. 61 -78). These two relationships intertwine to form the working alliance and the container- contained relationship.

3.1 The Working Alliance

The working alliance is the part of the therapeutic relationship that enables the client and therapist to collaborate even if the client has feelings and desires to the contrary (Clarkson, 1995). This alliance needs to be established early, as failure to do so can predict a negative outcome (Orlinsky et al., 1994; Strupp, 1994). The working alliance provides what I believe to be the resilient structure that sets the containing frame for all other aspects of relationship to emerge. Providing consistency, structure and a sense of being held, creates trust and a sense of safety, a secure base from which to

emerge. Meeting weekly at the same time and for the same duration can be experienced by the client as a "secure base" of reliable and firm boundaries from which to re-experience what has been disavowed. Techniques such as paraphrasing, reflections, and active listening act as "metacommunications" that indicate that the client is understood and affirmed (Watson 1994, p165).

I consider that the bonds, goals and tasks referred to by Bordin (1979) outline the core aspects of this mode of relationship. If these are mutually knitted together, then the sense of commitment and direction can support the client to work through repressed material.

Once established the visibility of the alliance frame fluctuates throughout therapy but should always be monitored, as without it the therapy can fall apart. Premature interventions and a lack of attention to underlying transference and counter-transference can contribute to the failure in building the working alliance. Ruptures, threats or "empathic failures" (Kohut, 1984) can be seen as a way into reviving and working through an earlier relational rupture as "a rupture in the alliance can itself be the catalyst for effective change" (Clarkson 1995, p53).

Issues of difference and diversity can further undermine the working alliance if not carefully worked through. Therefore a willingness to explore our "societal transference" (Kareem, 1993, pp.23) and who we represent for each other is vital.

3.2 The container – contained relationship

Focusing on the client's experience of ruptured relationships can facilitate the client's sense of relatedness. These may be internal or external, real or symbolic, conscious or unconscious. Therefore, in addition to providing the holding environment, I believe we must consider the container-contained relationship between client and therapist (Bion, 1970). He described the container – contained relationship as the unconscious process of projective identification used by the infant to propel painful feelings into the caregiver. This provision of containment by the caregiver or "maternal reverie" means the child can "park" unbearable aspects of self into the container. I believe this relationship is asymmetric purely in terms of psychic function (the therapist providing a containing function) and in now way diminishes the mutual respect between the two.

To me, the role of container is similar to that of "transmutating internaliser" (Kohut, 1984) in that there is a process where the client is given time and space to develop to a point where they can re-introject what was disavowed after it had been neutralised by the therapist. For example, if an idealised therapist fails in her idealising selfobject function, the client's increased frustration helps the client to build psychological structure that can withstand these disappointments.

Transference and counter-transference phenomena, can tell us about the client's early object relationships. As Heimann (1950, p 31–34) states" the analyst's emotional response to his patient is a significant pointer to the patient's unconscious processes and guides him towards fuller understanding". Assessing the quality and intensity of the transference or counter-transference can help the therapist to decide how to work with it; whether to allow it without comment, challenge it, or consider the need for a reparative response as in the selfobject transference (Kohut, 1984). Confronting the transference with a shame based client for instance may induce further repression and self criticism but a well timed interpretation can elicit a relief response from the client who feels validated. I place high importance therefore on discerning whether my internal response is my historical proactive counter-transference (Clarkson, 1995), or whether it is a client elicited response a reactive counter-transference. Personal therapy and supervision provide forums for this exploration.

4. The Middle Phase – Curiosity

After the working alliance is in place, there is enough trust to support the client's gradual curiosity and interest in themselves, others and the surrounding world. Winnicott (1971) states that unsatisfactory existence can be measured by how much the "creative and original aspect of self" (p92) is hidden by compliance which supports my view that being

actively curious can be reparative. I use my client's and my own imagery, intuition, and imagination in my struggle to understand my client. I believe that this struggle communicates to the client that they are worthy of interest and commitment. Hopefully this provides a model of loving relationship that the client can internalise. Sensitive paced questioning or "empathic inquiry "(Erskine, 2003) can act as a catalyst that initiates the client's exploration of subjective experience and subsequent exploration within the inter-subjective realm.

4.1 Experimentation and exploration

Research supports that opportunities for the client to experiment with new behaviours and ways of being is one of the major healing factors in counselling and psychotherapy (Shmukler in Joyce, 1999). When they begin to be curious about their shadow self, the client begins to form a bridge between their ego and ego ideal; their Hidden and Visible Self, which in turn leads to the internalisation of a compassionate self. Therefore, the therapist needs to adopt an attitude of "active curiosity" (Joyce, 2001; Kepner, 1996) to support the client to explore and clarify their own understanding. By being creative and playful with the client we are acknowledging their true nature. We are supporting their move away from compliance which carries with it "a sense of futility" (Kepner, 1996, p87). Taking an interest in the client involves suspending our own beliefs and listening to the client's unique story.

4.2 Facilitating the separation process

I see the encouragement of the client's curiosity as facilitative of the client's ability to separate. With a developed sense of curiosity, (Mahler, 1975) separation anxiety reduces and becomes more enjoyable. I believe that if curiosity is supported, the potential for ego mastery and sense of achievement is increased. Where there is a lack of curiosity, there may be a need to work with the resistance. Gestalt techniques such as two chair work can help to amplify polarities and conflicts. Guided visualisations, drawings and role plays can also access the implicit memory stored in the left brain.

As Winnicott (1971, p51) states: "psychotherapy is two people playing together". It involves trust, turn taking, attunement, using the body and hopefully some fun! Fonagy (2004) further supports the developmental significance of play as it develops the reflective functioning needed to develop the sharing and predicting of behaviour. This helps people to understand each other in terms of mental states and intentions.

4.3 Increasing affectivity.

Phenomenological enquiries together with cognitive insights can enhance the psycho-physiological flow of energy. Along with Joyce (2001) I believe that the breath is central to all our experience as after all we are embodied beings. In raising the client's awareness of the quality, rhythm and depth of the breath, they are invited to increase their capacity to use the breath as self support, and also to become aware of their affective state.

Mindfulness, the simple practice of noticing the body process, is "the prime psychological resource that allows people, mastery over the physiological arousal" (Linehan, 1993). This mastery starts with awareness, acknowledgement and later an understanding of the subjective meaning behind the affect state. This "mentalised affectivity" (Fonagy, 2004, p.5) is at the heart of understanding ourselves and others. With this understanding we are able to modulate our emotions more successfully.

5. The End Phase – Compassion

To me, a robust and compassionate relationship acts as an "emollient" that loosens the grip of negative introjects and shame. Within this relationship, the client begins to internalise a compassionate self. Compassion, Salzburg (1995, p103) states: is not at all weak. It is the strength that arises out of seeing the true nature of suffering… it allows us to name injustice without hesitation, and to act strongly." So it is important for the therapist to internalise their own compassionate holding via their own support networks e.g.: supervisor, peers, and therapist.

Part of this phase involves highlighting the contextual and environmental factors that may have contributed towards current dysfunction and dysregulation. When these are acknowledged, the client can begin to de-pathologise themselves and let go of narcissistic beliefs of omnipotence that may be stored as "Ego Ideals" (Kohut & Seitz in Siegal 1960 p.42–43), and let in self compassion. As Salzburg (1995, p110) posits: "To view life compassionately, we have to look at what is happening, and at the conditions that gave rise to it. Instead of only looking at the last point, or the end result, we need to see all the constituent parts." Therefore mourning and reconciliation are an integral part of this phase.

I view compassion as the antidote to shame; therefore I pay attention to how compassion can be communicated through the therapeutic relationship. Holding the other's gaze can be a validating experience that symbolises a commitment to holding their very being (Wright, 1991; Wolff, 1963; Gerhardt, 2004; Kaufman, 1996). However, I am aware that the subjective experience of being looked at can vary. As Wright (1991, p29) states" that shame is originally grounded in the experience of being looked at by the Other, and in the realisation that the Other can see things about oneself that are not available to one's own vision." During an interview with a psychiatric in patient, my client only looked at me when I looked away. Sensing her possible shame, I offered to continue with my eyes averted and she gladly accepted and we continued this "dance" successfully until the end. I am conscious that my large eyes, together with my tone, posture, body language, and even physical proximity can impact on the client. Therefore I concur with Kaufman (1996) who believes that naming the shame affect is a powerful intervention that can help the client to normalise what they believe to be a pathological state.

6. Concluding Comments

To conclude, I believe that the therapeutic relationship provides a flexible and containing frame that facilitates the client's ability to work through old object relationships. The therapist can act as container for the unbearable aspects of self and through a process similar to "maternal reverie" (Bion, 1962) the client can build a compassionate bridge that can support the retrieval of those lost parts of self. Overall, I view the whole process as reparative, in that it provides the client with a different emotional experience.

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Book Review By Helen-Jane Ridgeway

Trauma And The Body: A Sensorimotor Approach To Psychotherapy

By Pat Ogden, Kekuni Minton, and Clare Pain, (2006). Forewords by Daniel J. Siegel, M.D. and Bessel Van Der Kolk, M.D.

Published by Norton 2006.

Theory & Research / Key Themes; body psychotherapy, psychotherapy and trauma recovery.

This book is part of the Norton series on Interpersonal Neurobiology.

Ogden has collaborated with colleagues Minton and Pain to put together a wonderful book that should be of great interest to all practitioners and clinicians working with trauma. The forewords are written by Daniel Siegel & Bessel Van Der Kolk. 'Trauma and the Body: A Sensorimotor Approach to Psychotherapy' offers guidelines to working with clients' trauma and encourages safe considered practice.

This approach sits within a relational frame, where the importance of the therapeutic relationship and creating a safe environment for exploration are highlighted, in order to bring an understanding of how the structure and function of the mind and brain are shaped by experiences, especially emotional and interpersonal. Specifically focusing on the experience of trauma and how individual bodily responses can impact and perpetuate re-traumatising experiences, Ogden and her colleagues offer an integrative sensorimotor approach to working with trauma by integrating neuroscience, body psychotherapy, attachment and developmental theory, psychodynamic and cognitive psychotherapy.

This book suggests the importance and central role that the body plays in the experience of trauma and therefore the need for an integrative mind body approach to trauma. This is a somatically-focused treatment which addresses the devastating effects of trauma on an individual's mind, body and brain bringing bodily-based behaviours, feelings and thinking to the foreground of the therapeutic experience and how traumatic events can induce visceral alterations.

Constructed in two parts, this book is well written and well organised, guiding the reader beautifully through some thought provoking theory and practice.

In the first part, we see the development of a theoretical framework, integrating historical and current empirical research and scientific findings from a wide range of areas and approaches. The authors postulate that the integration of mind and body is central to well-being and posit the importance of practitioners understanding the nonverbal, neural and interpersonal processing of the individual client.

Ogden, Minton and Pain view people as self-organising systems which are psychologically organised around core material; this core material is developed around core memories, beliefs and images which shape our lives.

When there has been an intrusion of trauma this core material is infused with traumatic responses in the form of bodily somatisations, defences and reactions most of which belong to the event of the trauma and which are not necessarily helpful to the current situation.

In terms of the therapeutic encounter, we as therapists working with trauma often engage with clients who are either 'hyperaroused' or 'hypoaroused', over stimulated or under stimulated and in either case a state of dysregulation endures, making functioning in every day life extremely problematic. This can be especially observed in cases of post traumatic stress disorder, where the intrusion of the trauma, in the form of flashbacks, panic attacks and other related symptoms can be extremely debilitating, leaving individuals in a cycle of re-activation and re-traumatisation.

The Chapter entitled 'Window of Tolerance: The Capacity for Modulating Arousal' provides useful theories and research findings that support clinical thinking when facilitating clients in managing some of the related intrusive symptoms, evoked by 'unconscious procedural learning' (p 40). This chapter offers a plethora of information as well as some clear and concise visual tool representation. Here the authors explore the research and theory of Porges (2001) whose Polyvagal theory supports much of their hypothesis and focuses on the automatic nervous system. It explains how this system integrates and regulates bodily and psychological processes, emphasising that many of our client's difficulties could be explained by an 'automatic reaction' in their bodies to circumstances and events around them. The interface between the sympathetic nervous system and the parasympathetic nervous system is also explored thoroughly in this section of the book, drawing on the work of other authorities in the field.

In Chapter three 'Attachment: The role of the body in Dyadic Regulation' highlights how early attachment relationships lay down the 'blue print' for self regulation, the 'hard wiring' of the brain and of the automatic nervous system. How different attachment styles impact a person's bodily responses, ingrained movements and relating behaviours. Bowlby's attachment theory and the attachment work of Ainsworth et al, are drawn upon throughout this book, further highlighting the importance and potency of early attachment relationships, patterns and styles in the processing and integrating of traumatic material. This chapter also shows how the process of attachment, non-attachment and attachment rupture, structure the way we form movements, relate to ourselves, others and our environment throughout our lifespan and our abilities to manage, cope with and process trauma.

Developmental theories are referenced and integrated, with the therapists attunement to clients' 'bodily states' being a necessary given, upholding Winnicott and Stern's hypothesis that a child's bodily sense develops in relation to the mother-child relationship, through the mother's attunement and affirmation of the infant's bodily self, it also draws on the capacity for 'self regulation' and the forming of 'internal structures'. Schore postulates that our early relationships impact "mental representations" and orbital wiring in the brain (Schore, 1994 p 179), thereby bringing further credence to working relationally, by supporting the potential which the therapeutic relationship holds in the 're-wiring' of the brain.

Chapter four introduces us to 'The Orienting Response', where it is suggested that "many individuals find themselves compelled to anticipate, orient to, and react to stimuli that directly or indirectly resemble the original traumatic experience" (p 65). The focus here is on the individual's narrowing of conscious experience, how the client can be encouraged to re-orientate towards "stimuli that hold potential for resolving chronic patterns of traumatic orienting" in response to perceived threat, adverse stimuli and trauma-related cognitive schemas, paving the way for more appropriately adaptive responses and behaviours.

Chapter five moves into the realms of 'mobilizing and immobilizing responses', paying attention to 'defensive subsystems', how individuals react and respond in the face of violence, danger, natural disasters, sexual abuse and wars etc and how these responses have evolved historically in order to maintain survival, whilst reminding us and alerting us to the inevitable changes the person undergoes relating to these traumatic experiences. I found

the chapter on 'Psychological Trauma and the Brain' (Ogden, et al) particularly informative and useful, synthesising developmental theories with neuroscience, offering neuroimaging research findings to support the work of therapy.

Part two of the book is devoted to the therapeutic process, providing clinical interventions, offering case studies and examples which should be of use and support to any therapist no matter what their orientation, approach or theoretical stance. We are invited to develop and expand a phase-oriented approach using sensorimotor interventions. Part two is further divided into subsections providing deeper insight into working integratively with this approach. There is a measured and descriptive sharing of the foundation skills required in sensorimotor psychotherapy.

In part two there are a number of subsections devoted to 'Mindfulness' and the encouragement of this 'way of being' for our clients, with the emphasis on 'here and now' experiencing, more pointedly the "here and now experience of the traumatic past" (p 167). Whilst the authors and many psychotherapy schools agree that content and narrative are vital in gathering information into the clients past and current contextual experiences, it is the power of the 'here and now' that can facilitate lasting long term change. The authors hypothesise that it is this focus which is not only required but indeed necessary "in order to challenge and transform procedural learning" (p 167). Mindfulness can positively foster a safe 'self-reflective' process for clients in therapy.

In the subsection 'Tracking and Bodyreading' we are shown how the therapist pays careful attention to all forms of communication and information from the client. Integrating affect, cognition and body organisations, by 'tracking' the client's bodily experience and body organisations, not only those relating to the traumatic material e.g. trembling, restricted breathing, collapsed posture etc, but also the healthier resourceful body organisations e.g. deep regular breathing, good eye contact etc.. The information that is gathered is fed back to the client, used to inform interventions, or worked with more directly by changing posture, movement, attention to breath, body scanning and so on. The sensorimotor therapist synthesizes "… top-down and bottom-up interventions, attending to the body directly, so that it becomes possible to address more primitive, automatic and involuntary tendencies that underlie traumatic and post traumatic responses" (p 299).

This approach is not only about integrating body work but thoughtful engagement with the clients embodied experience. This is not necessarily a new concept, in fact many theorists, approaches and schools of body psychotherapy and experiencing therapy do hold this at the centre of their work and many of these are quoted and drawn on in the book. The work of Van Der Kolk is liberally referenced, used and cited throughout the book, in particular his seminal work with MacFarlane and Weisaeth (1996) 'Traumatic Stress: The effects of Overwhelming Stress on Mind, Body and Society', Ogden et al's work follows on from this, taking new steps in the treatment of trauma.

However, whilst some of the methods and ideas drawn on are rightly accredited to Ron Kurtz and the Hakomi method of 'mind/body' therapy, I was a little surprised that there wasn't more direct referencing and acknowledgement of Gestalt Psychotherapy or any referencing made to Eye Movement Desensitisation and Reprocessing (EMDR; Shapiro, 2001), when for me, there are many parallels and overlaps with these two particular approaches. There seem to be obvious bridges and parallels with other approaches, which as yet have to be explored. An example is with Judith Herman's (1992) phase-oriented approach to working with trauma. Although Herman's work is cited regularly throughout the book these parallels are also not explored, nor are the parallels with Kepner's 'Healing Tasks' (Kepner, 1996).

There was no mention of contraindications to using this approach and this is another area that could be explored further, as well as indications to working with clients who present as less verbal although not necessarily traumatised and individuals who work in performance, dance and sports; all of which, I feel would be useful.

Although as therapists we cannot change the events and experiences of trauma, this book brings the potentiality that through the integration of sensorimotor psychotherapy we

can facilitate clients in a process of changing the negative impact and effects of the trauma on their cognitive, emotional and ensuing body responses. This can be transformative, leading to feelings of empowerment, whereby individuals can support themselves as well as actively seek the support of others, rather than being caught in a cycle of restrictive and often re-traumatising overwhelming helplessness "… thereby achieving mastery over arousal coupled with the feeling that they are not alone" (p 300).

I believe as therapists we need to pay attention to the living body relationship we have with our clients, as well as the relationship they have with their bodily-self "…the self is first and foremost an intersubjective bodily self in a social matrix and cultural setting" (White, 2003, p xxvi). The relationship of self to body is intrinsic to a person's self concept and provides a 'felt self'. A focus on the body, bodily somatisations and the physiological aspect of self-experience when working with trauma and clients who present with PTSD is paramount and this multilayered book provides techniques for doing so in a clinical and research based manner.

This publication goes a long way to supporting and enabling, therapists and clinicians of all theoretical frameworks, to work more holistically, effectively and safely with trauma by integrating a sensorimotor approach. I highly recommend this book.

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Book Review by Bobby Moore

Narrative Inquiry And Psychotherapy

By Jane Speedy. Published by Palgrave Macmillan.

RM: There are a number of people involved in the reviewing of a book and I want to present this review as a conversation principally between two of them (me the reviewer and Maria Gilbert, one of the consulting editors of the Journal who invited me to compile the review) in relation to the third Jane Speedy (author of the book).

MG: Well I hadn't intended getting drawn into this when I asked you about the review but I'll go with it and see what happens. It is a book about what Jane calls the 'creative liminal space' between Narrative Inquiry and. I'm interested in three spaces really. That between the book and you as reader (experiential), between Jane's theory and your theory (understanding) and between Jane's practice and your practice (application).

RM: I know you didn't expect to be drawn in to this and I didn't even ask you if it was okay. However, I will let you see it before it is finalised and we can talk about whether it is alright. That is one thing about both narrative inquiry and psychotherapy that struck me in the experience of reading the book. As a client goes through a psychotherapy process the lives of others (partners, friends etc.) are effected whether they choose it or not. So too in narrative inquiry the ripples of inquisitiveness spread out into an ever widening circle of relationships with an unstoppable energy.

Jane begins poignantly in the intimate space around her kitchen table, her paper-strewn workspace and the lives of those around her. Mr Gingley, the imaginary friend, is a memory shared first with her brother and now with her readers. The narrative of the book drew me into this comforting, cherished world initially with voyeuristic anxieties and then surprisingly with ownership as my own world of memories, my own managing of death and dying burst into the scene. Suddenly a new, unsolicited series of ripples burst into awareness, as parallel universe like, my life story unfolded alongside the narrative of the book. I found myself in places long since explored in therapy with welcome and warm memories sharing space with intrusive disturbing recollections stirring intense disquiet. My guts were abuzz with butterflies as I bathed in the liminal waters between Jane's book and my life's narrative, drifting between my own kitchen table and a beach in Donegal.

Traditional psychotherapy research, based on the statistical, evidence-providing model, often left me feeling remote from both subjects and subject. Sometimes so much so that I wondered whether the research 'findings' told me anything at all, that was going to change my practice in a meaningful way. On the other hand psychotherapy practice of the dyadic kind, taking place behind closed doors with all the paraphernalia of confidentiality drew me into a very intimate world which others would only gain a sanitised insight into. Jane challenges the binary, apartheid thinking that separates these two worlds. Reader be warned, you will be drawn, even lured, into the privacy and

intimacy of a domestic scene that will bring you face to face with the narrative that lies just beneath the surface of your own everyday.

MG: How do you think Jane achieves that with the book?

RM: Unlike the anonymous researcher, Jane is in your face so to speak, right from the start. She took me on a human journey, which was a gamble for her. Using the interview style risked being thought too informal and not serious enough (like research ought to be). Putting herself in the picture makes it difficult for the reader to stay out. But I guess that is her purpose, to take us on a personal odyssey that not achieved by many books on research or psychotherapy.

Throughout the book Jane shows us how she goes about her work, which is a refreshing approach. Rather than simply articulate the final product of the professional knowledge she has developed she paints a portrait of how it emerged. The image acts as a kind of friendly invitation not so much to follow in her footsteps as to walk our own path and have a conversation across the hedge with her as we go. That is what I found myself doing. Intrigued with her methodologies our stories at times bumped up against each other, drifted apart or danced in rhythm. I was struck by how Jane introduced me to a work in progress as opposed to a finished product and the invitation to me to contribute in dialogue felt genuine. It seems as if a dialogue of sorts is the only way to respond to the reading of the book even if I have railroaded you into this Maria.

MG: Ok, I'm getting used to the idea and can see why you want to talk your review. What other parts of the book struck you apart from this being involved in the construction of a narrative?

RM: I get a sense that it was Jane's ability to show her vulnerability that allowed her co-researchers to be vulnerable and their stories come to life at different points in the book. Donald gives a powerful example of the connection between psychotherapy and research while in listening to Hyatt's story I heard her voice in my 'mind's ear'. An unnerving experience of closeness to people I've never met physically. I can't recall any other research that did that for me and Jane's use of 'our research' here is faithful to the experience. Gina's witnesses to her journey certainly spanned the worlds of the private and the public in a way that added depth to her process and the way I conceive of therapy and research. The resonance chamber of 'reading, writing, reading aloud, reflecting and re-writing' brought words to life and birthed meaning. This happened most powerfully with the introduction of poetic representations of conversations as the stuttering gave way to gushing flow. I've often been appalled to hear what I assumed was my coherent expression echo gibberish like in the transcription – the poetic option is both refreshing and transformative.

I must say I was daunted by the wide range of references that while helpful was also challenging in its comprehensiveness. Similarly with the idea that someone could do a 'quick re-read' before final submission. I still think it would have taken me a few days, if I had nothing else to do.

MG: So I guess Jane grabbed your attention in surprising ways by the very way in which she wrote the book. I wonder how you went on to make some meaning out of that experience?

RM: First of all the language post-modern, post-structuralist, deconstruction and social construction ideas were presented with clarity, and that is quite a feat. These terms became more meaningful as the text unfolded. In particular Jane's exploration of an alternative to binary thinking through occupation of the liminal, creative space abandoned as a no-man's land by the either/or emphasis was enlightening. Liminality permits the construction of a bridge that becomes as substantial as it is personal.

De Bono (1988) reminds us that in our haste to put uncertainty to bed we jump at emerging patterns too soon making unhelpful assumptions on the way. Jane provides us with a terrific tool for slowing down reflections and going deeper reflexively, drawing out rich, symbolic meaning in the process. The narrative that emerges, rather than explaining everything, is of the moment and fit for purpose. This is particularly so in the way she draws the parallel between psychotherapy and research.

I was reminded of Japa meditation with its invitation into the liminal gaps where the physicists now tell us all the energy is anyway.

MG: You are drawing attention now to the underpinning philosophy and underlying theory that informs Jane's reflections. How did you find that helpful?

RM: Yes and from my perspective the most significant factor of the book lies in Jane's contribution to the debate on the ethics of this kind of insider research, particularly in the area of consent. When co-researchers enter into the liminal spaces as imaginative sites that extend, provoke and create knowledge in new ways openness to and capacity for surprise makes a fool of 'informed consent'. I'm not sure that there ever was such a thing as fully informed consent and certainly not in this type of inquiry (and that goes for the psychotherapy process also). What Jane succeeds in doing is showing us how through on-gong, transparent dialogue with participants agreement can be explored at every step rather than some illusory notion at the outset of the adventure. It is a constant review as opposed to once off agreement.

There are particular ethical challenges when research invites the private into the public arena and notions of modesty, humility and openness to surprise are much more useful than reliability, validity and claims to have anticipated and covered all angles. This book will open up a reflexive space for therapists of all shapes and sizes to consider the narrative they unavoidably co-create. In this context we might ask if there is such a thing as an 'outsider researcher' or a 'technically neutral therapist'. That ethics isn't about getting it all wrapped up however, might still send some into a flurry.

Jane puts words to an ethics of collaboration, description, transformation and emancipation that provide a framework for research into the often hermetically sealed world of the intimate therapeutic space, which is isolated to prevent contamination. This alternative ethical framework can align the intentionality of research and of therapy facilitating a transformative and emancipatory conversation that is also informative. Maybe this is an alternative 'royal road' to the unconscious, here co-constructed by participants rather than dependant on the artful exploration and deconstruction of the analyst.

MG: Reading the book evoked heightened emotional awareness in you and shifted your theoretical understanding, but so what? The last of Jane's criteria for reading narrative research is 'does it make any difference to your practice?'

RM: When I read the parallel texts in Chapter Eight I struggled with the idea that there was some right way to read them turning the page this way and that, reading across the rows of text and then column by column. Finally, I stood on my chair (Dead Poets Society style) to get a different perspective on the environment in which I read the text. It may seem strange but the most powerful change interacting with this text has brought up for me is that of allowing an alternative perspective. While the exercise turned me inward it also re-awakened and re-invigorated by conviction of the importance of taking another perspective. This change of attitude is encapsulated in the words of Kim Etherington that Jane quotes:

> The capacity of the researcher to acknowledge how their own experiences and contexts (which might be fluid and changing) inform the process and outcomes of inquiry. If we can be aware of how our own thoughts, feelings, culture, environment and social and personal history inform us as we dialogue with participants, transcribe their conversations with us and write our representations of the work, then perhaps we can become closer to the rigour that is required of good qualitative research. (p. 41)

It seems to me that this could equally be said of researchers, therapists and supervisors. The intense emotional involvement of all participants is acknowledged and the emerging, applied meaning, as opposed to simple product of research paper, is much more than an analysed narrative but also a changed experience for the researchers. This is transformative.

I took great courage from Jane's anxiety about not being taken seriously for the style in which she presented her material in the book. I was reminded of how I still sting from the accusation, in a similar context, of 'not being a serious academic'. I was clearly discouraged

from pursuing my line of inquiry if I was to meet university criteria. This book helps me to believe that the butterflies in my stomach might indeed fly in a flurry of colour.

MG: Writing this review as a conversation between us echoes Jane's start to the book. She did invite a dialogue and maybe she will respond to what you have written.

RM: Yes that would be nice. We have met virtually and had what feels like quite an intimate experience. Jane reminds me that I have not reviewed the book she wrote and no one will read the book I have reviewed. I have reflected on what happened to me as I read her words and wonder how it might be for others. I would be intrigued to hear from someone who reads the book after reading my reflections on it. I came away with a changed mind, increased courage and new heart for my own collaborative ventures in narrative inquiry and psychotherapy. That's quite an achievement for a book. Thank you Jane for the book and Maria for the invitation to review.

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