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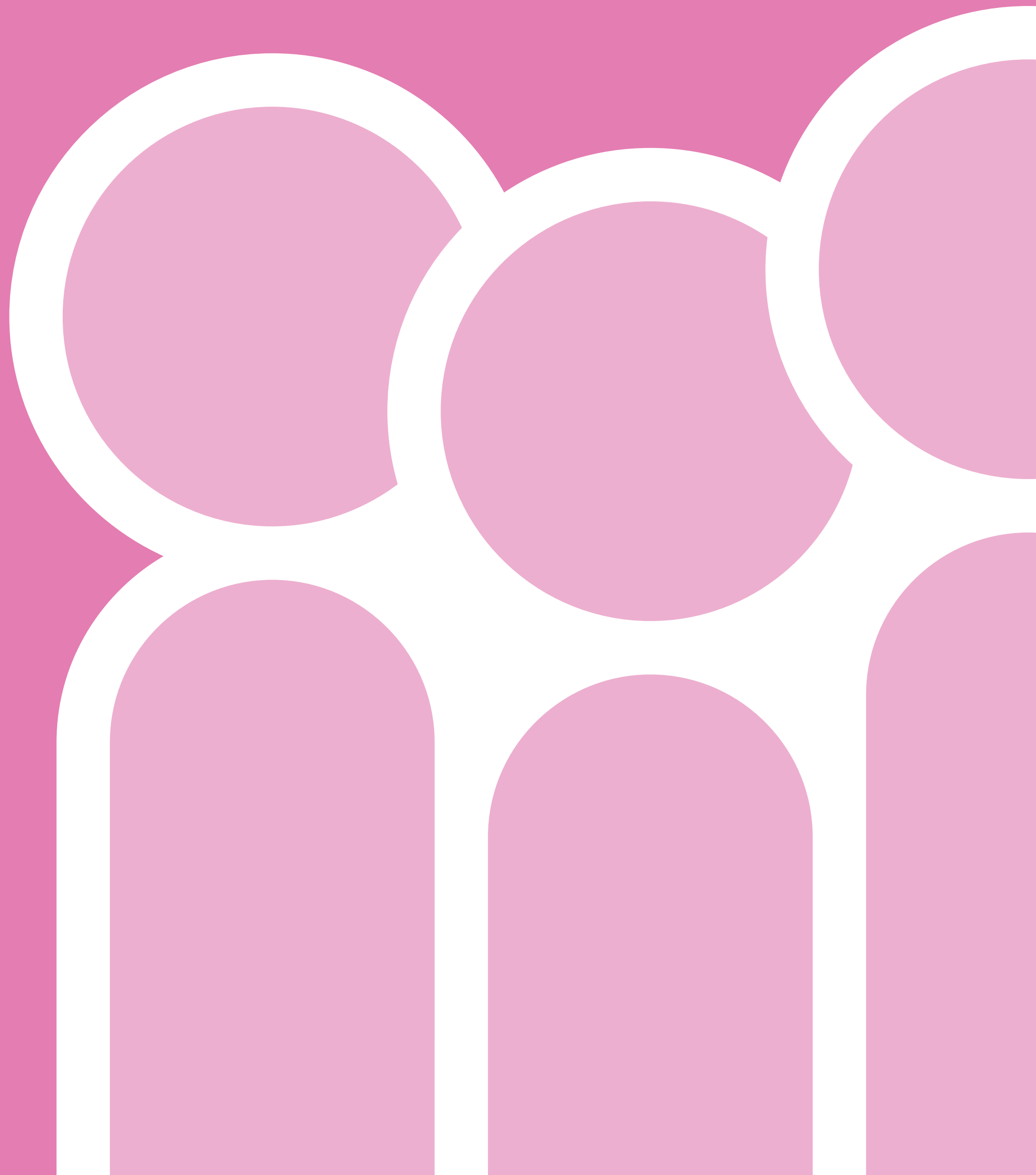
Integrative Perspectives On Clinical Practice



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Introduction

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

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Some 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 submitting please visit our web site (www.ukapi.com/journal/) and download a copy of the submission guidelines.

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Editorial

Integrative Perspectives On Clinical Practice

In this edition of the journal all the contributions are primarily practice-based where each contributor's integrative framework is implicit in their reflections. As in previous editions of this journal this collection of articles illustrates for us the broad-based tenet of psychotherapy integration: that there is no one and only integrative approach and that each practitioner is working within their own dynamic blend of theories and practice. We welcome the diversity of integrative practices represented here and each practitioner's individual embodiment of the personal and the professional.

Contents Of This Issue

Sharon Cornford discusses complex bereavement in terms of self object needs and the loss of the primary source of self object relating. Sharon reminds us of the psychic impact of losing a core relationship that has served this function in our lives, to the exclusion of other resources and attachments. She brings to life the desperate disintegration that such a primary loss has on the survivors' lives, their functioning and their sense of self. She reminds us of the particular nature of the grief work in these situations.

Asaf Rolef Ben-Shahar provides an in-depth exploration of the relevance of what he describes as relational hypnosis as a contemporary relational psychotherapy. In this way he reclaims a serious place for the therapeutic use of trance and touch within psychotherapy making an informed plea for its restoration into mainstream psychotherapeutic practice.

Herbert Hahn provides a delightfully personal exploration of social dreaming in many different practice settings. He conveys a sense of the spontaneous emergence of collective dreaming and illustrates how a group can learn about unconscious processes by taking a shared interest in their own and others' dreams. His account of his background in South Africa under the apartheid regime adds a poignancy to his later accounts of using Social Dreaming Matrices to provide a healing space in South Africa after liberation.

Phillipa Smethurst explores in a very accessible way and from an experience-near perspective, the phenomenon of secondary traumatic stress as it manifests in front line health professionals. She provides a differentiation between burn-out and secondary traumatic stress with helpful tables for the guidance of the practitioner and some helpful 'tips' for maintaining emotional balance.

Julianne Appel-Opper explores a living body perspective on psychotherapeutic process through the candid exploration of an encounter between what she describes as "two living bodies" communicating at the non-verbal level. She provides a case example drawn from work in a group and indicates the powerful therapeutic effect of one person's work facilitating personal and professional learning in a group context.

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

We have also included one book review.

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

Sharon Cornford

After The Death Of A Selfobject: Understanding And Working With The Impact Of A Major Bereavement On The Self

Abstract

In this paper I explore the impact of a significant bereavement on the self when the bereaved person experienced the deceased as a selfobject who sustained, regulated and repaired their self-experience. I offer an understanding of the impact of the death of a selfobject on the self and the grieving process from the perspective of Stolorow et al.'s 'Intersubjectivity' Theory (1987; 1992), informed by Hagman's 'self psychology of the mourning process' (1995), and integrated with the postmodern bereavement theory of 'Continuing Bonds' (Klass et al., 1996). Finally I present reflections, based on my work, for an integrative approach to helping bereaved clients maintain and repair lost selfobject functions after the death of a selfobject.

Introduction

For the past ten years I have managed the bereavement service of a large London hospice. For the majority of the adult clients who come for help, the person who has died under the care of the hospice is their partner or a parent. Some only need a brief intervention to gain reassurance that they are grieving "normally" as they adjust to their loss, to finish some "unfinished business", to address a particular issue about the death itself, or to come to terms with other losses and changes arising from the death. Most of our clients, however, come for help because they are devastated by their bereavement and cannot see a way to live without the person who has died.

Depending on their relationship with the deceased, these clients may have lost their companion, lover, best friend, confidant, carer, advisor or protector; their main source of emotional, practical, or financial support; the person who fixed things, organised things or solved problems; the one who was "always there". They may also have lost someone they depended on but who was abusive or neglectful to them. For those who struggle the most, the difficulty is not just that they were very close to the deceased and will miss them terribly. They are struggling because they were dependent on the deceased at the level of their self for their sense of who they are and how they function. The deceased was experienced as a selfobject who helped sustain and repair their self-organisation, self-regulation and self-cohesion. Without the deceased they also lose their sense of their identity, their emotional stability, their self-esteem and confidence, their sense of purpose and meaning, their hope for the future, and sometimes their will to live. If the relationship was very lacking or abusive they also lose their final hope of any improvement or repair in the lost relationship.

The extent to which these clients' self was dependent on the deceased determines the amount of re-organising of self-experience they have to do as they grieve to maintain

their old sense of self or create a new self. This task is usually extremely painful, challenging and confusing, and my role is to hold and facilitate the process so that the way in which self-experience is reorganised is as healthy as possible. The way in which they not only review their lost relationship but also retain and rework an on-going relationship with the deceased is a central component in this process. This continuing bond is often so powerful that it feels like we are working with the deceased in the room.

The Self And Selfobjects

I understand the impact of a major bereavement on the self from the perspective of Stolorow et al.'s 'Intersubjectivity Theory' (1987; 1992). Hagman's article "Death of a Selfobject: Toward a Self Psychology of the Mourning Process" (1995) is particularly helpful in this regard.

In their development of Kohut, Stolorow et al. define the self as a psychological structure through which self-experience acquires cohesion, continuity, shape and organisation. Self-experience is organised by our affects and is always embedded within an intersubjective field. Our sense of personal identity, self-esteem, affect regulation and sense of purpose are contingent upon sustaining selfobject relationships.

Stolorow et al. adopt Kohut's concept of the selfobject and define it as "an object experienced subjectively as serving certain functions [where] a specific bond is required for maintaining, restoring, or consolidating the organization of self-experience" (1987, p16f.). They expand Kohut's one-way self-selfobject relationship into a two-way intersubjective process of "reciprocal mutual influence" (Stolorow et al. 1992, p18).

Stolorow et al. agree with Stern (1985) that the way we organise our self-experience develops in an intersubjective context within which the caregiver's primary selfobject function is to provide attuned responsiveness. This selfobject function enables the infant to learn to tolerate, differentiate, regulate, contain and integrate affect and use affects as self-signals, whilst also affirming and facilitating the infant's strivings for self-delineation, cohesive identity, self-esteem and sense of purpose.

Experiences with the caregiver as selfobject are internalised as "cognitive-affective schemata", similar to Stern's 'RIGs' (1985) and Bowlby's 'internal working models' (Holmes 1993), so that they can be activated without the actual presence of the selfobject.

Kohut believed that self-structure is built when the caretaker's empathic failures create "optimal frustration" of the infant's selfobject needs, leading to "transmuting internalisation" of them into new structures that assume the psychological functions previously performed by the selfobject (Siegel 1996, p71) thereby freeing the self from dependence on the object. Stolorow et al. extend and modify Kohut's concept of transmuting internalisation by maintaining that self-structure is not built in the ruptured selfobject tie but in its repair when the caregiver's "optimal empathy" facilitates integration of the painful affects elicited by the rupture (Stolorow et al., 1987).

Selfobject functions are not just needed developmentally, but are necessary to sustain, regulate and repair self-experience throughout the lifespan. The aim of maturation is therefore not total independence but the ability to form more mature rather than archaic selfobject ties (Siegel, 1996) so that self-experience is sustained by them but there is sufficient self-structure that the survival of the self does not depend on them.

The Death Of A Selfobject

When someone dies who sustained and repaired our self-experience, in addition to the agony of our object loss, our selfobject loss plunges us into a "self-crisis" (Hagman, 1995). Our intersubjective mutually regulatory system breaks down and our self-experience becomes disorganised. If their selfobject function was to sustain our sense of identity, our sense of who we are may fragment. If they maintained our self-esteem we may lose our sense of self-worth and confidence. If they helped us regulate our affect we may find ourselves overwhelmed by some of the most intense affect we have ever experienced, struggling to self-soothe or to transition from negative emotional states back to emotional equilibrium and positive affects.

If our self-experience was dependent on the presence of the deceased for its cohesion, if the lost selfobject bond was therefore archaic rather than mature, and if we have not internalised and developed sufficiently resilient autonomous self-structure to maintain self-cohesion without the deceased, after the death of a selfobject, underlying developmental deficits and original trauma can resurface and threaten the survival of the self.

Grieving: An Intersubjective Process

I understand grief as our affective, cognitive, physical and behavioural response to our bereavement and to all that is lost and changed. Our grief is the price we pay for loving and making attachments (Parkes, 2006). It is an expression of our longing for what is lost as well as for what never was, and for what now can never be.

Grieving is not static but a process through which we adjust to our bereavement over time. Because we experience a major bereavement as a multidimensional relational loss, our grief is also a multidimensional relational process. Grief is clearly relational in the sense that our grief communicates our distress to others and elicits a needed response, but it is also relational because, as we grieve, we are reorganising our severed bond and, in postmodern thinking, our continuing bond with the deceased. After the death of a selfobject, the relational dimension of the grieving process assumes particular significance.

According to Hagman's "self psychology of the mourning process" (1995), after the death of a selfobject the grieving process is primarily a process of maintaining, transforming and repairing the structure and function of the lost selfobject:

"The network of cognitive-affective schemata (self-organizing fantasies) sustained by and within the selfobject tie is traumatized, broken down, reworked, and gradually transformed in such a way as to maintain the integrity of self-experience and restore self-cohesion and vitality" (p194).

When the mutually regulatory selfobject bond has been ruptured, according to Hagman the self initially fortifies itself defensively. When the reality of the death begins to sink in, the bereaved person exhibits archaic affective states which attempt both to restore the selfobject bond and to elicit the needed selfobject responses from others. As the finality of the ruptured bond becomes more real these attempts lessen, the intense pain of grief is experienced, and self-experience begins to fragment. Because, according to Stolorow et al., the self requires optimal empathy to integrate painful affect following a ruptured selfobject bond, during this temporary period of partial fragmentation of self-experience the bereaved person is most in need of the attuned responsiveness of compensatory selfobjects for the intense affect states, that may include despair, rage, guilt, fear and hatred, to be tolerated, contained, regulated and articulated. This is particularly needed where the affects are ambivalent and conflicted.

A bereaved person with sufficient internalised mature self-structure and a sufficiently responsive selfobject milieu begins spontaneously to restore and reorganise self-experience so that the structural cohesion and resilience of the self ultimately remains intact. The bereaved person has three options for transforming or retaining the lost selfobject functions:

1) They may be integrated through transmuting internalisation into new permanent self-structure – and in this sense bereavement becomes an opportunity for growth;

2) Their self-object needs may be obtained, either temporarily or more permanently, from other pre-existing or new selfobject relationships – and in my experience many bereaved clients transfer the lost selfobject functions permanently onto a replacement selfobject, thereby avoiding the need to build new self-structure;

3) Or they may be structuralised as an enduring, conscious image of the deceased that can be evoked when needed to maintain and restore the self.

Finally, the restructured self can reinvest in new experiences. The self may be experienced as restored to its pre-loss condition, or diminished,

or in many cases enhanced as bereavement becomes an opportunity for growth, particularly after the loss of an overprotective, abusive or neglectful relationship that inhibited rather than facilitated growth.

If, however, sufficiently resilient self-structure is lacking, if compensatory selfobjects are not available, and if the selfobject bond with the deceased was archaic, the process of transmuting internalisation does not take place, self-experience disintegrates and may be shored up defensively, and the grieving process becomes complicated. To avoid lasting dysfunction, the bereaved person will need either to find compensatory selfobjects to replace the deceased or will need to build new self-structures, by addressing underlying developmental deficits.

Continuing Bonds

By suggesting that an on-going bond with an inner representation of the deceased can be a healthy outcome of the grieving process, Hagman rejects Freud's theory of "decathexis" (Freud 1917/1961) and the most influential Western models of grief and mourning to emerge after Freud, including Bowlby's attachment-based theory of loss (1969–1980; Holmes 1993). Parkes's "phases of grief" model (1975), and Worden's "tasks of mourning" (1991), all maintain that the final goal of a normal grieving process must be to sever our bond with the deceased and make new relationships. To retain any ongoing attachment to or internalisation of the deceased beyond a temporary period was considered pathological or "stuck".

Hagman's idea of retaining a selfobject bond with the deceased integrates well with the postmodern bereavement theory of "Continuing Bonds" (Klass et al., 1996). Research data from a wide range of bereaved populations demonstrates that, after the loss of a significant relationship, bereaved people retain a continuing bond with the deceased that is neither a temporary phase nor pathological or "stuck" but a healthy outcome of their grieving process. Rather than leaving the relationship behind they incorporate it into their new identity and attachments. The strength of the continued bond usually reduces over time but is not necessarily relinquished.

Continuing bonds vary widely according to individual personality, culture, religion, family and the relationship with the deceased. They include:

1) memories of the deceased

2) thinking about the deceased

3) talking about the deceased

4) talking to the deceased

5) actively consulting the deceased for advice, support and decision-making

6) dreaming about the deceased

7) identifying with the deceased

8) introjecting the beliefs and opinions of the deceased

9) carrying out the wishes, roles or plans of the deceased

10) a sense of presence of the deceased that can take many different forms

11) believing the deceased exists in an after-life.

Memories of the deceased are actively combined and reworked as a dynamic inner representation of the deceased in the present, and the bereaved person's past relationship with the deceased is reorganised and renegotiated over time according to changing circumstances and need. Experiences of a continuing bond with the deceased are not always comforting or positive. The bereaved person may find thoughts, memories, dreams or a sense of presence of the deceased distressing, especially initially. If the deceased was abusive or neglectful, the continuing bond may be experienced as a source of ongoing harm and suffering rather than healing, not so much a bond but a chain.

Bereaved people may maintain an enduring bond with the deceased out of duty or commitment, as part of an ongoing desire to love and feel loved by them, to retain a source of

advice, guidance and values, or to mitigate their loss by providing reassurance that the deceased is okay somewhere and they will be reunited. At the level of the self, these functions help the bereaved person retain a sense of identity and purpose – what Moss and Moss term “reciprocal identity support” (in Klass et al.1996, p.167) – provide them with comfort, maintain their self-esteem, help them feel safer and less isolated, and help them feel they can cope and function.

Working With Bereaved Clients After The Death Of A Selfobject

Rather than describing a step-by-step approach, my intention here is simply to offer some reflections, based on my experience, on the various dimensions for helping bereaved clients maintain and repair lost selfobject functions after the death of someone they experienced as a selfobject.

The Multidimensional Impact Of Bereavement

Even if working with the selfobject loss becomes the central focus of the work, it must always be within the context of all the different ways in which the bereaved person is impacted by their bereavement that may be equally distressing and in need of attention. In a multidimensional bereavement assessment I aim to answer two central questions: What is particularly difficult about this bereavement for this person at this time? What exactly has been lost and what might also be gained? I also aim to ascertain whether there is an immediate serious practical or financial impact of the death, whether the deceased was the client’s main carer, whether the client is traumatised by the circumstances of the death, whether the care of children is an immediate issue, whether the bereaved person is also overloaded by other current stressors.

The Impact Of The Bereavement On The Self

Assessing the ways in which self-organisation is impacted by the bereavement is also a multidimensional process. I pay particular attention to the client’s affect regulation, their sense of identity, role and purpose, their self-esteem and confidence, and their sense of having a worthwhile future.

Self-experience may become disorganised or disintegrate as soon as the death occurs, or beforehand if the death is anticipated. Or self-experience my remain cohesive in the first few weeks or months following the death while the bereaved person may be busy with arrangements and immediate losses and changes, the death might not yet feel entirely real, and the self is being shored up defensively. After a major loss bereaved people often achieve a partial level of functioning in the first few months, then around six months after the death there is a new realisation that the deceased really is not coming back. The threat to the self suddenly increases and the process of re-organisation of the self has to take place at a much deeper level.

One aspect of functioning I always assess with bereaved clients – particularly after the death of a selfobject – is suicide risk. Although few of our clients actually attempt suicide, many feel their survival is so threatened by their bereavement that they pass through a period of suicidal ideation before the self regains resilience, cohesion, stability and purpose.

Affect Regulation

When clients’ grief is still very raw and overwhelming, I usually attend to their affect regulation first, particularly if the deceased was their main emotional support. Some bereaved people are experiencing the most powerful, distressing, unwanted and possibly conflicted emotions they have ever experienced, particularly when they were deeply ambivalent about the deceased, and they simply do not know how to tolerate and manage these affects. I may need to interactively regulate the client’s affect until the client is able to autoregulate. Since self-structure is built in the repair of the ruptured selfobject bond (Stolorow et al., 1987), it is important that I provide attuned responsiveness to help the bereaved client integrate the painful affects that result from the rupture and thereby build self-structure, particularly when the lost relationship was lacking or abusive and the client also needs to grieve and integrate their loss of hope of a better relationship.

I find it helpful to track bereaved clients' affective, cognitive and bodily experience of their grief phenomenologically to raise their awareness that grief is not usually present with full intensity all the time but comes in waves that overwhelm then recede before overwhelming again. They can learn to soothe and comfort themselves through the waves, knowing each will pass, and then rest, recuperate and even allow themselves to find some pleasure in the periods of respite between the waves. I help clients gain confidence in their ability to withstand and eventually manage these emotions by helping them strengthen their ability to self-soothe, by helping them to articulate their grief, and by encouraging their opportunities for finding comfort from others.

Lost Selfobject Functions

There is usually a strong correlation between the dimensions of the bereaved person's self-cohesion that disintegrate and the aspects of the self that were sustained, regulated and repaired by the deceased. When a client reports loss of identity, role, purpose, self-esteem, confidence and so on, I ascertain not just whether the deceased sustained these aspects of the bereaved client's self but also the client's sense of how the deceased did this: through words, behaviours, their example, or simply physical presence.

The extent to which the bereaved person's sense of self depended on the deceased's physical presence indicates whether these selfobject functions were mature or archaic, whether the bereaved person's self-structure is resilient, and whether developmental deficits lie beneath. It may be that the deceased was the bereaved person's parent, who inhibited the internalisation of autonomous self-structure by keeping them dependent or through some degree of abuse or neglect, or the bereaved person's partner who acted as a compensatory selfobject to maintain functioning, but who also did not facilitate building of needed self-structure.

As Hagman suggests, after the death of a selfobject the bereaved person has three options for transforming the lost selfobject functions in order to sustain, regulate and repair the self: transmuting internalisation of the lost selfobject functions into permanent self-structure; transferring the lost selfobject functions onto other selfobjects, either temporarily or permanently; or retaining the selfobject functions of the deceased through a continuing bond with the deceased. One of my roles is to explore with the client which of these options is the most available, achievable and appropriate for them, to facilitate these processes and to achieve the best balance between the options. This may result in a major re-organisation of self-experience and self-and-other experience.

The intersubjective field of reciprocal mutual influence of therapy provides a temporary fourth option. I may transitionally provide the lost selfobject functions, particularly in our transference-countertransference relationship, while facilitating the client's use of the other three options. I will certainly provide attuned responsiveness so that painful affect can be integrated and new self-structure can be built. If there are gaps in self-structure the client may also internalise me as selfobject.

Compensatory Selfobjects

Because, according to Hagman (1995; 1996), bereaved people need a sufficiently responsive milieu for their grief not to become pathologic or inhibited, I always explore with bereaved clients the availability of compensatory selfobjects. This is particularly the case if the bereaved client is already socially isolated, or if, as often happens, their network of family support breaks down after the death of the deceased, perhaps because the deceased held the family together, or because of family conflict, or because the family are unable to support each other while they are all grieving. This may result in the loss of other selfobjects in addition to the deceased, with further threat to the self and self-experience.

Encouraging clients to use existing available selfobjects and to extend their support network as needed requires particular sensitivity if the bereaved person initially rejects others because they are not the deceased. It can be very painful letting others perform selfobject functions that the deceased previously performed as the bereaved person is forced to re-organise the way in which self-experience

is sustained and repaired. Some bereaved clients need compensatory selfobjects primarily to help them integrate their grief and thereby build self-structure. Others need them temporarily to meet some of the lost selfobject functions while they internalise them into permanent self-structure. Still others permanently transfer their selfobject needs onto a replacement selfobject or selfobjects and avoid building self-structure, a solution that "works" unless this selfobject is also lost.

Continuing Bonds

All of the bereaved clients I work with maintain some kind of continuing bond with the person who has died. Whether this mainly takes the form of the bereaved client thinking about what the deceased would say or do, feeling their presence within or around them, or actively consulting and interacting with them, I always feel we are working with the deceased in the room.

I start by exploring the form that the continuing bond takes. If the client does not volunteer this information I ask, particularly because many clients do not spontaneously share that they regularly talk to the deceased or believe they feel their presence for fear of being thought "crazy". I also ask what the client believes about where the deceased is now, partly to ascertain the influence of culture and religion on the form the continuing bond takes, and partly so that I know whether the client regards the continuing bond as an inner representation of the deceased or as more concrete.

Crucially, I explore and assess whether the client's selfobject bond with the deceased was mature or archaic while the deceased was alive, and whether a continuing bond with the deceased will now facilitate or inhibit their process of re-organising their self-experience and their future growth. I often ask directly what the deceased would say, do or want at a particular moment or regarding a particular issue, not to encourage indiscriminate compliance and introjection but so we can assess together whether the bond feels healthy or unhealthy, healing or damaging, sustaining or inhibiting and therefore needs supporting, strengthening or loosening.

If the client's selfobject bond with the client was mature, I support the client's spontaneous process of internalising some of the deceased's lost selfobject functions into a permanent self-structure and maintaining others through a continuing bond with the deceased in whatever form this takes. With clients who fear that their self will disintegrate without the deceased but who actually have a resilient self-structure, I raise their awareness of the extent to which they have already internalised some of their selfobject functions. With others, I may help them strengthen their continuing bond, particularly if they are not sure how to do this creatively, if it will sustain the client's self-experience in a healthy way and not inhibit their self-delineation or use of compensatory selfobjects. A healthy bond with the deceased will not exclude the living but be integrated into the bereaved person's on-going life with the living, but this can be a delicate balance to achieve.

If the bereaved person's self-experience and self-esteem were sustained by feeling loved, accepted and valued by the deceased, I might encourage the client still to remember, visualise and voice what the deceased would say or do to communicate this. If the deceased was key to the client's affect regulation, providing comfort or strength, I invite the client to explore how they can still receive this, perhaps by feeling the deceased's arms around them or a hand on their shoulder. If the deceased sustained the client's self-organisation by providing advice or by example, I might ask "and what would x do" or facilitate a dialogue with the deceased. Occasionally I use the classic empty chair.

If the continuing bond feels unhealthy because it preserves the client's dependency on the deceased as selfobject and inhibits self-delineation and the building of needed autonomous self-structure, I may work with the client towards loosening or rejecting aspects of the ongoing bond. This is likely to involve working with the client's introjection of negative interactions with the deceased and can be achieved through a dynamic process of working with the deceased in the room as the deceased is exorcised rather than internalised. Where the relationship has been abusive or neglectful in some way, this may be an opportunity for the client finally to retain what was good about the relationship now that the destructive aspects

are no longer happening, and to free themselves from aspects of a continuing bond that would continue to be destructive. This often becomes a central part of bereavement work because the client would not have begun to address their adaptation to the deceased while they were alive and there was still hope of something better and while loosening the bond, however unhealthy, threatened their fragile self-cohesion.

Developmental Deficits

If the bereaved person cannot transform the lost selfobject functions as they grieve because they lack sufficiently mature self-structures, underlying developmental deficits may need to be addressed. Developmental deficits are most apparent in the transference-countertransference relationship. When the client has lost a relationship they were dependent on for self-organisation, I find I mainly experience a "selfobject transference" that may be used as a "developmentally facilitating selfobject transference" (Shane & Shane 1991, p127). If the client was ambivalent about the deceased, the transference is more likely to oscillate between the selfobject and "repetitive" dimension. I may then provide a developmentally-needed relationship in which the client can begin to build needed self-structures in the "developmental second chance" (Orange et al. 1997, p.8) of therapy.

Closing Comments

Working with people whose whole sense of self is disintegrating after a major bereavement can be extremely painful and challenging, both for the client and the therapist. None of us escapes death and bereavement, so this work really touches our own experiences, losses and particularly our fears at the same time as facing us with deep existential questions. It faces us directly with our own mortality and the inescapable mortality of those we love. It shatters the illusion of immortality that enables us to function by shielding us from our fear of death that always lurks just beneath the surface. But if life can only be fully embraced if death is embraced, then the rewards of this work, for both client and therapist, are potentially life-changing as it teaches us how to live.

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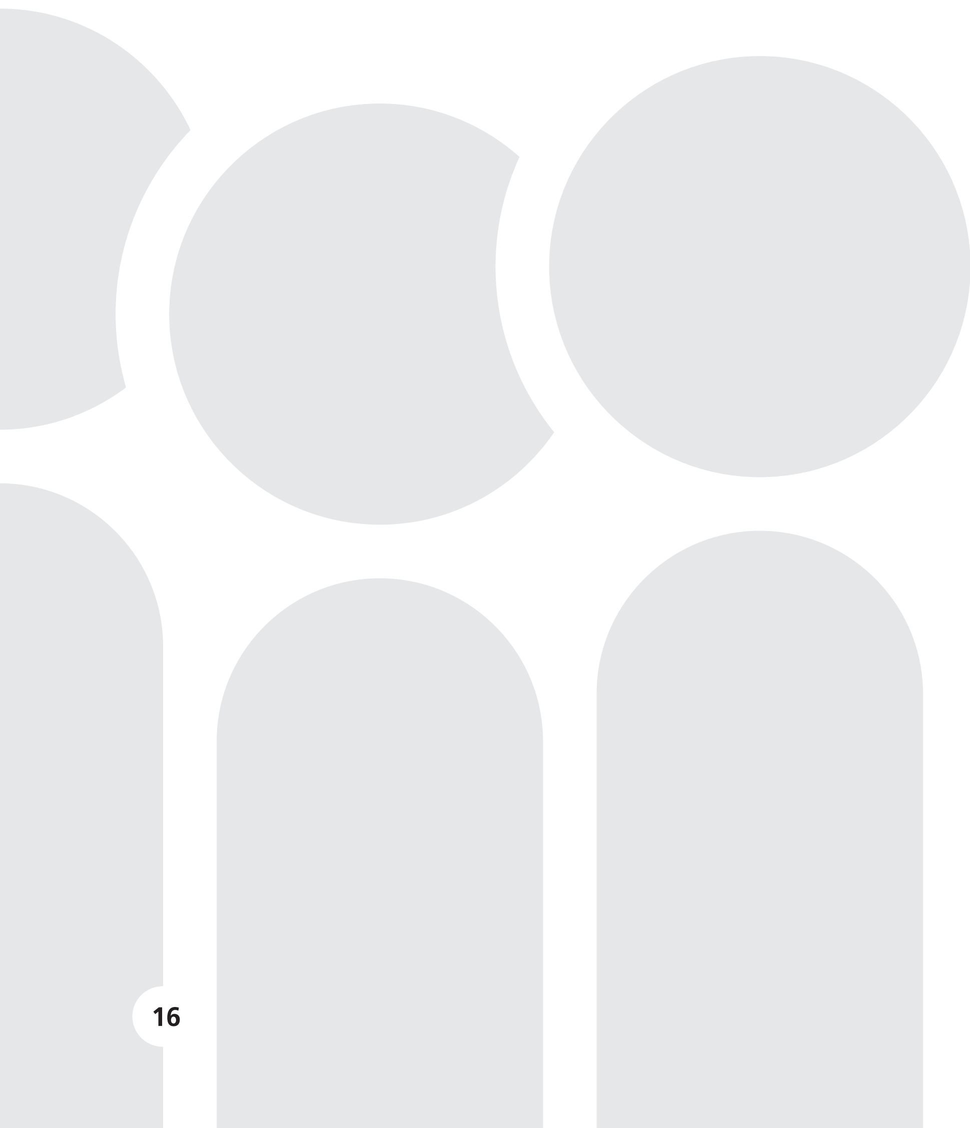

Asaf Rolef Ben-Shahar

Embodied Trances, Relational Hypnosis: The Place Of Trance And Hypnosis In An Integrated Relational Psychotherapy Organisation

Abstract

Since Freud's abandonment of hypnosis and touch, the therapeutic use of both trance and touch were largely alienated from the psychoanalytical milieu. As a consequence, research and clinical applications of both disciplines developed disconnectedly, and became fragmented. In this paper I propose a non-mechanistic, Buberian view of trance as a naturalistic process (Gilligan, 1987), in which transferential-fields (resonance) are more discernible, workable and concrete. I further wish to demonstrate the important relevance of embodied and relational hypnosis to modern relational psychotherapy, and in particular to attachment based work. The paper explores theoretical and clinical aspects for integrative and relational use of embodied hypnosis within psychotherapy.

Pay attention now:
a heart that's all by itself
is not a heart.
Antonio Machado, 1983

Introduction: Seeking Connections

"I hate you! I hate you! I hate you!" Rose (61-year-old) shouts at me. We are close to each other and everything outside us seems to blur. I feel so big, she seems so tiny, and I cannot hold back – she reminds me of my baby girl–and I burst out laughing. Rose joins in and for a long time, we giggle together. "I wish you spent more time with me daddy," she says, "I wish you were more real." Her own dad left home when she was three.

Relational psychotherapeutic approaches share the view that self-organisation is a dialectic, bodymind, relational process. What is meant by this is that our defence mechanisms and our psychological strengths, our body armours as well as our gifts and our activated predispositions all come into the world through dialogue with others. Our organism is first and foremost a relational organism, and our organising principles are relationships. It is our primary attachments around which our bodyminds are organised, and a positive (loving?) object-relation that holds the chance for a genuine reorganisation of self. It is my belief that trance states are the organising processes of our bodyminds, and I hope to arouse your curiosity about trance in this paper.

Relationality begins with the therapist's willingness to bring him or herself into the therapeutic relationship as a person, to weave the transferential reality with an I-Thou reality, and bear the consequences on his or her bodymind. Father of modern generative hypnosis, Milton Erickson, did exactly that. In 1965 he wrote: "How do you expect to make your living except by meeting your patients, by respecting and liking them–by thoroughly liking them?"

It is a great joy to live in a time where attachment-based practice and relational psychotherapy are no longer seen solely as breaches of the therapeutic frame but are actually celebrated and thoroughly explored. Now is the time to reconsider whether our previous therapeutic exclusions and inclusions were genuinely necessary distinctions between 'us' and 'not us' or perhaps an acting out of our fears of closeness – of being touched, or changed, or personally moved too much.

Hypnotherapy and Body psychotherapy are closely related. Their alienation from the psychoanalytic discourse, as well as the relative lack of mutual engagement between them date back to Freud's rejection of hypnosis and consequently, of touch. It is not a coincidence that both body-psychotherapy and hypno-psychotherapy suffered from this split from psychoanalysis so similarly: both involve highly influential, closer-to-the-unconscious tools. Both disciplines not only had to deal with understandable rejection of such ways of working (their proximity to unconscious material results in highly charged transferential/counter-transferential events); but also had to fight off an array of myths, misconceptions, ignorance and years of misuse of these tools. The survival of both disciplines throughout such trends and over time is an indication of the value of working with body, and working with trance in psychotherapy.

When we consider trance as a natural and biological set of phenomena, we come to realise that it is not merely a personal 'state' of enhanced concentrated relaxation but a relational process of opening up to a shared field of resonance. Furthermore, such a view of trance will illustrate to us that many psychotherapeutic disciplines regularly use trance. Natural, spontaneous phenomena that are commonly considered as trance phenomena include: catalepsy, time-distortion, visual and auditory hallucinations, dissociation, regressive patterns and more. All these are frequently observed in most 'affect friendly' psychotherapies, and in many complementary therapies.

Learning to recognise hypnotic fields, to join our clients there and work with these processes can be transformative in the therapeutic practice. This is a natural complementary set of tools for the body-psychotherapist and the psychoanalytic psychotherapist. By creating Integrative-Mindbody-Therapy (IMT), I have endeavoured to bring these three pillars (attachment-based psychoanalytic psychotherapy, body-psychotherapy and hypnotherapy) together into the therapeutic dialogue (Rolef Ben-Shahar, 2001; 2002a; 2002b; 2002c; 2003a; 2003b).

This paper wishes to demonstrate the relevance of embodied hypnotherapy to relational, attachment-based work. It will therefore explore the historical, contextual and clinical connections of these disciplines in their endeavour to come back from their exile.

The Garden Of Eden

Something happened to Adam and Eve when they ate the fruit from the tree of knowledge; they became self-aware: "Then the eyes of both of them were opened, and they realized they were naked; so they sewed fig leaves together and made coverings for themselves" (Genesis 3:7). The biggest pain of humanity, of having been sent away from the Garden of Eden, and the biggest gifts of humanity – those of self-awareness and sexual connection, are inevitably entwined, and are both at the very core of the human journey.

But why did God exile Adam and Eve from Eden? What was it about self-awareness, about sexual awareness that drove God to take such extreme measures of shaming and severing the connection? Or was it simply their disobedience? Somehow, before becoming fully human (before waking up into awareness), we can all be present easily, effortlessly. Zohar, my 6-month-old baby girl is always fully in the present moment. Yet at the same time she still lacks organised consciousness (self) to support her presence. It is the very 'sin' of eating the fruit (of opening up to our embodiment and sexuality) and the subsequent exile that have created humanity. To become fully human we have to leave home, be sent on exile into disconnection and isolation in order for us to find our humanity in the process of coming home. It is the very pain of exile that creates space for the journey back home.

Insofar as we are human, we are preoccupied with the process of coming home – of getting lost and coming back home. The healing and therapeutic arts all aim at supporting ourselves and others in this task of daring to inhabit our lives more fully, of daring to be present to ourselves and our world more fully; relating, connecting and staying in our centre; balancing giving and receiving, finding place for both integrity and compromise, for pride and humility.

Like God, Freud was in the business of creation. A single parent; a father with no apparent mother around, was trying to support two sexually curious children. What a mess! He was indeed a brilliant creator, yet the qualities necessary for a good creator differ from child-rearing qualities. The beginning of creation requires the masculine – sperm energy, the wielding male-warrior, Thor. Later, the feminine is called upon – an egg energy embodying compassion, inclusiveness, containment and attachment, yielding, mother-earth. It is the mother, the feminine that is also needed to support the creation inside the womb, and outside it–once the child is born. What happens when such a feminine presence, an anima, is missing? What happens when the sole attachment figure is a stern, if loving, father?

The absence of a mother is apparent in Freud's attitude: he was, in many ways, unforgiving to differentness and excluding. He excluded (exiled) those who dared to differ – even when these were the closest to him–including, among others, Jung, Adler and Wilhelm Reich (father of modern body-psychotherapy). It is my opinion that two such highly powerful exiles were those of hypnosis and body, Adam and Eve. Once Adam and Eve recognised their genital sexuality they could no longer bathe with daddy. Their bodily presence and the awareness that came with realising their embodied sexuality were too much for God to bear. Their sexuality/awareness was only acceptable in its regressive, pre-genital way. They were both, from that moment, on their own.

What's Love Got To Do With It?
In And Out Of The Garden

Like touch, the therapeutic use of hypnosis in psychotherapy was brought to the acceptable therapeutic arena by Freud. Both body-centred therapies and Hypnosis were practiced extensively long before Freud, and some forms of both were already accepted as valid medical tools. Yet Freud's research, practice–and indeed his person–opened a door to practicing hypnosis within psychotherapy in a systemic, methodological way. Body-psychotherapy, too, greatly owes its current, thorough and cohesive form to Freud and Reich. Freud's early practice involved extensive use of hypnosis and some therapeutic touch. In fact, his 'passing' technique (an old-fashioned hypnotic induction technique, of slow passing movements in a downward direction while giving suggestions to sleep), was a place where touch and trance met.

In an autobiographical note (1923–1925), Freud narrated the following incident: "And one day I had an experience which showed me in the crudest light what I had long suspected. It related to one of my most acquiescent patients, with whom hypnotism had enabled me to bring about the most marvellous results, and whom I was engaged in relieving of her suffering by tracing back her attacks of pain to their origin. As she woke up on one occasion, she threw her arms round my neck. The unexpected entrance of a servant relieved us from painful discussions but from that time onwards there was a tacit understanding between us that the hypnotic treatment should be discontinued."

It is not too speculative to assume that Freud was not particularly aware of his own body or body-countertransferences: these are current trends that were not encouraged at the time. Nor was Freud a particularly good hypnotist. His lack of skill made these two rich sources of human connection seem like futile, fragmented, sometimes dangerous techniques, which he gradually came to shame and dismiss as irrelevant to the psychoanalytic process. Hypnosis and Body were both exiled from Eden by a shaming father, and as a result (unlike the biblical couple) they stopped relating to one another.

And so, having been abandoned by Freud, touch and trancework were henceforth marginalised and ostracised from mainstream psychotherapy practice.

The therapeutic uses of both touch and hypnosis within psychotherapy have developed as a result in two separate routes:

1) On the one extreme we have a non-psychotherapeutic praxis, usually drawing from traditional disciplines and often lacking appreciation of the complexity of human dynamics (and a consistent split from the history of previous endeavours to understand the psychology of mankind). These practices are still legitimate ways of working, of bringing about change and healing – and can frequently be very powerful, only these are not psychotherapy.

2) The other route was the development of a relational, integrative way of working (body-psychotherapy/hypno-psychotherapy), informed by both traditional and modern psychotherapeutic perspectives. Some of these practitioners sought (and are still seeking) to come back home to the psychoanalytic/psychodynamic bosom, but are struggling to come back from their forced exile. To a certain extent, this paper represents my own knock on heaven's door.

Most controversies around touch, as well as those regarding hypnosis, argue against the complications these approaches bring into the therapeutic alliance. These may include contaminating transference and counter-transference with highly charged, undifferentiated material, treating 'the symptom' rather than 'the cause', or satisfying the narcissistic, unprocessed needs of the therapist at the expense of therapeutic clarity and integrity. Much criticism is directed at the perceived 'doing' of these therapies, which can seem as a compensatory defence against 'being with'. I hope to address some of these controversies in this paper.

As a result of the exile of touch, and alongside this split, the entire body has disappeared from the psychoanalytic dyad leaving the analyst and analysand present in head alone (with potential phantom genitals present as well).

Hypnotic therapies too, once announced 'suggestive' by Freud were exiled from the analytic practice (excluding 'research') and were often seen as manipulative, dangerous, short-lived or otherwise inappropriate. Hypnosis had become, in fact, the very thing that prevented good therapeutic progress: "Hypnosis" wrote Freud, "had screened from view an interplay of forces which now came in sight and the understanding of which gave a solid foundation to my theory" (1923–1925). All in all, hypnosis was excluded from the psychotherapeutic toolkit, and declared a totally different field of work: this is not psychotherapy.

But did the problem genuinely stem from the evil of hypnosis or from the sexually deviant touch? Could the father have also been responsible for the exile? It is my belief that Freud was not ready for relational work, where the therapist's person (not simply his persona) is not only present in the therapeutic relationship, but is a part of it, equally touched and affected as the client, potentially called to share that with the client as a part of the therapeutic process.

As demonstrated in Freud's writing (1913): "I hold to the plan of getting the patient to lie on a sofa while I sit behind him out of his sight. This arrangement has a historical basis; it is the remnant of the hypnotic method out of which psychoanalysis was evolved. But it deserves to be maintained for many reasons. The first is a personal motive, but one which others may share with me. I cannot put up with being stared at by other people for eight hours a day (or more). Since, while I am listening to the patient, I, too, give myself over to the current of my unconscious thoughts, I do not wish my expressions of face to give the patient material for interpretations or to influence him in what he tells me."

Focusing on the body in psychotherapy, as well as practicing hypnosis in psychotherapy is highly challenging for the practitioner who has sufficiently developed self-awareness. In self-aware practice of hypnosis or body-psychotherapy, the bodily aspects of transference and countertransference have a very powerful, somewhat unnerving quality–they cease to be concepts and become embodied in both client and therapist

in an undeniable way (for examples see Asheri, 2004; Maroda, 1998; Soth, 2005).

Freud recognised the relative transparency of his unconscious processes, and was not willing to bring these (i.e. himself) fully into the relationship. He was not willing to form an attachment to his clients; only their attachment–as long as it was not embodied–was allowed and encouraged.

Introducing a paradigm shift to the understanding of human psyche was a true act of genius, but relational psychotherapy required maturation that was yet impossible for Freud to attain. It required the feminine, the softening of Freud's solipsistic reign – it called on him to dare and ask to be held as well. He could not do that. And hypnotic approaches, as well as embodied ones, have a very different quality and value when they exclude relationality.

While practicing body-psychotherapy or hypnotherapy non-relationally is possible, it is limited in scope and loses its generative, humane connections (Rolef Ben-Shahar, 2007). I believe that it was this undeniable relational aspect of both these approaches, coupled with Freud's incapacity to work relationally with them that drove him to abandon these practices. Freud was not ready for his countertransferences, for his unconscious stream to be a part of the dyadic, shared space.

Relational psychotherapy is taxing; it forces us to work on the edge of safety, of boundaries. We are called to stretch our own person in a continuously dialectic organisation between our own processes and those of our clients. We genuinely risk having our own lives changed in the process. The Portuguese writer Clarice Lispector summed it up beautifully (1974): "What am I saying? I'm saying love. And at the edge of love–there we stand."

The frequent confusion between relationality and the therapist's selfdisclosure stem, in my opinion, from a similar fear: "I must not be fully present with my bodymind with the other; I must not fully surrender to the relationship." It is a result of lack of trust: "I cannot be me AND hold safe space. I cannot challenge my boundaries AND maintain them." Freud did not have the emotional language and sophistication, which have later developed only because of his work, to tolerate such reciprocated intimacy and openness.

Moreover, Freud's illusion that avoiding eye contact would have made him invisible (i.e. that he could be in the room in a bodiless form) is highly refutable. Love, hate and growth all happen in embodied relationships, these are not mere concepts. It is therefore no coincidence that it was relational psychoanalysis and relational psychotherapy that were able to be receptive to body-psychotherapy and welcome Eve back home.

Eve's Return From Exile

Three main movements facilitated the return of body-psychotherapy back from exile into the psychoanalytic and psychodynamic fields. The first two movements result from the maturation of the daughter (body-psychotherapy), the last with maturation of the parents.

The first movement concerns advances in neuroscience.

The second movement is relational body-psychotherapy.

The third movement is concerned with the maturation of the father (psychoanalysis) and mother (psychodynamic psychotherapy) and is related to the growth of relational psychoanalysis and relational psychotherapy, and within this field the capacity to receive differentness without being threatened. The third movement is about an inclusive expansion of the therapeutic milieu, to which different approaches can belong.

Below I shall shortly discuss the first two movements belonging to the daughter. While the third one, the emergence of relational psychoanalysis is, in my opinion, a paradigm shift in therapeutic understanding and practice, this paper is concerned more with the exiled parties. Suffice it to say that the maturation of the parent, the progression into working relationally and the willingness to engage in dialogue within the therapy room (the content) is manifested in the way relational psychoanalysis was willing to discourse with

other modalities (the form). What allowed the daughter to return was the arrival of the mother.

Neuroscience:

In the last few decades, advances in neuroscience suggested that bodily organisation is closely related to (and in a continuous dialogue with) mental/emotional/cognitive organisation (see Junah, 1988; Kandel. 2005; Schore, 1994). The holistic approach has greatly gained credibility in showing that our brains – and our bodies – are important in forming our cognitive, mental and emotional self and vice versa. Furthermore, it has been shown, particularly around trauma, (for example see Levine, 1997; Ogden, Minton & Pain, 2006; Rothschild, 2000; Shapiro, 2001) that body-centred interventions (somatic therapies) are frequently able to introduce change into the system more economically, and sometimes where other techniques prove inefficient.

Bodywork and body-psychotherapy disciplines have subsequently attracted many more practitioners. Yet, although we live in an age where bodywork and body-psychotherapy are 'trendy', this movement has not secured the psychoanalytic embrace and inclusion of body-psychotherapy.

Relational Body-Psychotherapy:

Relational body-psychotherapy presents a maturation of body-psychotherapy, manifesting a new level of relational organisation. Relational body-psychotherapy, while bringing the wealth of understandings gained by Reich, his followers and more traditional body approaches, seeks to establish these within an ever negotiated relationship in the therapeutic room. This process is an inter-subjective, relational reorganisation. I believe that the essence of relational body-psychotherapy is not in its body interventions, but in saying:"Let us bring the bodymind of the client and of the therapist into the dialectic relationship." "Let us dare to be stared at for eight hours a day (or more), to bring our own unconscious processes into the dyadic organisation, to even dare and have genitals present in the room, perhaps even be informed by them and our bodies."

And so, now that enough time has passed, Eve can come back to the softened, somewhat more forgiving mother and be accepted with her differentness. What separated body-psychotherapy from the psychoanalytic milieu were both the residues of a dogmatic non-relational father (Freud) and a shame-based, differentness-centred (mismatching) daughter (I'd never be like those distant, heady psychoanalysts). But it was also a generative, non pathological, separation that involved growth and maturity.

Relational approaches in body-psychotherapy claim that bringing body and touch into the therapeutic relationship can indeed introduce complications and challenges to client, therapist and community – but can also deepen connection, foster understanding and facilitate assimilation of therapeutic attachment within the client's (and therapist's) reality (see Bar-Levav, 1998; Keleman, 1985; Torraco, 1998).

But What About Adam?

Hypnosis was understood by Freud and many of his followers as a means to an end – a technique that was powerful but inaccurate. Mitchell (1988) wrote: "Eventually the analysis of unconscious derivatives within 'free association,' and later the analysis of defences, replaced hypnotism as the basic instrument for reclaiming memories."

Some later influential clinicians still held an appreciation for the powerful tools of hypnosis and its relevance to the clinical presentations of clients. "Any physical alteration that can be produced by hypnotism," wrote Winnicott (1931) "can also be met with in the medical clinic. The power of the unconscious over the body is only just being appreciated." Winnicott understood the naturalistic, biological foundation of hypnosis and therefore its relevance to learning about mind, mental-health and body. It is my understanding that the body is the unconscious.

Sarita, a 27-year-old Italian, arrived in my therapy room in panic. For the last three months she had experienced sudden (intermittent) episodes of blindness. Her neurologist found no organic cause, and suggested to her it might be

hysterical blindness. We connected very quickly, a fact that surprised Sarita, and although we were not able to trace back the cause for her blindness, these episodes ceased as soon as psychotherapy commenced. After six months of therapy Sarita brought up, for the first time, doubts regarding her boyfriend of 13 years, and as she spoke, for but a fragment of a moment, I experienced a sudden blackness. Sharing my experience with her made immediate sense to Sarita, this is what she fought not to see. How can she separate from a boyfriend who has been with her since she was fourteen? How can she do so when attachment has always been so costly?

But regardless of whether hypnosis as a set of techniques has been adopted or abandoned, whether studying hypnosis as a phenomenological, biological process was of interest or of no interest whatsoever, little psychoanalytic research was carried out into the relational value of hypnosis.

Relational hypnotic practice, where client and therapist enter a shared field and are both open to the full spectrum of mindbody resonance is more than a technique (extending the physics paradigm). Generative hypnosis offers a genuine skill of deeply 'being-with' one another, and demonstrates a deep rapportfull connection between two people, a way of relating deeply and meaningfully to self and others. Relational hypnosis is not done 'by the therapist' on or to the client, but is a joint exploration. This was the main aspect of hypnosis that was lost through the exile.

Ben is 84. He seeks therapy post-operatively, and following a depressive episode. "I don't want deep psychotherapy," he clarifies. "I simply want to feel more positive about life." Ben is a strong man, who had always been independent, and is now sporting a colostomy bag and a shattered ego. After ten sessions of futile dialogues, constant blaming and unexpressed despair, I feel utterly at loss. I dread the coming session. As he arrives, I have a feeling of giving up. We sit together in silence, a shared trance, and a tear drops from my eye. Surprisingly, Ben hands me a teddy-bear and takes one for himself. "I feel so alone in the world. I really miss my mummy," he says. Our psychotherapy work can begin.

Since the departure from the analytic setting, much development in the field of hypnosis was achieved in terms of tools, efficacy and feedback. Hypnotic techniques, when applied artfully by competent practitioners, are no longer the crude and clumsy, semi-stage-hypnosis rituals they used to be in Freud's time. Linguistic advances, greater understanding of cognitive, emotional and behavioural patterns, and systemic practice have created an artful path of mastery. However, it is only since Gregory Bateson (1972) and Milton Erickson (1965) became involved with hypnosis – and more so with the works of contemporary clinicians like Stephen Gilligan (1987) and Bradford Keeney (1983) that effort has been made to advance hypnosis in terms of relationality.

Severing the connections between body-psychotherapy, psychoanalytic psychotherapy and hypnosis had adverse affects on all three disciplines. Much of modern hypnosis had developed with little systemic understanding, which was developed and formed in the attachment fields. The hypnotherapist saw himself outside of the system, doing things to the client. Traditional and authoritarian hypnosis involved 'bypassing' the client's consciousness, 'rearranging' unconscious habitual patterns and bringing them back into the world. The fantasy, that reorganisation could be a non-relational process, created a great degree of fear, scepticism and all-together avoidance of hypnosis from the psychoanalytic field.

And the split between the relational potential of hypnosis and the technical ease and applicability of hypnotic techniques attracted a different crowd – those interested in the mysterious, the impactful, the influential (and usually, goal-oriented therapy) which is different from the analytic and relational folk. The split, however, lay not in trance or trancework itself but in the way it was practiced – or more accurately, not practiced, and in those who initiated the split. The same fears of relationality that led to non-relational body-psychotherapy practices also resulted in non-relational hypnotherapy practices.

'Professional hypnosis' had therefore become limited (and still is in many countries) to a practice by selected 'experts', primarily from

the medical professions. The medical and dental applications of hypnosis, while of great value, have little to do with psychotherapeutic hypnosis (just like a phone call to a BT help-centre is only remotely connected to psychotherapeutic conversation).

The 'lay' hypnotherapy became marginalised by the psychotherapeutic communities, and frequently practiced by untrained professionals with minimal psychological understanding. The relational practices of hypnosis remained only in the more esoteric branches of hypnosis, drawing from shamanic traditions or meditation practices.

The expelled son chose to walk a different path. When I ask, in this paper, to be welcomed back to the analytic field, I do so not to find a hiding place, but because I believe that hypnotherapy has a valuable body of knowledge to contribute to the relational, attachment based practices and that similarly, trancework could be enriched by dialoguing with relational psychoanalytic psychotherapy – in theory and practice.

Moreover, the double-exile of Adam and Eve, of Hypnosis and Body from the analytic milieu has also caused a separation between the two disciplines.

> *I remember the day Marietta sat me in the chair and declared that therapy should stop now, because it became very clear that I found her behaviour unacceptable, and she didn't blame me for it at all. An ex-catholic nun of 75, she explained how she felt my disapproval, following her transfixed attention on my genital area. I asked Marietta, who was an experienced meditator, to fixate on my genital area as she dropped into a trance. We followed through roads that were never allowed before, and her discovery of herself as a woman.*
>
> *At that time I had three supervisors: a hypno-psychotherapist, an analyst and a body-psychotherapist. All three were riveted with Marietta, all three necessary for our work. Allowing herself to openly embrace her sexual transference has opened a door for genuinely exploring her yet unrealised sexuality. At 77, Marietta started dating.*
>
> *In my training events, body-psychotherapists and hypno-psychotherapists alike recognise similar demonstrated processes (which I would call trance) by different names. Yet the lack of mutual theoretical and clinical engagement prevents these disciplines from using the knowledge accumulated by the other.*

Many practitioners of body-psychotherapy and bodywork view hypnosis as dangerous, manipulative and performance-oriented. Many practitioners of hypnotherapy view body-psychotherapy as dangerous, seductive and unethical. How come such close siblings ended up in such a feud? I believe that the historical background presented in this paper could offer an answer. Thus, Adam's homecoming will not only reunite him with his community of origin, but also bring him back into contact with Eve for a fruitful reunion. Body-psychotherapy and hypnotherapy are too similar to deprive themselves of mutual discourse, of learning from each other and contributing to one another.

A Naturalistic View Of Trance

The naturalistic view of trance relates to trance as a cross-contextual and biologically essential process. This description is largely based on Gilligan's (1987) exposition on naturalistic trance which can be summarised in the following understandings:

1) The experience of trance exists in all cultures, across nations, ages, sexes, mental abilities and stabilities. It is the rituals involving trance (labelled 'hypnosis'/'healing'/'spirit possession' etc.) that differ.

2) Trance experiences are distinguished by increase of Ideo-dynamism (ideas leading into action; thinking and 'being' which naturally and organically develop into doing and acting) and "both and" (systemic/recursive) logic. The effortlessness by which ideas are translated into actions is a strong characteristic of trance. 'both/and' thinking involves transcending linear processes of 'either/or' into the ability to step in and out of frames, and 'hold paradoxes' together in the same system.

> *Michael wanted a change. He wanted out of his marriage of twenty years, the last ten of which*

were without sexual contact, the last three in separate rooms. Michael realised how the early loss of his mother has created such an extent of abandonment anxiety, that he could not fathom leaving his wife. He seemed so certain about wanting to leave, though, only "needing a nudge", yet months passed and he was unable to make a move. One day, as we sat together I noticed my anxiety about 'our failure to change' and allowed it to consume me. "You know, Michael," I said, "I am just noticing how invested I have become in your leaving; so much so that we focused more on your leaving your wife than we have noticed you." After a long silence Michael whispered: "I fear that if I don't work hard, do the right thing and leave Jenny you would send me away." Finding a way to accept Michael without him needing to fix things, or change was something he rebelled against, yet it was the very shift in our therapy that allowed for change in his life.

3) We experience trance in many situations, and trance is biologically necessary. I believe that hypnosis is a process of parallel communication with somatic experiences, and trance is the context from whence such communication is done. Trance is an attentional and attitudinal shift, a principle of organisation. It is a required process for the balancing of biological and psychological rhythms of the bodymind. In trance, the different languages of our being (thoughts, emotions, sensations, images, functions) can relate to one another with greater ease than usually (Gilligan, 1987; Rossi, 1986).

Ronnie is a brilliant Israeli mathematician. He came to see me to help him resolve some traumas, having read all the books about trauma. He sent me long emails before our sessions emphasising paragraphs from books that he thought 'would help you help me.' We spent the first few months of work intellectually sparring, and his manner was always well thought, robotic, unemotional and so cold that I found it hard to relate to him.

During an embodied trance session, he described a horrific scene from his childhood, and as I sighed with pain he suddenly lay down on the floor, shaking. I held him for an hour, not letting go for a second, during which time he shifted ages, talked to me, not at me, and cried. He gained some significant insights and spoke as if the robot were gone. Towards the end of the two-hour-session Ronnie looked at me and I could see a slight shift. "Do you think it would be therapeutically advisable to cognitively understand the processes that took place today?" he asked in his robotic voice. "No I don't," I answered. "I didn't think so," he said, smiling.

4) As a balancing and synchronizing agent, trance is biologically and psychologically used for various functions. "Trance aids", writes Gilligan, "…[in] preserving and expanding the integrity ('wholeness') of an autonomous ('self-regulating') self-identity" (Gilligan, 1987). At its best, trance is a reminder to 'come home' to self-in-relation.

5) Trance can be generative (self-valuing) or degenerative (self-devaluing). Trance is a process, in itself empty of 'value' – it is neither positive nor negative, but instead context-dependent and form-dependent. It can help lead to integration or disintegration. Therefore, the quality and context of a trance process (the relationship in which trance takes place) is much more important than the depth of it or the rituals it involves.

6) Trance phenomena are the basic processes by which psychological experience is generated. The way we perceive psychic experiences, the way we make meaning of our reality manifests in trance phenomena (Winnicott, 1931). We remember certain aspects and forget others [Hyperamnesia/amnesia]; we make distinction and gestalts from our perceptions [negative hallucinations/dissociation]; we call upon memories and ideas [positive hallucination/symbolic expression] and immerse in them somatically [progression/regression] etc. During hypnotic work, these phenomenological experiences are intensified and can therefore appear unusual or out of context – but this is how we are in the world.

7) The difference between trance phenomena and clinical symptoms is their context. Symptomatology involves the same patterns of trance: dissociations, regressions, amnesias, symbolic expressions and hallucinations. The contexts differ greatly – while generative trance involves (mostly) enjoyable, expansion of choices and meaning (validating psychological contexts), symptoms tend to limit and be painful, invalidating psychological contexts).

Degenerative trances differ in their attachment organisation to generative trances.

This is how Sylvia described her binge eating sessions to me: She would walk with her trolley in a supermarket and engage in an inner dialogue: "surely if I'm strong enough I can pass the sweets aisle without being tempted". She would then turn to go into the aisle, and the next thing she would remember is sitting in her car, with dozens of wraps of snacks and chocolate fully consumed, feeling sick and bloated. Her capacity to use self-deprecating trances was phenomenal, and indeed our work used the structure of what she was already doing so well (using motivational self-dialogue, dissociating, operating amnesic barriers and having hallucinations) to support her recovery, and our connection.

There are many ways of developing trance. More than the 'traditional trance induction', any rhythmic and repetitive engagement, singing and attention absorption, myofascial balancing (muscle toning, massage, relaxation and drug-induced states) can all lead to developing trance. Any 'sinking into' connection involves trance. Relational hypnosis is based on inter-subjective trances, a deep meeting of bodyminds.

One day, when Kim (57-year-old) and I were drifting in and out of trance, discussing her relationship with her father, I heard whimpering sounds, like a dog crying in the distance. My heart was sinking. "What's that whimpering sound?" I asked her, "Oh, she replied, "there are two puppies in the window and dad's going to let me take one home. I have to choose one. I'm not allowed the two." We later learned that the second one had to stay in the shoebox, and Kim believed that it died a few days later, as the shoebox was no longer on display.

Relational Hypnosis, I Beg Your Pardon?

In one of the first methodological descriptions of Relational hypnosis, Gilligan (1987) writes:

"The cooperative approach emphasises an interpenetrating triad of units involved in the hypnotic interchange… This approach emphasises that trance always occurs in a relationship context in which neither hypnotist nor subject can be considered independently of each other."

"Creative solutions to vexing problems can emerge when therapist and client trust their unconscious processes to cooperate in a joint endeavour… Dedication and rigor are needed as the therapist discovers how to be 'a part of and apart from' the client's reality in this process… therapists must be in tune with and draw on both their own and their client's unconscious capacities if this process is to succeed" (ibid).

By 'dropping in' into the therapeutic relationship (surrendering to the relational field, to the somatic presence), we are able to harness skills that are collective and unconscious, that would otherwise be inaccessible to us. "Conscious purpose," illustrates Keeney (1983), "with its aim of achieving specific goals, cannot take into account whole ecological contexts." This is where trancework (as well as bodywork), by their very nature of working alongside consciousness, can assist in creating meaningful connections and transformations that cognitive approaches alone cannot attain.

If we are able to see trance as a biological state of organisation, then relational trance is a field of 'I-thou' organisation (i.e. a field of attachment). The therapeutic relationship offers a unique opportunity for inter-subjectivity, whereupon the therapist is both inside and outside of the client's reality, and both client and therapist engage in recreation of their relationship – and of their own organisation. This is neither a subjective, nor an objective organisation, and is – in my opinion – the exact difference between Object-Usage and Object-Relations (Winnicott, 1971).

Amy, 25-year-old, started therapy following a debilitating illness, which brought forth a deep neediness that was never before expressed or indeed experienced by her. Deeply attached to her mother, Amy's newly expressed need met with disgust, and I was expected to cure her from her unreasonable emotional state. Professional care (including psychiatric and CBT therapy) had all seemed to collide in the transferential story of mixed boundaries, excessive exercise of control and inappropriate behaviour – arousing suspicion in me. Yet Amy could describe no biographical detail that confirmed these suspicions.

After 18 months of working together, Amy began to spontaneously regress, during which episodes she was highly distressed and very 'little'. To my horror, instead of feeling sympathetic, I felt a combination of sexual arousal, rage and desire to hurt her, coupled with shame and disgust. During the next two years, bit by bit, Amy began to explore (using hypnosis, dreamwork and body-psychotherapy) a myriad memories involving incidents of sexual abuse by her father. As soon as the story was 'out' I stopped getting sexually aroused by her regressive suffering. My own body-countertransference, brought about by trance, became a gauge to her recovery.

Gregory Bateson (1904–1980) was in many ways a man of the renaissance, thoroughly exploring many areas of thought and art – from anthropology and evolution, through psychiatry and psychotherapy, to cybernetics and systems theory. (He was also the husband of anthropologist, Margaret Mead). He influenced many forms of psychotherapy including Family systemic therapy, NLP and brief therapy (Eaton, 2001a).

Mind, according to Bateson, was a cybernetic system. It was not only an intrapersonal but also the interpersonal connections ('patterns that connect') that constituted 'mind' (1979). When therapist and client sit together, 'mind' is not a personal, but a relational, inter-subjective process – including the two of them, a 'wider mind'. The relational hypnosis process is that very joining together into a 'wider mind' – this is interpersonal trance (or relational trance). And this very process happens in any good therapeutic relationship. Understanding trance can help clinicians across disciplines to recreate those situations by 'practiced surrendering' into this interpersonal (inter-subjective) trance. Bateson's student, Bradford Keeney (1983) further reiterates: "there is simply no way a therapist can avoid being a part of a cybernetic system recursively connecting his behaviour with that of other members of the treatment ecology."

Relational hypnosis engages with a process of self-reorganisation, whereupon the system includes the client, the therapist, the therapeutic relationship and wider contexts. The hypnotherapist recognises his or her part in therapy, for there is no such thing as 'client' or 'symptom' independently of the context, and while in therapy – independently of the therapeutic situation (Bateson 1972; Keeney, 1983).

The way we are positioned as therapists by our clients therefore becomes a part of their own organisation (object-formation is a part of object-relations) and changes in the course of therapy (Keeney, 1983).

Moreover, hypnotic processes are often the context in which transitional reality-formation occurs, a context that allows for reorganisation of attachment and of self (Eaton, 2001b; Keeney, 1983).

In relational hypnosis, we lend ourselves to join a genuine I-thou relationship with our clients (while still holding the transferential relationships), expanding the bodymind field so to allow for more possibilities, wider expression and deeper connection with self, other and with a larger system [community/collective/god/spirit] (Gilligan, 1997; Keeney, 1983). And so, through learning to cultivate interpersonal trances, we are able to 'hold a space of deep listening' (Cicetti, 2004) for our clients, ourselves and for the relationship that emerges.

Coming Together

A student of mine, a psychodynamic psychotherapist, wrote her Masters dissertation on Tummy-Rumblings. None of her lecturers were able to refer her to the substantial work that Gerda Boyesen, one of the foremost practitioners of body-psychotherapy, has done on this subject (Biodynamics). This is akin to an art and drama psychotherapist not knowing of Winnicott's work.

It is my hope that in the coming decades, the isolated accumulation of knowledge from the fields of relational psychoanalytic psychotherapy, of body-psychotherapy and of hypnotherapy could come together. We have much to give to one another. May we be able to remove the fig-leafs and be, if only for a fraction of a moment, less ashamed in our wanting to connect.

We shall not cease from exploration
And the end of all our exploring

Will be to arrive where we started
And know the place for the first time.

From:

T. S. Eliot – Four Quartets, 1963

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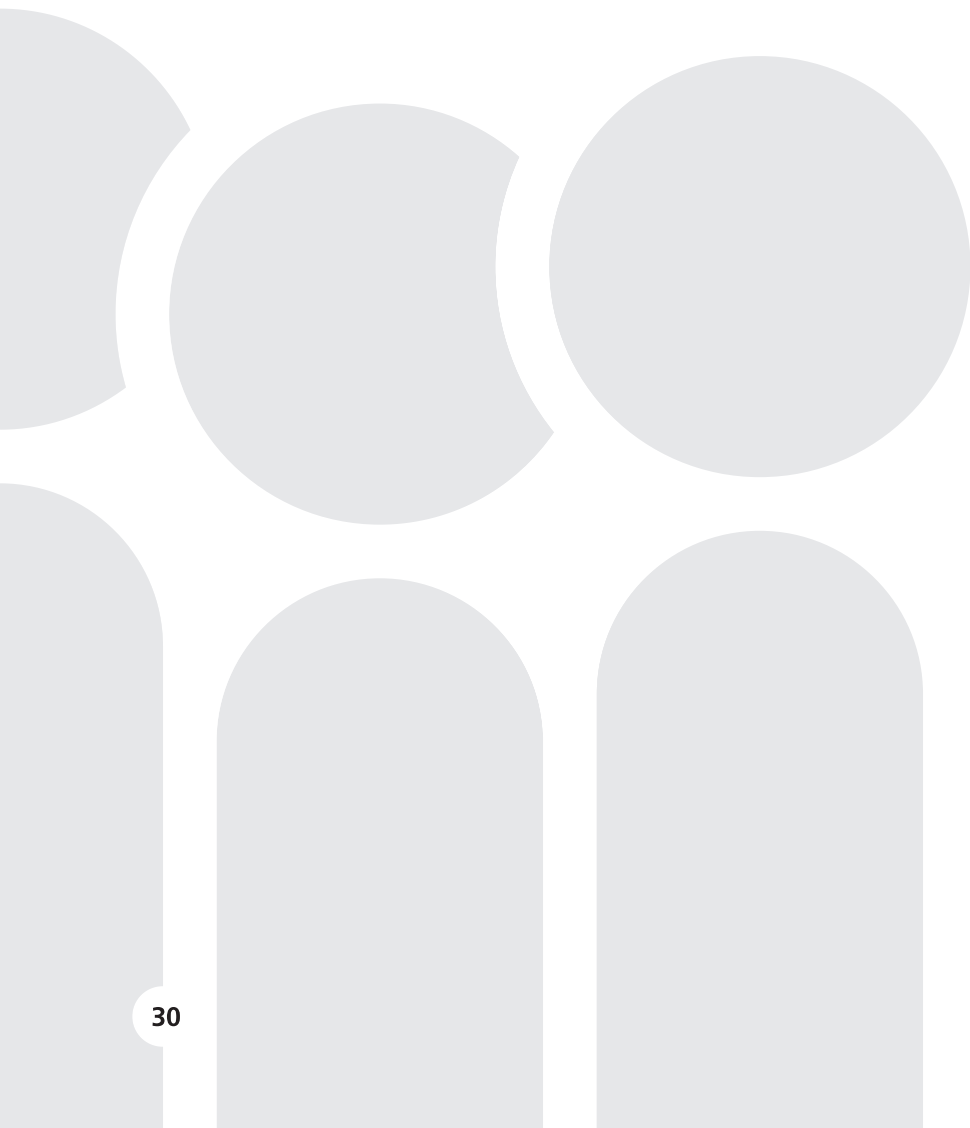

Herbert Hahn

Synchronicity, Social Dreaming And Surprises

Abstract

This paper gives an account of the author's ongoing interactive engagement with Social Dreaming in the context of his own professional and personal journey. Beginning with an account of surprise inclusion of Social Dreaming Matrix in a workshop, shortly after reading Gordon Lawrence's first published paper on his method (Lawrence, 1991), it goes to register and explore subsequent co-created endeavours and developments.

Preamble

My childhood in South Africa at the beginning of the second world war as the firstborn and male of an immigrant orthodox Jewish extended family included experiences of being spat on as a 'jew pig' or 'dirty yid' by peers whose parents were members of the pro-Nazi 'Ossewa Brandwag' political party; and being deferentially addressed as 'master' or 'baas' by African adults whom some whites contemptuously called 'filthy kaffirs' or 'black swine'.

During the apartheid era, as a post-graduate psychology student my dissertation was inspired by a liberally minded and psycho-analytically informed mentor (Prof. I. D. Macrone). It explored the similarities between a man who had been psychiatrically diagnosed and hospitalised as 'paranoid'; and the views of our then Prime Minister: The hospital patient's symptoms related to his pervasive fear and suspicion of 'the blacks'; and the Prime Minister's policies were based on his stated belief that all black people were mentally inferior, sexually primitive and socially dangerous. The dissertation evoked keen interest from two of my peers, one of whom wanted to draw on it to attack the government; the other turned out to be a paid state informer.

Later as a clinical psychologist seeking further training, I was encouraged by the London trained Independent Group Psychoanalyst Sam Stein, to train abroad. Arriving in (and escaping to) London in 1961, the shadow side of my good fortune in finding work at a psychoanalytic therapeutic community (the Cassel Hospital), and being introduced there to brief therapy and Balint groups (Tom Main) and at the Tavistock Clinic to Child, Adolescent and Adult Therapy (Martha Harris and Bob Gosling), was my bad luck in being referred to, and mistakenly staying stuck in, a 9 year personal analysis with a neo-Kleinian psycho-analyst[1]. I internalised the relationship with her to the extent of narrowing my range of theories; knowing that all clinical work other than my analyst's version of dyadic five times weekly analysis equated to mothers feeding babies on watered down milk; and believing that my dreams belonged with my analyst, as did the money with which I paid her fee.

1. This was shortly after the death of Melanie Klein herself who famously said to Betty Josephs and Wilfred Bion: 'I am not a Kleinian', at the time when the 'controversial discussions' were raging in the British Psychoanalytic Society between groupings which identified themselves as Kleinian, Independent or Freudian.

It took a subsequent analysis with Donald Meltzer, many years of supervision, including with Donald Winnicott, work in career guidance (Herbert Phillipson), learning about and delivering Group Relations and Management Selection and Development Programmes (Eric Miller and Harold Bridger), Group Analysis (Meg Sharpe and George Renton) and Management Education (On the staff of the European School of Management Studies) to be able to read with hope, inspiration and enthusiasm, Gordon Lawrence's 1991 paper about his systemic and democratic way of sharing and engaging with dreams.

Later when working on a book Anna Chesner and I co-edited, we included Social Dreaming both in our group meetings with chapter contributors and as part of the process of writing our editors introductory chapter (Chesner, A and Hahn, H. 2002).

My continuing professional journey has included staff membership of the Centre for Psycho-Social Studies at UWE, engagement with Relational Psychoanalysis, leading the leader's group of the Institute for Psycho-sexual Medicine, training in Reiki (Sarah Maude); working with the Spirit-Mind (Bert Hellinger), dialogue with Independent Psycho-Analysts (Patrick Casement and Neville Symington), and, thanks to Eve Steel, linking mind, body and spirit under the aegis of the Scientific amd Medical Network, where I was introduced to a range of links between mind, body and spirit including a Sufi perspective which was furthered in dialogue with Kunderke Kevlin. These learning opportunities have come to co-creatively bridge the interpersonal, group, systemic, societal, aesthetic and transpersonal dimensions in therapeutic, educational, managerial and business contexts, especially in the roles of Mentor and Group Faciiltator (Hahn, 2007; Clarke, Hahn and Hoggett, 2008).

Attendance at and engagement within recent presentations at a London conference of US Relational and UK Independent Psychoanalysts both provided an opportunity to dialogically learn more from Jessica Benjamin and her American Colleagues about the 'co-created thirdness' of relationships; and for synchronicity of networking with Maria Gilbert which enabled me as author and her as editor to co-create this paper.

A Beginning

Shortly after reading Lawrence's 1991 paper, a surprise opportunity arose to try a Social Dreaming Matrix during a two day workshop for a cohort of 15 trainee humanistic counsellors on 'psychodynamic viewpoints'. During the first day of our workshop, we explored key psycho-analytic concepts. The work seemed to go well-enough, but did not develop the level of dialogic participation I had hoped for; and I found myself reflecting aloud at the end of the day that taking an interest in our own dreams could be another useful way to learn about unconscious processes.

The next morning when someone asked if she was the only one to have had a dream the previous night, all but two said they had. I then spontaneously suggested we try the Social Dreaming Matrix as described in the paper I had read. We then proceeded to re-arrange our chairs in the recommended snowflake pattern and share our dreams, associations and elaborations, without recourse to interpretation or active engagement with interpersonal or group dynamics. The aim was to let our dreams engage with each other and for us to also be open to discovering, rather than imposing, themes which emerged (Hahn, 1998).

As our dreams and associations unfolded, the process began to develop its own rhythm, somewhat like musical improvisation. One of the participants who had previously thought he had not dreamt the previous night, spontaneously also recalled and shared his dream. Towards the end of the Matrix, we came to realise that there was also an overarching theme which linked the variety of dreams we had shared: they all included a focus on some aspect of being on a journey. We could then also link this shared external reality of their training coming to an end and being about to begin professional practice.

After a short break, our next activity was a lively engagement in live supervision. Surprises were forthcoming and some said that the social dreaming had freed them up. For example, at

one point the way in which the presenter had managed to creatively pick up on an apparently obscure remark of her client, one of the group noted that she had tuned in to something just as we might in that moment tune into the tone of distress being expressed in that moment by the birds outside our open window even though we could not see what was happening and were not experts in bird language.

Written feedback posted to me after on our workshop also referred to the usefulness of the Social Dreaming Matrix in enhancing their interconnection with each other. This, I was told, had also been noticed by the two group members who had been unable to attend the workshop. Overall they felt that they had learned something useful about psycho-dynamics but also found new links with each other in a way which enhanced the usefulness of their fortnightly experiential groups.

Subsequent Work With Dreams

For a many years I found myself firmly separating my work with dreams brought into the context of therapeutic work from those which were invited in Social Dreaming Matrices, and while this still has truth, there are a variety of situations where the range of my ongoing personal and professional learning and experience interact. For example, when an NHS multi-disciplinary psychotherapy team I had been facilitating decided to invite their secretary to join our meetings, and she, spontaneously brought and voiced her dreams, I mediated the initial anxiety of the rest of the team about this being 'inappropriate' and explored the possibility that the secretary, who had daily contact with all staff and patients might be dreaming on behalf of the service as a whole as well as in her own right. This also paved the way for a subsequent meeting where one of the therapists began with a dream of her own about having been criticized by her supervisor (who was also the consultant head of the team, normally at our meetings, but absent that day). With my encouragement, the team's associative way of Social Dreaming also led to someone else's dream finding a place. The meeting went on to explore various interests and concerns. Then right at the end of the meeting, she reflected spontaneously that during the course of our meeting she had come to the realisation that the critical supervisor she had dreamt about existed primarily in her internal organisation, and that she thought she could now deal with, and modify, its impact. And indeed subsequent meetings produced some evidence of her growing feeling of professional confidence and increased leadership effectiveness.

Soon after my first Matrix experience with the Counsellors, I signed up for a week-end Matrix run by Gordon Lawrence and his colleagues. My experience as a participant was similar to that of the student counsellors. I also had a dream while there which has stayed with me as a deep link with what I have come to think of as transpersonal or in Bion's terms, a glimpse of 'the ineffable' (Bion's O): In the dream I was presented with a profoundly mysterious yet strangely simple imaginal awareness that the beginning and end of the universe were aspects of a whole way which illuminatingly conveyed that both starting and ending were both facets of one system. An association which came to mind was a question in the I Q testing which was part of my regular work as a psychologist:

'How are first and last the same?' With the required answer being that they are both positions on a continuum. The psycho-analytically minded might conceptualise the question as having a bearing on a capacity to move beyond 'splitting' processes of the 'paranoid-schizoid position' to the capacity to bear the emotional pain of the 'depressive position'. The 'right' answer also has a link with Einstein's conceptualisation of 'relativity'; and poetically perhaps might move one on, like Rumi, to conceive with 'fierce wisdom' of engaging with a space or place 'beyond right and wrong'… It took a further dream years later in my internal Social Dreaming Matrix (whose participants include people externally credited above) to develop the theme:

I am at a point of interchange on a journey which involves passing through a tunnel and emerging at the required platform. While unsure, I saw a colleague I knew sitting at a nearby cafe whom I could ask, but I did not want to expose my ignorance to him. Instead I asked an official at the tunnel entrance, who then gave me simple directions, which I nevertheless got lost in trying to follow. Again

at a loss and back in the tunnel, I saw and approached another uniformed official standing available to 'help'. I was mindful all the time that everyone else was swiftly and purposively traversing the tunnel. The official responded to me in a relaxed and friendly way and giving what I heard as clear and simple guidance. However when I tried to 'follow' the 'directions', I once more became 'lost'. Then I paused, reflected and came to the realisation that I had missed the point of what they were telling me because I assumed they would be giving me directions for where to go next en route to my destination: What they had actually been communicating was that I had already arrived at my destination; that there was nowhere else to 'go' – I was already in life's journey – in the continuum between birth and death – there was no need to be so busily searching and all that was needed was to be mindfully present.

Humanimals

A recent Social Dreaming Matrices Day with the staff of a Counselling Service, began with a dream in which a father was about to kick away a calf which was coming too close to his lying-on-the-grass baby. An older child tried to restrain her father while his wife stood by. In the course of the day and the sharing of other dreams, associations and elaborations of this first dream also emerged, and came to see the man intent on kicking the calf as wearing shoes of calf leather in a way which widened our awareness of our human primitiveness and animal civilisation. This elaboration of this theme also brought a deeper understanding to another member of our matrix of the first dream she had brought to her training analysis.

The mood at the end our day was relaxed and thoughtful: an outcome of having allowed and enabled our dreams to interact with each other without trying to control, manage, censor or interpret them. The day reminded me of having held a fortnightly dream matrix with at handful of interested people over several months, during which time we came to notice that in our dreams the clear cut distinction between humans and animals had disappeared and the beings in our dreams often had both human and animal features and qualities. Time was also increasingly non linear and occasionally also included events which had not yet 'happened.'

Working with Dreams in South Africa.

In 1994, invited to run a workshop for members of the helping professions, just after South Africa's first ever democratic elections, I chose to draw on both the Tavistock Group Relations approach as developed by Harold Bridger and Social Dreaming Matrices. Permeated by the country's tumultuous political transition and the demise of the previously politically all powerful Afrikaner dominated racist Nationalist party, our workshop floundered into a confrontation between the two Afrikaans people in our membership: She screamed that he had physically abused her; he asserted that he had been outrageously provoked, and had just given her a gentle slap. Attempts at understanding, mediation and containment were swamped by adversarial polarisation which spread to our membership. Our workshop was rescued from disintegrating by the Social Dreaming Matrix. This was the gist of the first shared dream:

'I had just arrived at a party where I did not feel safe and could not see anyone I knew. Then I noticed a man beckoning to me from across the room, I uneasily wondered what he wanted: sex or drugs? Then I recognised him as my ex art teacher with whom I had previously felt safe, so I ventured cautiously across the crowded room. As I drew nearer, he indicated for me to follow him. I did so, keeping my distance, and was led out of the house and its adjacent garden and onto an overgrown pathway which had not been used for a long time. Keeping my teacher in sight, as we crossed plains, traversed slopes and rounded bends, we eventually came to a place where he halted and he beckoned me to come and stand alongside. I did so slowly and warily. When I was finally standing beside him, he pointed ahead. I looked and was amazed to find myself gazing onto a vast pool on whose surface was reflected the beauty of the heavens above.'

All present had become totally absorbed in this dream narrative and just as it came to an end, one person, putting a finger to his lips to maintain our silence pointed for us to look at a specific spot on the skirting board. There, emerging from its hole was a small grey mouse.

Enraptured, we silently watched as it came into the room, scampered across between our feet, and disappeared into a gap by the doorway.

Our silence was broken by a group member confiding with amazement that this was the first time in her life she had not screamed on seeing a mouse. Other associations which followed were spoken in the spirit in which we were experiencing and sharing both our dreamer's mouse's journeys.

We left the Matrix in a spirit of mindfulness, wholeness and silent connection.

The following morning's program started with a pre-breakfast Social Dreaming Matrix, which opened with the following dream:

'I have always been curious about other people telling their dreams. I have not in the past ever remembered having any dreams and thought I never would, but last night I felt as if I was awake even though I was asleep, so I supposed I had a dream. In it I was standing in a courtyard exactly the same as the one we have at this conference centre but with one difference: it was completely upside down with its branches disappearing into the earth and its roots were reaching into the sky.'

The associations and elaborations and responses to this dream were multi-faceted and myriad. There were shared associations about the image of a country being uprooted and stood on its head in a way many had not even dreamed to be possible. There was also mention of the oak tree being an alien British tree and that the indigenous Baobab tree's twisting and twining branches visually resembled the roots of other trees; another association was the banyan tree under which the Buddha had sat.

The workshop ending included a heartfelt hug between the couple who had fought and an enthusiasm for Social Dreaming which found subsequent local applications (Hahn, 2007.)

I engaged in subsequent Social Dreaming Matrices in South Africa with Art Therapists, Psychotherapists and Counsellors, Academics Organisational Consultants and multi-disciplinary and multi-racial groups.

One of these was part of two day workshop, some five years ago, and as often transpires the first shared dream, carried and held an ongoing presence in the ensuing matrices. It told of an experienced research scientist who could not, despite trying every way he knew, and much time spent in his dark room, develop and print crucial research photos he had gathered.

Many of the associations and subsequent dreams spoke to the pain and complexity of South Africa's post-apartheid era. Then the very last dream shared on the following day turned out to be reminiscent of the transformative dream which had had such a profound effect some ten years previously (as described at the beginning of this section of the paper).

This was again in the voice of a committed researcher who was again reaching a total impasse with a problem which resisted 'development'. In total frustration, well past what should have been the end of his working day, he stepped out into the night air where instead of lighting up a cigarette, he happened to look upwards. To his surprise, and as if he was seeing them for the first time, he apprehend the wondrousness of the heavens, and came to a profound loving realisation and understanding both of the beauty he had never before seen in the heavens above and of the way forward with his research. Associations focussed on the centrality of accessing both beauty and love in all their fierceness and toughness in turbulent times.

And Elsewhere

A range of situations and contexts come to mind where Social Dreaming Matrices made a creative contribution:

With the descendants of the perpetrators and victims of death camps where shared dreams illuminated unconscious aspects of transgenerational suffering, and freed the way for the healing space provided by the inclusion of Median Groups.

In a week-end workshop on Working with Love where shared dreams revealed aspects of the dynamics succeeding and failing in creative transformation.

A University based Learning Community where the Social Dreaming Matrices opened the way to a freer and more creative dialogue between academics, therapists and organisational consultants,

A national conference on ethics, where the shared dreams deepened subsequent dialogue and understanding by revealing the multi-faceted underlying dynamics.

Guy Fawkes day 2007 provided an opportunity for exploring the theme 'Celebrating With Fire' of a one day public workshop at a Community Creative Arts Centre at which Social Dreaming Matrices revealed themes which were then creatively elaborated in costume, collage, poetry and drama vignettes.

And Dreamwork followed by Creative and Reflective space were also drawn on in team building with the Staff of a University Department, a theological college, a G P practice, and a therapeutic community.

The journey continues

Sleep well en route to dreams and discoveries!

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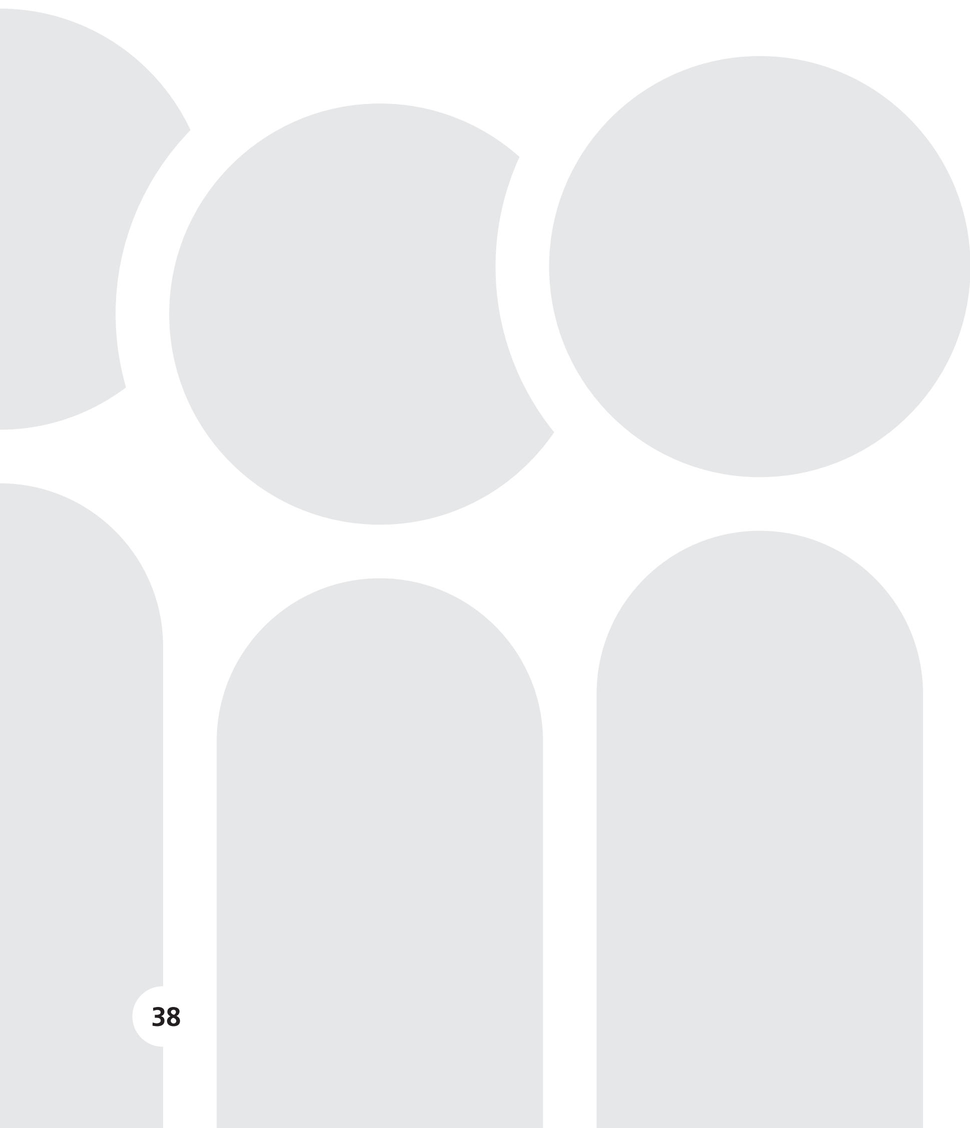

Phillipa Smethurst

The Impact Of Trauma – Primary And Secondary: How Do We Look After Ourselves?

Abstract

This article outlines the central features of trauma as observed by those at the "coal face" of the helping professions. It examines the effect of trauma on the psyche including dissociation, hyperarousal, repetition and intrusion. It attempts to make sense of a traumatized person's internal world, presentation and way of viewing the other. The second part part of the article reflects on the psychological impact of working with traumatized individuals on those who endeavour to help and examines the phenomenon of Secondary Traumatic Stress.

Introduction

I began thinking about this two years ago when I was asked to prepare a presentation for GP's at a national conference held at the Hyatt Hotel in Birmingham. The conference focused on supporting health professionals who specialized in treating asylum seekers and refugees. These doctors were discovering something about the trauma their patients experienced through the emotional toll they experienced in treating them.

In order to prepare my presentation, I decided to begin with definitions. To consider what trauma actually is seemed like a beginning place in understanding its impact. The Oxford Dictionary definition hardly gets us off the ground:

> *…an emotional shock following a stressful event, sometimes leading to long term neurosis.*

In my own definition, I would want to include the de-railing aspect of trauma that I believe is part of its essence. Trauma occurs when an event cuts across the path of an individual's life in a surprising or unexpected way and elicits an emotional response. Donald Kalsched (1996, p.92) uses the phrase "volcanic affect" to describe the impact of a traumatic event on the psyche. Volcanic is apt in that in response to a traumatic event, a person's powerful emotions, unprepared for, unbidden and previously unknown, spring up within their psyche.

Dick Blackwell (1995) writes:

> *"Exposure to extreme levels of violence, terror and destruction stirs up the most primitive feelings and anxieties, to a degree where many people's normal defensive structures are unable to cope".*

What Blackwell is pointing to is that the level and type of anxiety which is provoked in trauma is of a primitive level. Anxieties are stirred which threaten the very root of a person's survival and existence, such as heard in a baby's terrified howl when s/he perceives herself to be abandoned by her mother. A traumatic situation will threaten a person who may fear annihilation, engulfment, disintegration, abandonment or loss. Such a threat will initially arouse the person's sympathetic nervous system, stimulating an adrenalin rush and a state of alert mobilized for battle or flight.

Traumatic reactions occur when these flight or flight responses are ineffective. The human response system of defense then becomes disorganized and overwhelmed in the face of the 'volcano' and the psyche will respond in a variety of ways. The responses to trauma last far longer than the event itself. So, what does the psyche do with the volcano and what are these traumatic responses?

Psychic Numbing Or Dissociation

A common response of the psyche in the face of violence or threat is to go numb: to feel nothing and be largely unable to think. The person may feel as though the event is not happening to her, and perceptions may be distorted in this altered consciousness. This is a defense or safety mechanism that works in the mind as a kind of psychological circuit breaker. As Herman (1997, p.43) writes: "This altered state of consciousness might be regarded as one of nature's small mercies, a protection against unbearable pain". The GP's I worked with recognized the flat look of dissociation in the asylum seekers they worked with, as if they had been anesthetized and were not fully there.

Dissociative symptoms affect not only the person's state of consciousness, but also their memory. A century ago, Janet demonstrated that people with hysteria lost the capacity to integrate memory of overwhelming events. Patients in psychotherapy who have been traumatized can reclaim their memories as their feelings are brought further into awareness. A man I worked with who had been sexually humiliated by a religious Brother at school at the age of eight had told the story in a matter of fact way. It was not until years later in the therapy, when we had discovered and explored a pervasive feeling of shame and guilt in his current life that he was able to connect this with earlier experiences with the Brother. It felt like reconnecting an emotional wiring diagram.

Judith Herman (1992) describes the dissociative symptoms of trauma as constrictions. The same patient who had been traumatized by the Brother was deeply constricted, spending the whole of his long life avoiding any situation that might involve confrontation. Only after years of psychotherapy, did he begin to realize just how dominated his life had been by fear and how restricted he felt. He had protected himself from further trauma, but at a terrible price to himself. Internally he was disintegrating while functioning externally.

Fragmentation Or Hyperarousal

In studying World War One veterans, Kardiner (1947 quoted in Herman 1992) first interpreted their disorganized behaviour as being fragments of experience: nightmares, flashbacks, startle reactions, part of a shattered fight or flight response of the central nervous system. The psyche is quite literally shattered, like pieces of a jigsaw that need to be connected and integrated into a coherent story. The GP's I spoke to described the incoherence and confused presentation of many of their patients, reflecting a fragmented internal state, where identity, beliefs, experience, history, value and meaning can no longer be connected.

The traumatized person will startle easily due to chronic arousal of the autonomic nervous system. This can mean that traumatized people cannot tune out stimuli that others might be able to disregard, and they can find difficulties in sleeping. A patient of mine whose mother and stepfather went on frequent drunken binges where violence was often the end result, described as a child needing to keep awake to ring the police. Now, as an adult the danger is long over, but she is left with chronic sleep difficulties. She has no 'off button'. Another patient whose mother left at the age of 3 months cannot rest, always is hyper-vigilant in his concern to attend to his affairs. Over time and through analysis we have understood this 'clip boarding' to be a part of his defense against the deeper feelings of loss. Cairns (1992, p.112) writes about this hyper arousal in a graphic way, saying "It is hard for traumatized children to see pages of print, when their peripheral vision is scanning the environment for threats."

Intrusion

One of the features of trauma is the depth at which it operates. Perhaps a reason for this may also be partly physiological. When stress hormones are charging round the body in larger

quantities than normal, memories are more deeply embedded. It is as though the memory or event is engraved on the person's soul and time stands still. The person often has a compelling need to repeat the trauma or to relive it in some way. What is encoded in the memory is not a linear organized narrative which is assimilated into life events. What the traumatic memory holds is often more in sensation or images without context. A child who had lived the first year of her life in a Chinese orphanage was experiencing difficulties in adapting to her life with her adoptive family, particularly when facing school. During a brief spell with a play therapist, she was able to draw pictures of her early life including the caps that the nurses wore. These memories were indelibly encoded in her memory. It is at this highly visual and enactive level that trauma can operate.

Another way that intrusion can be understood is in the way in which the essence of a particular trauma is enacted. One patient had a severe congenital abnormality diagnosed at the age of 15 and then underwent significant surgery with little emotional support. She reported a recurring dream. In the dream, she was the only survivor of a terrible plane crash. When she told her sister of the experience in the dream, she was told 'Never mind!' The belief she internalized was that her experience was nothing much and should be kept secret. This denial became the defining experience of her life. She told no-one about what happened to her and said 'never mind' to herself. The essence of the trauma in this case was in the experience of secrecy and painful lack of support, the power of which had become split off from her consciousness and was expressed in her dream.

Cairns (2002) writes about the way in which the traumatized person's core beliefs about the world are defined by the trauma. Because any previously held illusions that the world is a benevolent place are threatened by the experience of trauma, other beliefs take their place, which Cairns calls "identity beliefs, defined by disaster'"(p. 116) My patient who was abandoned as an infant lives his whole life as though "my boat is about to be capsized and when it does I will hit my head against it because it will all be my fault".

Repetition

Fragments of the trauma may appear in dreams. Another patient who had been thwarted and terrified at boarding school from the age of eight had a recurring dream which he described as being like a Hugo Bosch painting, with images of horror and violent acts going on in every direction. He became very interested in Bosch's paintings, feeling as if the art could express something of his terrifying experience. In the reality of his life, he appeared to be re-experiencing the horror as he enacted a similar passivity in choosing unsuitable and exploitative life partners. Cairns (2002) writing about the therapeutic care of traumatized children writes about how such children will make their world chaotic and dangerous in order to feel sane (p. 120), thus enacting the repetition.

The need to repeat the original trauma in this way may be an unconscious desire to master or integrate the original trauma, but it can be deeply distressing for many survivors as they are continually re-experiencing the rage and terror of the original experience. It is typically at this point that someone might enter psychotherapy. In the specific context of the GPs working with asylum seekers, the doctors recognized the life or death intensity in the interaction with some patients, elicited by the trauma repetition. Also, the inhumane treatment, questioning or even hostility encountered by patients in the holding centre of the receiving country might re-traumatise the patient, triggering a repetition of the volcano feelings. Herman writes about the 'domino effect' of trauma. The doctors recognized how fragile their patients were psychologically and were rather daunted to consider the level of psychological collapse that potentially could be triggered as experiences and memories collapse into one another.

The GPs were very concerned to consider appropriate responses and ways of dealing with their traumatized patients. They were uncertain whether listening to a person's story was always helpful in the circumstances in which they found themselves, with limited time in consultations and little continuity. We discussed that their patients, in order to survive the impact of witnessing unspeakable things happening in their home countries, had largely compartmentalized their experiences.

Unless they really felt as though they had a safe space to do so, the asylum seekers tended to keep their unmanageable and overwhelming feelings at bay. They appeared to be struggling to prevent the tidal wave of the past from overwhelming the present and the future. Story telling may happen spontaneously with certain patients, but often did not. The GPs wanted to increase their understanding of other ways their patients might present as a result of their traumatic experiences.

The Adult And The Infant

The doctors recognized that the traumatic experience could play itself out in the relationship between their traumatized patients and themselves. The traumatic experience is likely to have involved a perpetrator, perhaps a physical and psychological intrusion into the individual. The subsequent emotional response to any person in authority who therefore has the power to be intrusive is likely to be skewed by the experience of terror. Either the patient might behave in a helpless or dependent way around their clinician, and/or idealise the clinician as authority figure and have high expectations of what can be delivered.

It was a relief to the doctors to hear me normalize some of the emotional responses clinicians might and do feel around traumatized and needy patients. We spoke about the invitation to assume too much responsibility, to believe that: “I am the only one to help this patient and I want to rescue him”. Within this might be the tendency to make a special case, to extend the consultation time. The grandiose position of caregiver might lead us to over care for a patient or infantalise him. The clinician might become overwhelmed by awful stories and begin to rationalise the abuse as a protection against feeling its impact.

Issues around traumatic transference are likely to centre on trust. Where interpersonal mutuality and confidence has been shattered, it is difficult for a traumatized person to trust again. Trust in the clinician may at different times be shaky, fluctuating, unrealistic or non-existent. The patient might be exquisitely attuned to any lapse in attention on the part of the clinician, and be able to uncannily pick up on their vulnerabilities. Perhaps more challenging for the doctors was the idea of ‘negative counter-transference’, or more specifically, the notion that they might feel boredom, scorn, impatience or hostility towards their patients. They might find themselves not believing them or wanting to be rid of them. This concept might be difficult because it could challenge the GPs view of themselves as caring professionals.

The Mind/body Split

As doctors of the body, the group were particularly fascinated in the idea of somatisation as an effect of trauma. Many of them had experienced puzzlement when their patients reported physical symptoms with an intensity that did not add up from a medical perspective. We reflected on what occurs during trauma with the mind and the body. When the affect stimulated through trauma is so huge that the mind is not able to give shape to words and images, the person literally has no words for their experience. As Kalsched (1996, p.66) says: “This will put him or her at a terrible disadvantage’”in that the psyche which makes links and works towards wholeness in the personality splits apart in order to allow the individual to survive the experience. I was reminded of McDougall’s(1989) work with a patient who had never been able to mourn and who, during the course of the therapy, suffered a cardiac infarct, which was a bodily way in which his grief and split with the mind could be expressed.

I quoted the words of Henry Maudsley, the nineteenth century anatomist: “The sorrow that has no vent in tears makes other organs weep” (quoted in McDougall 1989, p 139). I shared this quote with one of the doctors prior to the conference. The quotation spoke so powerfully to him of the multiple losses his patients carry that, when he first heard the quote he needed to stop driving his car, pull over and allow himself time to recover from its powerful emotional impact.

Victim/survivor

The traumatized patient may present himself or herself as either victim or survivor in a way that precludes the other. In the victim position they may present themselves as helpless, unable to keep appointments and be very demanding. As survivor, the person might present themselves as resilient and capable, undaunted by the experiences of the present and unscarred by the experiences of the past. We discussed how patients might appear to have a pseudo competence and the clinician may be unaware of their level of psychological vulnerability.

Survivor Guilt

The patient may feel persistent guilt about the choices they made during their traumatic experience or a gnawing guilt about the mere fact that they are alive when others are not. Herman writes about how some survivors of trauma endeavour to transform the meaning of their personal tragedy by social action (p207). The patient who had the never spoken about congenital abnormality had made a living making television programmes, some of which featured the victims of trauma. Through her own efforts and her alliance with others, she was able to feel like she was 'making a difference' in seeking justice for victims, and feel powerful where she had felt powerless. Other victims might seek more direct redress relating to their personal experience. My client who had been abused by the Brother within his school was involved in a legal process against the perpetrators. The danger in such a process might be that the original trauma is triggered or that the victim is deluded into believing that his own damage will be resolved by victory. However, there might be benefit derived from overcoming the debilitating effects of the trauma in confronting the perpetrator in this way, with a secondary benefit of protecting other potential victims through the action.

Overwhelming Rage

Rage may be hidden beneath a passive, accommodating and grateful presentation. I shared with the GPs the range of countertransferential reactions I might experience around such a person, from a rumbling fury, to frustration and righteous indignation. Sometimes, as a psychotherapist I might experience being berated by a patient and feel rather controlled or browbeaten by them. We spoke about the possibility of being over-deferential towards a patient or to identify with the patient's rage so powerfully that it is difficult to contain it and possible to react angrily towards them. The GPs identified most with the feeling of righteous indignation through working with so many patients with horrendous histories, whom they felt inadequate to help much due to the limitations of the system. One GP spoke about taking long walks along the cliffs as a means of processing and managing the power of her feelings.

Shame

Whereas guilt is a feeling that we have let someone else down, shame is a pervading sense that the victim of abuse or trauma has that they are bad or to blame. Even if cognitively the patient knows they are not to blame for what happened, the feeling of shame may tell them something different. Shame can be a pervasive cloak of a feeling that can protect someone from facing deeper more frightening feelings such as terror or rage. Shame works in a complex way in the psyche and may take considerable time in psychotherapy to be uncovered and understood and the underlying painful feelings expressed.

Loss

Many refugees will have suffered losses of family, friends and colleagues. This may have involved witnessing violence or perhaps arriving home to find the loved person simply gone. Perhaps they have suffered so many losses that they have been unable to begin a grieving process and appear untouched by their experiences. In other cases, loved ones may be 'lost' in the sense that they are left behind or fled to another country. They may well feel dislocated from the very roots of their identity. Their experiences leave them feeling alone in their grief, so to have someone who will believe them and believe in them can be vitally important. The therapist or doctor's role as a witness to the patient's experience can be a powerful force in assisting

the person to reclaim a sense of their humanity in the face of the devastation they have suffered. This capacity to be open to the impact another makes on us is at the heart of any such encounter. As Cairns writes: (2002, p 140)

> *"...(Traumatised people) need us to be prepared to engage in a dance of grief, to music they alone can hear."*

What Can Happen To Us?

"Trauma is contagious'"writes Judith Herman (1992, p.140). In the final part of the workshop for GPs, we focused on the impact of working with this client group and the kind of support they might need to protect them in their work. It was no surprise to the GPs that in their role as witness to disaster or atrocity, they might find themselves to be at times emotionally overwhelmed. Or that they can experience, to a lesser degree, the same terror, rage and despair as their patient. Psychotherapists perhaps more commonly recognize such experiences.

Theorists refer to the phenomenon in a number of ways:

1) Secondary traumatic stress

2) Burn out

3) Traumatic countertransference

4) Vicarious traumatisation

5) Compassion fatigue

We began by thinking about burn out and the kind of impact and symptoms that GPs or psychotherapists might notice in themselves as a consequence of working with and caring for a demanding and troubled patient group (Figure 1).

Both Burn Out and Secondary Traumatic Stress are natural consequences of caring between two people, one of whom has been traumatized and the other who is affected by the first's traumatic experiences. The most obvious difference between Burn Out and Secondary Traumatic Stress is in the speed of response. Whereas Burn Out is a slow fuse, in that symptoms generally develop over time, symptoms in Secondary Traumatic Stress can be quite dramatic. I remember listening to a woman's story in a primary care counselling assessment. My client's son had lain down in front of an intercity train. After an hour with the woman, I came out of the room, headed for the bathroom and immediately threw up. I had felt perfectly fine prior to the session, and pretty fine after vomiting. I had been so impacted by her story and attuned to the unexpressed and unmetabolised feelings of rage within this woman, that I believe my psyche and body needed to expel them. This physiological reactivity on exposure to trauma is illustrated in this table (Figure 2) outlining symptoms of Post Traumatic Stress and Secondary Traumatic Stress cited by C. R. Figley (1992) (Figure 2).

We noted other features of STS that the GPs may notice in themselves (Figure 3):

The GPs found reassurance in there being evidence to support the existence of the

Burn Out			
Physical	**Emotional**	**Attitudinal**	**Behavioural**
Fatigue Exhaustion Sleep difficulties Headaches GI disturbances Frequent colds Flu	Irritability Anxiety Depression	Pessimism Defensiveness Dehumanisisng and Intellectualization of Patients Reduced sense of personal accomplishment	Poor work performance Substance misuse Poor communication and concentration Withdrawal

Figure 1: *Aflter Maslach, C (1982) Quoted by R. Bale in Secondary Traumatic Stress*

PTSD	STS
Acting or feeling as if the traumatic event were recurring (includes sense of reliving the experience, delusions, hallucinations and dissociative flashback episodes including those that occur on awakening or when intoxicated. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.	Acting of feeling as if the traumatic event were recurring (includes a sense of reliving contact with the client and client's story in order to solve the puzzle and help the client.

Figure 2

phenomenon that they had observed in

STS Avoidance Features
1) Efforts to avoid thoughts, feelings or conversations associated with the patient's trauma. 2) Efforts to avoid activities, places or people that arouse recollection of the client's traumas. 3) Errors in judgment about conceptualizing and treating trauma cases. 4) Markedly diminished interest or participation in significant activities. 5) Feeling of detachment or estrangement from others. 6) Restricted range of affect (e.g. unable to know patient personally or saviour orientated.) 7) Sense of foreshortened future (e.g. does not expect or want to have long career.)
STS Increased Arousal
1) Difficulty falling or staying asleep 2) Irritability or outbursts of anger. 3) Difficulty concentrating. 4) Hyper vigilance. 5) Exaggerated startle response.

Figure 3: *C. R. Figley (2002) quoted in Rod Bale Secondary Traumatic Stress*

themselves. I quoted Allen (2002) from the Medical Foundation for the Victims of Torture:

> *"When individuals speak of their torture (and trauma) clinicians should expect to have personal reactions and responses themselves. Understanding these personal reactions is crucial because they can have an impact on one's ability to evaluate and address the physical and psychological consequences of torture" (quoted in Rod Bale paper).*

Dick Blackwell (2005, p.95) in Counselling and Psychotherapy with Refugees states:

> *"Given that the work… may focus on extreme acts of violence and destructiveness perpetuated in reality… this may resonate at deep and frightening intrapsychic and interpersonal levels in a way that the clinician has not previously experienced. It is often the case that clinicians, like people generally, deal with horrific experiences by repressing and dissociating. They can be quite unconscious of the effect the work is having on them, and can go on enacting defensive manoeuvres in their work with clients in their relationships with colleagues and in their personal lives."*

Caroline Davies, from the Medical Foundation for the Victims of Torture (2003) puts forward this list of commonly observed symptoms in case workers (Figure 4).

Effects Upon Case Workers Or Working With Survivors Of Torture
1) Unprepared: often shocked and disturbed. 2) Emotional flooding 3) Self doubt, inadequacy, overwhelmed. 4) Anger and shame 5) Depression and anxiety 6) Guilt 7) Deskilled feeling helpless and isolated 8) Assumptions questioned 9) Positive reactions to clients.

Figure 4: *Quoted in Rod Bale Secondary Traumatic Stress*

In The Light Of This, What Can We Do?

The question posed for GPs at the beginning of the session was: how do we look after ourselves? We only came to the question at this point in the workshop because my thesis was that a major way we might look after ourselves is in endeavouring to understand the processes outlined above and to increase awareness about their impact.

This cannot be done alone. As Herman writes (p151) "The dialectic of trauma constantly challenges the therapist's emotional balance." We need help to unpack and understand our reactions, some of which may be to do with the resonance with unresolved trauma in our own lives and our current stresses.

At the closure of the session, we reflected on the following kinds of help that GPs and psychotherapists working in the field of trauma might consider drawing on:

1) Personal counselling and psychotherapy.

2) Supervision – a place to understand and process inevitable STS reactions. Figley recommends a ratio of 1:3, for every three hours of working with clients there should be one hour of personal processing. Within the demands and limited resources of the NHS such guidance may be a council of perfection.

3) Workload and boundaries. In a situation where there is increasing demands on a clinician's time, it is maybe important to recognize that there may be adverse effects of raising one's game to meet such demands.

4) Humour and stress reduction methods.

5) A supportive team.

6) Team sports/group activities can be beneficial in lower stress levels. Spiritual and Meditative outlets may be helpful to individual workers.

7) Adequate rest avoiding stress reduction through excessive alcohol.

8) Being mindful of the health of colleagues.

9) Environment is key. Herman (1992) writes about the 'empowering principle' in work with trauma, in ensuring that interventions do not take power away from patients. There may be an irony in that, in working towards empowering others, clinicians may find themselves working in environments that are inflexible, demanding and non-supportive.

As Bale writes in the summary of his paper on Secondary Traumatic Stress:

> *"The psycho traumatic field is young and knowledge about experiencing and reacting to traumatic material evolves in fits and starts. If STS is acknowledged to be an entity then it is important that all who work in this field have knowledge about it."*

As clinicians in the helping professions responding to unbearable levels of pain, we are in the business of attempting to contain the uncontainable and the bear the unbearable. As psychotherapists, unlike many of the GP's, we may have the advantage of a background in psychotherapeutic theory to support our understanding of the processes I have described and some of the help GP's might welcome, such as supervision, is already built into our professional structures. However, my thesis is that trauma as an out of the ordinary phenomenon takes all who endeavour to help to surprising and powerful places which challenge and disturb our equilibrium. We need to be constantly vigilant about our needs and our reactions as we dare to undertake this work. The weight of the task, its cost and impact on ourselves should not be underestimated.

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Julianne Appel-Opper

Relational Living Body To Living Body Communication

Abstract

In this article I want to focus on the role that the non-verbal communication between two living bodies can play in the psychotherapeutic process. In a case study I will demonstrate the healing potential of such a communication. I will also discuss the theoretical embedding of my therapeutic approach.

Introduction

For some years I have been developing and practicing a certain style of working from a living body perspective. My psychotherapeutic work started in a Psychosomatic Clinic in Germany, back in 1989. The ongoing exchange in a multi-disciplinary team of medical doctors, sport therapists, psychotherapists and others was a good learning experience. What I learnt most was an holistic approach to the patient. In these early years I developed the impression that the body of my patient tried to tell me her/his story and it was dependent on me to try to listen to these stories alongside the words. In the last years I have been working in English. The words I hear are not my mother tongue and this has helped me to focus more and more on these unspoken stories. Since 2005 I have been offering seminars to teach this approach. The participants' supporting comments have encouraged me to present my work to a larger audience in this article. After a brief outline of the theories I will devote the main part of this paper to a detailed description of a demonstration together with my reflections.

On A Meadow…

In the seminars I use the metaphor of a meadow in contrast to a motorway. When I am on the motorway I organise myself in a certain way, I have a direction and I stay focused. On a meadow it is more about being there. I am less channelled, less focused. I am more in my senses, in a curious mode, I smell and I breathe deeply.

I physically attune towards the grace of the living body; as a living body I get a sense of how the world has been given to the other living body. There could be movements frozen in the body of my client. Or shadows and echoes from contacts with the other with related somatic patterns. I welcome the stories the body wants to / needs to share. These words are packed into the body as atmospheres and volumes. Schmitz (1989) writes about 'milieus' and 'atmospheres' in the body: "The felt perception is not a reception of signals but a lived body communication and incorporation" (Schmitz, 1989, my translation). His "alphabet" of the living body helped me to find words in this wordless world.

Parallel to the metaphor of the meadow I teach the image of an anchor. With a strong connection to my thinking as my anchor I can let myself be physically impacted by what is communicated to me as a living body. With the

metaphor of an anchor I combine the concept of inclusion (Buber, 1958/1984) with the concept of the participant-observer (Sullivan, 1953). Hycner (1991) explains that "inclusion is the back and forth movement of being able to go over to the other side and yet remain centred in my own experience" (Hycner 1991:20). Sullivan pointed out that an observer is also a participant. I agree with Gilbert and Evans (2000) about the importance of Sullivan's concept that "both psychotherapy and supervision are participative processes" (Gilbert and Evans, 2000:10). In my teaching I encourage participants to stay physically impacted by the process and to look at the process from a distance.

…Rooted In Good Soil

As a Gestalt Psychotherapist I learnt to explore the "here and now emerging experiences" (Joyce and Sills, 2001) as a figure emerging out of a ground. With awareness I attend respectfully to the unique world of the client with "embodiment, feeling and thought" (Joyce and Sills, 2001). I root myself in the phenomenological method of inquiry and in field theory. The philosophy of Merleau-Ponty provides me with the soil for these roots. As a living body we are in the world ('etre-en-monde', Merleau-Ponty, 1945). As Des Kennedy states: 'The phenomenal field as the lived body is part of phenomenology and carries all the richness and promise of what we call "field theory" (Kennedy, 2003). The world is given to us only as a living body. We make sense with our senses. In the "between" of a "healing dialogue" we also "share meanings" and phenomenology (Hycner, 1991;Yontef, 1988). Parlett (1991) points out, "through creating a mutual field each of us is helping to create others' realities". I could list many remarkable texts on field theory. Parlett's text touches me most. I like the way he so profoundly includes the impact of the person of the therapist into the forces of the co-created realities of the field to act as witness to the various "selfings" (or selves)' of both the therapist and the client (Parlett, 1991). My aim is to co-create a space in which two different living bodies can communicate with each other. I view us human beings as deeply interconnected. As soon as there are two living bodies there is a field of non-verbal communication unfolding.

Surrounded by thinking/reflecting space

I have been influenced by psychoanalytical thinking. Sometimes I have found myself torn between the rich experience in gestalt psychotherapy and the freeing reflective space provided by psychoanalytical theories. What I realize more and more is that I draw from both approaches, especially from contemporary relational psychoanalytic theories. Stolorow and Atwood see the between as a meeting and a negotiation of "worlds of experience" (Stolorow and Atwood, 2002). Pizer (1992) gives us examples of these "two person negotiations", in which analytic potential space can be ruptured and repaired. What about the living-body- to-living-body communication and negotiation? Beebe and Lachman (1998) see the non-verbal dimension of interaction as gesture or self-touch, as organized self- and affect regulation, which is mutual and co constructed by therapist and client. The authors add that it is the task of the analyst to 'read' the non-verbal communication.

I see a living-body-to-living-body communication as an ongoing process of negotiation in physical attunement and physical regulation.

I also want to mention two metaphors out of psychoanalytical thinking which truly talk to me. Bollas' metaphor of 'the shadow of the other' illustrates how all the lived relationships continue to live within us (1991). These lived relationships also leave shadows in our living body from how we were handled as a baby, how we were attuned to. Some of these areas of experience will be the realm of the "unthought known" to us, living in our bodies and waiting to be heard by 'some-body'. I also transfer Tolpin 's concept of the "forward or growing edge transference" into the living body (2002). For me there is also something like a hope, 'a healthy striving' in the body that one day 'some-body' will be able to listen, to see the invisible and just to be there.

In the following I describe a demonstration I did during one of my seminars. Following the description I reflect on my work. During my reflection I came up with some headlines which I have added. I hope this will bring some structure to the text and will help the reader to follow the process.

Work with J.

The work starts after a break.

Before the break I had told the group that I have sometimes had the impression that the body will bring the person into psychotherapeutic treatment. The body would ache and would tell stories and would cry out to be heard by another 'some body'. I continue to say that if it were possible that one part of the body could bring the whole person here to this workshop then what would this part of your body tell us? What kind of story would we hear? And for what would you be brought to this workshop?

I then invite the group to draw this part of their body. I encourage them to use crayons and felt pens. I give the instruction "let your hand do the drawing, your hand will know what to do, just watch your hand doing the drawing". I comment that I want to bypass the cognitive process and to let the body talk. I encourage them to colour in as much as possible. After everybody has finished we agree to have a break and to focus on the drawings after the break.

After the break we go back into the group room. As soon as we all sit down everybody is silent. The silence lasts for a few seconds. I find this silence nice and comforting. I am arriving in the group again, my breathing is flowing and I am curious about what will happen now.

A Little Girl Talks:

> *J. sits on the floor opposite me, her legs crossed. Her drawing is on the floor in front of her. Like J. I had returned to a similar position I was in before the break. I sit on the sofa. J. says that she wants to work with me. She adds that she wants to and not, that she also feels 'resistant'. As I hear the word resistant my breathing changes. The flow gets interrupted and I inhale and exhale in a quicker rhythm. As I notice this I am consciously allowing my breathing to flow again. I look directly at J. and I tell her that she could do this with resistance. For a few minutes J. and I do not say anything. We look at each other. We both wait.*

I hear such a softness in her voice, which resonates with me. I feel an atmosphere inside me, light, thin, small and young. I am thinking that this is a young voice talking, about seven years old. I let the atmosphere spread a bit more so that I am getting in touch with my seven-year old Julianne. I sense a nervousness, shyness and fear. I am thinking that my seven-year old girl has had experiences of that too. I sense that my breathing changes. I want to be touched by J's world and atmosphere and at the same time I want to be able to hold a meta-perspective' (Gilbert and Evans, 2000). I start to distance myself a bit; I am consciously allowing my breath to flow again. Now I sense my curiosity and my wish to look at J. I understand that her girl wants to be there and not to be there. I try to say something to invite her. With spoken words I tell her that she can do this with resistance. With my eyes looking at her eyes I try to tell her that I hear and see her. I hear this voice as a growing edge transference (Tolpin, 2002) and I want to acknowledge that I receive this voice. My hunch is that this voice very rarely talked to 'some-body'. As we both wait I imagine myself on my meadow, waiting and not knowing what will happen. I have a clear sense to wait, waiting for J.'s readiness to communicate further.

J's Body Talks:

> *Then I notice that there is something in her body of a hardening/stifling, her back stretches and she moves slightly up. There is an upwards movement in her back. Her back looks as if she is putting herself under tension. I see that her breathing gets slower. It is a bit as if her body prepares her for something to happen to her. As if somewhere in her body she knows what will come. I feel a somatic response in my body. My body feels the stiffness in my back and in my shoulders. This feels restrictive. My breathing rhythm changes becoming more shallow. I notice that I have an impulse in my body, I want to move. I am consciously opening my breathing, giving myself time to feel what is happening in my body. I discover that my body wants to do sideward movements and especially my hips want to move.*

Now that I reflect upon these movements I think these are movements of hardening yourself for the world around you. The seven-year old girl had to learn to toughen herself to survive. I still hear the soft voice of the girl and now I sense that she toughens herself up. I am touched by this. My body

responds to this somatic self-regulating pattern. I get a sense where J. toughens herself in her body. My body is impacted by that, I feel restricted. I react with impulses towards moving, which J. does not and did not do. These movements are frozen in her body.

I Want To Be With The Little Girl:

The impulse to move makes me think that I want to sit able to face her at the same level. I start feeling too high up on this sofa. I ask her how she would feel if I sat down on the floor. She says that this would be 'fine'. The way she says 'fine' sounds to me that I can do this. I slowly move towards her, watching the changes in her body. I notice that her breathing pattern stays the same and she continues to look at me. I read these as signs that it is okay for her that I am moving towards the floor to sit with her. As I touch the floor I sense the difference of the floor compared to the sofa. This feels much harder.

In this sequence of our work I decide to hold J's frozen movements a bit longer. Before doing anything else I want to create a good setting for a living-body-to-living-body communication. My body wants to communicate the held movements in my body. I doubt that J. will take them in as I look down on her. If J. and I were to work long-term I might have decided to focus on the looking down and her experiences about that. For this setting I decide to focus on the frozen movements in J's body and the possibility of de-freezing those a bit in this short work together. As I start moving I get a sense that J's body is taking in these movements. I am glad that I started to move and that I changed the setting. As I sat on the sofa, I also got a feeling that we might lose her seven-year old girl. As if she could disappear into her usual pattern of toughening and disappearing.

There are different levels involved. I need to stay close enough to J's somatic process. I also need to create space within myself so that my body does not freeze too much and is able to talk to her. I also need enough self-support. In parallel I watch how our bodies respond to each other and I keep an eye on the group.

My living body wants to talk to her living body

'The way I sit right now does not feel right' is my first thought as I sit on the hard floor. My hips still want to move. I follow both impulses and I start making myself more comfortable. I wobble a bit moving from one hip to the other trying to find a balance so that my back can relax. I am trying to find a position I feel held in and supported within myself so that my body can continue with this work. As I follow the impulses of my body I watch J.'s body closely. I get a feeling that her body listens to my movements and takes them in. These movements reach her, her back looks less stiff and tense. We both wait again.

In this scene I am with J. in the past field; I feel the hardness. I want to communicate something new in a new field. I do the movements slowly as if to honour and acknowledge the creative way she had to organize herself and I want to communicate to her body that there might be other ways now available. I also keep an eye on the group checking how they might be impacted by the work.

Are You Really Here With Me?
Will You Really Try To Be With Me?

Then J. pulls with her fingers on both sides of her open cardigan and closes it more. As her fingers make these movements her shoulders move slightly forward. Especially the movements of her shoulders and arms talk to me. I notice that my arms and shoulders want to answer. I start moving my hands, arms and shoulders in a manner similar to how J. did that. I do the movement slowly and let my breathing flow. I am also touching my top. Like her I am wearing a cardigan and I notice that the two buttons are closed. I tell her, I say "it is good that my cardigan is already closed". After having done this movement especially my right shoulder and arm want to move more. I go with that sensation and start moving forward. I notice some pens lying there on the floor right in front of me. These pens were still lying there on the floor from her earlier drawing. They are lying in front of her drawing, between her drawing and the place where I am sitting. I start to combine the movement which my body wants to do right now with the movement of putting away the pens which are still lying close to her drawing. Doing this my only focus is on my movements

and how her shoulders and arms respond to my movements. The pens are not in my focus. For me the movement of rolling away the pens allows me to look after the impulses in my body as I sit with J. I get a feeling that her shoulders and arms are taking my movements in, she starts breathing a tiny bit more deeply. She looks at me. We have eye contact. Then she looks down at the pens and tells me that these are her pens. I think 'oh, no', I did not mean to take away her pens from her. I respond by saying "Oh, I did not mean to take your pens away". I add that I could move them back. As I say that I already start moving them back. I do this very slowly to give J. time to respond. J. says that there is no need for putting the pens back because she could get them back at any time.

I see J's movements as a response to my wobbling movements from before. Her arms and shoulders look less held in as if a space opens in her shoulders. My response "it is good that my cardigan is already closed" does not make sense to me as I read this on the screen on my computer. Why is that important–that my cardigan is already closed? And why is that good? In the situation itself this made sense. I remember that I said these words with a soft and confident voice and I looked at her. I have a few assumptions: my living body communicating to her living body that I am different and being different I still try to be there with her, looking after myself. It could also be that my seven-year old communicated to her girl that she has had experiences of being nervous, anxious and shy. I then put away the pens so that I could keep the movements going. From experience I know that packed in with old patterns or fixed gestalten, there are feelings of shame. Sometimes I would go directly towards the shame and would welcome these feelings. Here in this short work with J. I try to stay away from any silliness. As I reflect on the no-nonsense style of my work with J., I assume now that a silliness would have stopped the whole process. My fantasy is that J. had experienced shame and that she does not need any more. So I am finding ways of letting my body talk to her body without a silliness being co-created. And what happened? I move away her pens. I focused on my movements and how her body might receive them, so her comment really took me by surprise. With hindsight I regret my response. I slow down, waiting, trying to open up therapeutic space for a dialogic negotiation (Pizer, 1992). I also hear J.'s response as a message that she could reach her adult at any second and that she feels in control. The two adult colleagues have to take part in this communication to let the worlds of experience of the little girls communicate with each other. This is also part of an anchoring, to make sure that there are many Juliannes and J's taking place in this process to contain the work and make integration possible.

Coming Closer To The Little Girl

The movement in my shoulder and arm stops. I look at J. I notice that she looks at her drawing. I wonder what she looks at and I ask her where her eyes wander? She answers that she looks at the 'gold on the top'. As she says that she slightly moves her arms towards the gold on the top. J. tells me that she did not have enough yellow/gold to colour in as much gold as she wanted to. Somebody in the group tells her that she feels sorry that she did not have enough gold and whether we should look for more gold/yellow. J. does not really respond. As I look at her I notice that there is still some movement left in her arms and shoulders. So I ask her whether she could do the movement again. She starts to move again. As she does this her eyes move away from the gold. I ask J. what she was looking at now. She says that it is the 'small ones' she is now looking at. With 'small ones' J. is referring to the smaller circular lines in her drawing. I notice her eyes becoming more lively and I see her rubbing her thumbs with two fingers of her hands. With a certain rhythm the thumb of each hand is somehow circulating over the two fingers. I am drawn to that movement. This speaks to me. I tell her that I want to do that, too. I try.

J.'s comment that she did not have enough yellow/gold makes me think whether there is a J. who is not seen enough. I continue to focus on her body and to help her body express what is held inside. I am touched about the way she says 'the small ones'. Again, her voice sounds soft and gentle. I assume that the 'anchoring' opened up more therapeutic space so that we were able to look at the small ones.

Entering the little girl's world

I think that this is hard sitting opposite her. I ask her whether I might sit next to her to see

how her fingers do that. I move slowly next to her and watch how her body resonates with this. Her breathing pattern stays the same and the movement of her thumbs and fingers continue with the same flow. Now I sit next to her. I keep on trying. I notice that I cannot do it. This feels mechanical, not as smooth as J. is doing this. I tell her that my movements look mechanical; she agrees and she says that my 'movements look mechanical'. I keep on trying. I am starting to use my right hand only. This feels easier. I am starting to get the movement now. I am letting my longer fingers find a different position to J.'s shorter fingers so that my fingers become able to do that. All my concentration and focus is on this. I want to learn this in my own way. And in this moment this seems to be the most important thing to do. I continue to learn and to translate the movement from her hands into mine. A bit later during this process J. tells me that she never thought, she would be able to 'teach somebody else anything'. She adds that the others might be bored. I tell her that I want to continue. I add that I would not mind if they were bored. I shortly look into the group and I get a feeling that they are all there with the two of us. So I continue wanting to learn from her with an energy that surprises me. I have a strong feeling that this is important. I am getting the movement more and more. We do this for a few more minutes. After a while we look at each other again. We both do the movement now at the same time. We have both found a way of synchronizing this movement each in our own style. This feels good. I also get a feeling that we could now finish. I feel we are at an end. I ask J. whether we shall finish here. Immediately she says 'Yes' and we stop.

The movement of J's fingers is like a magnet for my fingers. After I had expressed whether I could sit side-by-side to her I realized cognitively what I had asked for. Would this be too much, too close for her? I wanted her to stay and to keep her movements going so I thought I have to move. As I sat next to her I was looking out for reactions like tiny movements in her body, in her muscles, in her face, just for anything. I remember now that I felt a certain intimacy sitting with her on the floor and trying to join in with her movements. I could feel that we both had co-created a certain therapeutic space/field in which this had become possible. This felt special. J. made her comment that she had never thought she could teach somebody else anything in a way that suggested that we had changed this. Something new happened and we both witnessed what our two girls working together were able to do. For me there is a relation between that scene and the one in which J. tells me that she did not have enough yellow/gold to colour in as much gold as she wanted to. I am not sure yet how to put this into words.

After The Work:

We are all silent for a moment. I look into the group and wonder where everybody is right now. I also look at J. I am still a bit in this intense place I have just been in with her. So I am also looking out for her to check how she is doing after our work. I lost some bits that follow. I remember that J. uses the words "magical and important". She also says that "it did not matter what we did", "something happened really deep". I look at her as she talks and I notice that she looks different to the start of our work. She looks calmer. The group join in and they all talk about our work. I do not respond much to what is said. I notice that I am exhausted and that I cannot go into talking/thinking mode yet. I hear words like 'so much happened', 'magical', 'I could see what happened in your bodies' I could see how you communicated without words'. I realize that I felt safe during our work. The others were very important for our work as they held and contained both of us. I value that I am sitting with experienced colleagues.

Feedback By Email From J, A Few Days Later:

'Firstly thank you sooo much for the amazing workshop. I appreciate more than I can express the way you work, are and the level and depth of your availability. I feel the way you work goes beyond words. The means of communication you access/use is not primarily words. I felt you attuned/spoke to the core of me, my soul, and by doing so bypassed my defences, fears and resistances, of which I have many, to really give me what I needed. I didn't consciously know what I needed so to get to the place we did would likely have taken years. The beauty of the way you work is also so gentle and respectful so I was left feeling peaceful, calm an satisfied. I feel also I haven't quite caught the importance/ significance of what happened because the meeting/growth

happened on a level I don't visit often. My experience during our work was profound. I felt you were communicating with my higher self.'

Feedback From Another Group Participant:

'I had such a deep experience again on Sunday–and it is staying with me. I feel so RELIEVED–as I have been with my clients since–softer, quieter, more 'tuned in'–sensing a lot, sharing some–big impacts… You seem totally confident in what you do / what you offer–your belief of your body / our bodies... That comes from you as a calmness, and a sure-ity, I like your true-ness / honesty. You are doing what you do. There is no edge in that way as you work. You are so interested in that person / those people, and what they are experiencing, and your interest and commitment to be there with them to explore is more than tangible. You are sophisticated I think in knowing who needs what in terms of support to do what they are doing, whether it be to sit alongside, or facing, or touch or not, to stay with one figure, or to move through figures. You 'know, as you go along, according to what you feel and observe'.

Some Thoughts At The End

With this work with J. I very much regret that we will not continue to work with each other as an ongoing training psychotherapy. I miss that J. and I will not re-visit her inner little girl again to be with her. I would have loved to talk to her and to help her find words for what had happened to this little girl.

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Angela Douse

My Framework For Psychotherapy Integration

Editors' Note

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

1. Summary

My evolving integrative approach spans the humanistic/psychoanalytic spectrum. I believe that as social creatures we live in and need social relationships; and we have potential to grow and to self-actualise. In my view, our intrapsychic world develops alongside our interpersonal world, and in the process of relationships we are constantly internalising important others in our lives and laying down in our organising principles patterns of relationships that endure. To support this, I adopt relational theories of human development and developmental derailments in the caregiver-child dyad.

I draw from Bowlby's (1969) attachment theory the importance of attachment styles, which refer to these fixed organising principles. From Stern's (1985a) interpersonal theory, I draw particularly on the idea of the subjective self, referring to how mutual affect attunement is central to self development. Stolorow et al's (1987) intersubjectivity theory supports Stern's observation of the importance of interaffective interactions in the caregiver-child dyad. I use Schore's (1994) neurobiological research evidence on the significance of attachment bond experiences in the socio-emotional development of the right brain. Berne's (1961) term 'stroking' talks about our need for recognition and appreciation from others, and links into Bandura's (1977) social learning theory and concept of 'modelling' that influences new learning in dyadic relationships.

In my framework for integration, I prioritise the importance of the relationship as a healing process. I view the relationship as co-created and co-constructed, with both client and therapist contributing to it alike. My approach is based on an intersubjective, dialogic and phenomenological two-person psychology that is underpinned by gestalt principles.

2 Philosophical Beliefs And Values

My beliefs and values are influenced greatly by Aristotle, Descartes and Fromm who all promote the idea that, what our reason, minds, feelings and selves make of things, is important to how we experience the world. I believe we are born into a world where there is no absolute truth or certainty (aside from death). In my view, subjective reality composes an individual's truth and truth, therefore, is subjective. I feel, therefore I am. However, importantly, our subjective reality is co-constructed by our relational experiences and how we intrapsychically construct meaning from them.

I believe we have a moral responsibility to discover, "destruct and reconstruct knowledge, awareness and understanding" (Evans & Gilbert, 2005: 19). However, in my view, we

cope and manage uncertainty by conforming to a conditioned world governed by norms and standards that create values, morals, laws and informal, formal and societal systems. As such, this usurps the function of the individual and consequently, individual judgement grows increasingly uncertain of itself (Fromm, 1942). In my opinion, we are responsible for our choices of staying true to our self-knowledge and self-experience or conforming to introjected conditions, norms and standards.

I am aware that, while we may try to live our lives as best as we are able to and strive to be the best we can in life, environmental factors can limit the options open to us (e.g. oppression). Therefore, professionally, I am committed to implementing equality, challenging oppression, promoting and enabling independence, protecting vulnerable people and easing their pain; and supporting people to have awareness, grow, develop and heal to their full potential (ibid). These beliefs and values influence my practice as a psychotherapist.

3. Perspective On Human Beings

3.1 Human Motivation

In my view, our main motivational forces are a need for relationship and our search to make meaning of our lives. Whilst I am aware that our basic needs for food, shelter and safety are a means of survival and need to be met, I believe that these two needs are prioritised in psychotherapy.

We have an emotional need for relational contact with others. We need to love, to feel loved and appreciated; to feel seen and understood; to feel accepted and to belong; to have self-esteem, self-respect and respect from/to others; to feel worthy and validated; and to have virtue and power. We also have a psychological need to create meaning of our experiences and draw on intrapsychic structures in an attempt to achieve this. Human beings "cannot tolerate meaningless" (Crocker, 2005: 66).

Within my integrative approach, I place great importance on affect as I believe that our affective needs and experiences are central to the organisation of self. This reflects the view of the theorists that I integrate. Affective self-experience is prioritised in Stern's (1985a) work and by Schore who states that, "in infancy and beyond, the regulation of affect is a central organizing principle of human development and motivation" (2001: 9). "The motivational primacy of affect and affective experience" is central to Stolorow et al's (1987: 16) intersubjectivity theory; and affective 'stroking' (Berne, 1961) plays a role in attachment.

Most of our needs are met in relationships. Therefore, I embrace Bowlby's (1980: 442) view that, "intimate attachments to other human beings are the hub around which a person's life revolves, not only when he is an infant or a toddler or a school child but throughout his adolescence and his years of maturity as well, and on into old age". Furthermore, the "self-organization of the developing brain occurs in the context of a relationship with another self, another brain" (Schore, 2000: 1), and the sharing of affective states (affect attunement) is a "basic psychological need" (Stern, 1985a: 136).

3.2 Perspective On Self

My integration is centred round the concept of 'self' as a postmodern relational self and an intrapsychic self. I view self as an "experiential integration" involving a sense of self ('I') that constructs a self-concept ('me'). Through relational contact and intrapsychic understanding of self and "self-in-relation" (Evans & Gilbert, 2005: 20) our senses of self and self-concepts come alive.

From my humanistic/psychoanalytic perspective, I view self as a phenomenological experience that is processed by our conscious and unconscious psyche. However, importantly, I agree with Stern (1985a), Damasio (1994) and Schore (1994: 2003a) that affective experience precedes cognition in the organisation of our self-experiences. Our self-reference to and self-experience of 'I' is the centre of consciousness that is subjective. The 'I' is the 'knower' of our subjective experiences (Jung, 1973) and "observes, organizes and interprets" them (Evans and Gilbert, 2005: 51). Our unconscious is also active during our relational experiences, but is "dependent on consciousness for its contents" (Jung, 1927: 35). The organising principles

of our subjective world are unconscious and out of awareness. I acknowledge that all self-experience involves self-in-relation. This links into Stern's (1985a) domains of self: an 'emergent self' (process of forming organisation), a 'core self' (self agency, self-coherence, self-affectivity and self history), a 'subjective self' (intersubjective sharing), a 'verbal self' (use of language) and later, a 'narrative self' (life story).

We may have an illusion of stability, but self is a process that is not fixed or static. Instead, influenced by relational experiences it continually forms, adapts, constructs and re-constructs a multiplicity of selves (Clarkson, 1992; Spinelli, 1999) throughout our lifespan. This is a process of organising, disorganising and reorganising our self-experiences, while maintaining an enduring sense of coherence, continuity and history (Stern, 1985a).

It appears to me that our different self-experiences are reflected in the different selves that we present to the world based on our self-concepts. To understand our self-concepts, I adopt Assagioli's (1965) description of subpersonalities, which refers to the 'me' of one's self-experience. According to Assagioli, we adopt different roles and approaches (i.e. a social self, a parental self) in response to different relationships and situations, which all contribute to the multiple dimensions of our self-concepts. This fits with Polster's (1995) perspective of our 'population of selves' that have the potential to surface during our interactions with others. In my view, our multitude of selves is a process that unconsciously "provides the necessary resources to meet life's demands" (Jung, 1973: 31).

3.3 Developmental Considerations

In terms of nature vs nurture, I believe we are born with a biological temperament and genetic influences. However, taking the above as givens, embedded in a cultural context, the way self develops throughout our lifespan is shaped partly by relational interactions and partly through intrapsychic understanding of relational experiences. As Winnicott (1987: 88) said, "there is no such thing as a baby". At the base of my integration, I focus on the relational context of the caregiver-child dyad in the development of a healthy self that consists of adaptability, flexibility and stability.

For me, the ability to form intimate attachment relationships with other people is a principle feature of effective personality functioning and mental health (Gerhardt, 2004). In fact, I adopt Bowlby's (1969) and Schore's (1994) theories that attachment is a survival need in early childhood.

A secure attachment is co-created through reciprocal mutual affective interactions between caregiver and child (Bowlby, 1969). In the first six months, the caregiver attunes to the baby's needs and non-verbal signals. Here, the mutual looking and smiling between caregiver and child is a key factor in the development of an internal world in which attachment can be represented and regulated. The invariability of the caregiver's face, and recognition of it as a pattern, gives the baby a primitive sense of history and of continuity through time that is integral to the sense of self (Stern, 1977; 1985a).

During the second six months, the child develops attachment behaviours as an organised system to maintain closeness with the caregiver, and it is the role of the caregiver to respond positively and complementarily to the behaviour. Separation from a caregiver impacts on a child's attachment behaviour (Bowlby, 1973). Ainsworth et al's (1978) observations of children's attachment behaviours during brief separation from the caregiver identified three attachment patterns: secure, insecure anxious-avoidant and insecure anxious-ambivalent. Main and Solomon (1986) later identified an insecure anxious-disorganised attachment pattern. Using the caregiver as a secure base (Bowlby, 1988), a securely attached child is not too distressed during separation from their caregiver and will engage in a reciprocal mutual affective reunion. The securely attached child feels safe and protected by their caregiver, and develops self-esteem as well as resilience to stress situations. From 12 months onwards a child can recognise that she and the caregiver are separate individuals.

Verbal development helps to increase autonomy and awareness of a child's own feelings and those of others. The child's use of language and more advanced psychological system

creates a more complex attachment pattern to influence the caregiver to stay close (ibid).

Children internalise repeated attachment patterns of dyadic experiences as 'internal working models' of the caregiver and self, which become mental blueprints for future relationships (Bowlby, 1969). This is analogous to Stern's (1985a: 97) "Representations of Interactions that have been Generalized" (RIGS), used to form mental representations of self and others, and activated as "evoked companions" (: 11). A securely attached child builds an 'internal working model' of a loving, responsive, consistent and reliable caregiver, and a lovable and worthy self; and expects a positive response from others.

Affect attunement (Stern, 1985a) is very important to the attachment formation process. Through cross-modal matching, undermatching and overmatching of a child's affect the caregiver communicates to and teaches a child that her subjective affect is shareable, acceptable and met with empathy. The caregiver's attunement provides a 'holding environment' (Winnicott, 1965) consisting of a "psychophysiological system of protection, support, caring and containing that envelopes the child" (Holmes, 1993: 74), and fosters 'mirroring', 'idealisation' and 'twinship' (Kohut, 1971) experiences to her. Hence, affect attunement strengthens the attachment bond and helps the development of a child's sense of integrated selfhood (Stern, 1985ab; Schore, 2003a).

A child's neurobiological development (efficient right brain) is dependent on a secure attachment bond and supported by Siegel (1999), Schore's neurobiological ideas extend Bowlby's theory. Within a system of "reciprocal mutual influences" (Schore, 2003a: 6), a caregiver's affective responses to the child "directly influences the final wiring of the circuits in the brain responsible for future socioemotional development" (: 159), and shapes the child's "organization of new learning and the capacity to adapt to a rapidly changing environment" (: 151).

Like Bowlby (1973), I view a child's separation anxiety as her fear and shame of a threat of attachment bond breakage, and I integrate Schore's (1994: 2003ab) neurobiology of anxiety as an extension of Bowlby's ideas. Schore suggests that separation anxiety is a negative affective experience that a child needs to learn to manage to cope with stress. During 'interactive repair' (Lewis, 2000) of the attachment bond break, the caregiver models an attuned response and the child learns that "negative affect states can be endured and conquered" (Schore, 2000: 4). Acting as an "external psychobiological regulator" (Schore, 2003a: 5), the caregiver teaches the child to use interactive regulation (duo) and autoregulation (solo) so she can tolerate and integrate anxiety and shame, and regenerate positive affect. Such early dyadic experiences are stored and encoded in the brain as 'internal interactive representations' (Schore, 2003a) of an affect regulating other, and predict future responses.

Interpersonal learning and intrapsychic understanding influences the development of a child's personality. For the consideration of behavioural patterns, I view Berne's (1961) user friendly concept of 'stroking' as another version of Bandura's (1977) idea of 'modelling' and the whole social learning theory view of reinforcement. 'Stroking' is a form of any recognition from one person to another, including physical touch, which Berne viewed as critical for young children's development. In the process of attachment, a child develops strategies to receive pleasurable strokes (i.e. love, validation) from a caregiver in recognition and appreciation of who she is. Children consequently learn and adopt the behaviours that frequently get positively stroked. "Stroking reinforces the behaviour that gets stroked" (Stewart, 2000: 25), and what gets stroked develops.

Likewise, parental modelling influences what behaviours a child socially learns and develops (Bandura, 1977). When caregivers positively reward a child for new learned modelled behaviour, they reinforce the behaviour. Hence, in my view, a child's morals and judgements are influenced by modelling of parental introjections (e.g. "education is good") (Ormrod, 1999) and parental script messages (e.g. "you are good/loveable") (Hargaden & Sills, 2002).

Influenced by stroking, modelling and attachment experiences with a caregiver, a child makes script decisions about self, others and the world. The caregiver's reinforcement of these experiences also reinforces the child's script decisions, which are carried through into adulthood as script beliefs (ibid). Scripts subsequently become "blueprints for behaviour" (Atwood, 1999: 13) and relationships.

As we are intrapsychically constantly making meaning of our interactions with others our scripts "turn experiences into a story which is temporal, is coherent and has meaning" (Coren, 2001: 100). A child begins to compile her life experiences into a narrative that connects past, present and anticipated future, and provides an ongoing sense of self, identity, direction and purpose in life. We are "meaning seeking creatures" (Yalom, 2001: 133) and scripts organise a child's 'internal working models', 'internal interactive representations' or 'RIGS' into "even more meaningful patterns, so that our experiences make sense to us" (Moursund & Erskine, 2004: 21).

3.4 Context

A multicultural sensitivity envelopes my integration since "relationality as a universal, fundamental feature of human development, is ethnocentric" (Mitchell, 2000: xii). Humans need to be viewed and understood in the context of our environment as everything we experience, including "relationality and attachment", is "culturally relative" (ibid). In my view, culture is a socially constructed phenomenon consisting of a complex, shifting and inherited set of shared identifications, accommodations, values, beliefs, structures and systems (Lago & Thompson, 1996).

A cultural context encompasses socio-political/economical, historical, age, gender, ethnicity, sexuality, disability/ability, religious and class contexts. For me, cultural context is very important to human motivational needs and development, as it not only determines our opportunities, choices, options, behaviour and actions, but also hinders them through the infiltration of prejudices, oppression and discrimination. Lewin's (1951) field theory argues that there is an interdependence between humans and the environment, and our subjective reality always occurs in relation to others and the environmental context.

4. Human Dysfunction

4.1 Developmental Derailments

It is my view that a central causal factor of people's problems is derailed emotions and affect dysregulation. To explore these developmental derailments, I integrate derailment theories from Bowlby, Schore, Stern, and Berne.

It is apparent to me that repeated misattunement to emotional needs leads to a child becoming anxious and developing an insecure attachment pattern. In response to an unresponsive caregiver, a child develops an anxious-avoidant attachment. She develops an anxious-ambivalent attachment in response to an inconsistent caregiver. These maladaptive organised systems, "in which the caregiver must be accommodated" (appeased or pleased) (Holmes, 1993: 79), are adopted to avoid a threat of attachment breakage. A child whose caregiver is repeatedly frightened or frightening develops an anxious-disorganised attachment (Main & Solomon, 1986: 1990). The caregiver's unresponsiveness and inconsistency makes "an organized, effective adaptive state impossible to achieve" (Siegel, 1999: 77).

Insecurely attached children have an inability to sustain close relationships. I understand insecure attachment styles in terms of the interplay between a child's need for attachment and her fear of the threat of separation. According to Bowlby (1988), a child with an avoidant attachment style keeps distant contact with the caregiver and minimises her need for intimate attachment relationships by being independent and self-sufficient, in order to forestall rejection from the caregiver whom she needs. Through the expectation of rejection or abandonment, a child with an ambivalent attachment style clings to and can become enmeshed with the caregiver, often with excessive submissiveness and dependency. A child with a disorganised attachment style shifts between these two insecure attachment styles, or shows a varied combination of behaviours that do not have a clear goal (Main & Solomon,

1986; 1990) and result in unstable relationships. Although these attachment styles are carried into adulthood, we are open systems and can adapt our patterns of relating. Like Rutter (1980: 1981), I believe insecure attachment patterns can be repaired by other/later secure attachment relationships; but "it is also true that as we get older our internal systems stabilise and become relatively fixed" (Gerhardt, 2004: 64).

To highlight the pivotal role of attachment relationships in emotional derailments, I share and integrate Stern's (1985a) interpersonal perspective with Schore's neurobiological perspective. Consistent non-attunement of affect leads to the impossibility of interaffectivity and results in "cosmic loneliness" (Stern, 1985a: 204). When caregivers persistently selectively attune and misattune to children's affect they determine which subjective emotions are shareable and acceptable. This results in a child repressing, splitting off or disavowing unshareable and unacceptable affect, compromising them with 'racket feelings' (Berne, 1961) that defend against these feelings and maintain the attachment tie, but result in a 'false self' (Winnicott, 1965). Some children split off from their body and feelings, and live in an almost exclusive cognitive world that alienates intimate relationships (Winnicott, 1949; Corrigan & Gordon, 1995). Hence, emotions that are "not attuned to will remain private and may be experienced as idiosyncratic" (Schore, 1985b: 12). Neborsky (2003: 292) uses the term "primitive aggressive self organization" (PASO) to describe the unconscious "complex mixtures of feelings and defenses that exist inside the insecure attachment". A child's negative sense of self and self-concepts are shaped by the history of past and current attunements and misattunements.

From a neurobiological perspective, insecure attachments result in inefficient right brain development. During the caregiver and child's reunion after separation, the caregiver's misattunement in the interactive repair transactions of the attachment break creates a high level of prolonged traumatic episodes of negative affect in the child, resulting in a "toxic brain" (Schore, 2003a: 33) and affect dysregulation. Consequently, children with insecure attachment histories can develop "empathy disorders" (: 35) and display a limited capacity to perceive the emotional states of others.

Misattunement in the dyad during reunion, when the child has an expectation of attunement, can "blast" (Stern, 1985a: 53) a child into feeling exposed, punctured and embarrassed. It is my view that the distressed anxious state of the infant now evoked is a primitive shameful and angry response to the broken attachment tie (Bowlby, 1973; Schore, 2003b; Kaufman, 1985; Wurmser, 1981), which I refer to as 'shame rage' (Lewis, 1985) and not 'narcissistic rage' (Kohut, 1971: 1996). This contributes to difficulties in regulating anger, shame and self-esteem. For example, through under-regulation an insecure anxious-avoidant child excludes 'shame rage' during the reunion through "minimization of emotional expression" (Schore, 2003a: 28). Through over-regulation, an insecure anxious-ambivalent child expresses 'shame rage' with high levels of emotional expression. An insecure anxious-disorganized child's 'shame rage' is expressed in dramatic outbursts of high and low emotions that end as rapidly as they begin (on/off). Consequently, insecurely attached children develop an 'internal working model' of the caregiver as an affect dysregulating other.

Children with insecure attachments form negative script decisions about self, others and the world ("I am not good enough", "people cannot be trusted"). These script decisions are distortions of reality that not only 'explain away' the child's subjective experience, but also become internalised as script beliefs that narrate her life story and in turn, elicit responses that further reinforce the belief. Script beliefs "inhibit spontaneous" and relational contact (Moursund & Erskine, 2004: 49). By "telling us what to expect and helping us to behave so as to make those expectations come true, script makes life predictable" (: 21). Scripts contribute to a child's derailed self-efficacy and low self-esteem. However, they also have a 'survival value' as they help a child make sense of the world (ibid).

4.2 Effects Of Trauma

I have already given extensive coverage of early relational trauma, but other trauma also occurs

in childhood and adulthood contributing to severe emotional derailments and affect dysregulation. Traumatic events such as natural disasters (e.g. earthquakes), sexual abuse, poverty, illness, violence, kidnapping, war and torture (Van der Kolk & McFarlane, 1996) are a "psychophysical experience" (Rothschild, 2000: 5) that affects both mind and body.

Whilst cumulative trauma in childhood forms and deforms personality (Stern, 1985a), trauma in adulthood erodes personality. Single episode or cumulative trauma produces intense and enduring changes in and disorganisation of "physiological arousal, emotion, cognition and memory" (Herman, 2001: 34) that is debilitating. However, it is not the trauma that does the damage, but how an individual reacts and manages it (i.e. personal meaning), and how they are supported (Terr, 1980; Bloom, 1998). Trauma can fragment a person's sense of self and distort their view of self, others and the world. Through fear, helplessness, shame, guilt, distrust and loss of control, a person creatively adjusts and adapts herself to cope with trauma (Van der Kolk, 1996). She remains stuck in the past and cannot move forward in the here-and-now.

I am in support of Schore's (2003a) assertion that the most damaging effect of trauma is the incapacity to regulate affect. "The normal regulation of emotional states is disrupted by traumatic experiences" and memories (Herman, 2001: 108). To manage traumatic memories and intense feelings, some trauma victims develop growth inhibiting strategies such as disassociation, preventing integration. Stern (1985a) suggests that during disassociation moments the subjective self is non-functioning. Trauma results in "the loss of trust and knowledge of self" (Khan, 1963: 277), and disconnection from affect and intimate attachment relationships with others.

4.3 Psychopathology

In my view, all definitions of psychopathology are in part social constructions and cultural artefacts (Szasz, 1961). When trauma and development derailments are prolonged or chronic, people's adaptations to them become rigidified, inflexible and fixed dysfunctional repetitive patterns, which leads to adult psychopathology. All psychopathologies are adult manifestations of script patterns.

Neurobiologically, affect dysregulation "mediates transmission of psychopathologies" (Schore, 2003b:215). Trauma victims' emotional states range "from a baseline of unease" (Herman, 2001: 108) such as anxiety and dysphoria, through to panic, hysteria, anger, paranoia and despair. With difficulties in self-regulation of affect, it is not surprising that many trauma victims develop Axis I disorders such as anxiety, mania, depression and psychosis and/or Axis II Personality Disorders, as described in DSM-IV-TR. Schore's (2003a) compelling evidence asserts that all Axis I and II disorders result from affect dysregulation. I believe that "cumulative interactive patterns" (Stern, 1985a: 261) of traumatic affect dysregulating shaming experiences create "psychopathological attachments" (Herman, 2001: 98). Disorders of self are manifestations of traumatic experiences that are "invariably a source of shame" (Schore, 2003a: 31).

Affect dysregulation also leads to a marked poor capacity to self-regulate one's state of mind (Siegel, 1999). Through "crude over-generalizations" (Bowlby, 1973: 238), script beliefs become self-confirmatory and close learning opportunities of new and more information, reality and adaptive strategies. Berne (1961) states that traumatic memories of betrayal (from traumatic events) are filled out with meanings constructed from fantasy. These meanings block out the memory of trauma and produce increased distortions of reality, narratives and habitual functioning (Cohen, 2001).

To categorise ways in which trauma and development derailments have shaped adult behaviour, I use DSM-IV-TR's Axis I and II diagnostic system. In my view, diagnosis should not be used to pigeonhole or label clients (Szasz, 1991; Littlewood & Lipsedge, 1999). Therefore, integrating Benjamin's (2003) Interpersonal Diagnosis and a gestalt process diagnosis with DSM descriptions assists me to observe patterns, themes and repetitions that provide a wider and overall picture of how each individual client cognitively, affectively and interpersonally functions in the world, and at what level. This keeps diagnostic

systems "descriptive, phenomenological and flexible" (Joyce & Sills, 2002: 59). I may also consult other texts, such as Ware (1983), Sperry (2005), Johnson (1994) and Delisle (1991) for further guidance and understanding of personality styles and adaptations.

5. The Process Of Psychotherapy

5.1 The Process In The Therapy Room

My integrative view of the process of therapy is based on a two-person psychology that is embedded in an intersubjective, dialogic and phenomenological stance. As demonstrated above, emotional derailments, affect dysregulation and psychopathology occur through traumatic experiences, including traumatic insecure attachment experiences. Therefore, for me, healing and growth occur through secure attachment relationships built via dialogue and co-creation in the therapist-client dyad. The relationship with the therapist enables the client "to explore her intrapsychic conflicts and to move towards a greater relatedness to the therapist and eventually to others in the world" (Hycner, 1993: 57).

In my view, psychotherapy is an intersubjective process that is based on what Jung (1929: 71) first called a "reciprocal influence", or "reciprocal mutual influences" (Stolorow and Atwood, 1992: 18) co-created by the individual subjectivities of the therapist and client. "There is no such thing as either the patient or the analyst–only the patient-analyst unit" (Mitchell & Aron, 1999: xv). Both co-constitute the other's reality. From the mysterious realm "between" (Hycner, 1993: 83) the therapist and client, "dialogue between two personal universes" emerges (Atwood & Stolorow, 1984: 4). Through dialogue, the intrapsychic and the interpersonal meet in the co-created therapy process and are "vitally concerned with the relationship–the human engagement" (Hycner & Jacobs, 1995: 119). This meeting fosters an "attitude and awareness and openness about caring about the unique other person and our interhuman connectedness with that person" (: xi), and "there is healing through meeting" (: 25). From a neurological viewpoint, the unconscious meeting of minds, what Schore (2003b) refers to as 'right-brain-to-right-brain meeting', facilitates emotional healing.

5.2 Therapeutic Relationship Modalities

In my relational integration I use concepts of the Working Alliance, the Transference- Countertransference Relationship, the Reparative Relationship and the Real (I-Thou) Relationship.

5.2.1 The Working Alliance

The working alliance between my clients and I is a mutual agreement to work collaboratively towards the same objective. To me, it is crucial to the therapeutic process as it is a mechanism that enables the client to remain in and comply with therapy treatment. I believe that "at the core of the current formulation of the alliance is the notion of collaboration" (Horvath and Greenberg, 1994: 1) towards agreed goals and tasks. The attachment bond that I slowly develop with my clients fosters a 'good enough' connection that forms the foundation of our working alliance (Bordin, 1979). Research by Safran et al (1994: 226) reports that, "the quality of the bond mediates agreement about the tasks and goals, and vice versa", which is vital to the outcome of therapy (Orlinsky et al, 1994).

My mutually agreed contract with clients on the direction, goals and tasks of the therapy, and policy on fees, frequency, time span, location, cancellation/holiday and confidentiality, represents a working alliance with clients that is based on Berne's (1961) theory of contractual agreements. I perceive clients' and therapists' adherence to the agreement as demonstrating that they respect each other, the contractual agreement and the therapy. This is a sign of a 'good enough' working alliance.

I am aware that ruptures, which I view as analogous to attachment bond breakage, can occur to the working alliance. However, they can be an opportunity to make a breakthrough in therapy and an important turning point for the restructuring or reorganising of a client (Safran et al, 1994). Therefore, I take responsibility in identifying and sharing my contribution (i.e. countertransference) towards any ruptures with my clients, in order to allow us to collaboratively work through ruptures and interactively repair (Lewis, 2000) our working alliance. I hold in my mind that a

'good enough' working alliance is imperative to surviving such stressful, painful and difficult times during the work; to hold and contain risk situations; to enable clients to trust me with their vulnerable and confidential experiences; and to trust that I am consistently there for them, working in their best interest.

5.2.2 The Transference-Countertransference Relationship

My fascination with the unconscious influences my belief that transference "exists in all relationships" and is a "universal phenomenon of the human mind" (Jung, 1946: 172). Freud (1912: 1914) defined transference as the displacement of repressed emotions from the patient's obliterated past childhood onto the analyst, operating as resistance to 'memory work'. However, I believe transference is also a dramatic manifestation of the client's "not-yet-realized psychic potentialities" (repressed/disavowed feelings) (Mattoon, 2005: 108), that are capable of growth and healing.

It is my view that clients have forecasted perceptions and expectations of the therapist and therapy, which mainly derive from their 'internal working models' of attachment and are present in the therapeutic relationship. Consequently, I draw on Bowlby's (1973: 239) idea that:

"the analyst in his caretaking relationship to the patient is being assimilated to some pre-existing (and perhaps unconscious) model that the patient has of how any caretaker might be expected to relate to him".

This pre-transference intrapsychic process integrates well with the forecasting systems of RIGS, scripts and 'internal interactive representations'.

Transference is based on the there-and-then, but occurs in the here-and-now. It is therefore useful in gathering information on how trauma and developmental derailments have shaped clients' adult behaviour, in order to assist with the direction of therapeutic treatment. Through my clients' presentation with me in the here-and-now, I gain understanding of their attachment style; early affect attunement and affect regulation experiences; how they were stroked in childhood; what modelled behaviours they learned; and the script messages received.

In my view, clients' selfobject transferences are an unconscious attempt to reestablish a consistent "attuned attachment" (Pollard, 2005: 195) tie with the therapist, in order to feel safe enough to articulate and seek validation of repressed or disavowed material. I adopt Stolorow et al's (1987) idea that the client's selfobject transferences are 'bipolar' in their organisation. At one pole of the transference is the client's hope and longing to experience the therapist as protecting and enabling them to articulate thwarted aspects of their potentialities. The other pole holds the client's "expectations and fears of a transference repetition of the original" (Stolorow & Atwood, 1992: 82) traumatic rejection of her selfobject emotional needs. My course of treatment is therefore "characterized by continual shifts in the figure-ground relationships between these two poles of the transference" (ibid), longing and fear, whereby my accommodating attunement to clients' oscillating emotional and psychological states and needs is imperative to their healing.

Transference is both an intrapsychic and an interpersonal co-creation. The intersubjective 'mixing up' of clients' and therapists' individual subjectivities, generating Ogden's (1994) 'analytic third', is central to treatment and healing (Jung, 1946). In contrast to Freud's (1912: 1914) view of the therapist as a 'blank screen' and that transference is all the client's doing, like Jung, I believe that therapists' and clients' transferences influence the interplay between transference-countertransference. Through an "intersubjective process reflecting the interaction between the differently organized subjective worlds of the patient and analyst" (Stolorow & Atwood, 1992: 2), transference-countertransference is co-created (Racker, 1968). From Jungian and neurological viewpoints, two unconscious minds are unconsciously communicating together (Jung, 1946; Schore, 2003b).

I am aware that the therapist's attachment style and personality can influence what the client transfers. Just like the client, therapists bring their own 'internal working models' to the therapeutic relationship and contribute

to the client's experience of the therapist. For me, countertransference is when the therapist "constellates the patient's unconscious just as the patient does his" (Sedgwick, 2001: 81).

My awareness of my own countertransference assists me to understand clients' organisation of experiences better, make clinical assessments and plan effective treatment (Maroda, 1991). I recognise that I am an active participant in clients' enactments, which I understand is an unconscious attempt to replicate past dyadic experiences with the aim of achieving a new attuned and healthy outcome (Casement, 1985: 1990). Furthermore, I take into account that my own enactments that are out of awareness can be potentially destructive. By reflecting on my own processes, I try to distinguish between my own subjective feelings and clients' disavowed intolerable feelings projected into me to experience, hold and contain through the process of projective identification (Ogden, 1991). Racker (1968) refers to the former as 'concordant' and the latter as 'complementary' countertransferences.

In light of Western Eurocentric cultural norms and standards, and institutional structures of racism (Howitt & Owusu-Bempah, 1994), as a black woman, I recognise that when I work with both black and white clients there is a "status contradiction" (Littlewood, 1992: 11) and that clients could perceive me as inferior or second class. By naming difference in the room, I not only invite clients and I to explore our curiosity of each other, but also decrease influences of transference-countertransference "unconscious attitudes and prejudices" (Lapworth et al, 2001: 69).

5.2.3 The Reparative Relationship

Based on my belief that clients have a pre-transference perception of the therapist as a healer, in my view, they desire to be healed. Therapists cannot remove clients' pasts. They can, however, "provide opportunities for clients to grow, to experience and to re-negotiate" (Jacobs, 1999: 135), resulting in a new and positive outcome in the present. The way I see it, "the repair of the past is founded upon the connection in the present" (Sedgwick, 2001: 59), and providing empathically attuned responsiveness fosters an intersubjective relatedness that can repair clients' emotional derailments and affect dysregulation. Therefore, I conceptualise the reparative relationship as an opportunity for clients' "psychological growth" (Stolorow et al, 1987: 44) and for therapists' and clients' co-created "healing participation" (Sedgwick, 2001: 83).

As client and therapist grow close, their standards of attachment patterns and accompanying script patterns emerge as transference and countertransference. Clients' patterns are demonstrated in their transference bipolar organisation, whereby they oscillate between both poles. The attachment bond between therapist and client allows clients to feel safe enough to lessen defenses and experience their disavowed feelings in the present. Hence, through the "therapist's attunement and empathy the therapeutic repair occurs" (Neborsky, 2003: 297). Therefore, therapists' "reparative potential" (Clarkson, 2002: 123), involving secure attachment, attunement and empathy capacities, becomes the "harmful or curative factor" (Jung, 1929: 74).

I believe that a "central curative element may be found in the selfobject transference bond itself and its pivotal role in the articulation, integration and developmental transformation of the patient's affectivity" (Stolorow et al, 1987: 74). Hence, I understand the reparative relationship in terms of an "engaged countertransference", whereby therapist and client have an "unconscious connection" and are "involved" in a "mutative affective experience" (Sedgwick, 2001: 82).

To me, the engaged countertransference becomes the "medium for change" (ibid). In the engaged countertransference, instead of interpreting a client's feelings, through a 'mutative affective experience' therapists participate and connect with the client–empathising and understanding within an emotional framework. They empathically attune to clients' oscillating feeling states and accept, hold and contain their overwhelming feelings. This can provide a different outcome for clients. A 'mutative affective experience' between therapists and clients provides emotional "understanding that heals" (Orange, 1995: 4). To move on from being a technician

to creating a healing relationship, therapists must be "able and willing to enter the patients suffering and share the painful history" (: 5).

The reparative relationship mediates emotional connection between therapist and client, which provides new opportunities for the socio-emotional functions of the right brain to grow and develop adaptively. Schore (2003b) promotes psychotherapy as a vehicle for neurobiological repair. Through "right-brain-to-right-brain affective communications" (: 215), the therapist facilitates growth of emotional derailments and can also re-wire the brain. As Schore (2003a: 231) explains:

"The interactive regulation embedded in the therapeutic relationship functions as a 'growth-facilitating environment', specifically for the experience-dependent maturation of right orbifrontal systems. This context can alter attachment patterns from 'insecurity to earned security'".

I try to utilise attachment bond ruptures through enactments, projective identification or other transference-countertransference phenomena as reparative potentials. Through 'interactive repair', ruptures can be transformed into opportunities for psychological growth and new learning. This can be achieved by supporting clients to recognise and make sense of trauma and developmental aspects underlying the rupture, and teaching clients to integrate past experiences with present experiences.

5.2.3 The Real (I-Thou) Relationship

I am aware that not all interactions in the therapist-client dyad are transference phenomena. Some are authentic "human responses of one person to another" (Jung, cited in Mattoon, 2005: 108). These human responses occur when the therapist and client meet in the here-and-now on the "basis of mutual human equality" and respect (Clarkson, 1992: 204), as separate beings who are constantly changing. It involves appreciating the unique 'otherness' and whole separate existence of another, which is reciprocated by the other. This is the real relationship, which I refer to as an I-Thou process (Buber, 1958) that has transpersonal dimensions and includes awareness and dialogue.

In my view, we all have a desire to be validated by others for who we really are. I see having an I-Thou attitude as a way for therapists to meet, understand, affirm and validate clients' current existence and potentialities; to foster clients' awareness of other peoples' authentic subjectivities; and to promote clients' more authentic being and more authentic meaningful relationships with others.

"I-Thou as a special mutual form of interhuman meeting" (Yontef, 1993: 208) increases clients' awareness and promotes their growth. Therapists bring their autonomous and emotional selves to the therapy process. Their empathic attunement to clients' subjective experiences shows their authentic feelings, and validates clients' as worthy of empathy and respect. With awareness of what is–that the client's subjective emotions are acceptable and shareable, the "deepest part of the being of the person can emerge most fully" (Hycner & Jacobs, 1995: 125). Consequently, clients reciprocate emotional contact and risk sharing their private emotions with the therapist. Such emotional meeting is healing. It increases clients' "openness to intersubjective relatedness" (Springer, 2005: 126) and mediates a secure attachment bond and an authentic working alliance between therapists and clients.

I-Thou relating involves therapist and client "entering into a dialogue" (Hycner & Jacobs, 1995: 60) of "reality which encompasses" them both (: 94). Genuine dialogue between therapists and clients can open clients' awareness to their script patterns. When the therapist is absorbed with the here-and-now she may bring current experience to the client's attention. Therapists' self-disclosures can challenge clients' transference misconceptions and reveal to the client "'realistic' proportions" (: 140) of who they really are as a person. This promotes clients' capacity to authentically relate with the therapist as an authentic person and not as a transference figure (Aron, 1999).

Providing different and multiple viewpoints and perspectives on the reality of situations (i.e. self, others and the world) enables clients to analyse, pick and internalise the viewpoints

of the therapist that she believes and fits with her; and thus, opens clients' awareness to their process. Depending on the choices clients make, new awareness can "result in assimilation and growth" of their true self (Yontef, 1993: 204), and lead to clients' self-regulating by choice and not by habit. The outcome can be that the "inmost possibilities" of the client are released (Hycner & Jacobs, 1995: 59).

The self-disclosing therapist "provides the patient with a model of authentic being with which he can identify" (Clarkson, 1992: 305), which fosters clients' capacity for I-Thou relating. However therapists should only "take the patient to where the patient is" (Beisser, cited in Hycner & Jacobs, 1995: 63), so she can naturally progress from a brief 'moment of real meeting', what Polster and Polster (1973) call a 'contact episode', to longer periods of I-Thou relating with the therapist and others; revealing and regulating herself more and more in the process. I believe that, when clients can differentiate between me as a separate human being from a selfobject function, their potential to experience an I-Thou relationship with me can occur, and vice versa. This differentiation process is facilitated by modelling of appropriate and relevant self-disclosure that creates conditions for clients to also disclose themselves in an honest, authentic and unguarded manner (Yalom, 2001).

6. The Process Of Change

From the moment that we are born until the moment we die "change is inexorable" (Yontef, 2005: 82). As a relational therapist, I do not see myself as an expert who does something miraculously to make change happen or 'cure' the client. Instead, the aim is to provide support that "will aid a client's motivation and commitment, and their belief that therapy will help" (Holmes, 2001: 17).

I believe clients tend to know what they need from the therapist and communicate this unconsciously (i.e. projections) or consciously (i.e. direct communication). They have a self-actualising tendency, and a potential for growth. Hence, I respect the client as "resourceful and the primary architect of his own change" (ibid). However, I am aware that a client's level of functioning influences how much she can actively contribute and what she needs from a therapist (i.e. more/ less cognitive or emotional support).

Research shows that, while different orientations have diverse approaches to change, they all have implicit common factors that facilitate change (Lapworth et al, 2001). I believe consistency, continuity and trust are central factors. With regard to therapist-client matching, as a black woman, I see intersubjective contact as the key and do not believe that ethnic matching is necessary for change. By creating a secure base for us to "explore each other's transference and assumptions" (Kareem, 1992: 16), I can encourage clients to work with me towards growth in the I-Thou relationship. I "attempt to dilute the power relationship that inevitably exists between the help-giver and the help-receiver" (ibid).

I acknowledge change theories like Miller and Rollnick's (1992) 'motivational interview', which can prepare people for change. However, as change tends to occur when we are not actively attempting to seek it, I use Beisser's (1970) 'Paradoxical Theory of Change' to understand the change process. From this perspective, "change occurs when one becomes what he is, not when he tries to become what he is not" (: 77). By letting go of "what-is-wished-for" and focusing on "what-is-now" (Crocker, 2005: 72), the former can be accomplished naturally.

7. Techniques, Strategies And Interventions

Every relationship is an opportunity to repeat or to be different (Spinelli, 1999). Therefore, I use my authentic self as a main therapeutic tool to understand what conditions need to be created to meet clients' selfobject needs, and to provide new opportunities of increased awareness for clients in the here-and-now (Rowan & Jacobs, 2002). My style in the therapeutic process is intersubjective, dialogic and phenomenological, which arises from my original gestalt training. From this stance, my interventions aim to make a connected bond with clients and attune to, confirm, validate and heal clients through an intersubjective relatedness, curiosity, exploration, active listening, stroking, empathic attunement (including holding and containing affect), awareness, congruence,

modelling, humour, normalising experiences and active challenging. I implement my interventions and healing attitude towards clients through dialogic 'core conditions': presence, confirmation and inclusion.

For me, as "opposed to seeming" (Hycner & Jacobs, 1995: 54), "to be present is to be focused", "to be aware of oneself" (Melnick & Nevis, 2005: 110) and to actually be deeply aware, interested in, available to and attentive to clients' subjective experiences and the therapy process. When I am present, I bracket my "concerns and strivings" (Joyce & Sills, 2002: 45), and have a willing openness to be touched and moved by the impact of the client.

Confirmation involves my "step-by-step attunement" (Hycner & Jacobs, 1995: 125) to clients'experiences–listening to, attending to, valuing, validating, understanding, confirming and accepting the client unconditionally; even if I do not like certain behaviours, attitudes or beliefs. This reduces clients' need to judge and deny their experiences. However, "acceptance is only the prelude to confirmation" (: 25). Confirmation goes beyond acceptance of what a person is at the time and involves "affirmation of potential" (Yontef, 1993: 36).

Inclusion is a broader form of empathy. It is a mixture of empathy and attunement to and respecting and understanding of clients' subjective experiences, while having awareness of my own autonomous subjective experience and presence. This "bold swinging–demanding the most intensive stirring of one's being–into the life of the other" (Buber, 1965: 81) includes my capacity to "hold a metaperspective" (Evans & Gilbert, 2005: 53) of the co-created 'between' in the therapy relationship.

I verbally communicate inclusion by sharing my empathy, reactions, curiosity, observations, understanding and intuition to the client's subjective experience. I communicate it nonverbally through my bodily and facial emotional expressions. My empathic attunement in inclusion has been a growing experience that "creates relationship" and is "created by relationship" (Moursund & Erskine, 2004: 89). Thus, it is the vehicle of a 'good enough' working alliance and reparative relationship that promotes more growth and healing of emotional derailments and affect dysregulation than empathy alone.

In facilitating secure attachment experiences for clients, I use my dialogic attitude to tolerate and provide holding and containment of clients' disavowed affect, which is embedded within a "system of adaptive interactive projective identification" (Schore, 2003b: 79), to increase clients' tolerance of disowned feelings and self-acceptance. Within the 'holding environment', my presence and empathic attunement affirms and interactively regulates the client's affect. The combination of my secure 'working model' and secure attachment, and clients' potential for secure attachment, creates a "psycho-biological connection that mediates the attachment bond" (ibid) and strengthens our working alliance.

The psychobiologically attuned dyad generates empathic resonance that "induces a synchronization of patterns" (Schore, 2003b: 51) of interactive regulation of two unconscious right-brains. Hence, I use my efficient right-brain processes to regulate the client's inefficient right-brain processes. By modelling autoregulation of my own affect and acting as an "interactive affect regulator of the patient's dysregulated state" (: 53), I promote clients' autoregulating ability and secure attachment capacity. Learning to stay with my own difficult feelings has increased my ability to hold and contain clients; and has been a "potent mechanism for therapeutic change" (Stern, 1997: 12).

Implementing 'containment' (Bion (1962), which is an extension of holding, involves me modelling acceptance, tolerance and regulation of the client's unbearable and yet bearable disavowed affect; and returning it to the client digested in a "modified and acceptable form" (Bateman & Holmes, 1995: 113) so she can internalise and integrate her own capacity to accept and hold new affective learning. With knowledge that the client's "regulated right-brain experience can then be communicated to the left brain for further processing" (Schore, 2003b: 54), I support clients to co-process their affect with cognitive meaning and promote their ability to gradually verbally articulate their affect. Hence, the "interwoveness of intrapsychic and interpersonal phenomena becomes apparent" to the client (: 51).

I implement a phenomenological approach, which I understand as "knowledge of reality" (Spinelli, 1999: 1) that is experience dependent phenomenology, with my dialogic attitude. I work phenomenologically by staying as close to clients' and my own here-and-now experience in our co-created relationship. Tracking clients' process in the here-and-now moment raises their awareness, helps me gain understanding of their trauma, attachment histories and scripts behind their narratives, and helps to build our working alliance.

To focus on immediate data of experience, I implement descriptive phenomenological interventions rather than interpretive ones. In tracking my awareness of what is immediately obvious and sharing what I notice (see, hear, sense), I raise clients' awareness to how they organise self-experiences and make meaning. For example, "I notice…", "you seem…", "you look…", "I'm aware that…". This includes a "micro-process investigation" (Joyce & Sills, 2002: 21) of moment-to-moment regulatory strategies, such as "what is happening right now?" or "what just happened right then?" With regard to clients' dysfunctional repetitive patterns, this provides them with an opportunity to "scrutinize their current validity, and perhaps, also to revise them" (Bowlby, 1973: 239). As what I notice is often out of clients' awareness, it is therefore important that I am sensitive with my sharing so as not to expose, shame or be intrusive to clients who experienced a shaming or an intrusive caregiver.

My phenomenological interventions support clients to embark on free association and tell their narrative in a free-flowing mode, bringing what is unconscious into conscious awareness (Freud, 1913; Greenson, 1967). I reward clients with strokes in recognition of them making connections between there-and-then and here-and-now experiences to reinforce their new learning.

As a direct person, I appropriately direct experiments that include arranging for clients to test out a "risky-seeming 'first try' at a new behaviour" (Parlett & Hemming, 1996: 211), such as expressing their feelings or thoughts towards me, or doing empty chair or two-chair work (talking to a figure from the past or a polar opposite part of herself (i.e. weak speaking to the strong)). My interest in meditation influences me to model breathing exercises that provide interactive regulation of clients' affect through calming (Zinker, 1977; Grof, 1988) and "slowing down" (Melnick & Nevis, 1997: 102) of their emotions. I have learned that I can get it wrong with such risky experiments or other interventions, and that learning from my mistakes and having a different outcome is therefore vital (Casement, 2002).

8. Conclusion

In my integration, my value base is within a humanistic framework and I draw on some concepts that are psychoanalytic, and subscribe to the idea of our intrapsychic and interpersonal overlapping. The presented theories are integrated inclusively into my belief structure that holds and contains them together–just as the external fruit of the apple does to its core and seeds.

My presentation of self, self-development and developmental derailments preceded my view of the psychotherapy process. However, for me, the psychotherapy process is prioritised and precedes the theory on every occasion. Theory is supportive, but the "experiential engagement" (Hycner & Jacobs, 1995: 15) of the therapeutic relationship "is the therapy" (Kahn, 1997: 1). Therefore, at the core of my integration lies my intersubjective, dialogical and phenomenological approach, which attunes to and interacts with my clients, "depending on the context, culture, and presenting complaints" (Kottler, 2003: ix), in our co-created and co-constructed healing relationship.

Using dyadic theories of development and derailments has expanded my view and understanding of the therapy process with each individual client. Furthermore, it has increased my capacity for relational, collaborative and co-created healing participation, which is the seed that allows my therapeutic relationships with clients to grow to their full potential.

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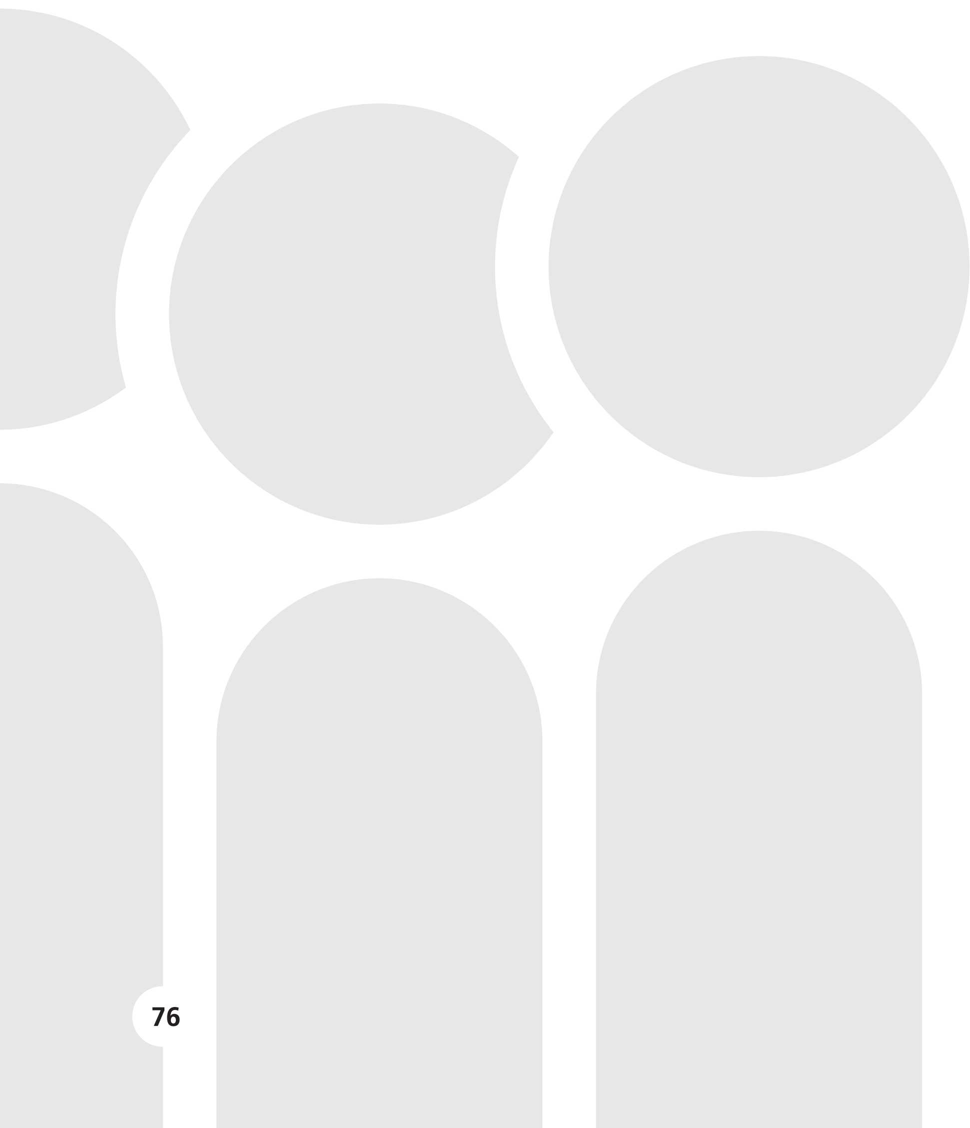

Book Review by Nigel Copsey

Case Studies In Relational Research: Qualitative Research Methods In Counselling And Psychotherapy by Del Loewenthal, Palgrave Macmillan 2007

This book needs to be widely read by anyone interested in qualitative research. What makes the book so interesting is that it explores a range of different research methods within very specific settings. The core theories of Action Research, Narrative Research, Discourse Analysis, Grounded theory and Phenomenological research are all explored in adequate detail. The great virtue of the book is that each case study shines the spotlight of the particular researcher onto the area of work in which the practitioner is engaged. Liz Bryan, who is a palliative nurse, explores the experience of palliative care nurses trained in psychotherapy. Maureen Taylor, a psychotherapist, uses Discourse Analysis to look at the experience of preconceptions of therapy. Anna Rowland Price, a nurse and midwife, uses Heuristic research to look at the place of counselling in breaking bad news to pregnant women. Dennis Greenwood, a nurse and psychotherapist, uses a Case Study to look at the place of psychotherapy when helping a person with dementia. Rhiannon Thomas, works as a counsellor with boys with learning difficulties, and uses Empirical Phenomenological Research to explore working with clients who have a learning difficulty. Elaine Heywood, a radiographer and counsellor, uses the same methodology to explore the outcome of Existential Analytical Counselling in an oncology setting. Val Todd, a counsellor and course convenor, uses Action Research to evaluate a youth counselling Service. All the contributors are connected to the Research Centre for Therapeutic Education at Roehampton University.

The relational link with all the researchers is Del Loewenthal who is the Professor of Psychotherapy and Counselling and also Director of the Centre. He co writes each chapter with each of the researchers. He also begins and ends the book with two chapters. The first, introduces the whole area of Relational Research and the final chapter where he challenges the reader with a number of very interesting questions. Both chapters are essential reading for any researcher. He convincingly makes the point that the relationship is central to all qualitative research. As the reader progresses through each case study it becomes clear that whatever the research method is used it is the relationship between the researcher and the co researcher that is central.

The structure of each chapter is most helpful to the reader. It begins with a brief description of the subject/issue that is being researched. There follows a very informative summary of the particular research method. The next section describes the way in which the method is implemented. The data is then analysed and conclusions are drawn out. There is then a

reflection as to why that particular method was chosen and whether or not it was suitable. At the end of each chapter the researcher reflects on the experience of using that particular method of research. I found this method of breaking down the different aspects of the research experience very helpful. At the end of each chapter I found myself reflecting upon how each case study was so interesting. I liked the 'standing back' and taking an overview of the whole experience.

Any therapist or counsellor who wants to understand the different style of qualitative research will find this book invaluable. Students who are unsure which qualitative methodology to use will also find this book a great asset. The book demonstrates the importance of qualitative research for the practitioner. It is not a book to read through in one sitting: it is best if having digested the first chapter the reader takes each chapter one at a time. In that way it is possible to gain most from the book. It is densely packed and needs time to digest if the reader is not familiar with all the research methods.

Having read the book twice I am left with the thought that in fact all research is as about case studies. I looked at each chapter and thought 'what if another theory was used for exploring this subject?' It is too easy to get 'stuck' with a particular methodology. I liked the way in which Del Loewenthal concentrated on the importance of the relationship.

There were only two areas which I would have liked a greater exploration. Clearly the author and his colleagues are enthusiastic qualitative researchers. Instead of fairly short sections on the suitability of each method I would have liked to have seen a greater willingness to look at the limitations of each method. I think we need to be reflexive in our own critical look at qualitative research. The final chapter was bubbling with very important questions which never got answered! Although the author raised the key question of social action, the politics of psychotherapy and research was missing from these case studies. Del challenges the reader in the final pages to look at justice and research, violence and psychotherapy. Maybe another book needs to be written to explore this very important area of research and social action within the field of counselling and psychotherapy.

In summary, I found this a very interesting book. It was well written and has provided us with an important addition to the ongoing discussion concerning the different approaches to using qualitative research.

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