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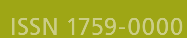
Integrative Practice in Different Contexts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Introduction

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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.

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Contents of this Issue

Editorial
Integrative Practice in Different Contexts 5

Rachel W. Nkumanda
Conflict in the Supervisory Relationship 7

Linda Finlay
An Existential-Phenomenological Approach to Integrative Psychotherapy 17

Albert Zandvoort
Living and Laughing in the Shadow of Death: Complicated Grief, Trauma and Resilience 33

Albert Zandvoort & Michelle Zandvoort
Trauma and the Use of Co-operative Inquiry to Develop a 'Survivor Mission' 45

João Pereira
Integrative Attempts: A Relational Model of Psychotherapy Integration 56

Editorial

Integrative Practice in Different Contexts

Over the years the journal has focused on integrative approaches to clinical practice. Integrative approaches are not just the province of clinical practice, however, and this edition of the journal includes integrative practice across a range of activities related to therapeutic activity. We have always encouraged and supported diverse integrative approaches and their applications in the acceptance of the articles. We welcome contributions from related to fields where people are engaged with the integrative project.

We appreciate the personal commitment combined with professional critique that was embedded in each piece truly reflecting that the personal is the professional. Rachel Nkumanda's paper explores the often-unspoken subject of anxiety and conflict in the supervisory relationship. She draws on her extensive experience as both supervisee and supervisor to illustrate the complexities of this necessary relationship and to point us to ways in which to reflect upon ruptures in the supervisory alliance. We appreciated her thorough investigation into this shadow side of supervision and psychotherapy. Linda Finlay has written a very accessible article exploring key ideas underpinning existential phenomenological practice in general, illustrating these concepts in practice in a comprehensive case study. The case study really brings her approach to psychotherapy and her reflections on her work alive for the reader.

Albert Zandvoort gives a clear overview of the intersection of trauma and grief with particular reference to the similar impact of trauma and complicated grief. This article embodies a rich integration of personal experience and relevant literary quotations and examples. We appreciated his drawing on theoretical literature on trauma and grief, as well as looking to the poets and playwrights. This article prefigures the following article by Albert and his daughter, Michelle, in relation to their work together. Their joint article demonstrates their particular use of co-operative enquiry to facilitate a transformative experience of trauma and complex grief. We appreciate this very personal account in which they maintain an exquisite tension between self-disclosure and self-reflexivity.

As is our practice we have included the theoretical section of João Pereira's clinical dissertation that forms part of his Doctorate in Integrative Counselling Psychology and Psychotherapy at the Metanoia Institute.

Peer Review

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

We will continue having themed editions with a guest editor and then issues more generally on themes of integration. We again invite readers

to contribute articles and we will also continue to invite contributions on particular themes.

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

Rachel W. Nkumanda

Conflict in the Supervisory Relationship

Abstract

In this article I will share experiences of conflict and impasse in clinical supervision. I will concentrate my attention on the earlier parts of my work. I will then discuss the middle phase of my work during which time I had taken time to look into the issues and find publications relevant to my experience. The latter part of my work will not be included in the examples that I will give. I will look at some of the experiences of conflict and whether they were resolved or not, if not I will share how I dealt with them. I will attempt to look at this from both the perspective of the supervisee and the supervisor. As a conclusion I will share my personal discoveries on this journey which I found helpful and crucial in developing and maintaining a good supervisory relationship which can hold the supervisee through the vicissitudes of their own journeys to become practitioners, and show to hold their clients in turn.

Introduction

The writing of this article has been inspired by experiences in my work as a supervisor over a 13 year period. My personal experience of supervision has been varied. I have had supervisors from different theoretical orientations. This was partly because of allocations to supervisors during my training and mainly due to placement supervision which is always determined by Project Managers. At one point I had three supervisors at the same time serving different parts of my placements. I did not experience much conflict in my experience of supervision. I am aware of a colleague experiencing conflict in the supervision group but I did not experience the supervisor in the same way. My very first supervisor I felt thought I was a waste of time for her and did not listen to any of what I presented concerning the first client I ever had. She did not feel that my client had a problem and should just get on with it. I was quite surprised at this but decided that perhaps I should do my learning without her supervisory support concerning the client. I reverted to the principles I had learnt and a lot of my work was by intuition which was very helpful. I always remembered how Jennifer, my tutor, used to tell us to trust our gut feelings. I never told my supervisor how I experienced her. Perhaps I thought that I would also be dismissed by her as my client problems were. At the back of my mind I was reminding myself that I am a black woman. Perhaps I am not good enough to warrant attention or what I presented was not important enough. To me this means I must fight for what I want i.e. my education and that essentially my tutors had given me information to get on with and I should do that. This is probably my only experience of challenge in the supervisory relationship. This was never going to be enough personal experience of conflict to pass me through what I experienced as a supervisor. I did not know what was coming.

The Motivation for Writing on the Subject

During my training as a supervisor I started working in placements for my Supervision Training. The first group I ever supervised

gave me my first experience of conflict. This was a very dynamic encounter and caught me by surprise by its vehemence. This prompted me to write about this experience in an essay and to peruse my text books looking for some indications that I am not alone in this experience. I subsequently had similar experiences in other supervisory relationships with my supervisees. I realised then that this was not just a one off experience; it was a phenomenon and I needed to understand and find ways to resolve the conflicts. I also accepted the fact that I was involved in this; it was not only the students' problem. How do I fit into this? What is it about me that brings up all these emotions in my supervisees? At times I wondered what happened with supervisory relationships they had before me, though I never asked my supervisees this question. I did feel that perhaps the other supervisor prior to me got the good part and I got the bad part of the experience. As these were my deliberations about my own feelings I did not voice these thoughts. I did take problems to supervision, but I never felt that this helped me to find solutions. What made me feel there was a personal journey of growth and development for me was because none of my colleagues ever presented similar conflicts with their clients in supervision. This also increased feelings that this was perhaps just happening to me. Supervision, therefore, did not always bring relief. I accepted that it remained my personal problem to understand and resolve. I had two supervisors, who worked with me during this period. My first supervisor was Humanistic oriented and my second Psychoanalytic oriented. I felt I had covered myself in terms of broadening my learning. In doing some research I discovered similar experiences of conflict described in the literature (Bauman 1972; Alonso 1983; Hutt, Scott and King 1983; Altucher 1987; Moskowitz and Rupert 1983).

Defining Conflict and Impasse

In the research I have found only one article in which the word "conflict" was used as the subject of discussion (Moskowitz and Rupert 1983). This was discussed from the perspective of the supervisees.

I picked three definitions which clearly define how I had experienced conflict:

Conflict

1. Opposition between two simultaneous but incompatible feelings (wordnet)
2. A state of disharmony between incompatible or antithetical persons, ideas or interests (thefreedictionary.com)
3. A state of discord caused by the actual or perceived opposition of needs, values and interests. A conflict can be internal or external(wikepidia.org)

Impasse

A situation in which no progress can be made or no advancement is possible or an agreement cannot be reached. (Wordnet)

How does this Supposedly Nurturing Relationship get to the Point of Conflict?

The word Supervision can conjure up many different thoughts, feelings and perceptions for the supervisee. Being supervised does suggest the supervisor looking into one's inner thoughts, competencies, behaviour and has an element of judgement and evaluation. Depending on the particular organisations and disciplines in which supervision takes place, it can seem similar to a weekly examination and/or evaluation of the supervisees' work. For those supervisees who are having supervision during training this can be very real. This can be a source of great anxiety. Supervision by and large is carried out on an experiential basis; therefore, it is not always very clear what to expect, what the parameters are or what the supervisor is going to be like. In the Voluntary Sector usually there is no prior information. The same can be expected for the clients who will be seen by the supervisee/counsellor. Anxiety therefore can be taken into the counsellor-client dyad resulting in an anxious counsellor and an anxious client. This indicates that supervision in the first instance must be helpful in allaying the supervisee's fears. Building a good supervisory relationship, allowing space to address these fears would be quite important,

inclusive of the expected core conditions for any relationship, warmth, genuineness and respect. This type of anxiety has been described as performance anxiety (Feltham and Dryden 1994; L J Bradley 1989) if the anxiety is about how the supervisee will be evaluated.

After the completion of my training in The Theory and Practice of Supervision I started including supervision in my private practice.

One of my first experiences as a supervisor was in a Community Voluntary Service doing group supervision for student counsellors and volunteer counsellors. My earliest experiences of anxiety in the supervisory relationship were far more powerful than I could have imagined or expected. I had asked questions about what models they were hoping to use in their learning. One supervisee responded with great anxiety with uncontrolled expressions of this and was shouting in a manner which caused me concern about these emotions. Keeping in mind that there would be some anxiety on my part as a training and fledgling supervisor, I had to define where my concerns and anxiety were in this process. It was clear to me that the level of anxiety displayed by the supervisee was way above any of my expectations and had also disturbed the other supervisees who did not understand what all the performance was. I decided that it would be inappropriate to talk to the supervisee in the group about the anxiety. I arranged a one to one session scheduled for us to meet as soon as possible before the next group session. The supervisee was quite willing to meet. I addressed the inappropriateness of the behaviour displayed in group supervision. On discussion I understood that the supervisee felt challenged by the fact that there was no clarity about the model the supervisee was going to use and that this might threaten loss of the position as a volunteer in the organisation. There were also other issues around obscure alternative therapy models which were not acceptable but perhaps would be acceptable in a different arena. I gave reassurance around what my role was in terms of supporting volunteer counsellors to learn how to apply theories that they had learnt and that the theories had to be main stream, accepted models which can be studied and applied appropriately. This was not as easy as it sounds as the supervisee was trying to argue about use of strange alternative models of working. I did make it clear what supervision we were offering and what we would accept from volunteers working with clients in the organisation. This issue was resolved during this meeting with clarity around organisational expectations of the volunteer.

As soon as I finished my supervision training, I was approached by the manager of a voluntary organisation, who had been referred to me to offer supervision for their staff team. The team consisted of counsellors who had finished their training and one counsellor who was still on training. The initial call was made by the manager of the project who was extremely anxious on the phone and expressed how difficult it has been to work with the staff team. She seemed to think that getting a supervisor would relieve her own anxieties. At this time my feelings were that she is the one who needed my support though she did also require a supervisor for the counsellors. I accepted the post and met the counsellors. My experience of the team was that there was pervasive anxiety in the room. I soon discovered that the anxiety was around their relationship with the manager. I also observed performance anxiety which was displayed by a lot of projections toward me displaying how some of the counsellors were feeling. I was the one who did not quite know what I was doing and anger was directed to me. I was chosen to carry the anxieties. I also felt that this was displacement of feelings they had towards the manager. In some sessions there was a very high level of distress expressed in the behaviour of the counsellors by being very defensive and at times quite unauthentic about their behaviour and owning this. An example of this is when a supervisee shouted at me in the session and then resorted to tears in such a way that it was impossible to do much except to be supportive and finish with an intention to address this in the next supervision session. My preference would have been to have an individual session with the supervisee as I felt there were some personal matters which perhaps needed to be discussed confidentially. I also felt that perhaps it should remain and be discussed in the group. In the next session I asked that we just look at the last session and resolve the problems that I had noted. The supervisee was in complete denial of the tears and the tantrums. I nevertheless pointed out that the anger and tears were perhaps displacements to

exonerate the supervisee's therapist and should be taken back to the psychotherapist. This was derived from information I had been given by the supervisee involving her therapist, which I cannot divulge here. However, the main problems were unresolved in the relationship with the manager. The sessions were so affected by this that I approached the manager and asked for a meeting in which I could try to address the problems. In this case a very anxious manager was exerting pressure on those she feared and the counsellors were also becoming more difficult with a lot of acting out in supervision by some of the counsellors. The manager did not feel that she had a problem and therefore was unwilling to agree to a meeting to address the problems. It was very clear to me that unless these problems were addressed, supervision was going to be fraught with anxiety and fear.

The other level of fear, as I observed it, was counsellors bringing some of the really frightening experiences which were brought to counselling which involved very violent encounters some ending in death and at times familial separations that were outside of client control. The raw fear would be tangible in the room at times. Not all the counsellors were presenting in this manner. Those who displayed defensiveness were struggling with the material but were unable to divulge their struggle in supervision though I was very clear what I was picking up. In this particular project I felt that lack of authenticity, projections, displacements and defensiveness was harming the supervisory relationship and its effectiveness in addressing the problems. As some of the counsellors were claiming to work psychoanalytically I felt that perhaps they had not attended to their personal therapy to the right level for them to cope with what was facing them. I also felt that the relationship lacked the authenticity I expect to be present when addressing the real versus the unreal. I felt we were at an impasse. I made my decision to end my supervision contract in this organisation. I could not see that I would get support from the manager to address the issues and that a lot of anger and anxiety in supervision was displacement and superseded any problems the counsellors wanted to address in their client work.

My next two examples are counsellors who attended individual supervision during what I will call the middle phase of my work. Both were well qualified professionals and were in training for counselling. I was working with them in private practice. The first experience I will share is with a counsellor on training. This supervisee had chosen to present a recorded cassette in supervision. The tape was inaudible and could not be used in supervision. The supervisee did not address this problem and continued to present inaudible cassette recordings so that I never really got to hear what transpired in the sessions. The supervisee also did not answer questions nor was there clear presentation of material about the clients since we could not use the cassette tape but the supervisee was keen to ask me questions. When I challenged this behaviour she would be silent and not respond at all. I therefore had no information from the supervisee or from the tape. I wondered if she ever wanted me to hear any of the work or was this too frightening. There was also anger expressed in our communication. This anger I attributed to defensiveness. I also suspected transferential issues between us. These could not be addressed due to denial on the part of the supervisee. I attempted to write down some of the problems and do a review but there was simply no response from the supervisee. She would just be silent right through. We were at a deadlock. At this stage I decided that we had reached an impasse in the relationship and that I should wisely end this relationship advising her to find another supervisor with whom she might feel able to communicate in a useful way for supervision to take place. I also suggested that there are issues for her that she needs to discuss in her psychotherapy due to the negative transference in our relationship. I cannot give further information on the nature of the transference in this paper. Normally I do not go over three months if there are serious problems in the relationship. I usually end the relationship by the third month or earlier if necessary so that there is no further conflict for the supervisee. My only concern in this is that some colleges do not have contact with the supervisor which does not leave an arena where serious problems can be tackled appropriately.

I will now present my next encounter in individual supervision with the second student counsellor. The supervisee seemed to be quite clear about theoretical interest and counselling models of interest to self. I soon

started experiencing difficulty when looking at ways of working with clients. There was a lot of resentment from the supervisee when we discussed the work. I soon observed that when the supervisee talks to me the posture changes to that of a very young person perhaps below 10 years of age. Communication at times was about the high professional position held at work when there were difficulties with the client work. This seemed to be a way of the supervisee saying that there are other areas that are good in the self, which I saw as seeking some approval. I understood that this was necessary as the present position of being a supervisee was threatening and meant that the same level of control over self does not exist. L J Bradley (1989) writes that some supervisees have enjoyed recognition and respect in the working place and could have been in positions of authority and can feel threatened by the focus on their counselling as they would have to relinquish autonomy and independence in the supervisory relationship. The degree of anxiety was so uncomfortable and I truly felt in those instances the appeal was to me as the psychotherapist rather than a supervisor. How did I get in this position? I encouraged the supervisee to use therapy to address the problems that were surfacing in supervision. As the supervisee was on training and it was crucial to get on with the practical experience necessary. We agreed that we could not work together due to the regressive behaviour and the anxiety levels which meant that I was not really interacting with the adult ego state at these times. We had an impasse in the relationship. What was good in this instance is that the supervisee was mature enough to be able to tell me exactly what the transference was so that I could understand. It must have been very difficult to do this as it was communicated at a time when the supervisee was in a regressed state and was very anxious. This was really the best outcome as we did tackle the problem appropriately in spite of the terrible anxiety the supervisee was experiencing. In this relationship I was placed firmly in the therapist's chair by the supervisee as the behaviour I saw was what I would expect in a counselling relationship. This was a very important encounter for me as it raised a lot of issues for me to think about and to research further in available publications the occurrence of such phenomena in supervision. How much should the supervisor incorporate some counselling in the supervisory relationship?

I have chosen a few of my experiences of conflict and impasse in the supervisory relationship. I will however say that I still experience these conflicts in my work but I now see them as a way of expression and I have a better understanding of the dynamics and ways of working with this. It arguably is the most challenging part of the supervisory process and also the most crucial in helping supervisees with difficulties in their development. I also see this as a test for the supervisor and their ability to hold the supervisee and also help them without being wounded by their behaviour. This means that the supervisors must be aware and own whatever belongs to themselves in the discussions within reason but not to burden the supervisee. This will also help in modelling ways of working with clients who present in the same way.

Discussion

Supervision has been described as an emotional and intellectual experience; the emotional part is most crucial (Altucher 1967), a learning process which implies change, though this is desired it is often feared by the supervisee (Bauman 1972). Hutt, Scott and King (1983) describe the supervision as a relationship which evokes intense negative feelings, anxiety, frustration and anger in the presence of the supervisor. And that it is often burdened by mistrust, disrespect and a lack of honest self disclosure on the part of both people. Hassenfeld and Sarris (1978) describe the sources of anxiety as a reaction to the treatment process and difficulties with the supervisory process. Anxiety is at times a pervasive one for adult supervisees who expect their performance to be scrutinised in an area of work that is new to them; two types of anxiety identified are performance or competence anxiety and approval or respect anxiety; the third type of anxiety is dominance anxiety related to the supervisor's dominant position (Bradley 1989).

All these descriptions confirm the experience of difficulties particularly at the start of the supervisory relationship mainly due to anxiety and fear of expectations concerning the

relationship with the client and the supervisory relationship. When the supervisee's feelings and areas of concern are either ignored, not recognised or suppressed, it makes it difficult to form a nurturing learning environment unencumbered by fear. If these problems are not addressed it compromises the supervisory relationship (Hassenfeld and Sarris 1978).

Over time I have experienced these anxieties which lead to conflict. In some instances the problems might not be noticed by the supervisor or if the supervisor tries to challenge the supervisee there might be denial or defensiveness on the part of the supervisee. It seems very important then to build a good supervisory relationship which is warm, empathic, respectful and open and will result in a productive working alliance. Openness is very important on both partakers of the process. The fact that there is a process to go through does include the fact that this will be challenging as it requires introspection. When the supervisor is not willing to be introspective this does not give the supervisee a model for repeating this type of behaviour with the clients. The challenge for us as supervisors is the question of psychological maturity, professional maturity and personal maturity. How can we ensure that when professionals undertake supervision with counsellors these areas of development have been achieved? It seems quite important for the supervisors, who do have problems in the area of introspection, that psychotherapy has taken place in a way that enables them to develop the supervisory relationship and to support the fledgling counsellor in their own process as far as this is acceptable in supervision. Other issues should be referred to psychotherapy with clear sharing and explanation as necessary for the supervisee to understand the nature of their problem area as perceived by the supervisor and how this affects their relationship with the client. This will also help the supervisor to understand the counsellor's areas of challenge and devise a way of working that would encourage development of the supervisee. Altucher (1967) supports the idea that critical changes must occur within and learning takes place when one's feelings are engaged.

Hassenfeld and Sarris (1978) cited the following problems

1. Discussion of feelings had not taken place
2. The supervisor had lost the ability to become helpfully critical
3. Meta-education was avoided and left both supervisor and trainee frustrated and perplexed
4. The supervisee may act out unresolved issues with the supervisor in the therapeutic relationship with the client.

The supervisee who is very fearful might not feel ok about revealing weaknesses for fear of judgement. In the cases I have shared there were several issues that I observed:

1. Lack of psychological maturity puts the supervisee in a defensive position where projection, displacement and anger may be used as the vehicle to deal with the high anxiety levels. Often the anxiety is also about being exposed and judged, and how this might affect their jobs. This might mean there is the threat of losing one's job. Therefore this does not encourage supervisees to be open especially if, as described above, there are already problems with management. It might not be in the supervisee's interest to share authentically about their work. Nash (1975) reported that trainees often distorted their process notes when there was a poor supervisory relationship; as a result, material to which the supervisor might object and descriptions of errors were omitted. Thus the supervisory relationship must be a safe one for the supervisee to be able to share vulnerabilities and errors in their work without anxiety and fear. In my experience it takes a good length of time for such supervisees to develop through the supervisory process as long as the supervisor is able to withstand the conflict and see through the challenging work of resolving conflict safely albeit painfully for the supervisee. If the supervisee overcomes problems in a genuine sharing and open relationship with a supervisor, who is able to be open and disclose whatever would be appropriate in the interactions, it would be an excellent learning experienced for both the supervisee and the supervisor. This keeps a balance as there are two people in the relationship. It will also be crucial to start understanding the supervisee's learning style from the beginning allowing

exploration of the models that are of interest to the supervisee as well as sharing other models that can be helpful in developing the supervisee's style of working. A supervisee who has gone through such a process would also be in a better position in their client work and also as future supervisors.

2. Make sure that the supervisee has the support of psychotherapy so that the underlying issues can be discussed. A negative transference towards the supervisor can have much deeper issues which might be divulged by the supervisee if they feel comfortable to do this. At times the revelation of material can be made in a fit of anxiety and anger. The outcome will depend on the level of distress. If the supervisee is merely disclosing to be understood and helped to overcome challenges the relationship can continue. In cases where the distress is too great it may take time, patience and understanding to facilitate progress. If the supervisee is not in therapy they should be encouraged to find a therapist. Difficulty in the supervisory relationship indicates that there may be problems in the counselling relationship. In some instances it might be more advisable to end the relationship if this is possible so that they may find a supervisor who works differently. The best outcome must be working through problems than to be collusive or to ignore the problems.
3. Another interesting area to explore is what the counsellor's relationship with the therapist is like. Anger might not always belong in supervision therefore some pertinent questions can be asked within reason as anger from the therapist may be displaced. It can be a matter of 'destroying' the supervisor instead of the therapist if there is difficulty in therapy. On several occasions the student counsellors have divulged problems in the therapeutic relationship and this is done out of desperation and not knowing how to proceed if there are certain difficulties in personal therapy. On one occasion the anger that was meant for the therapist was brought into supervision creating untold conflict especially as it was not clear what the catalyst for the anger was. Depending on what the problems are the counsellor should be advised and supported to make appropriate decisions. When a supervisee shared that the therapist constantly discussed her own issues with the supervisee including issues to do with the therapist's children, I encouraged the supervisee to seek a new therapist. Problems are not always straight forward, therefore, taking interest and time to decipher what is going on can be helpful in the supervisor making appropriate and focused interventions.
4. For counsellors where there have been problems with authority figures in their lives supervision can be more threatening and some disclosure can help in finding ways of supporting the supervisee into a relationship that fosters independence and growth unlike their previous experience. This is one of the areas in supervision where there might be similarities with the therapeutic relationship.
5. When there are difficulties in the supervisory process, it must be considered that there might be a parallel process, that there are problems in the therapeutic relationship. Explore this with the supervisee, if not the supervisee is burdened with issues generated in the therapeutic relationship which can paralyse the supervisory relationship. This is a very difficult situation for the supervisee who then carries the stress. The supervisor who recognises this is able to support the supervisee through interpretation to enlighten the supervisee about the dynamics in the therapeutic relationship.

Altucher (1967) writes that we have assumptions about the supervisees i.e. the counsellor is interested in learning counselling skills and is capable; we assume that the counsellor wants to and can learn to understand the client's communication. Altucher (1967) believes that the ability of the counsellor to tolerate discomfort with clients and with the supervisor in his work whilst learning constructive ways of dealing with it determines the effectiveness of learning. Langs (1980) cautions against placing the burden of conflict solely on the supervisee and advocates that the supervisor recognises his/her contribution to the problem.

Finally it is advocated in the literature that conflict exploration and resolution helps the supervisee with self understanding (Hassenfeld and Sarris, 1978; Mueller and Kell, 1978). The outcome of research with a focus on the supervisees indicated that personality styles

and personal factors of both supervisee and supervisor put a strain on the relationship. Trainees also expected the supervisor to identify conflicts and also initiated a discussion of the problem though this is unrealistic (Moskowitz and Rupert 1983). Fostering a relationship which is nurturing, open, allowing problems to be voiced by both parties is crucial and may avert crises occurring at times. It is clear that conflict will always be part of supervision due to various reasons discussed above but it can also be a good vehicle to teach supervisees to deal with conflicts in the therapeutic relationship. As supervision is a process of learning and change it can be expected there will be challenging experiences for both the supervisor and the supervisee.

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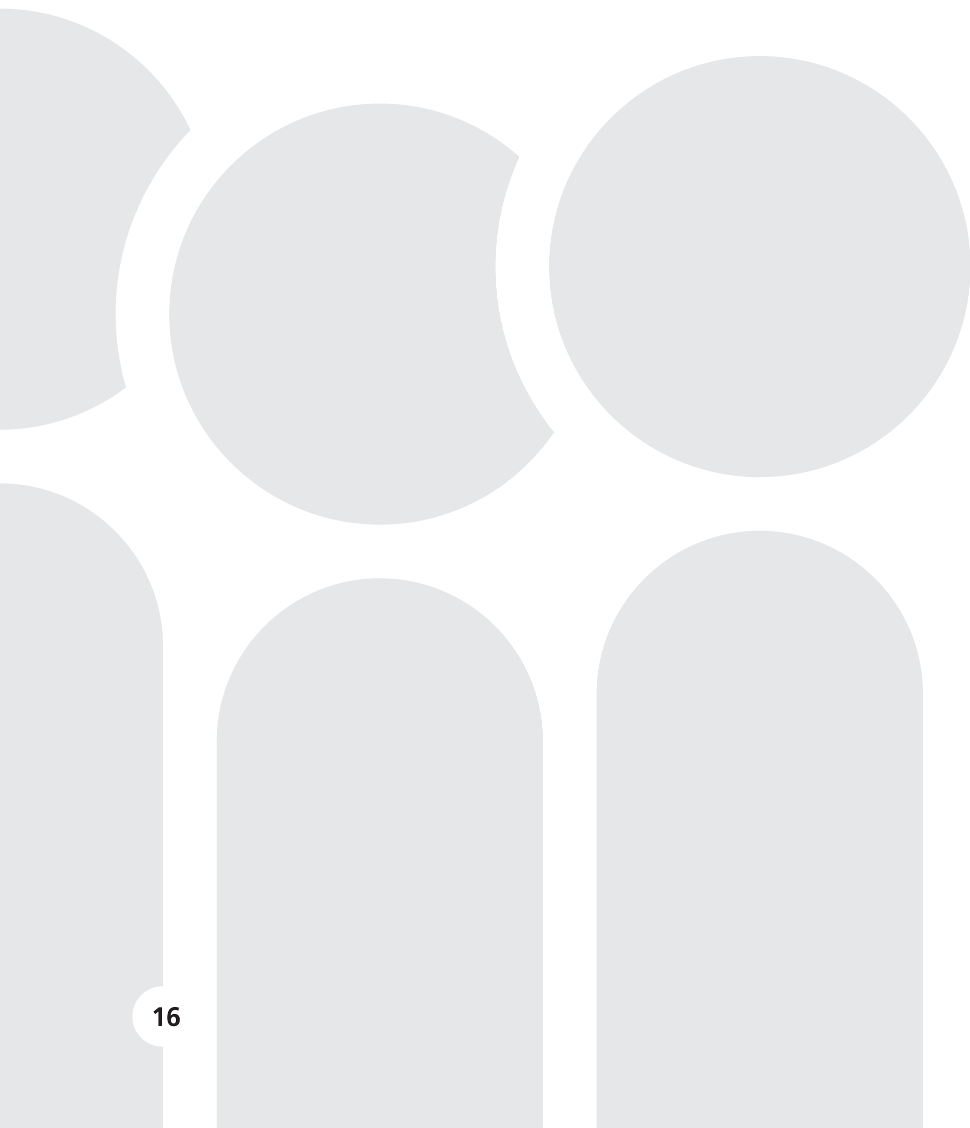

Linda Finlay

An Existential-Phenomenological Approach to Integrative Psychotherapy

Abstract

This paper explicates my use of existential-phenomenology as part of my work as an integrative psychotherapist. I put forward a relational model of working which encompasses four mutually dependent and dynamically iterative processes: 'Embracing the Phenomenological Attitude'; 'Inviting Descriptions of the Lived World'; 'Dwelling with Meanings' and 'Challenging and Integrating Body-Self-World'. Using philosophical references and personal examples from my practice, I attempt to show something of the infinitely layered and subtle experiential layers of the nature of how therapists might engage bodily being-with clients in the therapeutic space.

Introduction

Integrative psychotherapy draws on a range of therapy theories, modalities and techniques which are selectively applied as appropriate. My own practice of Integrative Psychotherapy is based predominantly on existential-phenomenological theory, in association with other relational and developmental models of therapy: dialogical gestalt theory, transactional analysis, and relational psychoanalysis. Much of my way of being in therapy mirrors the way I engage phenomenological research; for me, both therapy and research are ways of 'going exploring' (see Finlay, 2009; Finlay and Evans, 2009).

In this paper I seek to explicate my specific use of existential-phenomenology in therapy and I invite you, the reader, to consider how my approach is similar to, and different from, yours. First, I outline a few key ideas underpinning existential-phenomenological practice in general. Then I show how these ideas are applied in my practice as an integrative psychotherapist. I suggest a relational model of working which encompasses four mutually dependent and dynamically iterative processes: 'Embracing the Phenomenological Attitude'; 'Inviting Descriptions of the Lived World'; 'Dwelling with Meanings' and 'Challenging and Integrating Body-Self-World' (see Figure 1). This is not a four stage model or method. Rather, it is meant to point to the kind of processes involved throughout the therapy. It is about highlighting challenging issues rather than offering rules and recipes.

To demonstrate how the various processes might be enacted in practice, I also offer a case study example of 'Jayne' who was 38 years old when she first came into therapy with me. Recently separated from her husband, unemployed and struggling with her health, she was at "rock bottom". We worked together over several years. I aim to show how an existential phenomenological lifeworld focus on 'embodied self-identity' helped to enable her 'active choice and meaning-making' towards her 'project' of self-integration.

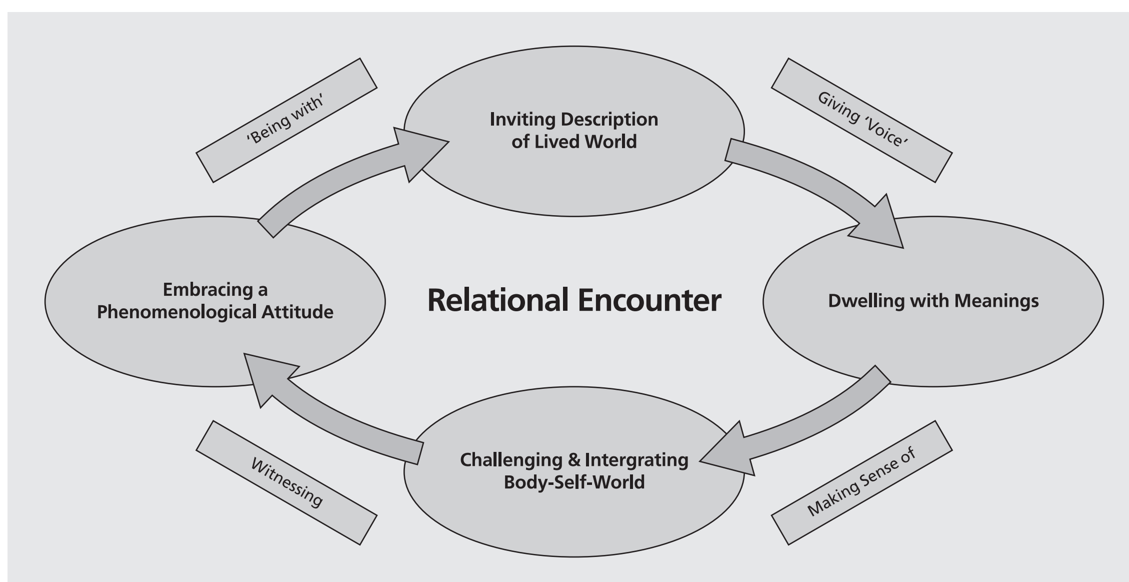

Figure 1: Existential-phenomenological Approach to Integrative Psychotherapy

Existential-phenomenological Theory Related to Therapy

Phenomenology is an umbrella term encompassing a philosophical movement and a range of research/therapy approaches. It is a way of seeing how things appear to us through experience. More than being a mere 'method', phenomenology demands an open way of being – one that examines taken-for-granted human situations as they are (inter) subjectively experienced in everyday life but typically go unquestioned (Finlay, 2011).

In the field of therapy, a phenomenological therapist asks the client such questions as "What is this kind of experience like?" "How are you experiencing this in your body right now?" The aim is to draw out the experiences, meanings, values and perspectives that have shaped the client while therapist and client together explore choices for being and becoming in the future.

Existential-phenomenological therapists (Spinelli, 2007; van Deurzen, 2009) are particularly concerned with existential issues (i.e. that which relates to the experience of existence; our human condition). The aim is to grapple with human concerns relating to human life: aloneness and relationships; ageing and death; embodiment and identity; belonging and needs; sense of time and space; freedom and oppression; embodiment and spirituality, and so on. Existential therapists encourage clients to reflect on age-old philosophical questions: 'Who am I?' 'How can I live a meaningful life?' 'Who is important to me?' Born into a certain time, place and culture, how have I evolved? Therapy involves seeing the givens of our existence (what Heidegger calls 'thrownness') through different eyes, while enabling a new freedom to change (or accept that which cannot be changed) and taking responsibility to act in the future(May, 1967; Barnett and Madison, 2012).

Existential-phenomenological therapists across the board argue against viewing clients as having a psychological dysfunction or disorder. Instead, the focus is on clients' way of being, which is seen as an expression of how they are currently choosing to live their life. As van Deurzen and Adams (2011, p.1) note, this means that we are "more concerned about doing justice to the way clients live their lives, rather than to eradicate specific problems or focus on particular symptoms."

Rather than emphasising a particular therapy 'method' or technique, existential-phenomenologists look towards philosophy, in particular to the work of Heidegger, Merleau-Ponty, Sartre, Buber, Gendlin and others. "Fundamentally suspicious of technique and skills-based practice" (van Deurzen and Adams, 2011, p.1), existential phenomenologists believe clients' issues and problems are best tackled by approaching them as part of the broader difficulties and dilemmas concerned

with the human condition. The emphasis is on the being and becoming of self-in-relationship and in context. The therapy journey tends to involve an individual exploring their own self and resources in relation with the therapist. Along the way clients learn that validation needs to come from self rather than others, and also come to become more aware and discover or clarify their own priorities: what is really important to them as individuals.

Three key interlinked philosophical ideas underpin existential-phenomenological therapy practice:

1) 'Being-in-the-World'

"The body stands before the world and the world upright before it, and between them there is a relation that is one of embrace." (Merleau-Ponty, 1964/1968, p. 271). Continental phenomenological philosophers such as Merleau-Ponty, Heidegger and Sartre, outline key structures of human experience as an interaction with the world. This is our being-in-the-world (Dasein as Heidegger, 1927/1962, calls it), with the hyphens in the phrase nudging us to grasp the central concept that a person is embedded in the world.

Applying this idea to existential-phenomenological therapy there is a shift from being 'client-centred' to being 'lifeworld-centred' (Dahlberg et al, 2009). 'Lifeworld' or Lebenswelt (Husserl, 1936/1970) is the matrix of meanings inherent in our on-going relations with our physical, relational and socio-cultural world. As humans, we all have an embodied sense of self which is always in relation to others, while our consciousness is shared with others through language, culture and history. We experience time in our recollection of past joys and trauma. We also anticipate what is to come in the future. We are placed into a matrix of spatial relations in the world, surrounded by things which have meaning while we engage with ideas and activities which become our projects. Lifeworld thus involves our: i. embodied sense of self; ii. relations with others; iii. discourse; iv. sense of temporality and spatiality; and v. project (Ashworth, 2006).

2) Eschewing Duality

Existential-phenomenologists champion a holistic, non-dualist approach to life. While western science has taught us to split mind from body, mental processes from the physical world, phenomenology wants us to relinquish such conditioning and bridge or meld together the polarities of mind-body, within-outside, self-other, individual-social, feelings-thoughts, body-soul, nature-nurture, mental-physical, subject-object. Importantly, this approach denies a separate existence for subjectivity, mind or inner feelings. The world does not exist 'out there', separate from our perceptions; rather it is part of us, and us of it.

An existential-phenomenological view of depression, for instance, is not so much concerned with an inner sense of despair, sadness and hopelessness. Instead, depression is seen in terms of how the world is experienced as bleak and dark, without meaning or hope for the future. "Flowers lose their colour" (van den Berg, 1972, p.45). Instead of the client being perceived as feeling anxious and threatened, the anxiety is seen phenomenologically as a pervasive atmosphere where the world is experienced as unsafe, where others are perceived as threatening, and where one's body is tense and alert to danger. Self and world are experientially related. Van den Berg (1972, pp.45-46), a phenomenological philosopher and psychiatrist, illustrates this when he describes how a person's world can "collapse" or how, as a result of feeling unbalanced, they "lose their footing".

Referring to the way our ontological disposition is related to mood, Heidegger likens this to a kind of atmosphere, what he calls 'attunement':

> *When I am in a mood of sadness, then things address me quite differently or not at all. Here we do not mean feeling in the subjective sense…Feeling concerns my whole being-in–the-world… Attunement…belongs to being-in-the-world as being addressed by things (Heidegger, 1987/2001, pp.202-203).*

3) 'Being-With'

This is a term originally coined by 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. Thus, existential-phenomenological therapists understand Being as fundamentally relational. All our "knowledge, awareness and experienced understanding of the world, or others and of our selves emerge out of, and through, an irreducible grounding of relatedness" [emphasis added] (Spinelli, 2007, p.12). Here the concept of relatedness involves both our relationship with others and with ourselves (such as when we dialogue with parts of ourselves).

Also of significance here is the work of the Jewish-German philosopher, theologian and educator Martin Buber (Buber, 1923/1958). Writing of the more spiritual dimensions of human relationships, Buber emphasised in poetic terms the potential of the I-Thou relationship where each person is accepting of and open to the other. The I-Thou relationship 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 instrumental and habitual ways of interacting (as found in the I-It relationship). Recognising the value of the other's personhood helps one's own authenticity and personhood come into renewed being (Finlay and Evans, 2009).

Buber talks specifically of the value of dialogue in a relationship where two people intertwine in openness and truth:

> *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).*

In this context, the 'therapeutic relationship' is seen as playing a key role. This embodied, intersubjective relationship between therapist and client becomes the vehicle for exploring the relational being of the client. The relationship can be seen as a microcosm which discloses the client's relational being-in-the-world (Spinelli, 2007).

The extent that we can ever truly achieve I-Thou relating is debateable, however. Most therapy dialogue is probably I-It given it is often more one-way in its sharing and disclosures and essentially instrumental. But I-Thou can be reached for in dialogues which are more open, honest, accepting of difference and mutual (Cooper and Spinelli, 2012). Here, the therapist duly sets aside any particular drive to heal, change, soothe or analyse the other in favour of simply being-with the client (Finlay, 2010). The therapist aims to be as fully present as possible, creating the space for the client to enter in and become present as well. Then the dialogical exploration can begin. What is happening in the mysterious space between therapist and client? What is revealed in the being-with? How is the client's relational way of being in the therapy space similar to or different from the way they relate 'outside'? Whatever intervention we make emerges from that 'between'.

The reality of the being-with is greater than the shared sum of the experience of therapist and client (Hycner, 1991). "It's the relationship that heals, the relationship that heals, the relationship that heals -- my professional rosary" (Yalom, 1989, p.91).

Embracing the Phenomenological Attitude

> *Our…journey requires us to be touched and shaken by what we find on the way and to not be afraid to discover our own limitations…, uncertainties and doubts. It is only with such an attitude of openness and wonder that we can encounter the impenetrable everyday mysteries [of our world] (van Deurzen-Smith, 1997, p.5).*

The immediate challenge for an existential-phenomenological therapist entering a therapeutic encounter is to remain open to new understandings – to be empathically open to the client – in order to go beyond what is already known or assumed. This is the phenomenological attitude (see Figure 1).

Engaging the phenomenological attitude, I strive to leave my own world behind and to enter fully into my clients in order to reflect on their meanings and experiential processes. This attitude involves a special attentiveness that savours situations described

by the client in a dwelling kind of a way that listens for, and even magnifies, details. This attitude is as free from value judgments and theoretical constructs as possible. I try instead – at least in the first instance - to focus on the meaning of the situation purely as it is given to my client (Wertz, 2005).

I suggest three key dimensions are involved in this phenomenological attitude: bracketing and openness; embodied empathy; and reflexivity.

Bracketing and Openness

The challenge is to engage a phenomenological attitude of non-judgmental openness and wonder. This special way of 'seeing' is the core element distinguishing phenomenology from other approaches focused on exploring experience and subjectivity (Finlay, 2008). In this attitude, past understandings (including previous psychotherapy knowledge and experience) are bracketed as much as possible so that critical attention can be paid to present experience, to what is emerging in the 'now' of the therapy encounter. Husserl, a phenomenological philosopher, proposed what he called the reduction or epoché. The aim here is to refrain from the positing that takes place in the 'natural attitude' of taken-for-granted meanings (Giorgi, 2009). At the same time I would try to hold at bay scientific knowledge and theory in an attempt to go back to the 'natural attitude' of experience. Although not always successful, I seek to be surprised, to push away any certainty that something 'is'; that it has a certain meaning. By so doing, I am prepared for preconceptions to be shredded; open to the possibility of new insight.

This bracketing process is often misunderstood as an attempt to be objective. What it actually calls for is an especially attentive attitude of receptivity, an emptying of the self in order to be filled by the other and what is occurring between. Bracketing is enacted alongside a genuine sense of curiosity, empathy and compassion. van Manen (2002) describes this process as "the unwilled willingness to meet what is utterly strange in what is most familiar". The aim is "to see through fresh eyes, to understand through embracing new modes of being" (Finlay, 2008, p. 29).

As part of this fresh seeing, I believe therapists have an ethical responsibility to respect and be open to the otherness of the Other. Thus I strive to maintain a genuinely open and unknowing stance – at least when I am engaging a phenomenological approach (I might take a different stance if I was applying a cognitive or psychodynamic approach). While recognising my potential power as a therapist, I also try to hold myself to being humble and modest in any claims, for instance, to understand and 'know'. The essential messiness and ambiguity of lived experience and relations demands a sincere 'unknowing'.

With this openness come fleeting moments of awe and wonder. Such elusive moments can be powerfully transformational (Finlay, 2008). When I'm struck with wonder, the habitual clutter of my mind is suddenly clear (van Manen, 2002). The other's experience – in its uniqueness and otherness - takes me in and I am in awe.

Explicitly humanistic principles and values such as acceptance, holism, creativity, spontaneous self-expression and transcendence are thus brought into play. This opens the way for embodied empathy.

Embodied Empathy

Empathy – arising from the German term Einfühlung - means the process of gently and in an embodied way 'feeling into' or sensing another person in order to better appreciate their experience. In popular parlance it is known as 'entering another's world' or 'stepping into their shoes'. In his classic definition Carl Rogers (1980/1995) describes empathy as a non-judgmental 'process' rather as a 'state', of being sensitive to - moment to moment - the flow of clients' changing felt meanings and frequently checking the accuracy of any sensings.

In practice, all therapists probably move in, out and through different intensities of empathy and distance during every relational encounter. One moment a therapist who is open to their client may discover some linking personal experience that anchors a degree of empathy. The next moment, they may get thoroughly pulled into an identification so intense that the sensation of merging and

(healthy or unhealthy) confluence with the client may be experienced (Finlay, 2005, 2008).

This idea of levels of empathy has been picked up by a number of authors. Hart (1999) offers nine different levels or facets of empathic knowing which occur in therapy. In particular, he contrasts 'external empathy' with 'deep empathy'. In the former, the therapist acts as observer, perceiving another's experience as if they were them. In 'deep empathy', there is a more direct knowing where subject-object is transcended.

Of particular relevance is the work by Cooper (2001) who puts forward the concept of somatic or "embodied empathy" where the therapist allows a space for embodied awareness and empathizes with clients' somatic experience. There is an:

> *experiencing of how another person is in their world that reaches down to the very depths of our toes, that infuses our body, and that gives us a lived, vital awareness of how it is for them as a cognitive-affective-somatic whole (Mearns & Cooper, 2005, p.130).*

In my own practice, I try to focus on the client through the 'being-with'. Given that much of what we can learn and know about an Other arises through the embodied dialogical encounter (Evans, 2007), it's a question of opening up to, and letting go into, the space between. In this co-created opening between "lurk ambiguity, uncertainty and unpredictability; anything can, and does appear" (Finlay, 2009). Ken Evans describes the process in the following poetic terms:

> *It is as if I am listening intently and with all of me for a tune that is all of us (me, other, and us). I listen to the tune being sung by the Other. I try and connect with the deeper song – the song of contact, meeting, connectedness, longing. Even when hidden beneath the negative or closed and cut off, I strain gently to listen to the quiet hum of faith buried beneath the weight of the life of the Other. The weight that I also know and have known – that we all know – of joy and sorrow and hope and despair…It feels like being grounded in a repose of lightness that is yet full and deep and open and present with myself and the Other in a spirit of acceptance and compassion to myself and other… (Finlay and Evans, 2009, p.125).*

Towards this attainment of a deeper interconnection, the challenge lies in letting go into it, in trusting the process. This means letting go of my being in order to be-with. It means relinquishing my knowing and ego – and it's a challenge at times, one that I often don't completely succeed in. It means allowing feelings, thoughts, impressions and intuitions to appear. It means going with whatever seems figural at the time. In this space, it becomes harder to disentangle what belongs to myself, what to the other. For instance, I attend especially to my bodily sensations and often find sensations like 'feeling dizzy' or 'having a wobbly feel in my abdomen', can be found to link in some way with my client's current experiencing. As the phenomenological philosopher Merleau-Ponty says, "To the extent that I understand, I no longer know who is speaking and who is listening" (1960/1964, p.97).

Reflexivity

In my own work, I try to be empathically open, even if I don't always manage it. But I also argue the need for therapists to maintain or develop a critical (and embodied) self-awareness, a capacity to reflect on their own (inter-) subjectivity, processes, assumptions and interests. I believe it essential to reflect reflexively on meanings arising in therapy and upon our role as therapists in co-creating those meanings.

At the same time, I try to guard against getting too self-absorbed, against becoming so caught up in introspection that the focus of the therapy shifts away from the client and the therapy relationship onto me. Equally I want to avoid situations where hyper-reflexivity results in objectifying myself and others.

Todres (1990), an existential therapist and phenomenologist, recognises how psychotherapists can develop a rhythm of interactive 'being-with' where closeness and distance are simultaneously experienced. The challenge lies in being intimately involved in the moment while also stepping back to look with interest at the quality of the interaction.

My personal approach is explicitly relational and involves an attempt to be empathically present with my clients while also engaging in reflexive embodied empathy (Finlay, 2005). I liken this to a fluid, shifting, paradoxical dance. In it, I move between bracketing lingering pre-understandings and reflexively exploiting them as a source of insight; between being empathically and naively open and being self-critically aware; between detaching myself from lived experience and becoming ever deeper involved with it; between going with the rhythmic flow of a dynamic, open-ended dance and technically following precise set steps:

> *The reward comes with extraordinary, though fleeting, moments of disclosure … and understanding acquires greater depth…For an instant or two, [we might share]… the rapture of the dancer: the sinuous embrace of something elemental, unexpected and almost beyond the possibility of being put into words (Finlay, 2008, p.29).*

Case Example

In her first session Jayne explained how she had lost everything and to me she felt 'lost'. Her husband's irresponsible spending had left her without house or money at a time when the slow process of emerging from suffering ME was making her easily fatigued. Previously she had worked in the probation service – a stressful job which had contributed to her current poor health. Helped by government benefits, she had moved into rented accommodation near her mother. She seemed depressed and appeared to have few resources. I wondered if she might be contemplating suicide. But at this stage I pushed away any diagnostic categories in order to remain open to her world and what she was bringing into our therapeutic space.

My aim was to create a safe therapeutic space from where Jayne and I could go off 'exploring'. In this safe space, I attempted to be as present as possible, and invited Jayne to be present as well. Being 'present' involves being grounded bodily and emotionally; it also means being fully engaged with the other, while also holding onto one's own self. Jayne's challenge was to hold on to her Self as I soon discovered.

Inviting Descriptions of the Lived World

> *[The concept of being-with] expresses the existential psychotherapist's respect for, and acceptance, of, the worldview of their clients as revealed within the therapy world (Spinelli, 2007, p.109).*

In order to access this worldview, or lifeworld, the starting point is usually to ask clients to describe their experience: to tell their 'story'. Rather than setting out to analyse, explain or theorise, phenomenologists seek down-to-earth description of the lived experience, in as much detail as possible. I might ask: "Can you describe this experience as it happened in detail?" Some prompts to help return the client to the specific scene may prove helpful: "Put yourself in that place, and look around. What do you see/hear/smell?"

Often when a person recalls an experience in detail it can be vividly evoked, almost re-experienced. Thus I seek to stay with this and stand-with the client, encouraging more description by not foreclosing too quickly (for example, avoiding making interpretations or assuming a clear understanding). This is an opportunity to go deeper, to ask for more textured description: "As you're now feeling a little of how it was for you, how are you experiencing it in your body?" "Stay with that body feeling: What is it saying?" Inviting more metaphorical description is also a possibility: "What would its colour/ sound be if it had one?" (Spinelli, 2007).

So my focus is on describing lived experience rather than dealing with pathological symptoms, analysing unconscious motivations, or attempting to explain and modify behaviour. I am not, in the first instance, seeking to 'educate', 'repair', 'change', 'analyse' or 'explain'. Instead, I celebrate the value of simply describing. By bringing one's world into focus, one's being itself is often altered. As new awareness arises, subtle shifts can occur. Along with other existential phenomenologists, I believe that I just have to be there with the client, and the combined power of both the relational context and process of description is potentially transformational.

Van Manen (1990) recommends that phenomenologists use four fundamental

lifeworld themes –he calls them 'existentials' - as helpful guides towards bringing a person's world into focus: "lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality)" (1990, p.101). Lived space is the way place is experienced: for instance, how a dark alley can be threatening, a home can feel cosy or a therapeutic space can feel safe. Lived body is the way we feel our body: sluggish, tense, dissociated or energised, for example. Lived time is subjective time rather than clock time: how a boring meeting can feel endless, for instance, or an enjoyably intense therapy session can flash by in no time. It is also the way meanings of past experience can get superimposed on present and future ones (and vice versa): perhaps a client in a negative transference with a psychotherapist anticipates persecution or neglect as the past leaves its stamp on the present. Lived relation is our experience of others: how we can feel shamed by another's critical gaze, for instance, or how we can blossom under a loving one. I find it helpful to see my clients' experience in these terms.

In addition to engaging experience in a concrete and embodied way, I seek to focus on experience in the present moment- though with a view to the future (Stern, 2004). Like other psychotherapists, I recognise that humans are historical beings who carry forward past experience. In common with gestalt therapists, however, I would focus more vigorously on the present moment (and the possibility of future choice). While I appreciate how habitual ways of being in the world can take hold and may link to past experiences, I would not usually dwell in the past but rather focus on what is being experienced in the present moment and what it can tell us. Therapy, in my view, offers an opportunity to become aware of current ways of being, enabling us as therapists to challenge habitual patterns. Clients may thereby open themselves to fresh possibilities, to new ways of being in the future.

It follows that when a client blocks something or avoids exploring it further, existential therapists (along with gestalt therapists) view this as a positive choice. I agree. I would see it as indicating a need to go slower in order to assimilate new ideas, or a wish to avoid something that at the moment feels too overwhelming. And perhaps the client is simply making a healthy choice to focus on something apart from the things that interest me. My therapist's role then is to respect and support the client's choice while encouraging them to become even more aware of the options at stake. It is "our future possibility that shapes our present purpose and direction" (Craig, 2012, p.17).

From the client's perspective, the experience of voicing one's own immediate lived experience and describing it in a deep and detailed way while being truly seen can be momentous. Feeling listened to means to have one's perspective witnessed. It opens up potentially transformative space and time, allowing the person to begin to make sense of their experience, and, moving beyond previous understandings, to work through it afresh.

Case Example

"The therapy has helped", Jayne told me as we started our second session; she felt better already. She continued sharing her life story and it proved full of long standing relational problems, in particular her tendency to sabotage relationships and run away from intimacy. She acknowledged how she often fell into the pattern of being needy and dependent when she became involved with men. She also spoke of hearing loud, critical voices in her head. At this point she presented as anxious rather than depressed; her world appeared threatening rather than empty.

A 'sassy', vivacious, intelligent, highly competent and professional Jayne suddenly appeared at our next meeting. I began to be puzzled by these dramatically changing presentations. I felt a little anxious in the face of her unpredictable, labile way of being. That I couldn't quite 'feel' her feelings in those early sessions, and resorted to 'head level' formulations, nudged me to speculate that Jayne might also be cut-off from her embodied emotions. Amongst all these varied presentations (fronts, selves?) where was the 'real Jayne'? Perhaps that Jayne was truly 'lost'; had she ever existed even? I couldn't help but wonder about diagnostic categories such as 'Dissociative Identity Disorder'. But she herself was conscious of the different 'selves' that emerged in different contexts, and this

led me to reject this formulation. Seeking to bracket my previous knowledge (and I own my aversion to engaging diagnosis and thinking in terms of 'personality types'), I resolved to continue to remain gently present with her, listening and responding to whatever was figural for her in the moment at each meeting.

Dwelling with Meaning

> *[Phenomenological description] must stick close to experience, and yet not limit itself to the empirical but restore to each experience the ontological cipher which marks it internally (Merleau-Ponty, 1964/1968, p.157).*

This process involves an immersion, a residing by the therapist in whatever the client is bringing, whether an account of their day, a dream, or a story from their early life. It means attending deeply in order to 'hear', to stay with the meanings that emerge and examine them towards ever deepening understanding. To understand what a client brings, means

> *to fully welcome it in its sonorous being … to hear what it says…The meaning is not on the phrase like the butter on the bread, like a second layer of 'psychic reality' spread over the sound: it is the totality of what is said … it is given with the words for those who have ears to hear (Merleau-Ponty, 1964/1968, p.155).*

The dwelling involves a focused act of discovering out of silence sedimented meanings, nuance and texture. The more you stop and linger, the more you will feel yourself engaging the phenomenon, perhaps re-experiencing the sense of it. Wertz (1985, p. 174) describes it well: "When we stop and linger with something, it secretes its sense and its full significance becomes … amplified." At its best, the process of dwelling with a client's meanings transcends a cognitive, intellectual exercise to become a 'receiving' which is an embodied lived experience in itself. When I am immersed in a therapeutic encounter I am there sensing, moving, empathising, responding and resonating with my whole body-self. As Romanyshyn (2007, p.232) puts it: "To linger and even loiter in the presence of what is present is to recover the animate flesh. It is the lived body that lingers in an erotic conspiracy with the world".

Therapists can of course use any number of techniques and 'experiments' to enable such dwelling. For instance, adopting a more creative or graphic approach, I might invite a person to draw a picture to represent a problem issue or suggest they 'sculpt' their family history by laying out small stones to represent the closeness or distance of family members. Such activities act as tools to visualise and grapple with meanings. When it comes to working with dreams, Gilbert and Orlans (2011) caution against any quick and easy use of interpretation. Instead they suggest that therapists engage in a phenomenological exploration of what the client makes of their own dream by inviting the client to re-enter their dream and tell the story of it as it is occurring in the present moment. In such situations I also use my own emotional and bodily responses as cues to possible meanings.

One way to dwell explicitly with meanings is through Focusing (Gendlin, 1996), which is both a technique and a way of being. Gendlin, a phenomenological philosopher and psychotherapist, was a student and colleague of Carl Rogers at the University of Chicago. His approach involves paying attention to intuitive 'gut' feelings, whether of the therapist or the client. It's about becoming aware of one's own on-going process through relationship with one's own felt sense. I might ask the client, for instance, "How is what we are talking about making you feel in the middle of your body?" or "What might that that body sensation be saying?", and then wait quietly for the client to focus and sense 'there'. The aim is for the Focuser to find exactly the right words or images for this bodily 'felt sense'. This can lead to deeper insight, perhaps even triggering an 'Ah ha!' moment where there is a sudden release of tension and a totally new idea, insight or solution comes into being.

But Focusing is more than technique. It is a gentle, compassionate way of being which is respectful to one's own (and the other's) being and pace of movement. It is something therapists can use for themselves as well as with clients. Focusing helps therapists and clients listen, to pay attention to experiencing at the "border zone" between what we are

conscious of and not quite aware of, by tuning into subtle bodily feelings that may be trying to tell us something. Time slows down, space opens up. Sensations, symbols and words emerge, fresh and alive. We are now open to allowing the wisdom of the body to guide us and surprise us. Gendlin argues that what comes from the experiencing and bodily sensed edge of awareness is more intricate while also more open to new possibilities.

> *Focusing is a mode of inward bodily attention that most people don't know about yet. It is more than being in touch with your feelings, greater than just thinking about a problem, and different from body sensations. Focusing occurs exactly at the interface of body-mind. It consists of specific steps for getting a body sense of how you are in a particular life situation. The body sense is unclear and vague at first, but if you pay attention it will open up into words or images and you experience a felt shift in your body. In the process of Focusing, one experiences a physical change in the way that the issue is being lived in the body…. The whole issue looks different and new solutions arise. (Gendlin online source)*

Whatever meanings and insights emerge, however, much more remains unsaid, our understandings can only be provisional, partial and incomplete. The relationship between the "said" (explicit) and the "unsaid" (implicit) remains obscure. Bodily, relational understanding exceeds any language description we can come up with. "All human speaking is finite in such a way that there is within it an infinity of meanings to be elaborated" (Gadamer, 1975/1996, p.416).

In his book Embodied Inquiry, Todres follows Heidegger and Gendlin to explore the mysterious relation between language and Being. As he sees it,

> *the 'unsaid' (i.e. implicit meanings), lives always exceedingly as that which the said is about. Speech in a broad sense is pregnant with this excess … the shape of understanding is first 'wet through' by the insight of intimate participation and this can come to language in tentative ways (2007, p.19).*

Case Example

Jayne's different 'selves' formed the centre of our attention over many months, during which I 'met' or was told about:

1. "Ice Queen" Jayne, who was distant, brutal, unemotional and powerful: she picked men up for one night stands but never got involved;
2. "Work Jayne", who was highly competent, conscientious, sharp, judgmental and organised;
3. "ME Jayne", who was weak, vulnerable, needy and terrified; and
4. "Mum Jayne" who was insecure and a resentfully self-less people-pleaser (like her own mother).

We explored how these different subjectivities might have originated in response to her different relationships. Of particular significance seemed the early childhood insecurely-attached relationship with her highly critical, aggressive, feckless father who disappeared regularly, effectively 'abandoning' his family.

One time Jayne arrived full of self-critical bile and negativity. The gains we had made over the weeks seemed to have completely disappeared; I hardly recognised her and was taken aback. Responding to my felt-sense that something didn't fit, I eventually asked "who" she was today. I might have punched her; with a deep outbreath she recognised how she had unwittingly embodied the critical side of her mother. This was a good lesson which showed her how easily she could fall into confluence with her mother and engage unhealthy 'drama triangle' dynamics. She learned to boundary her 'critical parent mother' without rejecting the loving nurturing part of her – a holding of polarities which seemed important.

Challenging and Integrating Body-Self-World

> *As clients face and overcome the blocks to that which is palpably relevant, they begin to discern the meaning of their odysseys… Whereas, formerly, a given client may have hidden herself in the world, now she is capable of standing forth in the world and pursuing her aspirations…The key here is not the discovery*

of particular meanings, but what clients bring to those meanings – their passions, creativities, and imaginations (Schneider, 2010, p.12).

Integration becomes figural in the final iterative process involved in my existential phenomenological integrative psychotherapy. At this point, I would often be more actively engaged in making an intervention, perhaps challenging the person to move beyond a safe, habitual position.

Once again, the embodied relationship lies at the centre of this process; techniques and method are secondary. Any integration that comes through therapy emerges out of a constantly evolving, negotiated and dynamic co-created being-with relational process to which both therapist and client contribute (Evans and Gilbert, 2005). As with relational psychoanalysis, therapist and client are seen to affect each other mutually as they 'co-mingle', sharing emotions generated in the therapeutic process (Aron, 1996). Here, the therapeutic relationship is continuously reworked through mutual, ongoing influence where therapist and client affect, and are affected by, each other.

Significantly, the relational dynamics themselves may reveal something of the phenomenon being discussed (Finlay and Evans, 2009). For example, a client may be describing a trauma in a distanced, dissociated manner which I receive in a similarly distanced, disembodied way. Here, "cut-offness", disconnectedness, is being revealed (and enacted) in the relationship, perhaps out of awareness.

I know from my own therapeutic work that in situations where I do not feel emotion in my body, I could be manifesting my client's own dissociation. I might then share this (self-disclose) with my client, implicitly inviting them to bring to awareness their own embodied – or cut-off - self. Or I might find myself feeling somewhat helpless, seemingly unable to find a helpful response to my client's distress. Perhaps my sense of helplessness is reflecting their own helplessness and my urge to 'do something' mirrors their own desperate search for a quick, soothing solution? Perhaps what is needed from me is to model the process of staying with that distress, however uncomfortable that feels(?)

In an attempt to nurture integration, I might simply act as a witness, a mirror or a sounding board. For instance, I might say, "I am curious about the way you are missing out your father here." Or "Your voice gets soft when you speak of …." Another avenue to the enabling of new awareness can be to invite comparisons between the therapy context and outside. Are there things that a client can say in therapy that they feel they couldn't outside? What would help them say it outside? How might they take their learning from one situation into another? It is through such opening up that integration of subjectivities/ selves/parts of self and contexts can evolve.

Gendlin (1996) describes this process in terms of what happens with Focusing as one becomes aware of different 'parts' of our Self, for example, the part that feels angry and the part that feels shame. He suggests that tuning into the felt sense enables us to be aware of our selves in different ways. The felt-sense part of me who feels angry or shamed, for instance, is 'there' while 'I' am 'here'. Understanding in this way allows us to incorporate vulnerable aspects – including the less healthy parts - into ourselves as a whole (and this applies to being either therapist or client).

There are also times when something more active is needed. A role play, enactment or a ritual ceremony, for instance, could offer an opportunity to symbolically 'complete' some unfinished business. It might be useful also to engage Focusing. Through the use of Focusing the client might say " 'It' feels stuck". I might reflect back and invite an unfolding of possibilities, "It feels stuck. What would it be like if it could move?" In Focusing terms, the process of letting a felt-sense know that you 'hear' it lets it change (Madison and Gendlin, 2012).

Sometimes, a client may need to be confronted, provided that this is done selectively and within the context of a strong therapeutic alliance (Schneider, 2010). For instance, I might say, "You say you 'can't', but don't you mean 'won't'?" or "How many times are you prepared to keep going back to being abused by her?" Therapist self-disclosure can also offer a useful – if occasionally risky - model of presence and openness. Recently, I shared with

a client that I felt "used" by her in the same manner as a soothing medication, which was then disregarded until she needed me again. Exploring this further, we realised how she herself had felt used and then abandoned in all her significant relationships. It was the start of her deciding to relate in new and different ways.

Often the growing edge for our clients (and ourselves) is what happens at the contact boundary where resistances are to be found. By resistances I mean those times when invitations to encounter or explore are abruptly declined. Notwithstanding their value and significance for the client, resistances may also signal a titanic battle: that between the side of the client that is struggling to emerge and become whole, and the side that seeks to remain partial, hidden or entrenched. As a therapist, I see it as part of my work to name this battle, to try to bring it to the client's awareness. For example, a client may say, "I don't want to shout at him but…" or "Part of me wants that, the other is scared". Here, it might be helpful to engage some two-chair work 'acting out' the two sides of the 'internal' dialogue (which is often carried on just out of awareness). Enacting such dialogues allows the client to attend to what they are saying and begin to make connections (Moursund and Erskine, 2004). In time the client may be able more comfortably to hold different polarities as part of their experience. Moursund and Erskine (2004), integrative psychotherapists, explain that such enactments can begin the process of integration as clients become more aware of their process and make connections. With increasing openness to their self and to the therapist, deeper contact occurs.

Schneider (2010), an Existential-Integrative Psychotherapist, discusses the healing process in terms of removing barriers to choice. As a result, he says, clients experience more centredness and a greater capacity to be choiceful and 'to respond to' rather than 'react against'.

Case Example

Our therapy 'project' over the course of the three years has been Jayne's search for a way of being which she liked, respected and could hold on to. Within our safe therapeutic space, she could test out and rehearse responses. "New Jayne" grew slowly as Jayne created and learned about aspects of her new self. She had always been extremely attractive, but now she was claiming a gentler, more natural look, matching a manner that was softer and less critical of others. Gradually, as her ways of being became less extreme and more integrated, she explored her darker side. Her deeply felt sense of loss, alone-ness and 'abandonment' by everyone she allowed close helped her understand her tendency to cut-off from relationships in a pre-emptive, self-protective manner.

Latterly, we worked with integrating her 'child self'; that part of her whose anxiety spiralled overwhelmingly when she felt 'abandoned' by friends or lovers. She initially struggled to accept, and have compassion for, this "weak" self. She would berate herself, try to deny her feelings, while engaging in potentially self-destructive self-soothing activities. Over time, she learned to recognise that part of her Self which was anxious (and why) and see it as a part, and not the whole, of herself (a process Gendlin, 1996, calls 'disidentification'.)

Conclusion

In this article I have tried to explicate how I use existential-phenomenology as part of my work as an integrative psychotherapist. The process involves residing in the 'between', a place of unknowing, where ambiguity and uncertain possibility reign. Of course, my practice often falls short of the philosophical ideals; I remain engaged in a project to develop and evolve my therapist being. This paper is part of a process of becoming aware of who I am in practice, recognising choices made.

I have proposed a relational model of working which encompasses four mutually dependent and dynamically iterative processes: 'Embracing the Phenomenological Attitude'; 'Inviting Descriptions of the Lived World'; 'Dwelling with Meanings' and 'Challenging and Integrating Body-Self-World'.

I want to stress that these four stages are not intended to be a simple model or method of practice. While I've presented my approach as going through stages, practice is – of course – not so clearcut. Much of what actually

occurs in practice remains mysterious and beyond words. Can we ever capture the infinitely subtle experiential layers of bodily being-with another? However, I hope that I have managed to describe something of the complexity involved through the philosophical references and practical examples offered.

I have tried to show something of the special potential of existential-phenomenology for opening up the therapeutic space. Further discussion is needed to evaluate the extent my personal approach to therapy mirrors those of other existential phenomenological therapists. And while much of my practice could be seen as fitting other ways of engaging relational-centred integrative psychotherapy, more dialogue to probe any differences would be useful.

As for Jayne, her continuing challenge lies in carrying (with compassion) her fragmented selves as a-part of herself, while also holding them a-part from her new, more integrated and better functioning self. While she is still working on how to stay with less comfortable emotions, she has learned not to abandon herself and she is aware of her ability to make active choices about how to be-with others.

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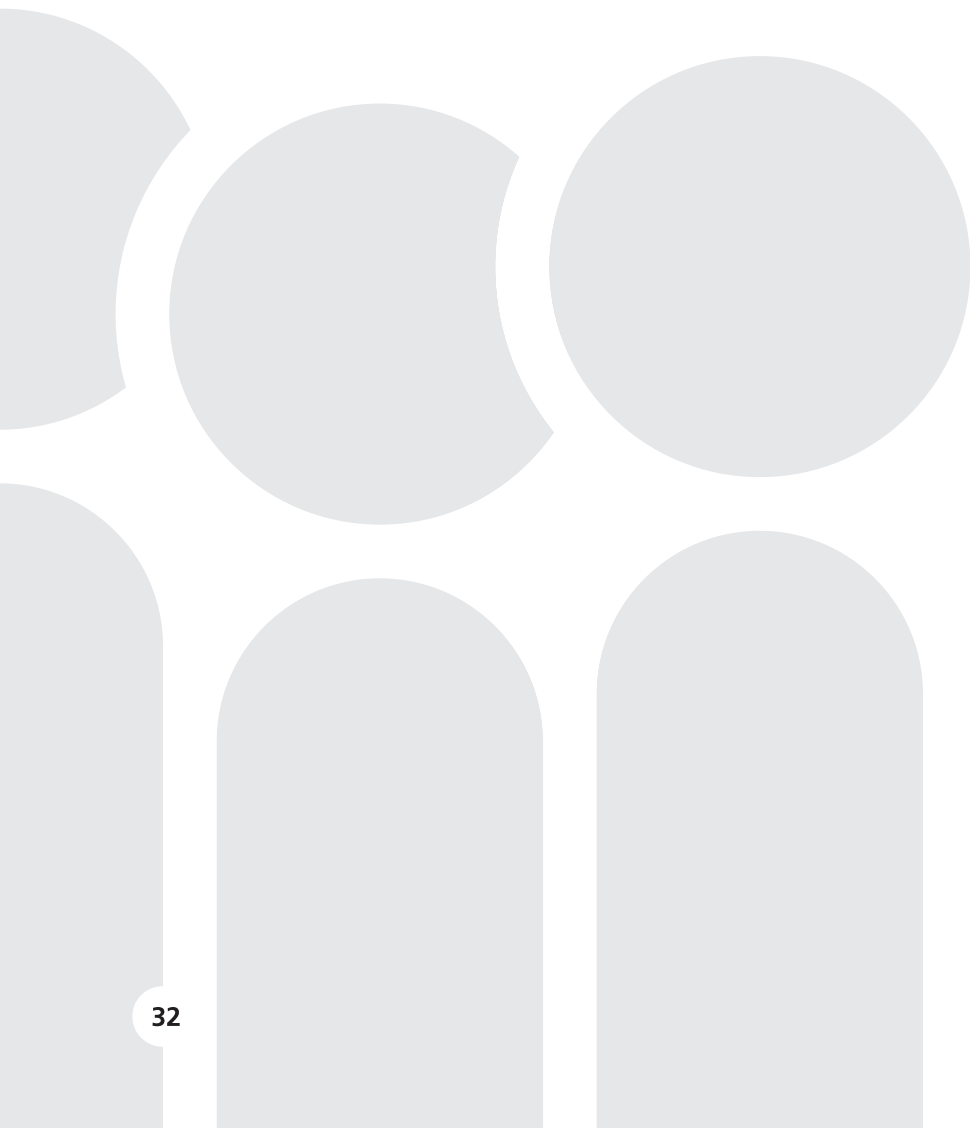

Albert Zandvoort

Living and Laughing in the Shadow of Death: Complicated Grief, Trauma and Resilience

Abstract

This article reviews and integrates aspects of complicated grief and psychological trauma. It explores the concept of resilience and briefly discusses coping responses like humour, positive emotions and meaning making. The article argues that the distinctions between complicated grief and psychological trauma may be only of academic interest for the therapist faced with a traumatically bereaved client and therefore proposes an inclusive vision of trauma and complicated bereavement. In essence, grief is a unique experience for each individual and the article discusses how attachment theory and meaning making may inform the therapist's work in this respect.

Introduction

Most people will experience some form of loss in their lifetime. This can be the loss of a relationship, the loss of a loved one to death or the traumatic loss of the security afforded to us by the ongoing assumption that we will be safe in this world.

In this article, I will review the salient aspects of complicated grief, possible overlaps with the findings from trauma research and potential synergies derived from looking at the two fields. Bearing in mind that we are all potentially vulnerable to bereavement and trauma, I will also consider the following questions: why are some people more vulnerable than others, what is the role of resilience, what are some coping responses and, finally, how might we work with complicated grief clients in our psychotherapeutic practice?

Having lost loved ones to drugs, cancer and suicide in the space of eighteen months, I may at times reflect on my own experiences of bereavement and trauma in the light of the research.

The Bible, Shakespeare and Freud on Complicated Grief

When my son died unexpectedly at the age of 29, I turned to my favourite poets and philosophers, the great spiritual books like the Bible, Koran and the Upanishads as well as any references to parental loss in the great literary and philosophical works produced by mankind. At the time, I felt deeply conflicted in my way of being in the world: on the one hand I needed to connect, to find a safe relational space where I could heal and at the same time I needed to isolate, read about the experience and pain of others and engage in a sense-making process. Above all, I needed to learn to be with my pain.

Through my reading, I found that parental bereavement, often resulting in complicated grief, is well documented throughout history in religious texts and in literature. The following two illustrative examples, one from the Bible and one from Shakespeare's King John reflected my own experience.

The story of the biblical figure of Jacob stands out as a case of complicated grief after parental bereavement. On recognising his son's bloodied tunic, Jacob responds as follows:

33. "It is my son's tunic. A wild beast has devoured him. Without doubt Joseph is torn to pieces."

34. Then Jacob tore his clothes, put sackcloth on his waist, and mourned for his son for many days.

35. And all his sons and all his daughters arose to comfort him; but he refused to be comforted and he said: 'For I shall go down into the grave to my son in mourning.' Thus his father wept for him." (Genesis, 37: 33 – 35)

And, in one of the most poignant descriptions of maternal bereavement in English literature, Constance of Bretagne is overwhelmed by her grief over the loss of her beloved son Arthur. She seeks confirmation from Cardinal Pandulph that she will see her son in heaven.

He responds: "You hold too heinous a respect for grief." King John, (3.4: 90), and Constance realises that the cardinal does not understand her maternal grief: "He talks to me that never had a son." (3.4: 91).

She then attempts to clarify her feelings:

"Grief fills the room up of my absent child, Lies in his bed, walks up and down with me, Puts on his pretty looks, repeats his words, Remembers me of all his gracious parts, Stuffs out his vacant garments with his form. Then have I reason to be fond of grief." (3.4: 93 – 98). "O Lord! My boy, my Arthur, my fair son! My life, my joy, my food, my all the world!" (3.4: 103 – 104).

I knew that this was the experience of the mother of my children, my wife for nearly thirty years. Exactly 18 months after my son's death, her pain became unbearable and she followed the calling of her 'fair son' through suicide.

At the time, I felt overwhelmed, numbed, unreal and fearful, and even now, eight years later, although these feelings have mellowed, the deep pain in my soul is still as present as ever.

I was therefore not surprised to find an apparent contradiction in the work of Sigmund Freud regarding mourning and grief. The research on grief and the attendant therapeutic practice has for many decades been influenced by Freud's (1917/1999, p430) position in 'Mourning and Melancholia', in which he described the "work of mourning"… as that of severing "attachment to the non-existent object". In normal mourning, according to Freud (1917/1999, p430), this 'work' takes the form of repeated 'reality testing' which gradually allows the ego to free its investment in the 'lost object'. He viewed complicated or 'pathological' grief as the result of the bereaved person's inability to manage the detachment process.

Knowing from Freud's biographies (Clark, 1980; Sternthal, 2006) that he himself had lost a child and a grandchild, I looked to his letters (Freud, 1961) for a less academic response to these tragedies.

It seems that, despite Freud's clear imperative to others to detach from the deceased loved one, he himself understood an ongoing involvement with memories of the deceased as a natural and even desirable feature that exists during and after the mourning process. He expressed his views in a letter to Ludwig Binswanger, who had recently lost his oldest son, in the following way: "April 12, 1929. My daughter who died would have been 36 years old today…Although we know that after such a loss the acute state of mourning will subside, we also know we shall remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it be filled completely, it nevertheless remains something else. And actually this is how it should be. It is the only way of perpetuating this love, which we do not want to relinquish." (Freud, 1961, p386). Freud still feels the 'ongoing bond' with his beloved daughter Sophie (1893 – 1920) and he shows clear signs of complicated grief after the death of his grandson Heinele when he writes: "… I find this loss very hard to bear. I don't think I have ever experienced such grief…I work out of sheer necessity; fundamentally everything has lost its meaning to me." (Clark, 1980, p441).

Despite these empathic and authentic responses, Freud's earlier view of grief work, emphasising the withdrawal of libidinal energy from the

deceased so that it can be invested in a new relationship, became the dominant paradigm in the wider mental health field. Lindeman (1944), in his work on acute grief, stressed the concept of 'work' and the need to let go of an overly strong connection with the deceased. Even as late as 1992, Stroebe defined effective grieving as: " …a cognitive process of confronting a loss, of going over the events before and at the time of the death, of focusing on memories and working towards detachment from the deceased" (Stroebe,1992, p20). Efforts were made to define 'grief work' in terms of stages and or phases, sometimes linked to 'appropriate' times for each stage (Kuebler-Ross & Kelter, 2005; Worden, 2001) and only in the past decade has there been an acceptance of the fact that we will always, depending on the circumstances surrounding the bereavement, experience a continuing bond of varying intensity with our loved ones (Field & Wogrin, 2011).

Grief and Trauma

Rather than repeating the well-known DSM-IV-TR (2000) descriptions of trauma, I would like to quote Robert Stolorow (2007, p10/19), who, reflecting on the death of his wife Dede and on trauma in general, views "… trauma as, in essence, an experience of unbearable affect…and…a shattering of one's experiential world – in particular, of those 'absolutisms' that allow one to experience one's world as stable, predictable and safe…"

This view chimes well with the concept of the 'assumptive world' developed by Parkes, (1971; 2010), Janoff-Bulman, (1992) and Kauffman, (2002) as the principle that ensures the conservation of our psychosocial reality. Psychological trauma and traumatic loss constitute a shattering of the conservation and coherence of our assumptive world beliefs and may, together with our efforts to hold together what is already broken in a shattered world, lead to a fragmentation of the self. For example, part of my assumptive world, and that of any parent, is the belief that we will die before our children. We accept this as the natural order of things, and our world is shattered if the order is inversed.

According to Kaufman (2002), the loss of the assumptive world coincides with terrible shame, helplessness, loss of control, panic, primitive affect disturbances, greatly heightened dissociative activity, and intensely self-destructive reliving of the trauma/traumatic loss. These trauma features all signify loss of safety. Or in the words of Jeffrey Kauffman (2002, p206): "The assumptive world order is the set of illusions that shelter the human soul."

Empirical evidence (Prigersen et al., 1999) suggests that when grief and trauma occur together, subsequent reactions are more prolonged and distressing and according to Regehr & Sussman (2004), the suddenness, violence and sense of justice associated with the loss, as well as the nature of the relationship between the deceased person and the survivor, may cause people to suffer trauma and grief simultaneously, leading to complicated grief. According to Bonanno (2010) complicated grief reactions tend to be more prevalent following extreme losses, such as suicide or murder of a loved one; and the death of a child is uniformly associated with prolonged and complicated grief in parents (Finkbeiner, 1996). Other complicating factors (Shear, Boelen & Neimeyer, 2011) are the personal psychological vulnerability of the bereaved, a possible history of mood or anxiety disorders, avoidant or anxious attachment and a history of trauma or multiple losses. In addition, social factors also play an important role in complicated grief, such as the context in which the death occurs as well as insufficient or toxic social support and/or severe financial or other hardship.

Prigerson, Vandewerker & Maciejewski (2008, p166) have summarised complicated grief as follows: "It constitutes a persistently elevated set of specific symptoms of grief identified in bereaved individuals with significant difficulties in adjusting to the loss." All of these symptoms are related to traumatised self-integrity/ loss of the assumptive world and include numbness, avoidance, purposelessness, disbelief, emptiness, hopelessness, feelings of partial self-death, shattered worldview and expressions of protest.

From the above, it appears that trauma and grief interface in multiple ways, and to attempt to distinguish the two is often not possible. Furthermore,

complexities in the inter- and intrapersonal dimensions of the bereaved can function with the same power to derail life function, as exposure to an external life threat, defined as trauma in the DSM-IV (2000). Finally, personal experience of traumatising proportions can occur in the case of bereavements that give no hint of external circumstances being particularly traumatic. Therefore, an individual's world may crash around them due to a stressor or to a bereavement that is subjectively experienced as traumatic or overwhelming but not necessarily perceived to be so from an outside perspective.

If we therefore assume that bereavement by itself is always a stressful life event and that it has the potential to be by itself an event of traumatic proportions for the individual, the distinctions between complicated grief and trauma tend to become rather academic for the therapist.

I would thus argue that both trauma as life-threat and trauma as bereavement exist on a continuum. The extent as well as the nature of the psychological upheaval in one's life in all circumstances are continuous rather than merely present or absent. Phenomenologically and psychologically, there are varying degrees and various levels of perceived life-shaking exposure occurring at behavioural, conscious, physiological, and unconscious levels for both trauma and bereavement.

Ultimately, there exist as many variations of traumatic events as there are variations of experience of bereavement events. The mix of objective, subjective, and symptomatic criteria for assessing responses to bereavement and trauma does not justify addressing only the distinctions between traumatic and non-traumatic events and so-called traumatic and non-traumatic bereavements. I propose that we work with an inclusive vision of trauma and bereavement, which takes into account the fundamental notion that individual interpretation of life experiences is the key feature of the experience.

In the next section, I will explore some coping responses to complicated grief, especially resilience, humour and positive emotion.

Resilience

There is an assumption that all adults exposed to 'potentially traumatic events' (Bonanno, 2010) experience prolonged distress and disruptions in functioning, which in turn leads to the belief that resilience must be rare and is found only in exceptionally healthy people (Bonanno, 2004). However, this is not supported by the research, and several studies quoted by Regehr & Sussman, (2004) have shown that 50 to 80% of men and women experience potentially traumatic events, but that the majority does not develop Post Traumatic Stress Disorder (PTSD), which requires that the symptoms continue for more than one month. A similar picture emerges for bereavement statistics. Bonanno (2004; 2010) reports from an analysis of the available research that only 10 to 15 % of bereaved individuals show acute or complicated grief reactions, as defined by Prigerson et al. (2008).

In cases of exposure to potentially traumatic events, some individuals will develop persistent symptoms and some of these will meet diagnostic criteria for a variety of disorders (Van der Kolk, McFarlane & Weisaeth, 2007). The same can be said for the experience of exposure to bereavement. In the case of individuals exposed to bereavement with potentially complicating factors as described by Shear et al (2011) above, only some will develop symptoms (Bonanno, 2010).

Overall, it can be said that the absence of pervasive and persistent dysfunction characterises the majority of the individuals subjected to these events in their responses over time, in other words, they show signs of resilience in the face/aftermath of potentially traumatic events.

Bonanno (2012) proposes the following view of resilience: when a person has experienced an extreme adversity but nonetheless still manages to maintain a relatively stable trajectory of healthy functioning and positive adaptation in its aftermath. It is important to note that resilience does not imply stress resistance, since even the most resilient individuals tend to experience at least some form of distress during or in the immediate aftermath of a potentially traumatic event.

This, of course, raises the question as to the nature of resilience, and why some people are more resilient than others?

Bonanno (2002; 2004; 2010) argues for multiple pathways to resilience. In the first instance he looks at the trait of hardiness and identifies three dimensions:

1. A commitment to finding meaningful purpose in life
2. The belief that one can influence one's surroundings
3. The conviction that one can grow from both positive and negative life experiences.

His research also indicates that strong positive biases in favour of the self, such as self-enhancement, can be adaptive and promote well being in the wake of potentially traumatic events. Even though self-enhancers score high on measures of narcissism and tend to evoke negative impressions on others, there may be a trade-off in the context of highly adverse events, when threats to the self are most salient (Bonanno, Field, Kovacevic & Kaltman, 2002). In other words, it does not matter if a traumatised individual is authentic and /or realistic in their view of themselves, as long as it aids their psychological survival in and after the event.

Added to this, is the research by Mancini, Prati & Bonanno (2011) indicating that favourable world views were related positively to adjustment over time for bereaved persons. Furthermore, Bryant and Guthrie (2007) reported that negative beliefs about the self among a sample of fire fighters undergoing training predicted elevated PTSD symptoms four years later. These findings suggest that positive world views tend to be associated with enhanced resilience and more adaptive coping.

In the light of these findings, I have reflected on my own capability for resilience and I would like to argue the case for contextual resilience. Feeling raw and overwhelmed shortly after the death of my son, I returned to working with clients and teaching within four weeks and my performance was undiminished. I paid my bills, went shopping and did all the 'functional' things that constitute normal life. A few months later, my father succumbed to a three-year battle against cancer and again I returned to work after a few days of absence. In the evenings, on my own, I wept in despair, consumed with yearning, wrecked with feelings of guilt and anxiety. Until the next morning, when I found that my capacity to shift negative emotional responses according to changing context (work) allowed me to function well in the moment and (in hindsight) supported my overall recovery from my traumatic losses. In his deeply sensitive account of his grief after the death of his wife, C.S. Lewis (1961, p7) makes a similar observation: "No one ever told me about the laziness of grief. Except at my job – where the machine seems to run on much as usual – I loathe the slightest effort."

Humour and Positive Emotion

"Humour was another of the soul's weapons in the fight for self-preservation….humour, more than anything else in the human make-up, can afford an aloofness and an ability to rise above any situation…" Frankl (1969, p42).

The prevailing paradigm about a show of positive emotion after a bereavement is that people are suffering from a form of "disordered mourning" (Bowlby, 1998, p153), in which there is a prolonged absence of grieving, despite "…tell-tale signs that the bereaved person has in fact been affected and that his mental equilibrium is disturbed." Among these tell-tale signs listed by Bowlby (1998, p156) are the positive emotions of pride and cheerfulness, as well as optimism and the appearance of being "…in good spirits."

However, there is significant evidence (Bonanno, 2004) that positive emotions can help reduce levels of distress following aversive events both by quieting and undoing negative emotion. Or, in the words of Bonanno (2010, p38): "What really matters, in terms of our long term health, is the ability to crack a grin when the chips are down."

True smiles, described as Duchenne expressions (Bonanno, 2010) in bereaved people in the first few months after their loss, were indicative of better health over the first two years after the bereavement. This is partly because smiling and laughter give us a temporary respite from

the pain of loss and, at the same time, it has a comforting effect on other people. Research (Keltner & Bonanno, 1997; Bonanno, 2010) has shown that bereaved people who are able to genuinely smile while discussing their loss evoke more positive emotion and less frustration in others than do bereaved people who cannot smile. Experienced bereavement counselors (Cartwright, 2012) report improved recovery in those people who can be with the pain and who can still smile and laugh.

These findings are supported by my own experiences, where friends and relatives at all three funerals remembered humorous incidents related to the deceased and had most of the attendants laugh out loud. And even in the somber atmosphere of a bereavement conference, where all of the delegates had lost loved ones, I have experienced how genuine smiles and laughter ease the devastating pain and burden people carry. As C.S.Lewis (1961, p48) suggests in 'A Grief Observed': "I will turn to her as often as possible in gladness. I will even salute her with a laugh."

Complicated Bereavement and Therapy

Payne, Jarrett, Wiles & Field (2002), in a study of 29 grief counselors, revealed that although they felt that each client experiences their grief as unique, they reported drawing primarily on the stages/phases/task/process models in their work. Although they also acknowledged that the phases/stages were not progressive or necessary, they still believed that the client could become stuck in certain stages, felt that grief was time bound, and many prioritised the facilitation of the closure of the relationship between the client and the deceased. A similar situation was found in a study of 50 British General Practitioners who had worked with the bereaved (Wiles, Jarrett, Payne & Field, 2002).

While these findings are concerning, they are perhaps unsurprising, given that material directed at helpers and in the popular press often reflects the assumptions inherent in the dominant discourse. It is also a clear indication that many practitioners uncritically accept the assumptions of the dominant discourse at a subconscious level and act accordingly with their clients.

Also, the provision of support following bereavement is complicated by peoples' discomfort with and anxiety concerning death. Studies have shown that counselors experience significantly higher levels of discomfort and display low empathy when dealing with death and dying when compared to other potentially sensitive issues (Kirchberg, Neimyer & James,1998; Kojlac, Keenan, Plotkin, Giles-Fysh & Sibbald, 1998).

My own experience has shown how 'uncomfortable' people are with the concept of death, which I feel has mostly been 'sanitised' in much of our western culture and has thus become 'unspeakable'. CS.Lewis (1961:11) felt this very strongly after the death of his wife: "An odd by-product of my loss is that I'm aware of being an embarrassment to everyone I meet. ….Perhaps the bereaved ought to be isolated in special settlements like lepers."

No doubt, in order to be effective, psychotherapeutic interventions always need to be individualised to the client's specific functioning. The therapist will join the client where they are, explore their ways of being and functioning in relation to the particular circumstances of the bereavement, and finally allow and encourage the practice of new ways of being that foster well-being and psychological development.

I believe that attachment theory provides a helpful framework for guiding the therapist in such an individualised approach and I will now provide a brief overview of the relevant research and the implications for therapy.

Attachment and Complicated Grief

Attachment theory posits the existence of cognitive-affective neurobiogical circuitry called working models that contain autobiographical information about the self and attachment relationships, as well as motivation for attachment related behaviour. When activated by separation or stress, this circuitry produces feelings of yearning or longing, prominent thoughts of the attachment figure and proximity seeking behaviours. (Stroebe, Schut & Boerner, 2010).

When a loved one dies, the working model must be revised but information that the death occurred is not sufficient to revise the model. According to Bowlby (1998) mourning is a preoccupying and erratic process by which bereaved people come to accept their changed circumstances, revise working models and redefine life goals.

Bowlby (1998) proposes that therapeutic change would need revision of the client's insecure working models into more secure models. The therapist should provide a corrective relational experience and thus offer a safe haven and a secure base from which clients could then explore their inner world, including painful memories and emotions such as grief reactions.

Crucial to the attachment perspective is the observation that the pain of grief leads to a gradual redefinition, reorganisation and elaboration of the representation of the lost relationship into an enduring continued bond.

The therapist needs to recognise and respond adequately to the client's experience of reorganisation. Winnicot's (1965) concept of the 'holding environment' is particularly useful in viewing the therapist's contribution to the client's reorganising. The therapist communicates this holding environment through an attitude and set of behaviours that signal to the client that he or she will not be damaged, engulfed or abandoned.

It would thus seem to make sense to explore the bereaved client's attachment style. Research (Fraley & Shaver, 1999; Mikulincer & Shaver, 2008; Parkes, 2010) indicates that attachment style predicts ways of dealing with emotions and handling stressful situations, in particular ways of coping with bereavement.

According to Stroebe, Schut & Stroebe (2005) securely attached individuals are expected to be able to access their attachment related emotional memories without difficulty and to be able to discuss them coherently. Dismissing individuals would suppress and avoid attachment related emotions and show few grief reactions. Pre-occupied individuals are expected to be highly emotional, cling to their ties with the deceased and develop complicated grief reactions. And finally, disorganised individuals would be unable to coherently think and talk about attachment related memories, and would also show complicated grief reactions (Stroebe et al., 2005).

Given the above insights from attachment theory, prompting emotional expression and exploration may not always be the best treatment option, and it has been shown that emotional disclosure is often not beneficial for everyone or in all cases of bereavement (Zech & Rime, 2005; Zech, Rime & Pennebaker, 2007; Bonanno, 2010). In the words of C.S.Lewis (1961, p10): "Part of every misery is, so to speak, the misery's shadow of reflection: the fact that you don't merely suffer but have to keep on thinking on about the fact that you suffer."

Especially pre-occupied individuals may engage in rumination about the deceased, whereas dismissing individuals may be primarily focused on restorative activities and avoid thoughts related to a deceased partner. Ogden, Minton & Pain (2006) would possibly describe the first group as hyperaroused (i.e. experiencing emotional overwhelm, panic, impulsivity and anger), whereas the other group is hypoaroused (numb, disconnected and shut down). Disorganised individuals would oscillate between hyperarousal and hypoarousal, which, according to Stroebe et al (2010) could lead to very disordered forms of grieving. Encouraging these three types of clients to explore their emotions at a deep level may potentially result in these clients being outside of their window of emotional tolerance. In a secure window, or in other words, in a safe relational space, both feelings and thoughts can occur simultaneously, they are tolerable and responses are appropriate in a given situation (Fisher, 2009).

At the heart of attachment is a sense of safety. Those who are insecurely attached, by definition, lack this emotional resource and may therefore be destabilised in therapy either by feeling that they are not being adequately supported (pre-occupied) or by being flooded with unwelcome and distressing emotions (dismissing).

One way of working with clients who might respond aversely to talking therapy, based on their attachment style, might be the sensorimotor approach developed by Ogden et al. (2006).

Sensorimotor psychotherapy integrates cognitive, emotional and sensorimotor processing in such a way that these systems support each other. As it would apply to complicated grief, clients would be encouraged to mindfully track their physical movements such as muscular tension, breathing, heart rate, and motor impulses with the goal of distinguishing emotional grief responses from physiological dysregulation. Such bodily sensations are observed as their texture and intensity fluctuate, until the sensation has stabilised (Ogden et al., 2006).

Without providing an in-depth description of sensorimotor processing, I would suggest that, although the narrative approach produces greater insight, an alternative focus on the embodied nature of grief can assist in normalising and treating the repetitive physical sensations and somatosensory experiences that accompany bereavement. As in trauma work, clients who are insecurely attached and who experience overwhelming physiological arousal and distress can benefit from a therapeutic approach that focuses on modulating such arousal.

As mentioned previously, meaning making after a traumatic bereavement has been shown to be instrumental in facilitating positive outcomes for clients. In the following section, I will briefly review the value of meaning making in the therapeutic process.

Meaning

Frankl (1969) holds the positive existential view that complicated grief could be accepted as a crisis that encourages new meaning in life. This would avoid unnecessarily pathologising the bereaved client who is trying to make sense of this inevitable human situation. As he poignantly points out …" We must never forget that we may also find meaning in life even when confronted with a hopeless situation, when facing a fate that cannot be changed. For what then matters is to bear witness to the uniquely human potential at its best, which is to transform a personal tragedy into a triumph, to turn one's predicament into human achievement. When we are no longer able to change a situation…we are challenged to change ourselves." (Frankl,1969, p135).

And according to Neimeyer & Sands (2011) the role of meaning making accounts for nearly all the difference in bereavement outcomes for people whose loved ones died traumatically, as opposed to those who died of 'natural causes'. Indeed, if deaths of loved ones are normative and expected, only a minority of the bereaved would report searching for meaning in the experience, and, according to Davis, Wortman, Lehman & Silver (2000), the absence of such a search is one positive predictor of positive bereavement outcome.

It is also worth bearing in mind that traumatic loss does not necessarily require a reappraisal of life's meanings, as many will find consolation in systems of secular and spiritual beliefs and practices that have served them well in the past (Neimeyer & Sands, 2011).

I would therefore agree with Frankl (1969, p171): "What matters, therefore, is not the meaning of life in general, but rather the specific meaning of a person's life at a given moment."

Personally, I engaged in multiple meaning making processes, finally leading to what Herman (2001, p207) calls "finding a survivor mission." Together with my daughter, we transformed the meaning of our personal tragedy into a platform for social action by founding a specialist treatment centre for addicted health professionals.

In my practice I have learned that we can only accompany our clients as they discover meaning in their loss. Far from attributing meaning or superimposing my meaning on the experiences of another, I travel with sufferers as they attempt to find their own meaning. I agree with Rollo May (Schneider & May, 1995) that we should explore with the grieving client what their world is like, rather than to 'solve the problem' of grief.

I believe, with May (Schneider & May, 1995), that not staying with the client in their pain will actually diminish the individuality of the client. It leads them to conforming with our culture's encouragement to repress our uncomfortable experiences related to death and precludes the engagement with new forms

of meaning making. My own experience and my work with clients have led me to accept that feelings such as anxiety, guilt, and grief are not destructive or pathological but provide the traumatically bereaved individual with opportunities for growth and creativity.

Final Thoughts

My focus in this article has been on the intersection of grief and trauma. In my own work with the bereaved, I have created the concept of 'potentially traumatic grief' to inform my therapeutic stance. I believe that this term allows me to hold my inclusive vision of trauma and grief and is deeply respectful of the unique experience clients bring to the therapeutic space. It allows me to hold in view the total continuum of the client experience as well as their potential for change and growth.

It also appears that not every bereaved person needs therapy. Research has demonstrated that therapeutic support for those with 'normal' grief shows little to no effect, and in a considerable proportion of the cases, the bereaved clients would have been better of without the intervention (Hannson & Stroebe, 2003; Jordan & Neimeyer, 2003; Schut, Stroebe, Van den Bout & Terheggen, 2001; Bonanno, 2010).

Therapeutic support, as described in this article, seems to be more effective for those with 'risk' variables and /or 'complicated' grief reactions (Jacobs & Prigerson, 2000; Jordan & Neimeyer, 2003; Schut et al., 2001), which again confirms the commonalities between complicated grief and trauma.

Finally, I would like to close with the words of Robert Stolorow (2007, p49): "…although the possibility of emotional trauma is ever present, so too is the possibility of forming bonds of deep emotional attunement within which devastating emotional pain can be held, rendered more tolerable, and hopefully, eventually integrated."

In other words: the wounds of traumatic grief may heal in a 'relational home'.

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Albert Zandvoort & Michelle Zandvoort

Trauma and the Use of Co-operative Inquiry to Develop a 'Survivor Mission'

Abstract

This article describes the lived experience of two therapists (daughter and father) of complicated bereavement and trauma and their creation of a survivor mission. Integrating reflective practice, cooperative inquiry and heuristic research principles, this deeply personal account, spanning eight years, argues for the social and perhaps even universal application of meaningful personal experiences. The authors elucidate the impact this process has had on their work in terms of their transformation of being in this world and the transformation of their practice as therapists.

> *"Co-operative inquiry…embraces what is called action research. It is …concerned with revisioning our understanding of our world, as well as transforming practice within it."*

Reason & Heron, A short guide to co-operative inquiry (2012)

Introduction

How do parents and siblings deal with the death of a child and brother? How do daughters deal with the loss of their mother? How does a father deal with the loss of the mother of his children? What are possible coping strategies for the survivors? What if there were complicating factors, like addiction and suicide?

In May 2004 our brother and son, Marius, suddenly passed away and just over a year later, in October 2005 Marius' and Michelle's mother Petro, unable to deal with this devastating loss, followed her son.

Where did this leave the surviving daughter and father? Initially we both plunged into study and work with an energy bordering on the obsessional. Our conversations about our traumatic bereavement were often fragmented, a cry, and a shout from pained souls, looking at each other and asking: why?

Over time our conversations turned into a deeper dialogue as we developed an ability to manage our emotions by simply being present to them and by accepting that we would feel the pain. Slowly and gently we started to engage with a "search for meaning" in our "unavoidable suffering" (Frankl,1969). Through our many conversations we developed a deep "participatory spirit" (Heron, 2009, see fig. 1), which inspired and motivated us as two traumatised individuals to develop our "survivor mission" (Herman, 1992) and to advance our daughter-father/therapist-therapist relationship to new depths.

We engaged in a very deep form of co-operative inquiry described by Heron & Reason (2000:171) as "…a way of working with other people who have similar concerns and interests to yourself, in order to: (1) understand your world, make sense of your life and develop new and creative ways of looking at things; and (2) learn

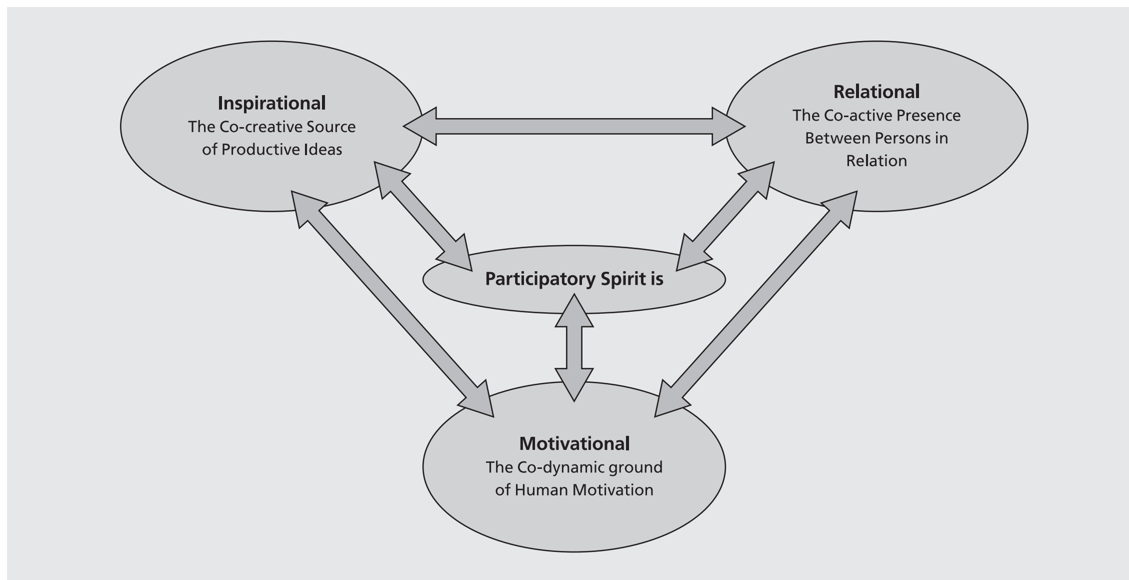

Figure 1: Heron's Model of the Participatory Spirit

how to act to change things you may want to change and find out how to do things better."

After many conversations which moved broadly along the lines of the Heuristic research model proposed by Moustakas (1990), we were able to formulate our 'survivor mission' as a 'research question': "How can we, as a team, provide a specialist, confidential and quality service that will enable addicted healthcare professionals to regain and maintain their well-being, return to work and in turn be able to continue to provide high quality care to their patients/clients?"

And, the second question for us was equally important: "How will this impact our practice as therapists?"

In this article, we offer a retrospective view on our process through a reflective dialogue. The dialogue between us (Michelle and Albert) took about two hours on a beautiful Sunday autumn morning early September 2012 and loosely followed the reflective practice and structured debriefing model developed by Graham Gibbs (1988).

We hope to provide an insight into our lived experience, which, as Moustakas (1990: 15) points out: "… is autobiographic, yet with virtually every question that matters personally there is also a social - and perhaps universal - significance".

We will try to illuminate our process and the resulting outcomes by offering salient verbatim parts of our dialogue followed by our reflections on our own processes, the process of co-operative inquiry and the heuristic research process.

Description of Our Initial Experience: A First Bereavement 18th of May 2005

On this day we were informed of the sudden death of our brother and son Marius in South Africa, where he had been working as a physician in the pediatrics department of a rural hospital. Marius had previously been addicted to heroin as a student and a young doctor.

Albert: "…I was teaching on a Tuesday morning. My administrator knocked on the door of the teaching room and asked me to come and look at something urgent… She had a message for me to phone Marius's friend. I did that, I phoned him. He just said, 'I'm very sorry, but Marius is dead.' He said it just like that…… Then I tried to think about a way of calling you and letting you know about this…"

Michelle: "… It wasn't until I got home, just after 5pm, that you gave me a call….You broke down and you just said, 'Marius died.' I felt a real shock come over me. I said, 'No, that can't be true.' You said, 'Yes, he died this morning.' …You said you were going to get a

flight so that you could go and be with Mum and go and see him at the morgue before his post-mortem examination. I asked if I could join you. You said you would get me a ticket and you would meet me at the airport."

Comments

One of our great difficulties at this stage of the reflective cycle, was to deal with our distress. We were deeply aware that we wanted to be clear about the key experience we wanted to share through our dialogue and, at the same time, we knew that we would not be able to move on if we had not dealt with our distress. In line with the second step of Gibbs' (1988) reflective cycle, we therefore decided to work through our feelings.

What were Our Feelings, then and now? Then

Michelle: When I put the phone down I felt I lost it. I just screamed in agony. I was in pain. I couldn't contain it. I just let go. I yelled and yelled and yelled and cried for my brother….. It was so painful that it really felt as if someone had ripped my soul out. It's a pain that is very difficult to put into words."

Albert: "When I left my classroom, part of me was really in denial. Part of me said it can't be true. I knew it was true but it's one of those conflicted things where I didn't want it to be true. I felt pretty numb…. I can't even remember how we went through the night on the plane. I have a very clear memory of the next morning, coming to the hospital and, I know that's where I totally lost it when they pulled Marius out in a drawer. I thought, 'How can they do that? How can they have your child in a drawer?'… I just remembered crying and shouting and trying to wake him up. Then looking at your mum's face, that brought me back a little bit, actually, just to see her devastation and pain…"

Michelle: Yes, it's a trauma. We all went together and got led down this corridor. They go around to the back, past the bins even and into the back part of the morgue. It was such an awful experience, having him pulled out, lying there naked on this cold drawer. It was awful seeing him there. For me, it was so traumatic, so terrible, seeing him. It didn't feel real. I just wanted him to wake up as well……I was holding him. I wouldn't let go and I was telling him to wake up. I was telling him, 'What happened?' It was a stupid mistake; wake up. 'You can't be dead. You have a daughter.' I was refusing; I was kissing his face. I was crying and willing him to stand up. I was saying, 'Come on, you don't need to be here. It's cold, let's get you dressed.' I was just-, I couldn't let go. I was crying and hollering. I wouldn't let go. It was like something inside me wouldn't let go…."

Albert: "Yes, we both felt this…"

Michelle: "We had to prepare for the funeral. That's my recollection of this horrible experience, that we could see him."

Albert: "Then, of course, there was the funeral service. I knew at that point that it was the final goodbye to the living Marius. I don't think I'll ever really say goodbye. Then we came home."

Now

Albert: "It's very hard… now, actually."

Michelle: "Yes, in such depth. I can see it's very painful for you." Albert: "And for you."

Comments

Peter Reason (2012:) comments as follows: "… the group must be willing to address emotional distress openly when it arrives: to allow the upset persons the healing of self-expression, which may involve the release of grief, anger or fear." This process of dealing with our emotional distress in the here and now clearly mirrored our original pain, and despite all of our attempts to work through these feelings then, we accepted that we had just learned to live with them and to accept them.

Evaluation and Analysis

Michelle: "I think it's painful for me losing a brother. I'm a parent myself now and the thought of losing one of my children is just awful. It would be devastating. To know you've lost your son, I think it's

unnatural. It's a pain that I think only another parent can comprehend who has been through a similar experience."

Albert: "Then when you came back, what did you do to cope? I know I worked a lot. What did you do?"

Michelle: "I just threw myself back into my studies. I had a thesis to complete…I was doing a large quantitative study on alcohol use and problem drinking…and I continued working at the drug and alcohol service. I explained what happened. People were shocked…. They could see my pain and the devastation that it had caused family members. A lot of them thought about the impact that their drug use had had on their families. It was a very reflective period…. I had personal therapy, went to see my therapist to work through this. Yes, therapy, support from Tal (Partner). We came to see you every weekend. I think we spent most weekends with you."

Comments

During those weekends we spent many conversations honouring the memory of Marius in the realisation that he would never really leave us. We did this without any sense of bitterness and we both felt a sense of spiritual catharsis through the conversations and the love we felt for him.

Description of our Second Bereavement

10 October 2006

On this dark day we were informed of Petro's suicide as a result of shooting herself. Marius' mother, a non-practicing Psychologist, had been living in South Africa with her partner and we were aware that she was experiencing depressive episodes and using valium and alcohol. She had agreed to come and live with Michelle in England as soon as she sold her house later in the year.

Albert: "I can't remember what it was like."

Michelle: "… I spoke to her at night. You spoke to her during the day. I spoke to her about half an hour before she actually committed suicide. So…it was really traumatic…. You had a trauma reaction and it makes memory become vague because you're so overwhelmed from what's happening…"

Albert: "Actually that's true. That's what happens. I do recall coming into her house in South Africa and just seeing some of the stuff that was there. I remember going to the next room and just seeing the sheets that were still there. They had forgotten about them."

Michelle: "The sheets were dumped in the wardrobe and they had forgotten so we found it still with the blood on it. It was difficult. That's why it seems fragmented for you, also from what happened before, leading up to it…. I can see the pain on your face as you talk about this now and try to piece it together."

Comments

Once we emerged from our despair, our conversations moved to a new and deeper level. These dialogues led to a further spiritual awakening which added immense depth to our initial sense-making process and to the resulting phases of deeper knowing described throughout this account of our journey.

Feelings then and now:

Albert: "And you coped well. I wasn't able to do anything. I just couldn't do it. I have thought about it often. Even though we had been divorced, it was just a paper thing. We were so locked in with each other even though we had different partners. I had spoken to her a few hours before she killed herself as well. I noticed she was very down….Something must have triggered it in the moment. I know that was difficult for you because I know I wasn't very helpful. I just couldn't be helpful. I couldn't deal with helping."

Michelle: "No, don't worry."

Albert: "To be honest, I'm still not dealing with it very well."

Michelle: "I never blamed you. I knew you couldn't. I knew you had this massive trauma from Marius that you hadn't really properly come to terms with, and then mum's death was a real blow…. I know how involved you had been in each other's lives since you were ten and twelve. You know, you couldn't make the marriage work but it doesn't mean you were able to let go of each other."

Albert: "A bit… part of me couldn't say goodbye. Actually, to be honest, the biggest part of me hasn't said goodbye."

Comments

The above exchange reflects the differences in the way we were coping with our second bereavement at the time and also currently in relational terms. It signifies that bereavement is an ongoing sense-making process and that the process of acceptance can stretch over a long period of time. In the months after Petro's suicide we continued our dialogue with each other, thus expanding our meaning making process into a heuristic 'research' process. We read voraciously, wrote, listened to music, had therapy – or, in the words of Moustakas (1990) did some serious 'indwelling' in our experience.

Evaluation & Analysis of our Double Bereavement

After this period of 'indwelling', we were even more driven to find meaning in these traumatic events. Reflecting on the struggles our loved ones had with drugs and alcohol, we started thinking about how we might be of help to people with similar challenges and started moving towards a deeper engagement with the formulation of our survivor mission.

Albert:"…I remember going to rehabs in South Africa where he was and thinking, 'How can anybody get better here?' He would say to me, 'Dad, you need to come and get me out of here, this is not working.' I went there and I thought, 'There's nothing here, there's no therapeutic programme,' you know, 'People just hang out.' I think that memory of his rehabs also galvanised us to come up with something different in terms of how we wanted to, first of all, honour both Marius and mum, but also find something that would be different. I wonder what your recollection is on that?"

Michelle: "I remember…we had this idea and many discussions, because I was visiting you on weekends. I remember being in a class, supervision class, at university, had a couple of months left or so, and I said that-, because we were talking about what everyone's plans were for after graduation and I said, 'Well my plan is that my father and I are thinking of opening up a rehab home in memory of my brother and my mum.' I remember saying that we wanted to open up a therapeutic community, and …you had come across the concept of therapeutic community."

Comments

In terms of Heuristic research this could be described as the period of immersion, the stage where the researcher lives the topic and comes ".. to be on intimate terms with the question." (Moustakas, 1990: 27) It also seemed to us to be the first stages of propositional knowing, i.e. knowing about something and developing ideas and theories about how we might work.

Conclusions

As part of the incubation stage of our heuristic process (Moustakas, 1990), we read everything we could find on addicted health professionals and found that no or little help was available to them. This had been our experience in the UK to find help for Marius when he was practicing as Locum doctor prior to returning to SA. We decided that we would start a drug and alcohol rehabilitation clinic that would consider the unique needs of health professionals.

Michelle: "…there was a lot of negativity and stigma towards healthcare professionals who need help…so we thought we could create a safe place where they could come to and be with other healthcare professionals… because many of them don't want to go to mainstream services, because they don't want to come across their own patients or the stigma that's attached to that, or the real feelings of having let family down and friends down and patients

down, and it's awful….so that's how we said we'll make it bespoke and different…"

Albert:" I remember that both of us developed a lot of passion around this, it was not just a fleeting idea, we really wanted to make this happen."

Michelle: "Oh yes, people were saying…we were a bit nutty and, 'Oh, how are you going to do that?' and, 'How are you going to open a rehab, do you know how much trouble it is?' and all that. We were like, 'No, we're going to do it.'

Albert: "I remember that too, yes."

Michelle: "I think when you talk about the passion, it really geared me up to also finish my doctorate, because I think that after mum's suicide, I threw myself into my studies, but I really started to struggle. I got pregnant a month after mum's funeral, which was a nice surprise, a surprise, a shocking surprise, I was not at all ready for having a baby. You know, with pregnancy, that was a lot, I decided to keep the baby and there was a spirituality aspect to it for me, you know, sort of life having been taken away, I was given life. That helped me cope….I remember working every weekend, I had a nanny come three days a week, and every weekend we came to your place, and I was just…."

Albert: "In there"….

Michelle: Working to get my deadline, so that I could qualify. I said, 'Well, I need to be qualified in order to open up this rehab,' and it just gave me, I think, life. It just gave me drive, and I knew I could do it, you know, and we could do it together, no matter what people's doubts were that we're going to do it. "

Albert: "We thought we'd just start"

Michelle:" 'We'll just start….. there was so much involved in this process, and after I finished my thesis, then we were really able to start putting our ideas into it. We had to do a lot of groundwork I remember, and reading, and research, and the more we read, the more we knew what we needed to do, the more we thought, 'Shit, this is a lot of work, but we're going to do it,' we set our minds on it and… I think the two of us combined, there was no way we were going to not do it, despite the hard work. We just became so focussed on it. You went to America.."

Albert: That's right, I did…research, and looked at some really good places. You know, I always carried this idea, of creating a field of care, and we both agreed, because we felt it so strongly that there must be something -, I think also, in terms of what mum wanted to do, you know, a place where you're not lonely. A place where you're in a surrogate family, and where people take decisions together, and get empowered. Then, finding the staff that would be able to support all of that, to be in our philosophy of love and care and empowerment, and not have it as a commercial enterprise, but at the same time trying our damnedest to try and run it as a business, so that we could survive. So all of these things came together for us, and…"

Michelle: "Also the prevailing narrative at the time was… 'We'll break you down in order to build you back up again,' which was…very traumatising for people. We didn't agree with that, because that didn't go with our philosophy of love and care and compassion, and overcoming loneliness, which addiction feeds on."

Albert: "Yes, I think we both felt that the original…twelve step approach was a bit moralising, and I think we wanted people to take power back over their lives. And doing that in a way that our loved ones didn't get was it…, You know, we wanted a place where people can actually be in a surrogate family. I think, when we opened our doors, that it was the good feeling people had when they walked in, and people said so of course, and that's how they got better. I also remember the personal commitment that we put into it"

Michelle: "Oh my, yes!"

Comments

The above dialogue describes quite accurately what Moustakas (1990) formulates as the movement from "illumination", where we uncovered new meanings and essences about our topic to "explication" which

involved a period of nearly obsessive focus on our topic. It also constitutes a further development of our propositional knowing.

Actions

In the following excerpt we have moved to the phase of "creative synthesis" (Moustakas, 1990:32) "…where a comprehensive expression of the essences of the phenomenon investigated is realized". At the same time we moved to the last area of knowing, i.e. practical knowing – actually having the skill to put something into practice - and we would like to provide a flavour of the ways of working and the values and principles we developed in our conversations that informed the work at our clinic.

Albert:" …you had the clinical director role, and were actually designing the whole thing from a psychological perspective. We also both agreed that there was going to be a big spiritual component, I think about this often, I think the spiritual component wasn't teaching people spirituality, it was the way that we were with each other."

Michelle: "It's the principles, spiritual values that we tried to put across."

Albert: "Yes, and I'm wondering, if we look at it now, what was that like for us to work as a traumatised father and daughter team? I recall being very, very close to you, I recall being very respectful of you as a professional, and I recall being very proud of your willingness to, sort of, go into this adventure together with me. I recall very clearly that this was a thing that we both really wanted. I think that spirit… stayed throughout our venture with the clinic. I recall-, it's not things that we did, the best thing that sticks in my memory, is the spirit of love in the house, you know, and everybody contributed to that. What is your recollection?"

Michelle: "Yes, it's very similar. I mean, I know I had a lot of comments with people saying, 'What, you're going into work with your father, how is that?' You know, I was happy to be in there….You know, and I think we have mutual respect…You know, we had each other, that's what we had left as father and daughter, and it was that wanting to really strengthen that relationship through something like this, that would honour the memory of Marius and mum, that we could work side by side on this…I felt that this was right, on a feeling level…"

Albert: "I also think that in the build up to the opening of the clinic, I was able to be very honest with you about who I am…and what drives me. Also be vulnerable, you know… I think it's often thought that it's partly difficult, partly good to demystify your role as a parent… So I think there was a sense of: 'Yes, we're just two human beings.' Vulnerable, full of pain, full of trauma, and both, in a sense, partly orphaned, just wanting to get together and do this. I remember people saying to me, 'How can you work with your daughter, does she do what you say?' I said, 'It's not about that.' It was never about that, it was about finding a way, together, of making this work."

Michelle: "Yes, side by side."

Albert: Side by side. We had a superordinate goal…a bigger goal, and we

were both working for the bigger goal, rather than for our egos.

Michelle: "Exactly."

Comments

We knew that if we did not work with emotional and spiritual integrity, if we were to treat our clients as objects to be processed as quickly as possible, if our clinic was cut off from the community it was meant to serve, then we and our 'treatment facility' would not be a healing agent. We wanted to work with residents and staff holistically (including spiritually), build community inside and outside the workplace, provide relationally oriented care, and make decisions based on these values, not merely the potential for profit. We felt that deep and sustainable healing can only take place within a web of supportive and caring relationships - that is, within a community. True healers represent the community and life itself, conveying healing energy in sacred acts of service.

Final Reflections

Over the years we tried to remain open and curious about the impact of our experiences and our relationship on us as clinicians. We also reflected on the impact this dialogue had on us in the here and now.

Michelle: "Yes, because we had that… adult - adult relationship, you know, not parent, daughter… I never felt any kind of differential between us when we worked, it just flowed. There was a flow that I felt that we could do, and I think…"

Albert: "… it was the absence of a power differential."

Michelle: "Yes."

Albert:" I think there was that sense of flow. I remember we sometimes would look at each other, or not even look at each other, and that we just built on each other's work with the clients in the room and it just was easy actually."

Michelle: "Of course…..we were very reflective on the impact that that could have on our clients, we didn't just, kind of, put it under the carpet, because you can't ignore that kind of stuff, so-, but we managed it, we managed it well. Like you say, it was just… the constant awareness, and we would give feedback to each other."

Albert: "…we would take it as an opportunity really, to look at it and see what the impact is. I think that, for me personally, has been a great growth process. So I think, overall, in terms of a sense-making process, we understood what mum and Marius stood for. We looked at their compassion and their way of being in the world, and we just wanted to take it further. So what was it like to have this conversation for you, are you okay to finish here?"

Michelle: "Yes….I think it's good ….it was really reflective and…. I think, this conversation parallels the feelings we had at the time of it happening, so it was very painful, a lot of pain and sadness in connecting at the beginning, in real life at the time and in this conversation. Then, as it progressed, and we started talking about what led to the clinic, I felt a lift in me."

Albert: "Yes, I felt that too."

Michelle: "I felt my feelings lift, and I kind of… reconnected with that passion that helped us establish it in the first place. You know, talking about it and feeling more animated in my discussion."

Albert: "Feeling the joy of the whole enterprise, yes."

Michelle: "Feeling the joy, I think, you know, and I think it's okay to feel the sadness, and it's okay to reflect on that, fine, it's good to feel that, not to avoid it. I can see the difference in how I was at the start of this conversation and how I am now, and talking about it, that we, having established the community, you know, and how much it had meant to me and meant for us as a father, daughter team, really. It's almost like a, as you have described as well, like a healing-, it's healing journey, it's a journey that we have been through, that helped us with our healing in the process of helping others."

Albert: "Right, yes, and I agree with you, I also had the sense-, I was very, very emotional at the beginning, and very pained at everything. You know, as we reconnected with the sense making, it felt like a parallel process, what happened then happened now, so I fully agree with you. At the moment I'm okay to finish the conversation here, because I'm actually in pretty good shape now, I'm thinking, 'Yes, this was good.' It was a very healing conversation, so thank you very much."

Michelle: "Thank you."

Reflections on the Process of Writing

How do you write up a process that is essentially messy, emotional and convoluted. Although our dialogue may create a possible impression of organised linearity, the actual process was characterised by many reflective cycles, periods of stuckness, sense making of the stuckness and transforming the experience into further learning. West (2001:129) points out that heuristic research "is not necessarily a linear process and certainly does not constitute a rigid framework" and Moustakas (1990:44) reminds us that: "…every method or procedure, however, must relate back to the question and

facilitate collection of data that will disclose the nature, meaning, and essence of the phenomenon being investigated". We felt that our use of co-operative inquiry and heuristic research was in line with the above statements.

Why did we do it?

As therapists, we wanted to focus on the wholeness of our experience rather than only on its constituent parts. We felt that writing up our lived experience and making sense of the process at the same time would lend at least a small measure of support to John Heron's call for a paradigm shift in research reporting: "The purpose of such reports is exhortatory: to point a way, suggest a method, evoke and portray a competence and how to exercise it, and so to inspire and invite readers to inquire into their own transformation and concomitant skills. Thereby, of course, readers who become active co- inquirers will also unveil a revisioned universe within which these outcomes are manifest" (Heron, 2000).

Implications for our Practice as Therapists

John Heron (2000) identifies two primary outcomes as a result of the co- operative inquiry process:

1. Transformations of personal being brought about by the inquiry, which are inseparable from
2. Transformative skills, the practical knowing-how involved in the domain of practice that is the focus of the inquiry.

Transformation of being: presence – as a result of our co-operative project we experienced deep connections between our personal learning and our being-in-the-world and how we are now different in the world. We experienced a very potent change within ourselves and became aware of our, often radical, impact on others. Through our work and the on-going process of reflective practice we were able to develop a heightened sense of empathy with our residents, which led to a deeper understanding of where our residents were in their process. At the same time, our self-awareness as well as our cultural and contextual sensitivity increased.

Transformation of skill: practice – as practitioners we experienced a great shift in the way we were able to present ourselves and our work. We developed an active anti-oppressive stance, especially against the backdrop of the potentially subconscious impact of having lived under the apartheid regime in South Africa. We promoted diversity in our staff group and reached out to GLB and other minorities. Community discussions and practices were inclusive of all spiritual traditions and we carefully avoided the emergence of one dominant discourse – even in 12 steps. We had developed the ability to stand back from our experience and look upon it with critical subjectivity.

We carefully developed the use of therapeutic disclosure to our residents. In the entrance hall of the clinic we placed a picture of Marius and Petro with a commemorative plaque, conveying the message to our residents of our real experience of loss related to drug and alcohol addiction. It also served as an inspiration for the whole community – their death was not in vain. To quote one of our residents: "If it was not for Marius, I would not have had my life back."

At the same time we were mindful that residents might want to take care of us. We held our principles of a modified democratic therapeutic community with strong internal boundaries and were deeply guided by our love for residents.

And finally we became able to contain vast amounts of distress exhibited by our residents. We grew more aware of own clinical intuition, yet remained reflectively critical and conscious of working within the limits of our capability.

Our continuing reflective process consistently informed the way we worked with our residents and helped us, as a community, to achieve some of the best recovery rates in the UK.

Where are we now?

Just before we expanded the client target group due to funding cuts and demand from non-health care professionals, Michelle had a second child. The boy had health problems demanding constant care and we decided to meet once again to check

where we were in our process. We asked ourselves the question if – given the emerging context - we were the right people to sustain the therapeutic community in the long term.

Together we decided that we had achieved our 'survivor mission' and that it would make sense to pass on our work to people who could move it into a new era with a new remit – a wider population should have access to high quality therapeutic programme.

On 6 October 2012 we delivered a joint talk on our experience of bereavement and our survivor mission at the annual DrugFam conference. DrugFam is a charity supporting families bereaved by addiction. This talk presented the opportunity for further reflection, a proper ending and letting go of our clinic and sharing our experience in a way that could be helpful to the delegates in their own bereavement process.

We had a thirty minutes to deliver our talk to nearly a hundred delegates. Inspired by our reflective dialogue we spoke about the impact our traumatic bereavements have had on us, how we had learnt to cope with the pain and how we had channelled our suffering into growth to develop our 'survivor mission'. We also spoke about the process of moving on from the clinic and handing it over to investors who could ensure its future sustainability. We ended with talking about letting go and focusing on different projects i.e. for Albert it is working as a psychotherapist in private practice and being a dedicated grandfather and for Michelle it is combining part-time private practice as a Counselling Psychologist with being available emotionally, spiritually and physically to her young children.

The talk was a cathartic emotional process and reflecting on the talk afterwards we shared feelings of sadness, hope and joy and concluded that this talk represented the final sense-making process of our entire experience. It culminated in a deeper acceptance and a fuller realization of being able to live with the trauma and move on to other fulfilling and meaningful activities in which we can celebrate the memory Marius and Petro in a daily lived experience. Delegates came to us afterwards and thanked us for giving them hope, enabling them to cry, and others thanked us for feeling permission to let go of their preoccupation and guilt and move on.

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João Pereira

Integrative Attempts: A Relational Model of Psychotherapy Integration

Editor's Note

This material constitutes the theoretical section of a case study submitted to meet part of the requirements of the Doctorate in Counselling Psychology and Psychotherapy at Metanoia Institute. The student is required to give his own framework for integrative practice.

Abstract

As a student of integrative psychotherapy at Metanoia I was encouraged to formulate my own model integration. In the present paper I describe my overall framework for practice, reporting on the main theoretical influences that shape the way I conceptualize clinical problems and the development of the psychotherapeutic process. This model is grounded by personal values and philosophical assumptions and a particular bias towards the therapeutic relationship as the healing factor.

> *I'm not thinking but, my mind is full of thoughts.*
> *I'm not dreaming, but not awake.*
> *Not listening, but church bells ring.*
> *My mouth's not dry, my cheeks aren't wet.*
> *Memories I can't forget.*
> *I am not here, but nowhere else*

Dichotomy, by Liv Biggar

> *Don't get involved in partial problems, but always take flight to where there is a free view over the whole single great problem, even if this view is still not a clear one.*

Ludwig Wittgenstein

> *What children can do with the assistance of others might be in some sense even more indicative of their mental development than what they can do alone.*

L. S. Vygotsky

> *Development, according to a well-known definition, is precisely the struggle of opposites.*

L. S. Vygotsky

> *Knowledge, after all, is justified belief.*

Jerome Bruner

Introduction

My view of psychological therapy has a strong relational basis. The relationship is so fundamental that I could not simply name it an integrative framework. This is the ground from where everything else emerges, and it is in the interface of two different selves that new meanings and possibilities are co-created. From here I then move in and out of different theories and techniques, making intentional use of my self and my capacity for empathic immersion (Kohut, 1971) to perceive the client's complex psychological configurations. I resort to my internal supervisor (Casement, 1991), as well as

formal supervision arrangements, to help me reflect on my levels of affect attunement (Stern, 1985), which occur largely out of awareness and automatically. This helps me being-with my client, in the service of his/her goals.

Of paramount importance to my way of working is the attempt to maintain a reflexive stance that can be of use to my client's self-awareness and transformation (metanoia). My reflections, however, are only useful if I am able to understand my self and my reactions; for this process I see personal therapy as fundamental and I certainly gained in self-awareness and sensitivity to unconscious communication in over 10 years of my own therapy.

I draw on humanistic psychology and the various schools of existential psychotherapy for my understanding of the co-created nature of the psychotherapeutic relationship and the embeddedness of human life in the physical, social and political worlds. Whilst I value a humanistic way-of-being-with-clients, with a particular ground in respect and humility, I see a number of limitations in this tradition vis-à-vis their understanding of the psyche and human personality.

Psychoanalytic developmental psychology and phenomenological inquiry are the theoretical foundations of my work. They offer me richer accounts of the complex dynamics of human relationships, counterbalancing the above limitations. My attempt is to integrate aspects of humanistic, existential and psychoanalytic modalities into an epistemologically coherent framework. Despite some antagonistic ideas and concepts, they can still be used integratively if the practitioner is able to tolerate uncertainty and hold polarities that can ultimately become useful in different ways and at different times. I situate myself closer to the relational psychoanalytic turn which has achieved some sort of integration between psychoanalytic theories and the phenomenological-existential tradition (Stolorow, 2011; Mitchell, 1996; Mills, 2005).

Although I am not a cognitive-behavioural therapist (in its pure form), I think it is impossible not to bring cognitive and behavioural elements into any form of psychotherapy. Mentalization-based-therapy, one of my strong influences, is highly influenced by cognitive and behavioural theories.

During this chapter, I will describe my overall framework for practice. The use of the term "psychological therapy" will invariably stand for individual work undertaken with adults as both a counselling psychologist and a psychotherapist.

Values and Philosphical Assumptions

The values and philosophical assumptions that inform my work with clients are no different from the ones that inform all my relationships. There is, however, a role that is assigned to me when working with clients; there is a setting, a context and a therapeutic frame that will make this form of relationship different from others. I assume the role of psychological therapist consciously, aware also of the unconscious dynamics that underlie the performing of roles (Goffman, 1959). I cannot forget the power encompassed in assuming this role, under the umbrella of an organization (NHS) and sheltered by professional bodies like the BPS or UKCP. In a Foucauldian sense, I carry the power-knowledge of these institutions and the discourse of mental illness (Foucault, 1972; 1975).

It is vital that the therapist does not forget these principles, or the risk of becoming a friend, a relative, a lover, or some other sort of unbounded companion is vast and potentially destructive. Despite the above forewarning I am still, when practising, a human-being-with-another-human-being. As a person, I endeavour to relate with respect, assuming what I believe to be an inescapable responsibility for my own actions and choices (Sartre, 1992). I am curious about other people's motivations, feelings and intentionality. I value their autonomy and take pleasure in observing hidden potential being unravelled. This personal gratification, however, is not the aim but the result of a relational process where I allow myself to be moved and impacted by the growth of the client. It is only through being involved and encouraging my client's involvement that I can truly be present to discover the client's being (Heidegger, 1962). Simultaneously, I recognize the complex nature of human beings by taking a position of humility and inquiry (Pereira, 2010). My

foundation is one of non-voyeuristic curiosity - not knowing but interested in finding out.

My overall epistemology is grounded in a phenomenological attitude (Heidegger, 1962). I believe, however, that I will never achieve full knowledge of the world or the entities I encounter. This belief, grounded in Kant's (1724-1804) philosophy, sits between a post-Cartesian (postmodern) view of the world and the anti-postmodern position defended by contemporary philosophers such as Alain Badiou:

The announcement of the 'End of the Grand Narratives' is as immodest as the Grand Narrative itself (Badiou, 1989, p.31).

This means that my way of thinking is only partially postmodern, by not subscribing to dogmas or absolute truths; however, I do not go thus far as to say there are no truths out there. As the anti-postmodernists, I believe in the truthfulness of an event (Badiou, 1989), like a moment of passion or an intersubjective moment in psychotherapy.

I am also indivisible from contextual and field conditions. I am aware that the meanings I assign to objects and subjects in the world are deeply influenced by the norms, values and pressures of the surrounding culture and society. Knowledge and meaning are, therefore, socially constructed.

Finally, I wish to say a word about common sense. I start from a position where the intentional use of the self, gut reactions and intuition - bounded by thought and reflexivity - are fundamental (Shaw, 2003). This way of practising is reflected in the relational turn in psychotherapy (Mitchell, 1996) and the questioning of classic premises such as neutrality, anonymity and abstinence, thus trying to resuscitate the person of the psychotherapist in the consulting room.

Concepts and Approaches Informing My Framework

Theories of the Self

There are numerous views of the self according to different psychotherapy traditions. From the position of some existential psychotherapists who believe there is no self but only self-in-relationship:

> *There is no essential self, as I define my personality and abilities in action and in relation to my environment. (…) the existential view is that self is relationship and process – not an entity or substance (Van-Deurzen, 1989, p.188)*

To the notion of self-concept in person-centred theory that admits the existence of self as entity, despite its changing and fluid nature:

> *(…) It is a gestalt which is available to awareness though not necessarily in awareness. It is a fluid and changing gestalt, a process, but at any given moment it is a specific entity. (Rogers, 1959, p.194)*

In the other extreme, there are classic psychoanalytic formulations that see the self as a rigid structure unable to escape certain developmental arrests or fixations. The self is seen not just as a discrete entity but as one that goes through Universal stages (e.g. Freud's psychosexual stages of development; oedipal complex; Klein's paranoid and depressive positions).

Whilst I see merit in some of the above views I see them as unnecessarily dichotomised. Language is an activity where words merge with one another in a fuzzy way (Wittgenstein, 1953). Consequently, attempting to describe experience in neatly organized concepts becomes, in itself, problematic.

I take, therefore, an integrated, non-dichotomized and less precise view of the self. I see it as both created and transformed in-relation and as an entity that is structured through the genes and the environment. I aim to make this view more evident throughout the rest of this paper.

Developmental Considerations

I am influenced by Bowlby's (1979; 1998) work on attachment, as well as further developments in affective neuroscience and regulation theory (Cozolino, 2010; Siegel, 1999; Schore, 1994). There is now considerable evidence to demonstrate that the right hemisphere in the human brain is the repository of Bowlby's unconscious internal working models (Henry, 1993; Schore, 1994, 2000b; Siegel, 1999). Infant studies and neurobiology have unequivocally shown that early attachment plays a crucial role in the crystallization of relational patterns, personality, and the ability to manage the complexities of human existence within a healthy range of responses.

Stern (1985) was instrumental in the onset of layered models of self development, contrasting with stage models like the Freudian psychosexual stages or the Piagetian stages of cognitive development. It is clear that there is a self in Stern's (1985) position, and that relational experiences are organized toward a sense of the self as a discrete entity (Balswick, King and Reimer, 2005); something that continues to exist, along the lines of the Winnicottian sense of "going-on-being" (Winnicott, 1956).

Stern (1985) defines four different senses of self: the emergent self, the core self, the intersubjective self and the verbal self. Each new sense of self is added to the previous one but does not replace it. In his later adaptation of the Interpersonal World of the Infant (2003) he concluded that some of these are already operating from birth! Stern (1985, 2003) added and, to some extent, transformed, the classic separation/individuation theory in saying that there is also an attempt of connecting, sharing and even merging with the leaps in development. I agree that attempts of separation and connection occur concurrently at any given time. Stern's (1985, 2003) findings were revolutionary but are now generically accepted in the world of developmental psychology, despite the understandable controversy within classic object relations theorists:

> *(…) internal objects are constructed from repeated, relatively small interactive patterns derived from the microanalytic perspective. Such internal objects are not people; nor are they parts or aspects of others. Rather, they are constructed from the patterned experience of self in interaction with another: What is inside (i.e., represented internally) comprises interactive experiences. (Stern, 2003, introduction XV)*

Stern (1985) initially named these internal objects as representations of interactions that become generalized (RIGs), changing later to ways-of-being-with (Stern, 2003) to emphasize this lived phenomenon in a more experience-near way.

Also significant in the shaping of my model of psychological therapy is the evidence for intersubjective relatedness discovered through research undertaken with infants (Trevarthen and Hubley, 1978; Stern, 1985). Concepts such as affect attunement (Stern, 1985) effected significant changes in the way I understood previous notions such as mirroring or echoing (Mahler, Pine and Bergman, 1975; Kohut 1977; Lacan, 1977) as well as adding important nuances to my idea of empathy, since it occurs largely out of awareness. I could now prove what common sense was already telling me: that being met and seen by another is paramount for a healthy development. It is important, nonetheless, that the mental state of the infant (patient) is not simply matched or imitated by the caregiver (therapist) but transformed and digested someway, before being returned. Much in the lines of Bion's (1984) notion of containment, where the mother bears the uncontainable affects of her baby and, through her reverie, detoxifies and transforms the affects into a form that allows the infant to reintroject and tolerate them. This notion has been operationalized in research with infants and developed into what Fonagy, Gergely, Jurist and Target (2002) named contingent marked mirroring. The infant learns about himself through the other but also needs to learn that he/she is not the other, since this fusion could be experienced as threatening or flooding, leading potentially to a psychotic personality organization (Kernberg, 1994).

This intimate process connects attachment with self-regulation, enabling the infant to soothe much more rapidly and to develop a second-order symbolic representational system for his mind states (Bateman and Fonagy, 2006). With the above in mind I started to

integrate mentalizing into my integrative lens. Mentalizing – implicitly or explicitly interpreting the actions of oneself and other as meaningful on the basis of intentional mental states - emerges from the attachment relationship and intersubjectivity but it is also more than that. It stems from Fonagy's (2003) definition of the Interpersonal Interpretive Mechanism (IIM), requiring a verbal and cognitive component, the abstraction of thinking about thinking, rather than just sharing of mental states. The acquisition and use of language comes as a double-edged sword: it is both an opportunity for richer levels of communication and, at the same time, a distantiation from the real and the other senses of self (Stern, 1985; Verhaeghe, 2004).

Through my clinical practice, I became gradually aligned with the relational turn. I do not, however, privilege the relational field over and above the individual, which I find a dichotomized and bizarre position to take (Mills, 2005). Earlier views on drive-theory, object-relations and/or self-psychology are still useful ways of understanding the two individuals in the dyad. This was my starting point and I still see it as the foundation of my present two-person psychology model. You need to have an internal world before any inter-subjectivity is created, even if, paradoxically, this internal world is created (parent) and modified (therapist) through intersubjective relatedness. In other words, you need two different minds for the co-creation of an intersubjective moment (the co-creation of a third, shared, meaning and space). This is comparable to Spinelli's (1994, p.294) existential-phenomenological standpoint:

> *Each of us is alone in our experience of reality (intrapsychic). And yet, paradoxically, this "aloneness" emerges precisely because we are in relation to one another (inter-subjective) (my parentheses)*

I disagree with Spinelli however, since I see the separateness of self and other as useful. This is crucial in the process of contingent marked mirroring, an important foundation for affect regulation and the development of the self (Fonagy, et al., 2002). It is in this sense that I also view the self as some form of autobiographical entity (Damasio, 1999). This is the intra-psychic and embodied sense of each person, the relation of self-to-self (Gilbert and Orlans, 2008).

Not disregarding the relational field, I continue to make use of intrapsychic theories as in the following formulation of borderline psychopathology (Bergeret, 1996): a structural conflict between ego-ideal vs. id and reality; anaclitic form of object relations, meaning a helpless, hopeless attitude of expecting the other to carry you, as a baby does; losing the object or fear of abandonment as the overall nature of anxiety (angst); splitting and projection as the major defence mechanisms.

It is through my interventions and my presence, rather than my detachment, that the above intrapsychic structure becomes evident. I take full part in this transformational process, giving magnitude to being a 'self-regulating other' (Stern, 1985), in helping the patient regulate affective states.

The Here-and-Now

The above views on development are only important if brought intentionally to the consulting room as a way of understanding the present. This means I work explicitly with the relationship. The implicit procedural/emotional mode of processing (Beebe and Lachmann, 2003) arising from the moment-to-moment inter-relatedness of two developmental histories gains in importance if the therapist makes explicit use of his observation and reflexive capacity to bring these relational patterns to the foreground of exploration. This awareness of the implicit (mostly non-verbal) dimension can also be used in the service of self-and-other affect regulation within the therapeutic dyad. However, as Beebe and Lachmann (2003) point out, therapeutic action can occur in the implicit mode without ever being translated into words. This notion, which I support, has obvious implications to psychoanalysis and Freud's classical statement 'where id was ego shall be' (Freud, 1933, p.80).

Since I see myself as an active participant, instead of Bowlby's (1979) Internal Working Models (IWM) of attachment, I am more inclined towards Stern's (2003) ways-of-being-with or Fonagy's (2003) theory of the

Interpersonal Interpretative Mechanism (IIM) that precedes mentalization. Whilst the IWM are primarily concerned with the regulation of secure attachment states, ways-of-being-with 'embody expectations about any and all interactions that can result in mutually created alterations in self-experience'; ways-of-being-with are 'conceived in terms of episodic memory, lending themselves better to the affective nature of being with others' (Stern, 2003, p.115), whilst the IWM is conceived in highly cognitive terms. Fonagy's (2003) IIM also diverge from the IWM. It does not contain representations of experiences, and is not a repository of personal encounters with the caregiver, as in Stern's (1985) RIG's. Rather, it is a mechanism for processing new experiences.

Despite different nuances all the models subscribe to the importance of the present moment in psychological therapy (Stern, 2004). Rather than focusing on the past, I prefer to maintain the focus in the present, exploring the client's current difficulties and how they relate to the therapeutic dyad. I may need to go back then (in the past) occasionally to increase the awareness of what happens out there (in the world) and in here (between me and the client); the establishment of a triangular connection would represent a full transference interpretation (Jacobs, 1989).

Freudian psychoanalysis is still grounding my work. However, I disagree with the view that the focus of this therapy is exclusively on the client's intrapsychic world. Transference interpretations, for example, are undertaken relationally, using the triangular aspect described above. What makes Freudian analysis a one-person psychology model is that the relational aspects of the therapy are used to understand the intrapsychic world of the client, being the main focus to bring internal conflict to awareness. Whilst in Freudian therapy the relationship is a vehicle for change, by bringing insight into the internal world of the patient, in contemporary relational models the relationship is the therapy. The goal is not solely to bring insight into unconscious conflict but to interactively learn to regulate emotions, to internalize security, or to discover the true self through the marked reflections of the therapist (parent). This could eventually happen in one-person psychology models but it is not an explicit aim.

The Influence of Transference

A central aspect in my integrative map is the concept of transference. This idea of repetition or of a displacement of reactions originating in regard to significant persons in early childhood (Greenson, 1965) became the cornerstone of psychoanalysis and has influenced almost every other approach to psychological therapy. The notion of transference is vital to my framework; it is the way I work with it that differs from its classical application. For the transference to emerge, I do not think it is imperative to maintain the same 'evenly-suspended attention' in the face of all that one hears (Freud, 1912). It is true that one may lose the capacity to see it operating by being too active. Nonetheless, transference occurs anyway, regardless of the level of directiveness of the therapist; the crucial aspect is self-reflexivity and the ability of the therapist to observe his role in the co-creation of transferential enactments. Transference and/or countertransference occur in the interaction, resembling a back and forward dance, within a process of reciprocal mutual influence (Stolorow and Atwood, 1992). That is why I prefer the term enactment as it encapsulates better the idea of a co-created event, although I see certain transferential aspects as the sole creation of the therapist or client, a view shared with others (Bateman and Fonagy, 2011; Mills, 2005).

Theory of Human Beings Underlying Problem Formulation

Contextual and Field Conditions

Despite having psychology as a focus, I attempt to understand every human being from a multiplicity of perspectives, aware of cultural, socio-political, biological and genetic influences.

The (co)creation and (co)identification of meaning is central in psychological therapies. Having meaning as the focus of psychology will inevitably transform psychology into a cultural psychology (Bruner, 1990). Bruner (1990, p.45) proposes the use of the term folk psychology to describe one of the most powerful instruments of every culture:

"Folk psychology" is the system through which people organize their experience in the social world, their knowledge about it, and their transactions within it.

According to Brunner (1990), we learn the folk psychology of our culture in the same way we learn to speak our language. When people go to the post office they behave in a way appropriate to the post office. I relate this concept with Lyons-Ruth (1998) 'implicit relational knowing': knowing how to proceed in social, particularly intimate, interactions.

Biology, neurobiology and genetics give us potency and limitations simultaneously. Culture can transcend biology by giving us the capacity to fly, to extend our memory (e.g. through computers) or to overcome disease. On the other hand, we all eat, defecate, and die. These common aspects of human beings are sometimes avoided, more or less intentionally, as they remind us of our animal nature and our limitations (Morris, 1967).

I see the liberal capitalist societies we live in (particularly in the West) as playing a substantial role in, for example, the necessity to repress our own biological nature. We live in a hasty, purchasing, instant gratifying society where being clean and fashionable is more important than, for instance, being old and wise. Rituals, institutions and traditions lost visibility and, perhaps not coincidently, unstructured personalities - the way Begeret (1996) defines the borderline - are on the rise. Society shapes psychopathology in many ways; if hysteria and neurosis were the main problems in the beginning of the 20th century, borderline pathologies are the reflection of the modern world. Johnson (1994), following a similar line of thought, believes that the vulnerability of the nuclear family in our highly mobile industrialized culture is largely responsible for the predominance of both schizoid and oral issues in psychotherapy clients. The impact of the socio-political sphere in psychopathology was also described, perhaps more radically, by Laing, Foucault and others in the anti-psychiatry movement that emerged in the 1960's.

In this complex amalgamation of influences it is a difficult task to understand what motivates people…

Motivation

I would like to start from Freud (1901) and the idea of unconscious motivation– the idea that the things we do, the symptoms we suffer or the dreams we dream, have causes that come from our minds, but of which we are unaware. According to Freud (1901) many of our dreams, neurotic symptoms or slips of the tongue are disguised or symbolic expressions of wishes. Freud's view was that behaviour is activated by biological energy, which he called libido. The source of drive is biological tension and its aim is the relief of tension. Since Freud (1920) assumed that relief from tension is pleasurable, he named it the pleasure principle.

I agree with Freud's ideas and cannot imagine a relational field theory where drives are no longer acknowledged as the basic constituents of psychic activity (Mills, 2005). I attempt to hold different positions view rather than dogmatically dichotomize problems; accordingly, I also see Maslow's (1954) basic needs hierarchy as a useful way of understanding human motivation. I think, nonetheless, that we do not satisfy one need at a time and in a specific order; they all influence our behaviour concurrently, becoming more or less figural depending on our circumstance.

Subsequent psychoanalytic theories added important nuances in the understanding of human motivation. Lichtenberg, Lachmann and Fosshage (2001), for example, suggest different motivational systems, each of which is linked to a fundamental need of the developing child: regulation of physiological requirements; attachment and affiliation; exploration and assertion; aversive antagonism or withdrawal; sensual enjoyment and sexual excitement. Ego-psychology, object relations theory and self-psychology put focus on different aspects, respectively, mastery and adaptation, relationship seeking and fine tuning of self-states. They all stress the need of the individual to cling to familiar patterns, even if these are dysfunctional.

Existentially, human beings engage in meaningful behaviour and they do so in order to organize their universe. Intentionality and meaning are inherent in most human behaviour, being expressed in direct and

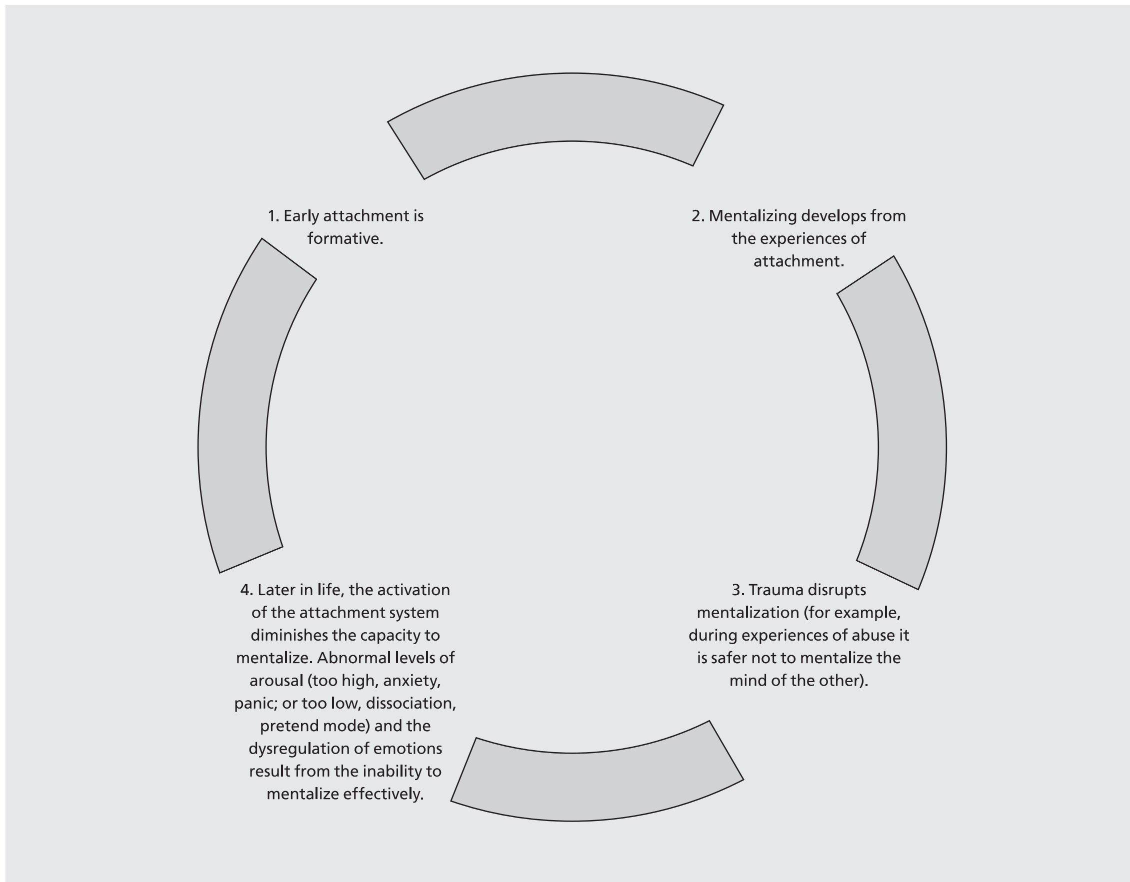

Figure 1: The Mentalization Model

indirect ways; many times we convey what we mean not by what we say but by what we do, wear or eat (Hendry & Watson, 2001).

I draw on the above theories since they allow me to make sense of a complex topic from a multiplicity of perspectives.

Function and Dysfunction

It seems clear thus far that early development and the experiences of attachment will have a decisive impact on the emotional well being of the adult. Behavioural problems in children and adolescents that lacked adequate care have been observed for years. With the help of neurobiological research we can now see how these suboptimal attachment experiences impact the development of the brain. Not discarding previous theories of psychopathology (e.g. Kraepelin, Freud or Jaspers) these studies revealed important processes within this intimate dyad, creating such concepts as affect attunement and regulation.

According to Stolorow and Atwood (1992) early developmental trauma is the result of a breakdown of the child-caregiver system of mutual regulation, a system that operates mostly out of awareness and non-verbally. Early affective experiences are greatly based on physical sensations rather than psychologically elaborated feelings. At this early stage, affect attunement is communicated mainly via sensorimotor contacts with the infant's body; early interactions, such as the handling and holding of the child's body become paramount in the development of a healthy or unhealthy self (Stolorow and Atwood, 1992). If this mutual regulation system is not grossly affected, the child's potential to successfully negotiate future relationships is secured (Schore, 1994)

One key aspect to this co-regulatory system is the caregiver's mentalizing capacity or, in other words, the ability to monitor and regulate her own affect, especially negative affect. Experiences of trauma in the caregiver can greatly impair this process (Truman,

Levy, Mayes and Slade, 2002) resulting in the perpetuation of pathology through generations.

The availability and interest of the caregiver will generate a feeling of companionship in the infant, and of not being alone, even in the absence of the other since a sense of security will be internalized. However, ruptures in empathy and responsiveness are unavoidable and, according to Kohut (1971; 1977), even essential, as certain levels of optimal frustration are vital for the self to grow. As follows, it is not the ruptures themselves but the inability of the caregiver (therapist) to repair them that is imperative.

I often use the mentalization model (Bateman and Fonagy, 2006) to understand borderline personality disorder (BPD):

Emotional regulation, according to Bateman and Fonagy (2006) is secondary to a mentalizing problem. Other authors, like Schore (1994) or Siegel (1999) see emotional regulation or dysregulation as the primary problem. I prefer to take a multifaceted view, where both positions are useful, rather than choosing a singular route of linear causality.

Taking this profound and delicate co-regulation system as the base of my understanding of function and dysfunction I then make use of a number of different theories that, in one way or another, attempt to explain the adaptations that result from the failures of this system – for example, potential traumatic "impingements" (Winnicott, 1960), developmental derailments or arrests (Masterson, 1981) or even Oedipal problems can be conceptualized as arising from failures in affect attunement.

Psychopathology

I am grounded in the above causal factors when understanding psychopathology and I use the DSM-IV-TR (2000) as an aid to map the patient's problems. My overarching principle when attempting to establish a diagnosis is, however, guided by authors such as Bergeret (1996), Kernberg (1994) and Varughese (2004). I divide the pathologies according to the personality structure into neurotic, psychotic or borderline (unstructured). The way I distinguish between different structures of personality and its possible decompensation into pathology is based on the understanding of the primary mechanisms of defence used; the kind of structural conflict; the contact style or object relation type and the nature of anxiety (angst).

Even if many of these models were construed in the premises of instinctual-drive derivatives, ego-function or self-and-object representations, they can also be used under the overarching theme of attunement, misattunements and repair.

In order for the above intrapsychic structure to become evident I pay attention to the client's history, existential issues, and cultural influences. I look for the possible contribution of trauma and early relationships for the current problems; I take into consideration the present context of the patient's life as well as socio-political influences. Issues of sexuality, gender identity and the client's relational style will form an impression on me (counter-transference) that is also invaluable to understand the client's presentation.

In addition to this overall view, I rely on a number of models of psychopathology that I find helpful for its integrative vision. Johnson's (1994) characterological-developmental theory is a good example, since it is grounded in psychoanalytic developmental psychology – an umbrella label for object relations, self and ego psychology – but seeking to incorporate the more active and engaging interventions of gestalt and bioenergetic therapy, as well as cognitive or behavioural procedures.

According to Johnson (1994), personality and psychopathology develop in particular constellations as a consequence of the interaction of a range of instinctual needs of the person and the environment's ability or inability to respond appropriately to them. These instinctual needs go well beyond those postulated by Freud and include the infant's needs I described earlier (e.g. attachment, individuation, self-determined expression and the need for an attuned-other). Responses to environmental frustration will be framed in varied adjustment-manoeuvres that will be more or less successful or adaptive. Different character structures will result from this

interaction and are seen in a continuum from character style to personality disorder.

I am also informed by Benjamin's (2003) Structural Analysis of Social Behaviour (SASB). This approach adds value to the DSM criteria by specifying a particular interpersonal context for each of the symptoms defining the respective personality disorder. The Masterson's approach (e.g. Masterson, 1981) is also helpful by providing maps of the split object relations units for the different personality disorders.

My attempt is not to fit the client into the different classification systems or models but to use them to add explanation to my phenomenological descriptions. Overall, I presume that interaction makes personality and produces psychopathology (Johnson, 1994). People's problems are, in a way or another, always relational, be this with themselves, others or the world.

Process of Psychological Therapy

From having practiced a number of different models I conclude that the effectiveness of therapy is dependent mostly on common elements, rather than specific techniques. These are thought to play only about 15% of influence, a position reflected in the common factors movement (Imel and Wampold, 2008). The person of the therapist is probably the most important factor to consider and, thus, the way I am with my clients will be determinant. The process of therapy will also vary according to the context and duration of therapy.

The Relationship

I do not focus specifically on any particular aspect of the relationship, be it the transference (the focus of many psychodynamic models), the real and co-constructed relationship (used in many existential approaches), or the transpersonal aspects of the relationship (the focus of transpersonal psychotherapy). It is in this sense that I find Clarkson's (1995) ideas useful, where different forms of relationship are thought to occur concurrently in the process of therapy. I start by attempting to build a working alliance with the patient and to establish trust (in some occasions, this may be all the work that is possible). I find Bordin's (1979) bond, tasks and goals a useful way of thinking about the working alliance, whether these are implicit or explicit.

Transference/countertransference will develop throughout the therapy and are particularly evident and useful in therapy of longer duration. It may be possible to use transference tracers (Bateman and Fonagy, 2006) in short-term therapy but it would not be wise to attempt to make full transference interpretations before having a good understanding of the client, which is usually only possible in longer forms of therapy.

Clarkson (1995) also defines the real relationship or the person-to-person relationship. I agree with this point and believe that some authors have gone too far (e.g. Kahn, 2002) in affirming that transference represents all reactions. Surely every human reaction is embedded in a frame of reference that was built overtime, with special emphasis on the infancy. However, as Sandler, Dare and Holder (1992) suggest, not all reactions contain colourings from the past or represent a re-enactment of the past. I acknowledge the difficulty to distinguish between what is real and what is transference but that is why psychotherapy should be a collaborative endeavour and a journey of discovery.

I often witness my involvement in what Clarkson (1995) defines as the reparative (or developmentally needed) relationship. I feel it is paramount to model a secure attachment figure, particularly when problems are deeply rooted, like in borderline pathologies. In here, I also assume that I will be subject to what Kohut (1971; 1977) named self-object transferences by being available for idealization, mirroring and twinship.

I also pay attention to the transpersonal relationship and to spiritual and contextual elements that shape the therapeutic dyad. These relationship components operate simultaneously and my only purpose was to increase clarity.

Process of Therapy Overtime

Thorne (1989), taking a person-centred perspective, described three distinct phases that would characterize effective therapy: establishment of trust; development of intimacy; and increasing mutuality between therapist and client. This resembles what happens in psychodynamic therapy, particularly relating to the development of the transference overtime. I often feel that patients move from an initial positive transference to a stage where their major conflicts become manifest in the therapeutic space - transference neurosis. Working through this phase under the integrative map described would eventually move the therapeutic process to a stage where I am seen as more real and human, as someone with virtues and imperfections as everyone else. This 'second stage' is dependent, to some extent, on the capacity of the therapist for intimacy and to hate and be hated, as Winnicott (1975) so eloquently stated. For therapeutic movement to occur, the therapist must renounce from the position of permanent good object. This is not, in any sense, an easy task, and I find the use of supervision invaluable to help me move through this process.

The assessment of the client should be a continuous process that evolves and changes overtime. In short-term therapy I pay special attention to the first session as a problem formulation needs to be conceptualized early. I always see endings as crucial and more so with clients that have a history of abandonment (Masterson, 1981). In time-limited therapy, even of long duration, I have seen benefits in setting a final date from the start, which allows for working on issues of loss and dependency since the beginning of therapy.

Process of Change

This is a controversial area that stimulated discussion ever since psychological therapy was invented. What is it that makes people change? What are the ingredients of change in the different forms of therapy?

The process of change cannot be explained by one single approach. I endeavour, in a person-centred manner, to create certain

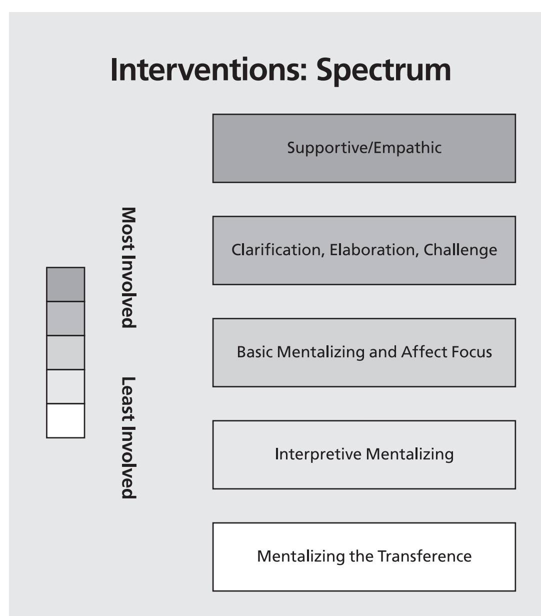

Figure 2: The Five Stages

conditions to facilitate change. Empathy, unconditional positive regard and congruence, as defined by Rogers (1957), would be necessary to unravel the inherent potential of the person or, in other words, the self-actualizing tendency that everyone possesses. I am sceptical, however, that all of the six conditions advocated by Rogers (1957) are possible to achieve. He was indeed unhappy with the term unconditional positive regard:

> *The phrase "unconditional positive regard" may be an unfortunate one (…). Completely unconditional positive regard would never exist except in theory. Rogers (1957, p.97)*

In this way, I think that some Rogerian therapists went further than Rogers himself intended to. The above conditions are, in my judgment, insufficient to achieve change. I feel that repetitive patterns must come to light and for this to happen some interpretative methods may be necessary. I see, therefore, the notion of transference cure (Freud, 1913) as useful but also not as the sole ingredient for change. Interpretations of the transference would serve the purpose of insight and change would occur in the process of working through.

Integrating these two perspectives, I would formulate the process of change as something intrinsic from the relationship with the therapist: a sort of a Rogerian stance, together

with the therapist's interest and curiosity, will engender a safe attachment relationship and a platform where the transference can be safely explored. By internalizing the safety of this relationship, sometimes the first one ever, the patient may be able to form other meaningful and safe relationships out there. In this process the therapist will also facilitate self-reflection and the capacity to mentalize and regulate emotions. With some disorders (e.g. borderline) change is seen mainly as the result of an increased capacity to mentalize (Fonagy, 2003).

Simultaneously, I think that the very process of co-regulating affect and attachment security influences change. Looking at attachment as the interactive regulation of biological synchronicity between organisms led me to the conclusion that an affect-focused developmentally oriented treatment can alter internal structure within the patient's brain/mind/body systems (Schore, 2003).

Strategies and Techniques

My primary and almost invariable strategy is the maintenance of a consistent, reliable and safe therapeutic frame. From this secure base (Bowlby, 1998) I utilize a number of different techniques.

This will depend on the client, the problem and the setting. I may use CBT with a motivated client presenting with panic disorder in an NHS primary care setting. If a confused and anxious client presents with BPD in a specialist NHS psychotherapy service the strategies will naturally change as there is a longer period to work. The therapeutic relationship and the transference would come more to the foreground.

However, I believe that with certain developmentally disordered patients who are not 'psychologically minded', the key to the treatment is therapeutic regulation and not interpretation and insight (Schore, 1994; 2003). Forty-plus years ago Loewald (1960/1980) stressed that a better understanding of the therapeutic action of psychoanalysis may lead to changes in technique.

Despite not mentioning Loewald's (1960/1980) ideas, I believe that Bateman and Fonagy (2004; 2006) followed these principles in their formulation of mentalization-based-treatment. The authors advocate that a modification of technique is needed in the treatment of BPD. The therapist must be more active as the still, silenced or inexpressive therapist may be experienced as the abandoning object. This transferential process cannot be interpreted to the client as his ability to mentalize when the attachment system is activated (as it is likely through the intimacy of the therapy situation) is very low. The interpretation would not be understood and could be experienced as even more disorganizing.

According to these principles, I make use of the five stages advocated by Bateman and Fonagy (2011):

I may need to go back to empathy and validation when the client's mentalizing is low. The other steps will follow as the mentalizing capacity of the patient increases. At times, the disorganization of the patient may also contaminate my capacity to mentalize. It is not adequate, in these occasions, to intellectualize the enactment and throw a 'clever' interpretation to the patient. I would need to position myself along the patient, in a collaborative manner, and be honest with my process, in this case, sharing my confused mind state.

Conclusion

My attempt as a psychological therapist is to maintain a position of flexibility and adaptability, reflecting on the problems presented to select the most appropriate intervention. Rather than replacing old models with new ones I tend to assimilate new theories and research findings into my previous conceptions. It is in this way that I align myself with the concept of assimilative integration (Messer, 1992) as well as common factors (Imel and Wampold, 2008). I do not attempt to construct a new meta-narrative, preferring to negotiate within a multitude of diverse positions.

To avoid a nihilist position, where nothing seems real or concrete enough I rely on an integrative map. This map is grounded on

the therapeutic relationship as a starting point or platform from where I elaborate and formulate different theories or avenues. I still see the Freudian model, together with a phenomenological stance, as the basis for my understanding of the client. Nonetheless, I have integrated different elements along the years and have explicitly changed my focus, which is now more aligned with relational psychoanalysis, mentalization-based-therapy, phenomenology and existentialism.

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