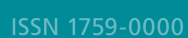
The British Journal of Psychotherapy Integration

Volume 7, Issue 2 (2010)

An Exploration of the Diversity of Approaches to Integration



Volume 7, Issue 2 (2010)

The British Journal of Psychotherapy Integration

Introduction

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

ISSN 1759-0000

Contacting Us

Please address all correspondence to:

Consulting Editors
PO Box 2512
Ealing
London W5 2QG

Alternatively you can email us at:
journal@ukapi.com

For general information regarding UKAPI please visit our web site:
www.ukapi.com

Copyright

Copyright belongs to the United Kingdom Association for Psychotherapy Integration. Material may only be reproduced in other publications with written permission from the Consulting Editors. Authors may use their own material elsewhere after publication without permission. Production of single copies for personal use is allowed without special permission.

Submissions and the Editorial Process

Articles for this journal are subject to an anonymous peer review by two members of the editorial board. If you are interested in joining the board, please contact us by email or call Maria Gilbert on 020 8997 6062. If you are interested in submitting please visit our web site (www.ukapi.com/journal/) and download a copy of the submission guidelines.

Consulting Editors

Maria Gilbert and Katherine Murphy

Editorial Board Members

Shoshi Asheri
Sharon Cornford
Harbrinder Dhillon-Stevens
Angela Douse
Jenifer Elton-Wilson
Ken Evans
Phil Lapworth
Patricia Moran
Marsha Nodelman
Jean O'Callaghan
Vanja Orlans
Tamar Posner
Werner Prall
Sue Profitt
Helen-Jane Ridgeway
Cynthia Ransley
John Rowan
Helen Rowlands

Editorial Board Members (continued)

Maggie Senior
Christine Shearman
Steven Smith
Michael Soth
Charlotte Sills
Biljana van Rijn
Heward Wilkinson
Sue Wright
Linda Finlay

Volume 7, Issue 2 (2010)

Contents of this Issue

Editorial
An Exploration of the Diversity of Approaches to Integration 5

Maria Gilbert and Katherine Murphy
Introduction to Peer Review 9

Julianne Appel-Opper
Intercultural Body-oriented Psychotherapy: 13
The Culture in the Body and the Body in the Culture

John Marzillier
My Personal Journey, From Purity to Integration 23

Linda Finlay
'Being-with': A Phenomenology of Relational Dimensions 33
Within a Psychotherapy Session

Biljana van Rijn & Ciara Wild
Research Clinic Approach to the Evaluation of Integrative 49
and Humanistic Psychotherapies

Julia McDermott
My Personal Framework for Integration 59

Editorial

An Exploration of the Diversity of Approaches to Integration

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

This edition is not a specifically themed edition, yet as is the way of these things we noticed a thematic thread as we brought the articles together. What emerged as we reread these articles in sequence and at one sitting was something to do with the more or less explicit nature of the Integrative Framework being explored in the context of comprehensive case examples, as too the validity of this way of working in the public arena of service provision and the commissioning of psychotherapy services.

Some authors clearly and explicitly chose an Integrative path; some authors evolved into becoming an integrative psychotherapist. Those originally trained in a single school approach, although integrative in style, have actively woven in aspects of other theoretical orientations over time, and practice in a manner that they would now identify as integrative.

Julianne Appel-Opper writes a rich article in a relational tone, explicitly integrating cultural phenomena and body process into an interesting account of her inter-cultural work with a client. Julianne illustrates this work in action with a comprehensive and candid case example which vividly conveys this body-oriented psychotherapeutic process to the reader.

John Marzillier gives a very personal account of his therapeutic journey and his evolution from a single school approach into an integrative framework for practice. This is a refreshing and critically reflective account of his professional development over the years, conveying a growing sense of the complexity of his thinking.

Linda Finlay offers a framework for integrating a multiplicity of relational dimensions into the work of the psychotherapist. Linda weaves existential and object relations perspectives into her experience as a gestalt psychotherapist to elaborate on the meeting between the two people in the therapy room. She supports her discussion with a comprehensive clinical example.

Biljana Harling and Ciara Wild provide an example of setting up a research clinic to gather practice-based evidence on the effectiveness of both integrative psychotherapy and transactional analysis. This style of research, we believe, can contribute to the current and very

political debate on therapeutic effectiveness by providing information from these two approaches which hitherto have not received attention in the current public debates.

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

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

Maria Gilbert and Katherine Murphy

Introduction to Peer Review

Introduction

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

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

Submission Guidelines

Please note that articles are generally 5000 words in length, with some leeway. Please also provide an abstract at the beginning and a short biography at the end (see examples in this and previous journals). Please also ensure that your referencing and reference list is complete.

1. Please supply the text portion or your submission via email. We accept RTF (Rich Text Format) or Microsoft Word files. Send it to editor@ukapi.com.
2. If your submission includes photographs, diagrams or illustrations please indicate within the body of the text where they should appear. Do not include them in the file.
3. Send photographs, diagrams and illustrations by post. We will scan or recreate them as required. For address information please email editor@ukapi.com. Your originals will of course be returned.
4. Please be sure to include references with your text. Refer to an existing issue of the journal as a guide for styling your references.
5. Please check your grammar and spelling.
6. Please ensure your references are complete and formatted correctly.

Referencing

The Ukapi Journal is formally adopting the APA style for references and in-text citations. We are providing a number of common examples as a guide.

1. Book by One Author

   Author, A. A. (Year of publication). *Title of work: Capital letter also for subtitle.* Location: Publisher.

   Maroda, K. J. (1991). *The Power of Countertransference.* New York: Jason Aronson.

2. Book by Two Authors

   Author, A. A., & Author, A. A. (Year of publication). *Title of work: Capital letter also for subtitle.* Location: Publisher.

Evans, K. R., & Gilbert, M. C. (2005). *An Introduction to Integrative Psychotherapy.* Hampshire: Palgrave Macmillan.

3. Book by Three or More Authors

   Author, A. A., Author, A. A., & Author, A. A. (Year of publication). *Title of work: Capital letter also for subtitle.* Location: Publisher.

   Lapworth, P., Sills, C., & Fish, S. (2001). *Integration in Counselling & Psychotherapy.* London: Sage.

4. Article or Chapter in an Edited Book

   Author, A. A., & Author, B. B. (Year of publication). Title of chapter. In A. Editor & B. Editor (Eds.), *Title of book* (pages of chapter). Location: Publisher.

   Bohart, A. C., & Tallman, K. (2010). Clients: The Neglected Common Factor in Psychotherapy. In B. L. Duncan, S. D. Miller, B. E. Wampold & M. A. Hubble (Eds.), *The Heart & Soul of Change: Second Edition* (83–111). Washington DC: APA.

5. Article in Journal

   Author, A. A., Author, B. B., & Author, C. C. (Year). Title of article. *Title of Periodical, volume number*(issue number), pages.

   Castonguay, L. G. (1993). "Common Factors" and "Nonspecific Variables": Clarification of the Two Concepts and Recommendations for Research. *Journal of Psychotherapy Integration, 3*(3), 267–286.

6. Article From an Online Source

   Author, A. A., & Author, B. B. (Date of publication). Title of article. *Title of Website.* Retrieved from http://www.someaddress.com/full/url/

   The Boston Change Process Study Group. (2008). Forms of Relational Meaning: Issues in the Relations Between the Impli cit and Relfective-Verbal Domains. *Boston Change Process Study Group.* Retrieved from http://www.changeprocess.org/

In-text Citations

The APA style, follows the author-date method of in-text citation.

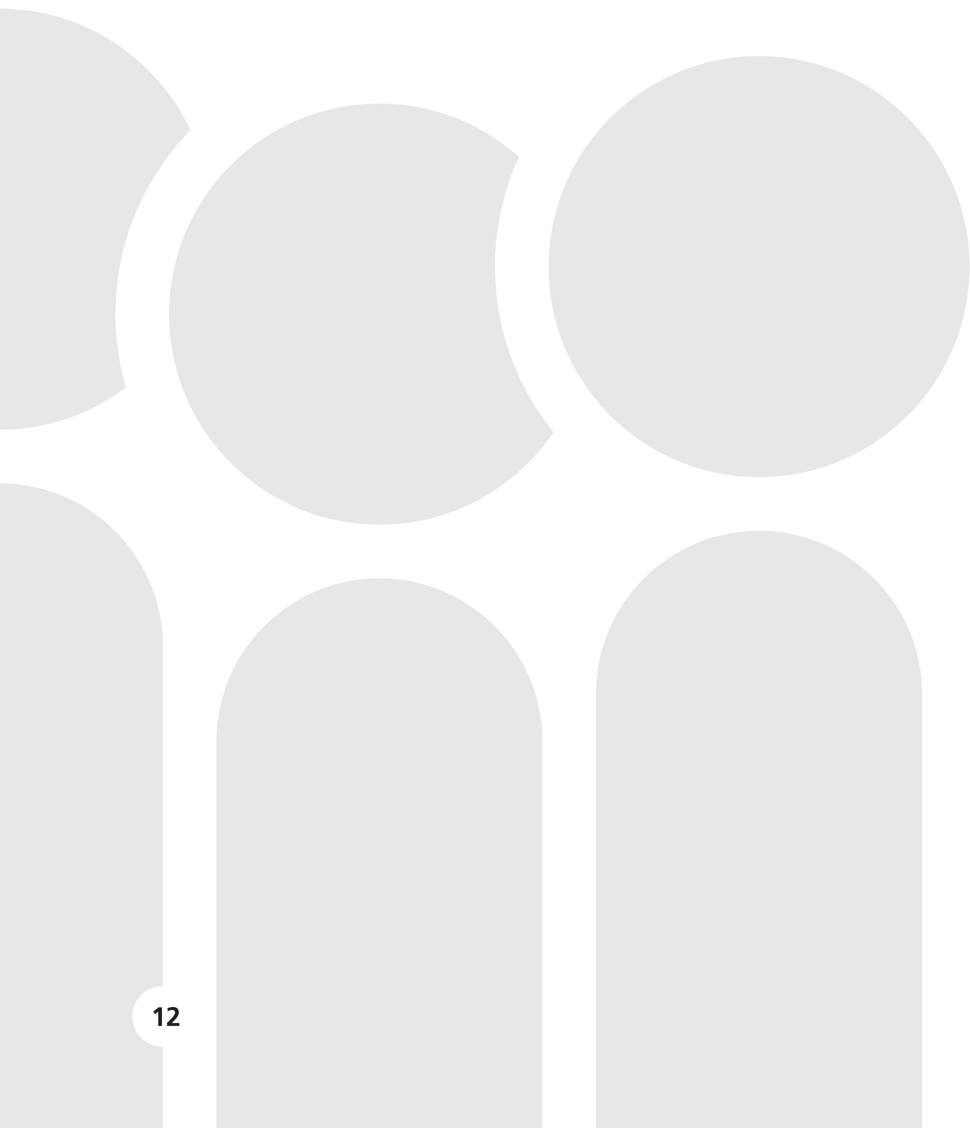
1. Quotation

   She stated, "Students often had difficulty using APA style" (Jones, 1998, p. 199), but she did not offer an explanation as to why.

2. Summary or Paraphrase

   APA style is a difficult citation format for first-time learners (Jones, 1998, p. 199).

For further information and additional examples please visit the APA Style website at www.apastyle.org.



Julianne Appel-Opper

Intercultural Body-oriented Psychotherapy: The Culture in the Body and the Body in the Culture

Abstract

In this article I will describe the therapeutic work with a Chinese client. Relevant concepts of culture, empathy, implicit cultural knowledge and implicit relational knowledge will be interwoven into the story of the therapy. I want to show how an incorporation of the implicit embodied communication between therapist and client can enrich intercultural psychotherapy. The chosen examples of embodied interventions and experiments will introduce the reader to a body-oriented intercultural psychotherapy.

The first contact…

A Chinese client asking for therapy in the English language had been referred to me by a German colleague. At this time I had been back in Germany for three years. Before that I had lived in France, Israel, California, and in Great Britain, for about twelve years.

> *During the first telephone contact the client, whom I will call A, told me with a breathless quiet voice that she needed help and that she felt depressed. As A had not much credit left on her mobile we arranged the first session via email. In the email A wrote that my colleague had said that she looked depressed. A acknowledged this and added that she struggled to concentrate. Especially after phone calls to her parents who live in China she felt very low.*

… and we are now greeting each other face to face

> *I remember how A seemed to glide into my room. Her movements appeared very light, her feet hardly touched the floor. She stretched out her right hand to shake my hand and smiled at me. Just before shaking her hand I noticed how the fingers were held together and also the thumb appeared to be sticking to her forefinger. My hand touched her fingers very lightly and I also smiled at her. I said "hello" and welcomed her.*

For nine years I had lived and worked in Great Britain. At the beginning of this time I had missed the German handshake and it had taken some time for my hand to learn not to stretch out automatically when greeting somebody (see Appel-Opper, 2007). Lichtenberg (2005) points out the cultural differences in our contact behaviour. As White (2011) does, he comes to the conclusion that there are no general rules, but adds that each cultural behavioural pattern is meaningful for the members of their culture.

Two Strangers with Two Different Realities

Culture is often defined as the system of values and practices shared by particular groups of people (see for example Acharyya, 2000; and Özbek & Wohlfart, 2006). In many texts the focus is on the understanding of the client's culture. The authors describe how cultures can differ from each other. Authors such as Lago and Thompson (1996; 2000, p. xix) and Rapp (1999,

p. 4) are aware of the danger that this knowledge could be used as recipes for discrimination. In the worst case the therapist could then believe to know everything about the culture of the other; the other then gets looked at through this filter.

But what role does the culture of the therapist play? Sapriel and Palumbo (2001) show how their own cultural background influences the perception and the understanding of their clients. Stolorow, Atwood and Orange (2002) talk about a meeting and negotiation of two worlds of experiences. Schmitz (1989) introduces his concept of the "mutual situation" which consists of the native language and the customs and conventions. He adds that "the initiated" could spontaneously master these situations. Tömmel (2010) refers to one's own culture as "the air that one breathes". With reference to Bollas's concept (1987) she adds that the culturally "unthought known" is more unconscious than the individual unconscious. In addition,the author states that the intercultural work challenges the therapist to overcome not just individual narcissism but above all cultural narcissism which she sees as more unconscious than individual narcissism.

For twelve years I lived as a stranger in a foreign context. These experiences have changed me and how I organize myself. In this first session with A, I felt a calm mindfulness which had grown over the years I had worked in the U.K. During this time I had learnt to sit more easily/comfortably with the not-knowing of the situation that I was in.

English Words and First Tones of a Different Melody

As A had come in she had introduced herself. For my German ears the way she pronounced her name sounded very different to the letters of her name which I had read before in her email. Therefore I inquired about her first and last name and whether she could tell me both again so that I would understand. We agreed to call each other by our first names. A then also asked how to pronounce my first name.

From my own experience I know how important it is to hear your own name in the correct manner of pronunciation. After some time in Britain it became important to me to hear my first name rightly spoken. I had missed the familiar tonal sequence. In my clinical work I had experienced how appreciative my clients had been when I tried to say their name in the right way. I remember the comment by a supervisee whose parents had emigrated from Jamaica. He had said at the end of our supervisory relationship that "pronouncing his name right had been the first and the most important sign that his culture had been welcomed in my consultation room".

As the first session went on, A told me that she had lived and studied in Germany for one year. She pointed out that she was pleased that the therapy could take place in English as her German was "quite bad". I learnt that she was 23 years old and the first child of her parents who live in China. A described the relationship to her mother as "difficult". Her grandmother died when her mother was one year old. A's grandfather remarried within a short time. Her mother had been beaten as a child by her stepmother. A added that she also had been beaten by her mother. A described the relationship to her father as "better".

In these first minutes of our being together I noticed an atmosphere of respect, mindfulness and a certain harmony and composition unfolding. The handshake, the rhythm of speaking in a low voice, the short sequences of direct eye contact and then quickly looking down were all ingredients of this different melody.

Özbek and Wohlfahrt (2006) describe their work with migrants as taking place in a "transcultural potential space" (with reference to Winnicott's (1971) concept of the "potential space"). The authors point out that none of the existing cultural meanings should be favoured. From my own experience I know how the migration process takes place in an area of tension between overadapting to the new culture and overidentifying with the old culture. Therapist and client move along similar poles. In the extreme the other would only be perceived as a representative of a foreign culture whereas the individuality would disappear; likewise, cultural differences could also be ignored. From his intercultural work in the Netherlands Gomperts (2010) points out the temptation to enter into a "narcissistic collusion". In this case both know that there

is discrimination, but it does not exist in the consulting room as "we are above all that".

Culture is Always Embodied – Embodied Messages as Another Language

> *The briefly mentioned comment of A that she had been beaten somehow disappeared like a minor part of a long harmonic piece of music. I could have easily not heard it. I remember how A had spoken with a low and even voice. The tonal sequence of her voice stayed melodic and evenly flowing even though she had mentioned the physical attacks by her mother.*

Elsewhere I introduce and describe how I work from a living body perspective – which I call "Relational Living Body Psychotherapy" (Appel-Opper 2008a; 2008b; 2009; 2010; 2011). With my own bodily resonances I sense the stories the body is broadcasting as atmospheres or echoes, and also as subtle movements, of mimic and gesture, of tonal sequence and eye contact behaviour. I regard this prereflective nonverbal behaviour as a body-to-body-communication which is cocreated by client and therapist. From my clinical experiences I believe that the therapist's embodied resonances also transfer something to the client. I see the therapist's implicit movements as important instruments of this embodied communication which can be developed into embodied interventions and experiments. With my concept of communication I wish to expand the theoretical world of embodied transference and countertransference. With reference to Bollas (2010), I look at this embodied communication more as an embodied free association. Drawing on Ogden (1994), the body-to-body-communication can also be seen as an Embodied Third.

Kohut's concept of empathy (1978) seems to stay focused on the psychological understanding of the other through exploring mutual experiences. It is of interest that Kohut believes that it is easier to experience empathy with a person of similar culture. I agree with Staemmler (2009) that many concepts of empathy neglect the body. The author refers to concepts developed by the phenomenological philosophers Schmitz and Fuchs. Schmitz (1989) writes about "milieus" and atmospheres in the body. For him the felt perception is not a reception of signals but a "lived body communication". For Clemmens and Bursztyn (2005, p.185) there is "no culture without embodiment".

During the years when I lived and worked in Great Britain I became fascinated by Dialogical Gestalt Psychotherapy and Relational Psychoanalysis in theory and practice. Both traditions have influenced and confirmed the way I work from a living body perspective.

Dialogical Gestalt psychotherapists focus on the "between" as a "healing dialogue", in which therapist and client share meanings and phenomenology. (Hycner, 1991; Parlett, 1991; Yontef, 1998). Parlett (1991) points out, that "through creating a mutual field each of us is helping to create other's realities" (p. 76). I wish to add that therapist and client also cocreate each other's physical reality. Authors such as Kepner (1987; 1995; 2003), Tervo (1997; 2007), Clemmens (2010) and Clemmens and Burstyn (2003; 2005) write about how they work in this 'bodily between' instead of talking about body experience. Tervo's description of her clinical work with children and adolescents shows how she develops games which give the child opportunities to breathe and to move allowing the child's body to structure, enliven and defreeze.

As I pointed out elsewhere (Appel-Opper, 2011) relational psychoanalysts have provided a rich variety of concepts with the focus on bodily based communication. Milch, Schreiber & Leweke (2008) talk about how embodied representations help us to react appropriately when meeting somebody else. The Boston Change Process Study Group (for example 2002; 2008) write about the unconscious nonverbal embodied unfolding process. Like many others, these authors relate their ideas to the findings on mirror neurons. These neurons link an observer's perception of another person's behaviour with the motor area of the observer's brain. Thus, the observer experiences the other as if having executed the same action, or feeling the same emotion (Gallese, 2003; Rizzolatti, Fogassi and Gallese, 2001). In that sense the existence of mirror neurons provides a possible neurobiological mechanism for understanding how we are able to read other people's intentions. Beebe and Lachmann's

(1998) concept of the co-constructed self and interactive affect regulation also focuses on how therapist and client influence each other. The authors add that it is the task of the analyst to read subtle movements – for example, of the hands or of a shift in the sitting position.

Following Schore's work (for example 2010) on right brain to right brain communication, many authors have pointed out the importance of the right brain related non-verbal messages (For example Chused, 2007). Dorpat (2001) views body movement, posture, gesture, and voice inflection as parts of the implicit processes which are seen as central mechanisms of the psychotherapy change process. Authors such as LaBarre (2008), Petrucelli (2008), Poettgen-Havekost (2004), Volz-Boers (2008) and Scharff (2008) describe similar embodied dialogues between therapist and client.

In these texts there are no explicit references to intercultural differences between therapist and client. But what is happening in intercultural therapy, if the 'appropriate reaction' is no longer valid in another cultural background? Are we really able to read the nonverbal behavior in an intercultural meeting? With reference to Leikert (2008) can we then still establish a "kinetic band" in the actual body-oriented togetherness with a client from a different culture and can we find the right tone for the other? Schore (2010, p.197) stresses the importance of the right brain communication especially with regards to "interactions with a new environment" and "when the 'going-on-being' of the patient's implicit self is dis-integrating in real time". In this respect I wonder how challenging the intercultural right brain to right brain communication might be for therapist and client?

I repeat my statement that the authors who write about bodily processes in therapy mainly focus on the implicit relational knowledge. The implicit cultural knowledge of therapist and client and the differences, challenges and misunderstandings involved are rarely mentioned. Benjamin (2002) does point out in her article on the mutual rhythms of recognition that humans can become incapable of reading relational patterns and negotiating difference. However, intercultural aspects are not mentioned. Knoblauch (2008, p. 197) writes that we have just begun to consider cultural influences that shape subjective experience and the intersubjective encounter. In fact the author focuses on "the clash of different cultural norms" but with regard to his "own psychoanalytic cultural beliefs and practices". His more implicit cultural expectations and perceptions towards his client whom he described as a "good Italian/ Catholic girl" are less explicitly taken into account. Tömmel (2010, p. 99) advises that "the analyst should be able to perceive early cultural imprints underlying the adaptation to the guest culture". But how should this happen?

As a migrant myself I experienced how one can feel less certain about one's own self movements. In a different culture the others reacted differently to my usual behavior and "I became a bit of a stranger to myself" (Appel-Opper, 2007). For many authors such as Özbek and Wohlfahrt (2006), Ardjomandi and Streeck (2002) and Parlett (2000) migration means a disruption of the self. A body-oriented intercultural psychotherapist should then receive and access the remains of the split off feelings and parts of the self which are linked to the mother tongue and a different world of experience. For some of our intercultural clients the language of the body can be the primary means of expression (Möhring, 1995).

Embodied Interventions and Experiments

There I sat with A in our first session and I had noticed how my shoulders had become tense. For me this tension did not fit in overtly to her behaviour. It seems to me that another voice wanted to find an expression. I decided to bring the embodied resonance of the tension in my shoulders into the therapeutic field. This seemed important. I assume now that I wanted to speak to the little Chinese girl who had at one time been beaten by her mother. In these minutes there was an atmosphere of loneliness in the air. It felt as if the little girl had tried to find a way to speak about her pain. I had the fantasy that nobody really had talked to the girl and that she had not talked to others much. At the same time it felt important to find a way to speak to the little girl and to respect the adult in the room at the same time. I had an image of the adult shielding the girl so that the little girl could not be exposed or laughed at again.

In a soft melodic voice I said: "as I sit with you I notice how my shoulders are slightly becoming tense". Then I added: "how are your shoulders in this moment?" At first, A started laughing quietly as if I had said something strange or funny. I then said that I was serious and looked at her. A immediately stopped laughing, looked for a short moment directly into my eyes and held her breathing for a split second. I remember how I also looked at her and how I was mindful to hold on to my regular breathing pattern. She then told me that her shoulders were really tight. She leaned forward a bit and asked me with an open, friendly voice, how I had known this. I then told A that I work in a body-oriented way and therefore paid attention to the body as well as, and alongside, the words. As A had held her breath I had thought that I had risked too much in telling her about my physical resonances. But then I experienced the forward movement and her tone of voice as signs that I had not given this intervention too early.

After all, this had been the first session and I had been aware that our meeting seemed filled with atmospheres of the Chinese contact behaviour which I did not know. In addition, the unfolding implicit embodied imprints from the client's relationship to her mother were also evoking a presence of her mother in our meeting. All this led to a careful way of communication between A and myself. I remember how I felt as if in an unknown world in which I developed the fantasy that I had to be cautious. So I used my own resonances as a compass.

As we focused on these early relational patterns we understood how A had to freeze feelings like anger and rage in her shoulders. This was also the place where her needs for autonomy and sense of belonging were held. These needs had been too dangerous in relation to A's mother. Later the client expressed how she felt "her mother inside her". In social situations at the university and in private relationships A was noticing a feeling of tension. We focused on some typical scenes and developed embodied experiments.

In a scene at the American consulate we worked out how frustrated A had been that the Americans were allowed to queue in an extra waiting line and were served faster and in a more friendly way. We discovered that A had disappeared deep inside of herself when she had experienced the loud voices of the Americans together with the different contact behaviour. As we talked about this I noticed how her shoulders looked tense and how my own shoulders also tensed up. I made use of this implicit body-to-body-communication, but this time my body explicitly transferred something to the client's body. First I announced that I wanted to move my shoulders up and down in a slow and mindful way and asked her whether it would be fine with her to watch this. Parameters to notice as to how the body reacted to my intention were changes for example in the eye contact behaviour, skin colour, breathing pattern or sitting position. Overall I got the impression that A welcomed my intervention. Her breathing pattern had stayed unchanged and I had not seen signs of subtle movements away from me. All this together with her prompt "yes" convinced me that I could carry on. Then I started moving my shoulders and I continued to observe how her body received this communication. For me, A's shoulders started looking less tense as they moved a bit more in the rhythm of her breathing. I also noticed that her mouth and chin looked a bit more relaxed than before, the skin was less pale and seemed softer. Her eyes somehow looked different and her breathing became deeper.

In our following conversation it became clear how the Americans from the scene in the consulate but also the German contact behaviour in general often directly represented her mother from whom she wanted to withdraw.

In another session we realized how challenging it was for A to express feelings of disliking something. A became aware that she would analyse everything instead. In these moments I saw that her shoulders moved down and stayed in this position. This led to the following embodied experiment to which A agreed. I took a tissue box and moved it along the table thereby twisting it from one side to another. This made various noises. I noticed how A's shoulders moved down and that she looked at me. She then asked me whether everything was fine with me. I remember that I continued my movements for about one minute longer and did not answer her question during this time. Then I stopped and we talked about what had happened. A remembered other scenes in which she could not express her feelings of disturbance. Together we worked out to repeat the intervention several times and A would try to say "stop". With every repetition this became easier.

I chose this experiment because it allowed me to impact both on the hardening of the shoulder and on her 'bottle neck' feeling. I believe that my moving shoulders had transferred movement impulses which also facilitated her saying "stop". The movement impulses somehow were defreezing the held movements in her shoulders and in her mouth. A became aware how her body had closed down in social situations. She had held her shoulders still and had sealed her lips as if expecting to be shamed or exposed.

I wish to point out the clear link of this particular communication to the findings of mirror neurons and the right-brain-to-right-brain-communication.

Paper and Humour

In one session A told me how unattractive she felt. She said that her ears were too big. As I noticed the change of tone in her voice I asked "who says that? She smiled. We both knew the answer, that this was the voice of her mother. Still smiling A added that her lips were also too thin. I remember that I took a piece of paper and asked her whether she could draw her lips. As I asked her about what these lips had experienced she told me that she had to kiss her mother and how unpleasant that had felt. Over the sessions we developed a fine humour which I read as signs that the introjects from her mother were fading and were becoming less powerful.

I wish to add that for me the drawing itself had not been the focus of the intervention. Instead I had looked for ways to help her mobilize and therefore defreeze her shoulders.

Therapist and Client Between Two Worlds

A told me about a meeting with other Chinese expatriates living in Berlin. She had felt strange in their company as if the Chinese culture had become more distant and further away. As a young girl and teenager A had not been allowed to have contact with others. She remembered how isolated and lonely she had felt as a child. It became clear that already in China she had felt different. We understood that A had moved to Germany and far away from her mother hoping to find a culture in which she could find her place.

This migration process of idealizing the new culture and distancing herself from the old culture resonated with me. At the time of the therapy with A I had been back in Germany for about three years. The process of re-immigration into my own culture had been at times quite frustrating for me. Sometimes in these years I had felt as if I were somewhere between Great Britain and Germany. A and I had focused at various times on how it had been like for her to live in Germany and the challenges and chances involved. I once mentioned that it had not been easy to find a way back into my own culture. A then had looked at me and had said that she was surprised to hear that. I assume that in moments like that she and I saw each other as two women between two worlds.

Concluding Remarks

At the end of the therapy, A told me that my perception of her shoulders' tension was most important. She added that something deep happened. In this body-to-body-communication she and I connected and met despite our different worlds of experience and languages. As a living body I received and understood something from her living body. A also mentioned that it meant a lot to her that I had not persisted in going through an experiment. She added that this had been a new experience for her, that somebody gave her the choice and really accepted her answer. I recall how A arrived with a list of things that she wanted to talk about. She somehow expected to be analysed and to be told what to do better. At times this felt as if she looked for a strict good mother, who would do everything right from now on.

I believe that the way I develop embodied interventions and experiments together with the client on a mutual stage was an appropriate method for A in order to invite her into an intersubjective relationship with two women, two cultures and two bodies in the room. Over the years my clinical experiences have confirmed the immense healing power of such explicit body-to-body-communications. With this article I wish to plead for a body orientation in intercultural psychotherapy. Beside verbal interventions the intercultural therapist should know and master body interventions and

the vocabulary of the body. I believe that the melody of the intercultural client's implicit individual relational patterns can only be fully understood when we also hear the tones of the implicit cultural knowledge. The body indeed is the compass into a different world.

References:

Acharyya, S. (2000).*'The Doctor's Dilemma: The Practice of Cultural Psychiatry in Multicultural Britain'*. In Intercultural Therapy: Themes, Interpretations and Practices, Kareem, J. & Littlewood, R., (eds) Oxford: Blackwell Scientific.

Appel-Opper, J. (2011). *Relationale Körper-zu-Körper-Kommunikation in der Psychotherapie.* Psychoanalyse & Körper. (in press).

Appel-Opper, J. (2010). Relational Living Body Psychotherapy: From physical resonances to embodied interventions or experiments. *USA Body Psychotherapy Journal, 9,1. www.usabp.org.*

Appel-Opper, J. (2009). What do we say without words?: Relational living body living body communication. *British Gestalt Journal, 18,1.*

Appel-Opper, J. (2008a). Relational living body to living body communication. *British Journal of Psychotherapy Integration, 5,1.*

Appel-Opper, J. (2008b). The unheard stories in our body. Relational living body to living body communication. *The Inside Out, Journal of the Irish Association of Humanistic and Integrative Psychotherapy, 55, p. 37-43.*

Appel-Opper, J. (2007). Intercultural Communication: My own personal Journey through Culture. *British Journal of Psychotherapy Integration, 3, 1.*

Ardjomandi, M.E. & Streeck, U. (2002). *Migration – Trauma and Opportunity.* In Migration and Persecution. Psychoanalytic Perspectives. Bell, K., Holder, A., Janssen, P, van de Sande, J. (eds) Gießen: Psychosozial-Verlag.

Beebe, B. & Lachmann, F.M. (1998). Co-constructing Inner Relational Processes. *Psychoanalytic Psychology. 15, 4: 480-516.*

Benjamin, J. (2002). The Rhythm of Recognition. Comments on the work of Louis Sander. *Pschoanalytic Dialogues, 12, 1: 43-52.*

Bollas, C. (2010). *On transference interpretation as a resistance to free association.* In Schloesser, A.-M. and Gerlach, A. (eds) Crossing Borders – Integrating Differences. Psychoanlaytic Psychotherapy in Transition. London: Karnac Books.

Bollas, C. (1987). *The shadow of the object. Psychoanalysis of the unthought known.* London: Free Association Books.

Boston Change Process Study Group. (2008). Forms of Relational Meaning: Issues in the Relations Between the Implicit and Reflective-Verbal Domains. *Psychoanalytic Dialogues, 18: 125-148.*

Boston Change Process Study Group. (2002). Explicating the implicit: The local level and the microprocess of change in the analytic situation. *International Journal of Psychoanalysis, 83: 1051-1062.*

Chused, J.F. (2007). "Non-verbal communicatin in psychoanalysis: commentary on Harrison and Tronick". *J. Amer. Psychoanal. Assn. 55: 875-882.*

Clemmens, M. & Bursztyn, A. (2005). *Culture and Body.* In: Levine Bar-Yoseph, T. (Ed.) The Bridge. Dialogues across cultures. Metairie, USA: Gestalt Institute Press.

Clemmens, M. & Bursztyn, A. (2003). Culture and Body: A phenomenological and dialogic inquiry. *British Gestalt Journal. 12, 1: 15-21.*

Clemmens, M. (2010). *The Interactive Field: Gestalt therapy as an embodied relational dialogue.* In: Levine Bar-Yoseph, T. (Ed.) (in preparation)

Dorpat, T.L. (2001). "Primary process communication". *Psychoanal. Inq., 3: 448-463.*

Gallese, V. (2003). The roots of empathy: The shared manifold hypothesis and the Neural Basis of Intersubjectivity. *Psychopathology, 36: 171-180.*

Gomperts, W. (2010). *Similar and yet different. Psychoanalytic psychotherapy with first and later generation immigrants in the Netherlands.* In Schloesser, A.-M. & Gehrlach, A. (eds): Crossing Borders – Integrating Differences. Psychoanalytic Psychotherapy in Transition. London: Karnac Books.

Hycner,R. (1991). *Between person and person: Toward a dialogical psychotherapy.* Highland, NY: The Gestalt Journal Press.

Kepner, J. (2003). The embodied field. *British Gestalt Journal. 12, 1, 6-14*

Kepner, J. (1995). *Healing tasks. Psychotherapy with adult survivors of childhood abuse.* San Fransisco: Jossey-Bass Publishers.

Kepner, J. (1987). *Body Process: Working with the Body in Psychotherapy.* Cleveland, Ohio: Gestalt Institute of Cleveland Press.

Knoblauch, S. H.(2008). *Tipping points between body, culture and subjectivity: The tension between passion and custom.* In Sommer Anderson, F. (ed.) Bodies in Treatment. The Unspoken Dimension. New York: The Analytic Press.

Kohut, H. (1978). *The Search for the Self: Selected Writings of Heinz Kohut 1950-1978.* In Ornstein, P.H. (ed) . Madison, CT: International Universities Press.

LaBarre, F. (2008). Movement Theory and Psychoanalysis —Kinetic Therapeutic Action. Studies in Gestalt Therapy. *Dialogical Bridges. 2, 2, 57–73.*

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

Leikert, S. (2008). Stimme und kinetische Semantik in der Musik und in der psychoanalytischen Arbeit. *Psychoanalyse im Widerspruch 39 : 71-90.*

Lichtenberg, P. (2005). *Culture.* In Bar-Yoseph, T.L.(ed): The bridge. Dialogues Across Cultures. Metairie/New Orleans, La. USA: Gestalt Institute Press.

Merleau-Ponty, M. (1945/1974). *Phänomenologie der Wahrnehmung.* Frankfurt am Main: Suhrkamp.

Milch, W., Schreiber, M. & Leweke, F. (2008). *Zur Frage der Selbstentwicklung unter dem Aspekt des frühen Körperselbst.* In Geißler, P. (Ed.) Der Körper in Interaktion. Handeln als Erkenntnisquelle in der psychoanalytischen Therapie. Gießen: Psychosozial Verlag.

Möhring, P. (1995). *Kultur, Krankheit und Migration: Zur Problematik interkultureller Begegnung und zur Bedeutung kultureller Faktoren für die Entstehung psychosomatischer Erkrankung.* In Möhring, P. and Apsel, R. Interkulturelle psychoanalytische Therapie. Frankfurt am Main: Brandes and Apsel.

Özbek, T. & Wohlfahrt, E. (2006). *Der transkulturelle Übergangsraum – ein Theorem und seine Funktion in der transkulturellen Psychotherapie am ZIPP.* In: Wohlfahrt, E. und Zaumseil, M. Transkulturelle Psychiatrie - Interkulturelle Psychotherapie: Interdisziplinäre Theorie und Praxis:169-176.

Ogden, T.H. (1994). The Analytic Third: Working with Intersubjective Clinical Facts. *International Journal of Psychoanalysis, 75: 3-19.*

Parlett, M. (1991). Reflections on Field Theory. *British Gestalt Journal, 1, 2: 69-81.*

Parlett, M. (2000). Creative Adjustment and the Global Field. *British Gestalt Journal, 9, 1: 15-27.*

Petrucelli, J. (2008). *When a body meets a body: the impact of the therapist's body on eating-disordered patients.* In: Anderson, F.S. (ed) Bodies in treatment. The unspoken dimension. New York: The Analytic Press.

Poettgen-Havekost G. (2004). Die Bedeutung von Körperinszenierungen in der analytischen Psychotherapie – Überlegungen zur Modifikation des Settings. *Psychoanalyse und Körper, 5: 5-28.*

Rapp, H. (1999). *Working with Difference: Culturally Competent Supervision.* In Lawton, B. and Feltham, C. Taking Supervision Forward. London: Sage.

Rizzolatti, G., Fogassi, L. and Gallese, V. (2001). Neurophysiological mechanisms underlying the understanding and imitation of action. *Nature Reviews, Neuroscience, 2 (9): 661-670.*

Sapriel,L. & Palumbo, D (2001). 'Psyche and Culture: An exercise in Peer Supervision' , *British Gestalt Journal, 10, 2, 86-96.*

Scharff, J.M. (2008): *Die Nürnberger hängen keinen Dieb, sie hätten ihn den. Inszenierende Interaktion und analytisches Arbeitsobjekt.* In Geißler, P.(ed) Der Körper in Interaktion. Handeln als Erkenntnisquelle in der psycho-analytischen Therapie. Gießen: Psychosozial-Verlag.

Schmitz, H. (1989). *Leib und Gefühl. Materialien zu einer philosophischen Therapeutik.* Paderborn: Junfermann Verlag.

Schore, A.N. (2010). *The right brain implicit self: A central mechanism of the psychotherapy change process.* In Petrucelli (ed), Knowing, not-knowing and sort of knowing: Psychoanalysis and the experience of uncertainty. London: Karnac.

Staemmler, F. (2009). *Das Geheimnis des Anderen – Empathie in der Psychotherapie. Wie Therapeuten und Klienten einander verstehen.* Stuttgart: Klett-Cotta.

Stolorow, R. D., Atwood, G.E. & Orange, D.M. (2002). *Worlds of Experience. Interweaving Philosophical and Clinical Dimensions in Psychoanalysis.* New York, NY: Basic Books.

Tervo, D. (1997). Body Process with Children and Adolescents. *British Gestalt Journal, 6, 2,76-86.*

Tervo, D. (2007). Zig Zag Flop and Roll: creating an embodied field for healing and awareness when working with children. *British Gestalt Journal, 16, 2, 28-37.*

Tömmel, S. E. (2010). *Culture-orientated psychoanalysis: On taking cultural background into account in the therapy of migrants.* In Schloesser, A.-M. & Gehrlach, A. (ed): Crossing Borders – Integrating Differences. Psychoanalytic Psychotherapy in Transition. London: Karnac Books.

Volz-Boers, U. (2008). *Sie haben eine Haut in mir berührt, die unter meiner Männerhaut liegt. Körperempfindungen des Psychoanalytikers als Zugang zu einem neuen Körperbild des Patienten.* In Geißler, P.(ed) Der Körper in Interaktion. Handeln als Erkenntnisquelle in der psychoanalytischen Therapie. Gießen: Psychosozial- Verlag.

White, K. (2011). Praxis der englischsprachigen Psychotherapie in Deutschland. *Zeitschrift für Individualpsychologie. (in press).*

Winnicott, D.W. (1971). *Vom Spiel zur Kreativität.* Stuttgart: Ernst Klett Verlag.

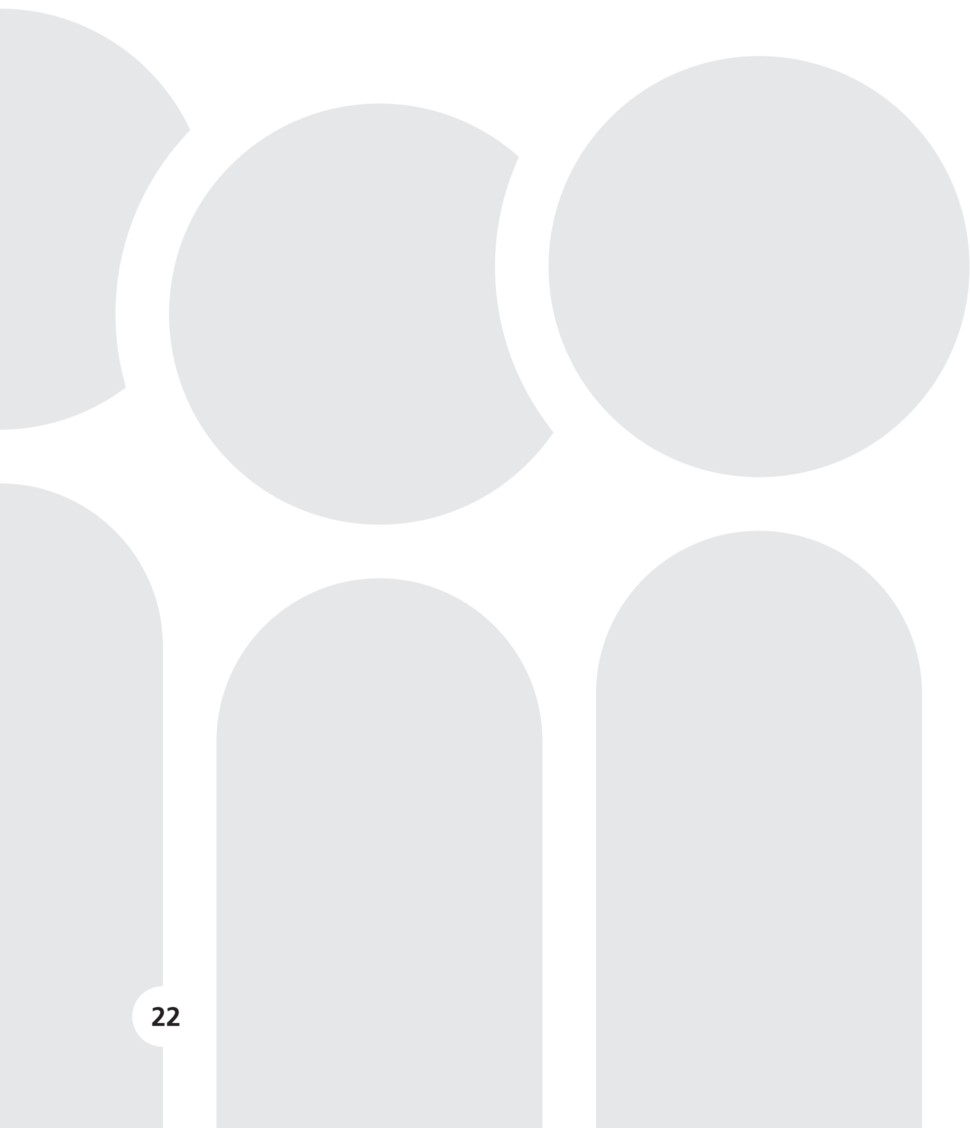
Yontef, G. (1988). Assimilating Diagnostic and Psychoanalytic Perspectives into Gestalt Therapy. *The Gestalt Journal. 1: 5-32.*

Acknowledgement

I want to thank A. for her permission to write about our work. I wish to thank Cynthia Ransley, Malcolm Parlett and my husband for their critical reading of the manuscript.

Julianne Appel-Opper, is a Psychological Psychotherapist, Clinical Psychologist, Registered Integrative and Gestalt Psychotherapist with the United Kingdom Council for Psychotherapy, supervisor and trainer with twenty years' clinical experience. She is a viva examiner and visiting tutor at Metanoia Institute in London. She has worked in psychosomatic clinics with a wide range of patients, both individually and in groups. For twelve years she lived and worked in various countries (France, Israel, California and Great Britain). Julianne is now in private practice in Berlin and also works internationally. She has developed her approach of the 'Relational Living Body Psychotherapy' which she has taught internationally. She is also particularly interested in the interface between body and culture and in intercultural communication. She has published articles on these themes. Julianne can be reached at julianne.ao@web.de.

www.Thelivingbody.de



John Marzillier

My Personal Journey, From Purity to Integration

Abstract

This paper is derived from my recently published memoir, *The Gossamer Thread. My Life as a Psychotherapist* (Karnac, 2010) in which I described my personal journey as a psychotherapist from a hard-nosed behaviour therapist with a strong commitment to rationalism and science to an integrative therapist with an interest in narrative. In the paper I use extracts from my book, beginning with my first therapy case, to illustrate key aspects of working as a psychotherapist. I consider what it means to take a problem at face value and what can be missed if one does. I allude to the difficulty of knowing what a successful outcome might be. I describe how I began working cognitively, relying primarily on intuition and personal knowledge, factors that are often downplayed. I describe my foray into Beck's cognitive therapy and what my first case taught me about the limitations of that approach. In my later years I developed a personal and integrative approach that emerged out of my long search for better and different therapies. Finally, I consider why looking back can be useful.

Introduction

In 2006 I gave up my private psychotherapy practice to become a writer. I began writing fiction, short stories, novels, poetry. Very little of this got published despite its outstanding literary qualities. Then in May 2010 my first book appeared. This was a memoir of my long career as a psychologist and psychotherapist (Marzillier, 2010). It was not entirely a reversion to non-fiction because, as anyone reading the book is told at the outset, I fictionalised aspects of the therapy cases I reported. I kept to basic truths – the nature of the person, the problems presented, what sort of therapist I was at the time, what I did in treatment, and what I achieved or failed to achieve. But biographical details were changed, dialogue reconstructed or invented, inessential aspects of the patient changed, all in order to protect the real patients from being disclosed.

I saw my first psychotherapy patient in 1969. I was 23 years old and knew nothing, though I believed I knew everything. I was at the Institute of Psychiatry in South-East London training to be a clinical psychologist. Behaviour therapy was beginning to make its mark in the UK. Jack Rachman, a major pioneer of the approach and someone I looked up to, asked me if I could take over a patient whose therapist had just graduated. Peter, as I call him in my book, was the same age as I was and was also in training for a profession. He had a phobia of using public toilets and he was being treated by Wolpe's technique of imaginal desensitisation. All I had to do, it seemed, was take over the reins and the treatment would take care of itself.

I tell the story of Peter in my memoir. He was my first patient and a great success. He set me on the path of becoming a behaviour therapist, a fervent believer in rationalism and certainty. When, years later, I looked back at Peter's therapy I realised how much he could have taught me if I had been prepared to listen. Here is an extract from my book. We had

switched from imaginal desensitisation, which was not working, to in vivo therapy. And we were going to meet in a pub. Somehow I had let slip I lived in Camden Town. Peter also lived in North London so why go all the way to Camberwell when we both could meet nearer to home? And what better venue than a pub?

Peter is already there when I arrive, seated at a small round table with a half of bitter in front of him. He smiles at me slightly self-consciously and I smile back. The pub is a more relaxed place than the claustrophobic treatment room at the Institute.

"What'll you have?" he says, making a move to stand up.

"No, sit down. I'll get the drinks. I can claim this back on expenses." I have no idea if I can but it does not feel right that Peter should pay. "Anyway," I say, as I move to the bar, "you need a pint."

I come back with two pints and sit opposite him. The pub is filling up with people after work. There is a buzz of several conversations going on at once, occasional bursts of loud laughter, the stuttering noise of the fruit machine as it pays out.

"What if any of your friends comes here? One of your fellow lawyers perhaps? We ought to have a story, something to tell them." This has the air of a conspiracy, a lark.

Peter shakes his head. "They won't. Anyway, I don't have many friends."

He says it factually, not with any sense of wishing it to be otherwise. We each take a sip of our drinks.

"We need to stay here at least 45 minutes, maybe more, for the beer to work," I say. "Then when you're ready, just go to the loo." He looks a bit uncertain but nods. There is a silence and I wonder what to say.

"Are you married?" Peter suddenly asks.

"No. I live with my girlfriend, G." I find myself telling him about G, how she is French and how her parents thinks she is flat-sharing in Earls Court whereas she is living with me. I make it sound like something more than it is, something I tend to do anyway, to make a story out of my own experiences often making me into the main player, the hero. Peter listens, seemingly genuinely interested. At a pause I ask: "What about you? Do you have a girlfriend?" He tells me about a girl he likes but has not plucked up the courage to ask out.

"Is she a lawyer?"

"She's a drama student. She's part of my film group."

"Film group?"

Suddenly, Peter is animated. He tells me about his amateur film group, how they shoot films around London. It turns out he is the director, this quiet, introverted youth and I begin to see a different side of him, a more steely, determined, artistic side. We talk about films. This is the 60s: the films of Godard and Truffaut, Bergman at the height of his powers and the Antonioni film, Blow-Up, which we both love. Time passes. I get two more pints. Eventually, Peter gets up. With a slightly nervous laugh, he says, "I guess I should try it. I had almost forgotten why we were here."

"Sure," I say nonchalantly, "if you feel up to it."

"I'll give it a go," he says, and heads for the stairs down to the toilets. A few minutes later Peter reappears, a big grin on his face. "I did it," he says triumphantly, as he sits down opposite me. "A man came in just as I was finishing, but I was okay."

"Great," I say. "Let's drink to that." We lift our pints in a salute, eyes shining. Our conspiracy has been successful.

After that, I met Peter four or five times in the pub near his work. We drank beer, talked, used the loo, talked some more. He never had any problems in the pub but outside it still remained a concern to him. One day when Peter arrives, he seems more excited than usual.

"I've got something to tell you," he says, a wide grin on his face. "I'm going to India."

"India?" I'm flabbergasted.

"Yeah, filming. I've wangled a six-month sabbatical from chambers. I've always wanted to go to India. If I like it, I might stay, give up the law, take up filming seriously."

Peter had already told me how he found his studies stultifying. His father is a solicitor and had always wanted his son to follow in his footsteps. He had dutifully done so. Now it seems he was rebelling. Peter talks on eagerly about his plans. He has applied for a visa. He wants to start in Bombay and later move to southern India. It is clear he has been planning this for some time, but it is the first I have heard of it.

I feel somewhat miffed at his not having discussed it with me first. I cannot help pouring cold water over this highly romantic notion. "You know in India, people don't use public loos. They pee and crap in the street. Doesn't that bother you?" (I am totally unaware of my latent envy of his sudden break with his studies, his ability to just take off and leave everything behind.) Peter in his enthusiasm pays my feelings scant attention. After all, I am only his therapist, a stepping-stone to something else, something he has now managed to do.

"I'm sure I'll be okay," Peter says airily.

His indifference to what had previously been a major anxiety takes my breath away. I do not know what to say.

"I have a lot to do," Peter goes on, "so I think this should be our last session." He looks me in the eye, confident, happy, relaxed. He holds out his hand. "Thanks, John. You've been terrific. A great therapist." I shake his hand. I could not feel less like a great therapist. In fact, I feel a failure. I have an obscure feeling that I have missed something important but I cannot for the life of me think what it is.

Taking Problems at Face Value

One of the precepts of behaviour therapy was to take what the patient told us at face value, not to interpret a problem as meaning something else, particularly any reference to some unconscious (and, it was asserted, untestable) process. Thus it never occurred to me that Peter's phobia might mean something else though it does now. This seems naive in retrospect but it had some value for both the patient and therapist. It meant that I was, so to speak, 'on the side of' the patient, treating him as an adult, not casting myself as the expert who knows better. As a young, inexperienced therapist it meant I was not anxious about what I did not know and my unabashed confidence in behaviour therapy bathed me and Peter in the warm glow of certainty. As Frank (1961) asserted many years ago, a large part of success in therapy comes from the confident belief of the therapist that what he or she is doing is right. Beginners need to have something of that belief and, whatever therapy approach is used, it is important that the novice has a strong notion of what to do and a belief that it will work. The closed systems of all therapeutic schools provide that in their own different ways.

I wrote that Peter was a great success. How did I know? By chance, two years later, I bumped into him again. He had returned from India and resumed his professional career. He seemed happy and relaxed. When I asked him about his phobia, he told me, 'Oh, I still have that but it doesn't bother me anymore.' That was an early indication of the fact that terms like 'success' and 'failure' are not as straightforward as behaviour therapy might like. Nor was the problem simply what the patient said it was. I was working at the Maudsley hospital at the time, employed as a clinical psychologist but what I wanted to do was behaviour therapy. In my memoir I describe some remarkable successes and some catastrophic failures. But by then I was not totally convinced by behaviour therapy. I found it strange that we ignored what the patient was thinking or, if we did pay thoughts attention, they were seen as 'covert behaviours' to be treated in the same way as other behaviours. This attitude is most evident in the technique of thought stopping. This involved a patient being instructed to think anxious thoughts and then after a few seconds the therapist would slam their hand hard on the desk and shout 'Stop!' Not surprisingly, this interrupted the anxious ruminations. After doing this a few times the patient was told to use the same technique themselves, firstly out loud and then subvocally. Looking back I cannot help thinking that thought-stopping symbolised the early behaviorist's attitude to cognition in general.

Thoughts and Fantasies

Thoughts came in, and with a vengeance, when cognitive therapy appeared and went on to take all by storm. In the latter part of the 1970s I moved to Birmingham and took up a post as lecturer at the University. I also worked as a therapist in a general practice. I began experimenting with focussing on patients' thoughts and seeing if by doing so, I could help people overcome their anxieties more effectively. I did this under the general rubric of 'behaviour therapy' but as the case of 'Angie' shows, there was nothing really behavioural about what I did.

'I sometimes wonder,' says Angie, speaking very carefully as though the exact words were crucial, 'if I could get taken over by the Devil. Like in the Exorcist.' She looks at me and there are tears coursing down her cheeks. I feel moved by her evident distress. 'Do you believe in the Devil?' she asks.

'No. But you do. Is that what you're saying?'

'No. I don't know. I don't know what I believe any more.'

Angie continues to cry. I don't know what to say. We are in a small side room of a GP surgery in Harborne, Birmingham. I have been invited to work there by one of the doctors as their visiting psychologist and behaviour therapist. I have been working here four months and am beginning to build up a caseload of patients. Angie is one. This is our second session.

Angie is 30, married with two very young children. She had worked as a dental receptionist but now stays at home to look after the children. Keith, her husband, works on the North Sea oilrigs. He is away from home for long stretches of time as he is now. The GP had referred Angie to me because she had become depressed a few months after the birth of her second child. He had diagnosed post-natal depression and suggested antidepressants. But Angie had refused medication. He had been seeing her supportively when she told him about the horrific fantasies that had first appeared after the birth of her second child. Angie confessed that she had awful thoughts about killing her children.

In his referral letter, the GP had written: "I am convinced that this is pure fantasy. She has never harmed her children and seems to love them dearly. I am sure they are not at risk. But Angie is so obsessed with the worry that she might harm them that her whole life is affected. She locks away all the kitchen knives, scissors, even nail scissors, and spends hours in deep distress, ruminating. I am sure she's depressed but there's an element of phobic anxiety in all this and I'm wondering if you could practise a bit of your behavioural magic and help her overcome the phobic anxiety…"

Magic. The Devil. Violent attacks on children. What is this about? In our first session Angie had told me about her fears and how she hid knives away in case she might harm her children. She wanted to know why she had these thoughts. Was she going mad? Her GP apart she hadn't told anyone about them, not even Keith because she was ashamed of having them. What sort of person thinks such things? I had young children myself and I could empathise with Angie's anxiety. I had had thoughts about the horror of waking one morning and finding one of my children dead in her cot. I told her this. I wondered whether our fears were similar in the sense that we both were so attached to our children that we worried about all sorts of dangers however remote. The fantasy may be just an extreme form of worrying, I hypothesised. This reformulation seemed to calm Angie. It also made psychological sense, something I was beginning to realise was crucial if I was going to find the best way of treating the problem.

Working Intuitively

I found a way of helping Angie after we had explored how her fantasies had first arisen (she had read in a newspaper about a couple who had ritually murdered their children) and what they might mean (excessive anxiety about her children coming to harm and not a wish on her part to harm them). I had no theory to guide me and my formulation came mostly out of my clinical experience, an intuitive sense of what Angie needed, and my understanding of what parenting can be like. In the treatment I used some aspects of behaviour therapy, for example, getting Angie to monitor her fantasies and I encouraged her not to avoid the fantasies but to stay with them, re-label them as anxious worries, and get on with whatever she was doing. In six weeks Angie's fantasies became less frequent and, when they occurred, they

no longer affected her in the way they had before. Our therapy came to a natural end.

Therapists frequently draw upon intuition, their own personal history and common sense in their work. But it is not something that is widely broadcast. This is because of the premium placed by therapeutic schools on technique and theory. Therapists who depart from tried and trusted techniques are sometimes labelled as 'wild' therapists or some other disparaging term. Things should be done by the book if one were to be a 'proper' psychoanalyst or cognitive therapist. I can remember teaching my trainees those very points, how it was important to have a theory and to use specific techniques. Was I wrong to do so? With Peter I did an awful lot of things that no therapist should do. I met him in a pub. I disclosed personal information about myself. I chatted to him about films. None of this was behaviour therapy. I did it because of who I was and because I knew no better. But I also carried out the in vivo desensitisation, seeing the pub at the opportunity for Peter to get over his anxieties. We had a rationale however much we did other things too. I do not now think that Peter got better because of desensitisation but because I treated him as an equal, was friendly and accepting, and because our contact gave him the opportunity to get to grips with what really bothered him, which was what he was to do with his life. Yet the rationale enabled us to meet and do the work. This is an example of what I call "Frank's paradox." For non-specific factors to work most powerfully, the therapist needs truly to believe that the specific techniques work .

The Rise and Rise of Cognitive Therapy

In Philadelphia at about the time I was seeing Angie, a distinguished psychoanalyst had been doing his own clinical experimentation on patients' thoughts, out of which was to emerge a new therapy, cognitive therapy (Beck, 1991). It is interesting that Beck derived his new approach not from cognitive theory but from clinical experience. He recognised that many of his patients had negative and self-punitive streams of thoughts that ran parallel to the free associations that psychoanalysis demanded. With considerable clinical acumen he found a way to help people to become aware of these thoughts and then to change them. This led to positive changes in mood and other symptoms. This approach was similar to the strategy I had been using with Angie. When I went on to train in Beck's cognitive therapy, I felt like Moliere's bourgeois gentil homme who, on being told he was speaking prose cried out, 'Mon Dieu! For more than forty years I have been speaking prose without knowing it.'

I was fortunate to have two outstanding therapists, John Teasdale and Melanie Fennell, to train me in Beck's cognitive therapy. I was at Oxford by this time and eager to embrace this new approach. It seemed to offer all the advantages of behaviour therapy with the added bonus of working directly on patients' thought processes. How could it be anything but a good thing? Yet in the eighteen months of my training I knew that cognitive therapy did not have the answers, at least not for me. I learned this primarily from the two patients I was treating under supervision. I write about one of them, Frances, at some length in my memoir. Frances's problem was depression which she had suffered from off and on for many years. At first she took readily to the cognitive therapy approach of monitoring and challenging negative thoughts. In fact, she became very good at it. The method seemed to be helping her get more control over her depressed mood. Then one day she failed to turn up for a session and when I contacted her, it was immediately obvious she had sunk into another deep depression. The extract picks up at the following session.

> *When Frances comes to our next session, I immediately notice a change in her manner. There is a slowness to her movements, a hesitancy that I have never seen before. She does not look directly at me and when I study her face, all I can see is blankness. I ask her how she is. She takes a while to respond. She says she feels lousy, tired, depressed, no energy, completely zonked. All signs of depression.*
>
> *"I'm sorry you're feeling so bad but I'm glad you came," I say. "It's a chance to do some work and improve your mood."*
>
> *She looks at me and sighs. "The good doctor's going to make me better. Hooray."*

"Well, I'm going to try. Tell me right now and in all honesty what you think of coming here."

"A waste of time."

"Why?"

She shrugs. "Nothing works and anyway what's the point. I get better for a bit and then I get worse. I'm just useless."

"Several very negative thoughts in that statement, I'd say. Do you remember how we dealt with, I mean, worked on your negative thought, I'll never get better? We listed the 'pros' and 'cons' and came to a more realistic thought. I have it here."

I search through my notes and read it out to her:

I can't know that I'll never get better and I recognize that this absolutist negative thought is a product of my mood state rather than a realistic appraisal of what will happen.

"Do you believe that now?"

"It's irrelevant what I believe," she says in a lethargic tone. "Life's meaningless anyway. We are microbes in the vast universe. Specks of cosmic dust. What does it matter? What does anything matter?"

"Something mattered enough for you to come here today. You're depressed, Frances. Something brought you right down in the last week. I don't know what. But I am absolutely convinced that your view that life is meaningless is caused by your depression."

"It's not," she says emphatically. "Life is meaningless. It's not a product of depression. It's true. And anyway I've always believed it so it can't be a response to a change in mood."

For the moment I am stumped. I am also feeling pissed off with Frances, with her certainty and resistance to my attempts to help her.

"Always?"

"Always."

"So you sprung from your mother's womb with the thought, Hey, why am I here? Life is meaningless. Let me back in?" I have spoken without thinking. I have let my feelings show. I have broken a cardinal rule: do not mock your patient. I am a crap therapist. But a small smile appears on Frances's face.

Life is meaningless. Beck would label that an absolutist negative thought, which of course it is. I pointed that out but it had little effect on Frances. I remember discussing this with my two trainers, John Teasdale and Melanie Fennell. They were honest and admitted that they too had a problem trying to change fundamental beliefs. Later, it become obvious to me that attacking the irrationality of the belief would get us nowhere. The belief is held not for rational reasons but emotional. Or, as Pascal put it: "The heart has reasons that reason cannot know." While there is considerable benefit to the cognitive therapy approach of monitoring, labelling and counteracting negative thoughts in order to gain control over mood states, applying the same rational methods to fundamental beliefs does not work. This was a flaw in cognitive therapy and a pretty big one at that. I wrote an article about this in a respected behaviour therapy journal. I also had a brief talk about it with Beck himself when he came for a sabbatical at Oxford. In my memoir I describe his response, which was revealing, at least to me. You will find out what it was if you read my book as well as a description of a titanic battle we had over something far more important than cognitive therapy, tennis.

My reservations were not shared by my psychologist colleagues. This was cognitive therapy's time and the bandwagon was not to be stopped. My resistance was seen, if it was seen at all, as pernickety and idiosyncratic. Then the numbers game started. Research trials were rolled out showing that Beck's cognitive therapy was a highly effective way of treating anxiety, depression and, eventually, many other psychological problems. We are reaping the legacy of all this today backed up by the supreme authority of the National Institute of Health and Clinical Excellence (NICE). This is not the place to write about the lunacy of psychologists' hanging on the shirt-tails of evidence-based medicine in an effort to bolster their own power and importance.

Integrative Psychotherapy

In the latter stage of my therapy career I worked as a private psychotherapist from my home in North Oxford. This was the most enjoyable period of my time as a psychotherapist. I had matured and no longer demanded of myself and my patients that they must get better. I realised that people came into therapy for many reasons, one of which was actually not to change, but to stay the same. I discarded the last remnants of the medical model and any sense that there was a best way of helping people in need. I was more attuned to the personal and interpersonal features of the therapeutic relationship, the gossamer thread as I call it in my memoir. By this time I had trained as a psychodynamic psychotherapist and that had opened my eyes to the value of not knowing, of uncertainty, of the power of discovery, of myself as a person and my patient as another. I had my share of failures. Two of my patients killed themselves. In my memoir I write about one of them, Leone, someone I had known and cherished for four years. I think about her to this day. Failures, even one as final as suicide, are more valuable than successes. As Beckett wrote, 'Ever tried. Ever failed. No matter. Try again. Fail again. Fail better.' A thoughtful, intelligent model for life as well as for therapy.

In my final years I worked as an integrative psychotherapist. What might that mean? It did not mean that I explicitly integrated different models of therapy like, for example, Cognitive-Analytic Therapy (CAT) does. I trained as a CAT therapist but I soon realised that another orthodoxy is created, one with its own jargon and rules. I do not like unnecessary prescriptions, nor convoluted language that makes essentially simple ideas seem something more than they are. My approach to integration was essentially pragmatic. Here is how I described it in my memoir.

> *I largely took my cue from the patient. If someone came for help with a defined problem...I focussed on the problem. Above all, it is the respectful thing. That was why the person had come to see me. Moreover, there were many occasions when a practical, CBT approach proved beneficial without the need to do anything further. Sometimes, as my psychotherapeutic practice developed, people would seek me out specifically for exploratory psychodynamic psychotherapy, wanting a period of time to reflect and work on themselves. Often they were involved in some capacity in mental health. Over the years I saw a fair number of counsellors, psychiatrists, psychologists, and psychotherapists, using predominantly a psychodynamic approach. As the years passed, I found that some people returned having had a period of successful, problem-focussed therapy. Occasionally...it was because the problem had come back. Some wanted a brief refresher course, a few sessions to help them through a particular difficulty. And then a few returned because they wanted help with other, more general problems, problems of living as they are sometimes called, or painful experiences from their past that had never been dealt with. They knew me and trusted me. We would embark on some explorative psychotherapy, sometimes setting a time limit, sometimes not.*

Seeing Things Differently.

There were several psychotherapists who, unbeknownst to them, helped me along the way. I read their books and was stirred by what I read. Peter Lomas was one. Lomas wrote about himself in a personal, haunting and revealing way. What he wrote resonated with the work of psychotherapy as I came to do it (Lomas, 1994). In a very different way, Irving Yalom was another. A brilliant writer he made psychotherapy accessible to the ordinary person. I particularly treasure his comment that a good therapist seeks to create a new therapy for each patient (Yalom, 2003). Patrick Casement was perhaps the most influential as he has been, I suspect, to many psychotherapists. Amongst other things, he showed how it was possible to listen to a patient and hear not just the spoken words but also the swirl of feelings and wishes behind them (Casement, 2006). And importantly, Casement communicates the practice of psychoanalysis without the distorting prism of abstruse language. All of these writers have the virtue of seeing things differently, something that is crucial to being a good psychotherapist.

I want to end by returning to Peter, Angie and Frances and try now to see them differently, to think about other ways of I might have helped them. I doubt if now I would see Peter in a pub although that was fun and it helped him relax.

There have to be boundaries if only to make it clear what is acceptable and what is not. I learned this early in my career when I offered to treat a patient in my flat as he too lived in North London. He spent the first session examining my room, reading the book titles on my shelf, asking about my hobbies and generally treating the meeting as the first step on the way to a friendship. I would let Peter talk more about himself. I would hope that way to have come earlier to what really mattered to him. I would still offer some help for his phobia as that was the problem he came with. But it is not the only or necessarily the most important thing to do.

What I would particularly seek to do is to leave a space that could be filled by the patient. I would definitely do more of this for Angie. Although her fantasies were extremely distressing to her, their importance was not necessarily in their literal meaning. Nor were they just a symptom of her anxiety about her children, which is how I labelled them. Had I given her the space to talk, I might have heard other things. She might have been generally unhappy, feeling trapped as a young mother and dependent wife, wanting something more for herself. She might have talked about her childhood and perhaps recalled an upbringing in which her mother had neglected her or her father terrified her, or where the birth of a younger sister felt like an intrusion. She might have discovered a long suppressed memory of harming her sister that her own children's rivalry had stirred up. I do not know if any of these speculations was near the mark. But that is precisely the issue: I do not know because I never gave her the opportunity to tell me.

As for Frances I was too easily seduced by her being the good cognitive therapy patient – she even typed up her negative thoughts and thought challenges on the forms provided! – not realising that being the good child was, to use Winnicott's term, a false self and that no real change would occur until she got in touch with deeper, disturbing feelings, a fierce rage that in depression she turned onto herself. In her case it may have been better not to have embarked on an active, problem-solving therapy at the outset. Had I sat back and asked her to take the lead, we might have got nearer to what truly mattered. Frustration and anger at not being explicitly helped could have come to the surface and its deeper meaning explored.

Hindsight is a great thing, people say disparagingly. But looking back and reflecting on things done and not done is valuable. My memoir allowed me to do that and, in that long, searching look, to see myself and others differently. As the novelist James Salter (2007) wrote in his own memoir:

> *"Certain things I remember exactly as they were. They are merely discoloured a bit by time, like coins in the pocket of a forgotten suit. Most of the details, though, have long since been transformed or rearranged to bring others of them forward. Some, in fact, are obviously counterfeit; they are no less important. One alters the past to form the future."*

References

Beck, A. T. (1991). *Cognitive Therapy and the Emotional Disorders.* New Edition. Penguin.

Casement, P. (2006) *Learning from Life. On Becoming a Psychoanalyst.* London :Routledge.

Frank, J. D. (1961) *Persuasion and Healing.* Baltimore: Johns Hopkins University Press.

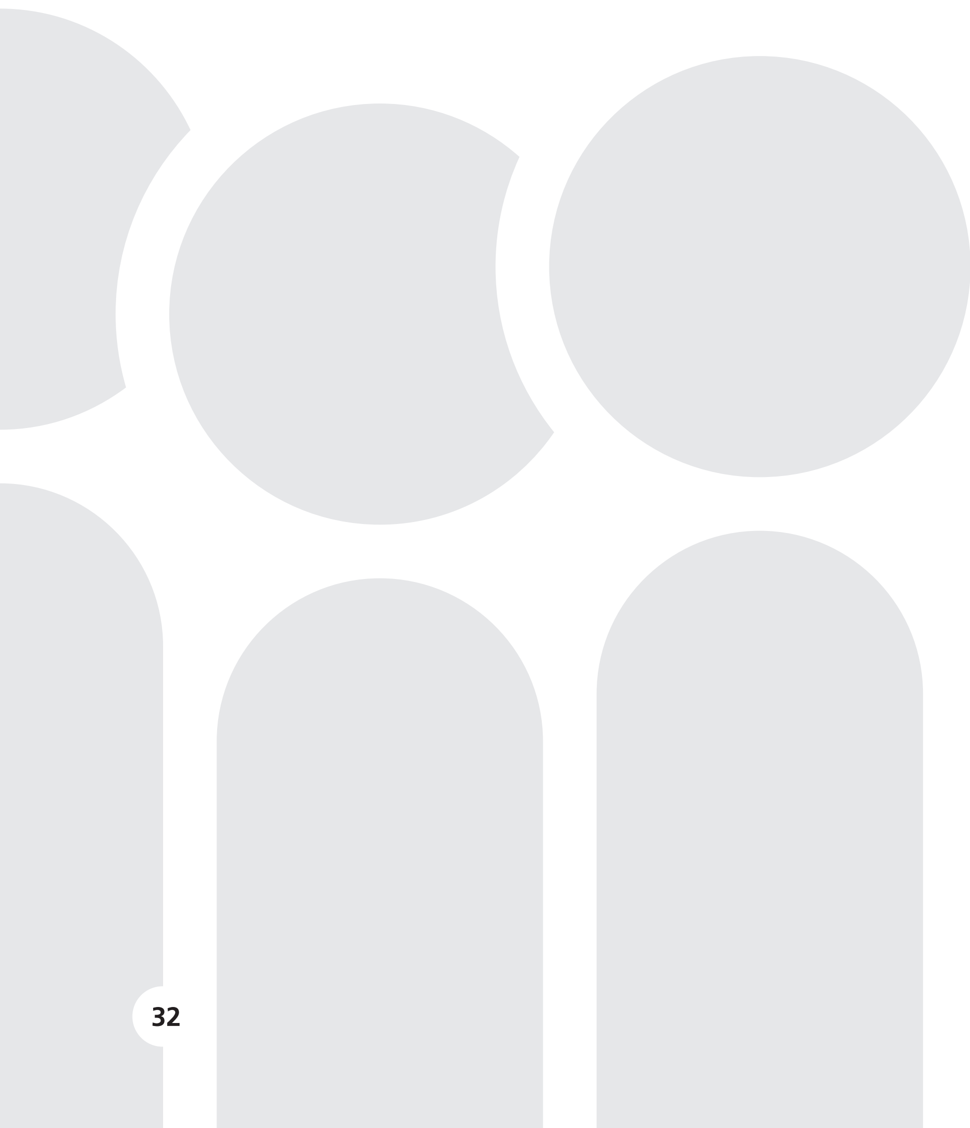
Lomas, P. (1994) *Cultivating Intuition.* Penguin.

Marzillier, J. (2010) *The Gossamer Thread. My Life as a Psychotherapist.* London :Karnac Books.

Salter, J. (2007) *A Sport and a Pastime.* New Edition. Picador.

Yalom., I. (2003) *The Gift of Therapy.* Revised Edition. UK : Piatkus Books.

John Marzillier is a clinical psychologist and psychotherapist who works as a writer. He is currently writing a book on peoples' experiences of major trauma, based around recorded interviews with trauma survivors. More information on John and his writing can be found on www.johnmarzillier.com.



Linda Finlay

'Being-with': A Phenomenology of Relational Dimensions Within a Psychotherapy Session

In the beginning is the relation
(Martin Buber, 1923)

Abstract

In this article, I suggest a way of conceptualising the therapeutic relationship as six fluidly intertwining dimensions of *being-with*: physical, personal, intrapersonal, interpersonal, structural and transpersonal. Using an example from a psychotherapeutic encounter with a client, I explore how the six dimensions might reveal themselves through dialogue. Our challenge as therapists is to try reflexively to integrate these different dimensions, rather than becoming unduly caught up in one dimension at the expense of others. I argue that having this broader holistic awareness opens up choices in, and enriches, our relating.

Introduction

Increasingly psychotherapists are focusing on the *relational nature of being* and how this reveals itself in therapy (Wheeler, 2000). "There is a growing urgency that we embrace 'We'", says Stawman (2008, p.52), referring to the relationship between therapist and client.

Psychotherapy's interest in relationship is twofold: Firstly, relationships (both early life and throughout adulthood) are seen as the source of meaning, validation and growth of self. In Gestalt terms, self process is seen to reside in the ongoing resolutions of the self-environment field while object relations theorists believe selfhood is made up of internalized versions of others and relationships. Secondly, psychotherapists are interested in the therapeutic relationship as a focus and tool of therapy to explore a person's needs, sense of self and relatedness. Spinelli (UKAPI, 2:1), for example, argues for a focus on the interrelational ground as our integrative project. It is these interrelational aspects that will have been damaged, denied or disavowed through life's traumas and failures of contact in relationships (Erskine, 1997). In psychotherapy we replay and rework these damaging relational dynamics. The therapy situation provides a unique opportunity as learned patterns of interaction are inevitably enacted in the therapy situation. The therapeutic relationship can be seen as a 'microcosm' which discloses the client's relational being-in-the-world (Spinelli, 2008).

The healing that comes through therapy emerges out of a constantly evolving, negotiated and dynamic co-created relational process to which both therapist and client contribute (Evans and Gilbert, 2005). In relational psychoanalytic terms, both therapist and client are seen to affect each other mutually as they 'co-mingle', sharing emotions generated in the therapeutic process (Aron, 1996). The therapeutic relationship is continuously reworked through mutual, ongoing influence where therapist and client affect, and are

affected by, each other. This is the experience of '*being-with*'[1] which I discuss in this paper.

First, I outline existing work that explores the therapeutic relational process. Then I discuss my own way of conceptualising *being-with*, focusing on the way we enact, embody and live the therapeutic relationship with our client. I suggest six dimensions of *being-with* which, rather than constituting separate layers, interweave in a fluid manner. To explain these dimensions, I offer a case study illustration which uses dialogue from one psychotherapy session. I argue that reflexively exploring the nature of *being-with*, potentially enables deeper, richer understandings of the therapeutic process

The Therapeutic Relational Process

The centrality of the therapeutic relationship, and its co-created nature, are among the most influential ideas in contemporary psychotherapy (Finlay and Evans, 2009). They are to be found, for example, in relational-centred gestalt theory (e.g. Hycner and Jacobs, 1995), in intersubjectivity theory (e.g. Stolorow and Atwood, 1992) and in relational psychoanalysis (e.g. Mitchell and Aron, 1999)[2]. In their different ways, these theories concur that much of what we can understand about an Other emerges within the intersubjective space between therapist and client. Whatever intervention we make, also, emerges from that between. "It's the relationship that heals, the relationship that heals, the relationship that heals - my professional rosary" Yalom (1989, p.91). The reality of the *being-with* is greater than the shared sum of the experience of therapist and client (Hycner, 1991).

The therapeutic relational process invokes a gestalt which is both ambiguous and layered. Initially, the therapist strives to be openly and empathically present to the client in terms of what they are expressing. The therapist seeks to achieve emotional and bodily readiness to go with that which is felt to be projected into the space. This requires a particular way of listening and 'being with' rather than 'doing to'; it involves becoming fascinated with and immersed in the other while not losing one's own ground. In Buber's (1923/2004) terms it involves both 'presence' and 'inclusion'. Here the therapist 'imagines the real' and experiences the other side of the relationship (i.e. the other) while being fully present (Friedman, 2009). Both the other and the self in-relation need to be brought to the foreground.

Different writers have explored psychotherapy's interest in this relational nature of *being-with* in contrasting ways.

Clarkson (2003) has written extensively about the different qualities that might be present in a therapeutic relationship putting forward her seminal model which comprises five relational 'modes' or 'facets':

1. The working alliance – the basic collaborative working alliance where goals and general approach are agreed
2. The transferential/countertransferential relationship – the experience of 'distortion' of the working alliance by wishes/fears/experiences from the past carried over into therapy
3. The reparative/developmentally needed relationship – the intentional provision by the therapist of a healing/replenishing relationship where the client's experience was previously deficient/abusive or overprotective.
4. The person-to-person relationship – the dialogical, authentically human sharing relationship

---

1. Being-with is a term originally coined by the phenomenological philosopher, Heidegger (1927/1962) who explains that being-with [others] (Mitsein) is a part of the structure of being. We are thrown into a world of other people: Even when we are physically alone or we ignore others, we are still always in-relation through our everyday engagement in our shared social world.
2. There are similarities with all these approaches though they each have their specific take and emphasis. In contemporary gestalt theory the therapist commits to and trusts the process of whatever appears figural at the moment of the dialogical encounter. With intersubjectivity theory, experiencing is seen to emerge out of interactions within the intersubjective field (past and present relationships). Relational psychoanalysts argue that learned patterns of interaction are inevitably enacted in the therapy situation and so careful attention needs to be paid to what is happening in the therapy relationship.

5. The transpersonal relationship – the timeless more spiritual, mysterious dimension involving a paradoxical letting-go into the between.

Clarkson's model can be seen as identifying types of relationship. Taking a different approach, Todres (1990, 2007) focuses on the therapist's attention within the therapy relationship. He explicates the way therapists can develop a rhythm where closeness and distance are simultaneously experienced. He highlights four modes of *being-with* the client:

1. Attentive *being-with* (where the therapist becomes absorbed in the world of the other)
2. Focusing being-with (where the therapist brings both an intuitive capacity and understanding together in such a way as to focus on specific aspects)
3. Interactive being-with (where attention is placed on the space between therapist and client in the here and now)
4. Invitational *being-with* (where the therapist listens to a future sense of direction or potential that is revealing itself).

These phases of the psychotherapeutic stance highlight ways the therapist is present in the therapy relationship. The challenge of the *being-with* for the therapist, Todres notes, lies in "being close enough to the immediacy of the situation to experience what is happening, yet also to be able to distance oneself from such immediacy in order to become interested in the quality of interaction as a phenomenon" (1990, p.40).

By giving us this way of thinking about the therapeutic relationship, both Clarkson and Todres offer us a valuable model for teaching or studying psychotherapy, one which shows how therapists' concerns shift and evolve during the course of therapy.

As a means to explore this process, Spinelli (1994, 2008) offers four dialogical realms of encounter which he suggests are interactively co-constituted:

1. I-focused, which attends to my experience of being in the relationship
2. You-focused, which attends to my experience of the other's experience of me
3. We-focused, which attends to our experience in relation to each other
4. They-focused, which attends to the experience of relationships with others in the wider world.

Elsewhere, Spinelli argues that from an existential-phenomenological perspective, assumptions of relatedness overturn traditional ideas about the individual as subjectivity is seen as a expression of relatedness. Therapy thus needs to be an investigation of the "impact and consequences of relatedness" (Melnick et al, 2007, p.33).

Mirroring Spinelli's concerns, my own model focuses on the intersubjective realm as I attempt to describe different modes of relating. I suggest six dimensions of *being-with* are present at every stage of, and in every moment of therapy. (In fact these dimensions are present in all relationships though often outside our awareness. In therapy, where we routinely explore self and other reflexively, they become more explicit.) Drawing on the work of van Deurzen-Smith, 1997 and Evans & Gilbert, 2005[3], I conceptualise *being-with* as involving:

1. Embodied *Being-with* (i.e. focus on physical and non-verbal aspects)
2. Person-to-person *Being-with* (i.e. focus on cognition and emotions)
3. Inter-personal *Being-with* (i.e. focus on multiple selves/subjectivities)
4. Intra-personal, transferential *Being-with* (i.e. focus on unconscious)

---

3. These 6 dimensions have emerged partly out of the work by van Deurzen-Smith (1997) and Evans and Gilbert (2005). Van Deurzen-Smith (1997) suggests we are all involved in a four-dimensional forcefield at all times modulated by physical, social, personal, spiritual dimensions. Evans and Gilbert discuss 6 unique aspects of experience:
    1. the biological: relationship of self to body
    2. the intrapsychic: relationship of self to self
    3. the interpersonal: relationship of self to others
    4. the intercultural: relationship to culture, race, nation, business world, wider context
    5. the ecological: relationship of self to nature
    6. the transcendental: relationship of self to the transcendent.

5. Structural, cultural *Being-with* (i.e. focus on social aspects)
6. Transpersonal *Being-with* (i.e. focus on spiritual aspects)

Each of these dimensions will be familiar to therapists and much literature exists which explores each dimension, but too frequently in isolation. The growing edge and challenge for all of us therapists supporting an integrative practice is to recognise the interlinked, complexly layered nature of these intersubjective dimensions and to integrate awareness of processes occurring at different levels in our practice.

In line with the models of Clarkson, Todres and Spinelli, I agree that often one or more dimensions may come to the fore at any one time and that it useful to reflect on what is happening in the moment of the relationship while also recognising that the manner of *being-with* clients shifts over time as the relationship evolves. But I would add that all the dimensions are always present – be it in or out of our awareness. Rather than focusing on types of relationship or choices about direction of focus, in my account of *being-with*, I am highlighting the multilayered nature of what it is like to be in relation to another and how the different horizons at play intertwine.

Put in other words, I am suggesting a version of how to practice as an integrative therapist. My integrative model is one which focuses on the multiple dimensions the therapeutic relationship[4]. In my practice, I try to integrate the different dimensions to avoid becoming overly preoccupied with one or two dimensions at the expense of others.

For example, I do not focus exclusively on transferential dynamics as this might sideline my awareness of cultural differences. Similarly, getting caught up in behavioural-cognitive-affective interactions may consign significant intra-psychic dynamics to the background.

My aim here is to nudge therapists to consider taking account of all these dimensions simultaneously. Being reflexively aware of, and engaging, all six dimensions - I suggest - helps to move us towards more a more holistic appreciation and integrated understanding. Having this broader awareness opens up choices to enrich our relating. While I am promoting an awareness of all dimensions, however, I am not suggesting psychotherapists must excel in them all. It is important for therapists to work authentically with their particular strengths and interests, and to work in whatever way meets the particular needs of individual clients (Lapworth, Sills and Fish, 2001). I simply invite a spirit of curiosity as we attempt to reflect upon and experiment with those dimensions of '*being-with*' not usually foregrounded in our own practice.

In recent years, integrative psychotherapists have become more focused on the relationship with the client as opposed to the more traditional focus of concentrating on the client. A growing edge for therapists, I believe, is to focus on this relationship more reflexively. (Reflexivity involves reflecting in a self-aware way and examining the impact of oneself on what is emerging in the therapy). A focus on '*being-with*' offers us a tool to use to ensure a more relational, layered, reflexive approach.

Lisa's Background and My Psychotherapy Approach

Below, I discuss each of these dimensions theoretically and show how they come into play in practice by giving a case study illustration. I use extracts of dialogue from one therapy session with my client who I am calling Lisa[5] to highlight how all six dimensions of *being-*

4. Integrative psychotherapy utilises a range of therapy theories, modalities and techniques which are selectively applied as appropriate. In my version, I combine existential phenomenological understandings which is my pivotal position (see van Deurzen-Smith, 1997) with other relational and developmental models of therapy, namely, dialogical gestalt theory, intersubjectivity theory, transactional analysis and relational psychoanalysis (see Finlay and Evans, 2009). My model of 'being-with' articulates this integration of different theoretical concerns. As an integrative therapist, I am conscious of the need to integrate sources of selfhood.

5. All names have been anonymised and some minor details changed to preserve confidentiality.

with are likely to be simultaneously present in any moment of therapeutic relationship.

Lisa is a bright, friendly woman in her early 40s who is married with four children and works as a Teaching Assistant at a school. After six months of financial and emotional struggle following her husband's redundancy, Lisa became ill with depression, anxiety and a range of physical symptoms including dizziness and headaches.

Prior to her therapy, Lisa had been overwhelmed by her emotions, health problems and life burdens. She felt her life was falling apart and she could not "see a way out". She admitted that she had spent the last ten years "papering over the cracks" – trying to put on a brave, smiling face despite a series of life traumas. She had not explored the possible links between her emotions and physical symptoms and she had only a limited sense of her own identity and emotional needs. We contracted to use therapy to discover who she was and to find new, more effective ways of coping emotionally.

My therapeutic choice in relationship with Lisa was to keep building our alliance and to focus phenomenologically on *being-with* her. This is the foundation of my relational approach to Integrative Psychotherapy where I am concerned to return to embodied lifeworld experience and commit to whatever emerges in the between of our relationship (Finlay and Evans, 2009).

In the extracts of dialogue used as illustrations below, Lisa explores her nascent feelings of anger towards her husband, Russell, and her excitement at flirting with another man (Darren) whom she fantasises might become a lover.

Physical, Embodied Dimension of Being-with

In this dimension of *being-with*, therapist and client are present to each other bodily: as therapists, we engage with the client's lived body, our own body and our embodied intersubjective relationship. Clients, too, are similarly impacted, be it in or out of their awareness.

The value of attending to the client's body is celebrated in Gendlin's (1996) psychotherapeutic work where the body is recognised as having its own special wisdom and 'felt sense'. Gendlin suggests his 'focusing' technique to bring to the surface the words, images, memories, understandings or new ideas that are needed to solve a problem. Since Gendlin, many psychotherapy writers have engaged the significance of the relational embodied field. Appel-Opper (2009), for instance, shows how in a psychotherapy context we can use our lived body to sense the world given to our clients. Similarly, Raingruber and Kent (2003), in their phenomenological enquiry into clinicians' use of their bodies, argue that clinicians' bodies can act like a Geiger counter, a detector of meaning that helps them understand and empathise with clients' experiences. For alert therapists, physical sensations such as 'stomach churning' can be crucial cues to attend to certain meanings. "When clinicians listen to the piercing wisdom and the immediate knowledge of their body", the authors argue, "they are more likely to make time to reflect and to develop an understanding…in personal, professional, and human terms" (p.466).

The relationship between therapist and client also can be fruitfully explored by tuning into the intersubjective space and what is emerging in the between. One way of doing this is to explore the embodied gestural 'duet' lying beneath verbal interaction given the way one person's non-verbal behaviour will have an impact on the other.

Turning to Lisa, quite early in our session she provided an example of non-verbal behaviour which had an impact on us both as she talked of flirting online with an old school friend. I reproduce the dialogue below, together with reflections (in italics) I noted down after the session.

> *Lisa – Well I've been chatting to him all week: texting and on Facebook. He just makes me laugh so much. It's like a flirty, chatty relationship that's going on and its like, and I think, that's what I've not got.*
>
> *[I hear Lisa express her enjoyment of this new 'online' relationship in contrast to the unsatisfying one she has currently with her husband. It is a surprising admission as, up until now, she has resolutely maintained her marriage is 'perfect'. She is smiling broadly as she describes her nascent*

flirty relationship and it's a smile I have not seen before. She is positively shining! To my eyes, she looks beautiful and 'in love'. I can't help but respond in kind and I smile broadly in return.]

Linda – You've got a sparkle about you when you're talking about it.

[On receiving the feedback about her sparkle she laughs – apparently pleased to be 'seen'. Previously in our sessions her laughter seems to be a deflection from emotion, in particular anger. This time her laughter felt real to me and I felt excited.]

As therapists, we do not simply notice our clients' non-verbal behaviour; our own non-verbal behaviour becomes engaged and enters into a relationship with that of the client. It is through our bodies that we engage the world and act as 'living mirrors' to each other (Merleau-Ponty, 1960/1964). The Other's world may be disclosed through bodily (inter) subjectivity. I take the position that it is our very embodied intersubjective commonality which makes empathy possible, thereby enabling understanding of the Other. To this end, I advocate the explicit use of 'reflexive embodied empathy' (Finlay, 2005, 2006).

We can apply this idea to the embodied intersubjective relationship between Lisa and myself. In our early sessions we worked intra-psychically, focusing on the 'I' of Lisa's history and lived experience. Occasionally I would suddenly feel overcome with a sense of dizziness. Checking it out with her, she sometimes disclosed that she, too, was feeling dizzy. At other times, I would find myself feeling anxious and wobbly in my stomach and my speech would lose its fluency. Rather than being a reflection of my own insecurity, I sensed I was picking up Lisa's own 'scare'. I explicitly used such intuitions to draw out possible links with her emotions and her own somatic experience. I tried, through my reflexive embodied empathy, to enter her internal experience of the world as far as possible in order to reflect it back to her. Slowly she began to appreciate how her tendency to push down emotions might have resulted in, or contributed to, her somatic symptoms.

Person-to-person Dimension of Being-with

The person-to-person dimension focuses largely on behaviour and processing that can be observed (or inferred) between two individuals in interaction. Here the client's behaviour, thoughts and feelings in the here-and-now (rather than the there-and-then in Yontef's 1993 terms) become figural during the encounter. What is said by the client is responded to by the therapist - more or less at face value.

In this space the therapist strives to be grounded, present, and empathetically attuned in order to meet the client while the client is supported to identify more fully with their own experience by being seen, heard and understood at deeper levels of their being (Evans and Gilbert, 2004). It is through the here-and-now psychotherapeutic relationship that the client's issues and needs are disclosed. And it is by comparing this specific lived experience with their wider everyday life experience that clients can find the means to heal and reconstruct their way of being (Spinelli, 2008; Clarkson, 2003).

An example of this person-to-person dimension of *being-with* arose in my dialogue with Lisa after she shared how her husband, Russell, had let her down by borrowing money from his parents and deceiving them about the purpose of the loan.

Lisa: I just hope to God he doesn't tell them. And they don't see it. How do you look at them in the face? [several seconds pause] He better get this job this week.

[I am hearing her shame. We have explored this subject previously, recognising its link to her 'working class' script and introjects about 'not taking charity' and not being dependent on others for anything. I'm also hearing her anger about her husband passivity about looking for work – something she has only recently begun to acknowledge. Now she is expressing some anger not only because of his lack of work but for taking the charity and in the way he is almost lying to his parents about why he needs the money. I hear her begin to recognise that Russell perhaps doesn't share her values, after all. Previously in her narrative of the 'perfect husband', she had suggested their confluence that they both felt much

shame about taking money from his parents. This is a change of story which I want to mark.]

Linda: …I'm curious about something: I've always understood you as saying that both of you hated taking money off of his parents. But it sounds to me like really its You; you really hate it.

[I nudge her to stay with her emotions ready to pick up both the anger and shame which she does. I model expressing anger by acknowledging she REALLY HATES IT. Lisa duly imitates my words and begins to admit a truth fully to herself.]

Lisa: I do really hate it.

Linda: But Russell feels that a little less(?). Had you been a little more okay about taking money then Russell would have been okay about taking money(?).

Lisa: Ah, maybe, I, don't know.

[I repeat the message about what seems to be the reality Lisa is confronting, and I stress the insight that she and Russell may well have different values offering some reality testing. As she dissembles and deflects, I wonder if I have been too challenging and this reality has come too hard and too fast for Lisa. I re-group retreating to more solid stuff I know she can own.]

Linda: So you hate, it's that charity stuff [Lisa: yeah] you hate.

Alongside being able to put oneself into the experience of the client, in this personal dimension of *being-with*, the therapist is also open to being affected by the experience. The relationship is thus continually and mutually reworked and co-created. This is shown in the next excerpt where Lisa goes on to explore how her view of, and her feelings for, her husband have suddenly changed. She discloses the way she now sees him in a different light. She is shocked to realise that she is finding she doesn't respect him.

Lisa: When I …met him I, sort of – this sounds a bit callous but – I thought he's stable, he's single, he's got a good job, he's got money in the bank, he'll look after us and support us… Russell was the sort of stable one.

Linda: So the one thing you valued Russell for is turning out not to be dependable

[I feel compassion for Lisa given this ironic twist of having valued Russell for what he is not. He has slipped off the idealising pedestal she placed him on.]

Lisa: Well he hasn't been has he! [Lisa gives tense laugh] But I just haven't obviously seen it. It's taken me this long to get over everything that had happened in those few years and start to –

[Her dreams are shattered now – rose coloured blinkers are off - but it's taken her 10 years. I am in awe at the creative adjustments we make to survive. I muse that she must have been quite desperate at that time to have invested so much in Russell as a (middle-class) knight in shining armour to rescue her. She was so invested in him that she couldn't see he was the one being rescued by her.]

Linda: -- [overtalking and brief silence. Lisa gives a tense laugh] I, I, ah, I've got so many feelings running around me and –

[I am momentarily overwhelmed with emotions – hers and mine – and we both talk at once. I realise I need to get a grip and focus us both. I decide to share my own feelings, modelling self-disclosure and how one may need to take a bit of time to puzzle out confusing emotions.]

Lisa: -I know! Don't tell me about what it's like!

[I am honoured by how accepting and trusting she is with me and how she believes I am, indeed, mirroring her emotions. I am mindful of the gift she gives me in this compliment. I move to reinforce the point that I am full of emotions that I'm picking up from her rather than these just being my personal emotions.]

Linda: And I can feel it's kind of like yours. Its partly, 'all this is really exciting' [Lisa: yeah] and you're connecting with who you are—

Lisa: --Yeah, its like I'm thinking 'shit!', I'm looking at my husband and until a few weeks ago or a week ago I'm like saying 'Oh I have a great relationship, blah blah blah blah blah' and all of the sudden I'm kinda like looking at it different and that makes me think, "Oh crap, is this all going to fall apart?" and I'm feeling [slight pause] really good!

[Lisa laughs and starts to tear up] It's like crap and good at the same time! How do you do that?

[She is describing her ambivalence extraordinarily well and expressing her emotions freely. Slowly but surely a clear sense of self is forming for her. To think just a few months ago she was shut down emotionally and caught up with her somatising headaches and dizziness symptoms. I celebrate her holding the dilemma of polarities.]

Interpersonal, 'Selves'-focused Dimension of Being-with

While the therapeutic relationship may only involve two people, there is a sense in which it involves more than a one-to-one interaction between two people. The idea of an interpersonal dimension flags up the potential of having multiple selves-in-relation in the mix. These selves evolve over time and include the shadow of others who we carry in our psyche.

The idea of 'multiple selves' (or more accurately, multiple subjectivities) is both a challenging and a contested one. While traditional humanistic theory has championed the idea of a core, authentic, self-contained, private, unique Self, postmodern versions now acknowledge the plurality of self-concept or 'sub-personalities' (Rowan, 1990). Explicitly relational and social theories about multiple subjectivities have also evolved (Rowan and Cooper, 1999). Relationally-orientated psychoanalytic theory, for example, posits that each person is psychologically made up of introjected or unconsciously internalised parts of others (Thomas, 1996).

Relationally orientated therapists assume that both therapist and client bring to the therapy the "sum total of who they are in all their complexity with their own individual histories and ways of organizing their experience [and] their unconscious process…and are then faced with the challenge of meeting the other in all his/her complexity." (Evans and Gilbert, 2005, pp.74-75). Multiple subjectivities - including our different social roles, introjected parts of significant others and/or different ego states - of both client and therapist inevitably interact, connect and collide. The result is that therapy involves a 'thickly populated' inter-personal encounter (de Young, 2003).

In the following two extracts, my session with Lisa reveals the complexity involved. As she touches on the guilt she feels about even thinking about having an affair, my own multiple subjectivities begin to come to the fore.

Lisa : I feel almost guilty –

[I suspect the guilt is wrapped in complicated ways with her shame from internalised critical introjects and anger against her parents which she cannot yet express. Time for a nudge to get her to face her emotion head on. I quash the impulse to soothe her emotions away prematurely as this could parallel the process6 of denial and avoidance of emotional expression. Instead I want to stay with her experience and help her focus on what her mixed emotions feel like to recognise those disparate aspects of herself.]

Linda: almost guilty?

Lisa: yeah, because well, a bit guilty then [Lisa laughs]. Because of some of the, you know, suggestive things that have been said you know

Linda: And it sounds like you're actually you're attracted to him, -

Lisa: Yeah, I am, I am -

Linda: So although you're not actually having a sexual affair -

Lisa: probably always have been [attracted to him] really, if I admit it. [long pause]

I am feeling at a loss about how to help her appreciate the complicated nature of her guilt. I quash my 'child' who feels inadequate and not up to the task of staying with these emotions. My 'feminist self' wants Lisa to emancipate herself from the oppression of only seeing herself in relationship to, and dependent on, various men but I know this is not the time and place for me to share my political views. My' phenomenologist self' wants to go more deeply and phenomenologically into her guilt. I am tempted to focus somatically on her guilt by asking her to tell me about how her guilt felt in her body. My 'therapist self' controls my interest in focusing at this point and decides to stay with clarifying her experience and the reality in general. I rationalise this strategy to myself by thinking she is not yet ready

to explore, only express. Some – unidentified – part of me becomes aware of anxiety (hers? mine?) so I work on trying to language it]

Linda: And the scary bit is that that suddenly you're in a completely different place. Suddenly… the blinkers have come off. [Lisa: hmm, hmm] It must be scary cos you thought you knew the world; you thought you knew…your relationship with Russell and now suddenly you're –

Lisa: - suddenly I'm just looking differently. He's boring! [slightly artificial tense laugh from Lisa followed by a long pause].

After acknowledging that she is attracted to Darren and owning up to her fantasies about having an affair, Lisa is confronted with the possible reality of what it would mean to her children if she left her husband for Darren. She remembers the history of her first marriage and the trauma of its break-up for her two older children.

Lisa: I could not do it to another family. I could not do it to another family. I certainly couldn't leave without them, the two little ones…No way could I take Dave away from Russ. It would just screw him up completely.

[I hear her shame of being a 'failed wife and mother' – a theme we have touched on in previous sessions in relation to her previous marriage. Perhaps also Lisa carries this theme for her parents whose marriage also 'failed'. Lisa's statement about her not being able to 'do it' to another family may be her mother's critical voice. It suggests my job is to respond to the possible developmental deficit to enable Lisa to become aware of this underlying process. Then a message can be given to her internalised critical mother that it is okay to express her feelings and to attend to her own needs. Together, perhaps, she and I can stand up to her mother (and survive) – a process which will hopefully disempower her mother and Lisa's sense of needing to continually live up to her expectations. Together, we can work to help the newly emerging 'adult Lisa' who is much more in touch with her feelings/needs find her own voice and to choose to listen to that instead.]

As the examples above show, the therapy encounter involves complicated entanglements where we can find ourselves responding to the 'selves' within and without, simultaneously and at different levels. The here and now, discussed in the description of the personal dimension, contains something of the there and then as the subjectivities of one person elicit those of the other.

There is a merging, says Gordon (1996, p.24), of the "visible and invisible, the dead and the living, the past and the present". Doucet (2008) develops these ideas in a poignant manner. While Doucet is referring to relational-centred research, the ideas equally apply to the therapy encounter where multiple transferences arise out of different subjectivities.

Intrapersonal, Transferential Dimension of Being-with

While the person-to-person and interpersonal dimensions are focused on thoughts, feelings, behaviours and roles that can be observed or that are in our awareness, the intrapersonal dimension is – by definition - more hidden. In this mode of *being-with*, the feelings and fantasies of both people are transferred unconsciously (or at least not entirely in our awareness) into the therapeutic relationship. The implicit relationships being transferred and enacted may or may not coincide with what is apparently taking place in the face-to-face encounter. Similarly, the 'other' whom the client is transferring may relate to an actual person or an internalised construction. The result is a complex system of partial and distorted introjects, often outside awareness. Whether actual or internalised, experientially the client's sense of relationships with others feels 'real'.

In general, clients are seen to repeat particularly painful or unresolved early relational patterns in an unconscious attempt to 'resolve' them. Positive or negative transferences - feelings of love or aggression towards the therapist, for instance - may be a function of transferring wishes and fears from past relationships which are then re-enacted symbolically in the present. While the seductive, mysterious pull of felt transferential relating in the 'between' of a relationship can be experienced as gently enchanting and loving, the opposite also applies. As psychotherapists know all too well, it can be painful and bruising to get suddenly

swiped by a persecutory projection or caught up in abusive toxic relationships from the past. Equally well, clients may be the unwitting recipients of the therapist's projections.

In this mode of *being-with*, then, both client and therapist re-enact relationships they have had with others throughout their lives. Here a client's relationships from early childhood may carry particular significance and become the focus in therapy. In other situations, attention may be held on current relationships. At the same time, the therapist's own transferences may enter the mix and have an impact on clients. Rarely, if ever, is the transference experience one-way – it's reciprocal with each person co-creating the field.

Whatever the source of the transferences, the experience of feeling or receiving them may involve intense primitive longings, urges to touch and be touched, love and hate, tenderness and aggression, compassion and guilt. Within this ambivalent storm, it is invariably challenging to work out where the different transferences experienced are coming from. An example from my dialogue with Lisa illustrates this point. Below Lisa describes the actions of her virtual lover who is teasing her with images of being naked in the bath.

> *Lisa: - He texted me saying "I gotta photo to send to you. Are you on your own?" And I said "oohh… that sounds you know ….interesting, intriguing! why?" He said "you must be on your own cos it's a photo of me in the bath!" "Okay I'm on me own now, send me photograph" And it's a bath full of water with bubbles and there's this big sign he's made with 'M.E.' on it on top of the water! It just cracked me up completely.*
>
> *[I can see why she appreciates Darren's style and humour. I am aware of feeling conflicted at this point and I feel different transferences bubbling up. A slight anger with Darren is building in me that he is flirting too skilfully which resonates with traces of cynicism I can feel against men in general. Lisa is too inexperienced at this 'game' and I fear she is going to get hurt. At the same time I am loving seeing Lisa so happy! I note my maternal counter-transference of wanting to protect her and feeling joy in her joy. I understand that her longing to be loved and nurtured is perhaps evoking this in me. From our previous sessions I appreciate Lisa's sense that she missed out on some love and nurturing from her mother who was inclined to be critical and her father who was more of a joking friend than caring father. I wonder about sharing my maternal response and how proud I am of her.]*
>
> *Lisa: [shared laughter] It's just weird. It's just weird.*
>
> *Linda: So you're having a 'mini-affair'(?) [shared giggles]*
>
> *Lisa: Yeah, an online, text, [shared giggles], chat on phone.*
>
> *Linda: A little bit of a flirtation just to remind you who you were [Lisa: hmm] and that you're still attractive [Lisa: hmm]. Good for your ego. A bit of fun.*
>
> *[Woman to woman, I have got to acknowledge this is an 'affair'! Perhaps there is some concordant counter-transference here? Or am I reflecting her jokey father? Our shared giggles partly feels like a sisters/friends twinship transference.]*

The process of *being-with* clients transferentially is ambiguous, mysterious, ambivalent, layered and complex. Rarely do we catch more than partial, emergent glimpses – transferences are often only felt and intuited rather than observed.

Structural, Cultural Dimension of Being-with

An ever present relational (back-)ground is our social world comprising the community and cultures around us and in which we are embedded. Structural dimensions such as our class, gender, ethnicity, age, race, sexuality, religion, language, nationality and discourse all influence who were are and what we become in relation to another. There are powerful political and community voices which influence us to see and act in particular ways (Doucet, 2008). We internalise the values and assumptions of our different social-cultural groups and these provide the ideological and discursive framework in which behaviour is deemed acceptable or not. These dimensions can also be understood as operating as a complex interweaving of introjections (often out of our awareness). Inevitably these internalised values impact

on the therapeutic relationship by shaping, constraining and moulding its possibilities.

Referring specifically to Gestalt theory, Stawman (2008) reviews the trajectory of the 'relational sensibility' across Gestalt therapy's history by suggesting four 'waves'(Organism-Environment, I-Thou, Intersubjectivity and Relational Ground). His fourth 'relational ground' wave, yet to be fully explored in Gestalt psychotherapy, highlights how the self is socially constructed within linguistic/discursive and cultural contexts, following Jacobs (2003) and Staemmler (2005). Stawman describes the concept of 'relational ground' as those "field conditions that craft and limit the possibilities from which individual life-spaces emerge" (2008, p.48).

These structural-cultural dimensions were ever-present in the relationship between Lisa and myself. Firstly, 'class and culture' were issues both for her at a personal level and for us at a relational level. Lisa, herself, is very conscious of her working class roots, family and community and of how she has slid into a middle class milieu by marrying her husband (whose father is a doctor and mother a teacher) and by training to become a teacher. Her social mobility causes her a certain amount of shame and anger. Sometimes she fears she is not 'good enough' while at other times she rues the loss of her strong working class family and community links. As Lisa and I negotiate these class issues together, I'm aware that she sees me as middle class and sometimes expects me not to understand. Sometimes she is right: I am, indeed, puzzled by some of her expressed values, such as wishing her husband was a 'proper working man' and she a 'stay-at home wife'. In the next extract, Lisa reveals her own Christian morality.

Lisa: If I acted on it, all it's going to do is hurt people… Standing in front of a church saying 'you and only you, till death do us part'. You know it's… supposed to be one at a time, isn't it? Fortunately… he's miles away. It's just 'suggestive flirting'.

[She is still holding on to her parental values – even more strongly by evoking Christianity. I figure she has had enough challenges for one day and I chose not to respond to her rhetorical question about whether or not it is acceptable to have more than one partner.]

Gender is another particularly significant dimension in our relationship. We are both conscious of being two women involved in sharing with each other, occasionally in a kind of jokey coalition against 'men'. Also, we share an understanding of what it is like to be a woman who is growing older and is past her best physically, as this next extract illustrates:

Lisa: I were in the bath the other day and Darren texted me…"Hello you what are you up to?" I said, "well actually you just caught me in the bath". He said, "Ooh, send me some pictures then!". And I'm like, "No [Lisa giggles] you'd be lucky! It's probably not …really …an image you want to see. You're better off using your own imagination." He said, "Oh that's not nice". So I put it like, "What being overweight, belly hanging over as a result of four C-sections and scars from that plus the scar where I had the breast lump removed?! You're better off with your imagination." And he texted back saying, "Why would I bother about all that?! You're still the girl I knew all those years ago."

[In her animation, I hear her flirting and enjoyment of this man. I also hear how skilfully he handles her comments about her negative body image in reminding her she is still a lovely girl. I melt a little inside and sense how she has longed for someone to say that to her over these last years. I know that when she was 18 years old that she truly was stunning and very slim. While she remains attractive, if older and plumper having had her 4 children, it seems significant that Darren still seems to see her 'past self').

Linda: And that's it, isn't it? It's that reminder [Lisa: hmm] of how attractive you were [Lisa: yeah].

As the above examples show, psychotherapy, with its focus on the individual, also holds itself open to biological, social and political factors that impact on the individual and shape their experience. As Stawman puts it, "Our subjectivities emerge from the crucible in which our biological constitutions, culture and language combine, melt and merge with experience, particularly our experience with others" (Stawman, 2008, p.48).

Transpersonal, Spiritual Dimension of Being-with

Hycner (1991) explains that the very recognition that there is something more to *being-with* than the sum total of the individuals physically present acknowledges the transpersonal element. The transpersonal (beyond personal) or spiritual dimension of *being-with* is the hardest to pinpoint. For some individuals, relationships may involve a mystical, religious, mysterious connection; for others, a spirit of love, compassion, empathy, intuition, healing, or delight-in-the-other and humanity may animate the relationship. For some, transcendence resides in a Divine other or sacred moment where one is taken beyond oneself; for others transcendence is located within the person and refers to our capacity to be moved and to move forward.

In an attempt to dissolve such dualisms Halling describes the experience of this transpersonal dimension of *being-with* thus:

> *Deep empathy, appreciation, or love for the other. It is also a moment when we, paradoxically come to our senses as we allow ourselves to move past self-absorption and self-consciousness to a connectedness with something or someone that… surpasses our own boundaries (2008, p.216).*

In a similar spirit, Rowan and Jacobs (2002) see the transpersonal relational way of being as involving an altered state of consciousness where the boundaries between therapist and client fall away and both occupy a soul-full or heart-full space in linked communion. Similarly, Todres (2007, p.162) explicates the soulful space of "human vulnerability, need, and 'unfinishedness'" where there is a beauty, poignancy and a we-feeling.

Writing of the more spiritual dimensions of human relationships, Buber talks poetically of the potential of the I-Thou relationship where each person is accepting of and open to the other. "I become through my relation to the Thou; as I become I, I say Thou. All real living is meeting" (Buber, 1937/1958, p.11). The I-Thou relationship, in Buber's formulation, is one of mutual regard; it is free from judgement, narcissism, demand, possessiveness, objectification, greed or anticipation. Persons respond creatively in the moment to the other, eschewing the instrumental and habitual ways of interacting characteristic of the I-It relationship. The I-Thou relationship is mutually revealing.

Buber shows us that the space between therapist and client is primordial and irreducible – self and other are always in relation. Recognising the value of the other's personhood helps one's own authenticity and personhood come into renewed being. Buber talks specifically of the value of dialogue in a relationship:

> *"The world arises in a substantial way between men [sic] who have been seized in their depths and opened out by the dynamic of an elemental togetherness. The interhuman opens out what otherwise remains unopened." (Buber 1965, p.86).*

The following excerpt of dialogue shows how Lisa and I began to embrace I-Thou relating:

> *[The pull of the maternal transference feels particularly powerful. I take the opportunity to share in the spirit of I-Thou. Committing to the 'between' I allow myself to raise what seems figural. I hope Lisa will receive this and reciprocate in I-Thou.]*
>
> *Linda: Suddenly I'm feeling maternal…Earlier I was feeling what you were feeling. Now I'm feeling more maternal and I'm thinking, I just want to say to you, 'Its okay,' [Lisa:hm] you know that every woman, probably every person but I don't know about men so much [brief laugh], but we all have these feelings when we're in a long term relationship. It's inevitable. [Lisa laughs]. So I kinda want to say 'don't feel too guilty [Lisa:yeah]'.*
>
> *Lisa: But that's not maternal is it?*
>
> *[I am astounded that Lisa has made this link and challenge to me. She is acknowledging, I believe, a juxtaposition between her experience of her mother and me.]*
>
> *Lisa: My mother would be saying 'Don't mess everything up! You've got this you've got that. Look at all the good things you've got. Don't screw it up. Just forget him. Aarararargh.'*
>
> *[She beautifully articulates her introjects here! That I may model for her a non-judgmental acceptance*

of her behaviour and give her permission to be who she wants to be – possibly unlike her mother – is hugely significant. I'm impressed that it is no longer entirely out of her awareness. It is moments like this when she addresses our relationship which confirms for me that we have moved away from the ego-building instrumental phase of therapy (focusing on the 'I' of Lisa).]

Linda: …I do 'mother' a little differently than your mother [Lisa:Lisa:yeah]. It's like, maybe with me and therapy you can, kind of, get some of your unmet needs from your mum. Maybe that's what therapy offers(?) [Lisa:yeah maybe]. Cos we kinda re-do it again. I mean, not really, but in spirit. [Lisa:yeah]. That's what it's about. [Lisa laughs and we pause for several seconds] So its your mother, giving you these scripts in your head, ' you shouldn't do this, don't mess with that, keep hold of this'(?)

[It is hard to explain the 'magic' of the therapeutic process in everyday language but I am reassured that she is accepting my explanation with her affirmative interjections.]

Shortly after, Lisa humorously characterises her situation.

…Lisa: Yeah, I've gone from him trying to kiss me last week, and now I'm talking about going away for the night and having sex with him now. In just one week. What the bloody hell will I have done by next week?! [she laughs]

[I make a mental note that over the next few weeks we might consider the active choices she could make but I leave it for now. I am struck once more by the strong intuitive image that keeps coming into my head of seeing several 'Lisas' standing at a mouth of a cave. The youngest (and wisest) one is 'hiding' but slowly and shyly she is coming out. She is no longer hiding her emotions from herself and others. I seek to end the session with my last bit of reaching out to the Lisa who has shyly, slowly, emerged out of the 'cave'. With a smile and my head to the side, I try and communicate a tender welcome non-verbally.]

Linda: I look forward to hearing about it! [Lisa laughs] But in the meantime, I just want to say 'hello' to this Lisa that has not come out before. [Lisa laughs again warmly]

Lisa : Hiya!

[She says this in a shy sweet voice and gives me a shy wave. I give a shy sweet wave back and we share a precious moment. It feels a true meeting…]

Conclusion

In this article, I have suggested a way of conceptualising the therapeutic relationship as six fluidly intertwined dimensions of *being-with*: physical, personal, intrapersonal, interpersonal, structural and transpersonal. All the dimensions of *being-with* are always present but at any particular time any particular dimension (or group of dimensions) may be figural to either or both of the individuals concerned. The challenge is to try to reflexively integrate these different dimensions, rather than becoming unduly caught up in one dimension at the expense of another. Having this broader awareness opens up choices in our relating.

Being a therapist involves attuning to our clients through trusting the process of going unknowing into the between and sensing what is occurring in the *being-with* space. Using the example from my psychotherapeutic encounter with Lisa I have focused reflexively on how the six dimensions might reveal themselves. I have tried to show how the therapist-client relationship might be fruitfully and holistically explored.

In a spirit of curiosity, openness and professional growth, I invite therapists to reflect on and experiment with those dimensions not normally foregrounded in our preferred practice model. Such a perspective would call on therapists' "willingness and capability to manage ambiguity and uncertainty, and the tensions that ensue from tracking and holding different perspectives" (Orlans, 2008, p.37).

With dynamically shifting boundaries between self-other, connection-separation, transparency-obscurity, involvement-withdrawal, the therapeutic relational process is infinitely layered and mysteriously complex. Once we focus, however, something of the profound and extraordinary richness of the *being-with* experience is revealed. Halling (2008, p.216) says, "To be a person is to live in

the world with others. Anytime we become truly present to this reality, we are both enriched and humbled". I agree. The magic of therapy is found in the *being-with* space.

References

Appel-Opper, J. (2009) What do we say without words?: Relational living body to living body communication. *British Gestalt Journal, 18(1), pp.61-64.*

Aron, L. (1996) *A meeting of minds: Mutuality in psychoanalysis.* Hillsdale, NJ: The Analytic Press.

Buber, M. (1923/2004) *I and Thou.* [Trans. W. Kaufman] London: Continuum.

Buber, M. (1958) *I and Thou.* (R.G.Smith, Trans.). New York: Charles Scribner's Sons.(Original work published 1937).

Buber, M. (1965) *'Distance and relation'.* In: M. Friedman (Ed.) The knowledge of man: The philosophy of the interhuman. New York: Harper Torchbooks.

Clarkson, P. (1989) *Gestalt counselling in action.* CA: Sage.

Clarkson, P. (2003) *The therapeutic relationship (2nd edition).* London: Whurr Publishers.

DeYoung, P. (2003) *Relational psychotherapy: A primer.* New York: Brunner-Routledge.

Doucet, A. (2008) "From her side of the gossamer wall(s)": Reflexivity and relational knowing. *Qualitative Sociology, 31, 73-87.*

Erskine, R.G. (1997)(Ed.) *Theories and methods of an integrative Transactional Analysis: A volume of selected articles.* San Francisco, CA: Transactional Analysis Press.

Evans K.R. and Gilbert, M. (2005) *An introduction to integrative psychotherapy.* Palgrave Macmillan.

Finlay, L. (2005) Reflexive embodied reflexivity: A phenomenology of participant-researcher intersubjectivity. *The Humanistic Psychologist, 33(4), 271-292.*

Finlay, L. (2006) Dancing between embodied empathy and phenomenological reflection. *The Indo-Pacific Journal of Phenomenology, 6, 1-11.*

Finlay, L. and Evans, K. (2009)(Eds.) *Relational-centred research for psychotherapists: exploring meanings and experience.* Chichester, West Sussex: Wiley-Blackwell.

Friedman, M. (2009) The outreach of dialogue. *Journal of Humanistic Psychology, 49(4), 409-418.*

Gendlin, E.T. (1996) *Focusing-oriented psychotherapy: A manual of experiential method.* London: Guilford Press.

Gordon, A. (1996) *Ghostly matters: haunting and the sociological imagination.* Minneapolis: University of Minnesota.

Halling, S. (2008) *Intimacy, transcendence, and psychology: Closeness and openness in everyday life.* New York: Palgrave Macmillan.

Heidegger, M. (1962) *Being and time.* Oxford: Blackwell (Original work published in 1927).

Hycner, R.H. (1991) *Between person and person: Toward a dialogical psychotherapy.* Highland, N.Y.: The Center for Gestalt Development.

Hycner, R. and Jacobs, L. (1995) *The healing relationship.* New York: The Gestalt Journal Press.

Jacobs, L. (2003) Ethics of context and field: The practices of care, inclusion and openness to dialogue. *British Gestalt Journal, 12(2), 13-27.*

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

Lapworth, P., Sills, C. and Fish, S. (2001) *Integration in counselling and psychotherapy – Developing a personal approach.* London: Sage.

Melnick, J., Robine, J-M, Schack, M-L, Spinelli, E. (2007) *Contact and interpsychic perspectives, Studies in Gestalt Therapy*: Dialogical bridges, Vol 2, 11-40.

Mitchell., S.A. and Aron, L. (1999) *Relational Psychoanalysis: The Emergence of a Tradition.* Hillsdale, NJ: The Analytic Press.

Orlans, V. (2008) The interplay of the intrapsychic, the intersubjective and the contextual: Integration in action, *The British Journal of Psychotherapy Integration, Vol 5(1), 35-39.*

Raingruber, B. and Kent, M. (2003) Attending to embodied responses: a way to identify practice-based and human meanings associated with secondary trauma. *Qualitative Health Research, 13(4), 449-68.*

Rowan, J. (1990) *Subpersonalities: the people inside us.* London: Routledge.

Rowan, J. and Cooper, M. (1999) *The plural self: Multiplicity in everyday life.* London: Sage.

Rowan, J. and Jacobs, M (2002) *The therapist's use of self.* Maidenhead, Berkshire: Open University Press.

Spinelli, E. (2008) The value of relatedness in existential psychotherapy and phenomenological enquiry. *Gestalt Journal of Australia and New Zealand, 4(2), 56-69.*

Spinelli, E. (1994) *Demystifying therapy.* London: Constable.

Spinelli, E. The dis-integrated psychotherapist. *The British Journal of Psychotherapy Integration, Vol 2(1), 4-10.*

Staemmler, F.-M. (2005) Cultural field conditions: A hermeneutic study of consistency. *British Gestalt Journal, 14/1, 34-43.*

Stawman, S. (2008) Relational gestalt: Four waves. *Gestalt Journal of Australia and New Zealand, 4(2), 35-55.*

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

Thomas, K. (1996) *The defensive self: A psychodynamic perspective.* In: R.Stevens (Ed.) Understanding the self. London: Sage.

Todres, L.A. (1990) The rhythm of psychotherapeutic attention: A training model. *Journal of Phenomenological Psychology, 21, 32-45.*

Todres, L. (2007) *Embodied enquiry: phenomenological touchstones for research, psychotherapy and spirituality.* Basingstoke, Hampshire: Palgrave Macmillan.

van Deurzen-Smith, E. (1997). *Everyday Mysteries: Existential Dimensions of Psychotherapy.* London: Routledge.

Wheeler, G. (2000) *Beyond Individualism: toward a new understanding of self, relationship, and experience.* Hillsdale, NJ:Gestalt Press/The Analytic Press,

Yalom, I. (1989) *Love's Executioner.* London: Penguin Books.

Yontef, G. (1993) *Awareness, Dialogue, and Process.* Highland, NY: The Gestalt Journal Press. (see also: http://www.gestalt.org/yontef.htm).

Address for Correspondence:

Flat 1, 29 Blenheim Terrace, Scarborough, North Yorkshire, YO12 7HD

Email: linda@lindafinlay.co.uk
Telephone: 01723 501833

Acknowledgements

I am indebted to Ken Evans for his teachings and support towards helping me better understand the process of *being-with*.

Linda Finlay teaches psychology (at the Open University) and qualitative research methodology (at various psychotherapy training centres across Europe/US). Trained originally as an occupational therapist, she is working to complete the requirements for registration as an Integrative Psychotherapist in association with the Scarborough Psychotherapy Training Institute. Linda has published widely. Since 2006 she has published two books with Wiley: Qualitative research for allied health professionals, a volume co-edited with Claire Ballinger; and Relational centred research with psychotherapists, a volume written and co-edited with Ken Evans. A further volume, Phenomenology

for therapists: Researching the lived world (Wiley-Blackwell Publishers), is due out in 2011.

Biljana van Rijn & Ciara Wild

Research Clinic Approach to the Evaluation of Integrative and Humanistic Psychotherapies

Abstract

This article presents a research project that led to the development of a research clinic within Metanoia Institute. The research is an evaluation of brief Integrative Psychotherapy and Transactional Analysis within primary care using standardised outcome measures, the Working Alliance Inventory and the measure of adherence to the therapeutic model. The research demonstrates effectiveness of these approaches within the NHS and suggests a model of evaluation that can be used within different clinical settings.

Introduction

The current professional climate within the United Kingdom calls for evaluation of theoretical approaches and the development of an evidence base for their effectiveness. A research clinic was developed at Metanoia Institute in London in 2010 to address this need, based on the experiences and outcomes arising from the collaborative research project with the Primary Care Trust (PCT) in the London Borough in Ealing. The paper will present the design and findings of this research and show how it influenced the development of the research clinic. The project took place between 2008 and 2010, with 78 clients and 9 therapists. The outcomes have been analysed and demonstrate effectiveness of these psychotherapies within the primary care settings.

Background

GP surgeries within the UK are significant in the provision of psychological treatments and the first point of contact for patients within the NHS. GP interventions include: usual GP care, medication, psychological intervention or a combination of these approaches. In order to establish the effectiveness of these treatment choices a number of research studies compared:

1. Usual GP care with effects of medication (Bedi et al., 2000; Rowland, Bower, Mellor-Clark, Heywood, & Hardy, 2000),
2. Effects of medication and psychological therapies (Bower, Rowland, & Hardy, 2003) and
3. Different psychological therapies, primarily CBT, psychodynamic and interpersonal or person centred (Mellor-Clark, Connell, Barkham, & Cummins, 2001; W.B. Stiles, Barkham, Mellor-Clark, & Connell, 2008; W. B. Stiles, Barkham, Twigg, Mellor-Clark & Cooper, 2006).

Other humanistic and integrative approaches have not been evaluated in primary care settings even though they are represented in the provision of psychological therapies in primary care, voluntary agencies and private practice. This lack of evidence is becoming particularly important in the context of national policies of clinical governance (Carter, 2005), statutory registration of psychotherapists and counsellors and the IAPT initiative (CSIP, 2008). Approaches more frequently represented

in the NHS such as, Cognitive Behavioural, Psychodynamic and Person Centred have had an opportunity to accumulate more evidence for their effectiveness in those settings. This challenges other humanistic and integrative approaches to develop their own evaluation and evidence base despite the outcomes of meta-analytic studies which show that there is no significant difference in the efficacy between different psychotherapeutic approaches(Asay & Lambert, 1999; M.J Lambert & Bergin, 1994; Smith & Glass, 1977; Wampold, 2001).

The Setting

Metanoia Institute is an integrative and humanistic counselling and psychotherapy training institute. The clinical service within the institute provides low cost treatments to the public and placements for students. Metanoia Counselling and Psychotherapy Service (MCPS) has been engaged in routine clinical evaluation (CORE 34) for over 10 years.

In 2008 MCPS received funding to provide short term (12 weeks) Transactional Analysis and Integrative counselling/psychotherapy in GP surgeries. It was agreed that evaluation would be quantitative, replicating features of the IAPT initiative (CSIP, 2008). The GP surgeries were all based in the relatively deprived, multiethnic area of the borough, which already had a functioning IAPT programme.

Methodology and Aims

Even though the national strategy of clinical governance drives the routine outcome evaluation and the development of evidence based practice, there is still a question about the optimal methodologies for this type of evaluative research (Hemmings, 2000; Nathan, Stuart, & Dolan, 2000) and whether it should be done in ordinary clinical settings (naturalistic studies) or randomised control trials.

Naturalistic studies show how therapy is practiced within services and are therefore applicable to wider clinical practice (they have external validity). However, in terms of research methodology they often have a number of flaws which impact the quality of research. Clients drop out of services (data attrition), assessment for treatment is not always defined clearly and there is a lack of clarity about whether and how therapists practice within the model (adherence to the therapeutic approach)(D. M. Clark, Fairburn, & Wessely, 2008; Nathan, et al., 2000).

An example could be seen within the MCPS. Ongoing evaluation has been conducted within this services since 1990, using the CORE System prior to and at the end of therapy. However, the annual reports show that only 61% of all clients have complete data sets. Although this figure is relatively high for a service, it still means that information about the end of therapy is missing for 39% of the clients. It means we have no information about the end of therapy or the outcomes for these clients. Although we know that therapists were studying and practicing particular theoretical approaches, there is no evidence of how much and how they used their theoretical approaches. The questions also arose about the effectiveness of individual approaches and comparisons between them.

In this project the researchers aimed to test out a design of a naturalistic study, that would show how Integrative and TA therapists worked in practice whilst developing the validity of findings in such a way that would allow further comparisons and replication. We used the term 'research clinic' to describe this design.

Values of transparency and empowerment were important within the project and informed the process of evaluation throughout.

Research Design

The research evaluated effectiveness of a 12 week Integrative psychotherapy and Transactional Analysis within four allocated GP surgeries. In order to achieve fuller data completion it was decided to use sessional outcome measures as well as the questionnaires evaluating changes pre and post therapy. Sessional measures ensured the research team had information about how clients were at their last session even when they ended suddenly. This design also replicated the evaluative methods used by the IAPT initiative (D.M. Clark, et al., 2009; CSIP, 2008), which enabled the researchers to make direct comparisons, even with a smaller sample.

In addition to the outcomes of therapy, the project evaluated a working alliance (Horvarth & Bedi, 2002), as one of the major theoretical concepts underlying the theoretical approaches taught within this relational training institute.

A model for measuring the adherence to the theoretical model has been designed for this project. The aim was to utilise the existing setting for evaluation and exploration of clinical practice in Integrative psychotherapy and Transactional Analysis – clinical supervision. Clinical supervisors would be invited to evaluate therapists' adherence to the model using the structured questionnaires designed for the project.

Clients

Inclusion criteria reflected the routine GP assessment practice for counselling. Each client was assessed at intake using a battery of standard assessment measures (CORE 34,BDI II,PHQ9,GAD7 and CORE 10).

The demographic details showed that:

1. The average age of clients was 42.
2. Approximately 74% of clients were female
3. 51.39% of the clients were white English/ European and 38% from minority ethnic backgrounds
4. 36% of the clients were unemployed and only 19% were in full time employment
5. Clinical status -77.25 % of clients were above the clinical cut off for anxiety and depression, and 82.1% on the overall scores on CORE 34

Therapists

These were senior students in Counselling Psychology/Integrative Psychotherapy and Transactional Analysis Psychotherapy at Metanoia Institute.

Adherence to the Model

Each theoretical approach was applied using the core skills, theoretical knowledge and attitudes defined in the Handbooks for each course. The courses at Metanoia Institute have been validated by Middlesex University and accredited by the national umbrella bodies – UKCP, BACP and BPS.

All sessions were audio-recorded. Clinical supervisors who assessed the adherence to the model were independent practitioners, recommended by the course. They had ongoing supervisory relationships with the students. Supervisors assessed adherence to the model through case presentation backed up by the audio recordings of the sessions. Recordings were submitted of four sessions for each of the clients. The assessment was made using the Adherence Questionnaires developed for the project.

Measures

It was envisaged that a percentage of clients would drop out of the service, as this is common within the low cost services.

To ensure the high percentage of full data sets measures included pre, mid therapy and post measures and sessional evaluation.

Clients completed pre and post measures in the session with the therapist, which gave an opportunity for discussion and reflection.

Sessional measures were given to clients at the end of each appointment. They completed them during the week and gave them to their therapists at the beginning of each session. This offered clients an opportunity to reflect on the sessions during the week and discuss the issues arising from them at the beginning of each session. This process aimed to facilitate the clinical work as well bring the therapeutic relationship into focus where needed.

1. Pre, Mid therapy and Post Measures:
   Beck's Depression Inventory
   CORE 34
2. Sessional measures- post each session
   Patient Health Questionnaire (PHQ-9)
   General Anxiety Measure (GAD -7)
   CORE 10 – post each session
   Working Alliance Inventory (WAI)
3. Adherence to the model
   Questionnaires contained areas of theory,

skills and clinical attitudes taught by each course and defined in the course handbooks.

Ethical Considerations

Ethical approval for the project was given by Metanoia Institute Research Committee.

All clients were given information about the project and signed the consent forms. If they chose not take part in research they were offered other counselling within their surgeries.

Evaluation outcomes were communicated to the therapists regularly and they were able to give their feedback about their experiences of the project.

Treatment Outcomes

Data set

78 clients were seen in the project. 75 had at least one session following the assessment session.

The sessional measures show a high percentage of completeness (97%) and allow us to analyse the outcomes at the end of therapy, even where the pre and post measures are missing.

CORE 34 and BDI-II we given to clients at the first, the sixth and the last session. Due to sudden endings there is a lower data set completion percentage for these measures (CORE 34-70.5%;BDI II -73.1%).

38 clients had Transactional Analysis and 40 saw Integrative therapists,

78% attended 6 sessions or more with an average of 9 sessions. 60% of all endings were planned.

The adherence to the model was high for all practitioners and shows the application of these theoretical models in treatment.

The high proportion of complete data sets indicates that both clients and therapists have engaged with the research.

Treatment Outcomes: Core 34 and BDI-II

CORE 34 shows that clients who were rated as clinical at the start of therapy showed an overall decrease in severity to 20.97 % and there is the overall improvement rate of 38% .

A paired t-test was employed to investigate the differences between pre, mid and post scores. The results showed a significant difference at $P < 0.05$ between scores for the pre-post ($t=4.341$) BDI-II and mid-post BDI ($t=4.524$), Core 34 totals, mid-post ($t=3.064$) and pre-post ($t=3.877$)

Treatment Outcomes: Sessional Measures

A paired t-test was employed to investigate the differences between pre, mid and post scores. The results showed a significant difference at $P < 0.05$ between scores. Pre-post PHQ-9 ($t=3.233$), pre-post GAD-7 ($t=4.842$), mid-post ($t=4.606$) and pre-post ($t=4.418$) Core 10 and mid-post ($t=-3.744$) and pre-post ($t=-3.261$).

The analysis of weekly scores shows that therapy, even within a brief therapy setting, does not lead to linear change, although mean scores decrease towards the end of therapy. The standard deviation of scores also increases and decreases across sessions and between participants showing periods of greater variation. This suggests that clients go through their individual processes of change which include periods of higher distress.

The overall achieved change outcomes are very similar for pre and post scores to that within the IAPT demonstration sites (D.M. Clark, et al., 2009) although their results show a marginally greater difference between pre and post scores which could be due to the greater number of participants taking part in their study or the higher percentage of clients above the clinical cut off.

The sessional outcomes show that the average percentage of clients who have improved is 57.7% (between 55.1% and 64.1%,) comparable to 50%-55% in IAPT demonstration sites (D.M. Clark, et al., 2009)

Working Alliance Inventory

The working alliance does not represent an outcome of treatment but an essential factor to the effective therapeutic process, according to the integrative and humanistic frameworks. WAI shows that on average, the working alliance increases as the therapy progresses.

Associations Between Variables

1. It was found that there was no significant association between orientation and improvement on any of the measures
2. There was a significant association between completion status (attendance of all 12 sessions) and Improvement on the BDI-II and the Core 34
3. Significant associations (P< 0.05) were found between the attendance of more than six sessions and Improvement on all outcome measures except Core-10.
4. Clients who attended less than 6 sessions had higher no change scores than clients who attended more than 6 sessions.
5. There was no significant association between therapist and improvement on any of the measures.

Differences Pre and Post Therapy

The IAPT report (Clark et al, 2009) found that on entering the service, approximately 86% of clients were scoring above the clinical cut off for the depression and anxiety measures. An average 77%of the clients seen in this research project were also classified as above the clinical cut off for these measures at the start of therapy. It would be expected that within the NHS, clients who are referred to counselling would present with less severity than those referred for CBT. However, within our sample that difference seems to apply to less than 10% of clients.

The analysis shows that first session outcomes significantly predicted (P< 0.05) scores at session 12 on all of the measures. This means that clients who have started at higher severity, presented with higher severity at the end of therapy. This could not be addressed within the project as there was no scope to extend the amount of therapy received.

Discussion: The outcomes

The outcomes show that Integrative psychotherapy and Transactional Analysis achieve change for an average of 57.7% of clients referred for a 12 session treatment within the GP practices, comparable to the IAPT demonstration sites (D.M. Clark, et al., 2009). Although the figures are limited by a small sample (78 clients), the high percentage of full data sets for sessional measures suggests reliability.

The improvement is shown within the pre and post measures as well, although the reliability is more limited by the lower completion rates.

The research has taken place in the inner city, multiethnic environment, with high levels of deprivation. The outcomes suggest that and Integrative psychotherapy and Transactional Analysis are equally effective as treatments in these clinical settings.

The Therapists and the Orientation

There have been no differences in effectiveness between the therapists or the orientations even though the therapists show a high adherence to treatment models.

The lack of difference in effectiveness between approaches was expected on the basis of the common factors research (Asay & Lambert, 1999; M. J. Lambert & Ogles, 2004; Smith & Glass, 1977; Wampold, 2001). However, the expectations of difference in the performance of individual therapists (M. J. Lambert & Ogles, 2004; Mellor-Clark, et al., 2001) was not met. The therapists worked with similar clients and numbers and all performed to a steady level. This may be related to the similarity in their training background, training levels of training and experience. Further research with higher numbers of clients and practitioners would be need to investigate whether this is common within the same training institution.

The Working Alliance

Working alliance outcomes show that the alliance increased within the duration of therapy. Therapists reported finding the measure useful clinically, an used it to attend to potential ruptures in the relationship. Although there is no evidence that the strength of the working alliance directly predicted the outcome, clients who stayed in therapy longer had better outcomes. This suggests that the increasing strength of the working alliance may have helped clients to stay in therapy and use it.

Experience of Using Evaluative Measures in Psychotherapy

The experience of using extensive evaluation during therapy was new for all the therapists. Most of them have already used pre and post evaluation within the MCPS, but the range of sessional measures and intensity of evaluation presented a challenge.

Use of shorter questionnaires (PHQ,GAD 7, CORE 10 and WAI) after each gave clients and opportunity to reflect on the sessions during the week and a tangible way to monitor their progress and give feedback to the therapists. Therapists would receive the weekly measures at the beginning of each session and this gave them an opportunity to follow up any issues raised in the questionnaires. This served to strengthen the therapeutic relationship and ensure shared aims and direction.

Meetings between the research team and the therapists highlighted what happened in practice and how therapists approached the challenge of a different style of communication by the clients. These discussions showed a lot of individual differences between the therapists, as well as differences in how they used them with different clients. They went through each measure at the beginning of each session with the client, used them to formulate the focus of the sessions with their client or left it up to the client to pick up the themes they wanted to focus on. Invariably, the Working Alliance Inventory was proving useful in putting the therapeutic relationship in the frame and identifying the ruptures early on.

Clients engaged with the measures and used them in different ways- for additional reflection and to give feedback as well as being willing to participate in a research project for the greater good.

On both sides, evaluation and research were used to enhance and deepen communication and the working alliance between the therapist and the client.

Future Developments

The outcomes of this research pointed to the need to conduct further studies with larger samples. The NHS setting did not allow for variance in the length of therapy to match the needs of the client, or for a follow up. The outcomes showed that severity of the scores at the outset predicted severity at the end and thus suggested that longer treatment may be more appropriate for clients with more severe difficulties.

To address the emerging questions the Metanoia Institute has applied this research clinic model to the internal service (MCPS) where a larger scale project has started in September 2010. This project will allow for a larger sample, longer treatments, an opportunity for a follow up and comparisons between several theoretical approaches.

The measure of adherence to the model follows a model already used in clinical practice, but offers an overt level of structure and evaluation. The intention of the researchers is to standardise this measure for the future use.

The research clinic will use the same research design and measures as they were well used by both the practitioners and clients. The advantage of standardised outcome measures also allows for comparisons with other services and theoretical approaches nationally and internationally.

Further information about this research project can be obtained from Biljana.Vanrijn@metanoia.ac.uk

References:

Asay, T. P., & Lambert, M. J. (1999). *The Empirical Case for the Common Factors in Therapy:quantitative findings.* In M. Hubble, B. Duncan, L. & S. D. Miller (Eds.), The Heart and Soul of Change:What Works in Therapy (pp. 531-537). Washington,D.C: American Psychological Association.

Bedi, N., Chivlers, C., Churchill, R., Dewey, M., Duggan, C., Fielding, K., et al. (2000). Assessing effectiveness of treatment of depression in primary care: Partially randomised preference trial. *British Journal of Psychiatry, October 2000(177), 312-318.*

Bower, P., Rowland, N., & Hardy, G. (2003). The clinical effectiveness of counselling in primary care: a systematic review and meta-analysis. *Psychological Medicine, 33(2), 203-215.*

Carter, M. (2005). *Clinical governance in counselling and psychotherapy in the NHS.*

Clark, D. M., Fairburn, C. G., & Wessely, S. (2008). Psychological treatment outcomes in routine NHS services: a commentary on Stiles et al.(2007). *Psychological Medicine, 38(5), 629-634.*

Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two demonstration sites. *Behaviour Research and Therapy, 47, 910-920.*

CSIP (2008). *Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit April 2008.*

Hemmings, A. (2000). Counselling in primary care: a review of the practice evidence. *British Journal of Guidance & Counselling 28(2), 233-252.*

Horvarth, A. O., & Bedi, R. P. (2002). *The Alliance.* In J. C. Norcross (Ed.), Psychotherapy Relationships That Work. Therapist Contributions and Responsiveness to Patients (pp. 37-69): Oxfrod University Press.

Lambert, M. J., & Bergin, A. E. (1994). *The Effectiveness of Psychotherapy.* In A. E. Bergin & S. L. Garfield (Eds.), Handbook of Psychotherapy and Behaviour Change (4 ed., pp. 143-190): John Wiley.

Lambert, M. J., & Ogles, B. M. (2004). *The Efficacy and Effectiveness of Psychotherapy.* In M. J. Lambert (Ed.), Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change (Fifth Edition ed.): Wiley & Sons Inc.

Mellor-Clark, J., Connell, J., Barkham, M., & Cummins, P. (2001). Counselling Outcomes in Primary Health Care: a CORE System Data Profile. *European Journal of Psychotherapy & Counselling 4(1), 65-86.*

Nathan, P. E., Stuart, S. P., & Dolan, S. L. (2000). Research on Psychotherapy Efficacy and Effectiveness: Between Scylla and Charybdis?. *Psychological Bulletin, 126(6), 964-981.*

Rowland, N., Bower, P., Mellor-Clark, J., Heywood, P., & Hardy, R. (2000). Counselling in Primary Care: a Systematic Review of the Research Evidence. *British Journal of Guidance & Counselling 28(2), 215 - 231.*

Smith, M. L., & Glass, G. V. (1977). Meta-Analysis of Psychotherapy Outcome Studies. *American Psychologist, 32(9), 752-760.*

Stiles, W. B., Barkham, M., Mellor-Clark, J., & Connell, J. (2008). Effectiveness of Cognitive-Behavioural, Person-Centred, and Psychodynamic Therapies in UK Primary-Care Routine Practice: Replication in a Larger Sample. *Psychological Medicine, 38(5), 677-688.*

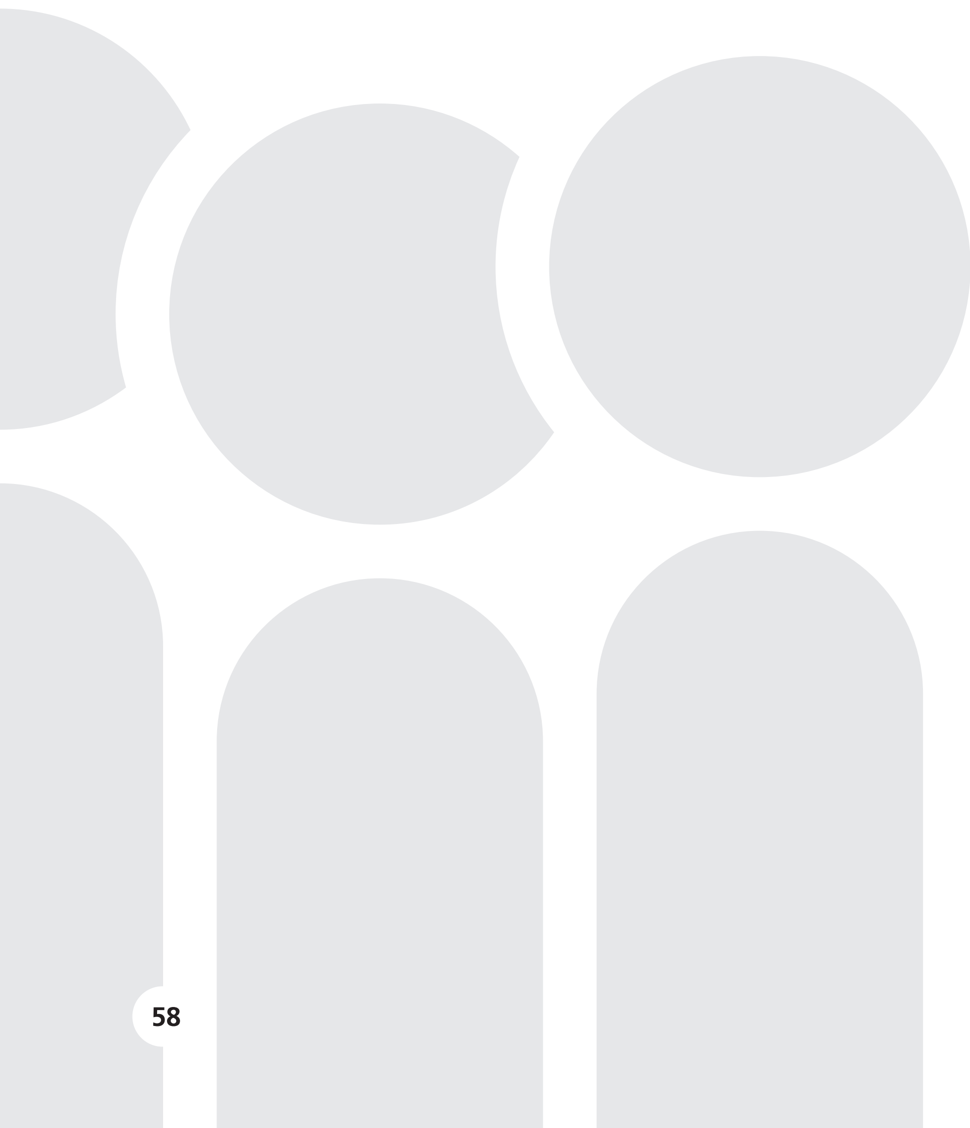
Stiles, W. B., Barkham, M., Twigg, E., Mellor-Clark , J., & Cooper, M. (2006). Effectiveness of Cognitive -Behavioural, Person-Centred and Psychodynamic Therapies as Practised in the UK National Health Service Settings. *Psychological Medicine(36), 555-566.*

Wampold, B. (2001). *The Great Psychotherapy Debate*: Lawrence Erlbaum Associates.

Dr Biljana van Rijn is a Head of Clinical Services at Metanoia Institute in London, where she has developed a research clinic. She teaches on the MSc programme in Transactional Analysis Psychotherapy and the Doctorate in Counselling Psychology

and Integrative Psychotherapy at Metanoia Institute and offers research supervision. Biljana also works a psychotherapist and supervisor in private practice in West Sussex.

Ciara Wild is the Researcher and Clinic Administrator at the Metanoia Institute as well as a member of the Centre for Practice Based Research. She holds and degree in Psychology and a Masters degree in Forensic Psychology



Julia McDermott

My Personal Framework for Integration

Editors' Note

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

Introduction

As a developing Integrative Psychotherapist, I conceptualise my framework as integrating aspects of contemporary relational psychoanalytic theory with the humanistic principles that support my way of 'being with' clients. Linking to "intersubjectivity" theory (Stolorow et al. 2004, Pix), I believe that it is the self of the therapist, in relationship with the self of the other, which leads to insight and change.

> *"Among the most significant contributions of relational psychoanalysis is its focus on the inevitability of the psychoanalyst's participation" (Slochower, 1996 in Aron and Harris 2005, P29).*

I draw upon current neurobiological research (Gerhardt, 2004; Schore, 1994 and Siegel, 1999) to understand the connection between development in the brain and attachment theory (Bowlby, 1989), attunement (Stern, 1977) and regulation of the self (Fonagy et al, 2004). My understanding is enhanced by recent infant research that informs adult treatment, describing the process of "interactive regulation between inner and relational processes" (Beebe and Lachmann 2005, P211).

I envisage myself moving between "one, one-and-a-half and two-person psychologies" (Stark 2000, P6), within Clarkson's description of the "Five Relationship" modalities (Clarkson 2003, P33), responding thoughtfully to the need of the patient at any particular moment in the therapeutic process. This provides me with a comprehensive and flexible model to work within, informing diagnosis, treatment planning and the evolving therapeutic relationship.

1. The Philosophy and Core Values that Inform My View of Integrative Psychotherapy

1.1. Core Values that Inform My Work with Clients

My way of being with clients is influenced by Rogers' core conditions of empathy, congruence and unconditional positive regard (Rogers 1961, P48). I aim to provide an authentic, co-created therapeutic relationship, respecting the uniqueness of the individual. I carry hope and belief in the human potential to change and grow, believing in "man's tendency to actualise himself, to become his potentialities" (Rogers 1961, P351).

I aspire to provide a "secure base" for clients – a safe, confidential, non-judgmental space – to support and invite them to explore the issues that have brought them into therapy. I am mindful to be careful with, as well as caring for, my clients.

> *"The therapist explicitly takes the position of the secure base to help patients face their fears" (Holmes 2001, P4).*

In accordance with Martin Buber, I believe that "man is not to be seen through, but to be perceived ever more completely in his openness and his hidden ness" (Buber 1957b, P227). I respectfully hold the tension between making an assessment of perceived symptoms and deficits for the purpose of diagnosis and treatment planning, with the ideal of not labelling or discounting the unique person of the individual.

I believe I need to be aware of, and respectfully hold, religious and cultural diversity, as I believe that people cannot be fully understood outside of these defining aspects of their lives.

> *"Learning to live with many points of view, many different ways of experiencing reality is perhaps the greatest challenge of the new, complex society in which we find ourselves" (Zohar and Marshall 1993, P9).*

Seeking to support and 'be with' clients requires me to strive to understand the circumstances of how they came into being, the context of their environment and the quality of their relationships. I need to be aware of, and critically examine, the values and assumptions that underpin the way I make sense of the world, being reflective and reflexive on the unfolding process. I remain wondering about my own subjective experience and the inevitability that it will, at times, impact the therapeutic relationship and I endeavour to stay open to recognising the implications of this.

I am learning to tolerate "extended periods during which I may feel ignorant and helpless" whilst believing that I have "a licence not to know" (Casement 2001, P3). I am striving to make meaning whilst acknowledging that there is more than one 'truth', believing that what one sees is determined by where one is 'standing' at the time.

1.2 What Integration Promotes and Allows

I believe that working within an integrative model encourages and promotes best practice in my profession. Integration both supports me theoretically, and gives me the confidence to work experientially, bringing my whole self to the therapeutic encounter, encouraging the real person of the therapist to meet the real person of the patient. In doing so, I resonate with Lucia Swanepoel's suggestion that integration equates with "doing what comes naturally. That integration is a sine qua non of being" (Swanepoel 2009, P31).

Most importantly, I believe that an integrative theoretical model allows the joining together of both an intuitive and informed response to what the client brings with them. As an advocate of integrative psychotherapy, I do not wish to be confined within the boundaries of a single orientation or adapt my way of working to follow the 'rules' of a theory that does not fit the present moment in therapy with my client. I believe in "meeting" (Buber 1973, P15) the client where they are offering a "real" (Clarkson 2003, P152) co-created relationship.

> *"Being integrative means being committed to the whole project of therapy rather than to a particular approach" (Hollanders in Dryden 2007, P436).*

2. Human Motivation and the Structure of the Person

2.1 What Motivates the Self?

Giving consideration to both developmental and neurobiological theory, it would seem that self-motivation is embedded in our earliest life experiences.

Allan Schore describes the "attachment motivation" of the infant which is directed towards the mother (Schore 1994, P111), validating my belief that, within the primary relationship, "a baby's self and motivational systems develop because the baby is securely embedded in the intersubjective realm of caregivers" (Lichtenberg et al. 2001, P204).

I am informed by Lichtenberg's "five motivational systems", each of which is linked to a "fundamental need" of the developing infant and child, based on "clearly observable behaviors" (Lichtenberg et al. 2001, P1). This model enhances and interfaces with Stern's

"layered model of development" (Stern 2003, Pxi) and internal "organizational change" (Stern 2003, P9) illuminating how these different systems might come to the foreground at different times.

> *"The fundamental needs formed in the neonate for the psychic regulation of psychological requirements, for attachment, for exploration and assertion, for aversive reaction, and for sensual enjoyment persist through life" (Lichtenberg et al. 2001, P203).*

If motivations arise solely from "lived experience" (Lichtenberg et al. 2001, P2) then the conclusion can be drawn that lack of experience, or bad experiences with primary caregivers, would adversely affect motivational drive in the infant and the adult. This appears to confirm the link between deficits in parental care and lack of motivation in the developing self.

My experience of working as an Integrative Psychotherapist has shown me that adult clients are often motivated to seek therapy by their longing to be in relationship and a wish to make meaning of their lives. When assessing clients, I am seeking evidence of a wish for change, bearing in mind that client motivation is a factor in the successful outcome of therapy.

> *"Clients' expectancies that therapy will be of help are related to motivation" (Tallman and Bohart in Hubble et al. 2008, P105).*

During the psychotherapeutic process, I observe individuals struggling to understand themselves and identify the causal links between their past experiences and present relationships. I believe these strivings illustrate the "motivation for learning and change that spring from the self actualising tendency of life itself" (Rogers 1961, P285).

2.2 The Structure of the Self

Building upon Winnicott's view that "there is no such thing as a baby" (Winnicott 1984, P99) but a mother/baby unit or "system" (Beebe and Lachmann 2005, P22), and believing that "the self is always self-in-relationship with others" (Evans and Gilbert 2005, P3), I view the person as an embodied mind – a structure or organisation of intraphysic and interpersonal processes. The baby is born into a relational field and the birth of the self happens within the primary relationship with the mother. In optimal circumstances, the mother provides an intersubjective experience for the infant, involving empathic connectedness, mirroring, sensitive touching and gentle handling (Siegel 1999, P89). In accordance with Siegel, I believe that "the regulation of emotions is thus the essence of self-organization. The communication with and about emotions between parent and infant directly shapes the child's ability to organize the self" (Siegel 1999, P279).

In adulthood, the self is in relationship both with itself intrapsychically, and others interpersonally. "Intrapsychic processes link to how people experience their self-awareness and control their ideas, feelings and urges" (O'Brien and Houston 2000, P34). In neurobiological terms, "coherent self-assembly of information and energy flow across time and context to create the subjective experience of self" (Siegel 1999, P316).

> *"The core of the self lies in patterns of affect regulation that integrate a sense of self across state transitions, thereby allowing for a continuity of inner experience" (Schore 1994, P33).*

Coherence between self-states is seen in healthy functioning adults and conversely, conflict between self states, brought about by "insecure or conflictual" attachments in infancy, is linked to "impairments in affect regulation, insecurity, unresolved trauma or loss, and dysfunctional social relationships" (Siegel 1999, P317). Most importantly for adult fulfilment and enjoyment of life, a sound, cohesive self-structure will influence the quality of our relationships with others.

2.3 How Do We Become a Healthy Self?

Maturation of the infant into an adult with psychological good health, and a sense of emotional well being, would appear to be dependent upon the quality of care within its first relationship. If this care is not available from the mother, it seems evident that sound

psychological health is still possible if the developing infant has another emotionally reliable attachment figure with whom to bond.

Intersubjective contact between a child and its mother either facilitates or obstructs the child's "negotiation of critical developmental tasks and successful passage through developmental phases" (Atwood et al. 1984, P65). It is the amount of support available to a child that determines its development into a psychologically healthy adult with a good sense of self. In other words, the job of the mother is to help their child grow up!

Current neurobiological research has linked attachment theory to corresponding developments in the brain. What has been behaviourally observable in the person is now scientifically observable in the brain. The importance of affect regulation within the first relationship with the primary carer leads to healthy structural development in the brain. This being established, the child's potential to successfully negotiate future relationships is secured (Schore, 1994).

My understanding is that healthy relatedness is connected to the ability to move between connectedness and separateness from others (Buber, 1958a) and that the balancing of these two polarities is the key to healthy living. Believing in the "natural tendency towards health" (Winnicott 1984, P101), I use "neutral interest" to explore a client's apparent 'stuckness' at one polarity, "displaying equal interest in both poles of the client's experience" (Clarkson 1999, P10). The oscillation between extreme polarities, such as that evidenced within the borderline personality structure (Benjamin 2003, P121), illustrates the child's failure to successfully negotiate the important developmental task of separation-individuation.

> *"The borderline patient suffers from an arrest occurring at the separation-individuation phase (rapproachement subphase) of development" (Masterson 1976, P337).*

Most importantly for the developing self, a positive experience in its first relationship can successfully facilitate another relationship with a third person, such as a father or grandparent, from outside the mother/infant dyad. Continuing development from a positive experience in our first relationship, promotes the possibility of gaining another perspective of the primary relationship, from the viewpoint of another person. The developing self receives encouragement to negotiate its relationship with others and build what Fonagy et al. refer to as "mentalization", the development of a reflective function (Fonagy et al. 2004, P11). Fonagy believes that "this capacity is acquired in the context of the child's early social relationships" and that "the ability to mentalize is a key determinant of self-organization and affect regulation" (Fonagy et al. 2004, P23).

Encouragingly, it would seem that all is not lost for adult survivors of deficiencies or neglect in their early care. Interpersonal relationships, including the therapeutic relationship of psychotherapy, can have a "powerful effect on the development and ongoing functioning of self-regulation" (Siegel 1999, P285), thus facilitating psychological growth in later life.

3. Concepts That Inform My Integrative Problem Formulation

3.1 Developmental Derailments Linked To Attachment Theory And Character Style

I value the writings of John Bowlby to understand the theory of attachment as representing the infant's attempts to "maintain an affectional bond" with the mother (Bowlby 1998, P42). He believed that negative experiences in this early relationship were internalised within the developing infant to become an internal "working model of an attachment figure to whom are attributed such characteristics as uncertain accessibility, unwillingness to respond helpfully, or perhaps the likelihood of responding hostilely" (Bowlby 1989, P140).

Further developing Bowlby's concept of "insecure" attachments between mothers and their babies (Bowlby 1989, P163), Mary Ainsworth described "ambivalent" and "avoidant" infant attachment styles, linking these to the typical parenting behaviour of their mothers. She later added a further category of "disorganised" attachment style (Ainsworth et al, 1978 in Bretherton 1992,

P11). Through her "Infant Strange Situation" experiments, which temporarily separated infants from their mothers, thereby activating their attachment behaviour, Ainsworth was able to determine that "emotionally unavailable" mothers determined "avoidant" attachments and "inconsistent" parenting tended to create "resistant" or "ambivalent" attachment styles (Siegel 1999, P76).

Adaptations made by infants and young children, in order to cope with deficiencies in care, are observable as symptoms and affects in the adult.

It appears irrefutable that the effects of developmental derailments and exposure to trauma lead to disorganisation of cognition, affect dysregulation and, in some circumstances, fragmentation of the core self.

> *"Dyadic failures of affect regulation result in the developmental psychopathology that underlies various forms of later forming psychiatric disorders" (Schore 1994, P33).*

Using the evidence gained during observation of the client - assessment of symptoms and affects, information and history taking - I consider and research the diagnostic clues I am shown. I reflect on the developmental stage when derailments appear to have occurred, realising the diagnostic importance of unsuccessful passage through specific developmental tasks, such as the "separation/individuation" issue at the heart of "borderline" pathology (Masterson 1976, P31).

I am also informed by Stephen Johnson's integration of developmental history with "characterological styles" illustrating "descending disruption in structural or ego functioning" (Johnson 1994, P14). This confirms what I have learned experientially, that is, the earlier the relational trauma occurs, the more severe will be the psychopathology. "Impingements cause a need to react" (Winnicott 1984, Pxl) and linking these reactive adaptations with the life history of the client will provide strong predictors for diagnosis.

Spatial issues, both physical and psychological, evidenced within the therapeutic process, are very informative for the diagnostic process. I seek to identify whether I am being experienced by the client as too close and 'suffocating', indicating a "schizoid" presentation (Guntrip, 1992; Johnson, 1994; Yontef, 2001), whilst looking for clues to confirm or deny this diagnosis. I ask myself, does the client's affect appear "frozen", do they have difficulty meeting my gaze - is there an absence of "real spontaneous" emotion? (Johnson 1994, P80). Does their life history illustrate the barren childhood that typically describes the "schizoid" experience?

The client who clings in relationships or withdraws, or oscillates between these two positions, may be describing the "borderline" process (Masterson, 1990; Johnson, 1994; Schore, 1994; Siegel, 1999; Gabbard and Wilkinson, 2000) or "dependent" (DSM-IV-TR, P295) style. Is the client evidencing difficulty with regulating their affect? Does their childhood history illustrate the "drama a day, veritable soap opera" experience of the "borderline" adult? (Benjamin 2003, P118).

Fixation and adaptation leads to psychopathology. Examining the client's sense of how they view themselves and others will give clues as to what was not provided. Observation of repeated dysfunctional patterns of relating will assist the recognition of the "touchstones" of therapy (Friedman, 1972b) with problematic "lived experience" being evidenced in the here and now (Lichtenberg et al, 2001).

3.2 Early Relational Trauma and Subsequent Traumatic Events

Early relational trauma and subsequent adult dysfunction appear inextricably linked. Michael Balint termed a rupture in the early relationship "the basic fault, a fragmentation and disjunction at the core of the self" (Balint 1968, P66). An infant with a mother who is emotionally or physically unavailable is likely to suffer early relational trauma. The immobile face of the depressed mother does not perform the necessary mirroring function and "cannot pass on left brain regulatory strategies either" (Gerhardt 2004, P122). Misattunement with the primary carer leads to dysregulation of affect and "as a result, the infant remains stuck fast in stressful unregulated

disorganizing states of unmodulated negative affect" (Schore 1994, P402).

The infant will need to adapt in order to survive and it is this adapted person who enters therapy, seeking to understand their psychological "dis-ease" in relationships, both with themselves intraphysically and with others interpersonally (Clarkson, 1999, P46).

"Neglect in the presence of the mother is associated with an inability to regulate an overwhelming stimulus barrage from within, an impaired taming of aggression and a failure to develop positive self-esteem" (Schore 1994, P417).

Neglect or abuse in the presence of the mother is particularly traumatic for the developing infant and child, severely impairing the ability of the self to regulate emotions and develop positive relationships. In these circumstances, the developing self is forced, in the interest of survival, to bond with a non-nurturing other, "manifesting an inability to sustain an enduring sense of self and a sense of relatedness with significant others during stressful moments" (Blatt 1991, P453).

"Caregiver-induced trauma is qualitatively and quantitatively more potentially psychopathogenic than any other social or physical stressor" (Schore 2001, P9).

In such circumstances, the child can become dislocated or estranged from its sense of self, "when the secure base is the threat" (Holmes 2001, P7). This has implications for the establishment of a therapeutic relationship, as it severely impairs the ability to trust in others. Some individuals have a higher tolerance of stress and anxiety than others and both Siegel (1999) and Schore (1994) link experience in early life as crucial to organising the way the basic structures of the brain develop and the later ability to manage trauma. Allan Schore states that "failures in attachment can contribute to an individual's vulnerability to developing Posttraumatic Stress Disorder or other disorders" (Schore 1994, P59).

Evidence of trauma, whether it has been an isolated incident for the client, or experienced over many years, needs to be a core consideration in the process of diagnosis, leading to "more structured treatment planning" (Herman 1994, P3). I am mindful of Ogden et al's theory regarding the "window of tolerance" set between the two zones of "hyperarousal" and hypoarousal" and the need to keep therapeutic exploration with traumatised clients within the "optimal arousal" zone (Ogden et al. 2006, P27) to help them learn to self-regulate difficult self-states. I understand that to avoid re-traumatisation of the client, it is necessary to "think about thinking" about the trauma and practice "resourcing skills" in advance of beginning memory work and the remembering of the trauma (Ogden et al. 2006, P241).

As a developing Integrative Psychotherapist, the symptoms I would expect to observe in a client with a history of severe trauma would include dissociation, memory impairment, disorganisation of cognition and fragmentation at the core of the self. I understand that dissociation is a defensive process (DeYoung 2003, P104), which allows a person to split off and disconnect from feelings and bodily sensations during traumatic events. When working with traumatised patients, I appreciate Kepner's advice that treatment should be "person and process centred rather than centred on content" seeing "healing as growth as opposed to cure" (Kepner 2003, P2). I consider, "when a client "can't remember" what support might be required so that the client can "afford" to remember" (Kepner 2003, P10).

I feel it is important to bear in mind that traumatic memories are stored in a different form to narrative memories. It appears that because these memories remain unprocessed and un-integrated, they do not fit into the narrative flow of our life story (Van der Kolk, 1991; Kepner, 2003). This could adversely affect the building of co-created meaning and derail the process of psychotherapy. Therapy with traumatised patients requires understanding the process of not remembering (Kepner, 2003).

"Trauma overwhelms and disrupts the psychological immune system altogether. Disorganised responses and narratives lack any clear coherent strategy for self-protection" (Holmes 2001, P3).

It is therefore difficult to construct a clear picture of the client's history from narrative memory, as trauma disrupts the

psychotherapeutic process of "story telling, story listening and story understanding" (Holmes 2001, P16) – memories do not come with a story or "model scenes" (Lichtenberg, et al. 2001, P4).

Responses to traumatic events can be embedded in the structure of the body (Herman, 1994; Rothschild, 2000; Ogden et al, 2006; Kepner, 2003; Schore, 1994) and stored as implicit memory that can be situationally accessible (Siegel 1999, P53) or subject to "state dependent" recall (Rothschild 2000, P35). Implicit and non-verbal body cues are particularly informative in the way that they can illustrate what was missing or traumatic in the client's past.

I exercise self-care when working with severely traumatised clients. I recognise the value of supervisory and peer support, together with personal therapy, in promoting psychological health and to avoid becoming overwhelmed by "secondary trauma" (Herman 1994, P151).

When giving consideration to problem formulation from an integrative perspective, understanding these different aspects of developmental theory, and the mechanisms and consequences of trauma, informs the process of diagnosis and treatment planning. These concepts underpin and enhance my knowledge, allowing me to practice in an informed and reflective way, bringing clarity of understanding to my client work and consolidation to my integrative model.

4. The Process of Psychotherapy

Using phenomenology, symptoms and affects observed in clients gives a sense of the developmental stage when "impingements" (Winnicott 1984, P183) took place and how this has interfered with their developing sense of self (Stern 2003, P37). From within the therapeutic relationship, I can observe how a client "attempts to solve a problem in the present by methods that failed to solve it in the past " (Alexander and French 1946, P95) evidencing the adaptations that occurred in early life when the infant became "derailed from an optimal course" (Johnson 1994, P3).

I strive to build a co-constructed psychotherapeutic relationship with the other, being aware of cultural, contextual and physical differences to myself. I give consideration to the fact that I am a white, middle-aged, heterosexual woman, a wife and mother and the transference and countertransference implications of this for both myself, and the client. I realise that my subjectivity will impact the therapeutic relationship to a greater or lesser extent, depending on the age, gender, race, and sexual orientation of the client.

I am aware of the power imbalance within the therapeutic dyad and endeavour to foster "mutuality" (Aron 2001, P123) in the therapeutic relationship, realising that this issue can be addressed and carefully considered without ever being able to be completely overcome.

> *"Psychoanalysis, then, is mutual but inevitably asymmetrical – inevitably because it is the patient seeking help from the analyst….." (Aron 2001, Pxi).*

I view myself as responding to, rather than guiding towards, what the client is bringing at this moment in time, seeing "treatment as a co-constructed interactive process at every moment" (Beebe and Lachmann 2005, P17). Following the humanistic tradition of working in the "here and now" (Clarkson 1999, P27), using congruence, empathy and unconditional positive regard (Rogers, 1961), I pay attention to what is "figure" and what is "ground" (Clarkson 1999, P6) in the moment-by-moment process. I am "matching and tracking the patient's attention and affect state" (Beebe and Lachmann 2005, P10), seeking to identify "touchstones" (Friedman, 1972b, P2) or signposts which will enable me to understand and appreciate major events in the client's life.

I believe there is a cyclical feel to the process to psychotherapy, similar to the cycle of "Gestalt formation and destruction" which flows between the sensations of "awareness", "mobilization" and "contact" (Clarkson 1999, P33) or, as a client once stated, being in therapy is like "being in the cycle of a washing machine!" I compare the process of psychotherapy with carpet weaving, whereby I follow the client backwards and forwards through the story of their life. With each pass, more colour, depth and detail

emerge into an increasingly clearer picture of their life history and intrapsychic structure.

5. The Integration of Modalities

Petruska Clarkson's exposition of five relationship modalities, "the working alliance, the transference/countertransference, the developmentally needed, the person-to-person and the transpersonal" (Clarkson 2003, Pv), provides a useful overview of five different viewpoints or lenses through which to experience the therapeutic process. Clarkson's model interfaces well with Martha Stark's integration between one, one-and-a-half and two-person psychologies (Stark 2000, Pxxii).

I believe that one-person psychology is happening when the therapist interprets the transference and the focus is wholly on the client's intrapsychic structure. One-and-a-half person psychology occurs within the developmentally needed relationship, supplying in the here and now "what was not provided by the parent early on" (Stark 2000, Pxviii). Two-person psychology encapsulates Clarkson's "real relationship" advocating that, "unless the therapist is willing to bring her authentic self into the room, the patient may end up analyzed – but never found" (Stark 2000, Pxxii).

I flexibly hold the connection between the present moment in therapy and working within a relationship modality, realising that in moving between them, I envisage myself responding to, and not guiding, the therapeutic process. I do not conceptualise these modalities as sequential stages but as overlapping "states" providing a flexible framework within which to conceptualise the process of psychotherapy (Clarkson 2003, Pxxi).

5.1 The Working Alliance

I regard the "therapeutic frame" (Gray 1994, P6) or "working alliance" (Clarkson 2003, P35) as the container or framework that holds the therapeutic work.

This is the formal agreement, discussed at the first assessment meeting between the client and myself, containing all the necessary boundary and contractual agreements, such as time, place, payment of fees and so forth. This shared understanding is formally recorded into a contract, signed by both parties, recording the agreements made between us at the commencement of our work together.

I believe the working alliance offers a containing and holding experience for clients, reflecting the professional boundaries of our meetings. For some clients, the consistency and reliability of boundaries, provides a sense of continuity and safety that was missing in their childhood.

Boundary violations, such as lateness or non-payment of fees, can alert the therapist to non-verbal communication from the client, what Patrick Casement refers to as "communication by impact" (Casement 2001, P72). Such events can provide useful clues at an implicit level leading to a possible breakthrough in treatment, requiring reorientation by the therapist or a reworking of the existing agreement between the two parties.

5.2 The Real Relationship

This relationship comes into being when real contact is established in the dyad. Clarkson describes it as "a quality of atmosphere that permeates the analysis" (Clarkson 2003, P176), occurring "in the context of an ongoing continuously evolving relationship between two real people" (Stark 2000, Pxx), and representing two-person psychology.

> *"Only when the patient finds the real person in the therapist and the therapist finds the real person in the patient does true psychotherapy happen" (Guntrip 1992, P352).*

The real relationship is founded on both therapist and client being grounded in the work and the therapeutic relationship, signified by the establishment of trust and the ability to work through and resolve ruptures in the alliance. Perceived ruptures require immediate attention as they represent "an opportunity for establishing important gains and for revising or reworking fundamental psychotherapeutic issues" (Clarkson 2003, P53). The real relationship is invested with quality and resilience whereby "each partner's

subjective experience is an emergent process, continually affected by the interaction as well as by the person's own self-regulation" (Beebe and Lachmann 2005, P212).

5.3 Transference and Countertransference

I view transference and countertransference phenomena as an unconscious co-created process whereby the person bases their perceptions and actions on past, lived experience. The 'adapted' individual is operating from an historical viewpoint. They have not updated their way of being in the world into the here and now, behaving and relating to others 'as if' they are still living in the past.

I am greatly informed by Marian Tolpin's concept of "forward edge" and "trailing edge" transference, representing "tendrils of health" waiting for more optimal circumstances in which to grow, versus the client displaying "self-protective resistance to further infringement" by the therapist into their world (Tolpin 2002, P167). I believe that "forward edge" transference represents "shoots" of "stunted" healthy childhood development held in suspension, waiting for more optimal circumstances in which to grow (Tolpin 2002, P168).

Interpretations can be formulated by the therapist, based on the experience of being with the client, using knowledge gained within this relationship to make links to the client's pattern of relating. Thus directing "the patient's attention to her relational dynamics – that is, those aspects of her internal dynamics that she actually plays out (or enacts) in her relationships" (Stark 2000, P24).

The emergence of co-constructed enactments is an important opportunity to "gain a window on unconscious motivations and meanings held by the patient that have not been previously recognized or articulated" (McLaughlin 1991, P29). Honest and non-defensive consideration of enactments by the therapist can provide useful information for the purpose of diagnosis and ongoing treatment.

I give careful consideration to the issue of self-disclosure, bearing in mind the needs of the individual client at any particular moment in therapy and always with a view as to whether it is in the best interest of the client. I have been inspired by Karen Cobb's illustration of carefully considered reflective self-disclosure in her work with a "primitively-organized schizoid patient" (Cobb 1998, P219). I have integrated her method of externalising her reflective process into my psychotherapy practice, having observed that it creates greater transparency and demystifies the therapeutic process, empowering clients to respond with more confidence to the exploratory questions that I ask them.

I define transference and countertransference phenomena as any unconscious co-created reaction between the therapist and the client, and remain wondering in the psychotherapeutic process, "why is the patient now doing what to whom?" (Heimann 1956, P307).

5.4 The Developmentally Needed or Reparative Relationship

I am informed by Ralph Klein's statement that, "without a firm foundation in developmental theory, much clinical practice would be adrift in a sea of uncertainty" (Klein in Masterson and Klein 1995, P33).

In consideration of developmental theory, and believing the aim of all therapies to be reparative, I envisage providing a nurturing environment to encourage growth and healing in the present, of the "tendrils" (Tolpin, 2002) or green shoots from the past which are suspended within the person. Overtly the client may wish to be rid of the impingements that curtail their enjoyment of life but, at the same time, they unconsciously cling to them for reasons that they do not understand.

Challenging this adapted script may require more than providing a "corrective emotional experience" (Alexander and French 1946, P66). Different developmental deficits require a therapeutic response that is individually tailored and sensitive to specific needs. A client with a narcissistic injury requires accurate mirroring and "interpretation of the patient's vulnerability to narcissistic disappointment of his grandiosity" (Masterson 1981, P31). In the light of a 'borderline' presentation, it is the frustration of the need that leads to change,

that is, "the therapist must avoid becoming the rewarding part unit" (Masterson 1981, P32) thereby demonstrating their belief in the self-actualising potential of the client.

5.5 The Transpersonal

I have experienced transpersonal moments during the process of psychotherapy. I do not believe it is something that is embodied by the one, but a co-creation between the two. Transpersonal manifestations have impacted me on a spiritual level and my sense is that these moments cannot be summoned forth. They do not appear to arise as a consequence of learned skills, experience or theory. I envisage it as a spiritual meeting of soul with soul, an existential finite moment that is difficult to define or quantify. I am in agreement with Steven Smith (Metanoia tutor, 2008) who compared the transpersonal with a "butterfly", warning that, "if you examine it too closely, you will destroy it".

I have experienced transpersonal moments as a visitation and felt them somatically, like a very deep resonance, which has been sensed and acknowledged by both parties in the moment. It was there because 'we' both felt it. I have never questioned it. Seemingly it just has to be believed, it is unassailable - it is what it is - bringing with it existential connection and transformation of both.

6. The Process Of Change In Psychotherapy

Research suggests that the common relational factors are the most powerful ones in the process of change, with more recent research stressing that the client is the most common factor in change.

> *"On the basis of his review of the extant literature, Lambert (1992) concluded that as much as 40% of the improvement in psychotherapy clients is attributable to client variables and extratherapeutic influences" (Asay and Lambert in Hubble et al. 2008, P30).*

I have witnessed that clients are empowered by determining their own future and that this engenders confidence and trust in their own abilities. I carry belief and hope for my clients, encouraged by Winnicott's view that people have "a natural tendency towards health" (Winnicott 1984, P101). I have observed that positive outcomes are more likely to be achieved by clients who believe they are 'optimistically viewed' by those from whom they seek help. This appears to help the client "discover within himself the capacity to use this relationship for growth" (Rogers 1961, P35).

Clients often articulate fear of change and what that might mean for themselves and their intimate relationships. I view the process of change, not as changing the person in that they become different, but believing more that they connect with and understand their true self. As Karen Maroda states, "transformation involves changing how you feel about yourself rather than who you are" (Maroda 2004, P33).

Having witnessed personal growth and transformation in my clients, I believe that people can reconnect to themselves and grow psychologically through interpersonal relationships. I see the client/therapist relationship providing "attachment experiences that can allow similar neuro-physiological changes to occur through life" (Siegel 1999, P285).

"Studies suggest that the orbitofrontal cortex remains plastic throughout life; that is, it is able to develop beyond childhood" (Siegel 1999, P285).

I believe that clients are cured by our interest in them, an interest conveyed to them by our presence, engagement, unconditional positive regard and the quality of our relationship. I remain curious and willing to "investigate any field of interest if it will assist the client" and "being prepared to make use of whatever insight she has gained from any field of interest if it can be of help to her client" (Hollanders in Dryden 2007, P437).

Conclusion

I am presenting my model as it is today but I envisage, in the future, that this structure will integrate and consolidate further theories as more discoveries are made through

research in neurobiology and ongoing evaluation of the process of psychotherapy.

What is most exciting about integrative psychotherapy is its ability to evolve by absorbing and embracing new concepts and I journey onwards in this belief.

References

Alexander, F. and French, T. M. (1946) *Psychoanalytic Therapy.* New York: Ronald Press.

American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) USA: American Psychiatric Publishing, Inc.

Aron, L. (2001) *A Meeting of Minds: Mutuality in Psychoanalysis.* Hillsdale, NJ: The Analytic Press, Inc.

Asay, T. P. and Lambert, M. J. (2008) *The Empirical Case for the Common Factors in Therapy: Quantitative Findings* in M. A. Hubble, B. L. Duncan and S. D. Miller (Eds) The Heart and Soul of Change: What Works in Therapy. Washington: American Psychological Association.

Atwood, G. and Stolorow, R. (1984) *Structures of Subjectivity: Explorations in Psychoanalytic Phenomenology.* Hillsdale, NJ: The Analytic Press, Inc.

Balint, M. (1968) *The Basic Fault.* London: Tavistock.

Beebe, B. and Lachmann, F. M. (2005) *Infant Research and Adult Treatment: Co-constructing Interactions.* Hillsdale, NJ: The Analytic Press.

Benjamin, L. S. (2003) *Interpersonal Diagnosis and Treatment of Personality Disorders: Second Edition.* New York: The Guildford Press.

Blatt, S. J. (1991) A Cognitive Morphology of Psychopathology: *Journal of Nervous and Mental Disease, 179.*

Bowlby, J. (1989) *The Make and Breaking of Affectional Bonds.* Abingdon: Routledge.

Bowlby, J. (1998) *Attachment and Loss Vol. 3: Sadness and Depression.* London: Pimlico.

Bretherton, I. (1992) The Origins of Attachment Theory: John Bowlby and Mary Ainsworth, *Developmental Psychology (1992) 28, 759-775.*

(Online) http://www.psychology.sunysb.edu.attachment/online/inge_origins.pdf

Buber, M. (1957b) *Pointing the Way – Hope For This Hour:* New York. Schocken Books.

Buber, M. (1958a) *I and Thou.* New York: Charles Scribner and Sons.

Buber, M. (1973) *Meetings.* La Salle, Illinois: Open Court Publishing Company.

Casement, P. (2001) *On Learning from the Patient.* London: Brunner-Routledge.

Clarkson, P. (1999) *Gestalt Counselling in Action – Second Edition.* London: Sage Publications Ltd.

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

Cobb, K. Y. (1998) *The Development of a More Than Binary Self: Constructing a Common Language Between the Therapist and a Primitively-Organized Schizoid Patient* in A. Goldberg (Ed) The World of Self Psychology – Progress in Self Psychology Vol. 14.

Evans, K. R. and Gilbert, M. C. (2005) *An Introduction to Integrative Psychotherapy.* Basingstoke: Palgrave Macmillan.

DeYoung, P. A. (2003) *Relational Psychotherapy.* New York: Taylor & Francis Group.

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

Friedman, M. S. (1972b) *Touchstones of Reality: Existential Trust and the Community of Peace.* New York: Dutton.

Gabbard, G. O. and Wilkinson, S. M. (2000) *Management of Countertransference*

with Borderline Patients. Northvale, NJ: Jason Aronson Inc.

Gerhardt, S. (2004) *Why Love Matters*. Hove: Routledge.

Gray, A. (1994) *An Introduction to the Therapeutic Frame*. London: Routledge.

Guntrip, H. (1992) *Schizoid Phenomena, Object Relations and the Self*. London: H. Karnac (Books) Ltd.

Heimann, P. (1956) Dynamics of Transference Interpretations, *International Journal of Psycho-Analysis 37*.

Herman, J. L. (1994) *Trauma and Recovery: From Domestic Abuse to Political Terror*. London: Pandora.

Hollanders, H. (2007) *Integrative and Eclectic Approaches* in W. Dryden (Ed) Dryden's Handbook of Individual Therapy: Fifth Edition. London: Sage Publications.

Holmes, J. (2001) *The Search for the Secure Base: Attachment Theory and Psychotherapy*. Hove: Routledge.

Johnson, S. M. (1994) *Character Styles*. New York: W. W. Norton and Company.

Kepner, J. I. (2003) *Healing Tasks: Psychotherapy with Adult Survivors of Childhood Abuse*. Hillsdale, NJ: The Analytic Press.

Lichtenberg, J. D., Lachmann, F. M. and Fosshage, J. L. (2001) *Self and Motivational Systems: Toward A Theory Of Psychoanalytic Technique*. Hillsdale, NJ: The Analytic Press.

McLaughlin, J. (1991) Clinical and Theoretical Aspects of Enactment. *Journal of the American Psychoanalyic Association, 39*.

Maroda, K. J. (2004) *The Power of Countertransference: Innovations in Analytic Technique*. Hillsdale, NJ: The Analytic Press, Inc.

Masterson, J. F. (1976) *Psychotherapy of the Borderline Adult: A Developmental Approach*. USA: Brunner/Mazel, Inc.

Masterson, J. F. (1981) *The Narcissistic and Borderline Disorders: An Integrated Developmental Approach*. New York: Routledge.

Masterson, J. F. (1990) *Search for the Real Self: Unmasking the Personality Disorders of our Age*. New York: The Free Press.

Masterson, J. F. and Klein, R. (1995) *Disorders of the Self: New Therapeutic Horizons*. USA: Brunner/Mazel, Inc.

O'Brien, M. and Houston, G. (2000) *Integrative Therapy: A Practitioner's Guide*. London: Sage Publications.

Ogden, P., Minton, K. and Pain, C. (2006) *Trauma and the Body: A Sensorimotor Approach to Psychotherapy*. USA: W. W. Norton and Company, Inc.

Rogers, C. R. (1961) *On Becoming a Person: A Therapist's View of Psychotherapy*. London: Constable and Robinson Ltd.

Rothschild, B. (2000) *The Body Remembers: The Psychotherapy of Trauma and Trauma Treatment*. New York: W. W. Norton and Company, Inc.

Schore, A. N. (1994) *Affect Regulation and the Origin of the Self: The Neurobiology of Emotional Development*. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

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

Siegel, D. J. (1999) *The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are*. New York: The Guildford Press.

Slochower, J. (1996) *Holding: Something Old and Something New* in L. Aron and A. Harris (Eds) (2005) Relational Psychoanalysis Vol. 2 – Innovation and Expansion. Hillsdale, NJ: The Analytic Press.

Stark, M. (2000) *Modes of Therapeutic Action*. North Bergen, NJ: Jason Aronson Inc.

Stern, D. (1977) *The First Relationship: Infant and Mother* in J. Bruner, M. Cole

and B. Lloyd (Eds) The Developing Child. USA: Harvard Press.

Stern, D. N. (2003) *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology.* London: H. Karnac (Books) Ltd.

Stolorow, R. Atwood, G. and Brandchaft B. (2004) *The Intersubjective Perspective.* Oxford: Jason Aronson Inc.

Swanepoel, L. (2009) 'To Integrate or not to Integrate?' Is That Really the Question? *The British Journal of Psychotherapy Integration, 6(2): 31-38.*

Tallman, K. and Bohart, A. C. (2008) *The Client as a Common Factor: Clients as Self-Healers* in M. A. Hubble, B. L. Duncan and S. D. Miller (Eds) The Heart and Soul of Change: What Works in Therapy. Washington: American Psychological Association.

Tolpin, M. (2002) *Doing Psychoanalysis of Normal Development: Forward Edge Transferences* in A. Goldberg (Ed) Postmodern Self Psychology: Progress in Self Psychology Vol. 18.

Van der Kolk, B. A. and Van der Hart, O. (1991) The Intrusive Past: The Flexibility of Memory and the Engraving of Trauma: *American Imago 48, 425-445.*

Winnicott, D. W. (1984) *Through Paediatrics to Psychoanalysis: Collected Papers.* London: H. Karnac (Books) Ltd.

Yontef, G. (2001) Psychotherapy of Schizoid Process, *Transactional Analysis Journal Vol. 31 (1) 7-23.*

Zohar, D. and Marshal, I. (1993) *The Quantum Society.* London: Bloomsbury.

Volume 7, Issue 2 (2010)

Production Information

Made in London by Matthew Gilbert

Printed in the United Kingdom
by Winstonmead Print.

Visit our web site for the latest
information about Ukapi.

www.ukapi.com