Volume 1, Issue 1

The British Journal Of Psychotherapy Integration

Integration: A Process

Introduction

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

Contacting Us

Please address all correspondence to:

Consulting Editors
P. O. Box 2512
Ealing
London W5 2QG

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

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

Copyright

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

Submissions

Future volumes of this journal will be on theme issues based in an integrative perspective. Two members of the editorial board will act as co-editors with the support of the two consulting editors. If you are interested in a particular theme, please contact the consulting editors and discuss your interest with them.

Editorial structure

Consulting editors:
Maria Gilbert and Katherine Murphy

Editorial Board members :
Diana Shmukler
Werner Prall
Maggie Senior
Patti Wallace
Annemarie Salm
Jane Speedy
Patricia Pitchon
Heward Wilkinson
Jean O'Callaghan
Christine Shearman
Phil Lapworth
Harbrinder Dhillon Stevens
Charlotte Sills
Graz Kowszun
Ken Evans

Guest editors will be invited from time to time.

Volume 1, Issue 1

Contents

Maria Gilbert & Katherine Murphy
Why A British Journal Of Psychotherapy Integration (Editorial) 2

Gillian Straker
Dream For A Time Of War: Integrating The Diverse Languages Of Psychotherapy 4

Marvin R. Goldfried
On The Interface Between Research And Clinical Practice 15

Werner Prall
Failing Better: Integrative Theory As Work In Progress 24

Diana Shmukler
Re-examining The Notion Of The Good Experience In Psychotherapy 33

Kenneth Evans & Maria Gilbert
The Philosophy And Values Of Integrative Psychotherapy 46

Tatiana Prokayeva-Ross
My Personal Approach To The Theory And Practice Of Integrative Psychotherapy 55

Editorial

Why A British Journal Of Psychotherapy Integration?

We welcome readers to this inaugural issue of the British Journal of Psychotherapy Integration.

There has been a growing interest in integration in the United Kingdom particularly in the past twenty years with the proliferation of training programmes and practitioners that identify themselves as integrative. In the developing field of integration, we have appreciated the contributions of SEPI (Society for the Exploration of Psychotherapy Integration) now an international organization, that has brought a well-informed view from outcome research to bear on clinical practice. We also appreciate the contribution of the EAIP (European Association for Integrative Psychotherapy) that is supporting the growth of training institutes and a dialogue about integration across Europe.

Integrative training organizations in the United Kingdom have for many years shared a base in HIPS (Humanisitic and Integrative Psychotherapy Section of the United Kingdom Council for Psychotherapy). The birth of UKAPI (The United Kingdom Association for Psychotherapy Integration) in 1999 has provided a 'home' for integrative psychotherapists. The three UKAPI conferences held so far have generated a great deal of interest and enthusiasm in the exchange of ideas. The time now seems ripe for a journal that will capture something of this spirit of integration within the British psychotherapy context. It seems important that there is now a public forum for gathering together the views of those psychotherapists who identify themselves as integrative, in all their diversity. We believe that this journal will provide an opportunity for discourse and the development of ideas in this field. We welcome contributions from the United Kingdom and from further afield, as we believe we can only benefit from a multiplicity of perspectives.

Contents of Volume 1, Issue 1

A strength of the British tradition in psychotherapy, in our view, is the thorough grounding of theory in clinical practice often outside an academic or hospital setting. Practitioners in the field have contribted in a profound way to the literature on psychotherapy and more recently that of psychotherapy integration. The American tradition in integration has often been located in the Universities and has contributed significantly to the growing body of outcome research supporting the effectiveness of psychotherapy, and of psychotherapy integration. We believe that a marriage of these traditions will form part of the focus of this journal. For this reason, we welcome the contribution of Marvin Goldfried from New York, who has written an article on "The interface between research and clinical practice". He looks at the need for creative dialogue between researchers and clinicians.

Gillian Straker has provided a moving example from the apartheid era of work in a troubled South Africa which demonstrates an integration of Western and African approaches to healing. Her article very much illustrates the integrative process in action.

Werner Prall explores the paradox of the very task of integration in a challenge to all of us to view the integrative project as dynamic and ever-moving.

Diana Shmukler gives a candid account of a therapeutic journey with a client showing how their experiences in the work fostered and deepened her identity as an integrative practitioner.

Kenneth Evans and Maria Gilbert make a statement about the philosophy underlying their framework for the integrative endeavour which embodies a commitment to self-reflexivity.

In our wish to honour the work emerging from integrative psychotherapy trainings, we are including in every issue a graduate piece on a student's own particular framework for integration taken from the student's final written submission for their qualification. In this issue we include an account by Tatiana Prokayeva-Ross of her integrative approach to psychotherpay. We hope that this will prove inspirational to other students and be of interest to all practitioners.

We are envisaging two issues a year (one volume), each on a particular theme related to integration. Each issue will be co-edited by two members of the editorial board in consultation with the consulting editors. To launch the journal, both issues in volume one will cover the broad field of the integrative endeavour.

Maria Gilbert and **Katherine Murphy**
Consulting editors and co-editors
of volume one.

Gillian Straker

Dream For A Time Of War:
Integrating The Diverse Languages Of Psychotherapy

Abstract

As the threat of war increases, there is a pressing need to remain integrated in a peace time rather than a war time morality. War pushes us toward fragmentation both internally and interpersonally. Holding together, even at the level of ethics and values becomes a challenge. This is especially so when trauma strikes. This paper shows how a peace time morality was encouraged in a group of sixty youth, aged twelve to twenty-two years, traumatised in South Africa's civil war. This morality was encouraged through the use of an integrated "multi-vocal" approach to the treatment of trauma. This treatment approach used a blend of Western and African healing practices, individual and group work and the integration of the "music and words" of the therapeutic endeavour. This integration of therapeutic modalities occurred in the process of analysing a collective dream.

Introduction

This paper presents an account of an integrated approach to the treatment of trauma in the context of the South African civil war. It shows how treatment is possible even when patient and therapist literally do not share a common language. It shows the possibility of integrating Western and African healing practices by translating meanings that may exist in each paradigm into the language of the other. It gives another meaning to the notion of the "music" rather than the "words" of psychotherapy (Meares, 2000). However most importantly it shows how promoting peace depends on the translation and integration of the language and morality of war into the language and morality of peace.

Trauma, Repetition and Dreaming

Freud's (1901) notion of the repetition compulsion points to the abiding tendency of that which is problematic and/or traumatic to repeat. As the world once more hovers on the brink of global conflict, it would seem that this repetition compulsion applies not only to the personal, but also to the political.

In thinking through the resolution of psychic conflict Freud (1900) strongly implicated the role of dreams. This paper asks whether in political conflict, certain dreams may serve a similar function. To this end this paper inquires 'what is a dream?' Is it only an individual phenomenon or can a dream be dreamed collectively? Furthermore, are there dreams for a time of war? Finally this paper explores whether dreams may assist in the alleviation of the psychological trauma of war and the promotion of peace.

Within this general framework the paper considers two dreams. The first was reported to have been dreamed collectively by a group of adolescents following the death of a community leader in South African's tumultuous liberation war. The second dream was more a daydream, a therapeutic reverie entered into in an attempt to understand the adolescents' collective dream.

Attempts to understand the dream involved the weaving together and integration of Western and African healing practices and of their respective understandings of existential dilemmas. It is also involved a flowing together of issues pertaining to early childhood, with issues of death and notions of rebirth.

The collective dream itself concerned death and followed on death. The therapeutic reverie drew on the structure of discourse beyond language, the music, not the words. This was a necessity as the dream was reported in a black language, which I did not understand, even though I had the benefits of translation.

In this circumstance I found myself somewhat like the child whose forms of feeling develop from the rhythm, tempo and intensity of the flow of the maternal discourse in which the child is immersed (Hobson, 1985). In understanding this experience, the work of Daniel Stern (1985) is instructive. As the dream work centrally implicated an immersion in the forms of its feelings, the work of Stern (1985) is elaborated below.

Forms of Feeling

Daniel Stern (1985) has written most eloquently of how forms of feeling develop in the young child. He describes this development in his work on the vitality affects. Stern (1985) distinguishes between the child's experiences of the categorical affects of the parent, viz their anger, their distress, their fear, their joy, their happiness and the experience of their vitality affects. Vitality affects refer to the tempo, the intensity and the speed at which categorical affects are expressed. In addition to experiencing the vitality affects of the parent, the child experiences the tempo, intensity and speed of his own bodily reactions as well as the intensity, tempo and speed of how his body is handled. All these experiences of tempo and rhythm come to constitute the child's own vitality affects. The child may experience and feel the parent's anger fleetingly or enduringly, similarly he may feel or experience his own bodily sensations of anger as building slowly or erupting quickly. He may feel happiness as a flow or as a burst of joy. This quickness, slowness, explosiveness and flow constitute the vitality affects (Stern, 1985).

Such 'vitality affects' affect every aspect of our lives, including the categorical affects such as anger and sadness, but also the way we walk, the way we reach for things, the way we talk and the way we locate ourselves in time and space. These vitality affects are communicated by the rhythm of our own bodies but also the rhythm of other bodies interacting with us. These rhythms continue unabated to communicate a different order of information to that in words, meanings and even in particular, categorical affects.

However, both categorical affects and vitality affects are bodily embedded and exist within and between bodies. Researchers like Tomkins (1962) have studied how our neural systems are hard wired both to receive and to produce certain affects via bodily feedback. Therapists such as Marsha Linehan (1993) and many philosophers and theologians before her have used this knowledge to promote human well being. The whole notion of the smile of the Buddha is based on this idea. So too are Linehan's (1993) notions that the production of a smile upon the face will generate an inner state of happiness, commensurate with this smile. In addition one's own smile will elicit a smile from others which will add to its beneficial effects.

However, the initial notion that one's own smile will generate happiness is primary, and is based on the hypothesis that our emotions are hard wired and that our neural systems interpret our bodily feedback in order to make sense of what we feel and indeed to make sense of what others feel. Given this, Tomkins (1962) for example believes that at some very basic level it is possible for us to read affect cross-culturally, and indeed my own experience of working across the language divide confirms this. It does seem then that there is truth in the notion of universals in the expression of affect and that these expressions are hard wired.

By adulthood, however, most of us have learnt to disguise our affects via the many cultural codes to which we are subjected (Tomkins, 1962). These codes then govern the expression of affect and it becomes much more difficult

to read affect in others, and perhaps even in ourselves as we learn to diminish our bodily feedback. However, in severe crises and in extreme circumstances, affect tends to be amplified and cultural codes are more likely to be dropped. In these circumstances basic affects, below the words and beyond the cultural codes that have been superimposed upon us, may once more be experienced and more directly communicated.

The degree to which language (which itself is a cultural code) shapes how we experience ourselves in regard to both affect and all else, has once again been described very eloquently by Daniel Stern (1985). He talks of the advent of language and how this makes us less and less attuned to the somatic and to the physical, as we become more and more reliant on the verbal. He also speaks of how we begin to privilege certain sense modalities, such as vision, above all others.

Stern (1985) indicates that as children we process information across all our sense modalities or amodally. This changes however as we get older. Thus in the beginning we do not privilege sight only or sound only or olfactory cues only, but tend to use all the modalities together and to cross-reference them. Thus an infant who has sucked on a particular nipple is able to visually recognise that nipple and differentiate it from others. The information automatically gets crossed over from the tactile, that is from the feel of the nipple to an encoded visual map. However, as we use language more and more, our capacity to process information across all our modalities recedes.

Given this, I would hypothesize that in its ideal form, analytic reverie involves to some extent a return to amodality. That is, analytic reverie, or the open state of the mind advocated by analysts such as Bion (1970), may well be based on a return to a more holistic, crossmodal mode of information processing. This mode of information processing prioritizes the lived experience of affect, indeed the music, beyond words, of which Meares (2000) and many others speak. Certainly listening to the collective dream which is the subject matter of this paper, felt like being immersed in affect beyond words, and required a return to a certain amodality. Before describing this experience however, it is necessary to both describe the dream and its context. This serves to act as a prelude to a focus on the therapeutic work which is the concern of this paper.

Context of the Dream

As already mentioned, the dream occurred after the death of a community leader in South Africa. This community leader was attacked in his home at a time at which the South African government was fostering so called "black on black violence". This was a strategy which deliberately sowed dissent in black communities so that the State could divide and rule (Straker, 1992).

The chief was killed by a rival group in the community. He was holding a group meeting in his house which was fire bombed. The sixty youth aged twelve to twenty-two years who dreamed this dream were at this meeting when he was attacked. They fled out of the back door while the chief went out of the front door. Here he was brutally attacked and hacked to death and his genitals cut off. The group itself fled to a church community centre where it was pursued. The police, using army helicopters and guns invaded the centre. One person was shot and wounded, two escaped and the rest of the group was arrested. On their release they reported that they had been taken to several jails. Some report having been beaten, tortured, and denied food.

After a number of days, following urgent submissions to the Supreme Court, they were released. Soon after this, the group began to complain collectively of insomnia and a common nightmare. It was at this point that I was approached and requested to form a team of therapists who might offer help to the group.

At first contact, the youth presented as very agitated. They said they were afraid to sleep and reported a dream in which the chief's spirit appeared to them and told them that he could not rest and would not allow them to rest until his severed genitals had been returned to his body. After further exploration it emerged

that while most of the group complained about being troubled by the chief's spirit, it was his daughters, who had first reported the chief's appearance in a dream. They were also the individuals who were most disturbed by the dream and the most afraid. Nevertheless, all the other members of the group reported that they too had had the dream and that they had profound anxiety in relation to it. This of course raises many interesting questions; what is a dream, was this dream in fact dreamed collectively or only reported collectively?

To move too quickly to the conclusion that the dream was only reported collectively would, I believe, be a mistake. It also would be against the spirit of the psychoanalytic endeavour. This endeavour is based on retaining an unsaturated frame of mind, open to all possibilities (Bion,1970; Ogden, 1982).

However, returning to our work with this group, we were presented with a dilemma. Although all members of this group were highly traumatised, the idea of a talking cure was foreign to them. This was particularly so, given that this was a time when spies were ubiquitous and informers were everywhere. To be asked to speak in this climate was itself suspect.

It was thus crucially important to our work that we were introduced to the group by community leaders and by individuals trusted on the street (Straker, 1988). Our mental health qualifications meant nothing to this group. We therefore had to find an indirect mode of approach.

After a team consultation we decided to ask the group whether or not any of them were interested in creating an oral history of the events in their community. We asked whether they thought this might be helpful for posterity, and indeed we did subsequently write a book recording the events in this community as a way of fulfilling this obligation. Most of the group expressed interest in this idea and through this process of oral history taking, a therapeutic climate was created. The group told its story through narrative, through praise songs, stories, prayers, laments, dances and chants. This facilitated both an outline of the facts and the expression of a great deal of emotion and catharsis. It represented the group's own natural healing processes.

This process took place over two to three days. Following this the team decided that it could be helpful to offer the three daughters of the chief personal time with us in order to further elaborate their story and to discuss their dream. We offered this to the three girls who agreed that they would indeed find this helpful. It was then decided by the team that one of my black colleagues, Thandeka Mgodusa, and I were best suited to work with the girls. My colleague was a student at the time. The question was thus whether I should be the therapist and she should translate or whether she should be the therapist and I should sit by, in the group and act as a consultant to the process. We decided on the latter course of action.

This meant that I would sit in the group and while group members spoke in a language, foreign to me, I would try to penetrate beneath the discourse, and serve as a resource whenever my colleague wished to consult with me.

Understanding the Dream

As a team we had already heard of the dream of the chief and his wish to have his genitals restored. We had met with the larger group over two to three days and had completed the oral history project. We had also spent time mixing informally with the group over lunch and tea.

In the oral history project we had used the structure and energy of the group, to introduce therapeutic issues, albeit indirectly. We had done this by discussing notions of psychological woundedness and speaking in terms that might be acceptable to self defined warriors. Within the team we had discussed our understanding of the group dream as well as our understanding of group members' symptoms. We had done so from an African and from a Western perspective.

From a Western perspective the group members' symptoms were conceptualised in terms of Post Traumatic Stress Disorder, given their insomnia, nightmares, vigilance, and flashbacks (Van der Kolk, 1994). Their symptoms were

also thought of in terms of trauma's capacity to breach the stimulus boundary (Garland, 1999). This breaching of the stimulus boundary occurs both at the level of the self and the external world and at the boundary between the conscious and unconscious processes.

From an African perspective the group members' symptoms were thought of in terms of contamination by death and how this contamination creates emotional and physical problems (Gunmede, 1990). This contamination was linked to the fact that, following death, there are certain required rituals of purification, and these had not been performed in regard to the chief.

The psychological functions of the dream were also examined from an African and a Western perspective. From a Western perspective the reparative function of dreams was stressed. In this regard Kohut's (1997) work was particularly helpful as he stresses the tendency in dreams for healthy aspects of the self to express concern for ailing aspects of the self. In this regard we saw the wish to restore the chief's genitals as a wish to repair damage as well as a wish to shore up a fragmented disempowered self state.

However, what was striking about this dream was the fact that the reparative wish was coupled with an injunction that was impossible to follow. It was not feasible in reality to restore the chief's genitals, and it must be remembered that the group took the dream literally. Thus the dream injunction acted to reinforce guilt and to perpetuate feelings of badness.

Certainly the group had expressed guilt concerning their survival in the face of the chief's death. Thus the dream, from a Western perspective, was seen as giving expression to survivor guilt. However, the dream also allowed group members to avoid a full confrontation with the loss that they had suffered, especially the finality of this loss. Remaining stuck in a sense of persecution around an impossibility seemed to serve the function of freezing the mourning process. Through frozen mourning and preventing individuals from moving on and acknowledging the finality of their loss, the chief could be entombed and memorialized in a static way and thereby preserved. Through this process the group could retain the fantasy that he was not actually lost. However, because of this failure to face loss, the group remained in melancholia rather than moving toward mourning.

Of course we were aware at the time that it was early days and that the group's frozen mourning was time appropriate and served a protective function. However, their sleeplessness and agitation was quite extreme and did seem to require some sort of address. This seemed equally true when the dream was conceptualised from an African healing perspective.

African Perspectives on Healing

Within an African healing perspective there are many diagnoses which may be given to the symptoms of this group, including the symptom of this dream. In brief, within mainstream traditional African views on disturbance and distress there are three major possibilities in regard to causation upon which diagnosis rests (Gunmede, 1990). These possibilities are mystical causation, animistic causation and magical causation. Mystical causation involves pollution via mysterious processes involved in, for example birth, death and menstruation. Animistic causation refer to disturbances created via loss of protection of the ancestors. Magical causation involves witchcraft and sorcery and is illness caused by another human being (Gunmede, 1990). The context in which the symptoms of the group occurred, that is the death of the chief, indicated that they were characteristic of an illness of animistic causation, although issues pertaining to the mystical were also implicated. That is their symptoms, including the dream, indicated a loss of protection from the ancestors, which in turn would make them more susceptible to pollution via contact with death.

In understanding this diagnosis it is important to come to grips with the cosmologies underpinning African healing practices. In most African cosmologies there is no split between the natural and the supernatural world, mind and body, individual and community. In understanding the dream within this framework

it is important to bear in mind that the group would see it as a direct message from the ancestors indicating their involvement in the group's current state. Thus within both the Western framework and within the African framework, the dream would be seen as representing the crossing of a boundary.

However, in the African framework it is not the boundary between the conscious and unconscious systems or between the individual and the external world that has been crossed. It is the boundary between the natural and the supernatural world that has been crossed. The dead have come to visit in order to be indirect communication with the living.

In these terms then, the group's dream represented a real conversation with the chief. His request indicated to them that he felt that they had a duty to perform in relation to him and that their failure to do so was the cause of their illness. The dream also contained suggestions concerning the way in which the illness might be cured. The cause of the illness was a neglect of duty and its cure would lie in following his instructions.

In many African traditions the appropriate response to a dream of the departed is to slaughter a beast. The ritual slaughter of the beast is similarly appropriate following the burial of the dead. The purpose of this is to provide purification from the pollution of death as well as to facilitate communication with and respect for the ancestors.

In discussing both Western and African views on dreams, at least as my colleague and I understood them, we felt that we should let both frameworks inform our work. We thus worked with the daughters of the chief in a manner we hoped would create a circumstance in which ideas derived from both African and Western frameworks might be explored without foreclosing on either, nor foreclosing on what might emerge from the group itself. The creation of this circumstance and the dream work are described below.

Dream Work

Despite careful planning, the initial stages of our work with the daughters of the chief went extremely badly. We did exactly what we intended not to do, and foreclosed on the group's exploration of these issues by offering our own solution too quickly. Having invited the girls to discuss the dream and to discuss again what had happened to them and their father, we, rather too quickly, suggested a traditional solution to such problems. The idea was offered, of the ritual slaughter of a beast to appease the chief's spirit and to show him respect. This idea was immediately rejected by the girls. They felt that the chief was indeed calling for remembrance and respect, but because of the particular circumstances, slaughtering a beast would not suffice to appease him.

As we reflected on their response it was clear to us that we had prematurely offered this solution to assuage our own anxieties. In retrospect I think we were informed by our own notions of political correctness and cultural sensitivity. It certainly was an example of the road to hell being paved with good intentions! We thus determined to contain our own anxiety better and to encourage a very much fuller elaboration of the difficulties as expressed by the girls themselves. We thus began again and asked the girls, to once again tell us their story as they personally had experienced it.

At this point then, I sat back and allowed myself to be immersed in waves of speech which rolled over me, without any understanding of the words. In this space I attempted to help my colleague by remaining in touch with the rhythm and the tempo of the group as she remained in touch with the words. From this perspective of immersion in the group process, I felt as though it went through three different stages which could be conceptualised within the framework on trauma outlined by Judith Herman (1992).

Within Herman's (1992) framework, the first stage felt like a prenarrative – when the trauma story is told flatly without infusion of emotion. The second stage felt like the narrative – when the story is retold with great emotion but the emotion is so great that it cannot be contained.

The third phase felt like resolution, with story and emotion more integrated. However, my experience of these three phases clearly did not come from any understanding of the words that were spoken, given the foreignness of the language. It was probably this incapacity to understand the words that resulted in the experience not being one of affect contagion. I did not feel swept up in the emotion of the group as has happened when listening to trauma narratives, when I have understood the language.

I have worked with groups that have been survivors of atrocities of many kinds and have also worked extensively with survivors of torture. In these circumstances, when I have understood the words and the true horror of what is said, I have often found myself infected by the affect, the emotion, the horror and the terror in that there has been some sense of vicarious traumatization (Van der Kolk et al, 1996).

In my experience of the current group, perhaps because I did not understand the content of what was said, I did not experience myself as affected in this way. It was more a conscious sense of some sort of absorption into an alimentary process, as Bion (1970) might say. Perhaps in another language it was some sort of subtle entrainment akin to mimetic communication as described by Trevarthen (1993). Entrainment of this kind refers to the synchrony which develops at a mirco level between individuals, most particularly mother and infant as they mimic one another's body movements at the level of temporality, intensity, tempo (Trevarthen, 1993).

And indeed I did feel entrained by the group. I felt caught in its pulse and vibration but nevertheless alert and separate. It was a state of mind that allowed me to work with my co-therapist not so much on content of interventions, but on the timing and the nature of them, when to intervene and when not to intervene.

While working with this group, I of course, was not at the time thinking within Hreman's (1992) or Trevarthen's (1993) intellectual categories. I was more in the mode of reverie (Ogden, 1982). These conceptual categories were applied retrospectively in my own subsequent processing of the experience. At the time it was enough to intuitively allow internalised knowledge of how trauma narratives unfold to unconsciously guide a more feeling mode of access into the group's story. The subjective experience was of an oscillating movement into my own reverie and out of it, into the forms of feeling and vitality affects of the group, but not into overwhelment by its categorical affects.

This was perhaps akin to the internal state of the mother who moves between experiencing and processing the 'forms of feeling' of the child. In this experience of the group, as in the mother's engagement with the child, some clarity is retained about what belongs to self and what belongs to the other (Fonagy et al, 2002). As I had frequently worked with trauma before, the unusualness of this struck me; the infectious nature of trauma is captured within notions such as the secondary transmission of trauma, vicarious traumatisation, inter alia (Van der Kolk et al, 1996). It seemed to me that it was being free of words in this situation that helped the retention of this clarity. It might therefore be useful to elaborate this experience more fully.

Sitting within the group, outside of verbal language, but with an awareness of the story, my phenomenological experience of the group ethos and its evolution proceeded as follows: In the initial stages, that is in Herman's pre-narrative stage (1992), the group's mode of expression was staccato, stilted, the phrases short and flat. There was little resonance in the voices, each voice seemed distilled from its overall context, there was little overlap or interruption as if each person waited in isolation for the other to finish. There was a chilling and freezing of syllables in mid air, gazes collectively fixed on the middle distance with no meeting point, body movements attenuated, gestures cut-off before completion, myself feeling frozen, blocked out, somewhat numbed but nevertheless at a deeper level, still feeling a sense of engagement in the tide of what was happening.

Then as the process shifted from pre-narrative to narrative, the story became infused with emotion - as yet raw emotion. The tempo and intensity of speaking increased, pitch higher, intervals between words shorter, words running

into each other. First I noticed the riveting of attention on the speech of each of the members of the group, by the other, no longer a gazing into the middle distance, as each began to entwine their own story with that of the other. Each contributed to the other, not in a harmonious, blended way but in a crisscrossing which left some amputation of the others' speech in its wake, mirroring perhaps the feeling and amputation of the trauma event.

In my own experience I found both the pre-narrative and the narrative left me outside of the circle. In the first experience it was a feeling of being frozen out, a certain deadliness of atmosphere. In the second it felt as though I was held outside by some invisible barrier, an experience of the currents coming off others, keeping me somehow outside of myself, simultaneous with a sense of internal disruption. It was almost an experience of being electrically shocked in the sense in which an electric charge pushes one outward, yet at the same time holds one in thrall in the same spot. I felt suspended, yet in an animated state, at the end of this second phase of the group.

Healing Nausea

At the end of this second phase in the group an amazing event took place. Within a few minutes of each other, each of the three girls had a nausea attack and retched. However, it seemed that this was more than a simple evacuation into a void, it was an evacuation made possible by my co-therapist's intuitive resonance and holding of the entire process within an African framework.

In African healing practices retching is seen as a literal evacuation of that which has illegitimately invaded the being of the self. This foreign invader which has been placed there by another, or has inadvertently been invited in by the self, by being in the state of pollution, is thus expelled. This notion of having been illegitimately invaded by the being of the other is highly reminiscent of Winnicott's (1965) notion of the traumatised baby who looks for himself in the mother's eye but finds only the mother, and is invaded by her presence and a false self takes up residence.

In this sense, from a meta perspective, it is possible to have some sense of overlap between certain African and Western existential knowledges. Both bodies of knowledge point to the potential of invasion by the other, but use different metaphoric terms. In particular Western frameworks we may speak of communication by impact, projective identification, or transgenerational transmission of trauma (Casement, 1985; Fonagy et al, 2002; Ogden, 1982). In particular African frames we may speak of pollution and possession by the ancestors (Gunmede, 1990).

Returning to the group however, it is significant for our purposes, that retching is a sign of purification which allows a return to normal processes of mourning and thinking. Indeed this retching marked a punctuation point in the therapy. It both signalled and created a clearing of an internal space, within the girls and within ourselves. This allowed for the emergence of an understanding of the meaning and experience of the trauma and the dream in a different way.

At this point in the therapy we all took a break. The girls were nurtured and cared for, and all given ritual hot water to literally calm and soothe them while my colleague and I discussed how to proceed. At this point, we decided to make a suggestion to the group, which we later placed in a more universal framework of the myth of Isis and Osiris and its place as a myth in a time of war.

Myth for a Time of War

Isis was a pre-eminent Egyptian goddess, Osiris was her brother and the father of her child. Seth was a sibling of both Isis and Osiris and was envious of Osiris whom he subsequently killed. He tore Osiris' body into fourteen pieces. Isis, on hearing this, sought and found Osiris' body parts, all except the penis, of which she made a replica. She then ceremoniously placed this replica with the body of Osiris. This served to revive Osiris who became ruler of eternity and king of the underworld where he restored order and ended chaos.

However, the essential point of the myth is that Osiris became ruler on the basis of his being refused revenge against Seth. Seth, having been spared, was in turn required to participate constructively in the new order. It was thus both the refusal of revenge for Osiris, as well as Seth's participation in the new order that was finally responsible for the triumph of justice and harmony between the material and spiritual world, and for the restoration of order.

This myth seemed very germane and important in regard to the dream of the girls and of the group, and was consistent with the suggestion we inserted into the group once we reconvened. The suggestion we made to the group was that they consider the possibility that there was a hidden message in the chief's communication to them and we asked them to think very carefully about this. We suggested the possibility of an encoded message in his request that his penis to be replaced with his body. We indicated that given the circumstances of war, a shrouding of the meaning of the dream might by appropriate. We asked that they consider this. Furthermore we asked whether they could imagine, what beyond his literal body, the chief could wish to have restored to its wholeness and integrity? What could the penis mean in this context and how could power be restored to the chief in another way?

The girls accepted this task with interest and did begin to think through the possibility that there was a hidden, coded message, in the chief's communication and that it was their task to decipher it. After a long discussion they eventually agreed that the chief's body was a symbol of the community body and that they themselves, as his descendants were a source of power. They now heard his message, as a call urging them to become empowered themselves and thereby to restore the integrity of the severed body of the community. This body through fragmentation had become disempowered.

They became animated and excited about this notion. As they spoke more and more about the empowerment of the community and a possible return to the community, they also began to think through the slaughtering of a beast and the ritual laying to rest of the chief's spirit. They therefore linked returning to the community, with the carrying out of this ritual and they began to plan accordingly.

We took this to be an enormously positive sign. We felt the ability to embrace this ritual meant a step toward a deeper grieving, a move from melancholia to mourning. We felt that something had been achieved in the group's ability to reinterpret what the chief had said in a more metaphoric way.

Once the girls had come to their own conclusions, they were very keen to rejoin the larger group and to communicate to them their thoughts and their resolutions. We facilitated this process. Following this the group did indeed return to their community and attempted to continue the work of the chief, albeit not without strife.

Postscript

Continuing the work of the group was a long hard haul as the group was attacked when they first returned. One person was stabbed but fortunately there were no fatalities. However, the group persisted in their pledge to the chief and eventually liberation came. As we know these events occurred in the late 80's and liberation was achieved only in the early 90's. However the war was won and the spirit of the chief did indeed triumph.

I followed this group's progress for ten years into the mid 90's and indeed they carried their scars each in their own individual ways. I have no illusions concerning the interventions described here. They could not heal deep wounds that group members had sustained. Nevertheless, I believe that we contributed in a particular moment to an undamming of the psychic tide of this group in regard to their relationship to person, place and meaning, a relationship that had become stuck and frozen in a particular instance of trauma.

On a more sober note though, as we look to the future and to the return of the spectre of war, we may end by asking what it is we may learn from the ancient wisdom of the myth of Isis and Osiris and from the historical experience of the chief's daughters and his followers.

For myself, I learned how great is the difficulty and pain involved in giving up the gratification of revenge and the impulse toward exclusion of the other in order to embrace the much harder task of real engagement with the atrocity of the other. Yet this task must be embraced. For in the building of a global body of many parts, which in its integrity can function less destructively and more harmoniously, a war time morality must be relinquished so peace may prevail.

References

Bion, W. (1970) *Attention and Interpretation.* London: Tavistock.

Casement, P. (1985) *On learning from the Patient.* London: Routledge.

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

Freud, S. (1900), *The Interpretation of Dreams,* 1976. Middlesex: Penguin.

Freud, S. (1901) *The Psychopathology of Everyday Life,* 1975. Middlesex: Penguin.

Garland, C. (1999) *Understanding Trauma.* London: Tavistock Clinic.

Gunmede, M. V. (1990), *Traditional Healers.* JHB: Skotaville.

Herman, J. (1992) *Trauma & Recovery.* New York: Basic Books.

Hobson, R. (1985) *Forms of Feeling: The Heart of Psychotherapy.* London: Tavistock.

Kohut, H. (1997) *The Restoration of the Self.* New York: International University Press.

Linehan, M. (1993) *Cognitive Behavioural Treatment of Borderline Personality Disorder.* New York: Guildford Press.

Meares, R. (2000) *Intimacy and Alienation.* London: Roultedge.

Ogden, T. (1982) *Projective Identification and Psychotherapeutic Technique.* New Jersey: Jason Avanson.

Stern, D. (1985) *The Interpersonal World of the Infant: A view from Psychoanalysis & developmental Psychology.* New York: Basic Books.

Straker, G. (1992) *Faces in the Revolution.* Athens: Ohio University Press.

Straker, G. & Sanctuaries Counselling Team (1988) *Child abuse, counselling and apartheid:* The work of the Sanctuary Counselling Team. Free Associations, 14, 7-39.

Tomkins, S. (1962) *Affect, imagery, consciousness. Vol. 1, The Positive Affects.* New York: Springer.

Trevarthan, C. (1993), *The function of emotions in early infant communication and development.* In: New perspectives in early communicative development, ed. J Nadel & L. Camaioni. London: Routledge.

Van der Kolk, B. (1994) The Body Keeps Score: Memory and the psychobiology of post-traumatic stress. *Harvard Review of Psychiatry,* J. 253-263.

B. Van der Kolk, A. McFarlane, & L. Weisnaeth Ed (1996) *Traumatic Stress: The effects of overwhelming experience on mind, body & society.* New York: Guilford Press.

Winnicott, D. (1965) *The Maturational Process and the Facilitating Environment.* New York: International University Press.

Gillian Straker, M.A. (Clin Psych) PhD. is a Clinical Professor of Psychology, University of Sydney. She teaches and researches in the area of psychoanalytic Integrations. She is an organizational consultant to Encompass, Australasia. She maintains a private practice in Sydney.

Marvin R. Goldfried

On The Interface Between Research And Clinical Practice

Abstract

This article deals with some of the issues that contribute to the long-standing gap that exists between psychotherapy research and practice. Many of the points of contention between the two are the result of the fact that researchers and clinicians live in different worlds, and each frequently has little understanding or tolerance for the professional activities engaged in by the other. With increasing demands for accountability, the time has come for us to close this unfortunate gap. After discussing how research can inform clinical practice, and how clinical practice can inform research, the article calls for a greater collaborative effort between researchers and clinicians, and offers some suggestions for bridging the gap between the two.

Introduction

One of my most vivid memories of graduate school involved the visit of Paul Meehl to our program. Back then, Meehl was well known as a key figure in clinical psychology. Moreover, he was my idol, and I had read most of what he had writtten on the topics of clinical judgment, the philosophy of science, and the importance of links between research and practice. I was among a small group of students who went out to dinner with him, which is the part I most vividly recall about his visit. During dinner, someone turned to him and asked: “Dr. Meehl, to what extent is you clinical work based on research?” Without hesitation, he replied: “Not at all.”

To this day, I still experience the sinking feeling in my stomach that I had at that memorable dinner. Here I was, a fledgling professional, struggling to form the identity of a scientist-practitioner, hearing from someone I believed to be the epitome of the scientist-practitioner that the link was not–and perhaps could not–be made. I don’t think I ever recovered (unfinished business?), which is perhaps why I have been so intrigued throughout my professional career with the challenge of integrating practice with research.

In many respects, my graduate education prepared me more for a schizophrenic than a scientist-practitioner approach to research and practice. During the time I was in graduate school, projective techniques occupied a salient place in the curriculum; I took three courses on the Rorschach alone. Virtually all that I read on the Rorschach and other projective techniques involved clinical speculation, none of which was backed by research findings. If individuals reported seeing a landscape off on the distance, the interpretation would be that they had the ability to obtain a perspective on themselves. Although it seemed to make intuitive sense at the time, there existed no research foundation for drawing such conclusions. The reason I found this all disconcerting was that I was also taking courses on learning, perception, and experimental psychology. In this facet of my education, I was learning about research methodology and the need to build up a body of evidence on the basis of careful experimentation. To reduce the dissonance that I experienced between what I was learning clinically and experimentally, I became

interested in carrying out research on projective techniques, and even ended up writing a book that reviewed the available research evidence for the validity of the Rorschach (Goldfried, Stricker, & Weiner, 1971).

Throughout most of my professional career, I have functioned as both a researcher and a clinician. As a researcher, I have conducted investigations of assessment and therapy, taught graduate courses on therapy research, supervised graduate student research, and served on grant-awarding committees and editorial boards. As a clinician, I have taught therapy practicum courses, supervised graduate student therapists in the Stony Brook Psychological Center, written about methods of therapy intervention, and have had a limited clinical practice. Although it was at times difficult to maintain, having a foot in each of the separate worlds of the researcher and clinician has given me a perspective on the clinical and research gap, and how it might be closed.

The Clinical-Research Gap

Given the fact that research and clinical work are typically carried out in different worlds, it should come as little surprise that communication problems exist between professionals who inhabit each of these worlds. Indeed, clinicians and researchers have a long history of mutual intolerance, if not outright disdain (Strupp, 1968). I have heard my academic colleagues refer to graduates of clinical psychology doctoral programs as "being lost to clinical work." According to many academic scholars, the only useful professional activity that will advance the field involves controlled research. From the point of view of many clinicians, the research that is often conducted has little to do with clinical work – in more than one respect, it is "academic."

I once participated in a roundtable discussion at a psychotherapy research conference, where the problem of disseminating therapy research findings to the practicing clinician was the focus of consideration. At various points during the discussion, the point was made that clinicians were "not good consumers" of research findings. Not able to contain myself, I finally made the observation that if this were a corporate board that was considering how to best market our product, we would not be blaming the consumer, but instead exploring how to make what we had to offer more appealing and useful. Perhaps what we are investigating, I added, or the way we were disseminating our findings, needed to be reevaluated. Following a moment of stony silence, the conversation shifted to a new topic.

Psychotherapy outcome research has made numerous methodological advances over the years. The earliest research on psychotherapy outcome was carried out in the 1950s and 1960s, and typically addressed the question: Does psychotherapy work? During that period, little specification or differentiations was made in either the form of therapy or the nature of the clinical problems addressed (cf. Kiesler, 1966).

During the 1960s and 1970s, the field moved to the second generation of outcome research, due largely to the efforts of behavior therapists. Rather than addressing questions about an unspecified intervention for unspecified problems, this second generation of researchers studied the efficacy of specific therapy interventions (e.g., systematic desensitization, role playing) for treating specific target behaviors (e.g., phobias, unassertiveness). Because behavior therapy had its roots in basic research, a number of methodological advances were made in the typical research design. Thus, participants were randomly assigned to treatment conditions, the interventions followed written guidelines (i.e., manuals), and different interventions were kept comparable in all ways (e.g., number of sessions), with the exception of the key aspects of the particular treatments.

The third, current generation of outcome research, began in the 1980s. In addition to adding a few methodological refinements (e.g., therapists were monitored to ensure they were faithfully adhering to the treatment manual), the state-of-the-art reflected a very definite shift to the medical model. This shift was the result of the psychiatric model of mental illness that dominated the National Institute of Mental Health (NIMH), the federal agency in the U. S. that funds most of the therapy research.

Outcome research was now called randomized clinical trials (the term used in drug research), and the target behaviors of the second generation were replaced by DSM diagnoses. In short, the problems in living that had been the focus of earlier outcome research was now a thing of the past; research was now directed toward reducing the symptoms associated with clinical disorders.

That this shift to the medical model has dramatically changed how the field thinks about clinical problems was brought home to me at a American Psychological Association conference in 1994 on the development of a core assessment battery to be used in outcome research. Representing a cognitive-behavioral orientation, I participated in a panel discussion to determine the types of measures that should be used when treating anxiety disorders. During the conference, I found myself in the unusual position of trying to convince psychodynamic therapy researchers on the panel – whose clinical research had been funded by the NIMH – that in addition to measures of symptom reduction, interpersonal variables and measures of self-concept needed to be included in the assessment battery. What was particularly unusual about this dialogue was that it was reminiscent of discussions I had with psychodynamic colleagues in the 1970s, except that our positions were reversed!

Although the current generation of outcome research reflects a high level of methodological sophistication that ensures internal validity (e.g., the treatment that is delivered is the treatment outlined in the therapy manual), it is lacking in external validity – how therapists actually practice. In actual clinical practice, therapists rarely use a therapy manual, typically draw on more than one theoretical orientation, carefully select rather than randomly assign a treatment to a client, and attempt more than symptom reduction. Indeed, even the framers of the current DSM version have acknowledged the limitations of the system when they wrote:

"Making a DSM-IV diagnosis is only the first step in a comprehensive evaluation. To formulate an adequate treatment plan, the clinician will invariably require considerable information about the person being evaluated beyond that required to make a DSM-IV diagnosis" (American Psychiatric Association, 1994, p. xxv).

Despite this obvious shortcoming, clinical trials, which have been designed to guide clinicians in how they should practice, are based on randomly assigning clients to a theoretically pure intervention solely on the basis of their DSM diagnoses. This limitation regarding clinical validity can have its obvious dangers when treatment guidelines are based on the findings of such research efforts, whereby the methodological constraints associated with conducting randomized clinical trials can become clinical constraints for the practicing therapist.

Barry Wolfe and I (Goldfried & Wolfe, 1996), who between the two of us had been involved in psychotherapy research for over fifty years, confessed to have participated in a research paradigm that lacked clinical validity. Inasmuch as we both have a very strong commitment to the use of research to inform the practicing clinician, we presented our dilemma as reflecting a conflict between a wish and a fear: "Our wish is that therapy interventions be based on psychotherapy research; our fear, however, is that they might" (Goldfried & Wolfe, 1996, p. 1007).

How Research Can Inform Clinical Practice

Although psychotherapy outcome research has its limits regarding what it can say to the clinician, basic research and research on the process of change has considerable potential for informing therapists on how they can practice more effectively.

Arkowitz (1989) has suggested that basic research on clinical problems can provide the practising clinician with answers about "what" needs to be changed. The findings of such studies can offer information about the variables/dynamics/determinants associated with certain clinical problems, information essential for any therapeutic intervention. For example, basic research findings that panic attacks temporally preceded the development of agoraphobic avoidance behavior led to

the reclassification of panic as the primary clinical problem, with agoraphobia as being secondary. Moreover, laboratory findings that panic patients differed from controls in the way they interpreted panic symptoms (e.g., I may be having a heart attack), rather than in the symptoms themselves (e.g., increased heart rate), supported an intervention that targeted panic patients' catastrophic interpretations of their bodily sensations.

Whereas basic research can address the question of what needs to be changed, psychotherapy process research deals with "how" change can be brought about (Arkowitz, 1989). Some of the earliest process research was carried out by Rogers and his colleagues, who analyzed wire recordings of therapy sessions (Strupp & Howard, 1992). For the most part, however, the early process research yielded few clinically useful findings, perhaps because it focused more on discrete and isolated aspects of the therapy interaction (e.g., silences) – the therapy process – rather than more functional units that might be associated with the process of change.

Contemporary approaches to process research has not only become more methodologically sophisticated, but also more relevant to the change process (Greenberg & Pinsof, 1986). The research question addressed by process research is: "What has the therapist done to make a particular impact on the client?" The implications for clinical practice are evident, especially if one rephrases the research question to read: "What can the therapist do to make a particular impact on the client?" By studying the change process, the hope is that the field will be able to compile evidence-based, clinically useful information on how change occurs within a therapeutic context, as opposed to the current array of different theoretical speculations put forth by competing therapeutic schools.

How Clinical Practice Can Inform Research

Sociological analyses of the progress of science have acknowledged the important distinction between the research questions that are deemed worthy of investigation, as opposed to the methodologies that have been devised for studying these questions. The former has been referred to as the context of discovery, and the latter as the context of confirmation (see Goldfried & Padawer, 1982). Most of what we see in the therapy research literature characterizes the confirmation phase; we see little in this literature about the most important discovery phase.

In a candid account of how he approached research problems, the celebrated psychologist Neal Miller described how he relied more on informal observation and intuition before studying a topic with an elegant or elaborate experimental design.

As he stated it:
"During the discovery or exploratory phase, I am interested in finding a phenomenon… During this phase I am quite free-wheeling and intuitive – follow hunches, vary procedures, try out wild ideas, and take short-cuts. During it, I usually am not interested in elaborate controls; in fact, I have learned to my sorrow that one can waste a lot of time on designing and executing elaborate controls for something that is not there" (Miller, in Bergin & Strupp, 1972, p. 348).

In short, his initial goal is to convince himself that something exists. Once he has done so, the next step is to design an experimentally controlled investigation that can convince his colleagues.

With regard to psychotherapy research, one may think of clinical practice as constituting the context of discovery. Working directly with clients and discussing clinical cases with colleagues, supervisors, or supervisees provides us with the opportunity to witness first hand the ever-varying parameters of human behavior and the process of change. It is within such a context that the clinician can uncover clinical questions and hypotheses that the researcher can then investigate under better-controlled research conditions.

In the 1970s, when behavior therapy was beginning to recognize the relevance of cognition for understanding and changing human functioning – now known as cognitive-behavior therapy – it was the clinical setting that

provided the venue for making this discovery. The clients seen by behavior therapists did not read the professional literature that maintained it was all conditioning. Instead, they manifested clinical problems that at times had their roots in faulty thinking and misperceptions. Consequently, behavior therapists' attempts to make an impact without dealing with these cognitions were often doomed to failure. It was only later that research findings were obtained to confirm what had been observed clinically.

The potential role of the practising clinician is that it can keep us honest as clinical researchers. In the absence of an ongoing clinical foundation, it is all too easy to get caught up in research trends and fads that may have more to do with challenging our methodological acumen than with producing findings that are useful to the practicing clinician. This very same observation was made some years ago by Bannister and Fransella (1971), who astutely noted that all too much of our research "… could win classification under categories such as exquisitely obsessional or the apotheosis of the platitude, but they could hardly be called acts of imagination. Most of them were born out of the literature and, no doubt, will be buried in it" (p.193).

Closing the Clinical-Research Gap

The conception that clinical work is "subjective" and that research is "objective" fails to accurately depict what actually goes on within each of these two domains. As noted above, reports of research findings do not reveal the intuitive and creative process that takes place in the formulation and design of research. Moreover, there is far more scientific reasoning that clinicians engage in than is often acknowledged (cf. Stricker, 1997). Indeed, there are some interesting points of similarity that occur in the reasoning processes of both researchers and clinicians. This can be illustrated by examining a description of the "art of research" made by two particularly creative and successful researchers:

"In any experiment, the investigator chooses a procedure which he intuitively feels is an *empirical* realization of his conceptual variable. All *experimental* procedures are "contrived" in the sense that they are invented. Indeed, it can be said that the art of *experimentation* rests primarily on the skill of the *investigator* to judge the procedure which is the most accurate realization of his conceptual variable and has the greatest impact and the most credibility for the subject "[Aronson & Carlsmith, 1968, p. 25 (italics added)].

Thus researchers have a hypothesis they wish to test about the relationship between an independent and dependent variable, but need to engage in some creative thinking in order to decide how to best translate those variables into specific procedures that are likely to empirically confirm the hypothesis in question.

The interesting parallel between the researcher and clinician can be revealed by altering a few words in the above quote to read:

"In any *therapy session*, the *clinician* chooses a procedure which he intuitively feels is an *clinical* realization of his conceptual variable. All *clinical* procedures are "contrived" in the sense that they are invented. Indeed, it can be said that the art of *therapy* rests primarily on the skill of the *clinician* to judge the procedure which is the most accurate realization of his conceptual variable and has the greatest impact and the most credibility for the *client* "[Aronson & Carlsmith, 1968, p. 25 (italics added and key words changed)].

Parallel to what good researchers do, practising therapists hypothesize a relationship between a general therapeutic strategy and a desired clinical impact (e.g, increasing a client's emotional experiencing to bring about therapeutic progress) and then use their creativity to use a specific intervention procedure that is most likely to work with a particular client.

In much the same way that researchers set out to test certain principles of human behavior, so can therapists profitably engage in clinical decision-making by using principles of change as their starting point (Goldfried & Padawer, 1982). If we set aside our different theoretical orientations and accompanying jargon, it is possible to delineate certain principles of change that cut across our various theoretical

school of thought. Thus there seems to be some agreement across therapeutic approaches that the change process requires our clients have some positive expectations that therapy will help. If the client is not engaged in the change process and does not believe that change is possible, it is hard to see how even the most effective of interventions can help. Another particularly important common principle involves the existence of an optimal therapeutic alliance, providing a significant interpersonal context within which change can take place. Therapists from different orientations have similarly written about the importance of providing clients with an alternate way of understanding themselves, others, and their environment. This new awareness can often set the stage for what many view as the very core of therapeutic change, namely the corrective experience, whereby clients take the risk of behaving in a therapeutically positive way despite their initial anachronistic fears and doubts. Such continued corrective experiences (action), along with resulting changes in clients' ways of understanding themselves and others (insight), afford them with ongoing reality testing. These principles can not only help guide therapists in their clinical work, but can also suggest to researchers potentially fruitful and clinically meaningful arenas in which to conduct psychotherapy process research.

Conclusion

Perhaps because of the greater pressures for accountability, there seems to be a growing awareness of the importance of having a more collaborative interaction between therapy researcher and practising clinician. Within the U. S., a prototypic practice-research network of clinicians and therapy researchers has been formed (Borkovec, Echemendia, Ragusea, and Ruiz, 2001). Efforts are being made to have such networks develop throughout the U. S. (L. G. Castonguay, personal communication, December 18, 2002), as well in the U.K. (Goldfried, Borkovec, Clarkin, Johnson, & Parry, 1999). The initial motivation of many of the clinicians involved in practice-research networks has been to reconnect to their scientific roots, which prompted them to join the network. As acknowledged by Borkovec, however, this source of motivation is not sufficient to sustain their involvement, and other methods are needed to ensure their ongoing participation (e.g., financial incentives, continuing education credit). Parry, who has been involved in a practice-research network in the U. K., has similarly acknowledged the practical challenge in providing ongoing motivation.

One way in which clinicians can collaborate with researchers is by contributing to an archive of research-based case studies. Methodologies have been developed in this area that can afford some reasonable degree of methodological control, while at the same time ensuring sound clinical intervention (e.g., Kazdin, 1981). A way to think of such replicated case studies is reflected in the thoughts of one clinician who has contributed to the research literature in this manner: "It is a lonely and sometimes frightening task to face a patient and try to help; what a comfort it would be if our colleagues' experiences could always accompany us!" (Maletzky, 1981, P. 287).

Another form of collaboration has been carried out by Sobell (1996), who worked with practising therapists in specifying an intervention for treating addictions, developing the research design, and implementing the study. Sobell's enthusiastic reaction to this collaborative effort is reflected in her stated regret that she had not done this before. Through this collaboration, she added, "I have reached more agencies, more practitioners, and ultimately, more clients than in my 25 years in the field" (Sobell, 1996, p. 316).

Still another way that the practising therapist can collaborate with the therapy researcher is by offering invaluable feedback about the application of evidenced-based interventions in routine practice. Within the U.S., after a drug has been approved by the Food and Drug Administration (FDA) for use in medical practice, additional information is often fed back by practitioners regarding any problems associated with its use in actual clinical practice. It could be both feasible and useful to have a similar line of communication established between psychotherapists and researchers, suggesting any changes in interventions or

conceptualizations that might need to be made to enhance clinical effectiveness.

As both a clinician and researcher, I firmly believe that the field of psychotherapy requires a blending of both clinical experience and research findings.

As suggested elsewhere:

"If one views the split between clinicians and researchers from outside the entire system, it becomes more evident that both groups are deluding themselves in thinking that they alone will advance the field. Stated more positively, it is perhaps more productive to conclude that both groups very much need each other. The experience and wisdom of the practicing clinician cannot be overlooked. But because these observations are often not clearly articulated, may be unsystematic or at times idiosyncratic, and are typically kept informal, it is less likely that these insights can add to a reliable body of knowledge. The growing methodological sophistication of the researcher, on the other hand, is in need of significant and ecologically valid subject material. Our knowledge about what works in therapy must be rooted in clinical observations, but it must also have empirical verification. For the researcher and clinician to ignore the contributions that each has to make is to perpetuate a system in which no one wins" (Goldfried & Padawer, 1982, p. 33).

References

American Psychiatric Association (1994) *Diagnostic and statistical manual of mental disorders (4th ed.).* Washington, DC: Author.

Arkowitz, H. (1989) The role of theory in psychotherapy integration. *Journal of Integrative and Eclectic Psychotherapy, 8, 8-16.*

Aronson, E., & Carlsmsith, J. M. (1968) *Experimentation in social psychology.* In G. Lindzey & E, Aronson (Eds.), The handbook of social psychology (Vol. 2). Research methods. Reading MA: Addison-Wesley.

Bannister, D., & Fransella, F. (1971) *Inquiring man.* Middlesex, England: Penguin.

Bergin, A. E., & Strupp, H. H. (1972) *Changing frontiers in the science of psychotherapy.* Chicago: Aldine.

Borkovec, T. D., Echemendia, R. J., Ragusea, S. A., & Ruiz, M. (2001) The Pennsylvania Practice Research Network and future possibilities for clinically meaningful and scientifically rigorous psychotherapy effectiveness research. *Clinical Psychology: Science & Practice, 8, 155-167.*

Goldfried, M. R., Borkovec, T. D., Clarkin, J. F., Johnson, L. D., & Parry, G. (1999) Toward the development of a clinically useful approach to psychotherapy research. *JCLP/In Session: Psychotherapy in Practice, 55, 1385-1405.*

Goldfried, M. R., & Padawer, W.(1982) *Current status and future directions in psychotherapy.* In M. R. Goldfried (Ed.), Converging themes in psychotherapy (pp. 3-49). New York: Springer.

Goldfried, M.R., Stricker, G., & Weiner, I. B. (1971) *Rorschach handbook of clinical and research applications.* Englewood Cliffs, N.J. Prentice-Hall.

Goldfried, M. R., & Wolfe, B. E. (1996) Psychotherapy practice and research: Repairing a strained relationship. *American Psychologist, 51, 1007-1016.*

Greenberg, L. S., & Pinsof, W. M. (Eds.). (1986) *The psychotherapeutic process: A research handbook.* New York, NY: Guilford Press.

Kazdin, A. E. (1981) Drawing valid inferences from case studies. *Journal of Consulting and Clinical Psychology, 49, 183-192.*

Kiesler, D.J. (1966) Some myth of psychotherapy research and the search for a paradigm. *Psychological Bulletin, 65, 110-136.*

Maletzky, B. M. (1981) Clinical relevance and clinical research. *Behavioral Assessment, 3, 282-288.*

Sobell, L. C. (1996) Bridging the gap between scientists and practitioners: The challenge before us. *Behavior Therapy, 27, 297-320.*

Stricker, G. (1997) Are science and practice commensurable? *American Psychologist, 52, 442-448.*

Strupp, H. H. (1968) Psychotherapists and (or versus?) researchers. *Voices: The Art and Science of Psychotherapy, 4, 28-32.*

Strupp, H.H., & Howard, K. I. (1992) *A brief history of psychotherapy research.* In D.K. Freedheim (Ed.), History of psychotherapy: A century of change. (pp. 309-334). Washington, DC: American Psychological Association.

Marvin R. Goldfried PhD is Professor of Psychology and Psychiatry at the State University of New York at Stony Brook. In addition to his teaching, clinical supervision and research, he maintains a limited practice of psychotherapy in New York City. He is a diplomate in clinical psychology, editorial board member of professional journals and author of several books. Dr Goldfired is cofounder of the Society for the Exploration of Psychotherapy Integration.

Author Note

Correspondence regarding this article can be addressed to Marvin R. Goldfried, Department of Psychology, State University of New York, Stony Brook, NY, 11794-2500. Electronic mail can be sent to: Marvin.goldfried@sunysb.edu

Werner Prall

Failing Better
Integrative Theory As Work In Progress [1]

Abstract

This paper raises some critical questions about psychotherapy integration conceived as a 'system-building activity'. The pursuit of an ideal of a (new) unified system runs counter to one important strand within the integrative project, i.e. the critique of (older) unified systems as necessarily limited and limiting. Furthermore, integrative 'systems' tend to blur the essential differences between the various approaches purportedly 'integrated'. I suggest, as an alternative way of operating with more than one perspective, the notion of an integrative process which engages the differences between theories rather than minimising them. It is precisely the different-ness of the different perspectives that allows for a more complex view of presenting clinical material to emerge.

Introduction

It seems not unreasonable to expect that any therapist operating under the banner 'integrative psychotherapy' can produce, on questioning, something that amounts to a satisfactory, that is, a coherent, internally consistent and practically useful, account of what is often referred to as their 'integrative theory'. For my part, I must confess, I always seem to end up feeling ill at ease, if not slightly fraudulent, whenever I force myself (there seems to be no other way) to come up with an answer to the question of 'my integration'. I feel like I am giving an incorrect reply to a question for which, I think I know, there is no right answer. With this 'admission' out of the way I would like to offer in what follows some thoughts on what might be meant by integration, what it is to succeed or fail in performing this act called integrating, and ask the question whether it is really such a bad thing to fall short of this goal of seemingly unquestionable merit.

The title of this essay already gives away the fact that I believe failing is something we can do and still realise, albeit often only with the benefit of hindsight, that our movement was not without a certain line of development. (Scientists know, at least since Popper, that failure is the condition of progress.)

My title is taken from Samuel Beckett's 'Worstward Ho' (1983, p.7) ; more fully (and 'rearranged' like a little poem) it reads:

No matter.
Try again.
Fail again.
Fail better.

Taking this fragment of text out of the context of Beckett's work (a work whose bleak aspects could only be overlooked by the most die-hard, incurable optimist) the notion of failing is evoked here in a way which runs counter to its usual associations with incapability and defeat. Failing, perhaps, could be something that tends to happen en route to - not succeeding, but to

---

[1] A version of this paper was first presented at the UKAPI conference in September 2001

a failure of a more satisfying kind. This evokes the idea that perhaps we could strive to become rather good at failing, that failing is something in which we acquire a certain expertise. In the context of the questions opened up here, we could ask what it would mean to fail better at formulating integrative theories. To begin with I want to set out my reasons for thinking that integration necessarily fails - and ought to fail -, reasons which are at the very heart of our project. Subsequently, I want to offer some thoughts on how we might fail better.

Integration - a divided ambition

Let us start with what the movement towards psychotherapy integration set out to do, when it began to announce itself under this description. In 1992 Norcross and Newman write:

"Psychotherapy integration is characterised by a dissatisfaction with single school approaches and a concomitant desire to look across and beyond school boundaries to see what can be learned from other ways of thinking about psychotherapy and behaviour change" (p.4).

The authors link the rapidly growing interest in first eclecticism, and subsequently integration with the end of the 'ideological cold war' between the adherents of the various schools. 'Integration' signalled a rapprochement and an end to the 'dogma eat dogma' style battles between the theoretical monoliths. Many practitioners had been disappointed by the reductive accounts and the limited results of the restricted practice suggested by their trainings. They heard the death knell of the single school approach and were attracted by its sound.

Integration was to be distinguished from eclecticism in that it was meant to designate a bringing together of disparate parts on the level of theory, not just as practice or technique. The word integration, by the way, stems from the Greek word for skin; so integration refers to that which is located within one skin - for instance, you might say, a person. The combining or blending of a plurality of approaches into a new synthesis, the convergence of the diverse, the unification of what was now looked at as parts of a new whole, were other descriptions given to outline the integrative ambition.

Norcross and Newman continue by offering what sounds like an apology for a less than satisfactory state of affairs:

"At present, we are in no position to judge, once and for all, which single theory, single technique, or single unification scheme is best. In view of the early stage of the integration movement and in view of fundamental philosophical differences separating therapists, it is unrealistic to advance exclusively anyone metatheoretical monolith" (ibid., p.5).

It is too early to know which unification, which next system will be the best. We can't say - yet; it is too early. But, this is implied, we will be working towards the achievement of the best unification.

I believe that there are two aspects, two tendencies at work within the field of integration, and that these two tendencies are deeply at odds with each other. The first I think of as its critical, anti-systematic, deconstructive aspect; the second is system-building and constructive. The first strives towards diversity and multiplicity, the second towards convergence and unification. There is a fundamental tension between, if you like, the many and the one, a tension which remains largely unrecognised and therefore untheorised in the 'integrative field'.

The opposition of these two tendencies produces an interesting paradox and helps us see the necessary failure of the project of integration. The success in creating the new unified system betrays the anti-systematic aspect of the project. This is one of the ironies of history: if the critical aspect succeeds too well it risks becoming the new orthodoxy, and thus undermining its own critical thrust. Integration as unification therefore, paradoxically, fails the moment it succeeds. If, on the other hand, the critical aspect, with its deep suspicion of unified knowledge, remains predominant, then, of course, coherence is always undermined.

The demand for an integrative practitioner to 'have a theory', in the sense of a unified system

of thought, (a demand which is perhaps more implicit rather than explicitly stated, but which seems, nevertheless, quite generally accepted without much reflection) runs counter to the critical strand in integrative thinking. Amongst other repercussions, this state of affairs has consequences for the way 'we' tend to feel about our work.[2] Of the therapists I know who, sometimes for want of a better descriptive label, call themselves 'integrative' many feel more or less bad about the fact that they cannot reach the point of an integration which can be satisfactorily articulated. I don't think feeling bad should necessarily follow, but I don't think either that a therapist should feel complacent about not knowing where he or she stands.

A quote by the German Romantic philosopher Friedrich Schlegel in my mind quite neatly expresses the dilemma I believe we are left with. Schlegel writes, "It is just as fatal for the mind to have a system and not to have a system. It will therefore have to decide to connect the two" (cited in Bowie, 1997, p.71). Let us keep this tension in mind, and review, on a general level, the lie of the land of integration; subsequently, we might consider a possible avenue for making the kind of of connection capable of addressing (rather than resolving) this paradox.

The lie of the land

Norcross and Newman (1989) identified three routes to integration, one of which, as we shall see, disqualifies itself from the start. The authors distinguish technical eclecticism, a common factors approach, and theoretical integration. I will offer no prize for spotting the odd one out - it is of course technical eclecticism, which has no ambition to attempt a systematic unification. Technical eclecticists feel free to choose what they deem best from different explanatory frameworks and intervention strategies. They let their practice be guided by clinical and research data suggesting what has worked best in the past for similar client groups and clinical syndromes. Theory is not viewed as important for the choice of treatment. Philosophically, eclecticism embraces pragmatism: good practice is what works, and good explanatory frameworks are those which have the power to guide us in achieving the desired results. We do not have access to, and indeed no need for,

[2] I am highlighting here the small and seemingly innocuous word 'we', since in my mind it contains much of the problematic of psychotherapy integration as a (rather large and still growing) patch within the field of psychotherapy. Who is this we, what are the defining characteristics that are shared by 'integrative psychotherapists' and which differentiate us, in a more or less reliable fashion, from those who do not operate under the banner of integration? Are those who count themselves (or are being counted) as one of the integrationists in in the sense of sharing these characteristics, and those who don't are out? I would say, surely not. What, then, makes for an integrative therapist, what makes for integrative theory, or integrative practice? Is it enough to say, as a first, rather general stab in the direction of an answer, that an integrative therapist is someone who 'draws on' more than one approach in his/her clinical thinking and practice? But doesn't everyone? Every therapist I know who happily settles for the term 'psychoanalytic' 'draws on' more than one psychoanalytic theory (which are in fact, of course, plural). But is this enough? Are these therapists crypto-integrationists? If not, what else is required? I am not sure we can answer any of these questions. I can't. But who could even claim, or who should feel called upon to try to formulate answers to these question on behalf of us? In the absence of answers to these questions, however, are we as a grouping of therapists constituted by more than a shared preference for this label? But even if we fail to come up with answers to these, in my mind not unimportant, questions of our identity shouldn't we try to - fail a bit better…

The thought cannot be dismissed out of hand that the label integrative psychotherapist proves so attractive precisely because it does not mean very much. It does not commit any therapist to be a particular kind of therapist, and it is possible (as it has been for me, I am happy to acknowledge) to be, over time, rather different kinds of therapists, without having to go to the trouble of explicitly redefining oneself. It is not entirely tongue-in-cheek then for me to say that one of the usages of the we is to denote the plurality of therapists that I myself have been, all under the label of integration. The positive side, if you can see it this way, of being a very loosely defined therapist is that it allows you to change, perhaps to develop even, without having to 'move camp'.

theories purporting to describe an underlying objectively existing reality.

If we rule eclecticism out of court, we are left with the two other integrative strategies named above, i.e. commonality and theoretical integration, plus a third one, which I suggest we add under the name of complementarity. For reasons of space I can offer here only the briefest of generic descriptions together with a beginning of a critical discussion (Goldfried, 1995, reviews the history of integrative endeavours).

Commonality seeks out the common factors shared between diverse therapies, e.g. an understanding relationship, empathy, trust in the concern and expertise of the therapist, the offering of an explanatory framework, emotional release, the arousal of hope etc. This kind of comparative work originated from Frank's (1961) historic cross-cultural review of healing practices. Commonality also attempts to find a shared language that straddles the different approaches, on the assumption that there is more conceptual overlap between the schools than their idiosyncratic terminologies would suggest. Commonality stresses similarities and de-emphasises differences. (A common factors approach takes the 'white noise' of differential outcome research as the carrier of the information we should be listening to.) The danger with this approach, in my mind, is that the 'shared ground' is gained by settling for the lowest common denominator, i.e. that commonality is achieved at the cost both of conceptual clarity and clinical effectiveness. Different theories are different largely for good reasons, i.e. precisely because they formulate different conceptions of the person, pathology, and the therapeutic process. This point, which gets 'forgotten' all too easily in the integrative field, is important to my disagreement with all three integrative strategies outlined here.

Metatheoretical integration strives to synthesise two or more existing theories, thus attempting to create a new theory - a whole which is more than the sum of the original parts and which manages to resolve any internal conceptual contradictions. This is, perhaps obviously, the more difficult the more divergence there is between the original schools. Apart from the problem, discussed above, of apparently succeeding in (the constructive aspect of) integration, this approach gives rise to the question, what happens once one manages (if one manages) to formulate one more new theory (if not school) of psychotherapy? Should the new multi-theoretical system be content to be one among other theories of integration and thus be part of a multiplicity of integrative theories? If yes, one wonders whether such a multiplicity would not in turn call for, well, more integration… A negative answer to this question brings me back to the point made previously, namely that the final achievement of integration (if there could be such a thing) runs counter to the whole idea of the integrative process as being based on a questioning mind, open to self-reflection, criticisms from outside and future new knowledge. This means in my mind that the problems which initially sparked off the whole movement of therapy integration cannot be finally resolved through integration.

Complementarity divides up the 'territory' between the different schools and allocates areas of validity. There are a number of ways of going about this: different theories can be viewed as particularly pertinent for certain developmental stages; different theories are seen as privileged to explain different aspects of functioning or experience; different theories are held to explain different pathologies etc. The problem with dividing up the territory in any of these ways becomes apparent once one asks the question from which position and on which grounds one determines this division. Clearly, this approach requires a theory which guides these decisions, a crucial aspect of these frameworks which is often left out. Furthermore, complementarity models often end up misrepresenting the original theories they claim to 'integrate'.

Having indicated my criticism of all three broad strategies of integration I would like to put forward an alternative way of thinking, one which I think is best not called an approach to integration, but which still seeks to preserve some of the original spirit of the integrative movement.

An alternative integrative process

Instead of integration, I want to suggest a notion of an integrative process which pursues neither the ideal of unification, not the assimilation of theories, nor an amicable division of the field, but which is centrally concerned with bringing different theories into dialogue with one another. The concept of dialogue is important to me because it both presupposes and preserves the otherness, i.e. difference, of the various perspectives whilst at the same time speaking about an exchange which leads to change.

Let us think of the different therapeutic approaches as different languages, each containing their own set of central terms and based on a usually very small set of key metaphors. A quote by the American psychoanalyst Thomas Ogden may help to introduce this idea. Ogden (1986) writes:

"Different psychoanalytic perspectives are much like different languages. Despite the extensive overlap of semantic content of the written texts of different languages, each language creates meaning that cannot be generated by the other languages now spoken or preserved in written form" (p.6).

I think we can extend this idea beyond the domain of psychoanalytic discourse. The point is that each of the different theoretical languages creates different meanings, each allows us to look at the same object or situation and see different aspects and to say rather different things about it. A plurality of languages opens up a multiplicity of perspectives from which to think about what we are looking at. For this to be possible we need to preserve the different languages and refuse to become 'unilingual'. If we 'forget' that the differentiation in theory and practice and the proliferation of the therapeutic schools did result, after all, from the more or less far-reaching differences between the various theorists, we lose the distinct meanings they intended to convey in their divergent accounts.

As a consequence I find myself disagreeing with the notions of 'anything goes (so long as it goes)' as well as with many other perhaps attractive, but nevertheless misguided metaphors of integration, such as 'melting pots', 'stews', or 'patchwork quilts'. Instead I tend to go along with ideas of a plural approach to therapy, as formulated, for instance by Carveth in his essay 'The analyst's metaphors'. Carveth (1984) suggests that we

"[…] intentionally diversify and alternate our conceptual frameworks and languages such that reality may be approached first from one angle and then from another. This is by no means to suggest that alternative perceptions should be confused or mixed […]. For when the flexible variation of one's metaphors enhances perception and understanding, the use of mixed metaphors simply leads to confusion […].

The suggestion that we ought to vary or circulate our theoretical frameworks and languages (not mix them). […] is nevertheless in direct opposition to the insistence by various theorists upon a unified discourse both in general psychoanalytic theory and, by implication at least, in clinical work as well. It is necessary, I believe, to oppose both the 'mixed discourse', which confuses alternative models, as well as the 'unified discourse' which emphasises one metaphor […]. In an important sense, the trouble with the neurotic is that his discourse is all too unified - the paranoid being exemplary in his consistency of vision. We do our patients no service if in our own theory and practice we mirror their rigidity and reductionism" (p.510).

Carveth makes a link here between the problems inherent in too unified a theory and the pathologies that psychotherapy theory is meant to give an account of. Knowing too well, i.e. knowing with excessive certainty, is more of a problem than a solution, in that it seeks to exclude other possible meanings, primarily in an attempt to reduce anxiety.

The idea that more or better knowledge leads to a unification of knowledge, or shows the internal cohesion of the thing supposedly known, seems to me at any rate to be a supposition not borne out by experience. No matter whether I consider my own experience of learning in terms of clinical practice or theory, it is not

unlike this process often called 'coming to know oneself': the more I come to 'know myself' (an expression I manage to use only in inverted commas) the less I appear to be understandable to myself in terms neatly coalescing around one set of central meanings.

Freud developed the concept of over-determination to address the fact that our behaviours and mental processes are the results of more than one set of motivations and that meaning therefore is layered. To understand the multiple meanings of over-determined processes one needs to shift one's perspective and needs at one's disposal more than one set of conceptual tools. Accepting the multiplicity of meaning 'knowing something' and 'knowing oneself' become rather suspicious achievements - even more so of course if one also entertains, as I do, a notion of the unconscious.

The argument I am presenting here parallels the constitution of personal (self-) identity (and its reconstitution in the therapeutic process where perhaps the 'integration' of the client becomes an aim we wish to subscribe to) with the formulation of a unified psychotherapy theory (aiming perhaps for 'psychotherapy integration'), and it raises the question of what is left out by such constructs. We do well to remember that for Freud the ego emerges in tandem with the unconscious; the two are always in a dialectical relation to each other.

Every self-description as well as every interpretation (and, of course: every theoretical framework for interpretation), whilst opening up one avenue for understanding, brings with it the danger that alternative meanings are closed down. Theories, like self-descriptions, can be used to exclude arguments from other perspectives, and they can be used of course in the service of avoidance of anxiety.

Peter Lomas, a British psychoanalyst, writes as a comment on Freud's achievement in showing us our propensity for defensive self-deception: "Paradoxically, however, his method has itself proved fertile ground for the development of a strategy for the avoidance of unwelcome experience. Explanation and interpretation are means by which we may attempt to control and diminish the full force of being" (1987, p.46). 'Self', like systematic theory, whilst giving coherence to experience and understanding is also, as Lacan had said about the ego, an 'alienating fiction'.

Given this analysis I have come to favour an idea of psychotherapy which emphasises the raising of questions rather than the provision of answers. The opening up of reductionist accounts is more important than the substitution of one account by another, which is supposedly (why?) 'better'. (In this I am with Freud: analysis takes precedence over synthesis.) I suggest that we take a step back from our quest for a theory which answers our questions and a practice which answers the questions of our clients (including, of course, our own questions when we are the clients). Instead we need a method of raising the important questions (usually the ones the clients/we do not want to think about) and a theory which assists us in doing so.

Theoretical viewpoints, like self-descriptions, need de-centring, i.e. questioning from alternative perspectives. In order to be able to do this we need to retain the difference between the various viewpoints, and resist the temptation to merge them into a mix. It takes a plurality of perspectives to escape reductionist accounts and to respond to the complexities of our clients' experiences and problems. I see it as the task of therapy to confront the limited and limiting ways in which our clients structure their experience. It takes a multiplicity of perspectives to open up this structure so that a more complex, multilayered account can emerge.

It should have become clear that what I take as true for our clients (and for ourselves as persons) I take to be true also for us as psychotherapists and theorists. In the same way that exclusive meanings need to be opened up through the sustained exploration (i.e. questioning) of the clinical material, psychotherapeutic theory must be subjected to examination and critical assessment, which can be done only from a position of difference. The acknowledgement of the multiplicity of meanings thus has as its consequence not only the indeterminacy of personal identity but also indeterminacy at the level of psychotherapeutic theory.

Having said this does not mean, however, that I believe that there are only ever questions in therapy and never the emergence of possible answers. Questions demand answers, after all, and on a personal as well as on a theoretical level there is always the tendency, and the necessity, to structure our experience in ways which makes it meaningful. Even after deconstructing such central notions as 'integration' - and, for that matter, 'truth' - the ideas contained by these notions continue to strike us as worth aspiring to. I think however that, in aiming for these ideal goals (if this is what they are), we must not lose sight of the fact that they cannot - and even, in the sense proposed in this paper, must not - be achieved.

The integrative project, which I am promoting here in opposition to an idea of integration as the unification of theory, views psychotherapy as both the construction and deconstruction of identity (personal identity and theoretical identity).

Ogden (1999) gives an account of therapy as a process of, almost simultaneously, creating and undoing meaning, which parallels what I have in mind. The analyst's language, which creates and conveys the best possible understanding of the patient's experience in the present moment, must

"embody in itself that there is no still point of meaning. Meaning is continuously in the process of becoming something new and in doing so, is continually undoing itself (undercutting its own claims to certainty). It is essential that the analyst's language embody the tension of forever being in the process of struggling to generate meaning while at every step casting doubt on the meanings 'arrived at' or 'clarified'" (p.218).

Theories, like the interpretations we develop in our clinical practice, need to strike the balance between offering an explanatory framework and keeping in mind that these frameworks are only temporary and rather unreliable constructions. They are needed to face the difficulties which life presents but they can at the same time be used for defensive purposes, i.e. to ward off experience in the name of 'truth'.

Conclusion

In conclusion, I suggest that we at least reduce, if not drop altogether, our investment in the pursuit of integration as a unifying system, but that we retain some of the original spirit of integration in continuing to pursue what I call the integrative project. Only a plurality of theories (which implies, to say it one more time, a difference, and a tension, between the theories) can ultimately hope to do justice to the multi-facetedness of our own and our clients' experience and thus assist us in an open-ended exploration of the important questions with which we are confronted in our work.

This paper has taken up the question of the place of multiple theories in integrative thinking on a general and somewhat abstract level. This was done, in part, to stress the generality of my argument; I would like to think that the points I am making here apply regardless of which particular theories are brought together by any integrative therapist. What seems to be required at the end of such a paper is, nevertheless, some clinical material to demonstrate, 'in action' as it were, my understanding of an integrative process. This cannot be achieved, I believe, by adding one or two brief clinical vignettes. Instead, I hope to publish in the not too distant future a more detailed discussion of a therapy, conducted, I would like to think, in the integrative spirit promoted here.

References

Beckett, S. (1983) *Worstward Ho.* London: John Calder.

Bowie, A. (1997) *From Romanticism to Critical Theory: The Philosophy of German Literary Theory.* London and New York: Routledge.

Carveth, D.L. (1984) 'The Analyst's Metaphors: A Deconstructive Perspective', *Psychoanalysis and Contemporary Thought, 7, 4 (1984) pp. 491-560.*

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

Goldfried, M.R. (1995) *From Cognitive-Behavior Therapy to Psychotherapy Integration.* New York: Springer.

Lomas, P. (1987) *The Limits of Interpretation.* London: Penguin.

Norcross, J.C. & Newman, C.F. (1992) '*Psychotherapy Integration: Setting the Context*'. In: Handbook of Psychotherapy Integration, Norcross, J.C. & Goldfried, M.R., eds. New York: Basic Books.

Ogden, T. (1986) *The Matrix of the Mind: Object Relations and the Psychoanalytic Dialogue.* London: Karnac Books.

Ogden, T. (1999) *Reverie and Interpretation.* London: Karnac Books.

Werner Prall MA, MSc, PhD is a UKCP registered Integrative Psychotherapist. Originally from a humanistic background with a particular emphasis on the body, his theoretical and clinical approach has been strongly influenced by psychoanalytical thinking and continental ('Old Europe') philosophy. He works as a trainer and supervisor for Metanoia and maintains a private practice in West London.

Diana Shmukler

Re-examining The Notion Of The Good Experience In Psychotherapy

Abstract

This paper reflects an approach to psychotherapy integration developed from the author's presentation at a conference with the above title. In this paper the author shares some of her thoughts about the process of psychotherapy and raises some questions for discussion—for instance, some of the difficulties in long term psychotherapy, the importance of supervision in the ongoing work with patients and some aspects of the need for theoretical structures in order to free the therapist to be present in the therapeutic space.

Introduction

In order to develop some of my ideas about psychotherapy I will refer to case material. I am indebted, and very grateful, to my patients and supervisees for their permission to use elements of our shared enterprise in the service of further learning. I also wish to express my indebtedness to Patrick Casement, whose ideas and supervision have had a powerful effect on my development and practice as therapist, supervisor and teacher of psychotherapy.

The decision to think about my own ongoing learning processes, and evolution as a psychotherapist and teacher, is based on a number of factors. Although this is a personal account of a personal journey, I know that many readers will be able to relate to different aspects of the story because these are embedded in the development and changes in the field of psychotherapeutic thought and theory of the last twenty years or so. This paper describes the process by which a therapist's growing understanding became the instrument through which the discovery of missing factors eventually led to a positive outcome in a field fraught with ambiguity. In this sense it underlines the need for developing an integrative stance. Also, it is a description that is much more about the therapist than the patients.

Growing up professionally in South Africa

I was educated in the 1960's in South Africa, which as a consequence of the government policy of apartheid and its implications, was already suffering from a "brain drain" and depletion of academics. South Africa institutionalized racism at a time when the Western world was attempting to move away from the historical effects of racism and redress some of its consequences. My experience as a student and a young professional was that it was difficult to find teachers, supervisors and mentors.

However, by the early 70s, the earliest stirrings of the need for change began to be felt. In the professional field there was a flurry of interest and excitement in encounter groups as well as active humanistic approaches — particularly Transactional Analysis (TA) and Gestalt Therapy. I was one of a small group of therapists that had formed a TA/Gestalt society in order to expand our understanding and develop our professional skills. We invited several international trainers and teachers who were willing to travel to South Africa and provide training workshops. These workshops

were a combination of therapy in the group, supervision and theory input. To us, the input felt like rain on dry soil and it powerfully affected our work.

The liveliness, the potential for addressing issues, and the sense of understanding created by a TA/Gestalt approach — as well as the opportunity to observe live work — added to the power of this impact on participants, especially as it took place in the absence of active training in psychotherapy. In addition, the cathartic and acting-out effect of this work was extremely gratifying. An unseen and misunderstood consequence of the unaddressed idealization was not obvious to me at the time.

Initially I learnt to do psychotherapy from this humanistic, active and somewhat person-centred perspective. In fact, it was not a bad way into the work, as listening carefully to someone is in and of itself very important in the process of therapy.

I responded, as I imagine many others in the humanistic field did at some time in their professional lives, to the simplicity, clarity and power of TA to provide maps, understanding, insight and a language to explain complex psychological ideas in a wide range of contexts. At the same time, on a personal level, coming from a fairly conservative and repressive middle class background, I experienced the freeing up of the natural child through TA/Gestalt processes in a way that was not only liberating but also exhilarating. Already in those days, however, I continually made the mistake of thinking that what had applied to me and helped my own personal growth and development, would of necessity be useful to most of my clients. I failed to account for the fact that many of them had issues, as well as developmental and cultural experiences, that were completely different from mine.

It should be remembered that I was working in an isolated context but in a culture that was "can do", well read, energetic and highly motivated to learn and succeed as best we could. So although we suffered from a lack of stimulation by, and supervision from, experienced and highly trained professionals, we were experience rich and rather brave at trying things out and experimenting with ideas.

At the time there were no psychoanalysts in the country and although we did understand that the lack implied a great gap in the development and thinking in the field of therapy, it is only now that I can fully appreciate the consequences of that deficit.

Moving to London

My move to London had a profound effect on my thinking, understanding and clinical work. In the first place, I was struck by the value I saw being placed on simple thought and reflection as processes to be seriously engaged in. In other words, taking time and space to think about problems rather than seeking solutions too quickly (of course, often out of an anxious need to settle the ambiguity and uncertainty) was something that had not been inculcated into us in South Africa.

Second, in London I had the good fortune to meet and begin to work with Patrick Casement as a supervisor. A necessary ingredient to sound clinical work is, of course, good supervision and the supervisor's ability to provide a holding and reflective space. Patrick Casement's stance of playing with ideas turns the space into a "play space" and removes the "critical parent" form the process. In this way, it is made a safe and containing space in which to experiment and take risks that lead to creative outcomes. Further, one of the most valuable benefits that a gifted supervisor contributes is help in making sense of theory and intuition, in order to turn that combination into effective clinical practice.

Casement's work emphasizes the transference /countertransference relationship and highlights the importance of constant, careful listening and attention to this process as the underlying and ongoing dynamic in the therapy relationship (Casement, 1985). His approach to clinical work and material, as well as his style and manner of supervision, provided me with the missing ingredients and support both in the case described below as well as more generally in my clinical work.

Countertransference and the therapist's transferences

Before moving to the clinical material I want to discuss how my clients and patients may have experienced me and the countertransferences as well as the transferences involved. I have long been interested in the kind of transferences that therapists attract to themselves. On the one hand every patient comes in to treatment looking for a transference object—i.e., a "somebody" on whom to project figures from their past. On the other, each therapist by virtue of their own personal presence, style and theoretical orientation will in general evoke a similar response, particularly initially.

Both as a therapist as well as a teacher in academic and psychotherapy settings, I tend to invite a strong transference reaction, usually positive but sometimes pretty negative. This is both conscious and unconscious. I first became aware of this when, after teaching large undergraduate classes (in child development, particularly), there would always be a queue of students outside my office. Many came to tell me personal stories often laden with emotion. Furthermore, a lot of them wanted to become my therapy clients, believing that I could understand something important about them. I realized that some of my throw-away lines and casual observations were reaching and addressing the "inner child" (Berne,1961). For example I would say something like "that would be really hard for a little child/boy/girl" without being fully aware of what an emotionally provocative comment this could be.

From an early age I was affected by the emotional responses of others; naturally this is a strong reason for wanting to become a psychotherapist. I tend to pick up and feel the emotional distress of others and have a concomitant wish to respond, ease the distress, solve the problem, or make something better. It has taken many years of self reflection, therapy reading and thought to become more in touch with the conscious and unconscious antecedents of both my own and others' motivations in adopting this "impossible" profession.

The story

I now turn to the central case that I want to use as a basis for illustrating and discussing the ideas about integration that arise from the work. The case provides a good vehicle for the description of an approach to integration that could also fall under the wider label of a contemporary relational approach or a developmental relational approach.

It is a story of a remarkable journey. Any story of a relationship needs two participants. So it is also a story of an extraordinary patient. I am deeply grateful to her for permission not only to talk about our journey (and so extend to a wider audience the privilege of hearing aspects of it) but also to use the mutual experience as a way of furthering understanding. It has been her constant wish that others benefit in some way from the understanding and knowledge that emerged from this work. She describes the therapy as a story of a breakdown or a journey to madness and back again.

"Have you ever cured some-one?"

This was a question put to me twenty years ago when I did my CTA (clinical membership of the International Transactional Analysis Association, ITAA) in the United States. At the time I felt it was a question difficult to answer. Yes, I had kept patients out of a constant process of admittal, discharge and re-admittal into mental institutions, but did that constitute a "cure"? In relation to psychotherapy, how does one know what a cure is, or what gets better? I am reminded here of Kohut's "How does psycho-analysis cure?" (Kohut, 1984). How indeed does psychotherapy cure? And isn't that a question we are all busy with one way or another in the work we are engaged in?

This paper provides me with the first public arena in which to describe some of the components that might make for a good outcome in a psychotherapeutic process. It is also the first time that I have discussed some of these clinical features with a wider audience.

The issue lay in the transference /countertransference relationship. It was a particular form of

a transference reaction that was problematic for me to manage. Although I recognized it as essentially a regression to the state of "absolute dependency" in Winnicott's sense (1961 p71), I was lost as to how to manage it in a twice-weekly therapy without the holding and containment provided by a psychoanalytic process. I knew that the humanistic models of "spot" re-parenting (Osnes, 1974), working with the "parent ego state" (Mellor and Andrewatha, 1980) and ongoingly gratifying the inner child were not helpful and, in fact, served only in some sense to entrench the idealization.

I began the work in the way that I had always worked. It seems that my presence and style had evoked an immediate and very powerful idealizing transference in the patient (Kohut, 1984). She regressed, or in her words "collapsed", in my presence. In fact, years later she told me that very soon after beginning to work with me, she had the "breakdown" that was waiting and needing to happen.

I began to feel more and more stuck and uncertain about how to contain this powerful and what felt like an all-consuming and total transference relationship. I was stuck, I think, in a way that many therapeutic processes begun off a humanistic base are often headed, some, of course, with less extreme consequences than others and ending with greater or lesser frustration on the part of therapist or client. Over the years while working in South Africa, I had got stuck with some clients. As I acquired more experience and understanding, it became clear to me that it was with essentially the same issues, and in a similar way, that this was occurring. Although I recognized that I was stuck I was unable to get help with how to proceed or even make sense of what was needed, even though I understood that some form of conceptual change was required. Intellectually, I was able to understand some of the dilemmas because the literature was available. Yet, what eluded me was how to turn theory into practice.

The impasse in this instance began with an idealizing transference, but one that had became psychotic because of the depth of the regression. In the client's mind the relationship had become real and had lost the "as if" quality.

Although I had read a lot of Winnicott (see Winnicott 1989) and felt that I both recognized the condition and understood this idea, I was lost as to how to manage the clinical process appropriately. As with many of his concepts, this idea, while seemingly simple, is complex, and begins to make sense clinically only when you are right in the throes of the work.

What came to make the difference between theory and practice for me was the guidance of a gifted and more experienced supervisor, who was able to provide the needed help in interpreting theory in relation to the practice. (In other words, it is one thing to understand something intellectually, but quite a different one clinically.)

One of the possible central questions to be gleaned form this discussion is how to extrapolate from psychoanalytic theory a methodology that allows for a more economical, and possibly effective, clinical approach than is usually more possible for the majority of clients and patients.

By the time I arrived at Patrick Casement with the case in hand I was well and truly stuck. The transference had become too real in the patient's mind. And I was increasingly uncomfortable and dissatisfied with the level of ever-growing dependency and vulnerability the client was experiencing. I could see that the process in which we were engaged was not helpful, but beyond that was in fact was exacerbating her condition in a way that felt completely out of control.

Having learnt some lessons from previous mistakes, I had not opened up a telephone line but had been available to read, process and think about letters. In terms of the "baby" metaphor (Winnicott,1969), so powerfully invoked particularly by Winnicott, the therapist begins to experience the role of the neglectful and abandoning mother. In many instances, therapists then attempt to compensate by trying to be on call or available on the phone, via e-mail or by way of additional time with more and more sessions running over.

The letter writing had began initially as a way of dealing with my absences when I was back

in South Africa for shorter or longer periods. Very soon however, writing to me between sessions took on a life of its own. The letters became a documentation of the breakdown and will form the basis of an expanded work on this process.

For present purposes I go into no further details than to say that the letters provided the patient with a channel of communication and allowed her to feel she could be in contact with me whenever she needed the connection. In this sense they became the patient's creative solution to some of the effects of the problem of dependency: by now what had developed for the patient was a desperate need to be in constant contact with the therapist.

At this time I was attempting to think about the situation as some sort of re-parenting, as this is how many patients, particularly where they knew TA themselves, thought about therapy. The re-parenting idea was a very powerful aspect of TA thinking through the 80s and in to the 90s (Schiff et al. 1975). It had generated a number of useful techniques such as parent interviews or therapy with the parent ego state as well as the more traditional working with the regressed or child ego state. I had tried many of these. They usually proved to be unsuccessful in alleviating her distress. Further, her dependency showed no signs of abating.

In this case there was no need to attempt a focussed regression. The patient came into the room and almost instantly regressed. In retrospect, I imagine that probably she was already regressed on the journey, as she would often get lost walking from the train station to my house. In fact I would describe her as internally regressed. Certainly in her terms of "breakdown" her inner state was a regressed one.

Here was a case where a lot of earlier TA therapy had been both damaging and hurtful. Even in the early 90's when our work began, she had been told by previous therapists and supervisors that she was using regression in a manipulative way. I remember being very relieved when I heard a speaker at a psychoanalytic forum in London expressing the view that "it's not that you make the patient regressed; their state of mind is one that is regressed." As I consider this point I think that many people, not only psychotherapy patients, spend a good deal of time in some kind of internally regressed state or slip very easily into one, particularly in their intimate and close family relationships.

Thus, what I had in the room, at this stage in the work, was an extremely regressed and preverbal child. Years later she told me that often she would respond to the tone or something about my voice and she would not even attempt to make sense of the words I spoke. In a way one could think of a recreation here of that wonderful Winnicottian notion of "alone in the presence of the other" (Winnicott 1967 p 571).

So, while I was desperately trying to grow her up, she was fighting to have the happy childhood that she had never had. She was really experiencing me as the good mother and the real mother that she had never had. In this sense we were locked in a struggle: her fighting to stay regressed and in the dependent child position, and not wanting to also hold onto the adult reality of our being two adults in the room with a therapy contract.

Early on in this work when I began seeing Patrick Casement, I was still doing "acting out" re-parenting work, which many humanistic (particularly TA-trained therapists) did in sessions: for instance, reading children's stories, icing cookies, and so on. Often, the patient would simply need to curl up, regressed on the couch. She continued in this gratifying but possibly necessary state of regression for months on end. I was not only uncomfortable with this state of affairs but also feeling more and more worried about what to do next. I knew of a number of cases where this regression had turned malignant and the psychotherapy had not ended well.

A moment from this stage of the work comes clearly to mind. I would describe some of what went on in the sessions to Mr Casement. I remember thinking that the expression on his face seemed to suggest he was thinking something like "You did what?" or "You actually said that?" Much later he confirmed this, saying that when looking back at his early notes he

observed that he had written something like "Did she really say that?" This underlined the difference in approach to, and in the conceptualisation of, the clinical process according to psychoanalytic and humanistic thinking.

Separation/Abandonment

Partly because of my own history I have found that the issues of loss, abandonment and separation/individuation have played out in many ways in my personal and professional life. I am a child of European refugees, who by living in a politically unstable, unsafe context, repeated at a personal level and perhaps even a cultural one the sense of vulnerability and the necessity for mobility should political contexts change suddenly. These issues have often been central to the work I have conducted as a therapist. This point certainly points to the fact that therapists, their own issues, and how they have constructed their lives to deal with them, are indeed all part of the therapeutic equation.

At a conscious and unconscious level my clients and patients in England often knew and experienced me as an immigrant and a traveller, with a strong and deep attachment to my homeland. The relevance in this instance was that I had started working with this patient before I actually lived in England: I had been seeing her every few months for about a year. Many international trainers in the TA organization were working in this way, even to the extent of holding "re-parenting" contracts. As I have described above it had certainly been part of my own training and even therapy experience. Today I am highly critical of these procedures and would certainly no longer undertake to work in this way, particularly in places that are not as isolated and under-resourced as we were in South Africa when I was training to be a psychotherapist.

Just as abandonment lies at the root of early psychological damage, so too does it lie at the heart of the psychotherapeutic process. Thus the question of working with, managing and addressing the abandonment issues remain a constant pressing therapeutic challenge. Therapists deal with this over weekends, breaks and any disruptions to the continuity of the therapeutic process.

The use of the object

Before describing a key feature of this work I want to consider a theoretical idea that often underpins the potential for transformative therapy. Incomplete separation, usually highlighted by the patient's extreme dependency on both the therapy and the therapist, as well as the vulnerability produced by any break or disruption to the process, demands containment and holding through the emotional stress generated by the separation. The paradox is the need for holding during absence. In order to explain this better I need to introduce another one of Winnicott's concepts. His notion of the "use of the object" (Winnicott, 1968) was only fully developed relatively late in his work and is difficult to fully understand even with clinical examples.

Mr Casement has expanded on and made this notion more accessible in his first book, 'On Learning from the Patient' (1985). It demands that the therapist grabs hold of and manages the idealizing transference. Where the idealization is unaddressed, the work remains stuck or incomplete. At the same time there is the danger of devaluation and denigration occurring particularly out of the therapy context. Further this also happens against a background where clients work very hard to keep their therapists good.

As the infant gradually begins to acquire a separate sense of self and comes to recognize that others, particularly those in close relationship (for example, the mother) have separate minds that are not under their control, they become able to "use" the object and move beyond what Winnicott describes as object relating. The infant uses the object to acquire an understanding of the external reality. What he/she begins to understand is that their emotions don't cause external events. Specifically their wish to either keep or destroy the mother is out of their control. Early trauma interferes with this developmental stage and often causes psychological damage, which manifests in subtle but highly significant ways.

For the purposes of this paper the clinical implications of this early developmental process need to be described. These have particularly to do with managing negative transferences. The inability to conceptualize an effective way for containing and holding negative feelings seems to me to be one of the major problems with a humanistic view. Inevitably we will fail our patients however hard we try to be the perfect/good mother. The re-parenting model is built on the assumption that "it is never too late to have a happy childhood". Unfortunately, it is. Psychotherapy is not about providing a better parenting experience but, rather, helping the patient come to terms with the unhappy childhood they had. This of necessity means failing them and then helping them to manage your failure. The developmental failure that occurred through inadequate parenting now gets re-created transferentially and provides the patient with a second chance.

Clinically, what is needed is that when a real failure between therapist and patient occurs, the therapist stays with the real feelings of disappointment, upset and disillusionment. Often there is an unconscious collusion between therapist and patient that results in the therapist making a mistake (Casement, 2002). When this happens, the therapist does not make a transference interpretation. Neither do they too quickly apologize, become defensive or in some other way divert the patient from the real impact of the negative effect. "In the taking it" the patient begins to know that their negative feelings can be managed and contained. By the therapist's being around for the feelings, the patient is helped to come to terms with the external reality and understand what is beyond his omnipotent control.

The clinical dilemma is how to actualize this process in the room and enable the patient to use the therapist to represent the 'bad' that is the 'abandoning mother'. The subtlety of this process has to do with the fact that, although it is a transferential process, it is also a real relational process between therapist and client. The drama of the transference/countertransference engagement requires energy, skill and wisdom. Further, the importance support from a supervisor who both recognizes what is happening and can help the therapist hold the process cannot be overstated.

The story continued; a key moment; breaks in the work

Breaks in the work serve the function of being experienced as failures in the "holding" of the work. They are both consciously and unconsciously arranged: consciously in the real sense that there exists an adult contract, and unconsciously because of the patient's need to be able to use the therapist to represent the bad experience and not try to make it better for the internal child. However, breaks work powerfully to represent the abandonment experience. In this case, during the English winter break when I would return to South Africa for a fairly long spell, breaks created a crisis in the therapy. The crisis was one that we went through a number of times over a number of years during the long process of the work.

We tried several ways of addressing the breaks. The process of experimenting with how to manage the breaks is an interesting example of the overall process of the work in that it was one of "try and adjust." The first year she decided to return to her previous therapist while I was away. It is important to remember that this was some years ago. My own thinking and understanding of the therapeutic process has evolved and changed considerably since then. This was not an effective solution to the problem. Today, I would consider the unconscious implications of going along with a suggestion like this much more carefully and what message it may be sending the client about our relationship.

The next year, she arranged to work with a therapist who was completely out of the humanistic or integrative network. In this brief psychoanalytically based work the focus was only on the unconscious process. She experienced it as extremely gruelling and it almost precipitated a breakdown.

Following on from these two unsatisfactory experiences, my gifted and creative patient suggested going to an art therapist while I was away during the following winter. Again in retrospect, she and I, naively thinking from a TA

perspective, saw this as an opportunity to play and have fun. In fact, the opposite happened. The blank canvas, almost without structure or boundaries, invited the outpouring of psychotic emotions. The art therapist became somewhat alarmed and her anxiety, rather than the process itself, unsettled my patient.

It was at about this time in the therapy that the holding and understanding provided by the supervision became central. Clearly, the challenge was to get the uncontrolled emotions that poured out on canvas, as well as in other ways, expressed directly to me in the room. These difficult feelings were emerging in the letters and probably in various other indirect ways, particularly during my absences that is, the periods when we were not physically together and irrespective of whether I was in fact in or out of the country.

The challenge for me was to create enough safety between us for her to be able to bring to me what she had begun to access and express through the art work. As I reflect on this work now, I feel that what had happened by this stage in the therapy was that what was pouring out, both on canvas and in the letters, was material previously unavailable to the patient's conscious mind. Having been locked internally, through the therapy it began to become accessible to the patient. This somewhat clumsy process on my part of trial and error (nonetheless within a frame of good enough experience between us) was beginning to allow the blocked experience to emerge and find expression in a therapeutic context. There was also value in the fact that although I was away, she was able to continue the work and express in other therapeutic arenas some of the experiential aspects of her feelings of abandonment.

One of my attempts to bring some of the negative dynamic into the room began by my saying something like: "You must be very disappointed in me that the therapy is taking so long, that you still feel so bad,if anything, even worse in some ways than before, and you had such different expectations of our work." Her reply was: "One thing I know about you is that if you don't know something you will try to find out." I understood this to be an unconscious recognition by my patient that something had changed in the way I was approaching the work.

Then the opportunity arose…

This case is an example of one of those largely unconscious situations created between therapist and client that provokes a crisis and presents them with a powerful therapeutic opportunity. For several years we had been sitting side by side on the couch, with me moving gradually further and further away from any physical contact during the session. She had however concretized the situation in the room by experiencing us as linked by the couch. (In psychoanalytic work lying on the couch symbolizes many things to analytic patients.)

I moved across the room into a separate chair and at that moment precipitated a therapeutic crisis. When she began to talk about feeling as if I were 10,000 miles away, rather than just a few feet distant, I realized that something of the psychotic element was now in the room. What had occurred was now directly related to a real action on my part and between us. At the same time, it became apparent that something of the experience of what happened for her when I really was 10,000 miles across the sea was suddenly occurring between us in the room. Some of my need/pressure to allow the abandonment experience into a space between us was now achieved. Somehow through staying close to the patient, working closely with her in fact and trusting her to articulate some of her needs, we had recreated her experience when I was overseas or absent — the experience of abandonment. Now it became possible to access and work with the feelings directly.

This became one of the turning points in the work. The transference that had now developed in this new space was such that the patient became able to use me as a representation of the "bad", abandoning mother/object. At the same time, she could also experience my real and different response to what was happening between us and to her distress. In other words, the experience was about what was happening between us in the present and also about the past. It had nothing to do with me but represented the early abandonment.

This is a good illustration of the point that the transference/ countertransference dynamic is all about you as the therapist while paradoxically having nothing to do with you at all. As a therapist, it is necessary to hold these two realities concurrently. Then, work in the present using yourself fully and at the same time retain the understanding, even if you refrain from making the transference for a long time. The past reality would have been in the patient's life and very often in the therapist's in another way. Part of the therapeutic task is to hold those two levels of reality while maintaining as much of the here-and-now focus as possible. The demanding nature of this psychological work then is related to the combination of intellectual and emotional pressure on the therapist.

In the face of this demanding task, the help from a supervisor who can listen for what the patient hears or reads from the therapists' intervention, at times unconscious, is invaluable. This drama — that is, the ambivalence inherent in the transference — is, in my view, central to all the countertransferential dilemmas that have formed a substantial literature over the last decade. As a principle for psychotherapeutic work it throws up many questions. For example, where is the line to be drawn in terms of the negativity (i.e., aggression) expressed to the therapist? In cases of trauma and abuse, how much abuse can be expressed and tolerated between therapist and patient?

Therapeutic mistakes, productive and problematic

The idea of a productive mistake is of an unconscious interplay between client and therapist in order to create therapeutic opportunities for failure by the therapist. Examples are forgetting an appointment, mistaking someone's name in the patient's life, and losing/misplacing something that the patient may have entrusted to you as the therapist. These unintended errors usually cause therapists to feel a great deal of guilt, self-recrimination and internal criticism. However, they can also be understood as providing a helpful platform to further the work.

The central point here is that what a therapist can provide is the reparation, the willingness to take responsibility for hearing and holding the feelings from a non-defensive and non-retaliatory position. As I have already explained, the goal is not to provide the better parenting experience but to give an adult a sense of a different relationship with someone. A therapist who is willing not only to "be around for the feelings"—a powerfully reparative experience in itself—but also to help understand and organize them differently, can prevent old games and scripts being re-enacted.

These "therapeutic fights" are about the need at certain points in the therapeutic process for the failure to be from a "good enough" mother. These experiences of failure form part of the working-through experience. An example of a fight of this nature would involve conversations about boundaries. This point is a departure from the way things were done in the humanistic frame. In some respects, attention to boundaries and the need to hold firm boundaries was part of my psychotherapeutic education. However boundaries between training, supervision and therapy were not always tightly held in many humanistic training models. Our "parents" as a generation of teachers did not model tight boundaries, with the result that some of us managed these training experiences better than others.

In this case, the patient wanted to cross many boundaries, such as having supervision and coming to training events or workshops that I would run from time to time. Many other trainers allowed these overlapping boundaries but I stopped agreeing to allow clients/patients to participate in other forums with me. I had come to understand that it was going to be too difficult for me to hold their therapeutic needs at the same time as concentrating fully on another task. This decision precipitated many fights. Real fights about real issues often generate powerful feelings. Although the outcome of these engagements was productive, sometimes they took a long time to resolve.

Another example along these lines was when the patient wanted to go to a workshop being run by a trainer who was working in this active re-enactment of the better parent. I had by now become critical of this approach to therapy. I had stopped any physical contact during

sessions. In the workshop in question, I imagined that there would be a lot of acting out of the patient as "baby", in the sense of holding and strong encouragement for regression.

We were dealing with my shifting to a much more analytic stance, session by session, and also the ensuing rage, distress and hurt that this therapeutic move provoked. To my mind, attending the workshop would have been a direct attack on her work with me. This is clearly a psychoanalytic understanding. When she asked me if I had changed my mind, the question showed me that she felt it was a matter of my permission rather than understanding the struggle we were engaged with.

I see that the willingness to engage in the fights about boundaries, about realities and interpretations are crucially part of the therapeutic engagement. They form the bedrock of the working-through process and the testing of the therapist's mettle. From a TA perspective this could be described as a fight from an OK/OK position. This process can be thought of developmentally as another form of the separation/ individuation process. What springs to mind is the "rapprochement" crisis (Mahler, Pine and Bergman 1975).

A number of crucial questions about therapy

A question for consideration would be of the value of a relatively long period in the early stages of the work of a gratifying, supportive form of therapy in which the idealizing transference remains unchallenged. I went along with the client's initial need to be "treated as a baby" who required nurturing and holding. Where the issues lie so early in the client's life, verbal holding did not seem to provide enough containment, particularly as the therapy was only ever a weekly double session. The symbolic nature of the verbal process was experienced by the patient in the early phases as having more to do with the sound and tone of my voice and less to do with the content of what I was saying.

So the first question is, did the long period of more concrete enactment provide a base from which both the patient and I were able to withstand the sturm und drang of the working through of separation/ individuation?

Second, engaging in a long developmental process of this sort with a client where the end result impacts dramatically on their lives and transforms aspects of it must inevitably leave its mark on the therapist too. This case changed for ever my view and understanding of the therapy process.

Another issue (though not unrelated) is that a lengthy therapy or work has inevitably to be regarded as a developmental process or as something that unfolds in stages. It would be too simplistic to think of it as inevitably following the pattern of child development although I must own up to being primarily influenced by developmental theory, particularly those of Winnicott, (1968) Bollas (1987) and others like Casement (1985; 2002) who follow in that tradition. This stems not only from my exposure and also experience as a parent, but also the research experience, and the way I have wrestled with my own history. Further, these maps speak to clinical phenomena in a way that I have always found compelling. Most relational work is consistent with these ideas.

Whatever it takes

In my experience there is something to the "whatever it takes" factor. The patient's motivation to get well, to change, to live life differently remains in my mind a key factor in good outcomes. This is about a commitment to the process and a willingness to endure its vicissitudes. The willingness to stay with the process and not give up remains both very moving and one of its most significant aspects.

In the case I have been describing, the patient displayed this commitment. She came to therapy through wind and rain, storms and train strikes over a number of years, making the therapy an absolute priority in her life. At the same time she would say she had no choice; to her it seemed like a matter of life and death. In this process she actively handed over the "hope", the hope of really getting better, to me. On more than one occasion she said, "You have to hold the hope."

It was also pointed out to me that in thinking about this “whatever it takes” factor in clients, it should always be borne in mind that from the client’s point of view there needs to be a matching sense of the commitment from the therapist to the client.

Although I have emphasized developmental perspectives in this work I consider other models helpful. Having said this, I must add, however, that consideration of these in more depth is beyond the scope of the present paper.

“Being organized by the patient/process”

In trying to conceptualize how I position myself in the therapeutic process I experience myself as consciously intending to remain as open as possible to the experience. In that sense, Bion’s notion of “without memory or desire” (Bion, 1974) is a way that I work to approach any session. During the session I try and clear my mind in order to free myself of pre-conceived notions about outcomes. This creates space in the mind for the client but also for myself to engage in the here-and-now and in the room.

I have noticed that I monitor not only my energy levels but also the quality and quantity of engagement. A clinical example is the best way to explain what I mean here. After a particular session a client complained about how much I had spoken (she was client-centred by training). In the next session, she commented that I had spoken much less that day. When I reflected on the two sessions, I came to the conclusion that there had not, in fact, been much difference in the way in which I had engaged with her. This example led me to think about how much and when I am mobilized to talk, and when not, and what the factors are that determine or control this engagement. My sense is that it has something to do with following the client and then understanding what it means about the work. I call this allowing the client or the process to organize me. I would then use my response as information about what is going on.

Conclusions

When I reflect now on this work and what I have learnt about the long-term clinical process I draw the following conclusions.

An initial engagement in which the idealizing transference is left unconfronted for a time is a valuable way in which to lay a basis for trust and provide good enough experience. When the client needs to use the therapist to represent the bad object, there is then another aspect of the relationship to hold on to. It supports both the client and the therapist with another reality of their relationship, particularly in the face of the inevitable failures between them.

A gradual process of disillusionment in the therapy follows the developmental need. Where this original process did not go well, the therapy will mirror the difficulties as each failure will be experienced as a powerful and painful disappointment. Therefore, the memory of the therapist’s caring attunement capacity to withstand the disappointment without defensiveness, withdrawal or retaliation is important.

There are many features in this story that probably led to the measure of its success. What the particular reasons and ingredients are and how they come together, and what works between a particular client and therapist at a specific time in their lives that leads to a successful outcome, remains to some extent a mystery. This case however has left me with a sense of confidence about the possibilities of psychotherapy in transforming and changing a person’s capacity to live their own lives and achieve a measure of happiness and contentment free from overwhelming and crippling anxiety.

I have taken the liberty of using this paper to reflect on a number of different issues and raise some questions about clinical work and the process of therapy. I feel that although it has been somewhat self-indulgent, and at times a bit wide ranging and not entirely sequential, it has allowed me to reflect on and share something of my own learning, thinking and development. I am grateful for this opportunity for another reason too: writing this has enabled me to start committing some of my thoughts

to paper. I end by saying that these thoughts form the basis of an ongoing work in process.

References:

Berne,E (1961) *Transactional Analysis in Psychotherapy.* New York: Ballantine Books.

Bion, W. (1974) *Bion's Brazilian Lectures.* Rio de Janeiro: Imago Editoro Prego.

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

Casement, P. (1985) *On Learning from the Patient.* London: Tavistock Publications.

Casement, P. (2002) *Learning from our Mistakes.* UK: Brunner-Routledge.

Kohut, H (1984) *How Does Analysis Cure?* Chicago: University of Chicago Press.

Mahler,M., Pine,F. and Bergman, A. (1975) *The Psychological Birth of the Human Infant.* New York: Basic Books.

Mellor,K. and Andrewatha,G. (1980) 'Reparenting the Parent in support of redecisions' in *Transactional Analysis Journal 10(3): 197-203.*

Osnes, R.E. (1974) 'Spot reparenting' in *Transactional Analysis Journal 4(3): 40-44.*

Schiff et al. (1975) *Transactional Treatment of Psychosis: Cathexis Reader.* San Francisco: Harper and Row.

Winnicott, D.W. (1961) *'Psycho-Neurosis in Childhood'* in Psychoanlytic Explorations (1989) Eds. Winnicott, C., Shepherd, R. and Davis,M. London: Karnac Books.

Winnicott, D.W. (1967) *'Postscript: D.W.W. on D.W.W.'* in Psychoanlytic Explorations (1989) Eds. Winnicott, C., Shepherd, R. and Davis,M. London: Karnac Books.

Winnicott, D.W. (1968) *'The Use of an Object and Relating through Identifications'* in Psychoanlytic Explorations (1989) Eds. Winnicott, C., Shepherd, R. and Davis, M. London: Karnac Books.

Winnicott, D.W. (1969) *'The Mother-Infant Experience of Mutuality'* in Psychoanlytic Explorations (1989) Eds. Winnicott, C., Shepherd, R. and Davis, M. London: Karnac Books.

Diana Shmukler PhD is an Integrative Psychotherapist, Supervisor and Trainer, Teaching and Supervising Transactional Analyst, Clinical and Research Psychologist (SA Medical and Dental Council), former Associate Professor of Applied Psychology (University of Witwatersrand South Africa), visiting Professor of Psychotherapy (University of Derby). She is currently in private practice in London and teaching at Metanioa Institute and Institute for Arts in Therapy and Education.

Kenneth Evans & Maria Gilbert

The Philosophy And Values Of Integrative Psychotherapy

Abstract

In this article, soon to form the first chapter in a book on integrative psychotherapy, the authors discuss the philosophical assumpions underlying their integrative framework in an attempt to clarify the basic suppositions that inform their work as psychotherapists.

Why an article on philosophy and Values ?

We believe that epistemology (theories of knowledge) is fundamentally important to an understanding of any approach to psychotherapy. Without at least a general knowledge of the philosophical bases of a psychotherapy model, it is impossible to adequately critique the theory underpinning the model or the values conveyed in the clinical application of the model. It is absurd to assume that a psychotherapist can suspend her values, which may sometimes be explicit but always implicit in her behaviour and attitudes. Knowledge is instrumental to power and it is never politically innocent (Tanesini, 1999). So it is highly relevant to ask what power, apparent or implicit in its values, might a psychotherapy method, assuming any particular form of knowledge, convey to the client?

Fundamental to our approach to integrative psychotherapy will be the notion of the psychotherapist as a 'reflexive practitioner' based on the practice of 'critical subjectivity' (Reason, 1994). The reflective function as defined by Fonagy et al. (2002) is "the capacity to envision mental states in self and others" and enables us to conceptualize "others' beliefs, feelings, attitudes, desires, hopes, knowledge, imagination, pretense, deceit, intentions, plans…" as different from our own (p24). We therefore intend to set out clearly in this chapter the philosophies upon which our approach to integrative psychotherapy is based and the values we derive from them, as a necessary prerequisite to an understanding and appreciation of our approach together with an informed basis for constructive criticism. We trust that this will be experienced as an invitation to dialogue and creative innovation.

First we feel compelled to ask, are there really 480 different kinds of psychotherapy as reported by Karuso? (quoted in Dryden & Norcross, 1990 p184). Or could it be that a number of theorists from different models of psychotherapy share some central tenets but express them differently and in different therapeutic languages? Arguably the increasing movement toward psychotherapy integration would suggest greater commonality than is often realized or acknowledged but it is difficult to judge since therapists rarely appear to establish or question the epistemological assumptions underlying their theories, models and approaches thus making it difficult to compare and contrast (Mace, 1999). Goldfried's plea for a common language for case formulation seems to us an attempt to find existing commonalities in conceptualization and create the bridge between different orientations (Goldfried, 1995).

There is some evidence to suggest that what attracts therapists to a particular school of therapy are personal reasons rather than

"neutral objectivity or logic" (Barton, 1974). Frank and Frank (1991) go as far as to suggest that it is belief that is central to an understanding and application of any psychotherapeutic approach. While therapeutic progress requires sufficient belief in the therapeutic method, on the part of both therapist and client, we agree with Downing that it is dangerous when those beliefs are held as absolute truths rather than as temporary and open to critique (Downing, 2000). There is also a sense, when people have invested large amounts of time and money in training in a particular approach, that it may be difficult to critically challenge that allegiance.

Over the past twenty years or so we have witnessed an important trend toward a more ecumenical spirit among the psychotherapies represented in the United Kingdom Council for Psychotherapy and the European Association for Psychotherapy and evidenced in the range of issues explored at professional conferences and published in The Psychotherapist (UKCP), the International Journal of Psychotherapy (EAP) and the Journal of Psychotherapy Integratrion (SEPI). All three these organisations require high levels of cooperation among and between the different approaches represented to maintain collaboration and dialogue. However, while acknowledging the significance of these developments it is abundantly clear that the 'many' schools of psychotherapy exist in relative isolation from each other with regard to access to and interest in 'rival' theories. Indeed the proliferation of 'different' schools of psychotherapy can be likened to the proliferation of religious denominations following the breakdown in the monopoly of the Roman Catholic Church. It appears to us that within each psychotherapy 'denomination' there is a fundamentalist element that preserves the founding teachings relatively unchanged and hold them to be universally valid for all time thereby underpinning dogma rather than supporting dialogue and critique. No wonder those brave enough to disagree can feel their views are tantamount to heresy and may go underground. Perhaps this is a contributory factor in the proliferation of 'schools' since a controversial idea may ultimately be forced to find a new home elsewhere?

Sophie Freud in a public lecture criticised her grandfather Sigmund Freud, together with Carl Jung as 'false prophets' by encouraging dependency and uncritical adherence among their 'disciples' (Freud, Sophie, Stockholm 2002). Her plea that we should relate to the leaders in the psychotherapy profession as 'brothers and sisters' rather than 'fathers and mothers' supports our view of the psychotherapist as a reflexive practitioner rather than a disciple.

The education and training of psychotherapists must bear some responsibility for this process. As Downing asserts, "while some doubts are tolerated by a training programme, challenges to the core assumption of the approach are usually discouraged, dismissed or treated as 'resistance'. The trainee learns rather quickly that there are ways of experiencing, behaving, and verbalising which receive praise and reward from the mentors, and those that are greeted with raised eyebrows, silence, or even rebuke" (Downing 2000, p 39). In our trainings it becomes incumbent upon us to foster dialogue across differences and respect individuality in developing frameworks and thinking.

In order to fully appreciate contemporary philosophical influences on psychotherapy we believe it is important to first understand the historical context out of which current philosophical ideas have emerged. Kuhn (1962) introduced us to the idea of paradigms, which are a way of looking at ourselves and the world that give meaning to our lives and shape an entire cultural age. A paradigm shift requires new theories and new assumptions that are contrary to and incompatible with prevailing theory(s) and bring about major changes in what is considered worthy of consideration for inquiry and inclusion in the field of study.

It is possible to distinguish three such paradigms or world views within western philosophy, religion and science. The Classical or Pre Modern Age culminated in Greece (429-347BC) with the Platonic notion that all reality was based on ideals and forms which transcended human reason. Truth was universal because it was grounded in universal forms such as beauty, goodness, justice etc. Such forms were metaphysical and human knowledge was contingent on the existence of these forms. Within the

Jewish and Christian traditions this was manifest in the notion of God as creator and everything, including human beings, were contingent upon God. Sin destroys our relationship with God and to restore the relationship we need to respond to revelation, repent and have faith. Faith results in a new form of knowledge - revealed knowledge. Truth is universal because it is grounded in an eternal and external creator.

In the 17th and 18th centuries the modern age, or Age of Enlightenment, moved knowledge beyond superstition and religious dogma and instead put its trust in the power of reason. Observation, calculation, checking results, deducing conclusions, testing ideas, developing theories were all made possible by new technology like the telescope and the prism. In the West people began to move out of the prison of dogma and fear of divine punishment. The experimental methods moved away from blind faith to observed fact. A process of de-centring the universe began. There was a paradigm shift from a theocentric to a ratiocentric way of thinking. The universe was rational and could be understood by reason. Truth was universal because human beings were rational. Descartes (1596-1650) epitomised this shift from dogma to reason with his famous statement 'I think therefore I am' as opposed to 'God is therefore I am'.

Now in the so-called Post-modern Age we appear to have lost belief in emancipation and progress through knowledge and scientific research (Kvale,1992). Personal knowledge and subjectivity are supported while objectivity is viewed with scepticism. According to Rosen "knowledge and meaning are constructed and reconstructed over time and within the social matrix. They do not constitute universal and immutable essences or objective truths existing for all times and cultures" (Rosen, 1996 p20). The essential reality of nature is therefore not separate and complete such that it can any longer be examined objectively and from outside. From a post-modern perspective there is no single, universal, privileged, accurate, truthful and secure way of understanding anything, including people! We are sympathetic to Loewenthal who writes, "Postmodernism blows the whistle on scientific intellectualism as one more form of Victorian morality which inappropriately tries to establish itself in relation to people" (Loewenthal, 1996).

The general tone of postmodernism is curious, confused, pluralist, fragmentary and open-ended and Tanesini (1999) believes that the idea of the post-modern expresses a widespread loss of faith in big ideals and theories. Lyotard (1996) describes the post-modern as "incredulity toward metanarratives". In the Postmodern Age "It is no longer possible for psychotherapy to intentionally or unintentionally don the mantle of science through the seemingly scientific nature of their theoretical language, their therapeutic methods, or the locale of their practice" (Downing, 2000 p 237). Indeed according to Heath "psychotherapeutic theories are not theories: they are mind-mind myths and therefore cannot be empirically tested" (Heath, 2000).

The origins of psychoanalysis, and thus of psychotherapy, are located within the modernist frame of nineteenth century liberal humanism when it was believed its hypotheses could be corrobated (Tolman,1994). While liberal humanism has been criticised by Schopenhaur, Kierkegard, Marx and Nietzche, more recently feminist writers have been critical of Freud's ideas for being culturally encapsulated in Judaic-Christianity, paternalistic assumptions, steeped in a eurocentric perspective and supportive of the "invidious relationship between the sexes, ratifying traditional roles and validating temperamental differences" (Millet 1969, p.78). A further criticism (in a similar vein) of psychotherapy across the broad spectrum of approaches is the emphasis on individual experience to the exclusion of contextual/social factors which tends to isolate the individual from his environment, context and external influences that may contribute to the root of their distress (Smail, 1998).

Alternatively the post-modern constructivist paradigm is based on "a relativist ontology (multiple realities), a subjectivist epistemology (knower and respondent co-create meaning) and a naturalistic (in the natural world) set of methodologies" (Denzin & Lincoln, 2000). What this means in our everyday experience of living is summed up by Cushman, "life is just a bridge, and a narrow one at that. It is shaky,

and when there is a storm it swings back and forth too much. In times of trouble we will want for the bridge to be more than a bridge; we will try to pretend that it is solid ground. We might even, to assuage our fears, try to build a permanent house on it …no theory can be a permanent house" (Cushman, 1995 p 330).

Postmodernism challenges the foundations of what we know and how we know what we think we know through "demystifying the great narrative of modernism" (Gergen, 1992 p 28). It encourages inquiry and questioning of all phenomena and is thus supportive of the notion of the reflexive practitioner engaged in an ongoing process of enquiry and self-questioning.

We agree with Orange (1995, p 46) that "today most psychologists and philosophers agree that all experience… is structured… observation (and) is theory-laden and presuppositionless knowing is impossible". However, while "…the post-modern emphasis on stories or narratives is intended as a statement of modesty, there can be an easy slippage into reification of narrative as a foundational form of knowledge. This can in turn lead to implicit assumptions about 'better' and more 'appropriate' narratives for clients and to a notion of therapy as a form of story assessment and repair. In such a case, the appeal of post-modern plurality has been diverted back into modern singularity" (Lowe, 1999 p. 82). The assumption on the part of the therapist that his/her judgement is superior and will in the end govern the 'storyline' may become a form of oppression.

While absolute truth is neither as absolute nor as true as we may like to believe, the opposite polarity that truth is indistinguishable from opinion means that "nothing is real, nothing is true and nothing is important" (Holland, 2000 p3). According to Holland modern scepticism as expressed for example in the writings of Jacques Derida does not attempt to cultivate a new philosophy of life but rather to critique the theories and prejudices of others. But if we take everything apart then on what authority do you judge anything? "Post-modern philosophy at its worst, presumes no authority at all except to claim with authority that there are no authorities" (Holland 2000, P365). We have considerable sympathy with Holland when he concludes that "neither the simplicity of grand narratives or scepticism deal with the complexities, inconsistencies and paradoxes of real life" (Holland 2000, p 360). Perhaps in the end what is important is the ability to hold the tension between these polarities and accept that our own narratives may be culturally embedded, but at the same time not move to a position where there are no serious values or personal belief systems allowed, for fear of becoming petrified in stone!

Lawson asks, "since we cannot stay where we are, and since a return to some form of realism is not a possible strategy, we must look elsewhere if we are to find a means to escape the contemporary predicament. But where might we look, and how?" (Lawson, 2001 xxxvii)

We believe that what is needed is a position between the nihilism of deconstructionism and the naivety of structuralism. Some have sought to establish this 'middle ground' based on pragmatism. Black and Holford for example maintain that from a post-modern perspective it is not important as to whether something is right or wrong, true or false but whether it works (Black and Holford,1999). In similar vein Polkinghorne writes, "one does not ask if a knowledge claim is an accurate depiction of the real – is it true? One asks, rather, does acting on this knowledge claim produce successful results" (Polkinghorne, 1992 p 151).

Others like Holland believe that while liberal democracy has become complacent, failed to understand and nurture spiritual needs and sold out to commerce at the expense of human values, nevertheless it may be possible to breathe new life into current structures rather destroy without a viable replacement. We agree and set out below to establish a 'middle ground' between conviction and uncertainty where, with Downing, we attempt to avoid our assumptions becoming reified in dogma and at the same time avoid the ultimate impotence of unyielding scepticism (Downing, 2000). We agree with Bernstein that there is an intrinsic relationship between absolutism and nihilism in that either polarity in the extreme obscures the other and is liable to become dogmatic (Bernstein,1992). We suggest therefore that a way through this demise is to consider

polarities from a paradoxical rather than an oppositional perspective.

Fritz Perls (Perls, Hefferline and Goodman 1951/73) believed that polarities were dialectical, forming two ends of one continuum. You cannot have one without the other e.g., good - bad, right - wrong, structuralism - deconstructivism, absolutism - nihilism …the one defines the other. So called opposite characteristics do not contradict each other but instead form two sides of the same coin. In Perls' paradoxical view, when one characteristic is foreground another polarity remains present in the background and it is possible to work with both polarities bringing both characteristics into awareness. In this way one can affirm the validity of both ends of the polarization. Polarization entails 'either – or' categories which can become stuck and impervious to change and into which one classifies events or perceptions (Korb, Gorrell and Van De Riet, 1989). The polarization of attitudes, feelings and behaviours tend to rigidify a person's view of self, others and the world. Polarization is appealing because it appears to offer certainty and thus security in an uncertain world. "…polarising of feelings, attitudes and values enable the individual to establish defining bases for relating to the world" (Korb, Gorrell and Van De Riet, 1989 p14). Polarization is arguably a prerequisite for fundamentalism for it can mean individuals strongly identifying with one polarity and denying the other. A dialectical approach to polarities helps to mitigate against seeing the truth as simple rather than complex.

This 'middle way' is a dialectical perspective and attitude to 'truth' which affirms the paradoxical nature of reality and, as such, is open to exploring the entire continuum between and including polarities. This requires a capacity for openness, a willingness for vulnerability, and the courage to sit with ambiguity and uncertainty (Gilbert & Evans, 2000). It involves a radical extension of Buber's I – Thou to facts, opinions, beliefs, evidence …as well as to people (Buber, 1923/1996). It is this radical extension of dialogue that we maintain exemplifies the post-modern spirit of open enquiry, rather than the nihilism of a scepticism that in extremis takes anti-rationalism to absurdity (Holland, 2000). "You are therefore I am" may well underpin this philosophy!

We outline below the epistemological bases of our approach to integrative psychotherapy. We do so with conviction and an openness to criticism that accepts them as being 'true for now'. With this attitude we hope to avoid the oppressive practice that can accompany belief in metanarratives and at the same time avoid the impotence to action that can accompany the more extreme expressions of constructivism and an absence of a belief in the importance of personal values.

The epistemological bases of our approach to integrative psychotherapy are interrelated and mutually supporting. Together they underpin the theory and method of our approach as well as providing the foundation for the values of our approach. In our opinion the epistemology, theory and clinical practice of any approach to psychotherapy should be consistent and explicit and thus accessible to critique.

Phenomenology

From the phenomenological perspective human behaviour is seen as determined by personal experience rather than by an external objective reality (Cohen & Manion, 1994). Emphasis is put upon direct experience and engagement, "…the most significant understandings that I have come to, I have not achieved from books or others, but initially, at least, from my direct perceptions, observations, and intuitions.." (Moustakis,1994, p41). The phenomenolgical method of enquiry honours the importance of subjective experience as a valid source of knowledge. Phenomenology is compatible with field theory.

Field Theory

Field theory according to Lewin (1952) is a way of looking at the 'total situation', which has been described as the organised, interconnected, interdependent, interactive nature of human phenomena (Parlett, 1991). In this context what the field produces is viewed as having intrinsic meaning and value in itself. An experience is

intimately connected with the current field conditions and cannot be understood in isolation. This underpins the importance of a sensitivity to the context of the client's life. Awareness is fundamental to field theory allowing the individual to become aware of,and to select from, options available. Awareness requires that an individual have sufficient capacity for vulnerability and openness to experience, to promote nourishing contact with the environment. The gestalt notion of figure and ground is helpful in discerning on what of the totality of experience to focus attention. At any point in our experience certain needs will take priority and become figural whilst others will remain in the ground of our experience. Attending to what is figural helps avoid being overwhelmed by all that is possible in the ground in the present. In focussing on the totality of experience at any given moment, field theory is compatible with holism.

Holism

Holism maintains that the whole is greater than the sum of the parts. From the holistic perspective nothing is deliberately ignored. Observation of the happenings in the external world is made in parallel with observations of one's inner subjective world. Holistic observation is therefore not simply 'looking' but rather looking mindfully and in depth. The holistic process offers active involved observation in all of one's being including cognition, sensation and emotion. One attempts to bring the whole of oneself to one's engagement with the world. This may be viewed as the interface between the "dialectical-intrapsychic" level of experience and the "dialogical-interpersonal" (Hycner 1991, p74) in the context of a person's total experience.

Thus the epistemological bases of our approach to integrative psychotherapy supports the non-linear and multicausality of field theory, the illumination of subjective personal experience of phenomenology, and the simultaneous exploration of both inner experience and outer engagement with the environment of holism.

The cocreation of dialogue and an adherence to a two-person view of psychotherapy

The dialogical perspective developed by the existential philosopher Martin Buber is compatible with all the above epistemologies and adds a further dimension crucial to our approach to integrative psychotherapy – the inter human dimension. Buber criticised the over-emphasis on individual existence at the expense of human inter-existence. The inter human focus of Buber incorporates both the I-Thou and I-It polarities of living and confirms our conviction that a paradoxical perspective toward polarities best fits the human condition. I-It is necessary for living, said Buber, and at the same time, without the I-Thou we do not really live! (Buber, 1996).

Buber's emphasis on the I-Thou of relationship leads naturally to a belief in the cocreation or conconstruction of all relationships. Central to our conception of psychotherapy is a focus on the co-creation of the therapeutic relationship as an interactional event in which both parties participate. It is not a one-sided relationship in which one party 'does' to the other while the other is a passive recipient but rather a constantly evolving co-constructed relational process to which client and therapist alike contribute. This is very much a two-person view of the therapeutic process, acknowledging that the client too will impact on the therapist in an ongoing way. Our approach is very much in line with intersubjectivity theory which emphasizes "reciprocal mutual influence" (Stolorow and Atwood, 1992 p18), contemporary dialogic approaches within gestalt with the focus on the healing dialogue in psychotherapy (Hycner, 1991) and contemporary relational psychoanalysis with this tenet: "The relational approach that I am advancing views the patient-analyst relationship as continually established and reestablished through ongoing mutual influence in which both patient and analyst systematically affect, and are affected by, each other" (Aron 1999, p248). Stolorow and Atwood (1992) succinctly summarize their position: "…our view (is) that …the trajectory of self experience is shaped at every point in development by the intersubjective system in which it crystalizes" (p18).They use the term 'codetermination" to describe this reciprocal process in development

and in psychotherapy (op.cit. p 24).These three approaches all stress the mutuality of the therapeutic process, although the techniques used, views of tranference and countertransference and the manner of relating varies widely.

We have attempted here to present some of the assumptions on which the values that inform our practice of psychotherapy are based. In summary, we see the therapeutic relationship as a microcosm of the client's 'way of being in the world' where clients may see and hear how they are experienced by the therapist. Therefore, it is important that the therapist's active presence is authentic and energised, honest and direct. This demands the therapist is cognisant of the countertransference and has developed significant self awareness to monitor the process and in particular the potential for the abuse of power in the therapeutic relationship. Indeed health may be described as the creative interplay between the individual and the environment. Adjustment without creativity is conformity to an external standard and conflicts with phenomenology. Creativity without adjustment is nihilism and conflicts with dialogue.

References

Aron, L. (1991) *'The Patient's experience of the Analyst's Subjectivity'* in Relational Psychoanalysis (1999) eds. Mitchell, S.A. and Aron, L. Hillsdale N.J.: The Analytic Press.

Barton, A. (1974) *Three Worlds of Therapy: An Existential - Phenomenological Study Of Therapies Of Freud, Jung and Rogers.* Palo Alto CA: Mayfield.

Bernstein, R..J.(1992) *The New Constellation: The Ethical-Political Horizons Of Modernity?* Postmodernity. Cambridge, MA: MIT Press.

Black, T. and Holford, L. Eds (1999) *Introducing Qualitative Research: A Distance learning Study Guide.* School of Educational Studies, University of Surrey, Guildford.

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

Cohen, L. & Manion, L. (1994) *Research Methods in Education (4th edition).* Routledge, London

Cushman, P. (1995) *Constructing The Self, Constructing America: A Cultural History of Psychotherapy.* New York: Addison-Wesley.

Denzin, N. K. & Lincoln, Y.S. (2000) Introduction: *'The Discipline and practice of Qualitative research.'* in Handbook of Qualitative research Second Edition. Denzin, N.K. and Lincoln,Y. S.Eds. Thousand Oaks: Sage.

Downing, J. N. (2000) *Between Conviction and Uncertainty. Philosophical guidelines For the Practicing Psychotherapist.* New York: State University Of New York Press.

Dryden, W. and Norcross, J.C. (1990) *Eclecticism in Counselling and psychotherapy.* Ipswich: Gale centre publications.

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

Frank, J.D. and Frank, J.B. (1991) *Persuasion and Healing: A comparative study of psychotherapy (3rd ed).* Baltimore: John Hopkins University Press.

Freud, Sophie (April 2cnd 2002) *Jung and Freud - False Prophets.* A lecture at Freud's Bar, Sodra Teatern/Kagelbanan, Stockholm, Sweden.

Gergen, K.J. (1992) *'Towards a Postmodern Psychology'* in S. Kvale (ed) Psychology And Postmodernism: Inquiries in Social Construction. London Sage.

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

Goldfried, M.R. (1995) 'Towards a common language for case formulation', *Journal of Psychotherapy Integration, 5(3): 221-244.*

Heath, G. (2000) 'A Constructivist Attempts To Talk to The Field.' *International Journal of psychotherapy Vol 5, No 1 pp11-35.* European Association of psychotherapy.

Holland, L. A. (2000) *Philosophy for Counselling and Psychotherapy.* Macmillan Press.

Hycner, R. H. (1991) *Between Person and Person; Toward a dialogical psychotherapy.* Highland: N.Y.: Centre for Gestalt Development.

Korb, M. P., Gorrell, J. and Van De Riet, V. (1989) *Gestalt Therapy, Practice and Theory.* Allyn & Bacon. Boston.

Kuhn, T. S. (1962) *The Structure of Scientific Revolutions.* University of Chicago press.

Kvale, S. (1992) *Psychology and modernism.* Sage: London.

Lawson, H. (2001) *Closure, A Story of Everything.* London: Routledge.

Lewin, K. (1952) *Field theory in social science.* London: Tavistock.

Loewenthal,D. (1996) 'The Post-modern Counsellor: some implications for Practice, Theory, research and professionalism'. *Counselling Psychology Quarterly, Vol 8, no 4 p 373-381.*

Lowe, R. (1999) *'Between The 'No Longer' 'and the 'Not Yet': Postmodernism As A Context For critical Therapeutic Work.'* In Parker, I. (Ed) Deconstructing Psychotherapy. London: Sage.

Lyotard, J. F. (1996). *'The Postmodern Condition: A report on Knowledge'* in L. Cahoone (ed) From Modernism to Postmodernism. An Anthology. Blackwell 1996.

Mace, C. (1999) *'Introduction: Philosophy And Psychotherapy.'* In Mace,C. (Ed) Heart and Soul: The Therapeutic face of Philosophy.

Millet, K. (1969) *Sexual Politics.* New York: Avon Books.

Moustakis, C. (1994) *Phenomenological research methods.* Sage: London.

Orange,D. (1995) *Emotional Understanding: Studies in psychoanalytic Epistemology.* New York: the Guildford press.

Parlett, M. (1991) 'Reflections on Field Theory'. *British Gestalt Journal Vol 1, No 2 pp 69-81.*

Perls F, Hefferline R& Goodman P (1951/73) *Gestalt Therapy: Excitement and Growth in the Human Personality.* Great Britain: Guersney Press.

Polkinghorne, D. E.(1992) *'Postmodern Epistemology Of Practice'.* In Kvale,S. (ed) Psychology And Postmodernism: Inquiries In Social Construction. London: Sage.

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

Rosen, H. (1996) *'Meaning-Making Narratives: Foundations For Constructivist And social Constructivist Psychotherapies'.* In Rosen,H. and Kuehlwein,K.T. (eds) Constructing Realities: Meaning: Making Perspectives For Psychotherapists: Inquiries In Social Construction. London: Sage.

Smail, D.(1998) *How to Survive without Psychotherapy.* London: Constable.

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

Tanesini, A. (1999) *An introduction to feminist Epistemologies.* Oxford: Blackwell.

Tolman, C. W. (1994) *Psychology, Society and Subjectivity.* London: Routledge.

Maria C. Gilbert M.A. is a chartered clinical psychologist and a UKCP registered integrative psychotherapist who practices in London as a psychotherapist, trainer and supervisor. She is the Head of the Integrative Department at Metanoia in West London. She is committed to promoting the process of integration in psychotherapy and in everyday life.

Kenneth Evans is a UKCP registered psychotherapist who practices as a psychotherapist, trainer and supervisor. He is currently the Director of Training at Scarborough Psychotherapy Training Institute and is also well-known in other parts of Europe as a trainer and for his service to the wider community of psychotherapy.

Tatiana Prokayeva-Ross

My Personal Approach To The Theory And Practice Of Integrative Psychotherapy

Editors' note

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

1. A definition of Integrative Psychotherapy

Those of us who are trying to develop our own models of therapeutic integration today are facing serious challenges. Psychotherapy is a new discipline, little more than a century old, and its role in society is still far from defined, which often makes for confusion of therapists with doctors, teachers, spiritual guides, substitute parents or management consultants. Some of this confusion is felt within the profession. Are we helping clients towards better adjustment or accompanying them on a journey towards emancipation (Rowan, 2000)? Is therapy a healing or a learning experience (Bohart, 2000)? Are therapists experts? if we are, then what exactly is our expertise (Spinelli, 1994, pp.313-4), and if not, how can we charge money for our services?

To me, integrative psychotherapy is a relational, co-creative exploratory effort, which increases people's awareness of how they interact with themselves and with the world, and enhances their freedom of choice. In the process, old traumatic affects are evoked, re-enacted, soothed, managed with better outcomes than in the past, and finally consigned to history as part of the client's reconfigured autobiographical narrative. This work involves both healing and learning, and as a result the client gets better equipped to struggle with the dilemmas of adjustment and emancipation.

My personal approach to integration is framework oriented rather than procedural (Mahrer, 1989). In my view, procedures described as technically identical are nevertheless applied and received differently by different practitioners with different clients, and therefore cannot be guaranteed to produce the same outcomes. I consider it more productive to discuss the intentions behind the procedures, the diagnostic thinking behind the intentions, and the broader philosophy behind the diagnostic thinking (Elton Wilson, 1993; Horton, 2000; Lapworth, Sills and Fish, 2001). This is how I intend to examine my own therapy work in this paper.

2. Consciousness, memory and the autobiographical narrative

I view the psyche as a multiplicity of dynamic processes within and between two levels of consciousness: the preverbal core consciousness, which reflects spontaneous homeostatic rhythms of our body, and the autobiographical extended consciousness, which observes, organises and interprets our felt experience of being. These processes involve activation of different types of memory, some of which are language-mediated and therefore conscious, while others survive in implicit form outside

extended consciousness. Our moods, desires, values and intentions are shaped by influences from both levels of consciousness, though we do not always realise this.

The core consciousness is associated with the brainstem – hence its deeply visceral, 'here-and-now' quality. It operates from birth, providing infants with a preverbal, rudimentary sense of self (Stern, 1985; Brazelton and Cramer, 1991; Damasio, 1999). Coloured by our innate temperament, the core consciousness forms the bedrock of our selfhood, our unique sensed experience of ourselves in the world.

Extended consciousness, on the other hand, represents the higher cognitive-affective faculties of our forebrain. This type of consciousness goes beyond immediate perception by placing it in the context of our remembered past and anticipated future, and is therefore heavily dependent on our capacity for language and on the episodic memory. It is the contents and processes of the extended consciousness that write our lifelong autobiographical narrative – a summary of our personal history, fraught with meaning and feeling.

Paraphrasing Descartes, it could perhaps be said that our primary experience is "I sense, therefore I am", registered by our core consciousness (Damasio, 1994), whereas our extended consciousness upgrades this experience to another level of complexity: "I think and feel, therefore I am a person".

Our personhood is thus simultaneously fluid and constant, experienced viscerally moment by moment and held together over time by long-term memory.

Our memory is imprecise. In physiological terms, synaptic connections tend to fade if rarely used, and to get disturbed as a neuroendocrine consequence of traumatic stress (van der Kolk, 1996). Psychologically, it means that some memories become privileged over others. This is how, in my view, our autobiographical narrative is shaped.

Fortunately for psychotherapists and their clients, our 'edited' self-representations are not the only source of information about our past. The same event can be remembered as a set of abstract facts or statements (semantic memory), a set of habitual responses (procedural memory) and a set of experiential episodes (episodic memory) (Beatty, 1995). An experience too painful to be retained as a live episodic memory can still survive below the level of extended consciousness – in the procedural memory of the body or the jumbled imagery of dreams. Partly disowned semantic and bodily memories continue exerting their influence on our cognitions, affects and behaviour.

> *Example: A client of mine complained of inexplicable panic attacks, which stopped him speaking at business meetings. The problem started soon after his promotion to a post that required interaction with his company's board of directors.*

We found a key to the problem in the client's childhood memory of his parents rebuking him for 'showing off' at family gatherings. This early experience was initially reported in therapy as a pure fact devoid of feeling. However, when the client described one such occasion in graphic detail, the forgotten childhood feelings of hurt, shame and fear suddenly returned, transforming a 'third-person' story into an episodic memory, replete with meaning and emotion. The panic attacks then acquired personal meaning – activated by the client's implicit memory of childhood trauma, they signalled potential danger associated with speaking out in front of his superiors.

It follows from the above that my therapeutic practice is based on a psychodynamic understanding of the psyche, which assumes the existence of unconscious mental processes, including repression.

However, while I believe that the extended consciousness largely performs the functions of the psychoanalytic Ego and Superego – reality-testing, impulse control and creation of the autobiographical narrative – my understanding of what psychic forces it is trying to control and why differs radically from classical psychodynamic theory.

3. Human motivation, affect regulation and the freedom of choice

a) Survival instinct and consciousness

I consider the theory of human motivation the cornerstone of any approach to psychotherapy. In order to conceptualise, explore and relieve human "problems in living" (Sullivan, 1970), we need to have a view on what people want from life, how they go about getting it, and what can go wrong in the process.

I believe that the most primary force in our existence is the evolutionary drive to survive, adapt and thrive in a given environment, and to pass the winning characteristics on to the next generation.

However, in contrast to other mammals, our behaviour is merely influenced, but not determined, by instinctual pressures. This is because we possess a higher form of consciousness, which gives us the power not only to experience physical urges and emotional upheavals, but to name them, ascribe different meanings and values to them, and above all, to choose what to do about them.

The lower, more archaic parts of our brain – the brainstem and midbrain - are the site of our physiological needs and basic affects; as such, they tend to activate impulsive behaviour. It is the neocortex that has the power to suspend our physical and affective turmoil in order to reflect on the situation and choose the most appropriate course of action (MacLean, 1990; LeDoux, 1998).

Described in a graphic if somewhat simplistic form, our psyche could thus be presented as a lifelong process of 'negotiation' between the housekeeping systems of the brainstem, the 'raw' emotional systems of the midbrain and the executive rational-emotional systems of the forebrain. The dominant force in this negotiation determines the style of our interaction with the environment.

b) Hierarchies of need and the freedom of choice

Our survival and adaptation needs are communicated to ourselves and to the outside world through emotions, which link our cognitions and bodily states. According to Panksepp (1998), there are four main basic-emotion command systems – SEEKING, RAGE, FEAR and PANIC - each traceable to a specific neural substrate in the midbrain and characterised by its own distinctive set of neurotransmitters. This classification provides a bridge between neurobiological research into brain activity and socio-psychological theories of human motivation (e.g. Lichtenberg, 1989).

Basic-emotion command systems underpin and shape our internal hierarchies of needs. For instance, individuative behaviour of a young child may be motivated by strong curiosity (SEEKING) or frustration (RAGE), but if his mother reacts by threatening to withdraw her love, abandonment anxiety (PANIC) is likely to prevail. As a result, the other two motivators may be suppressed – or even repressed. Where this conflict of needs is experienced repeatedly over a period of time, certain emotional and behavioural reactions become a habit. A once-adaptive response to environmental challenge is now replayed automatically, driven by affective memory.

Thus, our freedom of choice operates on the interface of cognition, affect and behaviour. It is exercised every time we use - or decline to use - our ability to mediate our physical and affective impulses by reflection. Some psychoanalytically oriented neuroscientists have even suggested that the essence of the "free will" is the capacity for inhibition – "the capacity to suppress the primitive, stereotyped compulsions that are encoded in our inherited and emotional memory systems" (Solms and Turnbull, 2002, p.281).

I do not see human nature as intrinsically good, or bad, or even a mixture of both. I believe that people are entitled to all their physical urges, emotions and thoughts. It is only when these get indiscriminately translated into action, with damaging consequences for self and/or others, that categories such as 'good' or 'bad'

can be used to describe the behaviour. Needless to say, the labelling of 'aberrant' behaviours as pathological or criminal is culturally and historically relative (Foucault, 1965; Fromm, 1998; Littlewood and Lipsedge, 1993).

In contrast to classical psychodynamic thinking (e.g. Freud, 1920; Freud, 1923; Segal, 1973), I do not see the libido and aggression as the fundamental drives underlying all other motivators and representing respectively the life and death instincts. Rather, I regard them as parts of our basic-emotion command system, which serve us – along with other emotions - in our lifelong attempts to prioritise and satisfy our needs. I agree with those writers for whom attachment and cognitive mastery needs constitute equally potent instinctual drives (Bowlby, 1988; Basch, 1984).

I believe that each of us has a 'second-tier' set of motivators at the level of autobiographical consciousness, which complements (and sometimes contravenes) the motivational systems operating in the lower brain. These are unique to each individual, but some of the more universal ones include:

- the need for structure and meaning (Lapworth et al, 2001);
- the need to reduce anxiety caused by existential concerns such as death, freedom, isolation and meaninglessness (Yalom, 1980; May, 1977);
- the need to manage the lifelong tension between the desire to be autonomous and to belong (Kegan, 1982; Guntrip, 1994).

The motivational systems that I have discussed above are of course theoretical abstractions. Our personal hierarchies of needs are unique and fluid modifications of these, shaped through our interaction with the environment. They are partly a product of mature reflection and partly introjects of parental and societal influences.

4. How personality is formed and what can go wrong in the process

Nature and nurture

I take the view that we are born with a unique temperament, which determines the general tone of our core consciousness, such as the intensity of our response to stimulation, or how quickly we calm down after the stimulus is removed. However, temperament is only a potential, a set of predispositions and probabilities, which require an actualising environment in order to develop into personality traits or behaviours. Our actual personality is created through the "continual interaction of genetically determined constitutional features and experiential exchanges with the environment, especially the social environment" (Siegel, 1999, p.85).

Thus, nature and nurture are inseparable. To use Kagan's vivid simile, "every psychological quality is like a pale gray fabric woven tightly of thin black threads representing biology and white ones representing experience, but it is impossible to detect any quite black or white threads in the gray cloth" (Kagan 1998, p.37).

New memory records are created every time we interact with the environment, which in turn affects our future interactions. In this sense, personality formation is a lifelong process. However, in my theoretical framework special importance is ascribed to early psychosocial development.

b) The role of early attachments in the development of a functional self

Self and other are closely intertwined at all stages of our development, but particularly in infancy and early childhood. A baby becomes part of her sociocultural milieu long before she is born, due to expectations projected on to her by members of her family. It is never possible to get a pure, uncontaminated picture of a child's innate temperament because it is always mediated by parental subjectivity.

We enter this world with physiological and emotional needs that cannot be satisfied without constant help from caring others.

These needs are experienced intensely on the bodily and primary affective level (basic-emotion command systems) but the language-based structures of the extended consciousness are not yet in place, so we can neither share our experience with others nor reflect on it ourselves. Neither do we know how to modulate the intensity of our affects. All these psychological 'services' are provided by our carers as they feed and bathe us, talk and sing to us, soothe or stimulate us.

These tasks require immense attention to the infant's nonverbal communication and a subtle attunement to affective states that are being expressed. Even then, some empathic failures are inevitable since the carer can only guess at the baby's inner life. However, if the primary carer is good enough, i.e. understands and responds to the infant's needs with sufficient consistency, the baby accumulates enough positive memories of interpersonal interaction. In time, these organise themselves into RIGs – generalised psychic representations of the child's experience of self-with-other (Stern, 1985, pp 97-9).

Cognitive and affective development that takes place in the context of good-enough early attachments tends to produce psychic processes, which together constitute a flexible, robust self. Informed by the work of Masterson (1985), here are the main attributes of what I consider a functional self:

- spontaneity and aliveness of affect;
- effective affect modulation and self-soothing;
- self-reflection linking memory, feeling, meaning and action;
- effective use of language for mediation between internal and external processes;
- self-activation and self-assertion;
- self-entitlement and self-esteem;
- resilience to frustration;
- creativity (using the self to change old patterns into new and different ones);
- empathy;
- intimacy (ability to form close relationships with minimal anxiety about abandonment or engulfment).

I share the view, held by most humanistic and many psychodynamic therapists, that pervasive maladaptive patterns emerge in people whose developmental needs were not met at the appropriate age and who had to adopt suboptimal alternative strategies to get what they needed (e.g. Winnicott, 1965; Johnson, 1994; Berne, 1964). Such early decisions are not pathological per se; on the contrary, in the original circumstances they were adaptive. The problem is that cognitions, affects and behaviours that constitute such patterns become rigidified and stereotyped. This reduces the person's adaptive functionality in adult life.

It is often the helplessness and dissatisfaction caused by compulsive recycling of old experience through such automatic patterns that brings people to therapy.

What happens in therapy

a) Assessment and goals

Since I assume that our psyche is shaped through relationships with significant others within a broader context of socio-cultural norms, I regard the self which the client (and, indeed, the therapist) brings to therapy as a threefold entity.

First, there is our core self experience – a highly subjective felt sense of who we are, deeply rooted in the core consciousness and implicit memory. Much of this experience defies verbal expression; words feel too crude to convey its subjective subtlety. Often, attentive gaze or some other sign of nonverbal attunement makes us feel more intimately understood than an interpretation, no matter how accurate.

Second, there is our personality, which I understand as an objectified, socially-constructed picture of who we are. We cluster together each other's behaviours and give them labels that have different meanings in different societies and cultures.

Finally, there is our autobiographical narrative - a complex compromise between our internal self experience and feedback from others on how they see us. This is our life told as a story

to ourselves and others. We try to keep it consistent, often at the cost of repressing the felt truth of our core experience.

I believe that there are painful splits and discrepancies between these three layers in all of us. Some – like the fact that only partial contact and approximate understanding can be reached between people - have to be accepted as existential givens. They can only be explored but not changed. However, others – for instance, when someone's body language clashes with their verbal self-representation – can be both explored and changed.

Consequently, I see the central task of therapy in creating opportunities for the client to reconcile (as far as possible) the public and private, felt and thought, valued and disowned aspects of his psyche, so that they form an integrated whole. Of course, this can never be achieved once and for all. The whole point of this balance is that it is dynamic. In my frame of reference, the main characteristic of a functional, integrated self is its open, flexible interaction with the world.

My problem formulation is based on the understanding of the client's motivational system in the context of his developmental history. "How did his primary carers respond to his needs? How did their response affect his core self experience? What sense did he make of those interactions? How are they recorded in his bodily-affective, semantic and episodic memory? How does that affect his autobiographical narrative? What are the most important needs in his current life? What does he do to get them met? Does this work?" These are some of the questions that I ask myself as I listen to the client and to my countertransference.

We can rarely obtain literal truth about what exactly happened or failed to happen in the past, but we do not need it in order to do the work - a metaphor that makes personal sense to the client is enough. It is also important to remember that remodelled versions of the lived past and anticipated future that emerge in the course of therapy are just as metaphorical as the old ones. The only difference is that the new metaphors (one hopes) facilitate a more integrated and fulfilling existence.

Not all problematic mental states and behaviours have psychological causes. I find DSM-IV (1994) very useful in restraining my intrapsychic bias. Its sections on differential diagnosis remind us of the importance of biological and social factors. For instance, an unprovoked panic attack can be caused not only by neurotic anxiety, but also by hyperthyroidism, asthma, substance abuse or a tumour. I encourage clients to explore all avenues. But even where the presenting problem (e.g sexual dysfunction) turns out to be somatic, there is still a therapeutic conversation to be had about its meaning and implications for the client.

People have more flexibility in some areas of their life than in others. Comparing these is a useful diagnostic exercise since it provides an insight into the client's coping strategies and defence systems. From the treatment planning point of view, it helps identify existing strengths which can support the client while he is developing new capacities of the self.

The process of change

Clients often come to therapy seeking to be healed or changed. While therapists do not have the power of magical transformation, we can create opportunities for clients to heal or change themselves, by providing (explicitly or implicitly):

- a relationship where historical deficits can be explored without retraumatisation;
- theoretical concepts and phenomenological observations that facilitate insight;
- a safe space for practising new ways of being;
- and faith in the client's ability to build himself a more satisfying life.

I try to be a "participant observer" (Sullivan, 1970) in the therapeutic encounter. My hope is that the client will internalise this experience in the form of an executive function of the self that both observes and cares – i.e. thinks and

feels at the same time. This concept is similar to Kohut's (1971) principle of transmuting internalisation.

I believe that lasting change in therapy can only be achieved if the work takes place on two levels: verbal (cognitive-affective) and nonverbal (bodily-affective). Nonverbal attunement establishes rapport and promotes affect regulation (Schore, 2000). This in turn lays the groundwork for a more robust inquiry into the client's way of being in the world.

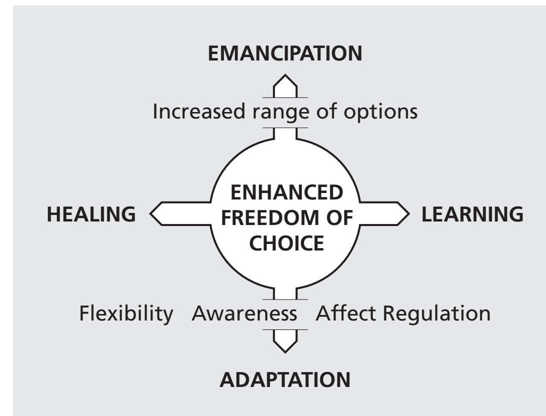
> *Example: While telling me that her mother never picked her up when she cried, a client suddenly looks at me and sees her pain reflected in my face. In this silent, spontaneous disclosure that her pain has touched me, I am not "picking her up". It is not within my power to undo her early abandonment trauma. Instead, I am acknowledging the validity of her need to be picked up, and grieving with her that she was denied this as a child.*

Accumulated memories of my empathic attunement slowly re-sculpt the neural pathways of her limbic system; her angry outbursts become less acute. As her RIG "unlovable self with rejecting other" gets challenged through both process and insight, the client discovers how her early trauma gets re-enacted in her present life, and her own role in this. Gradually, she comes to see that she is entitled to being cared for, but this need must be expressed and negotiated in an adult manner. She then starts exploring and practising new strategies, first in therapy and then outside. New experiences become incorporated in her autobiographical narrative.

The cognitive-affective-behavioural sequence for getting out of negative RIGs can be summarised as follows:

- a 'good-enough' relational climate of acceptance, verbal and nonverbal attunement;
- affect modulation experience internalised;
- insight into the problem;
- re-experiencing archaic affect in therapy without the usual traumatic consequences;
- using enhanced self-soothing capacity to suspend affect and habitual behaviour prompted by it;
- using neocortical reality-testing systems to evaluate options and make new choices;
- practising in increasingly difficult situations outside therapy.

To conclude: In my view, therapeutic change occurs through the interlinked processes of affective healing and cognitive restructuring, represented on the diagram below by the healing - learning axis. A new, better experience of self-with-other received in therapy becomes internalised via explicit and implicit memory. The resulting increase in the freedom of choice enables the person to operate more flexibly along the emancipation - adaptation axis, balancing his personal needs against those of other people and the broader sociocultural context.



References

Basch, M.F. (1984) *Selfobjects and Selfobject Transference: Theoretical Implications.* In: P.E.Stepansky, A.Goldberg (eds) Kohut's Legacy: Contributions to Self Psychology. London: Hillsdale, NJ: The Analytic Press, pp 21-41.

Beatty, J. (1995) *Principles of Behavioural Neuroscience.* London: Brown & Benchmark.

Berne, E. (1964) *Games People Play.* New York: Grove Press.

Bohart, A.C. (2000) The client is the most important common factor: clients' self-healing capacities and psychotherapy. In: *Journal of Psychotherapy Integration, vo.10, no.2, June 2000, pp 128-49.*

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

Brazelton, T. and Cramer, B. (1991) *The Earliest Relationship: Parents, Infants and the Drama of Early Attachment.* London: Karnac.

Damasio, A. (1994) *Descartes' Error.* New York: Grosset/Putnam.

Damasio, A. (1999) *The Feeling of What Happens: Body, Emotion and the Making of Consciousness.* London: Vintage.

Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (1994) Washington, DC: American Psychiatric Association.

Elton Wilson, J. (1993) *Towards a personal model of counselling.* In: W.Dryden (ed) Questions and Answers in Counselling in Action. London: SAGE.

Foucault, M. (1965) *Madness and Civilization: A History of Insanity in the Age of Reason.* New York: Random House.

Freud, S. (1920) *Beyond the pleasure principle.* In: S.Freud, The Essentials of Psycho-Analysis. London: Penguin 1986.

Freud, S. (1923) *The Ego and the Id.* In: S.Freud, The Essentials of Psycho-Analysis. London: Penguin 1986.

Fromm, E. (1998) *The Essential Fromm: Life Between Having and Being.* New York: Continuum.

Guntrip, H (1994) *Personal Relations Therapy:* The Collected Papers of H.J.S.Guntrip. (ed by J.Hazell). Northvale, NJ: Jason Aronson.

Horton, I. (2000). *Principles and practice of a personal integration.* In: S.Palmer and R.Woolfe (eds) Integrative and Eclectic Counselling and Psychotherapy. London: SAGE.

Johnson, S. (1994) *Character Styles.* New York/London: Norton & Co.

Kagan, J. (1998) *Galen's Prophecy: Temperament in Human Nature.* Oxford: Westview Press.

Kegan, R. (1982) *The Evolving Self: Problem and Process in Human Development.* Cambridge/London: Harvard University Press.

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

Kolk, B.A. van der (1999) *Trauma and memory.* In: B.van der Kolk, A.McFarlane and L.Veisaeth (eds) Traumatic Stress. New York: The Guilford Press.

Lapworth, P., Sills, C. and Fish, S. (2001) *Integration in Counselling and Psychotherapy: Developing a Personal Approach.* London: SAGE.

Le Doux, J. (1998) *The Emotional Brain.* London: Weidenfeld & Nicholson.

Lichtenberg, J.D. (1989) *Psychoanalysis and Motivation.* Hillsdale, NJ: The Analytic Press.

Littlewood, R. and Lipsedge, M. (1993) *Aliens and Alienists: Ethnic Minorities and Psychiatry.* London: Routledge.

MacLean, P. (1990) *The Triune Brain in Evolution.* New York: Plenum Press.

Mahrer, A. (1989) *The Integration of Psychotherapies.* New York: The Human Science Press.

Masterson, J. (1985) *The Real Self: A Developmental, Self, and Object Relations Approach.* New York: Brunner/Mazel.

May, R. (1977) *The Meaning of Anxiety.* New York/London: Norton & Co.

Panksepp, J. (1998) *Affective Neuroscience: The Foundations of Human and Animal Emotions.*

Oxford: Oxford University Press.

Rowan, J. (2000) Back to basics: Two kinds of therapy. *Counselling, vol.12 no.2, March 2000, pp.76-8.*

Schore, A. (2000) *Attachment, the Developing Brain and Psychotherapy.* Presentation at the Bowlby Conference, London 2000.

Segal, H. (1973) *Introduction to the Work of Melanie Klein.* London: Karnac

Siegel, D. (1999) *The Developing Mind.* New York: The Guilford Press.

Solms, M. and Turnbull, O. (2002) *The Mind and the Inner World: An Introduction to the Neuroscience of Subjective Experience.* London: Karnac.

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

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

Sullivan, H.Stack (1970) *The Psychiatric Interview.* New York: Norton & Co.

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

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

Tatiana Prokayeva-Ross graduated from the Metanoia Institute with an MSc (Distinction) in Integrative Psychotherapy in 2003. She also holds an MA (Distinction) in Linguistics and Philosophy from Moscow State University. In her previous career as an academic, a journalist at the BBC and consultant in the City of London, Tatiana had been exploring issues facing societies and individuals in transition. She currently divides her time between building a private psychotherapy practice and working as a consultant and coach with organisational clients. Based in the UK for the past 15 years, Tatiana maintains close links with her native country, Russia.

Production

Designed and typeset by Matthew Gilbert using Adobe InDesign® and Mac OS X.

Printed in the United Kingdom by Q3 Print Project Management.