UNIVERSITY OF DERBY

PROFESSIONAL KNOWLEDGE IN THERAPEUTIC PRACTICE

CLINICAL REASONING AS A 'HAZARDOUS JOURNEY'

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Statement of Intellectual Ownership

This thesis represents my own work and no part of it has been

reproduced in another form or another setting.

ABSTRACT

This thesis explores the therapist's use of professional knowledge in their relationship with patients. It addresses a gap between theory and practice and the challenges to therapist expertise in a postmodern climate in which there are a multiplicity of competing perspectives about psychological problems.

In semi-structured interviews eight NHS Psychodynamic Psychotherapists revealed narratives that underpinned their practice about the nature and treatment of psychological problems. These were organised as narratives about living the 'good life' psychologically, and the origins and treatment of psychological problems.

The central finding of this thesis is that, rather than relying on professional knowledge conceived as conventional psychodynamic theory, therapists engage in a largely intuitive process I have termed 'clinical reasoning' which is practice-based, 'reflection-in-action' that involves tacking principally between their professional knowledge base, their experience with the patient and their personal beliefs and experience. Such a process, I argue, constitutes a 'hazardous journey' in a postmodern climate in which the value of a psychodynamic perspective cannot be taken for granted.

A key implication is the value of therapists becoming more explicitly aware of their own particular narratives and the effect these have on the therapeutic encounter.

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INTRODUCTION

In this thesis I describe my exploration of the use of professional knowledge by NHS psychodynamic psychotherapists in their relationship with patients. I have addressed a gap that I perceived between theory and practice in psychotherapy where the professional knowledge of the therapist encounters the 'reality' of the patient. I had not found an adequate conception of the process whereby professional knowledge was applied in practice. I found this lack of clarity problematic for my own practice as a therapist.

Therapists practise within a postmodern climate in which a simple correspondence between psychological theory and the inner space of the human mind is no longer accepted. Fact and value are now seen as inevitably intertwined in keeping with the saying in the Talmud that "we see things as we are not as they are" (quoted in Phillips,1999). A therapist faces the hazard of practising in a climate of 'truth without certainty', taking account of the inevitable element of relativity without losing the capacity to have something relevant to say.

I explored the question of the application of professional knowledge in practice in a postmodern climate through qualitative, semi-structured interviews with eight NHS Psychodynamic Psychotherapists who worked in the South Trent Health Service Region. As I am myself an NHS Psychodynamic Psychotherapist working in the South Trent Region I have had the status of an 'insider' in this investigation and knew my informants previously as colleagues, supervisors and trainers. This 'insider' status has been a strength of the research but also an aspect to be monitored and taken account of.

I have structured this thesis to reflect as far as possible the way the research unfolded for me so that the reader can share the experience of the process.

Location in the Literature

I undertook a preliminary literature search in the areas of professional knowledge, its status and the critiques of its use in order to ground my enquiry in contemporary debate about psychotherapy.

I set out to establish the conceptual tools available to the therapist as described in the literature which could be said to constitute their professional knowledge. At this stage I was working with a rather 'flat' conception of professional knowledge as the sort of knowledge that could be found in textbooks about therapy. I explored the nature of object relations theory as it provided the main theoretical base for the practice of the therapists I interviewed. I tracked shifts in this theory towards a more postmodern sense of theory as a perspective and towards a greater appreciation of the intersubjective nature of therapy. I summarised the perspectives of key theorists.

I briefly considered the place of narrative in therapy but did not at this stage see its full significance. I also explored the literature concerning developmental stages in the use of professional knowledge which offered a way of conceptualising a tension between creativity/integration and conformity/avoidance in the therapist's use of their professional knowledge.

I explored the debate in the literature about the epistemological status of professional knowledge. I focused in on the debate about whether the therapist's professional knowledge could be viewed as being informed by a dependable body of knowledge and what criteria could be employed in a postmodern climate for judging this question. I looked at what empiricism, phenomenology and hermeneutics offered to this debate as traditional 'ways of knowing'. I found that the absence of a simple correspondence between theory and the mind of the patient had not led to an epistemological 'quagmire' for the therapist. The concept of 'pragmatic rationality' (Bernstein,1983) captured the sense that therapist's professional knowledge could be located beyond objectivism and subjectivism and could claim a status as 'dependable'

through an interweaving of epistemological criteria. Theory could thus be viewed as offering proven, emotionally powerful ways of organising experience.

I explored in the literature critiques of the use of professional knowledge in practice by therapists along with some responses made to these critiques by therapists. Some writers saw their critiques as invalidating practice while others saw 'flaws' to be addressed in practice by therapists. Critiques centred around four areas. Therapist thinking was too clinically individualistic and failed to take enough account of the intersubjective nature of the therapy encounter. Therapists assigned too much objectivity to their thinking and failed to understand the nature of power and influence. These critiques provided me with a base against which to compare the therapist accounts in the interviews. Craib (1992) offered the metaphor of the dirty bathwater of professional practice that need not lead to baby and bathwater being thrown out together.

The Enquiry

For my enquiry I adopted a qualitative approach, using a semi-structured interview format, rooting the therapist's account in their practice by focusing on their work with two patients, one judged to be more 'disturbed' and one less 'disturbed'. I took the view that the interviews comprised eight individual case studies that offered significant pointers beyond themselves to the practice of NHS psychotherapists. I clarified the nature of my involvement as well as addressing the ethical issues involved in researching into practice.

I have described how the categories I employed to organise my analysis evolved and settled later (as part of my core findings) on the concept of the *therapists' narratives of practice* which I found to fit and explain well the data. These consisted of a narrative of what constitutes 'living the good life' psychologically, a narrative of how psychological problems develop, and a narrative of how treatment is best conducted.

My initial use of grounded theory gave way to my sense that I was looking for patterns in the narratives and adopting the stance of a 'bricoleur'. I have given an account of

the 'natural history' of my research as well as addressing relevant ethical issues. I have discussed the status of my findings and argued they should be judged primarily on their plausibility and theoretical cogency.

Findings

After conducting five of the interviews I formulated my *initial findings*. The professional knowledge of the therapists that I interviewed I found to be saturated with values and morals, expressed in the form of narratives, requiring a facing up to of limits, emerging from a combination of personal and the professional experience, and employed in an intersubjective context that could be extremely stressful.

I then completed the remaining interviews and through further analysis came to my core findings which better explained my data. I undertook a further literature search at this point which I have included within my findings so that the reader can see the development of my understanding.

I revised my initial definition of professional knowledge as being like textbook theory similar to flat-packed furniture that is assembled in the therapy room in accordance with the instructions. I formulated a concept, 'clinical reasoning', that better conceptualised the processes I had found in the interview accounts. In the accounts I observed the therapists reasoning clinically in a way that was mostly intuitive, that involved 'reflection-in-action' and 'problem setting', and that was more practice-based than theory-based.

I discovered that the clinical reasoning of the therapists was not just expressed in the form of narratives but was *organised* in the form of narratives in the therapists' minds. The therapists had constructed, mainly intuitively, narratives of living the good life psychologically, of how psychological problems develop, and of how treatment is best conducted. These narratives were actively shaping their clinical thinking and practice.

The therapists' narratives, I further found, had emerged from an amalgam of their personal and professional experiences and were fostered and held within a community

of therapists. I applied Haraway's (1988) concept of 'situated knowledge' as a frame for understanding this. Clinical reasoning, I found, involved the therapists in a process I have referred to as 'dialectical tacking'. Broadly this can be conceived of as involving the therapist in tacking between their professional knowledge base, their experience of being with the patient, and their personal beliefs and experiences.

All in all I concluded that the therapists' clinical reasoning constituted a 'hazardous journey' in a postmodern climate, a journey which reveals the gap between textbook theory and practice. The therapists were employing 'situated' knowledge, within a demanding intersubjective encounter that required the capacity for on-the-spot reflection and 'dialectical tacking'. I had found in the concept of clinical reasoning a much richer way of conceptualising the use of professional knowledge in practice, one that was far more helpful in understanding and explaining the data.

A Note About Terminology

In this thesis I have used the term 'patient' to describe those receiving psychodynamic psychotherapy as this is the term used within the NHS and I would find other terms such as 'service user' out of context. The term 'patient' is not meant in any sense to imply passivity.

I have opted for the title 'therapist' to describe my informants as it fitted naturally within the context. Where it would have created any confusion I have reverted to the term 'informant'.

The title analyst, psychoanalyst, therapist and psychotherapist are used interchangeably at times within this thesis. The psychodynamic psychotherapy literature draws on practice that can be three or more times a week as well as practice that is once weekly. I saw no advantage in trying to overstandardise terminology. However the therapists who acted as my informants were describing the practice of once weekly psychodynamic psychotherapy.

LOCATION

IN THE

LITERATURE

THE PROFESSIONAL KNOWLEDGE OF THE PSYCHODYNAMIC PSYCHOTHERAPIST

At the beginning of this research project I undertook a preliminary survey of the literature to look at the conceptual tools that could be said to constitute a psychodynamic psychotherapist's professional knowledge. In this chapter I have outlined these through a description of object relations theory and its key theorists. I have also described shifts in psychodynamic theorising towards postmodern and intersubjective perspectives. I have described an initial look at the concept of narrative and concluded with a survey of the literature on the relevance of the developmental stage and morale of the therapist to their use of professional knowledge.

At this stage I was conceptualising professional knowledge as formal theories of the type that reside in books. So, in the context of psychodynamic psychotherapy, it could be thought of as comprising:

- Theories of psychological functioning i.e. how 'the mind' works from a psychological point of view.
- Theories about the process of being therapeutic for people by engaging in a talking/listening/relating process.
- Underlying theories, which I have referred to as meta-psychologies or philosophies of life that address the question of how we might envisage what it means to live 'the good life' (McLeod,2000).

Through my experience of the interviews and further literature searching I came to see this as too 'flat' a definition and I will come on to this later in the thesis. However, at the start of my research it was the definition I employed and, with it in mind, I surveyed the theoretical and conceptual tools psychodynamic psychotherapists had available to them and that constituted their 'professional knowledge'.

Object Relations Theory

I saw Object Relations Theory as providing for my informants the main organising conceptual tools for practice. I have set out here an understanding of the nature and content of that theory as it will inform the reader's understanding of the interviews and of my findings and conclusions. As it constitutes such a vast area I have been selective and covered those theorists referred to by my informants. In practice this has meant I have outlined British Object Relations Theorists. I have included also Bowlby's attachment theory as it also came to inform my findings.

Running through object relations theory is the tension between modern and postmodern ways of viewing the individual. I have highlighted these and in time they came to form a central thrust of this thesis and they are further discussed in the chapter on the status of professional knowledge.

Object Relations theory has emerged from an awareness of the way in which, as people, we carry other people and our experiences with them within us in an internal world. It makes the assumption that relationships are central to people's lives and focuses on how external relationships with actual others come to be represented in an 'internal world' within each individual (Fonagy and Target,2003). It is too diverse a theory to be containable within a single definition and Greenberg and Mitchell (1983:14) opted for the widest possible definition of it as comprising theories which are "concerned with exploring the relationship between real, external people and the internal images and residues of relationships with them and the significance of these residues for psychic functioning".

Greenberg and Mitchell (1983:2) summarised object relations theory in these terms:

> People react to and interact with not only an actual other but also an internal other, a psychic representation of a person which in itself has the power to influence both the individual's affective states and his overt behaviour.....what is generally agreed upon about these internal images is that they constitute a residue within the mind of relationships with

> important people in the individual's life. In some ways crucial exchanges with others leave their mark; they are "internalised" and so they come to shape subsequent attitudes, reactions, perceptions, and so on.

Gomez (1997:213) wrote of how we "import the other, and otherness metaphorically resides within us".

How we manage the relation between our internal and external worlds, how each affects the other, has become the major focus of psychoanalytic theorising. The term 'object' remains from Freud's original usage in which he was referring to the aim of the impersonal drives which he called the 'id' and which he saw as the main force of motivation for human beings. More relational ideas have been tacked on to this drive theory or relational theories have supplanted drive theories but the term 'object' has remained partly in recognition that we do not always relate to others as whole people (Greenberg and Mitchell,1983).

There has been a proliferation of therapies for the 'healing' of the modern self. Karasu (1986) counted over four hundred. The more respected forms of therapy can be thought of as socially sanctioned treatments for the modern self (McLeod,1997). Four approaches stand out within the field: the psychodynamic, the cognitive-behavioural, the humanistic/existential, and the systemic. They may be distinguished by their relative emphasis.

The psychodynamic approach, of which object relations theory is one part, seeks to evoke rather than direct, works with feelings as well as cognitions and behaviour and emphasises the mystery of life as much as mastery (Bakan,1966, Frank,1974). It employs more organic, botanical metaphors that emphasise growth and the need for a facilitating environment.

While there has been this proliferation of therapies, the range of therapies may be seen as having much in common. Frank (1974) suggested six factors common to the range of psychotherapies:

- An intense, emotionally charged confiding relationship, with a helping person;
- A rationale which contains an explanation of the patient's distress and of the methods for its relief;
- The provision of new information about the nature of origins of the patient's problems and of ways of dealing with them;
- Hope in the patient that he can expect help from the therapist;
- An opportunity for experiences of success during the course of therapy and a consequent enhancement of the sense of mastery;
- The facilitation of emotional arousal in the patient.

Object Relations Theory does not provide the therapist with a clear set of conceptual tools. There is a diversity to the theory such that it should not be thought of as comprising a unified view. It is best thought of as a gathering of theories that at minimum salute the same flag. Fonagy and Target (2003:289) liken it to a family of ideas "with resemblances, relationships and feuds, and with new members expected to take their place alongside the rest and respect the authority of the ancestors, especially Freud".

It is difficult to compare key theorists within the theory as they express competing visions and assumptions and have each developed their own particular vocabulary or shaped existing vocabulary to express their own meanings. Such diversity reflects the complexity of the phenomena being explored and the way professional knowledge is shaped by and emerges from a theorist's personal and professional experience.

The Self

The nature of the 'self' that object relations investigates is itself hard to define with any clarity or agreement. Psychodynamic psychotherapists, employing an object relations perspective, operate within culturally shared views of what it means to be a 'person' or 'self', within the phenomenology of the self. In their clinical reasoning therapists employ views of 'selfhood' to provide a frame for their thinking. Such views have changed considerably over the centuries from religious themes of the

soul's relationship to God into modern secular themes about the life and growth of the individual self (Kirschner, 1996).

However, clearer definitions of the 'self' seem elusive as Khan (1981:294) expressed:

> No matter how zealously, or critically, one studies the varied and perplexing literature on the subject, no clear definition of the self, as a concept, crystallises, though each of us feels very sure about what we mean when we use the concept of self, it is hard to communicate our particular meaning to another.

So therapists have to struggle with the difficulty that the concepts of the self and of the subject are central to the whole psychoanalytic project and yet are among the "least well-articulated psychoanalytic concepts" (Ogden1992:624).

McLeod (1997:4) described a shift over the centuries in the western world away from a sense of a *'person-in-community'* to a sense of a *'person-in-relationship'*, with the self seen as *'autonomous, masterful and bounded'*. Object relations theory has developed within this individualistic culture and contains the paradox within it that "it focuses its attention on individual experience while defining the essence of this experience as beyond the individual" (Gomez,1997:212). So the 'self' is frequently written about in object relations theory as if it were a relatively fixed identity within the individual. Spatial metaphors are often employed to describe it. However, and alternatively in the theory, the self may be seen as a more a temporal and multiple phenomenon (Mitchell,2000). The mental health of the modern self may be defined in positive or negative terms, as the presence or absence of a quality (Aggleton,1990).

The Classical and Romantic views of the self provide a dividing line that runs through Object Relations Theory (Strenger,1989; Fonagy,2001).

The Classical view within object relations theory draws on the Kantian philosophical tradition and is represented by Freud and Klein among others. They held a more

pessimistic perspective on humanity seeing it as flawed and conflicted in its basic nature (a kind of 'original sin'). They emphasised reason and autonomy and, through their application, the darker side of humanity could be held in check and some civilised living become possible. Reason provided an objective foothold for the experience of living.

The Romantic view within object relations theory draws on the thinking of Rousseau and Goethe and is represented by Winnicott and Fairbairn among others. They held a more optimistic perspective on humanity seeing it as basically good and loving but falling prey to the effects of the environment in the shape of the unempathic parent. Deficit rather than conflict was emphasised. They valued authenticity, spontaneity and imagination over rationality and saw humanity as full of potential, including the potential for healing (Fonagy,2001).

Within the literature common ground centres around the notion that we each have what can be thought of as a 'deep interior self' (Taylor,1989). Within that self we may exclude from conscious awareness parts of ourselves and our experiences that we find too painful to bear and thus we experience ourselves as divided and in conflict. There is value (as a general rule) in exploring our 'deep interior self', in evoking feelings held in within us, in exploring our mystery in the service of facilitating our psychological growth (Frank,1974, Sutherland,1968).

The close personal relationship that is created in the setting of therapy between therapist and patient is seen as a rich form of enquiry into ourselves which can evoke a potentially valuable and visible re-enactment of our psychological problems within the therapy relationship. What is lived and can be tolerably experienced is then more open to development and change (Mitchell,1988; Fairbairn,1952). I would argue that Frank's common factors are congruent with the aims and practice of object relations-based therapy.

A Shift of Focus towards Subjectivity and Intersubjectivity

There have been significant shifts in focus within object relations theory over the last half century in response to (and contributing to a shaping of) changing cultural views of what selfhood means. These shifts have involved a greater focus on subjectivity and intersubjectivity (Fonagy and Target,2003).

The paradox that runs through object relations theory is that we are both individual and social creatures (Greenberg and Mitchell, 1983). Object relations theory divides into strands that follow and make primary our individuality and strands that follow and make primary our relationality.

For Fonagy (2001) the relational or intersubjective approach has been and is still the most rapidly developing orientation in psychoanalysis. It repudiates the idea of an isolated individual mind as a "theoretical fiction or myth" (Stolorow 1988) and emphasises the co-constructed nature of the encounter in therapy which is seen as being between two subjects. At the same time the concept of our individuality retains a place as it 'fits' in an important way an aspect of our experience as human beings (Greenberg and Mitchell, 1983).

A growing emphasis on intersubjectivity has created a shift in the temporal focus of therapy away from archaeological-type attempts to reconstruct the past towards a deepened awareness of the present (Holmes,1998). Eliot (1960:11) wrote how "he is not likely to know what is to be done unless he lives in what is not merely the present, but the present moment of the past". It is that 'present moment of the past' that is seen by therapists as being re-enacted in the therapy.

There has been a shift from a view of the self as seen in mechanistic terms to the self as experienced by the person, in more phenomenological terms. Freud's theory, based on humans as instinctually motivated, gave rise to more mechanistic views of the mind as divided into parts that he called the id, the ego and the superego (Freud,1923). Winnicott (1965a) and Fairbairn (1952) reflect in their writing the shift to an interest

in the person's experience of themselves, their sense of self and their experience of themselves in relationship.

Alongside this has been a shift away from thinking about a person's psychological problems in terms of neurotic symptomatology and definable neuroses. Instead psychological problems are viewed as reflecting a person's disordered subjectivity' (Mitchell,1993) or their 'problems in living' (Storr,1979) or their 'pseudonormality' (Winnicott,1960b). This represents a shift from a concern with symptoms to a concern with whole persons (Mendes and Fine,1976) and therapy is seen as about the fostering of wholeness rather than the undoing of repression (Holmes,1998). The shift has involved a move away Freud's view of the people as drive-regulating animals to a view of people as meaning-generating animals for whom problems focus around a lack in capacity to generate and assign meaning to experiences. A lack of authenticity or meaning to living and too great an adaptation to society is part of the problem of 'pseudonormality' (Mitchell,1993).

Our self-knowledge is seen as necessarily partial. Phillips (1995:6) wrote of an enlightenment Freud who was involved in a project of self-knowledge which embodied a perspective on the self as a "knowable set of constituents". This Freud, he argued, described the ways in which we refuse knowledge in order to protect ourselves with ignorance. While we may be unacceptable to ourselves we are not unintelligible. He also wrote of a "post-Freudian Freud" who subverted the whole possibility of self-knowledge with the notion of the unconscious in relation to which one can not be an expert. This Freud, Phillips argued, requires us to consider what we use our 'knowledge' to do.

There has been a shift in the view of the therapist's participation from the possibility of a one-person-psychology to an awareness of the nature of intersubjectivity. This is in keeping with wider cultural understandings about the inevitability of participation. Therapy is seen as involving two active participants who co-construct the encounter.

Mitchell (2000:26) wrote that "the analytic relationship is no longer usefully understood as the sterile operating theatre Freud believed it could be...the analyst is not a blank screen". Psychodynamic theory increasingly explores the nature of the intersubjective encounter between therapist and patient. Holmes (1996) wrote of a shift in view from the therapist as like a parent figure to the therapist as a sibling who co-constructs the encounter. Scharff and Scharff (1998) emphasise how the therapist brings to the encounter their own matrix of relationships with which understanding of the particular patient starts to be framed.

The phrase, the *'betweenness of people'*, used by Clarkson (1994), speaks to the ways in the literature that therapists have tried to explore the area of intersubjectivity. Stolorow (1988:332) wrote :

> Clinical phenomena ....cannot be understood apart from the intersubjective contexts in which they take form. Patient and analyst together form an indissoluble psychological system, and it is this system that constitutes the empirical domain of psychoanalytic enquiry.

Therapists explore their counter-transference feelings thus making use of their connectedness to the patient (Symington,1985). The term counter-transference is a wide-ranging term that covers both the blind spots in the therapist that are thrown up by the therapy as well as the therapist's disciplined use of their subjectivity as a source of information about the patient (Hinshelwood,1999). Freud initially gave the concept a negative sense but Heimann (1950) developed it as a positive contribution which required the therapist not to clear their mind so much as to "sustain the feelings which are stirred up in him" and to make use of them reflectively. Winnicott (1971) wrote of the "potential space" that the therapist offered the patient.

Ogden (1994) suggested there are three subjectivities involved in the therapy; the analyst's, the analysand's, and the analytic third. The last refers to the intersubjective experience created by the analyst and analysand together. He postulated a dialectical movement between subjectivity and intersubjectivity in the therapy. As the focus of

analysis is on the patient's experience so the reverie is explored for its information about the patient and the intersubjective experience of analyst and analysand, seeing in the reverie and what emerges from it indications of what may be the as yet unarticulated and perhaps also not yet felt experience of the analysand.

Sandler (1976) wrote of the way the patient attempts to dictate the interaction with the therapist using a complicated system of unconscious cues. Through reflection on this process an underlying sense may become available to therapist and patient. Sandler is clear that the therapist also enacts roles and each therapist will have susceptibility to their own particular set of internal roles. Counter-transference, in this view, has become less about feelings and more about enactment.

Symington (1985) developed the idea of patient and analyst forming a 'corporate identity'. The analyst found in time their role allocated, as in a drama, by the patient and therapy proceeded as a process towards creative awareness of and disengagement from such roles. The single system and changes to it take place at a pre-verbal level and are sensed before they can be talked about. Such change, he argued, required an "act of freedom" on the part of the therapist.

Ryle (2003) argued that we seek out people who will reciprocate our established relationship procedures. What is important in the therapy is the way that the therapist does not always reciprocate and this experience leads to attempts to identify and make accessible to the patient's awareness the nature of their problematic relationship procedures.

Stern et al (1998) believed that, more than 'mutative information' (as in interpretations offered by the therapist), patients need a 'mutative relationship'. The main aim of therapy is to alter the intersubjective environment to create something new for the patient whether or not this is understood consciously. They suggest that throughout infancy and through our later lives we are building up a sense of 'how to be with someone' which they call 'implicit relational knowing'. It is built through interactive, intersubjective experiences and leads to what they call a 'shared implicit

relationship' with a person. Within the therapy there are 'now' moments which are particularly 'lit up' and which pull a patient and therapist more into the present. If seized by both parties they can become a 'moment of meeting'. Such moments create a 'disjoin' in 'implicit relational knowing' which opens a space for something new.

Fessler (1983:44) saw therapy as a "speech event" and offered a compelling description of how meaning emerges in therapy from the attempts each party makes to hear and be heard. He emphasised how therapist and patient each respond to what they have understood the other to be saying. Meaning does not originate in either party but "through their parallel attempts to be heard and understood".

Narrative

I found pointers in the literature to the potential significance for therapists of the concept of narrative. McLeod (1997) surveyed the place of narrative in therapy. In particular at this stage I took on board Bruner's distinction (1986) between paradigmatic and narrative ways of knowing.

Paradigmatic knowing refers to what we think of as scientific knowledge that deals in generalities and abstract propositions. Narrative knowing refers to the way we talk about our experiences, in the particular, from the inside. The distinction is also thought about by Hobson (1985) as the difference between 'knowing about' and 'knowing', or, in Buber's terms (2000), between an 'I-It' and an 'I-thou' relationship to knowledge.

At this stage of my research the potential implications of the concept of narrative for my research were only beginning to be seen by me. The importance of the concept of narrative grew through my experience of the interviews.

Key Theorists

I sought to survey and organise the contributions of specific key theorists to the professional knowledge of the psychodynamic psychotherapist. This was difficult to do succinctly and clearly without an organising principle that would bring some

clarity. Later in the research process I found that the concept of narrative provided me with just such a frame and I have summarised here the thinking of key theorists in a way that employs my later understanding of narrative. I am jumping the gun by doing this. However this way of viewing the contribution of these theorists has become so much a part of my thinking that it would feel artificial to present them in another form.

At this stage I have presented here an outline of the contribution of key theorists within the British School to the development of Object Relations theory. As already mentioned I have been selective in that I have outlined the thinking of Freud, Klein, Bion, Winnicott, Fairbairn (and Bowlby). Employing my later understanding of narrative I have approached their theory as understandable in terms of three narratives or stories which they tell:

- life is like.....a psychodynamic narrative
- psychological problems are the result of.....a developmental narrative
- treatment of such problems requires.....a treatment narrative

Sigmund Freud

In his narrative Freud described :

- our inescapable individuality
- the evolutionary, instinctual heritage that motivates us
- our need to accept our instinctual nature and use our reason to tame it
- the objectivity that his theory would provide for a therapist
- the capacity of a therapist to stand outside the therapeutic encounter

Freud's Psychodynamic Narrative

In his thinking Freud was informed by Darwin's understanding of our evolutionary heritage and the classical view of the 'self'. Freud emphasised our inescapable individuality and the way our subjectivity is shaped by our drives (also referred to as 'instincts'), which are blind impersonal forces (he referred to as the 'id') that cluster

around sexuality and aggression. Our more conscious self (which he called our 'ego') is a secondary development and can only borrow its energy from these drives in the way a rider steers a horse (Freud,1905b,1923).

The central task in our psychological life is to wean ourselves off our infantile hopes and wishes with the help of our reason and rationality. We need to leave the nursery behind (Mitchell,1993). So Schafer (1980a:30) wrote of Freud's Darwinist story:

> [which] begins with the infant and young child as a beast, otherwise known as the id, and ends with the beast domesticated, tamed by frustration in the course of development in a civilisation hostile to its nature.

We begin life as unsociable babies who seek gratification of our drives but soon discover the conflict that can exist between the search for pleasure and the reality of the environment. We have to learn to accommodate the society on which gratification depends. The tension and anxiety this creates within the mind is expressed in psychological symptoms which point in coded form to the underlying conflict. There is a price to pay for being 'civilised' (Freud,1930).

In order to cope with the impulses we find within us which feel unacceptable to us we practice 'forgetting'. The account we give of ourselves contains gaps and inconsistencies and contradictions due to our defensive manoeuvres in the service of our self-esteem. Phillips (1995:4) wrote:

> To be a person is to be a stranger to yourself..... To sustain a version of ourselves and to protect ourselves we work at ignorance..... A neurosis is a way of not knowing what one wants, a refusal of knowledge.

As an enlightenment man Freud advocated the place of reality over pleasure, the rational over the irrational and reason over emotion. This is expressed in his famous phrase "where id was, there shall ego be" (Freud,1933). This all reflects Freud's rather

stoic view of living where the hope is to transform a patient's "hysterical misery into common human unhappiness" (Freud,1933). In the "Future of an Illusion" Freud (1927) described how he saw life as "too hard" and bringing too many pains, disappointments and insoluble tasks as if in the plan of creation we were not intended to be happy.

Freud's Developmental Narrative

For Freud the Oedipus complex was a 'one-size-fits-all' developmental narrative (Phillips,1999) which provided an x-ray vision into the reality of subjective experience (Freud,1905b). It is experienced broadly between the ages of three and six years but it's resolution, or lack of it, has lasting effects. Freud wrote to Fliess (1987:271) that

> A single idea of general value has now dawned on me. I have now found, in my own case too, [the experience of] being in love with my mother and jealous of my father, and I now consider it a universal event in early childhood. If this is so we can understand the gripping power of Oedipus Rex.

He further wrote (Freud,1900:364) :

> It is the fate of all of us, perhaps, to direct our first sexual impulses towards our mother and our first hatred and murderous wishes against our father. Our dreams convince us this is so.

In this 'complex' a boy becomes sexually possessive towards his mother and aware of his father as a rival and a possible source of retaliation for his wishes. This creates a fear of 'castration'. The boy is led to give up on his hopes towards his mother, take on board the father's perceived view and turn his sexual energy in time more outwards and away from more incestuous desires. The female complex is less developed by Freud. He suggests the attraction occurs between the daughter and father and the daughter experiences 'penis envy' (Freud,1905b).

Freud's Treatment Narrative

Freud made the assumption that a one-person psychology was possible. He saw the therapist as an objective observer, standing outside of the problem and exposing the reality of it by interpreting in. Conversely he saw the patient as a subject who misperceives and projects the past onto the therapist. He did not regard the personality of the therapist as of significance.

The therapist's neutrality he saw as crucial to the emergence of hidden impulses and providing a screen on to which they can be projected. The therapist could then interpret what he saw. Restraint rather than expressiveness was deemed to be required (at least in Freud's *theory*) and a certain hard-edge was required in the application of the model. Freud wrote :

> The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him (SE, XII 118).

Therapy, for Freud, involved the development of insight, through therapist interpretation. Such insight would allow the patient to take more control of their lives by bringing infantile wishes and impulses out into the open so that they could come under more conscious, rational control. The patient needed to accept consciously what was within them. In particular the therapist interpreted to the patient the transference (Freud,1905a) which represented a displacement on to the therapist of the constellation of childhood impulses and relationships. So now the neurotic problem could be lived (i.e. re-enacted) in the therapy which made it more amenable to change. Therapy had the sense of something 'done to' the patient rather than an empathic 'being with' the patient.

The rational thinking, for Freud, would be done in the therapy by the therapist who enjoyed a privileged and objective vantage point. The patient's conscious narrative would contain gaps, inconsistencies and puzzles. The understanding that unconscious drives lead to repression meant that the patient narrative could be filled out and sense

made of what would otherwise be an incomplete account. Freudian theory can be seen as offering a fulfilment of the narrative (Phillips, 1999).

As Fonagy and Target (2003) relate, Freud moved from considerable therapeutic optimism (1916) to a later pessimism (1937) about the positive effects of analysis:

> Through the overcoming of these resistances the patient's mental life is permanently changed, is raised to a higher level of development and remains protected against a fresh possibility of falling ill (SE, Vol 17:448-463).

> One has the impression that one ought not to be surprised if it should turn out in the end that the difference between a person who has not been analysed and the behaviour of a person after he has been analysed is not so thorough-going as we aim at making it and as we expect and maintain it to be (SE, Vol 23:209-253).

Comment on Freud

In his account Freud displayed a limited sense of his theory as being located within a time and culture. Rather he emphasised his objectivity and the scientific basis of his theory. His one-person psychology, with it's heavy emphasis on the therapist's restraint and non-gratification of the patient, stands in stark contrast to current views of intersubjectivity. No doubt his practice did not always follow his theory in this regard (Gay, 1988). The 'self' for Freud was 'bestial' but could be 'tamed' and civilised in time with 'Reason' providing the counter-culture to our instinctual heritage. A mature and rational acceptance of our nature was regarded by Freud as a requirement for healthy living.

However, in order to summarise I have inevitably written as if there were one Freudian view rather than several. Phillips (1995) pointed to a very different strand in Freud's work, which he calls a 'post-Freudian Freud', within the account generally given of his work. He drew attention to the subversive nature of the concept of the

unconscious, not just as subversive of our self-image but also subversive of Freud's *epistemology* (to which Freud did not apply it). Freud, he wrote, drew attention to a problem with 'knowing' in contrast to the enlightenment's emphasis on the power of reason.

This led Phillips (1995:7) to write that "to be an expert on the unconscious is a contradiction in terms" and "this other unconscious ....is a way of describing both the limits of what we can know and the areas of our lives in which knowing and the idea of expertise, may be inappropriate". In this regard Freud was subversive of the whole notion of objectivity.

Melanie Klein

In her narrative Klein described :

- instincts as psychological forces
- our innately conflicted nature
- life as a crisis requiring of us to face psychic reality, tolerate our aggression and our experiences of loss and ambivalence
- the need in therapy for the therapist to interpret conflicts and, for later Kleinians, for the therapist to provide containment of conflicts

Klein's Psychodynamic Narrative

Klein's narrative combined both drive and relational ideas and she was in this way a bridge to object relational thinking. Her thinking about living the good life sits firmly within the classical view of the self, drawing, as Freud did, from a sense of our evolutionary heritage as creating within us an innate conflict. For Klein life requires the management of extremes of terror and anxiety that are psychotic in their intensity. Life is conceived as "a series of events : events that have to be endured, experienced and overcome" (Cassie in Dryden,1996:53). This is a biological 'given' so our very nature pitches us into a struggle between our love and our hate and healthy living requires of us as honest an acknowledgement as possible of our deeply mixed, ambivalent feelings. Our hate creates anxieties about our murderousness and our love leads us to repentance for our hate. We are pulled towards splitting and projection as

forms of disowning of the intolerable. In health there is a move towards integration and containment of the range of our feelings (Klein,1940,1946,1957). Psychological health involves the ability to see beyond our own projections (Gomez,1997).

Klein's thinking went through phases in which she emphasised alternately sexuality, aggression, depressive concerns and envy. Greenberg and Mitchell (1983:130) summarise her final thinking in this way :

> Klein's final vision of the human condition is of man struggling toward the integration of himself and his experience of others despite the suffering it necessarily entails, against the pull toward fragmentation created by his own destructiveness and envy.

So Melanie Klein's psychodynamic narrative suggests a strong and important ethical sense running through us which demands costly work within ourselves to achieve a sufficiently stable sense of integration.

Klein's Developmental Narrative

> The normal development of infants can be regarded as a combination of processes by which anxieties of a psychotic nature are bound, worked through and modified (Klein, 1952:81).

For Klein, a baby is born in a state of primitive anxiety engendered by innate destructive impulses of which it is aware and with which it is struggling. These impulses bring with them a terrifying fear of psychic annihilation. The self emerges from this conflict (Salzberger-Wittenberg,1970).

The infant experiences these impulses in an internal phantasy world where the anxiety is played out in graphic form in which there is no distinction between thought and deed (Segal,1957). Two dominant concerns are created; a concern the 'self' will be annihilated (which she called a paranoid concern) and a concern that damage will be caused to others (which she called a depressive concern) (Klein,1935,1946).

In order to cope with such intolerable feelings the infant adopts a range of strategies. Emotions and people (or parts of people) may be split into 'good' and 'bad' aspects. Feelings are also projected or introjected and this conveys a sense of the in-out nature of our experience, the interweaving of the internal and external. These processes can be creative or pathological. Klein believed that whole objects can be internalised in the second quarter of the first year of life (Klein,1935).

Projective Identification (Segal,1964) is a central concept in Kleinian treatment that tries to do justice to the clinical experience whereby it appears that a patient has projected unbearable aspects of themselves out onto other people or onto objects outside of themselves in a way that leaves the other person feeling them vividly. However this depletes and fractures the patient's self as well as distorting reality (Rosenfeld,1964).

In time the infant may learn to tolerate its own destructive feelings and so hold such bad and good feelings together inside without resorting to excessive splitting and projection. This constitutes achieving the 'depressive position' in which a child can acknowledge it has loving and hating impulses towards its caregivers (Salzberger-Wittenberg,1970).

Klein's Treatment Narrative

One key aim of Kleinian therapy for Steiner (1996:1075/6) is to help the patient to reintegrate projected parts of him/herself. The patient is helped to :

> utilise his own mental assets more optimally, so that he can struggle to resolve his conflicts in his own personal way.
>
> I will argue that the reversibility of projective identification depends on the individual's capacity to face psychic reality and in particular to confront the reality of loss and go through the mourning process that results from this confrontation.

To achieve this, patient anxieties are heard, projections and attacks received without retaliation and all these processes interpreted back to the patient (Gomez,1997). Klein gave more emphasis to the role of interpretation whereas later Kleinians (Bion,1967b) emphasised more the role of emotional holding that therapist played.

Klein (1955) believed that children could be worked with analytically. In place of the technique of free association she substituted the unstructured play of children in the belief that children's phantasies are literally played out and re-enacted in a visible way.

Klein (1950:78) set out her criteria for termination:

> My criterion for termination of analysis is, therefore, as follows: have persecutory and depressive anxieties been sufficiently reduced in the course of the analysis, and has the patient's relation to the external world been sufficiently strengthened to enable him to deal satisfactorily with the situation of mourning arising at this point.

Comment on Klein

Klein, in her writing, took a very limited view of the context of her theory. Her focus on the internalised and fantasised world of the childhood appeared to leave her out of touch with the interpersonal, social and cultural context of the therapy (Gomez,1997). As such she over-emphasised her objectivity and her theoretical stance and built in distance between herself and the patient. Her style has been criticised as being too technical and mechanistic and under-emphasising of the interpersonal encounter in therapy (Symington,1986). Her emphasis on interpretation was more in keeping with a 'doing to' style of therapy but later Kleinians have emphasised more the role of the therapist in providing containment for the patient, more a 'being with' function (Bion,1967b). Her sense of the need to face psychic reality puts her firmly on the side of the need for acceptance of what is within us rather than a focus on environmental provision.

In her theory Klein stares in the face the more bleak and terrifying aspects of psychological life as she explores the idea of the self as managing the terrors and anxieties that she saw as inherent in living. Perhaps more obviously than for others Klein illustrates the notion that 'theory is biography'. Her grim story of life's struggles (Grosskurth,1986) suggests her theory reflected the losses and conflicts that dogged her life:

> Klein was thus in a continuing state of mourning through much of her life. She used her pain to investigate in detail the early states of loss, guilt, loneliness, envy and persecution that make up her theories.(Gomez, 1997:32).

Wilfred Bion

In his narrative Bion described:

- the importance of our capacity as individuals to 'think', 'know' and 'choose'
- the key choice that we make whether to face or evade mental pain
- how the experience of being contained emotionally by another person promotes our psychological growth
- psychosis as a response to environmental failure
- the dangers of the therapist having a premature sense of objectivity

Bion's Psychodynamic Narrative

Bion was a radical thinker whose contribution is harder to define. Where Freud and Klein began with their reality of 'drives/instincts', Bion introduced a more mystical dimension into psychodynamic thought with his notion of 'O' as the ultimate reality which is unknown and unknowable (Symington and Symington 1996). He saw his aim as exploring how 'thinking' develops (Bion,1988a) and he felt he had found in psychoanalysis as good a tool for this as was available, though it had limitations. He took an explicitly phenomenological approach (Rustin,1991) with his concern to give attention to the subjective experience of the patient and of the therapy session.

For Bion (1988a) a healthy psychological life requires that we are exposed to 'truth' which leads to emotional growth. This involves 'thinking', 'knowing' and 'choosing', all words that have specific meaning for him. 'Thinking' is the emotional experience of trying to get to know oneself and others. 'Knowing' involves an engagement, rather than a knowing about. The 'choosing' is between evading mental pain or tolerating it and trying to modify it. The experience of thinking and knowing creates links within ourselves and with others. Bion set out to explore how 'truth' evolves and how it is blocked and this became his central focus (Symington and Symington,1996).

Bion (1962:42) wrote:

> A sense of reality matters to the individual in the way that food, drink, air and excretion of waste products matter...Failure to use the emotional experience produces a .... disaster in the development of the personality; I include among these disasters degrees of psychic deterioration that could be described as death of the personality.

Bion's Developmental Narrative

The foundation of healthy psychological development lies in the capacity of a carer to receive and contain the infant's distress and, in this regard, Bion is a fully relational thinker:

> If the infant feels it is dying it can arouse that fear in the mother. A well-balanced mother can accept these and respond therapeutically : that is to say in a manner that makes the infant feel it is receiving its frightened personality back again but in a form that it can tolerate - the fears are manageable by the infant personality. If the mother can not tolerate these projections the infant is reduced to continued projective identification carried out with increasing force and frequency (Bion,1967b:114-5).

Without such containment a hate and fear of contact with emotional reality may develop along with the destruction of the parts of the mind capable of thinking

(Bion,1959). As such a psychotic part of the personality will come to be dominant (Bion,1970).

Bion's Treatment Narrative

The therapist works to promote the ability of the patient to 'think' and to 'know'. This involves the patient in choosing to face their pain in order to progress (Bion,1962). Classical technique is used including free association and interpretation. Bion had a radical sense of the need to be open to the immediate experience of the patient rather than allow pre-existing assumptions to muddy the scene. He wrote:

> the psychoanalyst should aim at achieving a state of mind so that every session he feels he has not seen the patient before. If he feels he has, he is treating the wrong patient...[by this approach] his interpretation should gain in force and conviction because they derive from the emotional experience with a unique individual and not from generalised theories imperfectly 'remembered' (Bion,1967a:19).

The therapist, in Bion's view, works to provide an experience of containment that was missing to the patient in their earliest relationships so allowing more for the experience of 'thinking' and 'knowing'.

Comment on Bion

With Bion psychodynamic narratives can be seen moving in the direction of a far greater awareness of the professional knowledge as perspective and the intersubjective nature of the encounter. Bion voiced a deep wariness of the dangers of the therapist feeling a premature sense of objectivity about their understanding and then any imposition of that on to the patient (1967a). He advocated great restraint on the therapist's part until an experience had had time to be absorbed and learnt from in it's own terms. An interpretation he viewed as a contribution to making meaning rather than the final word or something that was in itself right or wrong. His view of the containing role of the therapist suggests a strong element of 'being with' is a necessary part of the therapist's stance. Bion described what could be called the

culture of the 'avoidant self', a self that needed a counter-culture of facing up to psychological realities, through which growth within the personality could occur.

Bion (1991) emphasised the need for each therapist to test out and to discover psychoanalysis for themselves in practice. He was not afraid of being innovative and voiced the dangers of being hard-edged in practice in a conformist way. Bion (1970) described a process whereby an idea would emerge through a mystic figure. In encountering the Establishment, the mystic finds himself viewed as a threat and his ideas, once so refreshingly open, turned into a closed system of thought. In his words:

> there are always No-alls about the place waiting to imprison/deify any thought or idea that causes trouble (Bion,1991:135).

Donald Winnicott

In his narrative Winnicott described how :

- becoming a creative person is a developmental achievement
- failures in maternal care lead to the 'arrested development' of the 'self'
- false adaptations are made to society
- the opportunity may be needed for the patient to 'regress' creatively with the therapist playing the part of 'mother'

Winnicott's Psychodynamic Narrative

Winnicott moved the focus of psychodynamic theory from constitutional conflict to environmental provision, from nature to nurture (Mitchell,1988). The roots of psychopathology lie in a failed environment with the parent as the villain of the piece rather than a 'bestial baby'. It is as if the infant's 'self' has been stillborn or failed to thrive due to the failure of caregivers and it is in need of rebirth or re-animation. "The analyst will need to play the part of mother to the patient's infant" (Winnicott,1960a:163).

Healthy living psychologically involves a capacity to generate meaningful experience, to feel authentic and creative and spontaneous. Winnicott refers to this as living from one's 'True Self' which he calls "the experience of aliveness" (Winnicott 1960b). However becoming a person in his sense of the word is something that should not be taken for granted. Rather it is a developmental achievement. An alternative is something that could be described as 'pseudo-normality' (Mitchell,1993). It represents a false adaptation to society, an inability to generate authentic and meaningful experience, an inability to be creative and spontaneous. In Winnicott's terms the individual then lives from their 'False Self' and this became Winnicott's central diagnosis. So we can be well adapted to society and out of touch with ourselves. Winnicott is emphasising that health is more than the absence of illness or the presence of sanity.

Winnicott further describes healthy living by way of paradox. We need to be able to be intimate but autonomous, available but not engulfed, individual but not isolated, and able to move fluidly between our subjective experience and objective reality (Greenberg and Mitchell,1983). He emphasises the ability to play as being at the heart of creativity (Winnicott,1971). Reality is encountered through a mixture of fantasy and actuality. This stands in contrast to Freud's emphasis on the giving up of illusions.

Winnicott's Developmental Narrative

Infants need 'good-enough mothering'(Winnicott,1960a). The baby is reliant on the mother for it's sense of existence and for the opportunity of healthy self-development:

> The child lives within the circle of the parent's personality and...this circle has pathological features (Winnicott,1948:93).

The mother initially adapts the world as it were to the infant's needs creating something of a sense of illusion for the infant of oneness and of it's own capacity to create what it needs (Winnicott,1947). This allows a sense of coherence and continuity of self to develop. In time the infant can gradually and helpfully be displaced from this position towards a greater awareness of others and their needs.

The infant needs an authentic, personal response from the mother because:

> A baby can be fed without love, but lovelessness or impersonal management cannot succeed in producing a new autonomous human child (Winnicott,1971:127).

When mothering is not good enough it is as if the infant's 'self' has been stillborn or failed to thrive and it is in need of rebirth or re-animation (Winnicott,1956). The twin dangers to the infant's sense of self lie an unresponsive or impinging parenting. These lead to the infant developing a false self as a protective barrier within which the infant's 'true self' is cocooned (Winnicott,1960b). While this protects it also prevents further growth and the experience of authentic and creative living. It is in this sense Winnicott (1950:213) warned against the possible "false assumption that the patient really exists". Where Freud talks of not extending our time in the nursery Winnicott thinks more in terms of the infant having to manage a premature expulsion from the nursery (Mitchell,1993). Where Freud took subjectivity for granted, Winnicott takes it's development as problematical (Greenberg and Mitchell,1983).

Winnicott (1963) distinguished two roles for a mother. In one role she is the environment mother who holds the child while the child is calmer. In the other role she is the object mother who receives the infant's fantasised attacks when the child is disturbed.

Winnicott developed the idea of 'transitional phenomena' (Winnicott,1971) whereby the infant invests significance in an object, such as a teddy bear or a blanket or its thumb. The object appears to hold an emotional significance as if it represents a parent's care in portable form and not dependent on the parent's immediate presence. This allows the infant some psychological movement away from total dependence (Gomez,1997). The object exists for the infant in a transitional realm between the infant and the external world in what is also referred to by Winnicott as "potential space". Such space can be immensely valuable and enriching to the infant's

development. The value continues in adulthood. Healthy development involves the capacity for creative use of 'potential space' as well as movement from absolute dependence towards independence and from fused and merged relationships to differentiated relationships (Winnicott,1960a).

Winnicott's Treatment Narrative

The experience of subjectivity itself is the issue in treatment for Winnicott which he contrast with Freud's approach:

> We disagree with Freud. He was for curing symptoms. We are concerned with whole living and loving persons (Winnicott quoted in Mendes and Fine, 1976:361).

Therapy provides a setting and a relationship that can be structured around the patient's subjectivity (Winnicott,1948) and in which "the analyst will need to play the part of mother to the patient's infant" (Winnicott,1960a:163).

The therapist offers the therapy and their own self as a transitional space, a potential space for transitional experiencing. The patient needs to feel psychologically held and contained and interpretations by the therapist convey this. Winnicott (1988:61-62) wrote:

> a current and well-timed interpretation in an analytic treatment gives a sense of being held physically that is more real (to the non-psychotic) than if a real holding and nursing had taken place.

In the transference relationship, the original maternal failure is re-enacted and so the point at which development was arrested can be reworked with a healthier conclusion. It is an important theme of Winnicott's that the therapist needs (for reasons of health) to be experienced in a graduated way as failing the patient, just as the mother needs to be gradually experienced as less constantly attuned to the growing baby's need.

The concept of the False Self (Winnicott,1960b) also applies to therapists who may be too well adapted to the culture of psychotherapy. The therapist needs to respond authentically to the patient just as the mother needed to. Spontaneity and creativity are needed and these can not be taught or found in books or mentors. In fact a pre-occupation with technique by a therapist could represent a 'false-self' response from the therapist (Symington and Symington,1996).

Comment on Winnicott

Winnicott brought an emphasis on mothers and the feminine into a psychotherapy that had had a very masculine emphasis under Freud (Gomez,1997). His views emphasised the role of the environment and intersubjectivity in contrast to Freud and Klein. He combined science and art in his approach (Davis and Wallbridge,1981).

At the same time Mitchell (1993) saw Winnicott as holding a realist stance in the form of a deep conviction about the objectivity of his views, that he really was uncovering the 'raw experience' of the patient (Mitchell,1993). In Winnicott's model, the therapist does not take a more fully relational and interactive position with regard to the patient. The therapist still stands outside of the process and the therapist acts not so much as a participant observer but as a pre-cipitant observer. The therapy room is populated by a subject and a facilitator (Mitchell, 1988).

Winnicott's stance as a therapist was very explicitly one of 'being with' the patient. He was remarkably 'soft-edged' in his application of his model, making himself unusually available to his patients out of hours and combining therapy with subsequent supervision. The 'self' for Winnicott had arrested in its development and the deficits in its culture needed to be made good with new experience.

Gomez (1997) suggested Klein and Winnicott held two sides of a split. Where Klein held a more pessimistic sense of the experience of life and particularly of childhood (in keeping with the classical model), Winnicott held a more optimistic view (in keeping with the Romantic tradition).

Loyalty to what had gone before in psychoanalysis was professed by Winnicott but he effectively redefined and reinvented analysis in his own way:

> He [Winnicott] recounts the history of psychoanalytic ideas not so much as it developed, but as he would like it to have been, rewriting Freud to make him a clearer and smoother predecessor of Winnicott's own vision (Greenberg and Mitchell,1983:189).

Guntrip (1975) commented that Winnicott was more revolutionary in practice than in theory. Winnicott himself wrote (1965b:94) how "mature adults bring vitality to that which is ancient, old and orthodox by re-creating it after destroying it".

Ronald Fairbairn

In his narrative Fairbairn described :

- our primary need as human beings for relationships
- our loyalty to our earliest relationships and our unhealthy tendency to repeat their pattern and distort our self-image
- healthy movement through stages of dependency from infantile dependence through towards 'mature dependency'
- the importance of the relationship with the therapist
- the need to be open to new experience

Fairbairn's Psychodynamic Narrative

As human beings our deepest need is for emotional contact and our deepest dread is the loss of such contact (also referred to as 'separation anxiety'). We live all our lives to differing degrees with the consequences of an early sense of maternal deprivation (Fairbairn,1944).

The roots of our psychological difficulties lie in the loyal attachment we develop as infants (as a result of the experience of maternal deprivation) to our earliest relationships and their patterns (Fairbairn,1943). We absorb, identify with and define

ourselves in terms of our earliest experiences of relationships. The degree of our pre-occupation with earliest experience is in proportion to the level of deprivation experienced. We maintain what Fairbairn (1943) variously refers to as an "obstinate attachment" or "unceasing devotion" to them. They are stored as "frozen dramas" in a "closed internal world." We remain locked into these early experiences and patterns of deprivation. We set up current relationships to re-enact the original difficulty in a self-defeating pattern. We are pre-occupied with them at the expense of external relating (Grotstein,1994).

Where the childhood emotional deprivation was most severe the individual experiences an existential sense of emptiness, deadness and futility which Fairbairn refers to as a 'schizoid state' (Fairbairn,1940).

We are psychologically healthy when we can absorb and learn from new experience and be able to differentiate past experiences from present experiences (Gomez,1997). The task is to separate from both our actual parents and the parents and relationship patterns of our internal world. This allows for new and richer relations to develop though for some the fear of loss and dread of the emptiness is too great for such a risk to be taken (Mitchell,1988).

Fairbairn's Developmental Narrative

We develop through our intersubjective experiences and where they are nourishing the infant is able to work through the stage of infantile dependency, through a transitional phase towards a state of "mature dependency" (Fairbairn,1952). This involves an increasing capacity for more complex inter-subjective relating, from primary identification to the capacity for differentiated relationships with more equal give and take.

The infant learns to manage the limitations of the personalities of the caregivers by distorting themselves and their self-image so as to leave the parent in the best possible light as a damage limitation exercise (Gomez,1997). An 'objective' assessment of the parent, even if it were possible, would create too much insecurity given the level of

dependence the infant experiences. This distortion is at the expense of inner security and a sense of wholeness:

> The child shapes, structures, and distorts his own experience, behaviour, and self-perception to maintain the best possible relatedness with the parent; psychopathology is a consequence of disruptions in these early relations. The personality of the child shapes itself in complementarity with the personalities of the parents (Greenberg and Mitchell, 1983:179)

Fairbairn's Treatment Narrative

Fairbairn argues that the patient seeks help with recovering or developing the capacity for real and meaningful contact with others (Greenberg and Mitchell,1983). Progress is made through and is dependent on the relationship with the therapist. In Fairbairn's view an intersubjective encounter between patient and therapist is at the heart of the therapy:

> In my own opinion, the really decisive factor is the relationship of the patient to the analyst ...not just the relationship involved in the transference, but the total relationship existing between the patient and the analyst as persons ..the existence of such a personal relationship in outer reality not only serves the function of providing a means of correcting the distorted relationships which prevail in inner reality and influence the reactions of the patient to outer objects, but provides the patient with an opportunity, denied to him in childhood, to undergo a process of emotional development in the setting of an actual relationship with a reliable and beneficent parent figure (Fairbairn,1958:6/4).

Therapy involves both a 'being with' the patient but also a 'doing to' in that the therapist has to force their way into the patients closed internal world, and "effect breaches of the closed system which constitutes the patient's internal world, and thus to make this world accessible to the influence of outer reality" (Fairbairn,1958:7).

The therapist finds himself assigned roles according to the patient's internal 'frozen drama' and necessarily enacts some of these while seeking to understand what is happening (Gomez,1997). Attempts at disengagement are likely to be another form of participation as there is there is no option of standing 'outside' (Mitchell,1988). There are only forms of participation, many of them unintended. Fairbairn moved psychoanalytic practice towards a more intersubjective position. The task then of therapy is to find a way of observing these forms of participation and explore new ways of relating that go beyond the script. If the relationship with the therapist can be broadened then so can others. The aim is to make a connection between patient and therapist and so help the patient reconnect with himself and with others, to loosen the grip of the closed internal world. The classic stance of analytic neutrality could, Fairbairn believed, feed the schizoid position by the analyst's avoidance of contact (Fairbairn,1958). Some measure of radical change is sought rather than a process of acceptance.

Fairbairn (1958) argued for a soft-edged element to the application of the therapeutic method in recognition that the method was made for the patient, not the patient for the method. As such it would be necessary to adapt it to avoid the implication of the joke that "the operation was a success but the patient died" (Fairbairn,1958:6).

Comment on Fairbairn

Fairbairn's situation of relative isolation in Edinburgh from the mainstream of the psychoanalytic movement perhaps provided the space in which to formulate his theory from such a radically different starting point (Gomez,1997). He abandoned theory built around the concept of instincts and placed instead relationships at the heart of his theory. He brought to therapy more account of its intersubjectivity. He combined a 'being with' and a 'doing to' though he himself was a very reserved man and restrained in therapy (Gomez,1997). Guntrip (1975) suggested Fairbairn was more radical in theory than in practice.

The attempt to summarise Fairbairn's developmental narrative highlighted how much emphasis he placed on the earliest years of life to account for later psychological

problems. Rutter (1981) argued that, while psychological problems in later life may clearly relate to early childhood experiences, they are equally clearly related to and dependent on later experiences. Fonagy and Target (2003) believed that psychodynamic theory needs to develop more understandings of psychological problems based on experiences in later childhood, adolescence and adulthood. This critique is not unique to Fairbairn but belongs with the range of psychodynamic developmental theory.

John Bowlby and Attachment Theory

The Attachment narrative described :

- our primary need for a secure attachment with an attuned other person
- how insecure attachment patterns are replayed by the person in their subsequent relationships
- how security allows for exploration
- the therapist as providing a secure base in therapy from which the patient can explore painful areas of experience
- how securely attached adults have the capacity to tell coherent stories

The Attachment 'Life' Narrative

We need the experience of being securely attached in our lives:

> All of us, from the cradle to the grave, are happiest when life is organised as a series of excursions, long or short, from the secure base provided by our attachment figures (Bowlby,1988: 62)

If we have experienced such security as children we carry within ourselves a self-esteem and an expectation that there can be enjoyable explorations and relationships to be made in the world (Bowlby,1988). If not, we are forced to develop less healthy defences that represent an attempt to keep some proximity to others. So we are forced to sacrifice exploration for the sake of security. Insecurity takes the form of patterns

of relating that have a quality of being either ambivalent or avoidant or disorganised (Holmes,1993).

As adults we replay our attachment patterns with others "as though there is a compulsion to find an object with whom the drama of attachment - however painful - may be re-enacted" (Holmes, 1996:104).

Psychological health is displayed in the capacity for 'narrative competence' which is the ability to give a coherent account of one's life. Such an ability points to the fact that the experiences of the narrator have attained within them a coherence of meaning and a sense of ownership (Holmes,2001).

The Attachment Developmental Narrative

Infants need an attuned other who can offer a secure attachment:

> Whether a child is in a state of security, anxiety, or distress is determined in large part by the accessibility and responsiveness of his principal attachment figure (Bowlby,1973:20).

Where this occurs the infant is able to internalise an inner security in the sense of carrying around their positive experience in a way that allows for expectations of further positive experiences and close relationships (Bowlby,1969). Attachment behaviour has clear timescales for the internalisation of attachments centred mainly on the first three years. By about the fourth year critical patterns have been laid down in the infant (Bowlby,1969).

The concept of 'attunement' refers to what is originally a parental task of being open to the infant in their need and individuality:

> Attunement is, by its very nature, non-controlling, following rather than leading, affective rather than instrumental. It is 'aimless' in the sense that it cannot legislate in advance what will emerge from the playful and

spontaneous encounter between therapists and patients (Holmes, 1998:237).

The Attachment Treatment Narrative

The therapist offers a reliable, attuned and responsive presence and so seeks to create a secure base for the patient in the therapy (Bowlby,1988). The experience of being provided with a secure base allows the patient to 'do' the business of exploring. From this secure base the patient is able to begin to explore difficult experiences and tolerate the emotion that is aroused by re-engaging with them. The therapist in turn needs to tolerate protest and anger from the patient. Once a secure base in the shape of the therapist has been sufficiently internalised, the patient is able to leave therapy (Gomez,1997).

Narrative competence and coherence is promoted by the therapy in so far as it allows raw experience to be objectified and meaning created around it. Holmes (1993:150) wrote:

> making the unconscious conscious can be reformulated as knowing and owning one's own story...narrative turns experience into a story which is temporal, is coherent and has meaning. It objectifies experience so that the sufferer becomes detached from it, by turning raw feelings into symbols. It creates out of fragmentary experience an unbroken linear thread lining the present with the past or future. Narrative gives a person a sense of ownership of their past and their life.

Comment on Attachment Theory

I have included a summary of the thinking of Bowlby and his followers though it is not an object relations theory in itself, as he said:

> I am with the Object Relations school but I have reformulated it in terms of modern biological concepts. It is my own independent vision (Bowlby quoted in Grosskurth 1986:404).

Bowlby brought together the differing fields of psychoanalysis and evolutionary biology. Attachment theory's more empirical footing met his desire for a more scientific status to psychoanalysis and it expressed his belief in the central role of the environment in the creation of psychological problems (Gomez,1997).

Attachment theory is explicitly relational and intersubjective. The 'self' in crisis is an insecure self suffering a deficit of attention. The therapist 'being with' the patient and providing a secure base is seen as allowing the patient to 'do' the necessary exploring of their feelings and needs in the therapy. The clinical implications of attachment theory are as yet under-developed.

As a theory it can seem too spatial and concrete which does not do justice to subtler emotions or to the concept of emotional absence (Gomez,1997). The meaning of loss may be as important as the fact of loss. Perhaps it is not loss per se but the meaning given to it that is important to comprehend. Perhaps too the general handling of a child is as important as the specific events that occur (Greenberg and Mitchell,1983). However, Bowlby put the maternal firmly within psychoanalytic discourse though paradoxically he had little to say about fathers perhaps reflecting the absence of his father in his childhood (Holmes,1996).

Secure attachments, according to the theory, allow the infant to explore more of their world, safe in the knowledge they can return to the care giver when they need to. I was struck by a parallel with attachments to a model of work. Where attachment is secure a therapist can explore beyond the model, needing neither to cling to the model in an enmeshed way, nor be avoidant and indiscriminate in the affection given to models. A secure enough hard-edged to attachment to a model would allow softer edges to be explored.

For Holmes (1993) attachment theory is not another model to set alongside other models. Rather it offers a commentary on other models and Holmes thinks of it more as akin to one of the common factors described by Frank (1974).

Professional Knowledge and Professional Development

Initially I was interested in whether professional knowledge was employed in different ways according to the stage of development of the therapist. As the work proceeded this ceased to be a focus but within the literature on developmental stages I found studies very relevant to the central themes of this research that reflected on the creativity and personal/professional integration or otherwise in the therapist's use of professional knowledge.

Creativity and integration

Skovholt and Ronnestad (1992) suggested that where a therapist's professional development proceeds along healthy and progressive lines, the therapist grows towards a 'professional individuation' in which a rigidity of approach gradually declines and concepts and working style become increasingly personally congruent. 'Continuous professional reflection' becomes the central developmental process and internal wisdom is relied on more than external expertise. In what they saw as a long, slow, and erratic process there is movement from "received knowledge towards constructed knowledge", a "decline of pervasive anxiety" and a "realignment from a narcissistic position to a therapeutic position."

Fleming (1953) suggested that positive professional experience facilitates a movement from imitative learning to creative learning. Hogan (1964) suggested a movement through levels from a very dependent stance, through a struggle between dependency and autonomy to a level of security and autonomy in which the therapist could see and address their own personal and professional needs.

Dreyfus and Dreyfus (1986) described five developmental levels of expertise: novice, advanced beginner, competent, proficient, and expert. Progression required, they argued, an increasing capacity to learn from and be guided by one's own experience.

Conformity and avoidance

The idea of development as always progressive was questioned by Jablon (1987) and Zukar (1979). The stage of being a beginner may be one in which a therapist is more open, healthily naive and less institutionalised into a profession.

Skovholt and Ronnestad (1992) described their findings of four typical orientations towards a conceptual system in students that reflect the struggle to choose and own a conceptual approach out of which a student therapist's clinical reasoning emerges:

- The *laissez-faire* orientation involves a lack of engagement and choice perhaps requiring some personal development and maturing to enable progress to be made.
- The *suspended judgement* orientation reflects the student's need for time before "a genuine commitment to a conceptual approach can be made."
- The *true believer* orientation reflects a commitment made without going through the struggle and search for a personally and professionally integrated position (though it may have involved this and so be healthier).
- A *multiple attachments* orientation may parallel the laissez-faire stance in a struggle or lack of struggle to engage and choose.

Skovholt and Ronnestad (1992) argued that trainings could only go so far in preparing a student for the reality of practice. They suggested the hazards of practice can result in the therapist, post-training, becoming overwhelmed with anxiety leading to the danger their professional practice is marked by "stagnation", "pseudo-development" and "premature closure". This can be thought of as a state of arrested professional development. Stagnation involves:

> The absence of Continuous Reflective Experiences and the fending off from experiencing anxiety arising from confrontation with challenges and complexities which the therapist is not able to handle (Skovolt and Ronnestad,1992:124).

'Pseudodevelopment' involves being guided by the work of others rather than choosing one's own professional identity. 'Premature closure' involves interupting the reflection process in order to defend the therapist from the taxing challenge of assimilating the experience.

Loganbill, Hardy and Delworth (1982) suggested that a recovery towards creativity and integration involved initially a stage of confusion when awareness had grown of wider thinking and the therapist's current limits. This was followed by a stage of integration where new but more flexible understanding was forged and strengths and limitations more openly addressed.

Summary

I have surveyed in this chapter the conceptual tools available to psychodynamic psychotherapists through an exploration of object relations theory and shifts within it towards postmodern, intersubjective perspectives. I have also looked at the relevance of developmental stages for the use of professional knowledge.

In the next chapter I move on to look at the question of the status of professional knowledge and what grounds there might be for viewing it as a dependable body of knowledge.

THE STATUS OF PROFESSIONAL KNOWLEDGE

In this chapter I have addressed the question whether therapists can find a basis for viewing their professional knowledge as being a *dependable body of knowledge*. Such a need reflected the shift in our culture away from what now seems to be a naive belief in the possibility of a simple correspondence between theory and 'reality'. Fact and value are now understood to be intertwined. As such therapists employ "truth without certainty" (Christopher,1996).

Phillips (1995:6) referred to the Freud who was engaged in an enlightenment project that involved 'knowing' in an objective sense. He argued that while, for Freud, we might find the truth about ourselves to be unacceptable, we were not per se unintelligible to ourselves. The self could be seen as an object whose constituent parts could be known. Freudian theory provided a kind of psychological x-ray into the foundational level of experience. The therapist, through their professional knowledge, enjoyed a privileged position when it came to knowing and understanding.

Kuhn (1962) and other writers drew attention to the way our understanding of the status of knowledge had undergone profound shifts since Freud began formulating his ideas. Scientific knowledge, he argued, was not objective in some pure sense and did not hold a direct and simple correspondence to reality. On the contrary, fact and value were intertwined.

Christopher (1996:18) argued we need to recognise the way that "values are intersubjective, unavoidable, and inextricably intertwined with facts" and he referred to "counseling's inescapable moral visions". Christopher (1996:33) quoted Bickhard (1980):

> the concept of knowledge as objective, to which we then attach values, purposes, goals, and so forth is mistaken. Objective knowledge is a myth. All knowledge is motivationally structured.

Mitchell and Greenberg (1983) asserted that psychodynamic theory rested (as did all theory) on untestable assumptions such that they were better thought of as involving "metaphysical commitments" or, in other terms, 'acts of faith'. Mitchell (1993:48) questioned the nature of the dilemma this had raised for therapists and whether it opened the door to a different type of knowledge:

> The shift from a view that the analyst knows the Truth to the view that the analyst knows one (or more) among various possible truths about the patient's experience has created a crisis of confidence in psychoanalytic theorising and a crisis of authority in the psycho-analyst's self-image. The certainty and its consequent hopefulness that pervaded traditional psycho-analytic theorising have become inaccessible to contemporary analytic theorists or clinicians. Is this a problem? Is uncertainty a cause for nihilism and dread, or the basis for a different sort of knowledge? If the content of what analysts know is not the Truth, is the authority that analysts can claim diminished ?

Mitchell's questions - in particular the question, "Is this a problem?" - went to the heart of my research question. So I focused my literature search on an exploration of the question whether the professional knowledge that informed the therapist could be viewed as a dependable body of knowledge and, if so, in what way and with what criteria.

Much of the literature I reviewed was concerned with this inability of therapists to claim anymore a simple correspondence between their theory and 'reality' and whether it had left therapists with only a relativist position available or whether there was a path "beyond objectivism and relativism" (Bernstein 1983).

McLeod (2001:28) provided a working definition of epistemology:

> epistemology...refers to the way in which people gain knowledge about the world and come to regard some beliefs as true and others as false.

Ways of 'Knowing'

In the literature I found described the three traditional 'ways of knowing', namely the empirical, hermeneutical and phenomenological approaches. I explored what contribution they might make to the question of the status of a therapist's professional knowledge.

Empiricism

Gellner (1985), Popper (1974) and Grunbaum (1984) were among those who criticised psychoanalytic theorising for failing what they regarded as empirical tests that would offer a validation of a professional knowledge base and practice. Truth in their view required an empirical demonstration of correspondence.

These writers opened up for me the question of the extent to which a therapist *had to* be able to lay claim to a solid empirical foundation for their professional knowledge for it to be seen as a dependable form of knowledge.

Counter-arguments to the views of Gellner, Popper and Grunbaum came from many sources. Rustin (1987:109) wrote of the relativity of empirical methods and argued that empiricism as a method belonged more to the natural sciences than the human sciences:

> there is no natural law that all aspects of reality must be equally amenable to investigation by the empirical methods favoured by certain philosophers of science. Some dimensions may exist yet only be accessible by particular, and in certain respects, contentious and problematic methods of investigation.

Mitchell (1998:8) suggested science produced empirically verifiable knowledge while social sciences produced:

> knowledge (e.g. the concept of unconscious processes) that is verifiable through plausibility and enrichment of common sense. Different types of

knowledge require different forms of confirmation to establish their credibility.

Nagel (1995:31) argued similarly that real life is more complex than empiricism is able to take account of:

> Much of human life consists of complex events with multiple causes and background conditions that will never precisely recur. If we wish to understand real life, it is useless to demand repeatable experiments with strict controls...[In any particular case] we simply have to decide whether this is an intuitively credible extension of a general structure of explanation that we find well supported elsewhere, and whether it is more plausible than the alternatives - including the alternative that there is no psychological explanation.

Bhaskar (1978,1979) described what he called "generative structures" which were more than could be observed but which could be deduced from their effect. Rustin (1987:125) saw this as a good description of the status of concepts such as 'the internal world' or 'the unconscious'. He argued that the natural sciences routinely depend on the measurement of such 'indirect' effects and that pragmatic criteria, rather than idealised criteria are needed for judging the validity of psychodynamic ideas and practice:

> The demonstration by the 'new sociology of science' of the degree to which all science depends on consensual procedures and on acceptance of the expertise of qualified observers should make one wary of an idealised view of the natural scientific method conceived as commonsensical in its methods of observation, open and democratic in its access to findings, and freely competitive in its modes of selection between competing hypotheses. There is no point in judging psychoanalysis by a normative standard to which virtually no scientific work conforms.

Mitchell (1998) believed empirical studies could only shape theorising but not decide on the basic assumptions in the context of which theorising takes place. Such assumptions are shaped by a therapist's professional community and life experience. Empirical studies are of value to and necessary for practice, he argued, but empiricism has set up a false standard against which to measure the dependability of the knowledge that underpins a therapist's clinical reasoning:

> I do not regard my model as empirically derived and objective, although it has certainly been shaped by empirical data and would likely be shaken and somewhat changed in response to disconfirming empirical data and any growing consensus of clinicians regarding some other viewpoint. I regard my model as one among many possible and valid ways of viewing Psychopathology, one that reflects both the interpretative community that I was drawn to and trained in, and also my own past and distinctly subjective experience (Mitchell,1998:20).

Hermeneutics

The hermeneutic approach emphasised the way that knowledge was created through acts of interpretation which were seen as "bringing to light an underlying coherence or sense within the action, behaviours or utterances of a person or group" (McLeod, 2001:22). A therapy patient could be viewed in these terms as a 'human text' with whom and for whom a hermeneutic perspective could be employed usefully.

The notion of *perspective* was central to a hermeneutical approach. As individuals we are immersed in our culture and need to accept that, while also reaching out to or into the text or subject to learn what it has to tell us from within its world. This approach seeks to develop understandings rather than explanations.

A degree of relativity was explicit in a hermeneutic stance with knowing seen as an active process of composing, arranging, interpreting and constructing. Mitchell (1998:16) wrote that "consciousness comes into being through acts of construction either by others or, through self-reflection, by oneself". Kermode (1985) felt that

commented that the past was constructed in the here and now rather that reconstructed. Viderman (1979) suggested that experiences did not have a structure of shape in themselves. Schafer (1980b:3) argued that :

> a version of the past can only be a narrative about past narratives. And the past towards which we might adopt a fatalistic attitude is not more than one contemporary historical narrative that, for certain purposes, we take to be true and final.

Dennett (1991:136) wrote of the way it is not possible to lay claim to a canonical version of events :

> Just what we are conscious of within any particular time duration is not defined independently of the probes we use to precipitate a narrative about that period. Since these narratives are under continual revision, there is no single narrative that counts as the canonical version, the "first edition" in which are laid down, for all time, the events that happened in the stream of consciousness of the subject, all deviations from which must be corruptions of the text.

While a degree of relativity was explicit, there was a fierce debate about the extent of it. Mitchell (1993) suggested some look to hermeneutics to solve the dilemma of 'truth' by giving up on correspondence altogether and accepting that 'truth' is created and not found. Erwin (1997) argued that, with more radical constructivism, we are left only with 'fictionalism'. In such a view our experience constitutes the world. Such a view entirely discounts the correspondence theory of truth. Neimeyer (1993) suggested as his criteria for constructivist validation the importance of internal consistency, social consensus, viability and multiplicity. Therapy became, for him, similar to art and poetry.

Sass (1988) criticised such views as involving the "subjectivisation of reality", if truth is regarded as only self-referential. He located such views in what he saw as a

postmodern sense of perspectivism and the current power of the image over the substance. It had led to a postmodern loss of reality and a potential loss of depth. Holmes (1992) sought to locate psychotherapy as between art and science, not wanting to lose touch with either.

Gadamer (1975) further emphasised how interpretations needed to be created out of an awareness of the cultural and historical context of the issue. Warnke (1987:107) described how in a hermeneutical study "understanding...involves a transformation of the initial positions of both "text" and "interpreter" in a "fusion of horizons" or consensus of meaning". The approach was described as much deeper than the making of simple acts of interpretation. It presupposed that an act of engagement had been made by the interpreter.

The hermeneutic approach could be viewed as requiring therapists to acknowledge the constructed nature of their professional knowledge and the need for an engagement and for an awareness of context. It did not necessarily require, I felt, a therapist take a purely relativist position with regard to their knowledge base and its dependability. It could be regarded as a disciplined way of knowing.

Phenomenology

The phenomenological approach sought to set aside assumptions and examine phenomena in an open-minded way, pulling away the particular so as to allow the essence of the phenomenon to be experienced. It was well applicable to personal experience. For early phenomenologists it represented a search for the objective (i.e. correspondence) and not the relative. McLeod (2001:40) suggested therapy is similar at times :

> There are points in the therapy when most therapists will encourage their clients to bracket off their assumptions about their problems, describe their experiences in detail, express their sense of their experience in fresh language, and, in general, 'overthrow and build anew' their understanding of self and relationships.

Rustin (1987) also saw parallels in a reaction within psychoanalytic practice against theory and theorising for its own sake. He suggested there had been a refocusing on the here and now so that in significant ways the question of origin or archaeology of the problem had been 'bracketed out' in favour of a focus on the experience of the present:

> Theoretical reasoning for its own sake seems to have been devalued in this tradition, except where a precise and emotionally resonant embodiment of theoretical concepts in phenomena of experience can be given".....There has been a reaction against mere 'theorising' and model-building unsupported by the evidence of analytic 'experience', and a great deal of attention is given in training to the development of what might be called 'observation skills' to ensure that concepts and theories are as securely and consensually as possible anchored in their perception of psychic events (Rustin,1987:114).

Post-Kleinian psychoanalysis, Rustin (1987) felt, had embraced the value of a phenomenological (and hermeneutical) view. The clearest example was in the work of Wilfred Bion (1967a) who stressed the value of 'not-knowing' and the importance, with deeply disturbed patients, of clearing out from the mind (i.e. bracketing off) all theory and preconceptions:

> Bion came to feel that in order to make any progress with analysis of psychotic disturbance it was necessary to empty the mind of theoretical preconceptions, which became in these conditions merely defences against what had to be experienced in feeling before it could be thought about, known before it could be known about (Rustin,1987:153).

Mitchell (1993) suggested some look to phenomenology to 'solve' the problem of truth by privileging the patient's truth. If we can not naively privilege the therapist's

account then some phenomenologists look to privilege the patient account and view it as the truth, the patient's truth. Schwaber (1990:238) advocated such a stance :

> the closer we can stay to their [the patient's] experience of the moment (the closer we stay to the data), the less we are tempted to teach another truth, the more deeply our patients will be able to observe and face their own.

However, Mitchell (1993) saw this as an attempt to return to the naive realism of Freud's day and quoted Dennett (1991:96) in support:

> If you want us to believe everything you say about your phenomenology you are asking not just to be taken seriously but to be granted papal infallibility and that is asking too much. You are not authoritative about what is happening in you, but only about what seems to be happening in you, and we are giving you total, dictatorial authority over the account of how it seems to you, about what it is like to be you.

Crotty (1996) was concerned that the radical tradition within phenomenology is lost when phenomenology is reduced to more simple description of subjective experiences without a critical questioning of the assumptions we have taken for granted within them.

Beyond Objectivism and Relativism

There was a search described in the literature for a stance "beyond objectivism and relativism" (Bernstein,1983), for middle ground between "anachronistic objectivism and irresponsible relativism....a position neither uniquely objective or idiosyncratically subjective"(Mitchell, 1998:26).

I looked for definitions of objectivism and subjectivism in the context of psychotherapy. Hobson (1985) pointed me some way towards evolving my own working definition in terms of Buber's (1937) distinction between 'I-Thou' and 'I-It'

relationships. Objectivism implied a belief that people could be characterised in terms of observations made in other contexts and employing existing classifications, definitions and frames of normality. An objectivist view drew on the perspectives of already existing cultural knowledge and found them sufficient. It implied the possibility of having a 'God's- eye' view of 'reality' (Haraway,1988). Subjectivism or relativism took as it focus what was particular, unique, a "universe of one" (Erickson, 1958). It could be thought of as privileging an "I-Thou" type of knowing, a perspective gained from the experience of being with someone. Subjectivism implied a lack of correspondence with 'reality', a relativism in which truth was seen as self-referential and one's participation framed the whole picture. Mitchell (1998) viewed it as a swing of the pendulum against objectivism.

Nagal (1974:178) suggested that "at present we are completely unequipped to think about the subjective character of experience without relying on the imagination - without taking up the point of view of the experiential subject".

Christopher (1996:24) wrote of the need to define a third way beyond objectivism and relativism:

> As counsellors, we need to continue efforts made by philosophers to find a path of understanding "beyond objectivism and relativism".....we must acknowledge that there are no ahistorical, neutral, or strictly objective criteria that counsellors can adopt. However, this does not necessarily thrust us into a debilitating relativism in the face of which we must conclude that every moral vision or way of life is equally "good" and that there are no grounds for criticising values and practices that we deem oppressive, racist, sexist, or otherwise unworthy ...we need to define a middle ground or third way beyond objectivism and relativism based on a search for truth and moral insight with full awareness that no final or certain formulations of them are possible (or even desirable).

Pragmatic Rationality

Barker et al (1994:11) drew my attention to Hamlyn's (1970) four fundamental epistemological positions or criteria:

- the correspondence theory of truth according to which a theory could be regarded as true if it 'matched' or 'corresponded' to reality.
- the coherence theory of truth according to which a theory could be regarded as true if it was logical and internally consistent.
- pragmatic and utilitarian criteria according to which a theory could be regarded as for practical purposes "true" if it was useful and produced practical benefits.
- criteria based around consensus according to which truth could be viewed as intersubjectively validated in that knowledge was shared and held by a group.

Bernstein (1983) disagreed with the notion that the loss of simple correspondence had led to a free for all. The lack of a direct correspondence between theory and reality, he argued, had not led to relativism but to the development of different criteria for making judgements based around use, consensual appeal and economy of explanation. He referred to this as the employment of a "pragmatic rationality". It appeared to me to have involved an interweaving of Hamlyn's (1970) four criteria.

Combining Criteria

A critical realist perspective in the literature implied that a measure of correspondence did not have to be abandoned. O'Hear (1991) argued that we have to be critical realists at the end of the day as without an assumption of a relatively stable world independent of us we could not hope to categorise our experiences.

He quoted Newatt's analogy that "knowledge is a ship on which we are afloat which we can therefore only change plank by plank". As a critical realist O'Hear (1991) made the assumption that both a real world exists with regularities but that our knowledge of it is necessarily uncertain and tentative. He argued we can still be realists about our perceptions without naively accepting that everything is as it appears.

Rustin (1991) also argued strongly for a realist position and felt that without the premise of a 'deep interior structure' a therapist has nothing different to offer a patient:

> What seems to distinguish psychoanalysis from other 'talking cures' is its postulation of 'deep structures' of mind unavailable to common sense observations, and the equipping of its practitioners with concepts and theories which, under specified observational conditions, can grasp hold of this ulterior level of meanings (Rustin,1991:126).

> The idea of unconscious states of mind, systematically and 'intentionally' hidden from the patient's conscious awareness, is the crucial hypothesis which prises open the possibility of bringing the patient fresh insight about himself. The essential theoretical hypothesis is that there *is* an ulterior structure. Without this the analyst will have nothing to offer beyond sympathy and common sense, resources which many patients will already have tried to the point of exhaustion among their friends and relations before seeking professional help (Rustin,1991:121).

O'Hear (1991) described a move to a social basis for knowledge. He argued that we know that the earth moves around the sun but we probably could not prove it ourselves. However that was not a problem if we moved away from individualistic, atomistic accounts of knowledge supported by traditional philosophical definitions of knowledge in which each knower would ideally have reasons for what he knew. Such a view was being replaced he suggested by a view of knowledge as a socially constructed systematic body of statements with no absolute foundations.

Habermas (1968) pointed to the common world we all shared. Our culture and society all pointed, he felt, to a sense that we were able to understand each other a sufficient amount of the time and that we shared ways of constructing our understandings of experience within a culture. This was a commonality into which a therapist could tap.

Nagel (1974:19) suggested:

> a view or form of thought is more objective than another if it relies less on the specifics of the individual's makeup and position in the world, or on the character of the particular type of creature he is. The wider the range of subjective types to which a form of understanding is accessible - the less it depends on specific subjective capacities - the more objective it is.

Rorty (1991) suggested a shift from the question 'what is truth?' to the question 'what are we justified in believing?' Phillips (1997:131) suggested a shift from the question 'is there an unconscious?' to the question 'in what sense are our lives better if we live as if there is an unconscious?' He also suggested a shift from the question 'what is a self?' to the question 'what do I use the idea of a self to do?'

A shift in such questions reflected for Mitchell (1998) a shift in understanding of the mind from something regarded as preformed, distinct and there to be revealed, to a view of the mind as ambiguous and too complex for simple reductionism (Mitchell,1998).

In Practice

Fonagy and Target (2003) have referred to the process that underpins the development of practice as 'enumerative inductionism'. Therapists, they argued, accumulate observations about particular patients and attend to them selectively in the light of their previous experience and their clincial theories, values and philosophies. Theory used in practice reflects what is found to be useful clincially rather than what is deemed to be 'true' in itself.

Fonagy and Target (2003) did not argue that this is inappropriate, so long as the therapist recognised how much induction was being used as a basis for theory and clinical reasoning. Theory develops according to what is found to be clinically useful rather than by a standard of whether it can be deemed true. They emphasised how most human reasoning shares this flaw of an inattention to what might disconfirm a

theory. They quote the quip as having some validity that "psychoanalytic clinicians understand the word data to be a plural of the word anecdote" (Fonagy and Targer,2003:283).

They held firmly to the point of view that clinical theory is not something deductions can be reliably made from. Rather it is a 'heuristic' device, a way of enquiring and opening out issues and it should not be elevated into the status of clinical 'law'.

Christopher (1996) employed the image of a 'hermeneutic dialogue' in considering how truth or understanding was arrived at in a therapy. He saw counselling as "an encounter between moral visions : those of the counsellor and those of the client" (1996:22). He described working earlier in his practice with the imperative of privileging the patient's moral vision and working to avoid any imposition of his own views. However, he concluded this idea of neutrality was itself part of a moral vision that he found increasingly problematic. He commented (1996:22) that:

> this relativism disempowers us as counsellors.....we are caught between wanting to respect the moral visions of the clients and needing to be able to make some normative evaluations or discrimination between what is proper and improper or what is psychologically healthy and pathological in human behaviour...there is no simple answer.

He referred to Gadamer's (1975) idea of a "fusion of horizons" emerging from a dialogue and suggested there needed to be a dialectic. This, Christopher argued (1996:22) would involve an openness to the possible truth or validity of another's moral vision, giving it a "provisional authority .....to challenge our own." However it would also involve a testing "in a critical manner whether the possible insights gained from openness really do make better sense of a person's concrete situation or reveal hitherto hidden features of it". He suggested such an ongoing dialectic between the two stances. The task is "to respect the client's moral visions while subjecting them to the challenge posed by the current understandings of mental health and the good life.

The counselling process can thus be fruitfully viewed as a form of hermeneutic dialogue."

Ogden (2003) employed poetic vein in an attempt to describe the nature of 'relative truth' and the way something that is experienced as relatively emotionally true is discovered and altered within the analysis. Psychotherapy involved, he argued, coming to say "something that feels both true to the emotional experience of any given moment of an analytic session and utilisable by the analytic pair for psychological work" (Ogden,2003:593). Relative emotional truths he regarded as "very close to the music of what happens" or "a momentary stay against confusion" as opposed to absolute truth. Such human emotional truths were universal and timeless but at the same time they also idiosyncratic and specific to a moment. They were independent of the investigator - a thought finding a thinker - and had a reality independent of their formulation. So thinkers did not create truth, they described it. However in the process it was altered (Ogden,2003:597):

> what is true is a discovery as opposed to a creation, and yet, in making that discovery, we alter what we find and, in that sense, create something new.

The analyst's idea of truth was a speculation, in Ogden's view (2003), until it was brought into relationship to something external to the analyst i.e. grounded in a world outside the mind of the analyst. So Bion (1967b) felt it took at least two people to think. For Ogden (2003:605) the question of who is the author of a relative emotional truth was not relevant:

> if there was an author, it was the unconscious third subject of analysis who is everyone and no one - a subject who was both Mr V, and neither of us.

For Mitchell (1993), psychoanalytic theory was "tested" in the clinical setting and revised, adopted or dropped but there were consensual standards. In a move away from a focus on what a therapist or patient knew, Mitchell (1993) suggested the task

was to help a patient with their capacity for meaning making and that psychoanalytic theories were emotionally powerful ways of organising experience and aiding the process of meaning making:

> For me the analytic process is about expanding and enriching the patient's experience of his own mind and facilitating his capacity to generate experience that he finds vitalising and personally meaningful (Mitchell,1993:24).

> Theories of mind such as those of Melanie Klein, Winnicott, Leowald, Kohut and others do not portray the actual, universal structure of mind, but they do provide emotionally powerful ways to organise experience (Mitchell,1993:75).

> The kind of knowledge and authority that I believe today's analytic clinician can justifiably claim is an expertise in meaning-making, self-reflection, and the organisation and re-organisation of experience (Mitchell, 1998:2).

Summary

At the beginning of this chapter I raised the question whether therapists could find a basis for viewing their professional knowledge as being a *dependable body of knowledge*. Such a need reflected the shift in our culture away from what now seems to be a naive belief in the possibility of a simple correspondence between theory and 'reality'. Fact and value are now understood to be intertwined. As such therapists employ "truth without certainty" (Christopher,1996).

I found in the literature arguments, persuasive to me as a clinician, that this did not need to lead to an 'epistemological quagmire' for therapists. Rather the employment of a "pragmatic rationality" (Bernstein,1983) was available to therapists, involving a

critical realist stance (O'Hear,1991) and an interweaving of Hamlyn's (1970) four epistemological positions.

The empirical, hermeneutical and phenomenological approaches could be thought of as providing differing emphases and as each offering a valuable perspective in studying psychological life without the need to be tied into any one. The empirical stance called for a grounding (where possible) in what was visibly demonstrable. The hermeneutical stance pointed to the way all understanding was from a perspective that needed to be engaged with. The phenomenological stance advocated a search for the essence of a phenomenon by setting aside all previous assumptions and this offered a valuable ideal.

The professional knowledge that therapists hold can, it is argued here, be seen as neither solely relative nor solely objective nor entirely pre-existent of the therapy. There are criteria (Hamlyn,1970) which, when interwoven, allow for a critically realist stance to be held.

THE USE AND MISUSE OF PROFESSIONAL KNOWLEDGE

At the beginning of my research I explored the literature for critical debates about the use of professional knowledge in practice in order to develop a base in the literature from which to assess the interviews. I found critiques emerged from within and without the profession. The debate in the literature was fierce and, for some, such critiques had the status of 'fundamental flaws' that invalidated practice. For others, such critiques pointed to 'blind spots' that therapists needed to attend to in their practice. Those critiques that relate more specifically to epistemology are addressed within the chapter on the status of professional knowledge.

The four main areas of critique particularly relevant to my research concerned the limitations of the body of knowledge that informs the practice of therapists and the employment of that body of knowledge. Critics charged that psychodynamic psychotherapists (among others), in their use of their professional knowledge, employed an inappropriately individualistic focus. They displayed a lack of awareness of the intersubjective nature of the encounter in therapy. They assumed too great a measure of objectivity on the therapist's part. They lacked a sensitivity to issues of power and influence.

Clinical individualism

A lack of cultural awareness

The professional knowledge of psychodynamic psychotherapists was charged with lacking an awareness of the way that the experience of identity is culture-dependent. MacIntyre (1981:216) and Bruner (1990:34) wrote respectively:

> I can only answer the question "What am I to do ?" if I can answer the prior question "Of what stories do I find myself a part?"

> When we enter human life, it is as if we walk on to stage in a play whose enactment is already in progress - a play whose somewhat open plot determines what parts we may play and towards what denouements we may be heading.

There were examples in the literature where authors started with a focus on society rather than the individual and so suggested ways in which our identity and experience were socially constructed. However these were not within the mainstream of literature that psychodynamic psychotherapists drew on.

Cushman (1990) wrote of the modern self as an "empty self" fashioned to be so by the needs of the modern consumer economy. Lasch (1984:229) described what he saw as 'the narcissistic personality of our time'. He felt it to be well suited to the needs of bureaucratic institutions which "put a premium on the manipulation of interpersonal relations, discourage the formation of deep personal attachments, and at the same time provide the narcissist with the approval he needs in order to validate his self-esteem".

Gergen (1994) saw the modern self as a "saturated self", bombarded with information, perspectives and opportunities which led to a sense of 'self' as fragmented and inconsistent. Seabrooke (2004) described the way he felt we are tantalised by a society which excites us with all the possibilities apparently available to us but leaves us then facing the impossibility of stuffing "eternity into a single human life" and "at a loss to know where to start".

An uncritical relationship to individualist ideology

Critics took psychotherapists to task for the way their professional knowledge reflected uncritically the individualist ideology of our culture so that fundamentally social problems had become 'privatised'.

Kvale (1992) pointed to the grip of individualistic ideologies in a culture where there appear to be no truths outside of man. Self-realisation, he argued, had become the goal of life.

Clarkson (1993) wrote of therapy's "interiority", its "ethical solipsism" and its "self-absorption". Banton et al (1985) linked individualism with the rise of capitalism. Leonard (quoted in Spinelli,1994) saw Freudian instinct theory as treating social factors as ahistorical and not about particular systems of social organisation and oppression. Pilgrim (1992) felt Freud placed in the centre of his understanding of what it means to be human not a social struggle but an "intra-personal instinctual struggle". Masson (1992) levelled the charge against Freud of underplaying the reality of sexual abuse in favour of fantasy.

In response, Holmes (1993) argued that while pre-war therapy might be accused of neglecting the environment and privileging the internal that could not be said of post-war developments in which the likes of Bowlby, Fairbairn and Winnicott had all explicitly sought to describe and theorise about the role of the environment. The reality of sexual abuse was not now questioned, Holmes (1993) argued, but the debate had moved on to an evaluations of its impact and treatment.

Holmes and Lindley (1989:14) suggested psychotherapists privilege the personal and private in a way that is paradoxically neglected in our individualist culture. They argued that therapy:

> restores the inner, private world of the individual and his family to what Habermas calls the 'public sphere'.....an area of social reality, subject to change, open to analysis and discussion. The feminist movement, which undoubtedly has psychotherapeutic roots, however critical it may be of the chauvinistic aspects of therapy, is an example of a social force that has brought a particular segment of 'private life' into the realm of public debate. Similarly, psychotherapy, both in its private encounter with the patient and in its public face, has responsibility for a part of human experience that, in our society, only *it* takes seriously.

Frosh (1986) argued that therapy does have radical potential both as theory and practice. He suggested it provided a person with " a position within discourse". The radical potential he saw in therapy was located in its capacity to "interrogate" the power structures of society that we find within ourselves and help alter our stance towards them. He argued that:

> if personality is socially organised then so is personal distress; investigating the desires and anxieties of individuals leads irresistibly to social critique...the position taken here is that psychoanalytic psychotherapy can operate to interrogate and alter the internalised stance taken up by each individual with respect to the social world (Frosh,1986:39).

Gomez (1997:212) saw Object Relations Theory as being still part of an individualist outlook while also looking to move beyond it. She pointed to a paradox at the heart of object relations theory, namely that it "focuses its attention on individual experience while defining the essence of this experience as beyond the individual". She saw the language used for the self as mainly spatial and physical in tone and suggested that reflected the culture in which the theory was born and its wish and need to experience the 'self' as solid and firm. She regarded this as a comforting illusion. Gomez (1997) felt it unreasonable to expect object relations theory to have shed its culturally individualist roots completely but saw the need to work towards developing a wider and more relational language for the self.

Misdiagnosis and Conformity

A lack of cultural awareness and an uncritical relationship to the dominant individualism of our culture, had led therapists to a misdiagnosis of *social* problems as *individual* problems thereby indirectly promoting a conformity in patients.

Masson (1992) argued that such an ideology promotes resignation and pathologises any protest. Smail (1987:11) felt psychotherapy to be "at best ... a temporary comfort, at worst a distraction" because of it's tendency to convert "real powerlessness into

personal inadequacies" and read "socio-political advantage as inner strength". Marcuse (1966) saw therapy in practice (though not in theory) as a "course in resignation" which aimed at returning to the individual "the capacity to function in a sick civilisation without capitulating completely". Szaz (1979) criticised therapists, from a libertarian standpoint, for being undisclosed agents of social control, hiding the imposition of their values beneath the cloak of objective professionalism.

Frosh (1986:53) wanted to avoid a reversal of the order of causality between the individual and society which he saw occurring within object relations theory :

> The idea that social processes may in some way produce psychological processes - that they may be constitutive of psychic structure - is outside the scope of object relations theory. Thus the proposals [of the theory, especially Fairbairn's] concerning mature relationships suggest that it is possible for them to occur whatever the social structure or, more accurately, without reference to the social structure in which they are embedded.

There was some acknowledgement from within psychotherapy of a neglect of the social and political dimensions of life. Samuels (in Dryden,1992:xv) wrote of the need to confront:

> psychotherapy's neglect (denial, repression) of the political factor in human experience and the manner in which the political dimension inflects all of human experience.....In order to make a contribution to political analysis, depth psychology must face the problem that it is not possible to depict a person divorced from his or her cultural, social, gender, ethnic and above all economic and ecological context.

An Intersubjective Encounter

Therapists were criticised for having been slow to take on in their thinking the importance of the therapist's personality, values and influence.

A slow but significant growth was described by some observers in the acknowledgement in psychoanalytic theorising of the role and place of the therapist's personality. Alice and Michael Balint (1939) argued that the mirror-like attitude of the therapist was now open to challenge whereas previously such a challenge would have been regarded as an act of desertion.

Mitchell (2000:26) wrote of the realisation that "the analytic relationship is no longer usefully understood as the sterile operating theatre Freud believed it could be...the analyst is not a blank screen; the analyst's feelings, including passionate feelings, are inevitably part of the process and, often, usefully so". However, he argued, not all therapists have taken on board what he referred to as the 'revolution in theory', with some still seeing themselves much more as observers than participants.

Klauber (1981) suggested this might relate to a fear that the perceived objectivity of the therapist might be misconstrued as having been undermined by such a recognition of the intersubjectivity of the encounter. Fairbairn (1958:6) wrote of the relationship between patient and therapist analyst as being the "really decisive factor" and he was referring not just to the transference relationship but "the total relationship existing between the patient and the analyst as persons".

Benjamin (1995) argued that there was still some way to go for therapists to take on board a fuller vision of the intersubjectivity of the therapy encounter. She described a tendency for subjects to be collapsed into objects and saw this as a problem a relational theory should aim to cure. She paraphrased Freud that "where objects were, there subjects shall be". She outlined a concept of "mutual recognition" that we have of each other and asked "where is the theory that tracks the development of the child's responsiveness, empathy, and concern, and not just the parent's sufficiency or failure?" (Benjamin,1995:46).

Lakin (1988:58) believed that "therapists are not trained to understand how their values and orientations are reflected in their interventions" and commented on how little research had been conducted into the process of 'value induction' whereby patients come to adopt the therapist's values.

McLeod (1998:264) described the dilemma for therapists of how to be "powerful and influential without imposing [their] own moral values and choices". Erikson (1976:52) wrote similarly that :

> therapists may not escape the task of acknowledging that they must make value judgements about what they deem healthy and what they deem pathological. Thus practitioners must create an ethical niche for themselves by clarifying their ideologies of healthy conduct.

McLeod (1998:295) further wrote of the therapist's work as being "moral work from a value position". Taking intersubjectivity seriously would involve the therapist in being aware of their values and how they informed their use of professional knowledge in their practice.

Assumptions of Objectivity

Therapists were criticised for making excessive claims for the objectivity of their professional knowledge in practice. Their expertise was at times idealised resulting in a *surfeit of objectivity* being attributed to the therapist. Holmes and Lindley (1991:12) suggested critics like Popper, Eysenck, Gellner and Medawar:

> portray psychoanalysis and many therapies as latter-day religions masquerading as science, immune to criticism or falsifiability.

Weldon (1993) described therapy as a new religion whose law is "know thyself" and which preaches "follow us and you will be healed". Therapists will tell you how to

live and what to feel. It had become, she felt, a whole industry which was in danger:

> of becoming a controlling and ravening monster....These are the gods, the priests of our new society, the therapists. I fear we trust them at our peril. Therapists like anyone else are prone to error (Weldon:1993:5).

An inflated view by therapists of their professional knowledge had led to closed systems of thought that were too self-referential. Spence (1993:7) wrote of the risk of "making 'discoveries' that are little more than projections". Bruner (1993) was critical of the way psychoanalysts became bound together suggesting it would have been better if Freud had left for his colleagues "the gift for ensuring there were always interesting strangers in the house."

Storr (1997) recounted many examples of 'guruism' among therapists and a willingness on the part of some people to be so led/dominated. Holmes (1996) posed the question as to who has agency and authority in the process of story telling and story making in therapy. A danger at the end of the day, he argued, was that the therapist would impose their own story on the patient, attributing too much objectivity to themselves. He suggested that enmeshed therapists tended to impose their own narratives on patients.

Mitchell (1998) voiced criticism of what he saw as 'authoritarian' objectivity which he associated with an earlier Freudian sense that the therapist knows best what is going on in the mind of the patient. He suggested the pendulum had swung towards at times an avoidance of any truth claims. He argued for a "democratisation" of the analytic relationship and redefined his expertise:

> I believe my expertise lies *not* in knowing what is there in him [the patient], but in devising ways of *construing* his experience that are potentially helpful, and also in enquiring into what happens between us when he is confronted by my ideas about him (Mitchell,1998:25).

Phillips (1995) saw us as living in the age of the expert, a time when people crave the advice of the expert, someone who must know and understand. He linked this to what he called the 'enlightenment Freud' who was involved in a "project of self-knowledge which Phillips saw as the problem :

> The project of self-knowledge is itself the problem, the symptom masquerading as the cure; as though we have turned the self into an object (the project of the enlightenment Freud) even an idol, and psychoanalysis can now help us to unlearn this modern religion of selfhood (Phillips,1995:7).

Phillips (1995:17) further felt the post-Freudian Freud could help us unlearn this. He wrote how "to be an expert on the unconscious is a contradiction in terms" and "this other unconscious...is a way of describing both the limits of what we can know and the areas of our lives in which knowing, and the idea of expertise, may be inappropriate". States of conviction (perceived objectivity), he felt, need to be open to the questions "what are we using them to do?" and "why do we want to be convinced of things?" and "what do we find in states of uncertainty?" (Phillips,1997:132).

Mair (1992,1988) criticised psychotherapists for failing to recognise the relativity of their professional knowledge. It is based, she argued, not on knowledge but on the myth of knowledge. Description is mistaken for explanation and hypothetical concepts are reified. Therapists hide their ignorance in "elaborate conjectures .....which are presented as hard data" (Mair,1988:138). She argued that therapists are faith healers, though reluctant to admit it. Various studies, she felt, had shown that therapists were the key ingredient in therapy rather than their theory or technique so that :

> [therapists] are not a vehicle for valuable theories of human functioning, rather the theories are a vehicle for them. Theories bring therapists to their patients, confident that they have the expertise to help patients, prepared to invade their privacy and willing to offer themselves as a model, guide and friend (1988:148).

Spinelli (1994) was critical of therapists for mystifying their theory and themselves and saw this is a common criticism of all professions. Dorothy Rowe (1995:1) castigated all those who set themselves up as experts :

> The secret of life is that there is no secret. All that you need to know about life is there for you to see...However down the centuries, many people wanting power have tried to keep the secret secret.

The 'non-specific' hypothesis offers a challenge to the various schools of therapy in their evaluation of their knowledge base. Frank (1974) argued that the value of therapy lay not so much in its specific perspective and techniques as in some non-specific factors common to the various types of therapy. He identified these as the creation of a supportive relationship, the provision of a rationale by which the patient can make sense of his or her problems and the participation by both client and therapist in healing rituals (McLeod 1998). Luborsky's et al research (1975) suggested similar success rates across the therapies despite differences of theory and technique. The research of Hattie et al (1984) suggested that relatively inexperienced therapists can be as effective as those with more training and experience. The research of Llewelyn and Hume (1979) suggested that clients rated the non-specific factors over the particular model.

McLeod (1998) cautioned against jumping to the simplistic conclusion that these common factors summed up all that was effective in counselling. In keeping with a wider understanding of professional knowledge he argued there was an ongoing interweaving of non-specific factors with the therapist's personality and his or her espoused model. Roth and Fonagy (1996) suggested the outcome is best if the therapist is firmly rooted in their model but also flexible to a particular patient's needs. Holmes (2001) emphasised the need for therapists to provide for patients both structure (as in a model) and attunement to the patient.

Rowan (in Dyden,1992) criticised Mair for writing as if the only options for a therapist were to be a scientist-practitioner or faith healer. He questioned why Mair

did not describe further options. It is as if for Mair there was no ground for a measure of objectivity in therapists.

Samuels (1992:xiv) wrote:

> if we choose Mair as the therapist of psychotherapy, then the question of identity...is deepened. What is psychotherapy? Is it art, craft, science, religious ritual, a combination of these, or something sui generis? And where within psychotherapy is this question to be discussed?

Power and Influence in Therapy

Meares and Hobson (1977) described the therapy relationship as an equal and yet asymmetrical conversation. They wanted to acknowledge the capacity in it for harm. The therapist may deny their own involvement and practice in a defensive or offensive way by being intrusive, derogatory, faceless, invalidatory or by sending contradictory signals. The potential is there for a persecutory spiral leading to the patient being discharged if the therapist responds to a patient's failure to improve with retaliation.

Rennie (1994) raised the question as to whether open dialogue is really possible in therapy for the patient or whether the patient feels only able to be deferential. Enns et al (1995) described how apparent examples of the 'recovery' of what are then questioned as 'false memories' have raised questions about the place of suggestion in therapies.

Weldon (1993) described attending a meeting of therapists and coming to a shattering "revelation" that they all presented as "thwarted novelists" unaware of their desire to impose their stories.

Bion (1967a:18) described a radical attempt not to impose his stories on patients. He wrote of the need for therapists to bracket out their assumptions and approach each

session "without memory or desire". He advocated that therapists "do not remember the past session" and "avoid any desires for results, 'cure' or even understanding".

Phillips (1997) felt therapists needed to be able to distinguish authoritative statements from authoritarian statements. The key, he felt, was in whether they were useable by the patient. He felt therapists needed to be "tenacious without being authoritarian". Disagreement would have to be faced with the differences put on the table. But he this should be;

> without having to decide now, or necessarily ever, which one of us is right. In fact the question of right and wrong is exactly the problem. What we have to see is who can produce a story, or a version that we can make something of what we want (Phillips,1997:138).

Samuels (in Dryden,1992,xiv) argued that

> what we need is an effective basis on which to examine the possibility of unwarranted and undesirable influencing of the client/patient. If we are carrying out that kind of examination, then psychotherapy may be able to live more easily with the idea that a degree of suggestion is unavoidable and may not be a wholly negative phenomenon.

Power was a central concern within all these critiques. However assumptions about the nature and distribution of power varied between the critiques. Masson (1992) equated power with oppression and appeared to see only two positions in therapy, the therapist as an abuser and the patient as a victim. He commented how "within the therapeutic setting, emotional power, at the very least, is almost absolute". I would argue he has conflated the unequal with the abusive.

Frosh (1986) did not hold an exclusively top - down view of power but saw power as being created at all levels in a system - though not equally. Craib (in Dryden,1992:247) wrote in response to Pilgrim :

> I find the early struggles in psychotherapy have more to do with the patient's attribution of power and knowledge to me rather than any power or knowledge I actually possess.

Embleton Tudor and Tudor (1994) suggested a variety of responses to the issue of managing power in relationships. One response was defeatism in the face of the difficulties (and they referred to Masson). Another was to ignore the power issue in some form of egalitarian denial. Another was to try and share it equally as in forms of co-counselling. Another was to try to give power away. They themselves concluded that "although power relationships may be inadequate, invasive or even abusive, our perspective is that they are not per se deforming" (1994:389).

Summary

Misuses of professional knowledge in practice were well described by critics though at times I felt that 'straw' figures of therapists were being set up only to be knocked down. Where critics allowed a validity to psychotherapeutic practice, concerns were expressed that the professional knowledge of the therapist was :

- too individualistic in its focus.
- inadequately informed by an intersubjective perspective
- given too great an objective status
- lacked sensitivity to issues of power and influence

How compelling such critiques are felt to be is dependent on the perspective of the reader. As a practising psychotherapist I was drawn to Craib's (in Dryden,1992:248)

awareness of the tension in professional life in which there is a need to avoid complacency while not setting an unattainable standard :

> The dangers and benefits of belonging to a profession go together, and the paradox is that without the dangers, there can be no benefits. The problem is always to hold on to both sides at the same time. The baby of psychotherapy can not be separated from its dirty bathwater; we have to remember that the baby is there and the bathwater is dirty. It seems to me this is a condition of any professional life.

THE

ENQUIRY

METHODOLOGY

In this chapter I describe for the reader how I set about exploring in a systematic, critical and discovery-orientated way the phenomenon of a therapist's use of their professional knowledge in practice and how I evaluated my findings. I have not sought to unfold my account as it happened chronologically from my point of departure with its many twists and turns on the way - though I have alluded to these. Rather I have opted to tell it from the perspective of where I arrived as this will offer the reader a more coherent account. It has inevitably involved an element of reconstruction.

I began this research with the aim of exploring how Psychodynamic Psychotherapists used their professional knowledge in their everyday practice. I had found this to be a hazardous area full of ambiguity, uncertainty and stress for myself. My conversations with colleagues and my reading of the psychodynamic literature strongly suggested I was not alone in experiencing it in this way.

I came to understand my 'foreshadowed problem' (Malinowski 1922/1984) as having focused on the difficulty I perceived for therapists, working within a postmodern culture, of finding an appropriate status for and conception of the use of their professional knowledge in practice, given that they were no longer able to claim a simple correspondence between their theory and the mind of a patient (Mitchell,1993).

As the research progressed I developed and refined my aim and the language in which I expressed it.

This research has been focused on the practice of Psychodynamic Psychotherapy within the National Health Service in what may broadly be called the South Trent Region. In this region four Psychotherapy Departments have collaborated over the past twenty years to provide training in Psychodynamic Psychotherapy for their own

staff. Their collaboration over this period has helped to shape a culture of NHS Psychotherapy in the region. The therapists I interviewed were all employed within one of these four Departments as I am also. All but one had been involved with the South Trent Training either as student or trainer. I judged them to be well integrated into the clinical practice of Psychodynamic Psychotherapy within the NHS in the South Trent Region.

A Qualitative Approach

I made an early decision that the kind of enquiry that I was looking to conduct would be better explored through a qualitative approach to data (Silverman,2000; Barker et al,1994; Miles and Huberman,1984; Denzin and Lincoln,1994).

McLeod (2001:viii) suggests that qualitative research "involves doing one's utmost to map and explore the meaning of an area of human experience". In my research I was not looking for 'objective data' to quantify but rather to explore and interpret meaning and practice in relation to the phenomena I was investigating (Barker et al,1994). Qualitative methodology allows for the discovery and exploration of subjective meanings and handles and values more complexity, ambiguity and difference, all of which I felt would be crucial ingredients in my research. Qualitative research is more in keeping with the idea of exploring a phenomenon within everyday life and the conversations that comprise our interactions (Barker et al,1994).

Qualitative research for me sits within a postmodern perspective with its emphasis on the multiplicity of possible meanings that we ascribe to experience. The distinctive type of knowledge that qualitative research generates is familiar to therapists, McLeod (2001:viii) suggested, in that it is "holistic, nuanced, personal, contextualised, [and] incomplete". It can elucidate new ways of understanding others or a phenomenon. If conducted well, it can be *clinically significant* (though not necessarily statistically significant). The emphasis within qualitative research is on exploring how knowledge is *constructed*, rather than discovering a knowledge that is objective, singular and waiting to be found by a single reliable method. So within qualitative research there

are many "competing traditions" (McLeod,2001) which reflect the many different ways that meanings can be constructed with no one way as being able to lay claim to being *'the way'*. A degree of relativism is intrinsic to a qualitative approach, though not, I will argue later, to the extent that one can not be a 'critical realist' (Cook and Campbell, 1979) in outlook.

Such research incorporates the understanding that it is not possible to stand outside of one's research in some apparently neutral position. Rather the qualitative researcher has to locate him/herself within the research and ask questions about their own participation and the way it is shaping the research (Bannister et al,1994). In fact it makes intense personal demands on the researcher in a way that McLeod (2001:10) described (while not wanting to over-romanticise this aspect) and which my experience had supported :

> Qualitative enquiry generates uncertainty, ambiguity, a sense of the unknowability of things, a loss of boundary between self and other. These are experiences that can not easily be contained within a set of standardised research procedures, or, to put it another way, *should not* be so contained. It is the willingness to enter fully into the process of inquiry, a willingness to draw upon, (or risk) one's integrity as a person, that gives the best qualitative research its 'edge'.

Assumptions

McLeod (2001) argued that there is an interconnection between the question of what is the nature of reality (ontology), on what basis can we 'know' about 'it' (epistemology) and how can we enquire into and learn about 'it' (methodology). In this chapter on my methodology I need to state the pre-conceptions (about ontology and epistemology) that I have brought to this research and that have provided a shape to the analysis.

Ontology

I have brought to this research an assumption (an 'ontology') that a real world exists that has regularities to it and can be known but not in a certain way. Rather 'knowledge' has to be acknowledged to be partial and situated. This belief is referred to as 'critical realism' (Cook and Campbell,1979). I share O'Hear's belief (1991) that we have to be 'critical realists' at the end of the day because, without an assumption of a relatively stable world independent of us, we can not hope to categorise our experiences. Being 'realist' about our perceptions, he argued, does not mean that we naively assume everything is as it appears. With this position, knowledge is viewed as being "intersubjectively testable" (Cook and Campbell,1979) and in that sense a finding can be replicated (Barker et al,1994).

Social constructionism (Gergen,1985,1994; Berger and Luckman,1966) provides a different starting point as it asks not what is actually there in the world (ontology) but focuses instead on the way we come to ascribe meaning to experience (epistemology). I take the stance of being a 'critical realist' who also sees 'knowledge' as being shaped by societies and cultures. However I retain the critical realist viewpoint that there are criteria for deciding on the merits or 'situated reality' of such constructions (Barker et al,1994). I have explored this further in the chapter on the status of a therapist's professional knowledge.

As part of my beliefs about the 'nature of reality' (my ontology) I hold a humanistic perspective on the individual person as "a self-aware agent striving to achieve meaning, control and fulfilment in life" (McLeod,2001:106).

Epistemology

In my research I have been informed by the traditions of hermeneutics (Taylor,1971; Gadamer,1975) and phenomenology (Moran,2000; Osbourne,1994) both of which underlie qualitative research (McLeod,2001). Very broadly, phenomenologists attempt to set aside assumptions and pre-conceptions and live within what is being explored to become in touch with its 'essence' which may then take them beyond current frameworks of understanding. A hermeneutical perspective takes the line that our

assumptions and our pre-conceptions can not be laid aside but must be taken into the equation. Our perceptions and those of the 'text' being studied need to achieve a 'fusion of horizons'(Warnke,1987), a speaking to each other of the two worlds.

I have tacked between these two forms of 'knowing' in my research because they both, in their separate ways, contribute to developing understandings and counter-balance each other. One invites us to step out of our situated pre-conceptions while the other invites us to engage with them. These are both tasks which the researcher needs to attempt, as too does the therapist when sitting with a patient.

Data Gathering

I have outlined my approach to data gathering by a focus on the following:

- interviewing
- interviewing as conversation
- selection
- case study as frame
- semi-structured interviewing
- transcribing

Interviewing

Within the array of qualitative methods of enquiry I chose to explore the phenomenon of the use of professional knowledge in practice through *interviews* with NHS Psychodynamic Psychotherapists working within my 'local' South Trent culture. Interviewing within qualitative research has parallels with the work of therapy as both involve the encouraging of story telling and the construction of understanding from the stories and their form of telling.

Direct observation of a therapy was never an option to me. Psychotherapy is rightly a private process and the presence of a researcher would, I felt, be too intrusive. *Studying published transcripts* of therapy sessions or video or audio records of sessions conducted by therapists would have produced more distance in the research by taking me away from the immediacy of my local culture of psychotherapy and the

immediacy of personal contact with an informant. *Surveying* by questionnaire a group of NHS Psychotherapists would not, I felt, have allowed me to explore enough of the complexity and ambiguity of the phenomenon and would again have introduced a distance between the therapists and myself.

To me this area of research required a *conversation* with an informant in order to explore it and this led me to the method of interviewing. I was uncomfortable with the idea of interviewing a therapist *and* their patient outside of the therapy to obtain their separate accounts of the therapy as that too would have effects on the therapy that are difficult to calculate and therefore harder to justify ethically.

I chose to interview NHS psychotherapists from the four South Trent Psychotherapy Departments and therefore base my research on *therapist's accounts* of their clinical practice (Kvale,1996; Patton,1990, Taylor and Bogdan,1984). As a therapist myself, I am comfortable with the format of interviewing. My work centres around therapeutic interviewing and I value it as a rich and personal way of learning about others and about their experiences. I felt confident that I would be able to obtain the agreement of colleagues to such an interview and that this method would offer an accessible and ethical way of exploring the therapist's use of their professional knowledge.

I conducted eight in-depth, semi-structured interviews which lasted up to an hour and a half. I taped and subsequently transcribed them myself. I did not set out with the number of interviews as set at eight but found that the number allowed me enough opportunity to compare and contrast and learn from differences. I have regarded the interviews as providing a therapist's narrative account of two therapies with a focus on their use of professional knowledge.

Interviewing as conversation

Interviewing as a form of conversation may reflect the perspective that conversation can be conceived as "a basic mode of knowing" (Kvale,1996:37). Rorty (1979:389) suggested that "conversation [is] the ultimate context within which knowledge is

understood". Knowledge in this view emerges between people in conversation. Similarly Shotter (1993:vi) wrote:

> conversation is not just *one* of our many activities in *the* world. On the contrary we constitute both ourselves and our worlds in our conversational activity. For us they are foundational. They constitute the usually ignored background within which our lives are rooted.

A research interview has been described as "a conversation with a purpose" and "a special type of conversation aimed at gathering information" (Barker et al,1994:87), whose purpose "is to obtain description of the life world of the interviewee with respect to interpreting the meaning of the described phenomena" (Kvale,1996:5). A qualitative research interview generates not objective data to be quantified but meaningful relationships to be interpreted (Kvale,1996:11). It gives the opportunity to explore the subject's point of view and take on their experience. Open-ended questioning is seen as characteristic of such qualitative research interviews as they allow issues to be explored in their complexity and ambiguity with less overt control set by initial questions (Barker et al,1994; Kvale,1996). Conversely such open-endedness generates a lot of data and the potential for "data overload" (Miles and Huberman,1984).

Kvale (1996:13) described the many varieties of interviews and commented that "there is no common procedure for interview research". His book was a response to the need he perceived for much greater clarity in the use of interviews for research. In particular he wrote of the need to steer between a 'no-method approach' to interviewing with a spontaneous 'let's-see-what-comes' style and an 'all-method approach' that structures any freedom out of the interview.

Selection

I chose my informants with the criteria that they had completed a formal training in Psychodynamic Psychotherapy and were immersed in the culture of NHS psychotherapy in the region. I sought a balance of gender and some range of

professional background (i.e. social worker, nurse, doctor, occupational therapist but not in this instance psychologist). But I am not arguing that my choice of therapists as informants has allowed me to consider them to be in some way a balanced or representative sample per se of local NHS therapists. They are best seen as comprising eight individual case studies.

Case study as frame

I argue that the case defines the object of a study (Stake,1994) and is not in itself a method of study. As such it can be employed with qualitative or quantitative methodology. It can be described as a "bounded system" (Smith,1978) or "a frame for determining the boundaries of information-gathering" (Stoecker,1991:98).

Case study has been defined by Yin (1984) and Stoecker (1991) in ways which, with one exception, reflect my understanding. Yin (1984:23) described case study as " an empirical enquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used". Stoecker (1991:108) defined it as "a research frame with structural and historical boundaries, an integral theory component, an involved rather than distanced researcher, and multiple methods which include collaborative methods." I distance myself from these definitions around their insistence on "multiple sources of evidence" and "multiple methods".

Stake (1994) suggested three principle types of case study that he found inseparable in practice but helpful at least in clarifying a researcher's thinking. With an 'intrinsic' case study the researcher is seeking better to understand *this* particular case rather than intending it to illustrate a phenomenon or be used primarily for wider generalisation. With an 'instrumental' case study the researcher is using the case to gain further insight into an issue, phenomenon or aspect of theory and to that extent the case is looked at to help with this wider interest. With a 'collective' case study the researcher is extending the principles behind an 'instrumental' case study to the study of several cases.

Eckstein (1975) referred to the 'heuristic' case study which explored a particular problem through the case in order to understand its complexity and what theory and principles emerged from it. Stake's 'instrumental' and 'collective' case studies (1994) are similar and, with Eckstein's heuristic case study, come closest to my own approach. However these types of case study point to a balance to be struck and a tension to be held rather than resolved.

A semi-structured interview

My interview schedule of questions is appended (appendix A). I began with an initial question about the length of time the therapist had worked in NHS psychotherapy and a guess at the number of patients seen for therapy. I then sought to *ground* the interview in the therapist's practice with particular patients and so avoid (at least until nearer the end of the interview) more hypothetical questions about their practice.

So I structured the main body of the interview around the request to talk about two particular patients, one whom the therapist regarded as more psychologically 'healthy' and one who the therapist regarded as less psychologically 'healthy'. This provided a contrast that helped clarify how the therapist experienced themselves as organising their professional knowledge about their patient's psychological difficulties. I could then ask whether and how they felt they had shared their professional knowledge with these patients (and vice versa) and, therefore, how they felt they had negotiated 'knowledge' with their patient. In this way the style of the therapist's participation became clearer to me.

Later in the interview I asked more general questions, in particular about their own values and life philosophy which they took with them into the session. These more abstract questions could be addressed I felt after the interview had been well grounded in two clinical examples. I found these to be among the most moving parts of the interview. I also followed up with a question about what they perceived to be the limits of the psychodynamic approach for these and other patients.

Transcribing

I opted to transcribe fully for myself the tapes of the interviews. By doing so I got to know the full content of each interview very vividly. However in transcribing an important immediacy of the experience of the interview as a conversation is lost. Kvale (1996:166) commented that "to *trans*cribe means to *trans*form" and conversation is "frozen into a written text". The interviews move from being an oral event to the form of a written language, from speech to prose. Ong (1982) has suggested that oral expression tends more to the situational, participatory and empathic while written expression tends more to the analytic and distanced. McLeod (2000) has experimented with using poetic stanza to capture better the feel in writing of a conversation.

In transcribing the interviews from audiotapes I 'tidied up' the English both advertently and inadvertently, taking out some repetitions and gaps. I am comfortable with this as I was not aiming at a conversationally exact transcript. I then selected from within the transcript for a summary of the interview in line with my research focus. For reasons of patient confidentiality I am not free to reproduce the whole transcript. To that extent the reader lacks some opportunity to make their own assessment of the interview's content and compare it with my own and that is unavoidable in this context.

A Participant and an Observer

I work as an NHS psychotherapist and therefore I am part of the culture which I have explored. Atkinson and Hammersley (1994) described a range of positions for the researcher along the participant-observer continuum from complete observer through to complete participant.

My own position with regard to these is complex. I am part of the culture that I have been exploring. I undertook the South Trent Training which involved a process of socialisation into practice through the provision of supervised practice, personal therapy and theoretical seminars. I had a pre-existing relationship with my informants, some of whom I trained with while some were trainers to me and others have been

supervisees. My informants language was and is my own. This research has been driven partly by my need as an 'insider'.

While conducting the research I experienced myself as being in the position of a participant working to be more of an observer. The translation competence (Spradley,1979) I needed was one of learning to think and speak about psychotherapy in languages other than its and my own. In interviews with informants there was a danger I might think I knew what they were talking about too readily because we shared a common culture, in which we could implicitly think in terms of "people like us" (Mcleod,2001). I have been a participant trying to be more of an observer or rather I have been a participant and an observer, but had to work far more at the latter to gain some *critical distance.*

Van Maanen (1988) identified three different genres in qualitative writing. The first he called the *'realist tale'* in which a third person voice is used and the report reads like a documentary in which the author is visible only as the voice of authority. The second he called the *'confessional tale'* in which the author is more visible while still maintaining an aura of scientific authority. The third he called the *'impressionist tale'* in which the author included themselves and blurred the boundary between themselves and those who act as informants.

Patton (1990) referred to two 'typologies' that needed distinguishing in research accounts. There were 'indigenous typologies' that were expressed more directly by the informants. Then there were 'analyst-constructed typologies' generated more by the researchers perspective and language. Patton (1990:358) referred to the "legitimate charge of imposing a world of meaning on the participants that better reflects the observer's world than the world under study".

Silverman (2000:122) distinguished between 'realist' and 'narrative' accounts. The former seek to describe the "gritty" reality of other people's lives while the latter try to generate plausible accounts of the world. I saw these two as to be held in tension within a single account.

Given my involvement in the very culture I have studied I have inevitably told an "impressionist tale" and constructed a mixture of "indigenous" and "analyst-constructed" typologies. I have mixed a realist and narrative perspective. By involving my informants in a feedback process I have sought to be sensitive and inclusive though I still take responsibility for what I have produced.

I acknowledge my partiality within this research process (Abramson,1992) but do not feel it requires defence as such. It has been my own involvement in the research question that has inspired and driven the research. It has felt to be an asset to the research but I have needed to keep in mind the limitations (by way of 'bias') it has also imposed and take these into account in my findings.

Two factors have been important 'drivers' for me in my participation in this research. Firstly, after nine years of immersion in the practice of NHS psychotherapy I felt I was becoming 'short-sighted' in my practice. I needed a chance to step out and take a longer view. This dynamic of immersion needing to be followed by an overview from a fresh vantage point has happened before in my life. At the start of this research I felt the need to locate my experiences within a wider context and understanding so that I could better see where I had been and choose more where I wanted to go with my practice.

Secondly I have a deep ambivalence within me about the use of 'knowledge'. I have had difficult experiences of other people's 'knowledge' (ideology) being imposed on me as 'truth' which created a feeling of intense 'claustrophobia' in me. I have also had the experience of working or living without a framework of conviction to react to and define myself against which left a feeling of intense 'agoraphobia' in me. In the context of this research, I was aware that a therapist's use of their professional knowledge could be too smothering of another's viewpoint or be too vague. So this research has reflected and been a response to my own needs in important ways.

Ethics

Three key areas stood out for ethical consideration in this research:

- the need for informed consent on the part of the therapists
- the need to preserve an appropriate level of confidentiality for the patient and privacy for the therapist
- the need to weigh up potential benefits and harm in the conduct and outcome of the research

Informed consent

I began with a conversation with therapists who I wanted to interview about the research project asking whether they would be willing to participate. I took care to explain the purpose and style of the interview and to obtain informed consent. I prepared and sent to each a letter outlining my research and what I was asking of them. At the beginning of the interview I went over again the nature of the research and the interview and asked informants to sign a consent form (Appendix B). I clearly stated that the therapist could withdraw themselves from the research at any point, that patient material would be anonymised and the therapist given a pseudonym. I clarified that the patient material would be used only as a route to understanding the therapist's use of their professional knowledge and would not itself be a focus.

Following the interview I sent each therapist a transcript of their interview and invited comments. Subsequently I sent each a copy of the final form in which their interview had been summarised and analysed along with a copy of my provisional findings and a fuller summary of what the research was about. I invited comment to what was a lot of paperwork. I made further changes for one therapist to increase the anonymity of the patient material. Otherwise no concerns were expressed with the form and content of my summary and analysis of their interview.

Confidentiality

The use of patient material in the interviews to inform understandings of the therapist's use of their professional knowledge raises significant ethical questions

(Tuckett,2003; Bloch and Chodoff,1993). In 1995, the International Committee of Medical Journal Editors (ICMJE) argued that (Tuckett,2003):

> Patients have a right to privacy that should not be infringed without informed consent. Identifying information should not be published.....unless....the patient gives written informed consent. Complete anonymity is difficult to achieve, and informed consent should be obtained if there is any doubt.

The Editors of the International Journal of Psychoanalysis differed as they felt that seeking consent could itself be unhelpfully intrusive of the therapy. They argued for different rules for psychotherapy (Tuckett,2003).

Casement (1985:224-227) addressed this dilemma with sensitivity. On the one hand patients have the right to expect their therapy to be treated as confidential, with the usual provisos that information may be shared where there is identifiable risk to the patient or others (NHS Code of Confidentiality on Confidentiality,2003). The use of material from a patient's therapy in research is clearly contrary to this expectation. On the other hand therapeutic practice has developed and improved through the sharing of clinical experiences.

One solution to this dilemma is *never* to use patient material. However the quality of the practice of therapists with patients present and future arguably benefits enormously from the sharing of experience between therapists. Another solution is to use patient material *only with their explicit consent*. This 'solution' is not without its own difficulties. To talk about research within the therapy may in itself be experienced as intrusive and may "rock the boat of therapy" (Casement,1985) in a way that is very destabilising of the therapy. A further solution might be never to use material from *current therapies*. However time delays do not address the fundamental issue of patient confidentiality.

I have gone ahead and designed and conducted interviews that make use of patient material. I have not enquired whether patients were informed and their permission sought. I left that question to the therapists involved with them. I acknowledge that my position has some ambiguity. However I have gone ahead in this way because I felt that my stance and the form in which the patient material has been used can be defended in ways I now describe.

I feel I have preserved *sufficiently* the confidentiality of the patient material in the interviews. I kept the full transcripts of the interviews to myself with the exception of sharing parts of them with my supervisors. The patient material that has been included in the final version of this thesis has been reduced and *anonymised.* I left out specific features that might lead to any possibility of identification. As mentioned, I conferred with my informants about the final form in which their patient material would appear. In one instance this led to a request early on to reduce further the level of patient information which I duly did. I consulted with the local NHS Ethics Committee who made no objections to my research from the point of view of patient confidentiality.

My main focus in the research has been on the therapists themselves, with patients and their material in a supporting role only. The therapists themselves have appeared in anonymised form in the final document in order to preserve what has felt like an appropriate level of therapist anonymity. The pseudonym I gave each therapist was also one way of reducing any risk of the patients being identifiable given the accessibility this thesis should have.

I do believe that research focusing on the actual practice of therapy, rather than more abstract questions of theory, is vital to the ongoing professional development of NHS Psychodynamic Psychotherapists and therefore to patient care.

Potential Benefits and Potential Harm

I weighed up the potential for benefit and the potential for harm in this research as it applied to different groups. I considered the NHS psychotherapy *patients* about whose therapy I was informed by their therapists. I hope that, were they (or any other NHS

patients) to read this thesis, they would find the patient material sufficiently anonymised such that they felt their privacy had been adequately protected. I also would hope they felt their material had been used creatively for a better understanding of therapy to the benefit of practice.

I considered the therapists who gave up time to act as informants for me. Barker et al (1994) described the 'critical researcher' who works with informants as equal subjects rather than as passive providers of data. Cameron et al (1992) described research as needing to be 'on', 'for' and 'with' subjects. My very participation as an NHS Psychotherapist has made my role as critical researcher inevitable. In reality I have had to work harder to shed a potentially too sympathetic position towards the therapists I interviewed.

Selecting Within the Data

Selecting from within the data involved me in a process of exploring and 'playing with' potential frameworks for selection before settling on one framework that provided a 'fit' with my research design and aims.

Developing a framework

I undertook my analysis broadly in two stages. These stages, I found, were interwoven rather than distinct but nevertheless there was value in considering them separately. The first stage was descriptive in that I immersed myself in the narratives and got to know them as well as possible. I then moved on to an interpretative stage (Murray,2003). This latter stage involves what Ricoeur (1991) called "appropriation" whereby you come to own and put your stamp on the material.

Atkinson and Hammersley (1994:31) commented on the re-working of questions and categories that I found went on in my analysis of the interview data:

> much of the effort that goes into data analysis is concerned with formulating and reformulating the research problem in ways that make the research more amenable to investigation.

This stage of "appropriation" was undoubtedly the hardest part of the research. Strauss and Corbin (1990) have suggested that categories emerge from any one or a combination of three sources; the analyst, the literature or the informants. This has matched my experience of a continual and necessary interplay between these three. I had at times to leave aside the interviews and search the literature and refer to my own practice in order to gain perspective on the interviews. As a researcher who is also a therapist I have been informed by my own practice in which ideas have been tested out.

Within a case study there is a tension between the researcher's theory (that shapes the enquiry) and the uniqueness of the case itself. The researcher employing a case study frame explores both the common and the particular. Stoecker (1991:102) described this tension as involving a "tricky decision" just how much to rely on theory, and thus risk missing important idiosyncrasies of particular cases, or restrain theory and thus risk over-emphasising the idiosyncratic".

Stake (1994:238) described the damage that can occur when the tension is resolved too much in the direction of theory:

> Damage occurs when the commitment to generalise or create theory runs so strong that the researcher's attention is drawn away from features important for understanding the case itself.....the case study researcher faces a strategic choice in deciding how much and how long the complexities of the case should be studied.

Cochrane (1987) argued that research that does not employ a guiding theory is just "an accumulation of anecdotes". Stoecker (1991:102) described the need to develop a theory of the *idiosyncrasies* of a case.

I read the transcripts of the first three interviews with three questions in mind. These questions had emerged from my initial interest in the values and organising frames of understanding which therapists brought to therapy and how these were negotiated :

- what core theories/philosophies of life and healthy psychological living did the therapist espouse in the interview and how did they describe their role for them?
- how did the therapist talk about the process of negotiating understanding with patients, with what degree of conviction did they convey their understandings to their patients and to what extent were they apparently ready to be 'corrected' by their patients?
- in what ways did the therapist see themselves as having changed over the years in the way they employed their professional knowledge with patients?

There were several further 'evolutions' of my categories which I have not recorded here. Subsequently my developed and final categories for the analysis came together through further reading in the literature about the concept. It was important to me that categories should be 'action-oriented' so that professional knowledge would be viewed as an active process of construction of frames for thinking about a patient and their treatment.

A settled framework

Phillip's account (1999) of the place of *narrative* in therapy helped me design a frame for my analysis. My interviews, I decided, constituted narrative accounts, constructed in the interview with myself, of therapist's use of their professional knowledge with two of their patients. I adapted Phillip's framework (1999) for subdividing a narrative.

- the 'psychodynamic narrative' became the therapist's own account of the central tasks and struggles in psychological living and of what a person needs to do in order to be living the therapist's version of 'the good life'.
- I retained the idea of a 'developmental narrative' which described the therapist's view of the developmental origins of the patient's psychological struggles.

- I retained the idea of a 'treatment narrative' which described the therapist's view of how psychological difficulties should be treated.
- I added to Phillip's subdivision a narrative of 'attachment' in which I analysed the therapist's description of their relationship with and developing attachment to their professional knowledge.

I did not consciously attempt to replicate my findings by exploring each interview in the light of the findings from the previous interview. Clearly though this would have occurred implicitly.

Interpreting the Data

There is a confusing array of methods of analysis available to the researcher (Denzin and Lincoln,1994; Barker et al,1994). No one method of analysis, I found, could simply be pulled off the shelf and applied in simple, pre-determined form to my research. No one method has been sufficient or appropriate in itself. For me the method has emerged in response to the unfolding task I had set myself. Every design, and therefore every interpretation of data, has its limits with inevitable questions to follow about its validity (Barker et al,1994). "Creative compromises" are required with an accompanying awareness of "the implications of the choices made" (Shapiro,1989).

I found the metaphors of being a *'bricoleur'* and engaged in a process of *'patchwork quilting'* resonated well with my experience of this research. Denzin and Lincoln (1994) describe the 'bricoleur' as a researcher who is flexible in method and strategy. They quote Weinstein and Weinstein (1991:161):

> The meaning of *bricoleur* in French popular speech is 'someone who works with his or her hands and uses devious means compared to those of the craftsmen.....the *bricoleur* is practical and gets the job done.

According to this viewpoint the researcher has to fashion his/her own versions that suit the needs of the task. Methods in this sense are context-dependent as Denzin and Lincoln (1994:2) suggested in a vein that is in keeping with my findings:

> The *bricoleur* understands that research is an interactive process shaped by his or her personal history, biography, gender, class, race, and ethnicity, and by those of the people in the setting.

Rather than producing grand theories the researcher "cobbles together stories" (Denzin and Lincoln,1994). In the same way Saukko (2000) wrote of the patchwork quilt which does not present a simple, continuous and unified picture. Rather varying themes and ideas are stitched together in a way that allows for both resonances and disjunctures to be seen.

Retrospectively I would describe my method of analysis as being one in which I looked for *'patterns in the narratives'* of my informants and used elements of different methods to help me with this do this.

Options considered on the way

I began by employing *grounded theory* for my analysis but came up against what I felt to be its limitations. I 'sat with' and 'immersed myself in' the transcripts and tapes of the interviews. Grounded Theory involves an 'immersion' and saturation in the data and constant comparison and testing of ideas within the data. It involves an attempt to 'bracket out assumptions in order to be open to new understandings:

> The goal of the analyst is to generate an emergent set of categories and their properties.....the analyst codes for as many categories as might fit.....as the analyst gets deep into the data, he discovers that all data can be subsumed as an indicator of some category in the analysis.....a total saturation occurs : all data fit (Glaser,1978 :56-60).

I sought to ground myself in the data but instead found myself *ground down* by the data. Useful categories would not organise in my mind and I found the quantity of data in the interviews to be quite overwhelming. I felt Glaser's description (1978:56) to be very idealistic.

Ethnography (Spradley,1979) focuses on the way 'reality' is constructed within cultures through communal actions such as rituals and other social practices of the culture. This was not in keeping with my exploration of the phenomenon of the use of professional knowledge. Narrative analysis (Mishler,1986; Riessman,1993) offered an emphasis on the story-as-a-whole as the primary data and the way 'reality ' is constructed through language. However my focus was not on analysing the story-as-a-whole for it's narrative style or approach, noting tone and emphases and sub-plots within the narrative. In retrospect I would say I have employed a *'narrative-informed'* analysis.

Discourse analysis (Parker,1999; Potter and Wetherell,1995), conversation analysis (Edwards,1995; Miller and Silvermann,1995) and narrative analysis each invite a researcher to look at the way meaning is *constructed* through our 'talk' and they are approaches that psychotherapists have hardly started to utilise (McLeod,2001). However discourse analysis and conversation analysis in particular both come from a social perspective that emphasises social agency and deconstructs psychological ways of viewing. While valuable, this does not fit well with my assumptions and the assumptions of psychodynamic psychotherapy.

Evaluation

Barker et al (1994:80) suggest five criteria for the evaluation of qualitative research:

- There should be an *openness* as regards the assumptions and orientation of the researcher.
- The method adopted should be described with sufficient clarity to allow another researcher to *replicate* the work.

- Enough data should be available for the reader to make their own judgement as to the validity of the themes and categories the researcher has identified from the data.
- The researcher should have demonstrated ways in which they have sought to validate their results.
- The results should be credible and have opened out and made sense for the reader of the phenomenon.

I have been guided by the above in my approach and have addressed the first three criteria already in this chapter. I describe now my perspective on the *validity* and *credibility* of my findings.

Validity

As a researcher I have necessarily addressed the question of the internal and external validity of my findings. Denzin and Lincoln (1994:100) defined internal and external validity in the following way:

> *internal validity* [is] the degree to which findings correctly map the phenomenon in question; *external validity* [is] the degree to which findings can be generalised to other settings similar to the one in which the study occurred.

Judgements about the validity of my findings will depend on the stance taken by the reader with regard to specific critiques of case study which have emerge from more traditional criteria as to what constitutes validity. I now set out critiques of case study validity, responses to these critiques and my own stance in relation to them.

Critiques of the validity of case studies

Case studies have been criticised as valid contributions to knowledge for being merely descriptive, lacking internal validity through being biased and lacking external validity through being incapable of generating findings that can be generalised.

Stoecker (1991:89) suggested some sociologists have viewed case study as "little better than journalism" and a collection of "anecdotes". Fonagy and Target (2003:283), in considering how influential case study has been within psychoanalysis, suggested that "there is some truth to the quip that psychoanalytic technicians understand the word data to be the plural of the word anecdote."

The criteria for validity in these criticisms are those employed within the traditional metaphor for the process of scientific discovery. This describes the scientist making observations, inductively organising a theory from these observations, formulating a prediction from the theory and then verifying (or not) the prediction and therefore the theory by further experiment or observation (Abramson,1992). The emphasis is on what is typical and normative. According to this criteria the *internal validity* of the case study is compromised by 'researcher bias'. The researcher lacks a 'scientific distance' from the data and has no built-in corrective for this (Bromley,1986, Becker,1968). (Additionally case study researchers are deemed too retrospective in their conclusions and arbitrary in their definitions). The *external validity* of the case study researcher is compromised by the researcher's inability to demonstrate that their findings can be generalised (Berger, 1983) which only wider probability samples can provide.

Responses to the critiques

One response has been *"to try to inject scientific rigour into the case study"* (Stoecker 1991:92). To meet the charge of a lack of internal validity, 'triangulation' has been advocated (Bromley,1986), continual data collection (Kazdin,1981) and comparisons with competing theories (Campbell,1975). To attempt to tackle the limits of external validity the use of case comparison has been suggested (Platt,1988) along with multiple methods and multiple sources (Yin,1984 and Stoecker,1991)

An alternative response has been to highlight how case study research *cannot and need not* meet the criteria set for it in these traditional terms. Case study researchers, it is argued, need to renegotiate the terms of the debate and the assumptions on which they are based. For Abramson (1992) case studies did not generate verifiable

predictions and constituted a "weak experiment". He advocated avoiding "unnecessary window dressing" in an attempt to "falsely inflate the scientific appearance of a case study" so that it meets these traditional scientific criteria.

Silverman (2000) questioned the assumption of a definitive version of reality to be uncovered within data and argued that a researcher cannot just aggregate data to get to an overall truth. Hammersley and Atkinson (1983:199) wrote that "one should not adopt a naively "optimistic" view that the aggregation of data from different sources will unproblematically add up to produce a more complete picture". Kvale (1996:4) advocated the metaphor of the traveller who reports in narrative form of his travels, rather than the metaphor of the miner who uncovers knowledge.

The researcher employing case study can, then, ask the reader to judge the validity of the research not by whether the researcher has generated findings that can be viewed as 'typical' or 'normative', but rather whether the researcher has generated findings that are 'plausible' (Stoecker,1991) and display a "theoretical cogency" (Mitchell,1983). Validity is to be judged not by the capacity to predict but by the capacity to explain. This criteria centres not so much on a claim that the research produces findings that correspond to 'reality' so much as on a claim that the findings are coherent and consensual (Hamlyn,1970).

The need for and logic of an unbiased 'scientific distance' is questioned as observation is always 'theory dependent' (Chalmers,1982) and requires "a creative leap from data to explanation" (Stoecker,1991:93) in order to produce theory. 'Scientific distance' is a form of "disembodied knowledge" (Haraway, 1988) and a "denial of connectedness" (Stoecker,1991). Scientific theorising develops within paradigms that shape theorising (Khun,1962). While the data offered in case studies will be marked by "forgetting, blending, personal bias, and factual distortion" (Abramson,1992), the data offered in quantitative surveys, are also marked by a degree of bias as questions posed mean different things to different informants (Stoecker,1991).

The attempt to be objective, if taken too far, may mean we miss out on seeing the idiosyncratic responses of ourselves and our informants. So Stoecker (1991:96) suggests we should perhaps develop "a theory of the idiosyncratic rather than a theory of the general" and look to ourselves for some measure of validity:

> Only when we recognise our personal involvement, and our 'subjects' personal involvement in the research process, do we understand how our feelings and perceptions affect our analysis...Rigorous, accurate research.....requires the self-conscious involvement of the researcher.....the less we know of the experience of a situation, the less we are able to tell whether our explanation works (Stoecker,1991:106).

A valid case for case studies

I share the views expressed above that researchers employing case studies as a frame do not have to meet traditional scientific criteria of validity. I hope the reader will judge my findings rather on the basis of their 'plausibility' and 'theoretical cogency'. My participation, also referred to as 'bias', is something for me to take account of in my findings rather than something that invalidates my findings per se.

Mine has been 'intensive' research rather than 'extensive research' (Harre,1979; Sayer,1984) in that my emphasis has not been statistical with a sole focus on the 'normative'. Rather I have explored the more particular and specific and sought to move outwards from that starting point.

I do not share the argument made by several writers that the general can be found in the particular at all times. Sacks (1984:22) wrote, "tap into whomsoever, wheresoever and we get much the same things". Eisner (1981) argued that "the general resides in the particular" and Burawoy (1979) that the case contains "the essential principles of the whole". While I see a measure of truth in this, I am cautious about it being too simplistic a position. Silverman (2000:109) cautions that "this solution is really only appropriate to the most basic research on social order guided by theoretically sophisticated positions like Sack's own conversation analytic approach".

In my findings I have sought to 'extrapolate' from the particular case studies (Alasuutari,1995). By 'extrapolation' in this context I mean a process of inferring more widely from a limited range of known facts. I have shared Silverman's stance (2000:99) that "it is usually far better to celebrate the partiality of your data and delight in the particular phenomena that it allows you to inspect".

I view my findings as a contribution to enlarging the scope of knowledge about human lives (Pletsch,1985); as inductive input that is relevant to the formation of theories and hypotheses (Abramson,1992); and as "a small step towards grand generalisation" (Stake,1994).

In order to avoid being unduly idiosyncratic in my research and findings I located my research questions within the literature. I involved my informants in my findings by providing copies of the analysed interviews and draft findings. Over the seven years of this study I tested out themes against practice, both my own and that of my colleagues. This has meant my findings were open to being refuted by my experience and my perception of the experience of my colleagues. There has been a continuous loop of feedback between my interviews, my reading and my ongoing practice as a therapist in a community of local NHS psychotherapists. Eight interviews have allowed a measure of comparison to be made across the interviews and a chance to note deviance of perspectives.

Credibility

Stake (1994:241) argued that "knowledge of the case faces a hazardous passage from writer to reader" and that "the writer needs ways of safeguarding the trip". Barker et al's (1994:80) fifth criteria for evaluating qualitative research was that "the results should be credible and have opened out and made sense for the reader of the phenomenon".

One way of "safeguarding the trip" is by offering the reader a space for discovery learning as well as propositional learning (Eisner,1985). So, on the one hand, the researcher teaches in a didactic way what they have learnt in the form of

'propositional knowledge'. On the other hand, the researcher also teaches by providing an opportunity though the narrative account for the reader to enter vicariously the world of the research and live within it through a form of experiential knowledge (Geertz,1983; Polanyi,1962; Stake,1994). In part the trip that needs safeguarding involves a highly personalised research project which then meets a highly personalised response in the reader. Stake (1994:242) commented:

> Case researchers pass along to readers some of their personal meanings of events and relationships- and fail to pass along others. They know that the reader too will add and subtract, invent and shape – reconstructing the knowledge in ways that leave it differently connected and more likely to be personally useful.....
>
> Meanings do not transfer intact, but take on some of the conceptual uniqueness of the reader, but there is expectation that the meanings of situation, observation, reporting, and reading will have certain correspondence.

I inevitably make an internal judgement on the credibility of my research and its findings. My submission of this thesis to the University of Derby for a Doctorate has expressed my internal judgement. Externally credibility rests to some extent on my capacity to convey to the reader an account that is experienced as 'plausible' and containing 'theoretical cogency' both in terms of propositional knowledge and experiential knowledge.

At this point arguments previously made in this chapter come to the fore about the limits of employing solely correspondence theories to judge credibility. Hamlyn (1970) offers three other criteria for judging credibility, namely coherence, consensus and pragmatic usefulness. I have addressed these in the chapter on the status of professional knowledge and argue there and here for credibility to be judged through a combination of the these four positions in interplay. No single criteria is sufficient in itself as each has value but each is fallible (Barker et al,1994).

Summary

In this chapter I have described for the reader how I set about and conducted a critical investigation into the way in which eight local NHS psychodynamic psychotherapists described their handling and management of their professional knowledge with a patient. I have outlined the qualitative approach I employed to gather my data and the ethical issues involved in the study. I have outlined the 'natural history' of the research and the nature of my participation in the research. The categories and method I employed for my analysis and the status of these findings has been described.

In the next chapter I have presented the interviews in the form of therapist narratives of living the 'good life' psychologically, the development and treatment of psychological problems and what I have termed an attachment narrative.

THE INTERVIEWS

Interview with Martin

In the interview Martin gave an account of:

- how he approaches the construction of an understanding of the patient's difficulties in psychological terms and works to establish whether a therapeutic alliance is possible.

- his professional knowledge in practice as reflecting "tentative understanding expressed with a reasonable degree of conviction".

- the need to assess realistically the possibilities of change and the significant risk of deterioration and alter treatment as required.

- the need to recognise the limits of understandings and not confine himself to psychological understandings that do not take account of biological and social factors.

- the importance for psychologically healthy living of not allowing the inevitable disappointments of life to prevent the enjoyment of what life may also offer.

- an understanding of the building of a 'closed internal world' in which traumatic experiences may be held 'incommunicado' and prevent the present being seen in its own terms.

Patient Summaries

Patient One was described as a woman who was "quite an energetic and organised person" and who had a career and a relationship. However she experienced a level of mild to moderate depression that meant that she paid an 'eternal price' of feeling bad about herself. At the time of the interview Martin was in the process of providing six sessions of therapy that he hoped would be enough in themselves to engender some hopefulness and possibilities for change given that the patient appeared to him to have the capacity to tackle psychological difficulties. So this patient was presented as the psychologically healthier of the two. A central issue was described as her tendency to avoid conflict due to early experiences (unspecified) that had led her to repress her assertion. Martin hoped that in six sessions she might become more able to detach past responses to her assertion from the present possibilities and so be 'launched' towards a different relationship with her own assertion.

Patient Two was described as a woman who, around the time of giving birth, 'remembered' experiences of being sexually abused as a child. She was felt initially to be suffering from a 'moderate depression' and referred for psychotherapy. She was assessed and taken on by Martin. However she became increasingly depressed, retarded, unable to sleep and had some thoughts of suicide. She then described delusions and alternated between being convinced of their reality and knowing they were delusional. She had not disclosed these delusions up until this point. Both Martin and the patient linked the worsening of her mental state to the attention being given in the therapy to her previously repressed and deeply upsetting experiences. She became unable to dissociate her present situation from her past experience and Martin arranged for her admission to psychiatric hospital. If Martin had known at the start that she was already experiencing delusions then he would not have offered therapy. Once it became clear, then the patient was steered away by him from uncovering, exploratory therapy towards a different type of containment.

Martin's Psychodynamic Narrative

Martin describes a psychological task of managing the difficulties of life in a way that allows us to enjoy the good things life offers. He expresses concern that a culture of disappointment or disillusionment might gain the upper hand in our internal worlds. He expresses this in these terms:

> Well that pain and disappointment are part of life, that it's often a struggle, that in a broad sense hatred is inevitable not necessarily I think because of a biological endowment but it results from the impossibility of providing a perfect environment, but that those difficulties can be managed in a way that allows the better things to be experienced and owned and lived so that on balance it's worthwhile and that you have to accept the flawedness of the world and the people in it and not be so totally disillusioned by it that you can't experience also the joy and pleasure, the love in the world. This stuff sounds like Desiderata or something doesn't it?

It is important to be able to see the present in its own terms rather than automatically viewing the present through the lens of previous experiences. Martin refers to this as "the capacity to dissociate the past from the present" and "to detach the origins from the present". In Object Relations terms this task can described as the management of our internalised bad objects in a way that does not allow them to overwhelm or dominate our internalised good objects.

Our lives involve the interpenetration of three spheres; the biological, the psychological and the social. It is important to keep a perspective that includes awareness of the influence of all three rather than over-privileging and over-objectifying one. There is a tension to be held between being too soft-edged or too hard-edged about a psychological perspective:

But I suppose in my way of thinking there is likely to be something within the [second] patient and who knows possibly with a strong biological basis that predisposes her to psychotic breakdown and some patients become terribly obsessional [while] others become very significantly phobic....why should someone become psychotic as opposed to any other thing that can happen with people to break down to various illness patterns? I don't think the answer can be wholly psychological. I don't think it can but that does not mean to say I have got the answer. But my inference and my guess would be that there is a biological component.

A realistic assessment of the possibilities of change is needed:

.....for people with this sort of problem ..... it seems that the illness has woven its way into their personality so they become rather depressive personalities, so that a careful assessment needs to bear in mind that change is difficult and the last thing people like this need is another experience of failure.

Sometimes you find with people like this particularly as they reach middle years that they are so bedded into social and interpersonal structures that their room for manoeuvre, for change, is very limited. They may be struggling with some real physical impediments to striking out on a new course.....change is not always possible, it really isn't.

Martin refers to the 'stress diathesis model' which he links to the metaphor of architecture. The reality of the flawedness of life means that we all have 'fault lines' in our psychological development. These can be thought of as predispositions or weaknesses that sufficient stress can open up so causing severe mental pain. In architectural terms our foundations carry an number of weaknesses that severe weather might expose but benign weather may leave quite undetected. Severe stress may overwhelm the defences of repression in the closed internal world in an uncontrolled way and lead to breakdown.

Martin's Developmental Narrative

Within the psychological realm Martin draws on the thinking of Fairbairn for his developmental narrative. Fairbairn emphasised the impact of the very earliest years in creating an internal culture within a person. While Martin takes a slightly wider view he comments:

> But at least it is arguable that early experience leaves a pretty indelible stamp.

The better the quality of childhood experience the greater is the development of an inner strength that Martin refers to as 'ego strength'. So the first patient:

> .... is a person who feels bad about herself and yet in many ways her life actually is reasonably successful in that she works, she holds down a relationship in life. She has come through quite a difficult childhood with some chronic impingements on her development and some difficult to manage, if not traumatic, events. She has grown into adult life with what you might call a serviceable ego - psychotherapists would talk about ego strength - with a level of ego strength that enables her to manage many aspects of her life but with an eternal price to be paid in terms of low self-esteem and a mood of mild, sometimes moderate depression.

He suggests that when experiences become unmanageable for the infant they are internalised as a form of defence and locked away in a 'closed internal world' where old and new experiences can not be held in tension. He describes this closed internal world as:

> .....the repository of defensively determined introjections that the child, developing in a situation which he or she cannot manage, can't deal with, [which] causes intolerable mental pain, so it is defensively introjected and it is deposited in a closed internal system, so it is no longer an open

> system, no longer something that can be modified by experience, it's a bit of the patient that remains immature and ground down ..... and therefore it operates at the thinking level of the immature mind and there may be primitive splits made between good and bad objects and the self in relation to those objects.

Under sufficient stress the defences of the closed internal world can later collapse in an uncontrolled and terrifying way. Perhaps the greater the degree to which an experience can not be managed the greater the force with which it is repressed and held 'incommunicado', as it were, in the closed internal world. The more closed the system the less it is open to 'reality checks' and the less able a person is to respond to the present in its own terms.

For Fairbairn the emphasis was on actual experiences of the world which are then internalised with a mixture of objectivity and subjectivity. These internalisations are not analogous to photographic memories but are transformed and distorted. So for the second patient the delusions were a representation of her sense of something menacing and bad inside herself. In object relational terms they were distorted part-objects.

Martin's Treatment Narrative

As both of Martin's clinical examples come from the early stages of therapy so he is describing his approach to organising his thinking and this shapes to some extent the treatment narrative he describes.

Martin feels the need to gain a sense of the patient's difficulties and then organise his thinking around a diagnostic sense which provides a provisional sense of objectivity, as it were. He acknowledges the limitations of this approach:

> Well I like to see the phenomena in themselves, the thing in itself, before trying to make a meaning of it or sense of it. The approach has grave limitations in terms of trying to reduce the complexity of human nature to the diagnostic categories. But I feel on balance that if I don't do anything like that I am rather at sea. So I try if possible to get some kind of descriptive category assigned to a patient....kind of psychiatric.....yes, some sort of diagnostic sense.

Further the patient needs from Martin "a thoughtful response", "as good an assessment as possible" and "not another experience of failure".

Then there is an exploration of whether common ground can be found between therapist and patient in terms of seeing whether a shared psychological understanding of the patient's difficulties is possible. This requires the patient to have an ability and willingness to think in psychological terms about their difficulties:

> There is a dimension that one tries to take note of and assess called psychological mindedness. It's a quality of personality that varies between individuals and what one tries to do is see how a particular person is in terms of that dimension, on the basis that the more psychologically minded they are , the more they can make use of the psychotherapeutic process. And conversely the less psychologically minded.....though it's gradatious, it's not an absolute thing, it's not an on or off, it's one patient has more or less.
>
> I suppose central to this would be - when I am working to a psychodynamic model - would be the extent to which I can build with a patient a preliminary, prima facie psychodynamic understanding. An important part of that would be my offering trial interpretations, to see whether an understanding fits with the patient..... What you are looking for in therapy is the therapeutic alliance, you and the patient have some sense of shared understanding of where the difficulties are, how they have

arisen in interpersonal terms, or for you and I in object relations terms..... So I am looking for the response of the patient to my observations framed in the form of interpretations as to what the problems are and what hopefully often, how they may be tackled. And if there is a sense I can have with a patient that they are of a similar mind, that they can get hold of something that makes some sort of preliminary sense to them, then I think that is the basis for the therapy.

What I want to convey to a patient at the outset is the tentative understanding, expressed with a reasonable degree of conviction " look I think this is what is happening" but either implicit or even explicit is "but I may have got this wrong".

Therapy focuses on an exploration of the internal (and external) world of the patient and requires a balance between a sense of security in doing this and a sufficient level of risk. The concept of 'containment' is employed to describe the necessary sense that exploration can be managed without difficulties spilling out in an uncontrolled way. A key task of therapy centres around the concept of the closed internal world and the tendency for people to view the present in terms of past experience even when the links appear tenuous. Therapy involves trying to detach the past from the present :

Sometimes you can see in a relatively short therapy some insight into the origins of that [problem with assertion] and an ability on the patient's part to detach the origins from the present. It frees them up to be more assertive in the present.

Ongoing assessment is needed and Martin clearly voices the need to take careful account of the risk of an exploratory and uncovering therapy prompting a break down or being insufficient and the patient becoming unable to manage themselves. There is a need for therapists to notice when an alternative form of treatment might be necessary. Martin talks about this in terms of an alternative form of 'containment':

If we work with the more disturbed patients then the potential is always there in any of the patients of having significant breakdowns.....the containment that is required may need to be much wider than can be provided in [once weekly] psychotherapy. The process itself of encouraging patients to look beyond their defences can result in a worsening of the symptoms or ...illness. When a surgeon operates there is a bit of blood around. There has to be ... But you think, 'well the trauma of the operation is worth it because of the benefit that will occur in the long term'. You have to recognise that therapy itself - and this is one reason why therapists place so much value on their own experience of therapy- can be jolly uncomfortable and itself a disturbing process.

It's difficult when you have to make some sort of assessment at the outset and during the course of a therapy as to whether or not.....the evolution of the therapy will be bearable and manageable by the patient. There are some who break down or become symptomatically much worse. You can make things worse as well as get better. You need as a therapist to be able to spot that, rethink your strategy and involve other agencies if necessary.

I think this particular sort of patient [patient two] will be contained by say attending the Day Hospital for five days a week for four or five hours a day which is more than we can provide in a once weekly group for instance and I think it's a question not so much of giving up containment as the nature of the containment that is required and it might be a psychiatric hospital that is required.

A further problem in treatment is described in terms of the passivity of some patients:

Patients who seem passive and don't interact in a thoughtful and questioning way are hard work in therapy, if they can make much progress. So that would be another aspect of the assessment that would be crucial and it's linked to psychological mindedness. With an extremely

passive patient, one who is overawed perhaps with a sense of authority from the doctor/therapist is one where it might be difficult to strike a therapeutic balance. So I am certainly looking for a patient who can come back at me at some things if they think they are misunderstood.

Therapy needs to take account of the limits to change and the capacity for insight to be double-edged and add to a sense of despair and failure:

Well if you look at the long term outcome for people with this sort of problem [patient two] when they are mildly or moderately depressed then it seems that the illness has woven its way into their personality so they become rather depressive personalities, so that a careful assessment needs to bear in mind that change is difficult and the last thing people like this need is another experience of failure.....Sometimes it seems in talking to a patient that there are certain areas of their personality functioning that might be open to change. Sometimes you find with people like this particularly as they reach middle years that they are so bedded into social and interpersonal structures that there room for manoeuvre , for change, is very limited. They may be struggling with some real physical impediments to striking out on a new course.

.....or supposing that insight into their situation is necessarily very welcome. It may be that it adds to their sense of despair. It does not have to but occasionally I see that if these issues have not been carefully handled....a patient can become even more dissatisfied with ....their situation at their inability to cope.....

The more closed the system the less it is open to 'reality checks' and the less able a person is to respond to the present in its own terms. So, with the second patient:

So what seemed to have happened with the course of the therapy was that the defensive structures around this closed internal world had broken

down and the therapy had played a part in doing it, it had encouraged it. I had said "look this may be difficult.....get to the other side of it". But the defensive structure of her mind ,which was holding this closed internal world collapsed in an uncontrolled way , a way that she did not experience herself as being in control of and .....it was no longer containable.....

Well, one I think that her ego strength was insufficient to bear the...pain associated with undoing of repressed traumatic memories and it fractured, it split off in accusatory objects and projected them into the [delusions] so that what I believe was that the impact of therapy was very significant in disturbing her mind .

Martin's first patient appears to him to be somebody well-placed to use psychotherapy over a few sessions and to tolerate the more 'doing to' side of therapy. He views her as "energetic and organised person who can tackle things". His language conveys the aims of treatment. Six sessions of therapy might be sufficient to "launch her", "free her up to be more assertive in the present", "give her enough sense of hopefulness or the possibility of change".

Martin's Attachment Narrative

Martin describes how his professional knowledge and reasoning is informed by an interweaving of his personal and professional experiences:

It [my philosophy] sustains me.....well it keeps me going and if I was not able to keep going then I would not be able to function as a psychotherapist. Well I don't know if I would be able to function as a human being and certainly not as a doctor or therapist.

I suppose it [my understanding] is a way of thinking about the world that was clarified by my psychotherapy training - the way of thinking then

became clothed in analytic language, became much richer because of the unique way it has of describing and understanding human nature but clearly it was there before.....It found a mode of expression. I am not sure but I could have been a surgeon theoretically and done good by being a surgeon which would have been satisfying in the way of expressing something of my wish to be useful and assert the value of life but in a very different way from what I am doing now.

However his attachment is a 'critical' one. It involves acknowledging the limits of understanding in general and inherent in any one perspective on the world. No one view holds a monopoly of understanding but he postulates his own 'law' of theorising whereby people attempt to assert such a monopoly:

good ideas always get taken to the point at which they no longer are good ideas. Everything is pushed to the limit where it fails. Perhaps it has to do that. So biological understanding of the minds processes becomes patently absurd at some point. But so does the psychoanalytic work.

There is a risk, he feels, of mistaking understandings for explanations:

Well I think finally that analytic models are for understandings of human nature and understanding is not the same as explaining.....Well you might see somebody who seems in a very happy mood, boisterous, lively, joyful and you might think that something good has happened to them, perhaps they have won the pools, they have met somebody rather wonderful or their PhD has just been accepted or whatever. But actually somebody might have spiked their drink and they could not tell it. They think it's just a cup of coffee but there is actually something in it which is affecting them but they don't know it and they may be attributing their good mood and boisterousness to whatever.

Martin reflects on the domains of the biological and the psychological noting that it is very difficult to talk about them in a way that does not suggest a 'dualistic split', that does not distance one from the other. He suggests that there is perhaps a biological component that predisposes a person to develop a psychosis rather than a phobia. He does not want to support the idea it is all about the domain of the psychological. However his view about possible biological components to the patient's illness is classed as an "inference" and a "guess":

> Yes particularly when it comes to what is termed the interaction between something biological and what is termed psychological. And we use those terms for convenience. However much we want to get away from the dualistic split in fact it's very difficult to talk about these things except in language which then distance themselves one from the other. Depression can be thought about in terms of changes in brain chemistry as well as in terms of conflicting forces within the psyche.
>
> Practically holding a position as I do, it's an aspect of our work in the clinic and the team as a whole that I have been particularly mindful of.....Why do some people, in relation to traumatic experiences which happen, develop neurotic conditions, like neurotic obsessional-compulsive disorder, why do some breakdown for instance, why do some people for instance develop serious personality disorders? I have not felt my understanding of the process has not been very enriched by psychoanalytic theories but there are still many areas where that understanding may be false perhaps because it's difficult to check out or where they need explanatory mechanisms of a different sort, belonging to a different domain, a biological domain or part of the social world domain.

Martin declares his own position that the brain does not determine the function of the mind :

> ...I locate the mind in the brain but suppose that brain function constrains mind function, does not necessarily determine it but it will constrain it and the ways we have of understanding brain function may require a different a different language, a different science from the way we understand mind function. But I think .....we function with the mind.

Summary of interview with Martin

In the interview Martin expressed :

- the tension to be held between competing perspectives, namely the biological, psychological and social perspectives and the hazards of over-privileging or over-objectifying one perspective at the expense of the others.

- how his professional knowledge reasoning is informed by a mixture of his personal and professional experiences and so emerges from his life 'situation'.

- the importance for therapy of the two subjects involved, namely the therapist and the patient negotiating a shared space where they can come together around some measure of a psychological understanding of the patient's difficulties.

- the potential for closed, 'hard-edged' internal cultures within our personalities.

- the need to recognise limits to change and to possible selves within the patient such that potential counter-cultures within the patient may be unable to thrive.

- the hazard that the actively exploratory 'doing' side of therapy might overwhelm the defences of a patient such that they need a different culture of therapeutic containment.

Interview with Mary

In the interview Mary gave an account of:

- the importance of facing 'reality', both internal and external.

- the centrality to the therapy of the lived experience with the patient.

- the importance of being direct as a therapist and addressing risk but within the context of a long-term therapy relationship.

- a fit between her theoretical base, her own philosophy and her professional style.

- her understanding as situated in a particular place, time and set of personal values.

- the value of being able to recognise how much is unknown and the importance of holding a tension between open and closed systems of understanding.

Patient Summaries

Patient One was described as the more disturbed patient. She was a single woman involved in highly conflictual relationships and with high risk behaviour, designed, Mary felt, to keep at bay disturbing feelings within herself. She had described a very disturbed upbringing in a family permanently 'on the edge'. Her own mental health appeared also to be 'on the edge' and Mary felt her disturbance was powerfully re-enacted in the therapy. For Mary, the therapy was experienced as "hard work" and "worrying" and necessarily focused at times on questions about the patient's safety and risk to herself and others and whether Mary might herself have to intervene. (Perhaps this was similar, Mary felt, to the professionals who observed the patient's childhood family and debated whether and when to intervene.) The patient appeared to lack a capacity to observe herself and to 'speak reality' to herself - a role which Mary felt she had to take on. Therapy involved working to enable the patient to 'face reality', both in terms of her own internal feelings and in terms of her behaviour and its effects, potential and actual, on others. Mary saw evidence as the therapy progressed that the patient was becoming better able to reflect on herself and her behaviour and challenge herself.

Patient Two was described as a less disturbed patient. She was a woman with many obviously healthy aspects to her personality. She held down a good job, generally functioned well and could make and sustain relationships though not without difficulties. Mary understood her to have come to therapy out a sense that she found it hard to trust herself to a relationship and did not feel a sense of control and direction in her life. Her well-loved father had died in her childhood and Mary understood the experience of this loss as an ongoing deterrent to further deep attachment. The therapy relationships felt warm and engaging to Mary. The patient's affairs with older men were understood by Mary in oedipal terms. The patient was creative and responsive in the therapy as well as being able to voice disagreement. As therapy progressed the patient voiced her sense that she was becoming more able allow intimacy and more able to direct her life creatively.

Mary's Psychodynamic Narrative

To live a psychologically healthy life we need to be able to "face reality". The 'reality' Mary is referring to is of the disturbance and psychological need within ourselves, at whatever level we find it to be as well as the reality of our behaviour and our relationships. Mary describes this as involving a 'doing' and a 'being'. The 'doing' is implied in the idea of 'facing' reality and the 'being' is implied in the idea of the need to 'bear' psychic pain. She describes it this way:

> I suppose it is about facing reality. I think we all evade reality all the time but some more than others and yea I think it's that, facing reality and the pain that that involves and learning that that pain is bearable. I think a lot of people believe that reality is too - too unmanageable. I suppose that's the main thing.

Evading reality has consequences:

> I suppose it doesn't work not to [face reality]. People run into such difficulties. Obviously there must be some people who manage. I suppose if you are extremely rich and can organise your life in such a way but then I still think you damage other people so I think there is still something about - well, obviously there is the experience of the individual but there is the impact you have on those around you and if an individual is not facing what is going on in their life often they are damaging those people close to them, if they have people close to them.

> I was thinking of someone like Paul Getty who sounds like he has got a lot of difficulties but he is so wealthy that he can create an environment in which he does not have to get close to anyone. But I imagine if you worked for him it would be hell. So the idea that you could construct a life where it wasn't damaging anyone else - pretty unlikely. But not

everyone will come for therapy. People who come have some sense that something is wrong.

Evidence for such psychological health is found in the capacity to maintain more equal, non-abusive relationships, to sustain meaningful employment and to live honestly with oneself and others. In therapy health shows itself as the capacity to use the therapy creatively.

Psychological ill-health may show itself in a variety of ways; psychiatric symptoms such as delusions or hallucinations; in drug and alcohol abuse; in high-risk living, and in the making of emotionally avoidant relationships. Some people are unable to perceive their reality and need others to point it out to them, to provide 'reality-speak' until such time as they are able to provide this function to themselves. This may be done by a friend or, in this instance, by a therapist. The facing of reality, where life has formerly been lived in a more manic and thrill-seeking way, may paradoxically lead to a sense that life feels more "boring" but "better".

The concept that, for healthy psychological living, reality needs to be faced in an honest and direct way adds an explicit 'moral' and 'ethical' flavour to the narrative.

Mary's Developmental Narrative

Mary's account focuses on the role of nurture rather than nature in the development of psychological difficulties. (No reference is made to innate, constitutional factors.) Mary's first and more disturbed patient had had a childhood described variously in Mary's account as "cruel", "deprived", "violent", "chaotic", "sadistic" and "disturbed". There is vivid privation and deprivation to be lived with in the absence of a loving and containing caregiver. Such realities can feel so fragmenting to a person's nascent sense of coherence that, Mary felt, psychotic aspects to the personality form.

A childhood lived 'on the edge' may be repeated in an adult life also lived 'on the edge'. The relationship with others, including the therapist may also share this quality.

Some people's earliest experiences are of a more loving and supportive nature such that their psychological difficulties occur at a developmentally later level, when a sense of coherent identity has become formed. So the second patient's problems are seen as at an oedipal level and, for her, more normal oedipal issues had been exacerbated by the death of a parent while she was a child. This had led her, Mary hypothesised, to a pattern of re-enacting oedipal dynamics in her relationships by having an affair with an older married man (symbolically her father), so usurping another older woman (symbolically her mother). As a consequence of this early loss of a parent a fear had developed that intimacy would lead to unbearable loss and so would be best avoided.

Mary's Treatment Narrative

Mary states quite explicitly that her treatment narrative is a Kleinian narrative. For her this means she takes a very proactive and direct approach. This involves a 'doing to' the patient and an openness on her part to the potential value of being more directly expressive with the patient:

> I think they [Kleinian analysts] are much more active and direct.....I suppose it's about technique rather than theory but obviously technique isn't divorced from theory but the more I know about Kleinian technique that seems to be how Kleinians work and certainly it was a surprise for me. I particularly sought out a Kleinian analyst when I was training for my own personal therapy and I had a fantasy about what that would be like and the experience was very very different and much more akin to the way my current supervisor supervises me which is a very direct, active, challenging style.

I think this is where supervision helps me to – because often – I don't know what it is like for you – I'll go to supervision and I'll sort of give them 'you know I was thinking this and this and this' and she'll say 'well why didn't you say it?' I think often we hold back on what we think from this fear that we are going to be imposing our view but as someone once said 'if your therapist can't say it to you who the hell can?' I think that is something I have learnt over time from this particular supervisor about having the courage to be more forthright.

This involves her in various forms of "reality speak" when, to Mary, there appears to be significant and damaging evasion taking place. The patient does need to have "enough of a hold on reality" for therapy to be possible. 'Reality' and 'Safety' are two key watchwords for work with more disturbed patients:

I said to her 'I think you are very disturbed' .... and talked with her about the seriousness of her symptoms at times.

I suppose the main thing I think we have done is confronting her with what she has done to herself.....constantly, repeatedly, pointing out to her what she is doing and the possible consequences. I think that has really been the main work..... standing up to her because she is very manipulative.

It's probably something I've learned particularly with this [first] patient not to be too cautious really. Actually, I think it does help her and what she says about previous counsellors is that she felt they kind of beat around the bush and did not actually get hold of her.

When unacknowledged oedipal struggles are perceived by a therapist as being repeated in relationships, the ongoing work includes bringing them to the patient's attention:

> I suppose what we call conventionally oedipal issue – she had difficulties in her relationships with men and she tended to – she had a pattern of getting involved with older married men and I think part of the work was helping her to see that there was some sort of unconscious replay of revenge on the other woman, the mother.

With a more disturbed patient the experience can be like being on the end of a "barrage" with a lot of work required to sift through and make some sense of what is happening. The level of disturbance in the patient forms part of the shared experience of the therapy and is re-enacted there :

> I am often sitting here thinking 'now what on earth is going on here ? What is this about?' There will be loads of material and I try and step back and think 'what is this?' So often it is trying to – out of this barrage of stuff, trying to get hold of what she is telling me, what she is not telling me.

Mary describes how a therapeutic alliance may be ambivalent on both sides and may be deeply strained by dishonesty on the patient's part. However some repair to the alliance is possible when the deception can be talked about and the reasons for it clarified.

Some patient behaviour (as with the first patient) raises questions for a therapist of whether they need to intervene in the patient's life outside of the therapy on the grounds of a risk to the patient or others. Where a patient describes a life style that makes them unfit for the employment they are pursuing, should the therapist inform an employer? When drink-driving is described, should the public be protected? Where suicidal behaviour is described, should the patient be protected? Where childhood abuse is described and details provided of the abuser by way of name and address, should the therapist inform the police? Such issues might also be understood as a replay of childhood family dynamics in the sense that professionals who were aware

of the first patient's family may well also have debated what interventions to make and agonised over what to do.

Mary sets the relationship between therapist and patient as the core of the therapy and initially she experiences anxiety about whether a working partnership can be formed:

> I certainly think that there has to be some way of finding a way of getting on together sufficiently to carry on working. I suppose that is one of the problems about working in the NHS is that patients don't have much opportunity to choose who they get.....I always get anxious starting with a patient and I suppose it is that kind of initial feeling around and thinking 'are we going to find a way of being sufficiently able to communicate with each other that we can do something useful together ?'

The lived experience of the dynamics of the relationship is viewed as offering essential clues to an understanding of the patient's internal world. Mary suggests that therapy involves a relationship 'plus', a 'doing to' stance built on the foundations of a 'being with' stance. Interpretation and therefore insight are necessary as well as relationship :

> I don't think the relationship is sufficient but it is crucial and I really do believe it is through the relationship, through the transference and counter-transference - that is how therapy works. That's how I can begin to understand the dynamics of her is through that reaction and what happens between us.

A pro-active and direct style could lead to patients acquiescing to the therapist in an deferential way. This does not appear to be the case for Mary with the two patients she described as both appeared well capable of disagreeing and answering back. ("I've read all that stuff - Freud - what a load of rubbish.") Mary suggests that in these instances there was a greater risk to the patient if she was not firm enough. Both patients could go on 'negotiating' after disagreement. Mary describes a process of

negotiation involving her own persistence with her view but employing both a sense of timing and some 'evidence' to support her view:

> I suppose I'm fairly persistent ! She was someone with whom there could be quite a lot of humour...I'd just laugh because the challenge [to my comments] was so direct. I'd tend to not pursue the point then because there would not be much point. But I might come back to it and say 'I know you dismiss what I said and think it's just ridiculous theory but' – so I'd put it again and again and I'd put it with evidence that might demonstrate that this might be a helpful way of looking at it. And she was the kind of person who would usually dismiss what I'd say initially and then she'd come back the following week and say 'Actually maybe you've got a point' and she'd supply evidence.

Mary describes a debate with herself over whether or not she was imposing her own psychodynamic narrative on her patients as if with a too great belief in her own objectivity. She concludes that would be too simplistic an analysis:

> I don't feel I'm imposing those because I think I will present them and she is well able to fight back. And also, I don't think she would keep coming if – she could say she doesn't understand me. Occasionally she'll accuse me of being middle class, having middle class values, not having an understanding of the kind of world that she comes from, you know - haven't got a clue.
>
> But I just feel – it can't be that simple. There must be something about the way that I view things that she is buying into by continuing to come and at times she will be quite explicit about that and say – one of the main things she will say is 'it's boring to be normal and I miss the excitement but I know my life is better as a result'.

Progress in therapy for Mary is indicated by both external factors and internal factors such as living 'safely', making more equal and non-abusive relationships and being able to be honest within oneself. Value clashes are described, for example over whether it is appropriate to pursue an affair with an older married man.

The importance of consulting colleagues through supervision or team meetings is emphasised by Mary. It is seen as providing a form of 'reality check' for a therapist. Mary expresses regret that it is not possible to observe a patient's progress in the years that follow the therapy as this would provide another form of 'reality check' on the hypotheses that shaped the experience of therapy.

Mary's Attachment Narrative

Mary describes how her professional knowledge is nurtured particularly by and within the Kleinian community of therapists. She experiences a 'fit' between such Kleinian views and her own personal philosophy of life. She spells out in practical terms what her attachment means:

> I particularly sought out a Kleinian analyst when I was training for my own personal therapy.....and then choosing a supervisor who is a Kleinian analyst.
>
> Well it means that I tend to, when I get the International Journal of Psychoanalysis, I tend to look first at the papers by the names that I recognise so I read more in the field of Kleinian theory. I suppose it's familiarity, it's a way of thinking that I am used to it, it makes sense, so I can immediately – whereas – in this reading group I belong to I have suggested a few Kleinian papers and I'm fascinated by others people's reaction who don't read so much, [they say] 'I can't understand what they were going on about' or 'I found this very off-putting' whereas for me it's a bit like talking to a colleague, we are speaking the same language. And I

think traditions do work that way whereas I find reading Winnicott, although I think he was brilliant, it's the most frustrating experience – 'for God's sake say what you want to say'. I think the Kleinians write in a very direct way. It's familiarity.

She describes how the development of her clinical understanding has involved initial clinical experiences becoming informed subsequently by a psychodynamic theoretical framework:

I suppose I have much more grasp of theory than I had then. I'd worked in the Henderson with analysts and group analysts and had supervision and had an individual patient in London. So I had a lot of experience and obviously absorbed a lot of ideas and techniques but I did not really have a framework for it. So that was one of the things that was wonderful, having the opportunity to think about and talk about - 'ah that's why people thought that that was the way'. So it was kind of fitting together past experience with the theoretical framework.

Mary describes how she had developed more confidence that she does not always need to feel she understands what is going on and that there are not necessarily pre-set correct ways of being a therapist. So in her use of professional knowledge she has more freedom now to experience her uncertainty and lack of knowledge :

I don't think I've changed enormously in the way that I think about things but I think I have got more confident, more - I used to get terribly worried about what should I do or what's the correct way of doing something but I think I've sort of learnt -well I've got experience but I've also learnt there is not always a correct way. I think I have learnt that there is so much we don't know.

I think I had an idea that there were people who had got it sussed - it sounds so naive - and it's the sort of classic thing that the older you get

the more you realise what you don't know. I think that's definitely true for me. But that does not worry me. Whereas before I knew I didn't know things but I used to get really worried about not knowing but now I think 'that's how it is, you can't possibly' - in a way that is wonderful because there is lots to learn. I see that as one of the joys about qualifying that somebody said 'you are OK' so it's OK not to know.

Perspectives are seen by Mary to be situated in a time and culture which shifts over the years:

I think it would be more a strong working hypothesis along with all the caveats that this is me functioning at this time in this society with all the sort of cultural influences - so I don't imagine if I were a therapist twenty years from now I would be working in the same way.....I suppose what I always think about is I worked at the Henderson when I was first qualified so that's twenty five or twenty years ago - and I think we did our best and we worked very hard and we tried to understand and all of that but now I realise a lot of those patients were sexually abused and we just didn't think about it because the culture was such that it wasn't really thought about.

And I think that's one big shift in our way of thinking and understanding and we do listen and believe patients now and that wasn't true when I first started in psychiatric work. There were a few patients who we knew were the victims if incest but we had no idea how widespread it was and we used to talk about people being hysterical and imagining and fantasies. So I just think there are bound to be other things that we have no idea about. In time we will understand better.

Perspectives are also situated in a person so value clashes occur and Mary described being very challenged over doubts about the wisdom or morality of having an affair with an older married man:

> And that's her choice [patient two]. I wasn't going to impose my view because- equally it makes you question your own thinking – maybe we all marry our fathers or mothers or some version of them. In that sense she was good for me because she made me think very hard about what I thought and what my values were....I think I learnt that really. You may have a view about what may be in a patient's best interest but you can get it seriously wrong. Maybe not - I don't know. That is one of the frustrations. I have no idea what happened.

She sees a tension to be held between open and closed, soft-edged and hard-edged systems of understanding both of which have dangers. Systems that are too open or soft-edged can be too ill-defined to inform a therapist's clinical thinking. Systems that are too closed or hard-edged may be too restricting in their informing of the therapist's clinical thinking. She relates this to the culture of South Trent Psychotherapy Departments:

> But why I hesitate about saying I'm a Kleinian'. I'd hate to think I was narrow minded and was not open to all sorts of ideas. I try not to restrict myself to one view because I think that's dangerous.
>
> I don't think you can - I think you can talk about the culture within Departments. I think it varies enormously so I can comment about the culture in [my Department]....its version of South Trent, as I see it, is a mixture. There is a strong Kleinian link .....but also there is a tremendous eclecticism.....So I think there is an open-mindedness which I suppose, because of my links through supervision with the Institute of Psychoanalysis, that is something that I think is positive about South Trent in contrast to quite a lot of the London trainings.
>
> But on the other hand I think the danger of that is that sometimes I think that it can get too woolly and not - I don't know how to put it - I suppose

it's something about boundaries and whilst I think it is important to be open to ideas there is something about having something that defines what you are doing and I think you can be too open to other ideas so that you are not clear what you are and what you do think. I sometimes feel that's a danger here. I think a worse danger is people being very closed- this is the way it is and that certainly isn't true in [my Department]. And I think that I could broaden it out and say that is one of the features of South Trent that there is a pretty open tolerance of difference.

She cautions against idealising one's own abilities as a therapist and argues for exercising restraint in the face of such an emotional pull:

And I suppose, kind of thinking, about my grandiosity and omnipotence that I thought it would be different with me than with everybody else because she is very seductive so there is a bit of me that thinks you know 'I am a special person, I'm the one who understands her'. I think that is always a danger in this kind of work, you can get pulled into thinking 'I understand, other people didn't'. Then it's a real reminder that you're just, you're not that wonderful.

Summary of the interview with Mary

In the interview Mary emphasised:

- the perspective from which her professional knowledge is drawn as situated within a culture and a time, and the hazard that it may only subsequently be open to evaluation and new perspective.

- how the intersubjective encounter (with a patient seen as more disturbed) can be dominated by a powerful re-enactment of the patient's disturbance, a re-enactment that, for the therapist, is of a deeply disturbing intensity.

- the way an internal culture of avoidance can be created and maintained by patients as a way of managing unbearable pain and the therapeutic task of fermenting a counter-culture within the patient based around 'facing' and 'bearing' psychological pain.

- a firm belief in the sufficient objectivity of her perspective allied to a questioning and checking out of its validity within her community of therapists and with the patient.

- a stance on the part of the therapist involving a 'doing to' the patient but built on a foundation of a therapist stance of 'being with' the patient.

- the potential benefit of a direct expressiveness on the therapist's part in their comments to the patient.

- The need for a therapist, in their use of their professional knowledge, to hold the tension between soft-edged, open systems of understanding and practice and hard-edged, closed systems of understanding and practice.

Interview with Mike

In the interview Mike emphasised :

- his particular knowledge base and the intersubjective nature of therapy.

- the need for the therapist to be an empathic, attuned, 'other' person, providing a 'holding' environment and a 'containing' relationship which offers 'deep' contact with the patient.

- the importance of the therapist waiting for understanding to emerge over time in the therapy, out of the shared experience of the therapy, rather than their seeking to understand processes prematurely from 'without'.

- the powerful enactment of the patient's psychological difficulties that can take place in therapy and that requires a response from the therapist of thoughtfulness and restraint.

- the need for the therapist to have a core of healthy belief in themselves and the process of therapy in order for them creatively to manage the stress of therapy.

Patient Summaries

Patient One was described by Mike as the more psychologically healthy patient. He was a professional man, married with children who came for psychotherapy on account of recurring depressions and crippling anxiety. Mike described him as a man with a "well-formed personality" with an ability to have his own clear views and to hold life together despite his psychological difficulties. Mike saw the roots of the patient's difficulties as located in a rather distant childhood family life and in specific traumas. During the course of the patient's childhood the family had lost their home, the father his livelihood and the patient his health for a time. Mike had a view of this patient as losing his "holding context" at crucial times. These experiences were seen by Mike as shaping the patient's inability to trust himself at all to the therapy process in the first two years such that therapy was experienced as "slow" and with an "awful" atmosphere marked by tension and anxiety. Mike understood this in time to be a recreation of the atmosphere of the patient's life at particularly stressed times. In time the atmosphere eased as if they had come through something undefined together. Mike saw his role as providing a 'holding context' and a 'containing relationship' and felt the patient left therapy better able to bear his disturbance.

Patient two was described by Mike as the less psychologically healthy patient. She was a well-respected professional woman who had received a variety of psychiatric and therapeutic treatments for what was broadly called 'depression' over the years prior to beginning psychotherapy. Her difficulties were constructed by Mike in terms of her being a "tortured person" working to keep at bay a severe disturbance inside herself, the effort of which was eating up much of her energy. She could be severely self-critical. Her personality seemed to have a disorganised and unintegrated quality. The roots of her difficulties were not gone into in the interview. Her marked agitation in sessions led Mike to the view that what she needed most from him was the provision of a containing and sensitive space. Mike found her disorganised presentation made it difficult for him to organise his thinking about her in a coherent way. Therapy was ongoing at the time of the interview.

Mike's Psychodynamic Narrative

Healthy psychological living requires a quality of relationship to others and to our social context. We experience this as being 'held' and 'contained'. We feel 'contained' when we experience deep and meaningful contact with other people. We feel 'held' when we 'fit' and 'belong' somewhere. 'Containment' refers to relationship with other people while 'holding' refers to our relationship with the nonhuman environment (Searle, 1960). Implicit in Mike's account is a sense that holding and containment can not be forced or manufactured to order. They develop in time and reflect the reality of one's situation.

Our sense of self may feel integrated or unintegrated, organised or disorganised, fragile or intact. This depends on whether we have been able to internalise a sufficiently good experience of being held and contained. Psychological problems involve a continual confusion between the past and the present such that we live the present as if it will inevitably be a repetition of the past.

Our difficulties may not be immediately visible to others as they are experienced as a deep underlying sense of disturbance inside which impairs us and "eats up" valuable energy. It may involve a person in a sado-masochistic relationship to their own needs, for which they attack themselves with self-criticism or literally with self-harm.

Mike's Developmental Narrative

The roots of a problem with a sense of self can often be traced back to childhood and the limitations of what was offered by way of a 'holding context' and a 'containing relationship(s)'. Severe disruptions to one's environment such as the loss of home are referred to by Mike as examples of the loss of a 'holding context'. Perhaps by way of emphasis in this interview, Mike appears to attribute more aetiology to the losses in the nonhuman environment than to relationship losses.

The distinction between 'holding' and 'containing' is not always clear. Mike appears to suggest that an infant's prior need is for a 'holding context' before a containing relationship. He views 'holding' as a developmental process and 'containing' as a transformational process. He links them to Winnicott's distinction (Winnicott,1965a). between the 'environment' mother who handles and manages the infant and the 'object' mother who responds to, copes with and survives the infant's urgent demands.

Mike's Treatment Narrative

The psychotherapist provides a 'holding context' and a 'containing mind'. Mike describes the 'holding context' in the following terms:

> There is about providing the holding environment which is I think [that] the patient deserves to have a well-organised therapeutic arrangement and so that's easy to say but it's not always easy to do. So like they need to have regular, well thought out space and time and commitment to them. And all of that, and it's part of our philosophy to be on top of that, to do that as well as I possibly can.

The 'containing mind' is equated with being open to deep contact with the patient :

> I think it is something probably to do with contact, being able to make, to do deep and sustained contact with someone....the patient also needs a mind to engage with, to project into or to help think with. And that I see as fundamentally the containing function of being a therapist.

> I do try to respect the patient, respect the person I'm with and I do feel I am here to try to understand but that the deal is that I am here for you for this period of time however long it might be and if it's like with open-ended therapy it's like mostly 'OK. I'm here for as long as you need this'

and only very occasionally have I said 'no I'm not going to do this anymore'. But mostly I think even though with some patients you probably go through some very difficult times with them, the job, the nature of the contract if you will, is that I provide the time and provide the room and I provide my mind and I try to use those and let the patient use those as freely as possible. I think that's my philosophy.

The metaphor of 'attunement' is used to illustrate the process of being open to 'deep contact':

Quite often, particularly in the early phase of the therapy [first patient] it was as though we weren't particularly attuned. It was a very painful experience for him, very difficult to know how to proceed here, felt very anxious, tense, it seemed formless and I was at a loss as to how to ease it for him, to find a way of saying something that might ease it for him. But, as we went on there were measures of, if you like, attunement that came out of some of my interpretations so that was encouraging from my point of view that I had got something that meant something to him.

Mike conveys a very strong sense of the therapist's need to 'be with' the patient, over and above any 'doing to' the patient. This involves, he feels an openness to the patient's projections. So the therapy with patient one was seen as being dominated by projective identification whereby a deeply hurt and damaged part of the patient was experienced by Mike as if part of himself:

I think what I was subjected to with the [first] patient was some of the awfulness of their inner world and through projective identification I think I was very much gripped in the awfulness of their inner world. ..... being gripped by them, not being able to move, a sense of not very much freedom and thinking, certainly not much emotional freedom and responsiveness within the therapeutic relationship.

So through this I was faced with the problem of how do I get to engage with this man ? How do I cope with this gnawing feeling of being with him. And it was only after we had progressed a good way through that I began to have a sense of what all that was about and to get my bearings really, if you like.

In some senses Mike suggests that therapist and patient identities become mixed-up together at an unconscious level. Projections, interpersonal struggles and general patterns of engagement are seen as a form of communication by re-enactment, re-enactment of problematic earlier and current states of mind and relationships. So the key tool Mike describes is the use of counter-transference which emerges from his "reverie" and which shapes the response he makes and the stance he takes.

Implicit in his account is the immense restraint required by the therapist in the face of such powerful re-enactments by the patient. Also implicit is Mike's care not to expect too much of the patient. He adopts, when necessary, a particularly empathic, 'being with' stance that affirms the patient's experience, limits his own therapeutic ambition and seeks to find the most containing way of being with the patient:

I did try and formulate interpretations about how difficult it was for him [first patient] to just allow himself to say whatever came to mind or even to consider that as a possibility and I tried to understand his difficulty with that and talk about that in terms of this struggling against allowing the therapy to do what it might do for him.

So I was aware the patient [second patient] could be very easily unsettled and that has been a feature of my dealing with her, an awareness that I can unsettle the patient, I can disturb her so that makes me very careful, needing not to be overzealous, therapeutically over-zealous. I felt that from pretty early on with her, this carefulness, this caution, needing to be careful. .....Within the sessions quite early on I got an awareness of her being agitated..... I'd become quite sensitive to how she is as a physical

presence and as she would come in and sit down I'd become aware of 'how agitated is she today at the moment ?' or 'how agitated is she becoming in the session ?' or 'is the agitation easing or not ?'.....this isn't just side effects to medication - it isn't that at all - it's much more a sense there was a shaky person being physically expressed.

So I think she would come in and one day be relatively receptive to doing some measure of - to engage in therapeutic dialogue if you like. And then on other days I think it's much more painful and I'm aware of sitting with a tortured person who - actually I could easily - I mustn't try to do too much with her.....I think my first patient in a strange way my formulation was very much to do with holding but with projective identification there was a key containing issue going on.

Now for this patient, I think predominantly it's a containing issue and it's like the need for the container and the nature of the container has to change in that the container must be very receptive and there will be many many different facets of her and it's quite a challenge for my mind to find the right position to be with her.

Mike views it as important to 'hang in there' through the difficulties, to simply survive the experience together and to take a no-blame stance which is 'soft-edged' in his expectation of the patient:

I believe that - maybe this is one of the things that helped [the first patient] - I believe it didn't turn into a kind of 'you are not doing it right' type of situation rather that 'this is a very difficult struggle and you are trying to find a way of dealing with this strange situation'. And I think he got a measure of understanding about that even though it did not initially make it any easier. I think I had to go through something with him really.

The pace of the interview, its quality of story telling, conveyed and mirrored Mike's sense of the value and necessity of waiting. Therapy involves an experience with a patient that is then reflected on before an understanding emerges. Mike is wary of what he calls "premature thinking". He wants to approach the patient with a sufficiently open mind in keeping with Keat's notion of 'negative capability' and allow reflection to crystallise into something useful. He believes that time is needed for these processes of holding and containing to unfold and develop sufficiently. Within the therapy he allows time for his own and the patient's understanding to begin to emerge and coalesce:

> I think I probably don't jump to formulations.....I do do time-limited work and it seems to me that you are trying to force the pace and make the formulation. And the formulation often warps and changes and shifts about but nonetheless you do try and do that. But I think my sense of - my normal, if you like, therapeutic stance is not to make formulation but rather to kind of follow pieces of the narrative that emerge.
>
> Now somethings will naturally catch my ear more than others perhaps or I'm stirred up by some things more than others and those tend to be the things that I work on. And I do tend to make fairly lengthy notes. I'm quite a note taker. And I think it's in that process, that bit of taking the notes, that I invariably bring some kind of attempt to bear my theoretical outlook on whatever bit has come up. But you are right. I don't think I do try to make an overall formulation like one does say in an assessment or in a slightly different way when one does move into a time-limited groove.

Mike reflected on how much more difficult it was to have an organised understanding of a patient when the patient is themselves quite disorganised :

> Part of the problem is they're not organised. They're far less organised in terms of their personality and themselves and their psychic sort of

structure if you like. And so, correspondingly, I think I don't have an organising thing that pulls it all together.

Mike's Attachment Narrative

Mike sees himself as temperamentally suited to the kind of approach to therapy he outlined in the interview. He is clear that what emerges in therapy is a co-construction, a particular co-creation between therapist and patient:

> I am sure there were other ways you could make sense of him [first patient]. But I was his therapist and I was kind of like given the job if you like of being with him and trying to talk with him and I suppose me trying to make sense of him and draw on some of my reading, the ideas that came to me, that meant something to me. I don't know whether I would call it a truth. I don't know what a truth - I think it's meaningful - my formulation of him I think is meaningful. I think there'd be other meaningful formulations....Yes I am almost certain if someone else had been with him they would have had a different formulation and the therapy with him might have turned a very different shape.

> I think I feel quite privileged ....and feel it is quite a responsibility to have a particular responsibility for an individual who comes and indeed with the group because in other ways the same with the group therapy, that it's inevitably going to be somewhat shaped by me as well. I think for better or worse that's the way it is. I'm sure that there would be better therapists than me for all the patients I've seen. But I am the one they come to see and I am the one in the seat and in some senses it's an ordeal or can be but it's a privilege and a responsibility, that's the way I see it.

He voiced a strong sense of the pressure on the therapist's/his personality that is inevitably part of the process. He developed the theme further in an article he had

written and which he sent to me. Doubts in the therapist can lead defensively to a false sense of their capacity for objectivity or a self-attacking relativity:

> The whole process is doubt-ridden for therapy is a world of bits and pieces, hints, changes of mind, conflicts and mere glimpses of truth....self-doubt is rarely far from the therapist's mind and this can be especially uncomfortable for uncertainty is focused upon oneself. I believe, however, that self-doubt is realistic and therefore a healthy state of mind for the therapist. The desire to quickly resolve self-doubt can lead in two directions. Negatively, it leads to a guilty self-admonishing frame of mind, 'I'm useless and no good at this job'. Positively, it can lead to a state of grandiose denial, 'I know I'm right because I've got talent for this work'. Both a false resolutions to self-doubt and draw one away from the difficult task of reflecting on the true quality of one's therapeutic work.
>
> In order to bear self-doubt the therapist needs a core of healthy belief in him/herself and in psychotherapy as a treatment. This core belief provides the foundation for sound and secure practice. Put simply, one has to believe in oneself and in what one is doing.

Alongside the uncertainty Mike describes a marked and considerable faith in and certainty about the value of therapy, that engagement of the type he describes can create shared relationship and meaning from which something useful can emerge.

Critique of psychotherapy is made with regard to what he sees as an under-emphasis on the nonhuman environment:

> Psychoanalytic thinking is skewed towards understanding the human environment and this leaves a vast realm of human experience relating to the non-human, as background that is not thought about. I suspect this creates an analytic blind spot.

Summary of the interview with Mike

Mike expressed in the interview :

- a clear statement about his professional knowledge as a therapist, employing a particular perspective within an intersubjective and co-created encounter.

- a 'being with', empathic stance as being his fundamental stance as a therapist.

- the importance of thoughtful restraint and disciplined expressiveness on the part of the therapist in the face of powerful emotional re-enactments by the patient.

- a sense that he gives his treatment model an objective/realist status such that it 'holds' him while he works, in the intersubjective context of therapy, to 'contain' the patient.

- a firm belief in a 'true spirit' of psychotherapy and a clear form for its practice, that appears relatively unconflicted within Mike, that could be described as hard-edged in his expectations of the therapist but soft-edged in his expectations of a patient.

Interview with Amanda

In the interview Amanda gave an account of :

- two patients who portray different levels of disturbance; the greater level of disturbance (an underlying psychosis) requiring more the management of aggression while the lesser disturbance (narcissistic wounds) requiring more the management of dependency.

- the importance for psychological health of being able to be kind to oneself in the sense of managing critical aspects of one's personality.

- a preferred egalitarian style of therapy whereby patient and therapist are co-explorers.

- therapy as an 'enacted narrative' involving the experiencing and tracking of psychological processes, in particular the uncovering of defences and the owning of projections.

- therapy as involving a necessary disillusioning of idealisations or re-owning of projected aggression.

- the therapeutic relationship as providing a corrective emotional experience through the experience of unconditional positive regard and thoughtful enquiry

- the need for the therapist to be realistic about the patient's potential for change when the patient experiences a high level of disturbance.

Patient Summaries

Patient one was seen by Amanda as the psychologically less disturbed patient. He was described as a professional man who had had a depressive illness for which he could not account. He attended therapy for two years. During therapy Amanda felt he became disillusioned of his view that he had had a perfect childhood and instead came to feel himself deeply hurt by his parent's attitude to him. Amanda viewed him as "narcissistically wounded" and having learnt a self-reliance and a perfectionism. He was experienced by Amanda as re-enacting in the therapy his relational difficulties with dependency by adopting a superior stance, by struggling to acknowledge any reliance on Amanda and by his need to be perfect. Amanda felt she enabled him to be more tolerant and kind towards himself, to accept that being less than perfect did not make him unlovable and to allow himself to lean on his partner. Amanda felt he was unlikely to become as depressed again.

Patient two was seen by Amanda as the less disturbed patient. She was a single woman with a long psychiatric history which included self-harm, anorexia and petty crime. She appeared never to have had an ongoing relationship or successfully held down a job for any length of time. The roots of her difficulties were located by Amanda in an upbringing in which she was treated with cruelty. Amanda approached the therapy aware from the background that therapy might prove too much for the patient's resources and with a sense she needed to hold limited ambitions for the therapy. She had been seen by Amanda for three months at the time of the interview. She self-harmed grossly during an absence of Amanda's and also presented herself as having multiple personalities. Some personalities appeared benign and others quite destructive. The patient's difficulties were seen as being re-enacted in the therapy. She was viewed by Amanda as having an underlying psychosis such that the world seemed a very terrifying place for her to be in. Amanda's therapeutic hopes were confined to helping the patient feel more trust in engaging with the world. Therapy was at too early a stage for an outcome to have become clear.

Amanda's Psychodynamic Narrative

Healthy psychological living is seen by Amanda as involving the capacity to be kind to oneself and moderate internal critical voices. While she voices this with regard to the two patients it appears to be for her a more general philosophy of living:

> I guess in ordinary everyday language I'd say that they [the patients] need to be kinder to themselves and by that I mean a lot of patients have enormous superegos, this internal critical voice. I was just thinking that Fairbairn calls it the internal saboteur, you know. And they've never questioned that. When they come into therapy that's usually looming quite large. If you can sort of feed and nurture the ego, not in a way that sort of gives positive strokes that are sort of empty but if you can help it develop and grow then I think this superego loses some of its power.....and I think the more damaged they are, the bigger the more critical objects are.

Different levels of disturbance 'set' different psychological tasks for living, Amanda felt. The first patient with 'narcissistic wounds' has to learn a more adaptive and kinder relationship to their own dependency and limitations. For them psychologically healthy living involves the capacity to allow dependency and tolerate their own imperfections without losing a sense of their own worth. It involves accommodating in a kinder way the 'child within'.

The second patient who was struggling with an underlying psychosis has to learn to manage more creatively their own aggression and feeling of fragmentation by owning more of their experience and their frightening emotions. This requires the context of a empathic relationship with a therapist because:

> Psychosis is terrifying for the person experiencing it, that they lose sight of any goodness in the world and, because of the splitting that happens, they become terrified. The world seems like such a hostile, awful place.

Unbearable feelings (such as anger) may be projected out and disowned. This leaves the individual feeling depleted and with a fear that what has been projected will return. This was illustrated by the second patient:

> She projects a great deal to the point where she actually feels she does not exist.

> She has disowned bits of herself and how frightening it is when she thinks that she sees those aspects of herself in other people and expects it to be forced back into her. So it has been a sort of protection but it also adds to her fear of other people.

Alternatively or additionally a person may turn their anger on themselves in self-harm. Healthier psychological living involves the taking back of projected feelings and tolerating them inside in a way that means they do not poison the internal world with self-criticism.

Amanda's Developmental Narrative

The concepts of 'narcissistic wounds' and 'underlying psychosis' capture for me the developmental story that Amanda told in the interview.

Narcissistic wounds are the result of a felt rejection or distancing:

> He [the first patient] had been very narcisistically wounded by his father who clearly found it difficult to tolerate his presence. There were some very painful memories of being excluded .....the very few memories he had of his relationship with his mother .....were very sparse, very mechanical, not intimate, not connected really and that was deeply painful for him.

Amanda employs the analogy of having a tiny boy inside the adult who is hungry for attention and love but who has to be hidden away from awareness out of fear such needs will always be rejected and the ensuing psychic pain will be intolerable.

An underlying psychosis is described with the second patient as a result of deprivation and abuse on a level that had led to a fractured internal world:

> Her early years were absolutely appalling...anyone who grew up in this family would show a level of disturbance.

With such patients multiple personalities might develop as with the second patient:

> I think that she was so battered by her childhood that in a way she sort of preserved bits of herself by this other personality..... But I'm not sure that I understand it all. You know how children can have a friend and the friend can be very naughty and they need that little friend for a while when they are feeling distressed or upset about something. I suppose I've seen it to some extent like that. That is the more benign personalities that she presents to me. But when she presents the [other] personalities .... I think they are actually very destructive and they represent a part of her she doesn't want to be around.

Amanda's Treatment Narrative

Amanda described her treatment approach as more egalitarian with an encouragement to mutual enquiry or co-exploring:

> I am thinking about people like Margaret Little and Betty Joseph and Rosenfeld and how they try to talk with the patient 'let's have a look at what is going on here'. And certainly I do that with patients - 'my hunch is that this and that is going on and I think that's because you expect me to

be so and so and so and so'. But I try to do it in quite a conversational sort of style that isn't setting myself up as the expert and try to make it safe enough for the patient to realise that, if we can find a way to talk about what goes on between us, maybe we can find a way to talk about what goes so painfully wrong for you outside.

The core of treatment appears to be encapsulated in Roger's notion of unconditional positive regard (Rogers 1957) through which the therapist encourages and supports a growth in the patient's capacity to tolerate their own aggression and dependency and become kinder to themselves:

I guess in ordinary everyday language I'd say that they need to be kinder to themselves and by that I mean a lot of patients have enormous superegos, this internal critical voice..... If you can sort of feed and nurture the ego, not in a way that sort of gives positive strokes that are sort of empty but if you can help it develop and grow then I think this superego loses some of its power.

Amanda placed great emphasis on the enactment of the patient's difficulties in the relationship with the therapist. The type of enactment and the ability to reflect on it subsequently perhaps depends on the degree of disturbance.

With the first patient Amanda is describing the treatment of someone whose dependency needs had not been sufficiently met in childhood to the extent that he had adopted a stance of being very self-reliant and self-sufficient. He had continued this stance as a defence in adult life presumably out of a conviction his previous experience would be bound to be repeated to his cost. Enactment took the form of the repudiation of some of his need of Amanda:

...how difficult it was to allow himself to be helped by me, to show any need of me, to have any response to breaks, those sorts of things.

> It was very difficult to withstand his superiority.....there were times when he was very defended and very omnipotent.

With this particular psychological difficulty defences (such as a superior attitude) need addressing in manageable ways, with sensitive timing and in the patient's language:

> He found it very difficult that I might see something on an angle that he had not perceived himself.

> And I was always very careful to use any analogies that he brought into the conversation so that it couldn't be - I hoped he wouldn't feel that any analogy that was used was derogatory in any way because he was hyper-sensitive to anything which could be construed as a criticism. And so I always tried to get behind these sort of walls and shields that - they were words that he used - to the feeling that might be behind it.

> And I had to be careful not to introduce my insight into that [defence] until I felt he was ready for it.

One particular defence is that of idealisation, in this instance the idealisation of childhood experience. Treatment in therapy may involve a 'disillusioning', an undoing of the defence of idealisation:

> And as we came to the end of therapy, he said that this picture of this golden childhood, that he had had when he came to therapy, had really moved and he was shocked by that.

A combined process of 'talking about', 'enacting' and jointly observing the enactment may be coupled with a teaching role, principally of teaching kindness. The combined

effect may together enable a patient to lower some of their defences and become more flexible in their response to relationships:

> I think I needed to teach him how to be kind to himself. I think that actually he was extremely self-critical to the point where I had images of hair shirts and when people whip themselves on the back. He could not allow himself to have any human needs or frailty at all. So I think I taught him to be kind to himself..... I hope mainly by the way I treated him but also by making him question some of his attitudes towards himself and being curious about where they came from and how they got formed, what they were defending against.

A positive outcome is seen in a more tolerant attitude, a kinder response to the experience of dependency and limitation and this was observed in the first patient:

> He can live with himself more and he can allow himself to have need of his partner and not be so self-contained....and I think I sort of showed him how to give himself permission that, if he's got a few bits or foibles or bits that aren't perfect, it's all right. You can still be loved.

Amanda felt that an underlying psychotic level of functioning was not uncommon among patients referred for psychotherapy:

> And my impression is that the patients that we deal with here, and I don't know if that is the same for all Psychotherapy Departments, there is often an underlying psychotic level of disturbance.

However the greater degree of disturbance points to a greater level of internal criticism which in turn makes engagement with the therapist so problematic:

> Yes, and I think the more damaged they are the bigger the more critical objects are and so the more difficult it is for them to engage with the

therapist because they project that into the therapist and expect the therapist to be so critical and attacking that they are terrified. So all of that, all those difficulties that are arising are because they are trying to fend them off.

I think that the terror and the paranoia that she has in relation to me are because it's her early childhood that is being re-enacted with me.

Treatment in such a situation involves holding on to a therapeutic stance, bearing the visible signs of self-abuse, tracking carefully a patient's anxieties, projections and expectations and reflecting on this with them:

[I need to] bear in mind that I am going to have to withstand a great deal of anxiety here, that she is going to provoke a lot of anxiety that is going to need to be contained so that she can feel that she can't knock me out of my analytic stance. And she has certainly lived up to that.

In particular there is a focus for Amanda on aggression:

There's her own inner aggression that she brought to her relationship with her parents and I think there was great deal of aggression towards her from her mother. And so what she brings into therapy is her expectation of me pushing something into her - something unhealthy - and her response to that is that, because her ego is so weak, she projects a great deal and to the point where she actually feels she does not exist.

And recently we have been able to talk about how this has made her feel more comfortable in that she has disowned bits of herself and how frightening it is when she thinks that she sees those aspects of herself in other people and expects it to be forced back into her. So it has been a sort of protection but it also adds to her fear of other people .....she has talked

about how it is much better if the other person is angry.... So she provokes me to try to make me the angry one who will reject her.....

I guess I have thought about it in terms of the anger she felt towards me which she is terrified of because she is afraid that, if she is angry with me, then I will actually physically attack her back because that has been her experience in her family. And so she turned her anger on herself.

Her response to a patient's aggression is instinctively to pause and think before reacting:

Well I guess patients are often attacking but I try to see the anxiety behind the attacking. So I don't think they are attacking ...I just think 'yeah they are attacking me. I wonder what that is about. I guess there is a worry behind that'. But, if I feel the attacking is continuing even though I've tried to look behind it, then I will say to a patient, "you are attacking me and I am wondering what that is about". So I won't just sit and accept it and be beaten up and just let them sort of walk all over me. I'll be curious about it all.

But I might also do a lot of work in-between a session in which I've been attacked, thinking about what might that be about? How do I need to respond to that? And formulate my sort of plan of action if it continues in the next session. If it doesn't continue in the next session but perhaps it feels like there has been an absolute right moment sometime down the line to bring it back again, I will. But I think it's ever so hard to say what it is that makes you feel that it is the right moment to make that interpretation. Something has moved on between you and the patient and you think 'now I think they can stand me saying that'.

Where she believes the presentation of different personalities by a patient has a sufficiently conscious element she will put back to a patient their tendency to talk as if they were different personalities:

> I said to her I wondered why she felt she had to present herself to me as though she was different people.

Underlying psychotic difficulties are a measure of a deeper disturbance for which more limited and realistic aims may be appropriate. So with the second patient (and another patient) Amanda has much more limited aims:

> But I think it is very important that I don't have too much therapeutic zeal as it were.

> I guess I would hope the outcome would be something fairly subtle in a way in that I hope that her everyday functioning would improve enough for her to be able to go out and go shopping or walk down the street without feeling that somebody was going to attack her, to have a little more trust and security in the world.

A centre piece of treatment that goes generally unremarked on in the interviews is the format of once weekly therapy in the NHS. Amanda comments on this:

> But I think there is a South Trent way of doing Psychotherapy and it is based I think on once week therapy. That was the sticking point that was flagged up when we had this UKCP visit. Some people see that as good and some people see that as bad and some people say 'well it's the NHS, it's what we can offer our patients and we have to work within that'.

A final comment is on the difficulty of the work :

> I think the very nature of Psychotherapy Departments makes them difficult places to work in because we work with difficult patients and it's bound to affect us. We are carrying a lot of projections from patients and you know the type of patients you work with always affects the people that work with them.

Amanda's Attachment Narrative

Her particular professional knowledge base has emerged in part from the experience of her own therapy. Equally her attachment to what she characterises as a post-Kleinian perspective is based on the help it has provided to her in making sense of her clinical experiences:

> I think that Klein was a sort of starting point and [I] then moved on to post-Kleinian. It gives me a way of trying to analyse what difficulties the patient might have in thinking. And my impression is that the patients that we deal with here, and I don't know if that is the same for all Psychotherapy Departments, there is often an underlying psychotic level of disturbance which, without say the work of Bion (and I am thinking about like his 'theory of thinking' and 'attacks on linking') I would completely flounder. His paper on how patients attack links between their thoughts, between them and the therapist - I would be a far less capable therapist without that understanding because I think that a lot of the patients that we get here have had long psychiatric careers and have not really benefited from whatever interventions have gone on in the past - though that sounds a bit arrogant and I don't mean it to be. It's being able to think with the knowledge I have gained from Bion's work which helps me to see what's going on.

> Well, I think the idea of needing to be kinder to yourself certainly comes from my own therapy. My own therapist was not a Kleinian as far as I knew, did not draw on a post-Kleinian [view]. I think my sort of leaning towards post-Kleinian theories has evolved out of difficulties that I knocked up against with patients while I was training and thinking, 'oh my God what can I read so that I can understand this and help this' , because I think my background in nursing taught me that there is a saying about 'first do no harm'. I don't want to do anything that is going to be damaging to patients so, if I would read something, often it would be a post-Kleinian paper and I would have this 'Aha, that's what I think is happening with these patients'.

Her attachment is not exclusive of other approaches. Rather she sees a need for a plurality of approaches:

> It has always been my view that to think that one model is superior is to have a very blinkered and rather arrogant view. In my past, when I worked as a CPN, when I worked in a day hospital, I worked with quite a few patients with anxiety problems using a much more cognitive model and they found that very helpful. I don't think that psychotherapy or the psychodynamic model is what everybody wants or needs. And I think that you have to be mature enough to say, 'I don't think I'm the right person to help. I think they might be better helped here, there or wherever'.

However she sees herself as at an early stage of development when it comes to assessing the strengths and weaknesses of the psychodynamic approach and her particular version of it:

> I think that I am at a stage in my development as a therapist that is still fairly new in that I think I am quite enamoured with the psychodynamic model and I need a bit more experience post-qualification in order to take a more objective view of it.

She voices an attachment to the NHS context in general and to her experience of NHS Psychotherapy Departments in particular:

> I think I saw a lot of very solid stable practices that were the same throughout - wherever the Departments were set up, the ambience of the Departments, the quietness, the confidentiality that somehow gave a real sense of solidness. I think to see the differences - you can get little inklings of them as an outsider - but I think to be more aware of the differences you've got to be working within that group of people.

Summary of the interview with Amanda

In the interview Amanda described :

- her values / philosophies concerning how to live well psychologically that inform her professional knowledge in practice and which have emerged from her personal life experience, her professional experience and her own therapy.

- the way theory (and specifically post-Kleinian theory) offers her a map and guide for practice without which she feels she would "flounder" when faced with the patient's re-enactment of their psychological difficulties in the therapy.

- how a more critical assessment of her approach and its relativity is not yet possible for her as she needs further post-qualification experience before she can make a more objective evaluation.

- the importance, though, of not being so invested in a psychodynamic approach as to be unable to see when another therapy (or another therapist) might be more appropriate for a patient.

- a steering towards a stance of a restrained but careful 'being with' the patient in a more egalitarian way and a steering away from the role of objective expert.

- the need to help create in patients a counter-culture of kindness to themselves (rather than such intense self-criticism), and of ownership of feelings (rather than their projection).

Interview with Jo

In her interview Jo emphasised :

- the need for a realism about life along with a sense of hope that "it may not be perfect but it can be good enough".

- the importance of experiencing attunement so that we can develop as people who can be intimate and separate.

- the importance of allowing time for a patient to develop at their own pace.

- the value of being eclectic within the model

- the hypocrisy contained in some more disengaged therapist stances

- the "heavy-duty" nature of much NHS psychotherapy whereby rewards for the therapist may feel limited and sustaining oneself in practice is a key task

Patient Summaries

Patient One (seen as the more damaged patient) was described as a single, professional woman in her 40s who lived a socially withdrawn life and suffered from marked obsessionality. She had attended therapy for some years following an experience of a breakdown. Therapy was experienced by Jo as slow and 'heavy-duty' as the patient presented in a life-less, emotionally detached and unengaging way. Jo understood this pattern of engagement to be the product of a childhood lived with a depressed mother (as single parent) who was unable to 'attune' to her child's needs and be engaging towards her child. Jo viewed the patient as struggling in her adult life to achieve any quality of relationship both externally with others and internally with herself. She saw the therapy as offering an opportunity to develop both. Furthermore, she felt the patient needed to accept the limits of life and relationships, recognising when it may be "as good as it gets" rather than waiting for a better deal from 'life'. This would, paradoxically, enable her to take up the more positive sides of her personality. At the time of the interview therapy was ongoing and progress felt to be slow but the patient was seen to be kinder to herself and to have more capacity to relax.

Patient two (seen as the healthier patient psychologically) was a married woman who came to therapy on account of a deteriorating relationship with her daughter. Jo understood her to be seeing and rejecting in her daughter an unwanted and bullied aspect of herself. She needed, Jo felt, to make this connection. Her health was shown in her capacity to be aware of others as separate persons, to feel her own guilt and distress without losing touch with her strengths. She was experienced as engaging to be with, a "breath of fresh air" and very capable of using available supports. At the end of a short and emotionally intense therapy the patient described an improving relationship with her daughter and a greater ability to stand up for herself.

Jo's Psychodynamic Narrative

At one point in the interview Jo said life "may not be perfect but it can be good enough" and this quote captures a sense of Jo's outlook for me. There is a streak of realism but also of hope running through her account. Life contains many "adversities" and Jo highlights the experience of not being adequately 'attuned' with as a fundamental impediment to psychological development.

However, she emphasised how important is our response to adversity. It is no help to hold out for it all to be 'made right'. Maybe this is "as good as it gets" so it is important to start from the reality of the present position. Limitations need to be accepted. A relationship, grounded in such 'realities' needs to be forged with ourselves and others. 'Connection' is needed both internally with ourselves and externally with others and health can be measured in terms of this ability. Jo expresses it in the following way:

> I think psychological health is many different things and I suppose for me it's something about personal contentment and comfort with self. So it's something about being able to relate freely and openly with yourself with the bits you are happy with and the bits you are not quite so happy about, to have an open and free relationship with that, to recognise that there is an element of suffering in life and that from time to time bad things happen and that sometimes those things can be very unbearable. But it is possible to think about those, to come to terms with them and to recognise one's limitations and live to the best of your ability and capacity and achieve the most fulfilment possible within your own personal bounds and limitations.

The ability to connect to others goes hand in hand with the ability to be separate:

> I think she [second patient] actually was quite a healthy individual compared to some patients we see because she could relate, see me as a

separate person. She had a warm relationship with her husband and sustaining friendships.....

The evidence for psychological maturity is shown in a person's response to life events:

> So it's not so much about the things that have happened - it's about a person's capacity to think about those, to modify them, to hold them inside and to have a relationship with themselves about it I suppose.

Making developmental changes takes time and can not be rushed. It involves employing the more positive aspects of our personality and tolerating the experience we are actually having.

Jo's Developmental Narrative.

The fundamental developmental need for a child is to be connected with an 'attuned other', to experience an attuned other who is attentive and responsive to them in an intensely personal way. Jo describes the difficulty experienced by her first patient in presenting herself in an alive way in the therapy and presumably to others in her external life. The root cause of such a presentation is located in her childhood experience:

> She had a very depressed mother because the father left .....mother collapsed into a depression and never really came out. So I think she [the patient] did not really have an attuned other.

The second patient's ability to relate is taken implicitly as evidence of a far greater experience of being attuned to as a child.

Jo's Treatment Narrative

Jo describes a number of tasks that a therapist undertakes in providing treatment to a patient. Firstly, the therapist needs to attune to the patient and this quality of relating is an "essence" of therapy:

> I think what is important for me about therapy is something about being available and really trying to understand the person.... Its about relationship and its about the quality of relationship ... it is about the quality of your relating and crossing the bridge to the other person.

So in her practice Jo works to avoid an opaque stance that is wooden:

> I guess opaque can be keeping an analytic stance and being objective and I am certainly with that. But I certainly would not be wooden . I think when I started out I was rather wooden. I remember once a patient threw a pot plant at me. It whizzed past my head and I just said " I think you are feeling very angry with me". I did not know - I was covered in earth with it and I felt terribly humiliated and I did not I react at all and she left the therapy and years later I think I am not surprised actually. I was just totally wooden. So I suppose the key for me is about trying to attune. So that includes having a laugh sometimes. I'll make a joke. The patient makes a joke - that sort of thing. Even if it is defensive there is warmth and life. I think you have to be human at the end of the day. If the person sitting opposite you can't connect with anything human then what are you doing?

Secondly, the therapist needs to allow time for developmental change to occur:

> For myself I think that developmental changes take time.... change comes when it comes. You can't hurry it.....change happens when people are ready and I suppose the value base for me is that people who get to this

department have often had a lot of short term help via the psychiatric services and most of those these days come in packages. So it is packaged therapy, you get a cognitive behavioural package, you get three weeks to work on the fact that you've been horrendously screwed up in your background and that kind of thing. So for me there is something very valuable about the length of time.

Thirdly, the therapist needs to sustain herself in particular when what is re-enacted by the patient in the room is so lifeless and disengaging. Jo comments on how therapy has become more "heavy-duty" over the years:

For me therapy patients have changed. They seem more stuck and more difficult and a lot of the rewarding work gets done at primary care level. There are a lot of people who have done counselling courses and psychotherapy courses so they see the more rewarding people who are on the cusp of a change, who can move on quite quickly..... I think that the rewards of doing long term, heavy duty psychotherapy .... you have to be grateful for small things.

Sustaining myself is a constant difficulty I think in therapy and it is one of the hot issues in psychotherapy.....supervision is one of the ways of sustaining myself .... one of the ways I sustain myself in isolation is by trying to keep thinking and for me the task of therapy is to keep thinking and to keep my thinking alive. So that might mean that if I am absolutely sick ...I try and find a way of bringing some life to myself in a situation or just recognising that I am heartfelt sick of it and trying to be very aware of that.

So I suppose it's staying in touch as much as I can with the feelings a patient brings up in me and how I feel, taking it to supervision and reading sometimes and recognising that that is sometimes a desperate activity to manage a counter-transference feeling. Silly things like when she has gone

throwing the window open, doing some exercises in the room, going out for a walk, phone a friend - anything like that really. So kind of a whole heap of different things.

The tasks for the patient run in parallel. They need to experience the possibility of an attachment to the therapist and an attachment to more of their own experience. There are a lot of active verbs used for the patient's tasks:

I do have a game plan ! ....my hope is that she will attach to me, work through some of the grief about what she has not done, come to terms with the fact that life isn't about being constantly fed and that it's possible to have bad and good experiences and think about them and recover from them, to accept that people come and go but they do come back and to let go a bit in her internal world and be less defensive I guess.

So it's something about making connection with your self, learning to love the person you are with the background you have and accepting the limitations there are. There are some things that change, other things that don't change and actually that's OK in the end. It's not perfect and for some people it's as good as it gets. I don't know whether you ever saw that film 'As Good As It Gets'. It's that kind of thing and as long as it's liveable with - so I guess it's about helping the person to live with themselves and live with more of themselves.

A re-enactment of what is viewed as the patient's core pattern of relating appears to be marked with the first and more damaged patient and is at the centre of the therapy experience and work:

I think for me perhaps the thing I think most about is attunement and trying to cue in and listen and it's very easy to switch off because she switches off. And the moment I start to drift off and think 'oh that's a lovely tree out there, I am so glad I've got a lovely tree outside my

window' I realise something has gone dead between us and that I have become like a dead mother and she is like a dead infant with me.

Her understanding of what is needed and what is being re-enacted is shared with patients but in an indirect way:

> I have shared parts of it with her I think because I suppose I make comments about what she is doing now so 'rather than miss me when I go away I think you do this'. Its probably a bit of a veiled thing to say.....so I think I do share it in lots of different ways in the way I speak rather than saying 'this is where you are. I think you need to move to here'. I don't tend to do that but I make comments about the areas where I think she is stuck and - and I guess I don't always say 'I think you are stuck and you need to get here' but I often say 'you are doing this instead of this'..... Sometimes if I want to say something I am not sure about I will preface it with 'I am not really sure about this but I've got a feeling that' something about this and share the uncertainty or sometimes share the dilemma - 'I am sitting here wondering whether to say this to you or whether to say this and I think you make....'

However, Jo expresses how it is important to her to be sure when she is sure and such moments occur for her when head and heart meet up:

> You know it's like every now and again when you kind of know something and you know it , it comes together and you've been thinking / puzzling about something for ages and you suddenly think 'I am sure' - you just feel really sure about something.

However it remains important to be open to alternative views without necessarily acquiescing:

It felt like a piece of insight and it felt like one of those pieces of insight that is really important..... But I am always willing -if she had come back and said 'no..... I think you were wrong'. I think it would have been really important for me to acknowledge that. I may not have retracted it, you know, I may have said 'well maybe it's something we could think about again'.

Treatment is not particularly helped by over-pursuing a line of thought and going on what she calls a "witch hunt". It is not necessarily helpful to label disagreement as resistance:

I have a sort of theory about her that sort of changes and I suppose a sketchy map of some of the things I think she brings in to the transference but if I try and link them to her family she completely blanks off and changes the subject or switches off and drifts and finds it very difficult. It could be very easy to sort of go on a bit of a witch hunt, you know do a sort of Malan's triangle, you know I must make this interpretation but it just does not go anywhere so I have learnt that it isn't helpful to her and she can't seem to hear that. She can link it to me but not link it to the past which I guess goes in to attachment theory and borderline understanding of not having a narrative. She did not have a narrative and if I try and offer an understanding it does not go anywhere.

I think I have worked with it enough to know that even if were resistance it isn't lessening at the moment. And I am not sure it is resistance actually, I am not really very sure what it is but I think to just name it as resistance would not do it justice somehow. I can't really give you any greater understanding it's just a feeling about what is right for this particular patient.

Jo's Attachment Narrative

Jo voiced in the interview how her 'realism' and sense of hope were not abstract or theoretical ideas to her but were rooted and grounded in her experience of her own therapy. So her attachment to them is personal as well as professional:

> Certainly for me one of the things I have learnt through therapy training and my own therapy is that it is possible to think about parts of yourself which have perhaps been difficult to accept and to bear and difficult experiences which you would rather forget or which trouble you and somehow make connections with those - not disavow them but learn to love yourself in spite of them and know that you are loveable, grieve about the things that have happened that you can't change, the parts of yourself which you would rather were different but aren't and that's OK actually.

> It isn't about having a perfect life, it isn't about avoiding adversity, it's about how you deal with adversity and how you manage in the face of things. And some things are unmanageable and that's OK. But I guess running away from things and defending against them means that they are going to happen and happen and happen again.....

Her attachment to the profession of psychotherapist has a strong element of wishing to be helpful and useful and also an element of masochism:

> I often think psychotherapists go into psychotherapy because they want to help but they are not very sure they can so they are making reparation for something so there is this fear they may not be able to help. That may just be me personally and I'm acknowledging that is a personal thing but I think it is wonderful to have somebody able to move on. It's just so rewarding for me, so encouraging in validating what I do as a useful activity so that was a good experience.

I think I am probably quite masochistic actually, there is a masochistic edge to psychotherapy really and I think I am probably more comfortable with the idea of not being given to than given to actually.

She described a critical attachment to the practice of psychotherapy. She referred to "hypocrisy" and "dishonesty" and "crap" centred chiefly around a more disengaged and inhibited therapeutic stance. She saw ways in which she had moved towards a personalised professional position:

There are somethings where I have moved away from my original teachings and become much more free. Sometimes that makes me wonder if I am still a psychotherapist but other times I think I have found an analytical freedom and I have become myself as a therapist. And I think I am a better therapist for it.

I think there is quite an element of hypocrisy - probably quite a strong word - which is to do with the idea of corrective emotional experience and teaching - the area you are interested in I guess which is that for example I was taught that you don't ask a question in psychotherapy - I don't even know why I was taught you don't ask a question- and yet we ask questions all the time - I wonder if ? perhaps you feel ? which is asking a question. So I often think we are not really that honest with ourselves. All the stuff about being opaque - I suppose I have quite a sense of discomfort about that. I think of the Nina Coltart paper about being a round peg in a round hole. I am not sure I feel bad enough to be a square peg in a round hole.

I think what is important for me about therapy is something about being available and really trying to understand the person. And I suppose there is an essence of psychotherapy which I think sort of cuts across all the other kind of crap. Sometimes I think for example I smiled at a patient when I went to get them from the waiting room and I thought 'what am I doing. I

am supposed to be an opaque person, I am not supposed to smile. What message would that give. Oh for goodness sake get a grip here'. So I don't particularly like that lifelessness bit to therapy.

It's about relationship and it's about the quality of relationship and there may be aspects - it is about the quality of your relating and crossing the bridge to the other person. So there is for me a lot of theory, the blue print of psychotherapy which I don't particularly adhere to. Yet there are other things I am quite rigid about. For example I would never touch a patient but that might be me because I am not particularly a touchy-feely type of person. But I think I have good reason for not doing that. But I would not judge particularly someone who did.

She described a more "eclectic" attitude to the application of psychodynamic theory whereby she responds to her sense of which theory best fits the particular patient:

I don't think actually -I think I am going to be one of those eclectics. Not in a wishy-washy way. I don't think. For me theory is something which can move and change with the patient so I don't particularly favour one theory and there are some patients where I just think 'this is Kleinian stuff'. Other times I can be with somebody and think 'Winnicott' and think of various things. Some patients I don't particularly think of any theory. It's different at different times and as my understanding moves and changes over time the theory that pops into my head can also change.

She presented openly a tension in practice around the application of her professional knowledge. At one point she talked of having a "game plan" while at another she referred to a "sketchy map" and a "sort of theory". She emphasised the importance of being sure when she felt sure and of being open to revision of views but also talked of the risks of being "dictatorial" and "foisting" her view on a patient. The danger of having expectations of a patient which might constrict them was articulated. Intuition was clearly valued by her as a guide.

Summary of the interview with Jo

In the interview Jo stressed :

- her values / philosophy that centre around the patient's need for realism, their need to make connections with others but also be separate, and their need to hold on to and modify internally their experiences.

- the way her values/philosophy of living life well psychologically have emerged from her personal and professional experiences, in particular her own therapy.

- the heavy-duty nature of some therapies in which it is so difficult for the therapist to sustain themselves and their creative involvement and not be overwhelmed by the culture of the patient's internal world.

- the importance of the therapist being 'attuned' to the patient, 'being with' them with a quality of attention and care allowing them in time to internalise the experience.

- that a degree of expressiveness is required of the therapist and that some of the inhibited and disengaged stances practised by therapists are unhelpful and lacking in integrity.

- the importance to her of being eclectic within the model and of carrying a soft-edge to her practice within the model.

- the careful task of sharing her thinking with a patient and being open to their response without having automatically to defend her own view or acquiesce to the patient's view.

Interview with Paul

In his interview Paul gave an account of :

- damaging interpersonal patterns of behaviour that are created and maintained by individuals.

- therapy founded on promoting a corrective emotional experience, with the patient taking 'significant action' whereby an old story has a new ending.

- his particular structure of time-limited therapy which emphasises therapy as a preparation for life rather than a substitute.

- the task for the therapist of remaining creative under intense pressure from the patient to join a re-enactment.

- the importance to practice of being opportunistic, evidence-based and of privileging effectiveness over compliance to a model.

Patient Summaries

Patient One was presented as the more disturbed patient. She was a woman in her forties who had experienced periods of severe depression and suicidal impulses. At times she presented a risk to herself and others by, for example, acts of self-harm or dangerous driving. Paul constructed an understanding that experiences in childhood of being rejected and left feeling unlovable had created a pattern whereby she kept other people away to prevent them from engaging with the more vulnerable and needy side of herself. She pushed people away in a very denigratory manner. This both 'protected' her from the risks of intimacy and confirmed her belief that not only was she unlovable but she was also 'evil'. It was this self-fulfilling interpersonal pattern that formed the focus of the therapy for Paul. Previous psychotherapy had not been able to 'resolve' this pattern. The alliance with Paul was experienced as precarious as the interpersonal pattern was re-enacted with Paul feeling the full force of her denigration. He described a struggle to maintain a creative engagement and a need to monitor his own retaliatory impulses. Therapy ended with an uncertain result.

Patient Two was presented as the less disturbed patient. He was a man in his late forties whose relative psychological health was shown by his capacity to hold together a career and maintain a marriage and family life. Paul organised his thinking about him around the concept of 'narcissism'. He saw the patient as someone who reacted badly to criticism or a perceived lack of attention. He could become enraged and storm out on people. This behaviour was in evidence at home and at work and with friends. It was as if his whole self-esteem was on the line so much of the time. The roots of such a pattern of response were understood by Paul to lie in the childhood experience of feeling an 'unwanted appendage' and being sent away to boarding school at a young age which he described as an alienating and isolating experience. This pattern was not re-enacted in the therapy which was experienced by Paul as 'enjoyable' and 'moving'. The patient was prepared and able to listen and experiment with new ways of responding to others.

Paul's Psychodynamic Narrative

For Paul healthy living psychologically involves:

> ...living as good a life as you can but being realistic about that, that everybody has often contrary and often devious parts of themselves which causes them to do all sorts of things.....

We can become enmeshed in interpersonal patterns of relating that are repetitive, self-fulfilling, limiting and isolating. Such patterns reflect the 'contrary' and 'often devious' parts of ourselves. They need owning as choices people make within themselves, though for some people, change may be experienced as 'beyond their capacity to will'. So Paul gives the example of the patient who pushes others away in a denigratory manner such that the response she receives confirms her critical self-view. He also gives the example of the patient involved in enraged protests (at perceived slights) which will not bring him the recognition he craves.

In such ways we may defend ourselves against the pain of intimacy. Dependency and vulnerability may be eschewed and other people actively pushed away from awareness of them with the strategy that 'the best form of defence is attack'. Alternatively others may be punished for their perceived neglect. While the past has relevance, for Paul, focus is better given to the present and future because that is where living is taking and will take place.

Once established such patterns may endlessly repeat themselves with other people drawn into the script with set roles to play. There is a sense of there being the same old story with the same old ending. The degree to which such patterns and the sense of deprivation underlying them restricts a person's creativity is an indicator for Paul of the degree of disturbance in a person. External signs of health are noted in terms of the capacity to hold done a job, maintain a relationship and provide parenting. Similarly

changes in interpersonal patterns will show in external changes in behavioural responses.

In order to move on we need among other things a capacity for 'differentiated perception' that enables us to distinguish when another person is reacting to us or to some other issue or person. This enables us to avoid relating every aspect of interaction solely to ourselves.

Healthy living involves making meaning and recognising our part in the wider community:

> I am impressed by the existential position, that this is the life you have and to try and make some meaning out of it, find some purpose for yourself by all the sort of things this lady [first patient] said slightly ironically about reliability, patience and tenacity. I think those are important parts of living.
>
> I think also that all of the Adlerian principles of social interest are very important. We are individuals, we follow our own interest but you also have an objective, shared interest of which psychotherapy is one manifestation, one part of this larger community of people who subdivided the things that they are going to do. You are doing your little bit to promote the social interest.

Paul's Developmental Narrative

A pattern of attacking to defend is understandable to Paul in terms of profound and ongoing experiences of feeling disowned and ignored as a child to such a level that intimacy then becomes very threatening and interpersonal patterns develop to limit that threat.

A pattern of enraged protest at perceived slights and neglect (which Paul describes as narcissistic difficulties) is rooted in a lack in the consistency of loving attention given to a child by its parents (as opposed to an absence).

There is limited focus beyond this in the interview in keeping with Paul's greater interest in the present and future.

Paul's Treatment Narrative

Paul's professional knowledge is directed towards the evocation of change in the patient which would have a significant impact on how they live their life in interaction with others in the future. He approaches the evocation of change through a focus on interpersonal processes. He sets less store by intra-psychic processes and symptoms and he is very at home with the idea of narrative:

> So I want the best as I see it of the two worlds, the technology of changing behaviour and changing how people actually can do things differently which people do in groups and individual therapy and focal therapy, together with some much more interactive perspective which comes out of the life that the person creates as they go along.....
>
> Unless there is change in the external world I don't see there has been any great value come out of that [therapy].
>
> I have always been interested in relationships, about people's stories and felt that psychotherapy, if it has anything to deliver, will deliver it in that area rather than the symptoms. So I certainly looked around to find elements that are focused on relationships rather than the symptoms or on intra-psychic processes which I don't find all that interesting. So that would lead me to be happy to describe myself as an inter-personal

therapist, but less reluctant or more reluctant if I am going to be pushed into certain forms of psychoanalytic therapy.

He has developed a particular pattern of delivering therapy which has an 'intensive phase' of weekly meetings for a year. This is followed by a 'less intensive phase' of monthly meetings for a year which offers a chance to support the putting into practice of insights gained in the first phase. Paul also describes something he calls 'anchoring therapy' in which he might meet someone every few months:

> There are a lot of people I have seen over many years I keep in contact with but perhaps only every few months so that the supportive model is what I call anchoring therapy which provides a little bit of ballast and I think it's ..... a very effective way of containing the self-damaging personal relationships. What you do every few months can really stabilise that person. So I am very happy to do that.

This pattern reflects his sense that therapy is a preparation for life and should not become a substitute and that longer term therapy may convey an unhelpful message:

> I think it [open ended long term therapy] encourages an inward looking focus on the therapy and an over-valuing of the therapy as opposed to the purpose and meaning of their patterns of interaction that would lead them to lead their life better outside.

> it is easy to get caught up in thinking that you might provide a substitute life for that person whereas in fact therapy, as I see it, is a preparation for the life outside. It comes up very sharply in group. People would want to go on in groups for a long long time or they want to have relationships with each other but actually the group is there to prepare them so they can make those new and independent friends and relationships outside.

For Paul there are particular qualities needed by therapists generally and also particular temperamental variations:

> I am pretty averse to open ended long term therapy.....I think for two reasons. One would be that temperamentally I am not suited to long term therapy.

> Among the qualities required [by therapists].....are reliability, empathy, patience, good sense of humour and the tenacity to see the work through to a positive conclusion.

He seeks to construct a treatment alliance around an interpersonal agenda from the beginning of the contact and enlist the 'non-neurotic parts' of the patient in this process:

> I was therefore keen to review and freshly contract with her [first patient] at those points to try and enlist, as far as possible, the non-neurotic part of herself...so right at the beginning we had ten sessions together just to see if we could work together and try and mark out the territory, what it was going to be for and so I was trying to set an interpersonal agenda right from the beginning which she signed up to, to look and see the part that she might play in creating the absence of relationships or the relationships patterns.

As therapies proceed Paul is on the lookout for a 'shared image' that in some way is experienced as summing up the core of a patient's interpersonal struggle:

> I often look for an image that can form part of our shared language we have between us, something that sums up in some central way that person's life and situation.

With the first patient this was an image of a traumatic moment when her mother disowned her and left her feeling abandoned and somehow non-existent for her mother. With the second patient there is not a single, clear incident from childhood so much as a collection of experiences that create an image of feeling an 'unwanted appendage'.

Ongoing treatment then seeks to address the identified interpersonal patterns. Re-enactment of the patterns takes place in the session when the level of disturbance makes it so compelling for the patient. With a less disturbed patient the enactment may take place more outside of the therapy with partners, work colleagues and others:

> [The therapy with the second patient] isn't particularly focused within the room, only if we get stuck. That's a good distinction because the first [patient], maybe I tried to focus entirely within the room, on staying as much as I could within the room because it seemed to me that what we lived and touched and experienced we could know in a way that would be different from what happened outside and it might give us a chance to do something useful, whereas [with the second patient] the issues aren't particularly with me, maybe they are ...but they are much more clearly related in the every day to his wife, his children, what happens at work.

When the re-enactment takes place in the room (as with the first patient) the therapist's preferred style of relating is put under intense pressure:

> this particular patient made me think deeply about the preferred self I like to operate with and which generally I operate with quite well, quite effectively both in therapy and in a whole variety of other settings, but where this particular person kept on knocking me out of that particular position and caused me to make a whole series of errors which weren't huge in themselves but which I regretted and which she then hauled me over the coals over. So that in that particular person there was very much an interaction between a particular style of being with patients which I

find most of the time serves me quite well and I think serves them quite well and not being able to maintain that and with this particular person then attempting to try and understand .. about the fixes that we got into and finding it a very taxing process, one that was at the time almost too difficult for her and certainly very difficult for me.

The impulse to retaliate has to be monitored and owned when acted upon. It would constitute for Paul a potentially very unhelpful joining of the re-enactment. With the first patient Paul became aware of less conscious ways in which he might be retaliating against the patient. One involved 'forgetting' the patient's particular request not to be brought to the session by a route that took her past her previous therapist's door:

a week or two later I brought her up past the other therapist's office and I think that was probably more than thoughtlessness, that this in some way was a counter-attack by myself on her because she had been pressing me so hard, she had been so difficult and critical and unpleasant and I suspected some part of my mind knew it would be upsetting to bring her up that way but that is what I had done.

And that is an example of how, despite all of my best attempts to stay in a purposeful, positive, constructive position with her, I found myself slipping into counter-attack in the way that she perceived me overall and perceived other people. So what happened between us came, in its more fraught moments, to resemble some of the more persecutory things that she'd experienced with other people and which had been formative and which she feared in the most profound way....

there were other small incidents when I would press her in a way that I knew she probably would not be able to manage and so there was a little bit of tilting the balance of power back in my own favour and not the other way.

When such painful re-enactment takes place Paul feels a therapist needs to consider whether the problem might lie in the combination of the therapist's and patient's personalities being 'toxic' in some way such that it would be better for the patient to see another therapist:

> But certainly if a toxic combination had control or if there had not been any sympathy for her then morally and professionally it would have been right to ask somebody else to take over.

However, in this instance with the first patient, a reading of the notes from the previous therapy suggested that a similar struggle had taken place there as well. Paul felt the patient's reactions to him needed to be seen not just in personal terms but as transference which would contain projection and distortion. In this way he sought to practise his concept of 'differentiated perception' :

> As a therapist one needs to take what patients do personally and not personally. You have to stand back and think this isn't always about you as you are. This is also about transference and projection and distortion and that I think helps you in a difficult situation to make a separation between you and the perceived self in the other person. But at the same time I think you have to step back and constantly think 'in this created selves together is there something to listen to and to learn about oneself and about the other person or about the way they interact with other people which will make their story intelligible?'..... So I had to come back and try and renew myself each time before the session in order to contend with it.

Re-enactments can feel almost unbearable at times such that there have been occasions with patients when Paul felt he had to make it clear that there would need to be a change for therapy to be able to continue. The therapist also has needs:

I think my maxim is that 'the therapist must survive'. If the therapist gets killed off then the therapy comes to an end and then you've got two casualties.

I certainly can think back and remember a number of times when I have said to people that we are at the limit of what I can do and if we continue in this particular vein I just won't be able to continue with you. You've got a choice. You've got to kind of cool it down to a manageable, tolerable level. The few times that I have done that most of the patients have been absolutely devastated by that. They've had a notion that either they weren't so toxic or difficult or that I should be able to cope with whatever they - but those few occasions have led to a more fruitful engagement. They haven't broken off. They've been outraged but somehow something about the reality and the responsibility for that shared and created reality has come home to them.

However this first patient was one who Paul felt was unable to respond differently to him. It was "beyond her capacity to will." Additionally, she was a patient at risk of suicide and the ethically correct thing to do he felt was to continue and not demand a change.

Paul described constructing an understanding of the patient's difficulties which appeared to 'hold' him in his struggle and he believed the patient owned it too (as a co-construction at times). It centred around the shared image of her sense of abandonment and disowning by her mother who would not listen to and respond to her cries for help. Paul understood the patient's treatment of him as a re-enactment that functioned both as a communication to Paul of her own inner experience and as a punishment of him in loco parentis:

she needed me to be the person who heard those cries and was punished for not being able to respond to them. So that the way I partly understood it and tried to bring back into our conversation was that we were caught

up in a process that was trying to tell an old story but in a slightly different way, that might get to a different end point.

I felt that she needed to, in a way that wasn't fully thought out on her part, but she needed me to experience that painful position that she had been in and go on living in and basically gone on surviving it and trying to come back in as reasonably positive, constructive unattacking way as I could muster and that would then [link to] my idea that my doing that long enough and sensitively enough might well add up to a corrective emotional experience for her.

Therapy can then 'seesaw' between the therapist being allowed near and being pushed away.

To assist with the development of a more 'differentiated perception' Paul will at times try to introduce 'reality' to assist a patient:

I therefore thought it was important to try and acknowledge that with her directly and try and separate out, to the best of my ability, the times when that [my manner] was a response to her or it was a response to something else in the attempt that this would allow her to make a more differentiated perception. Sure, sometime she had indeed succeeded in discomforting me or upsetting me or making me doubt myself. And it was important to recognise with her that she had that capacity but other times she got it wrong. There was some external event that I had been thinking about or I was tired because of some other processes that were going on in my life. It was then important to say 'yes you are right I am feeling tired or feeling a bit under the weather today but I think it is because of something outside, on this occasion.' On another occasion, yes there was a link to how we were together the previous week.

For progress to be made and as evidence of progress 'significant action' needs to be taken by the patient that constitutes a re-writing of their own narrative:

> This is another key bit of the model that I am very keen on - people taking significant action which will help them re-write their own narrative. So that what significant action would be [for the second patient], to monitor how the situations break down with his wife before they get to the point of inevitable breakdown and he is going to have several days of sulking, can he actually do something that will break that pattern, something really quite simple like taking himself off and calming down or calling for time out or apologising, something that would be quite significant.....So he goes off and he practises that.

Forays into the past take place only when warranted:

> And then [with the second patient] there has been some excursions into history particularly when he has got into some real time difficulty but it does not seem very much to do with the situation as it is now but clearly has historical antecedents so that his rage at being ignored, which is quite disproportionate to the situation, would then prompt an excursion .

As an outcome of therapy Paul looks for there to be a 'corrective emotional experience' that prevents an ongoing repetition of the interpersonal pattern indefinitely. He sums this up as:

> trying to tell an old story but in a slightly different way, that might get to a different end point.

Outcome to both therapies is described in the following terms:

> Maybe who knows, perhaps she [first patient] has made a shift and that struggle symbolised something positive to her.

He [second patient] is less narcissistically involved in an extreme way.....he is more able to feel he is loved as a person by his wife even though he is being criticised in that particular moment whereas before those two were one and the same thing. He didn't have a robust sense of being loveable unless it was constantly being topped up and affirmed. So again in this particular case there was an importance in his external life of addressing the reality of his situation, if he was behaving in an obnoxious fashion, recognising that and apologising and making amends in some way and try not to make that into a blanket condemnation of himself.

Paul's Attachment Narrative

This narrative unfolds through a series of contrasts through which he locates himself as an interpersonal therapist at the 'soft-analytic' end of the spectrum taking a more evidence-based and 'opportunistic' approach to the model emphasising the search for what is 'effective' in promoting change. He voices some of the conflict that exists between psychotherapists. The contrasts are:

hard-analytic vs soft analytic:

I really struggle with [the culture of NHS psychotherapy in the region] because I am not sure there is a fully shared culture at all. There are, it seems to me, a number of quite distinctive cultures going on which co-exist but I am not sure they, in a deep way, that they have respect or acknowledgement for each other so that in terms of a spectrum, there is quite clearly a spectrum from hard analytic to soft analytic and I would be at the softer end of that spectrum.

idealised vs opportunistic:

> I think there is a spectrum of attitude to the model in the sense that some people idealise the model, thinking that practising within it is a good in itself. There are other people who are much more opportunistic.

right vs helpful:

> Well, I think that some people think that there is a right way to practise therapy and, with that patient, if you don't practise that way then that's wrong whereas I think that's a funny way of putting it. I can see a question which would be 'is there a right or better way to help patients with particular kinds of problems'? That is a research question and you could tease that out. You might come up with the answer that this way is the best way but you might actually find that a lot of it is, not exactly mumbo jumbo, but does not have that - isn't that crucial to the success of the project.
>
> ....to constantly go back to 'is what you are doing the best that you can do for this particular person's problems, is it working, is it proving helpful' rather than 'am I doing the therapy right'.

Paul emphasises his central criteria of 'effectiveness' and the need for evidence-based practice. He feels he has been 'paring away' over the years at what in the psychodynamic approach has seemed superfluous to the aim of evoking change:

> I've always thought that effectiveness is the name of the game and unless you are doing something or trying to do more the things which are effective, what are you there for ? But I think other people seem to value the model and doing things within the model as being a good in itself. I have never been able to see that at all.

So within my development whenever I have come across people being absolutist or reductionist I tended to react against that. I didn't fancy that very much and over the years have pared away some of the elements which don't seem to me to be essential for evoking change. So, history, yes it's important but you can't do very much about it..... what you or I are going to do in the next few moments, tomorrow and the next day. It strikes me that that particular focus is the one where there is a chance of altering minds.

There are a number of things about psychoanalytic models, the way it is practised by some people .....which I don't find to my taste, they include people being certain about the truth of those constructs or the primacy of those constructs. There are alternative ways of seeing things. Perhaps the research evidence does not really support the assumptions.

Paul's approach reflects his training:

My medical background, I was brought up to question and to test and to weigh evidence and it seems to me that that is a model that, over time, tends to advance, tends to discard what is wrong-headed and does more of what is right and so I am fundamentally quite questioning about all sorts of things. I am very happy to have those things on the table.

It doesn't seem to me that we are likely to have got the model perfectly worked out, an example would be the benefit of long term therapy. Long term therapy tends to be used for people with major problems or for people having training therapies who can commit themselves for such a long time.

There needs to be a study that will investigate other particular groups of patients, do you actually need that length of time or is it the case that people get to a particular point and then they tend to plateau and there are diminishing returns and could you achieve the same amount of benefit by perhaps having, what I tend to do, an intensive phase and then a much more distributed phase of sessions. It is a really good research question with huge implications for the way we organise our services and Departments.

Summary of the interview with Paul

In the interview Paul stressed :

- the intense pressure some patient's evoke on the therapist's personality in the therapy that results in the therapist feeling 'pulled out of shape', and in their joining the re-enactment unhelpfully.

- that a developing understanding of the patient assists the therapist in tolerating the pressure and maintaining appropriate restraint.

- the need to consider whether the personality of the therapist is part of the problem in a therapy.

- the importance of the therapist's professional knowledge being informed by and anchored in an evidence base which provides a measure of objectivity to practice.

- how 'being with' a patient needs to lead to the patient 'doing', by way of their taking "significant action" interpersonally and how therapy's value should be judged by its effectiveness in bringing this about.

- the need for a soft-edge to the model of practice that privileges pragmatic and opportunistic practice over compliant practice.

- the need for a counter-culture within psychodynamic therapy that would challenge a culture of longer term therapy, an undue focus on the past, and an undue reliance on a pre-set model of practice.

- how the map or guide to healthy psychological living that informs his professional knowledge focuses on the interpersonal dimension of life and the way a culture of self-fulfilling and damaging interpersonal relationship patterns are created and sustained by individuals.

- that his values/philosophy as a therapist have been shaped by his own temperament, his medical training, the research evidence for practice and his clinical experience.

Interview with Peter

In the interview Peter gave an account of :

- the importance of a pluralistic acceptance of yourself and your experience and of letting other people in on that experience. The alternative involves a 'mutilating' of yourself internally by the disowning of unwanted aspects or experiences.

- the problems that arise in relating when 'Basic Trust' has not developed and there is a paranoid quality to relating.

- the centrality to therapy (and struggle) of 'being with' a patient in an 'I-Thou' relationship.

- the need for realistic ambitions as a therapist when therapy needs to be more about promoting 'management' than promoting 'change'.

- the need to accept the limits of theory, the struggle with uncertainty and the value of the 'unknown'.

- common reference points that allow for understanding between people.

Patient Summaries

Patient one was presented as the more disturbed of the patients. He was an older man with a long history of abuse in childhood and within the psychiatric system to some extent. In childhood he was 'terrorised' and 'virtually imprisoned'. As an adult he had repeated admissions to psychiatric hospital and was often suicidal. He had ongoing out-patient involvement with Mental Health Services. There has been a paranoid quality to his relating in the sense that he had not been able to trust others and had to be guarded and secretive. His active mental life had not been translated into an ability to relate and express himself with others. He was viewed by Peter as developmentally at the 'paranoid-schizoid' level. He had been seen for weekly therapy for some years with the aim of assisting with psychological 'rehabilitation'.

Patient two was presented as the less disturbed of the two patients. She was an older woman who had had an experience of being depressed to the point of feeling suicidal. Peter constructed an understanding of her as desperately trying to avoid her depression as she felt persecuted by it. Therapy lasted around 18 months and focused on helping her tolerate and be in touch with her feelings. Depression was seen by Peter in her case as not so much a pathological condition but as part of the texture of her human experience. Her background was seen as containing deprivation and abandonment but not, as with the first patient, a damaging level of persecution. As a result she was seen as less disturbed.

Peter's Psychodynamic Narrative

Healthy psychological living, in Peter's view, requires a 'pluralistic acceptance' of ourselves, an attitude of 'inclusivity' and a 'letting in' of people. Acceptance is of the experience you have and of the person you are, including those parts you feel most ashamed of and most want to be rid of. Non-acceptance of aspects of ourselves is akin to self-mutilation:

> I think the task is to learn to live more tolerantly with how it is.

> I suppose the idea that you can't be selective about your inner experience that it is as it is but that if you start categorising it as ' that's a good thing to feel, that's a bad thing to feel , that's sick, that's OK' then you start mutilating yourself in a way that is profoundly unhelpful. I suppose that the ideal is a much more pluralistic acceptance of one's range of experience not that that does away with conflict - in fact the very opposite..... I suppose if I have a sort of an ideal, a psychological approach it would be very much an inclusive one where the emphasis was in some way on valuing the experience you are having and finding a place for it and that includes experience that is painful.....so I suppose if I have a therapeutic philosophy it's probably that.

> I think I see therapy as enabling people to have the experience of themselves and of the world that they have actually got .

A number of defences are described which can be thought of as intra-psychic and inter-personal strategies for managing the psychological risks of life. They are described as 'hiding', 'pretending', 'avoiding', 'managing', 'introjecting', 'sustaining' and 'guarding'.

So (as with the second patient) experiences such as that of depression are fended off and avoided where possible but at a price:

> I suppose the overall understanding that I got of her was of somebody who was desperately trying to avoid being depressed .....I think that was the work in a sense - something like helping her develop the capacity to be in touch with and tolerate her own experience. That is seeing depression not as a pathological condition which it can be, but more a part of the texture of human experience...

When people function at a more 'paranoid-schizoid' level strategies include managing other people and trying to keep them going out of a fear that they might become attacking or they might collapse (as previously experienced). Other people can not be taken for granted in a healthy way [as with the first patient]:

> There is quite a theme you can not rely on the other, you have to sustain them.

> So he has to humour me to keep me concerned because otherwise I become totally persecutory and seek to destroy him.

> ....because I have a sense of his need to manage me and so I am not always sure - sometimes it is obvious that he is managing me and that is easy because we can talk about that..... I don't know sometimes whether he is managing me or not.

Knowledge may be withheld from self and others:

> The way I think about it is that what is happening inside of him is happening inside of him [the first patient] - he has no control over it. He can neither make it happen nor stop it from happening but he has spent

most of his life trying to pretend that it isn't happening so that he has gone into the psychiatric system asking them to make him better and to look after him without ever telling them anything about what the problem is.

In an attempt to stay attached (originally to parental figures) it is as if an attempt is made to introject or swallow whole the other. There is a process of introjection but not digestion or integration [as with the first patient]:

I think some people keep their parents alive in a very literal and concrete kind of a way by allowing part of themselves to become them. I think we all do that to some extent but in this case it's swallowing wholesale something, some very paranoid quality that his mother held and identifying with it as himself and I really do get a sense of it as a huge foreign body inside of him at times. Not an internal parental object - I am not quite sure what these words mean - but sort of an introject where you have somehow got someone stuffed inside of you that is acting quite independently and it just takes over, somebody like a nazi regime in occupied France, it runs the show but does not really belong there but it is in control.

Peter's Developmental Narrative

By implication the foundations of mental health are laid for Peter in the experience of being accepted and valued for the person you are. This promotes a 'Basic Trust' in life.

Peter addresses through the first patient the impact on the 'inner self' of earliest (and ongoing) relationships that have had a severely unreliable and persecutory quality such that there is a 'basic mistrust' of people. He prefers the concept of level of disturbance rather than the terms health/ill-health. Peter has a sense that his patient has

not had a sustained experience of being accepted, of being able to bring himself to his caregivers and experience something like 'unconditional positive regard'. Instead the patient had:

> a very long standing history of abuse of a particular kind so in effect he was somebody who was terrorised and virtually imprisoned for most of his childhood and has spent most of his adult life in the psychiatric system in a sense repeating that pattern.

Such experience can lead to the emergence of 'entrenched mental structures' based around a 'paranoid-schizoid' type of functioning.

Peter distinguishes between the experiences that have an abandonment-rejection quality and those that have a paranoid-persecutory quality. The latter result in more severe pathology:

> She [second patient] was much more of a depressive position than a paranoid-schizoid patient. Her despair was a depressive one about abandonment and rejection, not a paranoid-persecutory feel.. I think there was an element of feeling paranoid about the depression. I think people can feel attacked by depression and that is very unhelpful as they try to fend it off..... but there was no comparison in terms of the severity of pathology. She had a deprived background but not such a persecuted one. She was a bit of an ugly duckling brought up in deprived war time circumstances but not depressed in a persecuted sense, more in the sense of being left out than picked on.

Peter's Treatment Narrative

A treatment narrative is more implicit in the interview and appears centred around the therapist 'being with' the patient in a manner that offers an experience of

'unconditional positive regard' and therefore tolerance and acceptance of what the patient brings. It is an evolutionary and relatively non-directive approach. Peter, therefore, steers far more towards a 'being with' stance than a 'doing to' stance as a therapist.

This fits with Peter's therapeutic ambition and he links it to an experience with a supervisor:

> I suppose my ambition therapeutically would be to be the person that I would feel comfortable with when it came to the things about myself I am most embarrassed about and most ashamed of.....
>
> Some supervisors you can take yourself to and some you just can't and some you can sit down and say what is really happening and others you just don't .....it is profoundly affecting being on the receiving end of that kind of experience [of being able to take yourself] because you know at first hand the value of it. Again I am not saying that enables me to do the same for other people but that would be my ideal.

Such an experience in therapy may allow the patient to develop a more open relationship to themselves, their experience and to the world:

> I think I see therapy as enabling people to have the experience of themselves and of the world that they have actually got.
>
> But I suppose at the end of the day for all of us therapy can do that for us. It can help us not change who we are but maybe we are feeling more able to go out into the world, if you like, which is both relieving and disappointing about it. I think that's how I would see it.

So treatment should not have over-ambitious aims but its potential limits should be acknowledged. There is a clear sense that Peter has taken on the first patient in full

knowledge of the limits of the patient's capacity to change due to the entrenchment of his 'mental structures'. So this therapy is described as 'rehab' type therapy and there is an unhurried air to it. The emphasis is placed not on 'change' but on 'management' and 'acknowledgement' and 'tolerance' and 'letting others in'. The task is about helping the patient manage the culture that they find within themselves rather than attempt to set up a counter-culture. This is in keeping with Peter's sense he is less ambitious now as a therapist:

> So I suppose it's something about managing better his mental state, not necessarily changing it.....I don't feel that ambitious about him.....I think I probably think of him as a rehab patient more than as treatment patient, in the sense that I don't sort of imagine that he can get better. I think the task is to learn to live more tolerantly with how it is and perhaps to take a few tentative steps...

> I think it's a matter of managing one's mental state rather than transforming it. I am not saying it could not be transformed in other cases, there are changes but that there is something about very entrenched mental structures that I don't see the need to be anxious about in terms of wanting to change.

The danger of somehow being incorporated in an undigested form by the patient is noted. Just as a patient may introject parental figures as a way of staying close to them (as a defensive way of 'being with' them) so too the therapist may be introjected. Ideally the patient would have 'an identity that refers more to his inner self'. Instead it can be as if:

> ..... you have somehow got someone stuffed inside of you that I is acting quite independently and it just takes over, somebody like a nazi regime in occupied France, it runs the show but does not really belong there but it is in control. My fear of course is that I am seeking to replace the nazi

regime with a humane, liberal but just as much an introject regime, just as much of a foreign body.

An enactment of the difficulty occurs in the therapy and a key task for the therapist is to 'monitor' and attempt to track the enactment, to understand on what journey the patient is taking the therapist. It takes the form of an interpersonal struggle and a negotiation. With the first patient such a fundamental level of distrust leaves them with a difficult task of managing the situation and the therapist with a difficulty in 'reading' what is offered:

So this is a constant difficulty for me to keep in mind that what is on the surface and what is underneath are I think very discrepant. So it's a difficulty of understanding what's in front of you and trying to work out to what extent you can trust your experience because you know there is a lot that is hidden in a paranoid state. [Peter clarifies that, by paranoid, he means 'automatically guarded and secretive'.]

I think he sees me as someone who needs to be sustained, as someone who is potentially helpful and part of that is to avoid me turning on him. So he has to humour me to keep me interested and concerned because otherwise I become totally persecutory and seek to destroy him. So I see him as having really a quite difficult management job with me. How to sustain me is his problem and he is still quite a long way from being able to be sustained, to take me for granted.

Peter works to retain an awareness that nowhere may feel safe for some patients and to monitor and restrain grandiose ideas in himself:

I think it is very easy to think that he is all right here and it is very important to remember that he isn't. That rather complacent sense of knowing what is better and what's best is precisely one of the dimensions he has always [experienced] ....I think it's more that I try to monitor

myself. Because I find that all sorts of things happen inside me. For instance I feel I am better than them and if only he had been here 30 years ago how much better this would be. None of this was necessary and stuff like that. I try to monitor that sort of grandiosity and try to think of that as something that in a sense he tries to feed because one of his tasks is to keep me going because he does not have any great faith in anyone he values being able to keep on going without his being there to keep them on track.

He both knows and does not know when some patients are managing him:

> I think I do know when he is managing me, when he is saying things he knows I want to hear. I think I can pick that up. What I don't know about is what is happening the rest of the time. I think it's the same with her [second patient]. I kind of know when she is saying things - a little present to keep him going, I think he likes me saying this. For the rest of the time - uncertainty - you live with that and you don't know.

A description is given of a complicated and frequently unclear process of negotiation:

> When I very first saw him it occurred to me that he did not trust me at all and I said that too him and I said that felt like it was part of the problem, not just me but he did not trust anybody. I still think that is right and we talk about that and he refers back to that occasionally. That's partly an illustration of the negotiation process. I say something and he agrees or he does not agree or he says something - so there is a kind of a built up mutual understanding over time as to what it is that is happening inside of him and what it means. And then there is also the issue of the fact that he does not trust me and then I never know what to make of what he says because I have a sense of his need to manage me and so I am not always sure - sometimes it is obvious that he is managing me and that is easy because we can talk about that.

Progress in treatment is described in terms of a patient's growing ability to communicate:

> I suppose I think he [first patient] has gradually been able to tell people more about his inner experience - and I am mainly thinking about his family - so that they now understand him a lot better and I think that's enabled them to manage him better and it's enabled him to trust them a bit more and be with them a bit more so that now everybody knows when he is going off and they can talk about it and it's no longer such a paranoid secret.

He distinguishes between the level of disturbance in a patient and the experience of disturbance in a therapist:

> There are people who are very disturbing to me and there are people who are very disturbed and perhaps even more disturbed - whatever that word means - but not necessarily as disturbing to me.

Peter's Attachment Narrative

There is acknowledgement of his particular perspective, based on his values and philosophy, which shapes his approach to the patient. This is displayed in the phenomenological account he has constructed of his first patient's inner world:

> I suppose I have a particular idea about who he is and how he has come to be that and what has gone wrong for him with that and that set of ideas inevitably informs everything I do and say and think and feel about him. So, though I would not put it as a matter of conscious technique, I think that orders my being with him ....

Yes. I think there is something in that in the sense that all psychotherapists have their own understanding about what the world is about and what people are about and they can't dispense with that so I'd probably say....it's not a criticism. I'd think of it as something to be reckoned with and acknowledged.

Theory plays a holding function for the therapist but theory should not be taken too literally or as too certain. In this way Peter is subversive of too great a sense of a therapist's objectivity:

Our theories are what in a sense sustains us while something else is happening that we don't understand which is why theory is really important. I use theory in a very broad sense I include our values, our philosophy as well as our particular understandings of the way we work but we need that in order to keep us going when something else we don't know about is happening. Hopefully those ideas are not alien and incompatible with that something that is happening but essentially there is something we don't understand and can't understand and what is crucial is our capacity to not know but without that being a cliché.....

[certain concepts] are a useful short-hand for thinking about some of the way he presents [first patient]. For me that's a bit like a nail or a screw. I make use of it. They are useful things and they do the job.

I don't think we have a proper understanding of people and how they tick..... talking about not knowing, esoteric and incomprehensible...for me that is nearer the truth of things. I'd say that theories are useful but not necessarily true.

Over the years his therapeutic ambition has lessened, with movement away from the need to 'do to' a patient, away from an the urgent need to help create a counter-culture within the patient :

> I think I am much less ambitious and therefore much less.....tense? I am much more tolerant of myself. ...I think I kept feeling I had to prove myself when I started and perhaps I have come now to the conclusion that I can't but I think the difference is that I don't mind that so much. It's not that I feel I am better than I was. I probably don't mind not being as good so much.....which helps me to be a bit more down to earth.

To inform his professional knowledge, Peter seeks out theories, such as those of Bion, that he finds address a deeper level of experience that is often missed:

> There is something about Bion that I think that, although he is pretty incomprehensible, he addresses a level of experience that not many psychoanalytic writers do and I think it is that level of experience - I don't know how to describe it any better - that psychotherapy is all about really. A lot of psychotherapy writing I find quite alien and unhelpful because it talks about that level without contacting it. Whereas for me Bion talks out of that level which means that he can be conceptually very difficult to understand but experientially very powerful to be with.

He sets out his strong belief in there being an 'inner self':

> There is little doubt in my mind there is an inner self independent of the external environment which is not to underplay the importance of the external environment and the way it affects us but a good environment enables us to realise a pre-existing inner self. I feel that as an absolute truth really. I have no doubt about that. So I would say Goffman is talking about people who have lost their inner sense of self as a reference point so they are very prone to external influence, more prone than is good for them whereas people who have progressed more on their own inner innate nature can sustain themselves and be transformed by the outside world

rather than being taken over by them. That is my particular faith if you like.

He goes on then to articulate a more general, epistemological view of the possibility of common ground between people. Such common ground allows sufficient alliances to be made in therapy between therapists and patients around co-constructions of the journey that therapy is taking or needs to take. He drew on the ideas of Jung about 'the collective' to suggest that, as persons, we each have an 'internal collective reference point' to measure ourselves against:

> If I was to take the view that it's perfectly OK to sleep with patients, in fact it would probably do them good and therefore one should really do it - I think if I were to say that I would be out of touch with my own sort of collective internal reference point, that it would be a disaster.
>
> But I might equally be out of touch with my collective reference point if I took the view that the only interpretation a psychotherapist should make is a transference interpretation. Again that would not be in tune with my inner reference point and if I was trying to do it I would be doing something very alienating to me and therefore very peculiar for the patient.
>
> It sounds like I am saying I am right about everything - so long as it feels all right inside it's OK. I don't mean that either. But I think at the end of the day you do your best. You try and do what feels right and to try and be as inclusive as possible about the other experience.

He talks then of an external collective reference point which is society and its influence on the individual. It is, for Peter, our participation in both that allows us to understand each other "because ultimately we share the same set of psychological possibilities". The relationship between the two collectives Peter describes as follows:

I don't see the collective as being external and the individual as being internal. I see the individual as mediating between the internal and external collective - which is what enables me to share an experience with each.

It's partly that we have been brought up in the same culture to use the same language and partly that we share in a psychological culture that enables me to talk about these kinds of issues and for you to know from inside yourself what I'm on about. I don't create that internal collective culture any more than I create the external one...I think of as being somewhere in the middle of the two and having to work out a position.

That is my sense of what people are about and that is where the more completely individual the scenarios, the more collective they become. There would be no point in doing psychotherapy without that collective inner experience...because you would not have collective internal reference points.

However such reference points do not provide for certainty. Rather uncertainty has to be lived with and also valued. Peter conveys both his sense of security within a psychodynamic culture and his experience of the level of stress that is inherent in therapy given the uncertainties that have to be lived with:

Half the problem in psychotherapy is understanding when we don't understand something. That's really difficult because you don't know that you don't know about it.

The closely guarded secret which it [psychotherapy] will not allow the uninitiated to know is that actually we value not-knowing. Now that would sound criminally appalling - what have we been doing all these years ? It would not be immediately [easy] to say what an immense value that is.

It's hard to have faith without certainty. At the end of the day you are doing what you can do or think you can do and you hope it is OK and you know it is not always. When you come up against when it isn't you do your best and struggle with that and suffer from it. That is all highly unsatisfactory from one point of view. From another point of view it is truly human.

I think at the end of the day you do your best. You try and do what feels right and to try and be as inclusive as possible about the other experience.

Summary of the interview with Peter

In the interview Peter emphasised :

- how his perspective is informed by values / philosophy that centre around fostering in the patient a culture of pluralistic acceptance of self and experience.

- his need as a therapist to acknowledge and take account of the relativity of his values and philosophy and their impact on a therapy.

- theory as a useful (but not necessarily true) guide which sustains him while he engages with the uncertainty and the unknown in therapy.

- how common ground between patient and therapist (and people in general) enables some alliance to form and understanding to be co-constructed such that there can be a sense of therapist and patient being on a shared journey together.

- nevertheless, the difficulty there can be for a therapist in understanding and keeping track of the journey on which the patient appears to be taking the therapist.

- how hard it is, as a therapist, for practice to be based on "faith without certainty".

- the importance for his practice of steering firmly towards a stance of 'being with' a patient in a way that communicates an acceptance of the patient and enables them to better manage their internal culture with appropriate realism about what they are able to do.

- an emphasis on the value of the unknown and the limits of theory, an emphasis that is subversive of too great a sense of the therapist's objectivity and of too hard an edge to the application of the model.

Interview with Maria

In the interview Maria gave an account of:

- the need for a person to feel seen, recognised and engaged with in their individuality.

- the enabling of the development of a sense of personal agency or authenticity, of a capacity to become more one's own advocate.

- therapy as a reflective space which a patient can learn to use and thereby move away from more reactive and impulsive responses that lack this sense of agency.

- an experiential kind of 'knowing' emerging from the experience of relationship with a person.

- a caution about wider claims to knowledge and a non-directiveness when it comes to patient choices and decisions.

- how the emergence of inner disturbance may seem to others to be making the patient more 'ill' while it may in fact be therapeutic for them.

Patient Summaries

Patient one was presented as the more disturbed patient. She was a middle-aged woman who had been professionally successful and maintained longer term relationships. However her life appeared characterised by a lack of agency. She had not been able to be reflective, to stop and take stock. Instead she had lived in reaction to others' wishes and adopted a compliant stance, particularly with authority figures. She voiced for herself a sense that she had not actively chosen where she had got to in life. Her underlying difficulties had come to a head with long term sickness from work. Therapy had continued for more than three years.

Patient two was presented as the less disturbed patient but focused on only briefly in the interview. She was again a middle-aged woman who had experienced the trauma of nursing a dying parent and then subsequently 'breaking down' emotionally herself. For Maria, the therapy felt naturally focused on these events and she found herself more able to think in a coherent and integrated way about this patient's life and needs. She took this as a sign of a lower level of disturbance.

Maria's Psychodynamic Narrative

Healthy living psychologically requires a capacity for agency, for the making of authentic choices that emerge from a capacity to reflect and then be proactive. Maria talks of a capacity to be our own advocate. Such health or lack of health may not be immediately visible to another person. In fact someone may seem to function well externally while inside they have 'borderline' aspects to their personality and experience "internal world disturbance" :

> what patients I see externally maybe seem to be functioning all right but once they're in therapy .....they might be struggling with a lot of disturbance inside.

> I think I'd use the word 'authentic'. How authentic are the together bits that the patient presents?

> I don't know if I see any neurotic patients. I think they are all more borderline. I don't know what terms you want to use but they seem to have more disturbances unless I am not seeing something. I don't know what a neurotic patient is sometimes. I think I've lost sight.

Maria's first patient, deemed more disturbed, illustrates this struggle. She is someone who has been professionally successful and has had a number of valued personal relationships in her adult life. However she conveys to Maria an impression that she has no sense of agency in her life and her apparent external success disguises an inner disturbance. So Maria comments:

> ..over her lifetime people could have looked at her and thought she was a fairly healthy person.....what she is coming to understand is that none of this has been about her. She has no sense of her own agency in all this.

If we think about false self or whatever it feels like that is very much it. So as a therapist I would say there is something quite disturbed inside even though on the outside some people might think she has been fairly healthy.

now she's got there it's like what's all this about but she has no idea. I don't think she has ever stood back and thought what was she doing and what was it all about ...I think she is just beginning to think who am I doing all this for.

"Internal world disturbance" reveals itself, in Maria's view, in the quality of the person's relationships and their ability to function, for example in employment. Symptoms, for the first patient, are detailed by Maria as stress leading to time off work and a tendency towards punishing perfectionism, along with a previous history of anorexia. However Maria does not talk much in terms of symptoms as generally understood. Instead she describes wider 'existential' themes.

Maria describes a need to foster a culture of authenticity inside ourselves, an existential sense of being true to ourselves in some way:

....it is about a sort of true self and when I say that I don't mean I think there is one core -we are changing all the time but all the time I think we need to retain some kind of true self within us, true selves perhaps or whatever. You know I think we change all the time but I think it's a position, a position we can perhaps hope to find as we go through life. So I am not the same as I was when I was 19 or 20. I am not the same person. I don't believe I am the same person at all. The skin's older and you change inside don't you .....but throughout all of that I think it would be nice in life if one had good enough experiences to feel that each and every stage they at least felt - value I suppose as well - you have a voice and that people do see you as a whole being.

Maria's Developmental Narrative

Each of us needs a sustained experience of being related to in ways that enable us to feel recognised and engaged with as an individual of worth. This experience is internalised such that a person can become their own 'advocate'. They can then act with 'agency' in the world and experience a sense of 'authenticity' in regard to themselves. When such a relationship has not been available to someone in their childhood or later then the therapist might offer this in a way that begins to be corrective.

Maria illustrates this in the particular biography of her first patient whose mother struggled to bond with her:

> Mother could never contain her as a child. It sounds like mother was very depressed after having her. ..... it sounds like she was quite rejected by her. . .... there is a sense of not being contained, of overwhelming feelings, of feeling not wanted, when siblings came along pushed out..... deprivation, the [lack of] sense of someone wanting to be with her..

Childhood relationships can be enmeshed in a way that does not allow a child to be reflective, to become able to distinguish its own needs and wishes and learn to act autonomously:

> Therapy is about reflective space and I think that particularly with her, because she seems to have spent her life just jumping. That is what she has not had. That's part for me of what the therapy is about, learning to use reflective space.

Maria's Treatment Narrative

Maria offers the patient an experience of being personally engaged with and 'recognised'. She seeks to 'be with' the patient, learn from the experience and allow an understanding to unfold:

> I know what it is for me, I think. I think it is about the process of them being with you, being with another and what that's about and I think it's about being recognised and I think it's something about being heard, being recognised, somebody struggling with you, not when you are going off mark saying you don't understand me but someone staying with you and trying to want to recognise whatever it is you are trying to - so it's something about recognition. And I don't think it's about clever interpretations, it's just about for me the process of being with somebody, what goes on.

When such recognition is experienced Maria implies it can be internalised such that the patient can offer it to herself. So she can be her own advocate and feel more confident about her presence in the world and have the capacity to tolerate experiences of difference from others:

> Advocate. It's like being your own advocate in a way.

> I think what I am trying to say is that if they are recognised in therapy, there is something about recognition, they are probably less frightened of being invisible out there and they can exist. I think that is what I am trying to say.

> Yes they have the right to some space. They can exist. They have as much right as anybody else.

It's about feeling you can be different with people but still have something to offer. You have a right to be there. You don't have to be the same...that's OK, not always to see eye to eye.

At the heart of the process of therapy is the provision and experience of reflective space. Agency is fostered in the patient by this experience of being provided with a reflective space:

What I often say to patients at the start of therapy or at assessment when they say "what is therapy about ?" it's about a space for you to come and think about yourself , your relationships and ...

She models a reflective stance that can tolerate uncertainty and not knowing:

I will often say to patients " I am not sure about this but" or "I don't know this but I am getting the [impression]", "I wonder if ". But I know with her [first patient] I use it a lot .....it's only recently she said it's all right to say I don't know this. And I smiled and said "I say that a lot don't I" and she said " oh yes you do". And it was something about she has to be so perfect and get everything right and I was even unconsciously with her modelling a different position which is I can be here and I can talk ... but I haven't a clue what's going on.

Maria is sensitive to the need to negotiate understanding and keep open a reflective space on both sides:

I am going to have to wait and see what she does with that [comment] .....it's about allowing yourself to think 'well OK' but leave some space for something different.

I do have the overall sense sometimes of wanting to be aware of a wider view. Or I like to think that the patients might be able to tell me

something. It's not that I have all the theories and that is going to fit .....I try and keep it open to other possibilities.....It might be that I have missed something else and they are trying to tell me something else.

I have heard myself say ....."I Think". But.....I only use that with patients who .... can say no to me if it's not right.

When patients make dramatic changes while in therapy, such as leaving a partner, this poses the question for Maria whether this is an impulsive or reflective act and what may have been Maria's own contribution:

I must admit I feel I have done something dreadful.

It's like she is either doing a lot of reflecting very quickly on her own or something is just being acted out but I can't stop it. I can't take full responsibility for that.

Patients, she says, sometimes quote you back and you think 'I never said that'. Her intention is to be non-directive and this can be frustrating to patients:

I would not overtly direct patients I hope.

Well she comes to see me and I don't tell her "no, you should go back or yes you shouldn't go back". I am trying to help her find her own way which patients can get very frustrated with at times .....

The experience of therapy may draw out the patient's inner disturbance such that it is seen by others who might see this as a backward step. Maria holds to the potential value in the long run of disturbance being allowed to emerge:

she's recently actually become more disturbed - some people would see it like that. This is the trouble with being a therapist, I actually think she is

doing something positive and useful in this disturbance ....Some people might think she has been fairly healthy and how dare therapy disturb her. You have made this woman ill.

The first patient supported Maria in this:

But she is saying it has really helped me. I might look like I am falling apart but I feel better about myself than I have ever done in my life which I think is interesting.

A lack of agency can be seen to be re-enacted and Maria described an occasion in which she clearly and expressively challenged the [first] patient over this:

You are doing it. You have been to see [X] and he has said do this and you are telling me how angry you are but you are doing it. Where are you in this ?

The greater the disturbance the harder it can be for the therapist to maintain a coherent construction of the patient in their head:

So it seems like the work [with the second patient] seems more focused and ... somehow it feels like it can be held together more where with the [first] patient I see as more disturbed... trying to get [it] all together.....I feel it's harder to get hold of.

Different patients bring out different responses:

You can't make interpretations to someone who is about to keel over.

And it can feel different with different patients. Some patients it might be full of transference interpretations but with somebody else it might not and actually I think that's patient led. .....There are things I might be

saying to one patient that I would be saying differently with another patient and I don't always know exactly why.

Maria voices her criteria for judging a successful outcome of treatment with her first patient:

> How do I know what is authentic with her? I will know when she demonstrates for me in a way that she is finding something for herself.

> Yes, if I feel she can hear both what he says and maybe what she thinks I say or anybody else but then can take stock and think about it and come to some solution herself, that to me feels more authentic.

Maria's Attachment to Professional Knowledge

Maria did not make explicit links in the interview between her approach and her own personal experiences.

Maria regards her form of 'knowing' of a patient as experience-based:

> A sense of something about her rather than saying "I know"..... It's a sense of her life experiences and how, what that means to her...how she feels about herself..... I know what it's like being with her , being with her is the story you hear so it's the experience of being with and the gathering of information that gives you a sense of who she might be, what's going on for her.

> I know something but it is the other sort of way of knowing which is about experience.

However, people are never 'known' in some definitive and objective sense anyway:

I only know or have a sense of what she brings to me but I always think there are parts of patients we don't know.....you never know anybody fully. I have worked with patients for years sometimes and can feel I have not got a clue about them. I don't feel I know much about them at all.

Her clinical thinking is informed by theory but hers is not, she feels, a very 'theory - conscious' approach in practice:

I don't think I go and think in models. I'm with patients but I do sometimes think whatever particular model is coming into my head at that particular time....rivalry, oedipal stuff as well .

Some people can hold on to bits of theory out of books and bring it up . If I do that it's probably only because I have re-read something recently. I am not very good at that sort of holding on to..... I might be able to call on one or two things I have recently read.

She describes ways in which she checks the ongoing 'validity' of her approach. She compares her understanding against her own experience and tests it out with colleagues for their 'recognition':

I suppose one of the important things I am saying is about being seen and recognised. If you are in isolation there is no-one to see you or recognise you . .....it's almost like I heard you almost saying that if I was going to go off at some weird tangent someone would step in and say "here Maria"..... Personal experience comes to mind . How do you get to the position? You get to the position through experience.

She looks to the outcome of therapies for confirmation or otherwise of the value and usefulness of her clinical thinking. These outcomes are not presented in idealised terms:

> How do we evaluate the outcomes of therapy ? My overall sense is that I might have a few therapies end, it's not been a brilliant ending or whatever but generally patients seem to find something useful. I would like to think they did overall. You know when they start telling you how they are dealing with their relationships differently and that side or they are doing things they did not do before, could not do before. It sounds really weak in a way but I suppose that is how you know or you have a sense that there is just something valid in it.

> But the stories they [the patients] tell change. So if they are coming and telling you they can hardly go out and socialise and have to hide in a corner when they do or basic things like they have not been able to work for years and all of a sudden they get a job or they buy their own house and tell you about having better relationships, more intimate ones, you start to get a feel that something is changing.

She sees the psychodynamic model as containing multiple perspectives that a therapist has to choose between. It needs to be open to further development:

> ..we know there is more than one model. And because thoughts are developing all the time, particularly with all the modern papers thinking more intersubjectively.....so I suppose it was like - what model were you thinking of ?

> Well if we weren't like that [staying open to new ideas] where would we be with - theories developed. We'd still all be Freudians wouldn't we and we would not be thinking about Object Relations. But it's a struggle.

> Yes even with the models we do have there are times when there might be at least a choice of three or four ways of looking at something. It's interesting then which do you choose at any one moment in time, if you were going to make a comment about something, it's interesting which you happened to be thinking.

Throughout the interview Maria implies a problem for her with 'knowing' and a need to negotiate knowledge based on the experience of the encounter. She is concerned to avoid claiming too objective a status for her clinical thinking:

> ....I will often say to patients " I am not sure about this but" or "I don't know this but I am getting the [sense], I wonder if..."....
>
> I don't know that I ever do know for sure, do I ?...
>
> I think it would be omnipotent for me to say 'I know'.....
>
> I know something but I don't know if I can tell you what it is I know [in response to an assessment].

The psychodynamic model at times stands in sharp contrast to other perspectives such as a psychiatric focus on illness. Maria quotes the example of the patient whose psychiatrist told her she was ill and psychotherapy would not help:

> ...but it is a different approach isn't it .....I think she has struggled all her life. I don't see her as having an illness. I disagree with him. It is a different perspective isn't it ?

Maria is aware of a punitive side to the model. As a therapist she can feel quite criticised by 'the model':

> I think the model can become quite punitive if we let it. You know how it is when you are struggling with some patient sometimes and you have those sessions when you think "God that was not very dynamic. I should not have said that" or "am I doing psychotherapy with this patient rather than thinking what is this about?" "What did this patient mean?" "This patient is trying to get something else out of me. Maybe it's because actually that's what they need rather than"....you know we end up punishing ourselves thinking 'Oh God am I doing psychotherapy here?'

Summary of the interview with Maria

In her interview Maria emphasised :

- that the psychodynamic approach contains multiple perspectives and a therapist is continually choosing between alternatives

- how her professional knowledge is informed by values / philosophy that centre around our need as individuals for someone to 'be with' us in a sustained way, recognising, valuing and engaging with us.

- that such experiences allow for an individual to develop an internal culture of 'authenticity' in their living, of 'agency' in their choices, and of self-advocacy.

- that one hazard encountered in the therapy journey is the pressure on the therapist to make decisions for the patient and thereby provide a map of what to do and how to act, so re-enacting in the therapy the patient's lack of agency.

- the importance for her clinical thinking of steering always towards the experience-near, emerging from the subjective encounter rather than steering towards and being led by more general theorising. This reflects her sense of the limitations of what a therapist can know about a patient.

- how an ability in the therapist to express views to the patient as 'enquiries' models for the patient a thoughtful and reflective stance.

- the need as a therapist to have a stance that steers firmly towards a 'being with' the patient that fosters a culture of reflection in the patient and allows them in time to 'act' with a sense of agency.

- a pressure she has experienced to be more hard-edged in her application of the model.

FINDINGS

Findings

I have described in this chapter my findings in two parts to reflect the sequence in which they developed in order to give to the reader more of a sense of the way in which these findings unfolded.

My analysis of the interviews resulted in a set of *initial findings* about professional knowledge and its use that focused around six areas:

- that the therapist's professional knowledge was drawn from their personal and professional experience.
- that its use constituted 'moral work from a value position'.
- that it was expressed in the form of narratives.
- that it was employed in the context of a relationship.
- that its use involved the therapist and patient in enacted narratives.
- that its use required the facing of limits.

A period of further analysis, literature search and the completion of the final four interviews resulted in five further findings which are the *core findings* of this thesis;

- that the use of professional knowledge in practice involved for the therapists a process of 'clinical reasoning'.
- that such clinical reasoning was organised in the form of narratives in the mind of the therapists.
- that in their clinical reasoning the therapist drew on 'situated' knowledge.
- that it involved a process of 'dialectical tacking'.
- that, in a postmodern climate, it constituted a 'hazardous journey' for the therapist.

Initial Findings

I have now set out my initial six findings along with a selection of references from the interviews that illustrated them.

1.1 The therapists' professional knowledge was rooted in and developed from a combination of their personal and professional experience.

The therapist's professional knowledge had emerged within the context of their particular life story. It was a perspective, drawn from an amalgamation of the therapist's own personal history, their professional training and experience and the local culture of psychotherapy within which they practised. It had developed within socially available discourses and practices. The individual personality was both the resource and the source of limits.

Peter and Mike articulated this clearly:

> All therapists have their own understanding about what the world is about and what people are about and they can't dispense with that so I'd probably say ...it's not a criticism. I'd think of it as something to be reckoned with and acknowledged (Peter).

> I suppose there were other ways you could make sense of him [first patient]. But I was his therapist and I was kind of like given the job if you like of being with him and trying to talk with him and I suppose me trying to make sense of him and draw on some of my reading, the ideas that came to me, that meant something to me. I don't know whether I would call it a truth...I think its meaningful - my formulation of him I think is meaningful. I think there'd be other meaningful formulations.....yes I am almost certain if someone else had been with him [the therapy] might have turned a very different shape (Mike).

Martin and Amanda described significant attachment to their professional knowledge which they felt was an integration of their personal and professional experience:

> It sustains me...well it keeps me going and if I was not able to keep going then I would not be able to function as a psychotherapist. Well, I don't know if I would be able to function as a human being and certainly not as a doctor or therapist...I suppose it is a way of thinking about the world that was clarified by my psychotherapy training - the way of thinking then became clothed in analytic language, became much richer because of the unique way it has of describing and understanding human nature. But clearly it was there before...it found a mode of expression (Martin).

> Well, I think the idea of being kinder to myself certainly comes from my own therapy (Amanda).

The experience of feeling at home within psychodynamic thinking and/or particular schools within the model was mentioned. Mary described a 'fit' between her experience and Kleinian thought. Amanda and Mary both recounted experiences that were thought of as 'a-ha' moments when they were reading theory and it vividly illuminated their clinical practice.

> I think that my sort of leaning towards post-Kleinian theories has evolved out of difficulties that I knocked up against with patients while I was training and thinking, "oh my God, what can I read so that I can understand this and help this ?" .....so if I would read something, often it would be a post-Kleinian paper and I would have this 'aha, that's what I think is happening with these patients' (Amanda).

1.2 The therapist's use of their professional knowledge constituted "moral work from a value position" (McLeod,1998).

The therapists' narratives shared a common theme or assumption of the 'reality' of what might broadly be called a 'deep interior self' (internal world) that could be helpfully explored and given room to develop within a relationship. Thereafter, the therapists were involved in working to determine what constituted 'the good' for a particular patient. Common ground was found in the way that the therapists valued the *integration* of a patient's sense of 'self' which was generally seen as split in some crucial way. Therapists valued too the capacity for *agency* in life, the ability to be proactive in life rather than just reactive. Therapists worked to support subjugated sides of the patient's personality and subjugated knowledge within the patient and in so doing subvert and change the balance in the internal world. The therapists also valued appropriate acceptance of the 'realities' of life.

I have selected quotes to illustrate some of the particular morals and values that were expressed by the therapists in the interviews:

> I suppose its about *facing reality*. I think we evade reality all the time but some more than others and yeah, I think it's that, facing reality and the pain that that involves and learning that pain is bearable.....I suppose it does not work not to (Mary).

> I think the task is to learn to *live more tolerantly* with how it is. I suppose the idea that you can't be selective about your inner experience, that it is as it is, but that if you start categorising it as 'that's a good thing to feel, that's a bad thing to feel, that's sick, that's o.k,' then you start *mutilating* yourself in a way that is profoundly unhelpful (Peter).

> I guess in ordinary everyday language I would say that they [the patients] need to *be kinder* to themselves (Amanda).

> You have to *accept the flawedness* of the world and the people in it and not be so totally disillusioned by it that you can't experience also the joy and the pleasure (Martin).

> It [life] may not be perfect but *it can be good enough* (Jo).

> It's about feeling you can be different with people but still have something to offer. *You have a right to be there.* You don't have to be the same...that's OK, not always to see eye to eye (Maria).

1.3 The therapist's professional knowledge was expressed in the form of narratives.

Each therapist had, I found, a stock of stories/narratives that they worked from, mainly implicitly. In the interviews each informant told their stories in relation to two particular patients but they were also presented as characteristic and generalisable. In summarising them here I acknowledge I have adopted an oversimplified style in an effort to bring out some headlines themes.

Martin's narratives included the need to take up and enjoy what life does offer and not allow the inevitable disappointments of life to stand in the way. The present needed to be seen in its own terms and not solely through the lens of the past. We carry fault lines in our personality that can be opened up by stress and defences can be undone to our cost. The therapist needed to think more widely than their psychological model and embrace biological and social factors and recognise when an alternative treatment was required.

Mary's narrative focused on the importance of facing reality, both internally and externally. She facilitated this as a therapist by being direct and where necessary quite confrontative within the context of the therapy relationship. Helping make the unbearable bearable and the avoided faced up to might be said to characterise the narrative.

Mike's narrative focused on our need for holding environments and containing relationships without which we experience ourselves as fragile, disorganised and unintegrated. Therapy may be corrective of some deficits through the therapist's in-depth relating in a reliable and ongoing context.

Amanda's narrative focused on the way we can become our own worst critics and enact destructive patterns of relating to ourselves and others. Her story lines were about narcissism and psychosis. Childhood deprivation may create an experience of a psychotic level of terror. As a therapist she looked to provide an experience of positive unconditional regard and thoughtful enquiry that would allow the patient to address their internal critics, track their aggression and develop a more creative and less destructive relationship to themselves and others. Supporting the development of more affirming sides of the personality might be said to characterise the task in her narrative.

Jo's narrative focused on our need as individuals for experiences of being well related to so that we can in turn relate well to ourselves and others. So as a therapist she looked to provide a quality of relating. A realistic sense is needed that life will not be perfect but can be 'good enough' so that we do not unnecessarily fail what is on offer. Staying open to the potential in living is perhaps characteristic of this narrative.

Paul's narrative focused on the way we develop and perpetuate patterns of relating that work restrictively for us. Therapy then is offered in his approach to promote a change in the pattern, a new ending to a familiar story line. This involves the therapist remaining creative under intense pressure to enact the familiar story line. What goes on in the therapy is in the service of change outside of the therapy.

Peter's narrative focused on the need for a pluralistic acceptance of ourselves and of our experiences and the 'mutilating' consequences of disowning parts of ourselves. As a therapist he aimed to offer an empathic presence, with a realistic level of ambition and with an openness to the unknown in the therapy. Fostering wholeness in the face of splits might be said to characterise his narrative.

Maria's narrative was focused around her sense of our need as individuals to be seen, recognised and engaged with so that a sense of our own personal agency and authenticity develops and we become capable of being our own advocate. To facilitate this she offered, in her role as therapist, a reflective space which the patient could learn to use and so move away from more reactive and impulsive responses that lacked agency. Inner disturbance needed to be facilitated to become outer disturbance if it was to be treated.

1.4 The therapist employed their professional knowledge in the context of a relationship.

This theme was explicit in some of the interviews and implicit in them all:

> And I suppose there is an essence of psychotherapy.....its about relationship and its about the quality of relationship - it is about the quality of your relating and crossing the bridge to the other person (Jo).

> I think it is something probably to do with contact, being able to make, to do deep and sustained contact with someone..... the job, the nature of the contract if you will, is that I provide the time and the room and I provide my mind and I try to use those and let the patient use those as freely as possible (Mike).

> I think it is about the process.....of being with another.....about being recognised, somebody struggling with you.....staying with you.....it's about recognition. And I don't think it's about clever interpretations, it's just about for me the process of being with somebody (Maria).

Such an experience of being attuned with was seen by Maria as providing an experience that could be internalised by the patient in terms of the quality of their relationship to themselves. As a result they could become more 'self-attuned' and be

more their own "advocate", have more of a sense "they can exist" and "have a right to be there". Peter talked of aiming to be the kind of therapist with whom he imagined he himself would be more comfortable sharing shameful aspects of himself.

It was a quality of relationship within a context that was being talked about. Therapy was offered within the NHS and followed an assessment for suitability. Martin explicitly pointed to the way that he actively assessed at the beginning of contact whether there was enough "common ground" for the therapy relationship to develop, whether there was a sufficiently "similar mind" and "shared understanding".

However, there was agreement that, while the relationship was the foundation of the therapy, more was involved. It was a matter of relationship *plus*. This *plus* was thought of as being about new experience or insight or a combination of these. However the establishment of an alliance was seen as essential to other components being usable. Mary commented:

> I don't think the relationship is sufficient but it is crucial and I really do believe that it is through the relationship, through the transference and counter-transference - that is how therapy works.

1.5 Therapies gave rise to 'enacted narratives' that could be deeply disturbing.

Phillips (1999) described life as an "enacted narrative" and Holmes (1996:104) suggested that it was as if there was "a compulsion to find an object with whom the drama of attachment - however painful - may be re-enacted". Such ideas fitted well the descriptions of the therapies given to me by the therapists.

The therapists actively looked for this re-enactment in which they felt the quality of the relationship was tried and tested. Each gave a central place to a view of therapy as 'enactment' and attempted to make sense of the enacted journey on which the patient was taking them. Therapists described how they experienced the more disturbed

patients (in the therapist's view) as more vividly enacting their disturbance within the therapy encounter. The patients viewed as less disturbed were experienced as far less testing to be with in therapy. The patients viewed as more disturbed were much more the focus of the interviews and as such these findings relate to the sharper edge of practice.

> I think what I was subjected to with the [first] patient was some of the awfulness of their inner world and through projective identification I think I was very much gripped in the awfulness of their inner world (Mike).

> So I suppose it's staying in touch with the feelings a patient brings up in me and how I feel, taking it to supervision and reading sometimes and recognising that that is a desperate activity to manage a counter-transference feeling (Jo).

> I felt that she need me..... to experience that painful position that she had been in [in her childhood] and go on living and basically go on surviving it and trying to come back in as reasonably positive, constructive unattacking way as I could muster... (Paul).

Some bruising encounters were described. Mary referred to the patient's presentation as like a "barrage" while Jo talked of "heavy duty" psychotherapy. Amanda described her reaction to viewing the patient's brutal self-harm. Paul talked of "a very taxing process", "almost unbearable". Martin described a situation where the exploration overwhelmed the patient's defences leading to a breakdown. There was no capacity in the patient, he felt, for any critical distance from what was happening. Peter described an enactment with a paranoid quality that emerged from a profound lack of basic trust in people.

The enactments, described by informants, were seen by them as involving a playing out in the therapy by the patient of important aspects of their internal world with the therapy structured to facilitate this. A hazard was seen as lying in the patient's cueing

of the therapist to join a re-enactment with a familiar outcome. The tasks of the therapist in response were variously described by informants as non-retaliation (Paul), endurance (Mike), staying with (Maria), a change of containment (Martin), staying alive (Jo), and providing holding and containment and offering empathy with the struggle along with a stance of no blame (Mike). Such enactment led to experiential knowledge (Maria) and new experience (Paul). This emerged from a mix-up at an unconscious level (Mike) and led to selves being 'created together' (Paul). Amanda talked of the need to tolerate aggression, withstand superiority, resist provocation to anger and withstand near psychotic levels of anxiety.

Paul talked of the need for the therapist to be able to take things personally and *not* personally at the same time. He voiced his maxim that the therapist must survive for the patient's sake and their own and so there might be a need on occasions to tell the patient to 'cool it'. He was also the one informant who described openly querying in his own mind whether he and the patient might have formed a 'toxic combination' such that another therapist was required. He talked of the need to enlist the non-neurotic part of the patient and of the danger and inevitability of being knocked out of position. Mary talked of the need for speaking reality to the patient, confronting and not being over-cautious in so doing. Maria countered impulsiveness and lack of agency with the provision of reflective space. Martin emphasised how the patients did not need, in the drama of therapy, another experience of failure.

1.6 Limitations had to be faced.

The therapists described the need for both patient and therapist to face limits. The sense that *life* imposed limits was described in various ways :

> ...it's possible to recognise one's limitations and to live to the best of your ability and capacity and achieve the most fulfilment possible within your own personal bounds and limitations. It's as good as it gets (Jo).

Well that pain and disappointment are part of life.....you have to accept the flawedness of the world and the people in it and not be so totally disillusioned by it that you can't experience also the joy and pleasure, the love in the world (Martin).

You can't be selective about your inner experience (Peter).

...living as good a life as you can but being realistic about that, that everybody has often contrary and often devious parts of themselves which causes them to do all sorts of things..... (Paul).

Several therapists described what they saw as the limits to *change* in some patients:

There are some who breakdown or symptomatically become much worse (Martin).

...illness has woven it's way into their personality. ...so bedded into social and interpersonal structure that their room for manoeuvre, for change, is limited.....change isn't always possible, it really isn't (Martin).

I think it is a matter of managing one's mental state rather than transforming it. I am not saying it could not be transformed in other cases, there are changes but there is something about very entrenched mental structures that I don't see the need to be anxious about in terms of wanting to change (Peter).

How do we evaluate the outcome of therapy? My overall sense is that I might have a few therapies end, its not been a brilliant ending or whatever but generally patients seem to find something useful....you know when they start to tell you how they are dealing with their relationships differently..or they are doing things they did not do before, could not do before...the stories they tell change (Maria).

> It's something about making connection with yourself, learning to love the person you are with the background you have and accepting the limitations there are. There are some things that change, others things that don't change....it's not perfect and for some people it's as good as it gets...as long as it's liveable with .....I guess it's about helping the person live with themselves and live with more of themselves (Jo).

The limits of *understanding* were repeatedly commented on. Professional knowledge was seen as only taking a therapist so far. Such knowledge was both affirmed and subverted by the therapists:

> Good ideas always get taken to the point at which they no longer are good ideas. Everything is pushed to the limit where it fails. Perhaps it has to do that. So biological understanding of the mind's processes becomes patently absurd at some point. But so does the psychoanalytic work (Martin).

> Our theories are what in a sense sustain us while something is happening that we don't understand which is why theory is really important..[certain concepts] are a useful short-hand for thinking about some of the way he presents. For me it's a bit like a nail or a screw. I make use of it. They are useful things and they do the job....I'd say that theories are useful but not necessarily true (Peter).

> What I want to convey to a patient at the outset is the tentative understanding, expressed with a reasonable degree of conviction "look I think this is what is happening" but either implicit or explicit is "but I may have got this wrong"...and I am looking for that as well (Martin).

I have learnt that there is not always a correct way. I think I have learnt that there is so much we don't know...and it's the sort of classic thing that the older you get the more you realise what you don't know (Mary).

I don't know if I ever do know for sure (Maria).

I think it would be more a strong working hypothesis along with all the caveats that this is me functioning at this time in this society with all the sort of cultural influences - so I don't imagine if I were a therapist twenty years from now I would be working in the same way (Mary).

Core Findings

The core findings of this thesis are that, rather than relying on professional knowledge conceived as conventional theory, the therapists engaged in a process I have termed 'clinical reasoning'. This involved a process of tacking principally between their professional knowledge base, their experience with the patient and their personal beliefs and experience. In their clinical reasoning they drew on 'situated' knowledge which was held in mind and organised in the form of narratives. Such a process, I argue, constituted a 'hazardous journey' in a postmodern climate in which the value of a psychodynamic perspective could not be taken for granted. My core findings emerged as I completed the remaining interviews and engaged with a further literature search.

2.1 The use of professional knowledge in practice involved a process of 'clinical reasoning' in the therapist.

At this point I felt strongly the limitations of my working definition of professional knowledge as theories of psychological functioning, theories about the process of being therapeutic for people, and underlying theories about living the 'good life' psychologically. It did not do justice to the processes I was finding in the interviews to be involved in the use of professional knowledge in practice.

So the central finding of this thesis is that the therapists were involved in a process best described as 'clinical reasoning'. This concept offered a far richer conception of the use of professional knowledge in practice. The accounts given of the therapies in the interviews showed me that far more was involved than could be summarised as the application of theory to practice. A significant part of the interview I felt involved the therapist in making explicit what was a largely intuitive process of 'reflection-in-action' in which they drew substantially on their previous clinical experience as much or more than on theory per se. Their clinical reasoning involved the therapists in an interplay between not just their professional knowledge but also their personal

experience of life and their experience of the patient. I have given examples of this in my initial findings.

I had found the phrase 'clinical reasoning' in two textbooks of practice (Mattingly and Fleming,1994; Dutton,1995) for occupational therapy students where it was used to conceptualise the process of occupational therapy in practice. There 'clinical reasoning' was seen as having three characteristics. It was a goal-orientated activity aimed at enabling the patient to achieve their best possible functioning. It was a form of reasoning that involved applying general theory to the particular patient which required 'situational thinking'. It was a cognitive process of problem-solving (Dutton,1995:3).

I reformulated this concept and reshaped it to apply it to the use by the psychodynamic psychotherapist of their professional knowledge in practice. I found within the interviews and within the literature support for such a deeper conception of professional knowledge, one that filled out the content of this concept.

Within the literature Schon (1983) challenged the view that real knowledge should be seen as residing in theory and technique, which are then applied to specific problems, as this did not do justice to the reality of practice. There was, he argued, a gap between professional knowledge and the demands of practice in the real world.

Polkinghorne (1992:14) suggested that while theory was useful in constructing cognitive order, it could not capture human complexity sufficiently and in this sense it was always at the level of inadequacy in itself. In practice there was an "unprecedented requirement for adaptability". Professional practice was characterised by "complexity, uncertainty, instability, uniqueness and value conflicts". He argued that practice was divergent and required divergent thinking skills in that the knowledge base had to be adapted to the unique situation. Problem *solving* approaches missed the point that professional practice required problem *setting* in terms of finding the right problem, naming and framing it.

Mattingly and Fleming (1994) used the concept *'clinical reasoning'* to capture more of a sense of a moment-to-moment process in the practice of Occupational Therapy. They were describing a process of 'reflection-in-action'. In my understanding of the concept I have combined these various more clinically active perspectives to conceive of the therapist's clinical reasoning as their attempt to stay in creative and exploratory therapeutic contact with a particular individual in a particular context and time. Such a perspective was filled out further by other writers who argued that such clinical reasoning might often be known only tacitly and that it emerged from practice.

Often 'tacit'

While such theorising might become explicit much of it was often 'tacit' knowledge, which was absorbed in less formal and conscious ways. Polanyi (1966) distinguished between 'distal' and 'proximal' knowledge. The former was that knowledge which could be expressed and so was reasonably accessible. The latter was less easy to identify, to find words for and be clear about but it was more significant and influential for practice. He captured the tacit nature of most professional knowledge with his comment, "we know more than we can tell." Given the complexity of practice it is perhaps inevitable that much remains tacit.

Emerging from practice

Mattingly and Fleming (1994) argued that what was most useful to the therapist in informing their clinical reasoning tended to emerge from practice and was based on experience out of which meaning had been made. Similarly Argyris and Schon (1981) distinguished 'espoused theories', which were those more likely to be written about in books, and 'theories-in-use' which were practical theories that formed a guide for practice and supplemented espoused theories at the points where they were experienced as lacking. Such theories-in-use might in time become espoused theories. In order to be useful to the therapist in their reflection, ideas needed what Gendlin (1962) referred to as a 'felt sense' of a 'fit' before they would be used, as when a metaphor or symbol 'works' and so unlocks a sense of meaning or new meaning.

Fonagy and Target (2003) argued that theory tended to focus more on the elaboration of psychological models such that, of Freud's twenty three volumes of his collected work, only part of one volume was specifically about technique. Practice, they argued, was not rooted in a theory-based certainty. Rather it was rooted in "cumulative clinical experience" such that "what we are theorising may be at most a useful adjunct to clinical practice - but not its justification" (p291). Clinical practice had developed on the basis of trial and error, based on inferences drawn from previous practice. Quite different techniques could apparently emerge from the same theory and quite different theories could appear to be behind the same technique.

2.2 The therapist's clinical reasoning was organised and held in mind in narrative form.

My initial findings had shown to me that, in their use of their professional knowledge in practice, the therapists I interviewed employed narratives. Further analysis led on to my second core finding that the therapist's clinical reasoning was organised and held in narrative form in their mind. As I have shown in the initial findings the therapist's accounts revealed the intrinsically 'storied' nature of their clinical reasoning. The narratives acted as frames for organising their thinking and included narratives about living the good life psychologically, about how psychological problems developed, and about how treatment was best provided and understood. I returned to the literature to explore this further.

Mitchell (1993) argued that in a postmodern climate professional knowledge could not simply be said to 'correspond' with 'reality' as if it provided an x-ray into the mind of patients. On the contrary Christopher (1996) argued that the therapist had to recognise the inevitability of fact and value being intertwined. Such a climate McLeod (1997) and others felt had fostered an enormous growth in interest in the idea of narrative as:

> "we are born into a narrative world, live our lives through narrative and afterwards are described in terms of narrative" (Murray,2003:111).

> "the story represents the basic means by which people organise and communicate the meaning of events and experiences" (McLeod,1997:x).

So McLeod (1997) argued that we construct ourselves through narratives but are also lived through narratives as we are part of wider social narratives. Ricouer (1987:437) commented that "we may learn to become the narrator of our own story without becoming the author of our life". Our personal narratives give us a sense of our location within time and our individuality. Ricoeur (1984) suggested we needed narratives because of the temporal nature of the world. They brought a sense of order to chaos by helping us define a 'plot' to our lives.

For Kvale (1992) the multiplicity of stories in our culture pointed to a loss of faith in single grand narratives as well as the extent of cultural diversity. Our narratives and the stories that comprised them were seen as emerging within a context such that they were context-dependent in keeping with the Talmud saying, "we see things not as they are but as we are" (quoted in Phillips,1999). The challenge provided by the concept of narrative was to open up an understanding of how stories help us construct and constrict a sense of reality. Booth (1991:78) captured this in his description of the novelist's focus:

> The novelist who chooses to tell this story can not tell at the same time that story; in centring our interest, sympathy and affection on one character, he inevitably excludes from our interest, sympathy and affection some other character. Art imitates life in this respect as in so many others.

McLeod (1998) charted the development of the use of the concept of narrative by therapists.

- Sarbin (1986) described the difference between the machine metaphor which he saw being employed in psychology and the narrative metaphor.
- Bruner (1986) described two different ways of knowing which he called paradigmatic and narrative ways of knowing. Paradigmatic knowing refers to what we think of as scientific knowledge that deals in generalities and abstract propositions. Narrative knowing refers to the way we talk about our experiences, in the particular, from the inside. The distinction is also thought about by Hobson (1985) as the difference between 'knowing about' and 'knowing', or, in Buber's terms (1937), between an 'I-It' and an 'I-thou' relationship to knowledge.
- Gergen and Gergen (in Sarbin,1986) outlined what they saw as the social construction of personal narratives. Social narratives are instrumental in defining both the culture and the experience of individual identity.

By way of definition McLeod (2001:104) argued that a story could be "tentatively defined as an account of a concrete, specific event, with a beginning, middle and end, active protagonist and some kind of dramatic climax." He further defined a narrative as an "organised interpretation of a sequence of events" which attributed agency to the characters and pointed to causal links. A narrative implied a narrator who brought to a story comments that provide evaluation of the story for the reader. Taylor (1989) referred to weak and strong evaluations which were statements within the narrative by which the narrator conveyed the relative importance of different aspects of the story. The terms 'narrative' and 'story' tend to be used interchangeably in the literature. I have not found that problematic and have also used them interchangeably.

Narratives were thought of as having one of three structures (Gergen and Gergen in Sarbin,1986). A narrative with a *progressive* structure conveyed a sense of a struggle that had led to success. A narrative with a *regressive* structure conveyed the sense that a struggle had led to someone becoming overwhelmed. A narrative with a *stable* structure conveyed a sense of a struggle that had resulted in little change one way or another. Narratives could be thought of as a combination of these.

McLeod (1997) suggested that story telling used to have an important role within western culture as a way by which people aligned themselves with their society. In modern western culture such a social role had reduced. However therapy was one setting for individual story telling with a focus now more on the individual's story. He described three approaches to stories within the therapies :

- a therapist can look beyond or behind the story to what he/she views as a deeper and more foundational level of reality and such therapy would be "narrative informed".
- a therapist can work with the individual's actual story, keeping it as the focus of attention.
- a therapist can attend more to the cultural, collective stories that lie behind the individual story.

Psychodynamic Psychotherapists, McLeod (1997) argued, practice in a way that is narrative informed whereby they have looked beyond or behind the story for a deeper level of reality.

Phillips (1999) applied the concept of narrative and story to Freud's work with patients. While 'narrative' is not a term Freud used, Phillips argued it was very relevant to Freud's project. Given the centrality of this concept to my research I have quoted Phillips (1999:28) more fully:

> While Freud did not use the terminology of narrative, his entire enterprise was built upon the introduction of the unconscious to fill in the gaps of the patient's conscious narrative; i.e. the patient would attempt to tell their history, the story of his or her life. But the story would be filled with breaks, incoherencies, missing links, all of which Freud came to attribute to defensive processes that kept the missing portions out of consciousness.
>
> These breaks in the attempted story were usually marked by the eruption of symptomatic behaviour (e.g. the patient presents a story as a happily married man and then reports his incomprehensible and self-destructive

visits to prostitutes). Freud treated these symptoms as a break in coherence of the patient's consciously enacted life narrative and he argued that coherence could be restored through the insertion of unconscious content into the broken narrative.

> The patient came in with a story that did not make sense in significant ways, and the consequence of psychoanalytic treatment would be the restoration of sense. In this original formulation, therefore, the unconscious did not represent a limit to the life narrative; in fact, it represented the opposite, a fulfilment of narrative.

Phillips (1999) then divided what he saw as the Freudian narrative into three parts:

- a psychodynamic narrative which comprised of the patient's telling of their story which evolved as the therapy proceeded and a psychodynamic perspective was absorbed.
- a developmental narrative which comprised Freud's account of how the patient's difficulties had come about.
- a treatment narrative which involved the patient in free association, giving rise to transference and defences and the interpretation of conflict and needing a period of 'working through'.

Phillips (1999) argued that, for Freud, these three formed a 'unitary narrative' as he gave the Oedipus conflict pride of place in psychological life. Phillips described this as a "one-size-fits-all" approach. The patient's psychodynamic narrative would display how oedipal issues were being addressed or repressed. The therapist's developmental narrative would describe when oedipal issues arose. The therapist's treatment narrative would involve the patient re-living in the transference his or her oedipal difficulties. Such a unitary narrative, Phillips felt, was too constricting for a time in which we live with theoretical and clinical pluralism. This I found to be reflected in the way that narratives had the potential to be quite diverse even within the psychodynamic approach.

McLeod (1997:23) commented that "each therapist has a story to tell about how life should be lived, and can not help but convey this story to clients." Phillips (1999:35) believed this required of therapists a capacity to choose and defend their narrative choices:

> Since any person's life can be seen from many perspectives, and since the life story can be told in many ways, one must choose one's narrative approach and be prepared to defend it.

Phillips (1997:2) posed a question central to my study :

> To walk into a psychoanalyst's consulting room, like being born into a family, is to walk into a very elaborate family of stories about who one is supposed to be. But if analysts can help patients discern the family stories they have inherited, who can help the patients, and the analysts, with the analysts' stories ?

I found that the concept of narrative had been used to date in limited ways within psychodynamic psychotherapy which remained a lightly narrative-informed approach. Only two examples of its use stood out in the literature.

- Luborsky et al (1994) and Strupp and Binder (1984) and others had explored the patient's stories in therapy for evidence of core storylines that illustrated 'core conflictual relationship themes'.
- Therapists employing an attachment perspective had pointed to a demonstrable link between the quality of childhood attachments and later adult narrative style. Securely attached infants, it was said (Holmes,2001), told coherent and engaged stories as adults. Narrative style provided then a clue to the nature of childhood attachments.

However there were ways in which some writers felt that psychodynamic psychotherapy could be more readily thought about in narrative terms. Mattingly (1991) suggested the therapist initially constructs *a prospective treatment story*. The

raw data for this, particular to the patient, was drawn from referral letters and initial contact. At that point the therapy itself was an *as-yet-unwritten story*. The patient and therapist became involved in *story making* which required a 'doing-with' each other, a co-scripting. Ricoeur (1984) referred to this as 'emplotment'. Telling stories was a retrospective activity while story-making was a prospective activity. A sufficient sense of '*sharing the same story*' was needed for therapy to progress.

When the *prospective treatment story* met the 'reality' of the interaction it would then be modified, revised, rewritten and adapted (Mattingly,1991). The therapist was an "assistant biographer" (Holmes, 2001) who worked to help the patient develop a coherent biography in which they could distinguish their own experience from that of others, tell the story of their feelings and have a capacity to break up and reform their stories, to construct and deconstruct their narratives when new experience required it.

Where such shared progress was not possible a painful sense of a loss of story, or *"falling out of story"* took place which might or might not become part of a newer more encompassing story (Mattingly and Fleming,1994). In this way of thinking, stories developed (or fell apart) through shared experience. The story had a future focus in that it involved a vision of what might be achievable, in keeping with what was seen as living the 'good life' psychologically.

When experience had been traumatic the patient might have narratives that remained *"in the raw"*, in search of a voice (Holmes,2001). The therapist then was like a witness who looked on the unbearable with the patient who feared that in any attempt to tell the story they would become *stuck in the story*. However, Holmes (2001) suggested that the experience of engagement with the therapist could allow the patient to engage with their story and develop some critical distance from it in the way that was being modelled by the therapist.

2.3 In their clinical reasoning the therapists drew on 'situated' knowledge and understanding.

In my initial findings I had come to see that the therapist's professional knowledge was the product of both personal and professional experiences. There was sense in which theory *was* biography. However I felt on further reflection that I had understated and underplayed the importance and significance of this finding. The clinical reasoning of these eight therapists had emerged from a context and was being held within a context and the implications for practice of this 'reality' needed further attention. This was most in evidence in the sections I entitled 'attachment to professional knowledge'. I found two particular contributions from Mitchell and Haraway in the literature opened out this area for me.

Mitchell (1988:276) as a practising therapist described what he saw as the context in which a sense of self develops. I have included it here as quite a long quote as it became central to my thinking.

> One cannot become a human being in the abstract; one does so only by adopting a highly specific, delimiting shape, and that shape is forged in the interaction between the temperamental givens of the baby and the contours of parental character and fantasies.....the prolonged condition of childhood dependency makes the discovery and forging of reliable points of connection not just an emotional necessity but an apparent condition for physical survival....
>
> .....I become the person I am in interaction with specific others. The way I feel it necessary to be with them is the person I take myself to be. That self-organisation becomes my "nature"; those attachments become my sense of the possibilities within the community of others; those transactional patterns become the basis for my sense of interpersonal security and competence to function in the world.

> Adhesive devotion to the relational matrix reflects a deep terror of total loss of self and connection with others, as well as deep loyalty and devotion to the interpersonal world which, no matter how skewed, allowed one to become one's own particular version of human.

Haraway (1988) coming from the perspective of epistemology had deep criticisms to make of the kind of objectivity that implied a view from above, a "conquering gaze from nowhere", a transcendence in perspective. She described such knowledge claims as "unlocatable" and "irresponsible" in the sense that no one takes responsibility or is accountable for them. She was equally critical of relativism which she described as "a way of being nowhere while claiming to be everywhere equally. The "equality" of positioning is a denial of responsibility and critical enquiry" (1988:584).

Such objectivity and relativity, she argued, were "perfect mirror twins" of each other and missed the point :

> [Both are] "god tricks" promising vision from everywhere and nowhere equally and fully, common myths in rhetorics surrounding Science (Haraway,1988:584).

> The only way to find a larger vision is to be somewhere in particular (Haraway:1988:590).

She identified a task of 'seeing from below' and argued for an "embodied objectivity", for "partial locatable critical knowledges", for an "epistemology and politics of engaged, accountable positioning" and a rationality that "does not pretend to disengagement".

Haraway (1988:583) redefined objectivity as:

> a particular and specific embodiment and definitely not about the false vision promising transcendence of all limits and responsibility. The moral

> is simple : only partial perspective promises objective vision. All Western cultural narratives about objectivity are allegories of the ideologies governing the relations of what we call mind and body, distance and responsibility. Feminist objectivity is about limited location and situated knowledge, not about transcendence and splitting of subject and object. It allows us to become answerable for what we learn how to see.

She further looked to remove the individuality from traditional views by seeing situated knowledges as "about communities, not about isolated individuals."

The combination of these two perspectives from Mitchell and Haraway further informed my finding that the clinical reasoning of the therapists I interviewed was drawing on 'situated knowledge' held and developed within a community. Mitchell (1988) had written about the process of becoming one's own particular version of being human. Haraway (1988) had argued that to have a larger vision one had to be somewhere in particular. So the clinical reasoning of the therapist could not be separated from the therapist who employed it and needed a community to foster it.

Inseparable from the therapist

McLeod (1998) argued that the clinical reasoning of the therapist could not be separated from the person who employed it and operated on intuitive-subjective lines as much as on scientific-objective lines. Bergin and Garfield (1994:499) suggested that "the ability to forge a positive working alliance, make accurate interpretations, act in a plan-compatible fashion involves skills that reside in individuals, not in a body of theory". Mattingly and Fleming (1994:11) quoted Aristotle (1985:51) that "...getting angry, or giving and spending money, is easy and anyone can do it; but doing it to the right person, in the right amount, at the right time, for the right end, and in the right way is no longer easy, nor can everyone do it. Hence [doing these things] well is rare, praiseworthy, and fine."

Fostered within a community

Just as the clinical reasoning of the therapist could not be separated from the therapist who employs it, so too it could not be separated from a language community (of therapists) in which it has been held, developed and maintained. This community contained an "oral tradition" which could not be subsumed within a textbook but was, in the words of McLeod (1998:199):

> A richer, more comprehensive, more open-textured version of what is known and believed...Books and articles convey a version of this approach, rather than the approach in its entirety.... [Theorising is better seen as] an active, subtle, personal and interpersonal process...embedded in social life, and the written word inevitably abstracts ideas and concepts from their actual usage.

Such theorising was often communicated in story form between colleagues, perhaps over a cup of coffee in the kitchen, and it might become part of the shared, collective experience of the group and/or become part of espoused theory. Rustin (1991) wrote of the method by which psychotherapy was taught as being like a "craft apprenticeship" in the sense that understanding was fostered in supervisory and therapy relationships in which the detail of sessions and the therapist's own life respectively were gone into in depth.

The therapists I interviewed articulated their sense of their 'situatedness' in that they were aware that they were offering their version of being a therapist. There was less comment on their roots within a particular therapist culture in which particular narratives were favoured and fostered while others were not. I was reminded of Booth's comment (Booth,1991:78) that the writer cannot tell all stories but has to focus. I was also reminded of Mitchell's comment (Mitchell,1988:276) that we become human beings, not in the abstract, but by adopting a specific shape forged in interactions with specific others through which we develop our own particular version of being human. This, I felt, applied also to the experience of becoming and being a therapist.

This finding seemed both self-evident and new to me. After all therapists engage in their own therapy precisely to understand better their own 'situation'. And yet the idea of 'situatedness' had not been clear to me as a practising NHS psychotherapist. This finding posed for me a question about the particular psychotherapy culture in which the therapists had 'grown' and the particular culture of therapy they offered to their patients, with its strengths and limitations.

2.4 In their clinical reasoning the therapists were having to negotiate tensions by a process of 'dialectical tacking'.

The interview accounts I found to be full of the interplay in the therapists particularly between their professional knowledge, their experience of the patient, and their personal experiences and beliefs. I found these tensions could be further divided and conceptualised. I observed in the therapist accounts that they were tacking between:

- viewing themselves as an observer with objective vision and viewing themselves as a participant with subjective vision. Another way of conceiving this was in terms of the therapist viewing the patient in terms of generalisable 'norms' and viewing the patient as a 'universe of one'.

- 'being with' the patient empathically and 'doing to' the patient in a way more deconstructive of the patient's psychological world. This could also be viewed as a tension between the aims of evolution and revolution.

- being expressive and being restrained towards the patient.

- supporting culture or fostering counter-culture in the patient and the wider social system.

- adapting the psychodynamic model (with a 'soft-edge' to its use) or applying the perceived psychodynamic model (with a hard-edge to its use).

Tacking is a word with several meanings that include tying, varying, navigating, deviating and changing one's mind. In the context of this thesis it refers to a process that involves alternations and variations and movements between polarities. The term 'dialectic' implies for me opposing forces acting on each other. Ogden (1994:14) described a dialectic as :

> a process in which opposing elements each create, preserve, and negate the other; each stands in a dynamic, ever-changing relationship to the other. Dialectical movement tends towards integration's that are never achieved. Each potential integration creates a new form of opposition characterised by its own distinct form of dialectical tension...In addition, dialectical thinking involves a conception of the interdependence of subject and object...one cannot begin to comprehend either subject or object in isolation from one another.

I have now expanded on these tensions in the interviews and incorporated the results of the further literature search that I undertook.

2.4.1 Therapist's clinical reasoning involved them in a process of 'dialectical tacking' between seeing themselves as observers with objective vision and participants with subjective vision.

I found a range of literature that addressed my sense that the situated nature of the therapist's clinical reasoning in a postmodern climate had led to a need to tack between objective and the subjective perspectives, between reasoning clinically about the patient in generally classifiable or normative terms and reasoning clinically about the patient as someone who is unique, "a universe of one" (Erikson,1958).

Bruner (1986) described what he called 'paradigmatic' and 'narrative' ways of knowing. The former referred to more abstract and scientific forms of knowledge and knowing that involved causes, effects and predictions. The latter referred to a form of

knowing that was held in personalised story form, specific to the individual rather than abstract. Hobson (1985) adapted Buber's concepts (1937) to suggest professional knowledge involved the ability to think in both abstract, theoretical terms about the patient (I-It) and also in particular personal terms (I-Thou). An interweaving of both, he argued, was needed. Likewise Corwen (1995:28) described a process of 'tacking' between the general and the particular, which was expressed in:

> ...a therapeutic stance that neither eschews specific cultural knowledge or behavioural theory out of concern for stereotyping or false 'knowing'.... nor overlooks idiosyncratic perceptions and interpretations of the culture... a full understanding of another's point of view involves a process that Geertz (1983:69) described as a 'continuous dialectical tacking' between idiosyncratic perceptions and meanings and broad characterisations of culture and grief experiences.

Ogden (1994) argued that too much objectivity constituted a clinical problem as well as too much subjectivity. Bion (1975) wrote of the need for a therapist to hold together their knowing and not knowing in what he called 'binocular vision'. One eye focused on what the therapist felt he did know about the patient and the other on what was not known. This required the capacity for free floating attention which he called 'reverie'. Bion was particularly concerned about the danger posed by the therapist prematurely concluding they understood the patient.

Phillips (1995:8) described the need to "straddle" two projects:

> The contemporary psychoanalyst - who must straddle both projects, contain within herself the Enlightenment Freud and the post-Freudian Freud, the knowing and the problem of knowing - becomes a new kind of expert: an expert on the truths of uncertainty. She has to recognise the sense in which each person revises - is inevitably a threat to - the available description of what a person is.

Fonagy and Target (2003:291) suggested therapists needed to manage a tension between linking theory tightly to technique and so gaining from advances in theory, and decoupling theory from practice so that technique can progress on the more empirical grounds of what is effective.

Keats was regularly quoted in the literature for his concept of 'negative capability', "that is when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after facts and reasons" (quoted in Casement,1991).

In the interviews I perceived that the therapists had and needed a sense of their *objectivity,* a frame of reference that they could take sufficiently for granted. A correspondence was implied between their frame and 'reality' such that the frame could be thought of as having been 'found' more than constructed. A strong conviction was evident about the 'presence' of a deep interior self affected by nature and nurture which gained from a sympathetic exploration. Peter talked of this inner self as "an absolute truth".

I observed that a way of structuring their thought, a way of classifying a patient as part of a norm or a diagnostic category, was generally a necessary first and ongoing step. This corresponded with Buber's notion (1937) of an I-It relationship in which the perspective of available cultural discourses provides the basis for understanding. A strong level of conviction was apparent in all the interviews (with some variation of level).

Martin voiced the need to assign a descriptive category to the patient' problems in order to orientate himself and without which he would feel "all at sea". Jo spoke of moments of felt objectivity when head and heart came together. Peter spoke of the way theory held him while he encountered what was unknown in the patient.

The perceived location of this sense of objectivity varied. The therapists did not voice a strong sense it was locatable in the patient. Several talked as if it resided in the model itself though this was criticised by Paul who suggested objectivity implied an

evidence base. There were suggestions it might reside in the space between patient and therapist. There were references to the idea that part of the assessment process involved trying out the psychodynamic perspective with a patient to see if they were willing and able to give it a status of provisional objectivity. The patient could be seen then to objectify the approach (and the therapist) as a necessary part of making informed consent to treatment.

The therapists described the need to recognise their *subjective* involvement, their participation, how they were part of what they were observing in keeping with Haraway's concept of "situatedness" (Haraway,1988). There was an awareness of the impact of their own unique personality on the process of therapy. Subjectivity was strongly located in the patient's perspective. There was less of an articulated sense of the subjectivity/relativity of the model itself, its situatedness. The model, as a participant, was accorded more objective status. So, the constructed nature of the insights arrived at in therapy was acknowledged but with some limitations. Subjectivity was felt to involve a 'being with' the patient in an I-Thou relationship with an awareness of the patient as constituting a "universe of one" rather than the patient being made to fit a 'norm'.

Subjective and objective had an 'in-out' feel to them. The subject participated and the objective person observed. Perhaps it is best to say that the therapists sought to temper each perspective with the other, to observe their subjectivity and to subjectify their objectivity. In the interviews informants appeared to struggle with the *middle ground* perhaps describable as the wish to be either *objectively subjective* or *subjectively objective.*

Objectivity and subjectivity were thought about both as resources and limits and there was a strong sense of practice involving tacking between them. The therapists could also be said to be tacking between Hamlyn's four epistemological positions (1970) and between their pre-existing narratives and emerging new narratives. There was a sense for some that the model provided the objectivity leaving the practice free to be particular and individual.

Maria talked of her knowledge as experiential i.e. it was a *participant's* knowledge. While she stated clearly her convictions she emphasised her uncertainties and how she never really knew. Martin looked to make judgements that were tentative but based on a reasonable degree of conviction with an implicit acknowledgement he may have got it wrong. He also felt all ideas got pushed beyond the reasonable and he was wary of dogma. Peter talked of the "esoteric" and "incomprehensible" being nearer the truth of things when it came to our knowledge base.

Mike wanted to avoid premature conclusions. Jo wanted to avoid simply labelling disagreement as resistance and talked of having a "sketchy map", and a "sort of theory", of being sure but of the danger of foisting a view on a patient. Mary talked of formulating strong working hypotheses. Amanda was reluctant to assume the role of expert. The developing understanding of the therapist was thought about more in terms of patchwork quilting than a neat, objectively based knowledge (Saukko, 2000).

2.4.2 Therapist' clinical reasoning involved them in a process of 'dialectical tacking' between 'being with' a patient in a way that supported and contained them and 'doing to' a patient in a way that was more deconstructive of their sense of self.

There was evidence in the interviews of the therapists weighing up their stance with their patient and tacking between these two particular stances.

'Being with' implied an attuned, empathic, non-directive way of being with the patient which allowed time for development within a 'low-structure' frame to the therapy. It involved an emphasis on togetherness, mutuality, sharing and reciprocity. It involved a process of working with the patient to hold together a particular version of the patient's self.

'Doing to' implied a stance that was more interventionist, exploratory, directive and challenging, It emphasised the aloneness, distinction and autonomy of the patient. It

was subversive of the patient's established patterns as it involved a deconstruction of their apparent objectivity.

Managing this tension involved a constant assessment by the therapist of the resources and limits of the patient and a judgement of the hazards of conveying either intrusion or a lack of presence. This was presented as linked to the patient's psychological health on the basis that the psychologically healthier patient could tolerate and make use of a greater degree of 'doing to', of de-construction of their sense of self. I thought this could also be thought about in the interviews as the difference between the aims of psychological evolution and psychological revolution in the patient.

There was literature to support my perception of the therapists tacking in this way. In particular there was a paper by Wolff (1971) which addressed what he called the developmental and therapeutic functions of psychotherapy.

The developmental function of psychotherapy, he argued, paid attention to areas of arrested development or 'knots' in the patients development. The therapist was seen as providing a holding function, an empathic 'being with', rather as a parent would do for a child. It involved the therapist in being empathic, being intuitive, being reliable and being sensitive. The focus was less on symptoms and more on the patient's development needs and the evolution of their personality. Such empathic work, he argued, had to be allowed to follow the patient's developmental timetable.

Buber's (1937) concept of an 'I-Thou' relationship appears to me to reflect a similar stance. Roger's (1957) description of the therapeutic relationship as needing to be characterised by an attitude of empathy, warmth and unconditional positive regard on the part of the therapist also appears to me to reflect this 'being with' stance.

The therapeutic function of psychotherapy Wolff (1971) regarded as more in line with the classical medical model with its emphasis on symptom alleviation and results. The patient was viewed more as an object to whom the tools of the trade are applied in order to 'do something' therapeutic. This approach is characterised by action

language, for example when the therapist *gives* an interpretation, *challenges* a stance, *explores* an issue or *addresses* a problem. Wolff believed some separateness was implied between therapist and patient in this stance and areas of the patient's experience are isolated and focused on. Outer behaviour took more of the attention.

Phillips (1997:160) suggested the twin risks were that a therapist would be "too happy to settle for too limited a version of the patient" or that the therapist would be "too demanding of the patient to be many people ...a repertoire of possible versions of oneself". So in their clinical reasoning the therapist had to tack in their mind between these possibilities.

These two functions were not in Wolff's view entirely separable and he emphasised how correct 'doing to' depended on the right kind of 'being with' and how 'doing to' came after 'being with'.

To these functions Holmes (1993) added that of 'doing with'. He suggested that psychotherapy had moved from Freud's father principle and the patriarchy of the time, through to the maternal principle post-second world war and on now to the principle of the sibling which he saw as a phase of "therapeutic co-constructionism" whereby "therapist and patient collaboratively build up a picture of their world and history". This appears to me to be a combination of Wolff's two functions.

Hobson (1985:73) offered a parallel tension between aloneness and togetherness in therapy which he saw as a process requiring a rhythm of 'aloneness-togetherness' which was not a static state. Rather "it is continually recreated out of verbal and non-verbal conversations between people in a balance of stability and change with a rhythm of intimacy and distance". He was describing a hope, an ideal, but not, he said, an idealisation. 'Doing to' emphasises a patient's aloneness in terms of their separateness from the therapist while 'being with' emphasises more the experience for the patient of intimacy with the therapist.

Generally the therapists emphasised how an attitude of 'being with' provided an essential backdrop and pre-condition to a necessary attitude of 'doing to'. The therapies described were for the most part longer term work which allowed for evolution. However, the exploratory element of psychodynamic psychotherapy implied a 'doing to' as well as 'being with'. So there was a need to be open to more than a gradual evolution and therapists varied in this regard in their examples they gave. Differences emerged as to whether therapists found a relatively fixed position within the continuum or tacked between positions in the context of the particular patients they were talking about.

As regards 'being with', Maria talked of 'recognising' and 'engaging with' the patient and providing reflective space, Jo of 'attunement' with the patient and how developmental change can not be hurried. Mike talked of providing holding and containment provided in an unhurried way, and Amanda of providing something akin to Roger's notion of unconditional positive regard. Perhaps Amanda's account can be thought of as 'evolutionary Kleinian' compared to Mary's 'revolutionary Kleinian'. Images employed in the interviews were generally along integrative lines e.g. connect, accept, bear. The implication or faith was that growth would occur with the right conditions - though it may be limited.

As regards 'doing to', Mary talked of "confronting", "standing up to", "being very blunt", "putting in black and white" and avoiding being "too cautious". Paul stressed the importance of the patient taking "significant action" in their lives outside of therapy and the dangers of being over-valuing of and over-investing in the therapy such that it became a "substitute life". He saw value in limiting the time spent in therapy. Martin's account pointed to the dangers of exploratory work when the patient lacked the 'ego strength' to cope. With his other patient Martin spoke of using six sessions to help "launch her", "free her up", "give enough hope." The risk of 'doing to' was described by Peter in terms of the patient taking in/introjecting the therapist as akin to a foreign occupying force.

The idea of *'doing with'* perhaps represented an attempt to hold both in tension. Informants gave a sense that they *'do'* reflection with their patients. Paul talked of generating "shared images". Maria spoke of making a reflective way of thinking available to patients. Amanda spoke of her egalitarian style of co-exploring. Mike spoke of offering his mind to the patient to think with. This is in keeping with the notion of reflexive self- functioning as a goal to be prized over insight per se.

2.4.3 Therapists were involved in a process of 'dialectical tacking' between expressiveness and restraint towards the patient.

In the interviews therapists reported experiencing a dilemma as to how restrained or expressive to be with the patient. While they gave accounts of some alternation they described generally erring well more on the side of restraint.

I found support for this finding in the literature. Classical psychodynamic theory, Mitchell (2000:216) suggested, was heavy on injunctions to be restrained, neutral, abstinent as if following a maxim, "when in doubt, don't.....silence and emotional flatness are safe". Mitchell questioned whether this constituted a form of "posturing non-involvement" and "hiding". What he saw in the post-classical literature was "an emancipatory tone of expressiveness" and a taking account of the engagement of the therapist being at a deep emotional level.

In the same vein Paula Heimann (1989:317) wrote of the therapist's need, not for neutrality, but for "tamed naturalness". Kennedy (1998) saw the tension as being between the therapist as coming over to the patient as being too friendly or too unempathic. Coltart (1986:142) wrote of the need for "intuitive, unlaboured spontaneity" and of the strain of restraint and the loneliness of the consulting room. Ogden (1989:127) wrote of therapy as "intimacy in the context of formality" and suggested "we have yet to work out a way of fully taking into consideration both expressiveness and restraint in theorising about clinical technique".

Mitchell (2000:146) suggested disciplined self-reflection is a pre-requisite of spontaneity:

> Both restraint and spontaneity can be either thoughtful or thoughtless. It is a central feature of the analyst's craft to struggle with these distinctions, to make what seems to be the best choices at the time, and continually to reconsider past judgements and their sequelae, in order to expand and enrich the context in which current choices are made.

He distinguished the restraint needed by the therapist from that of the patient. The patient is encouraged to be expressive, to allow buried emotions to be heard, in a sense, he says, to be irresponsible with their emotions - an analytically constructive irresponsibility. Conversely the therapist is responsible for keeping the experience analytic. The patient is able to let out feelings not, he suggested, because of the therapist's anonymity as in the classical model of therapy, but rather because of the therapist's disciplined engagement.

Therapist can be passionately feeling and also remain analytic because, Mitchell (2000:29) argued, feelings are context-dependent. We shape our feelings such that what we feel depends to some extent on what we want to feel. So "we all construct contexts and cultivate relationships in which certain kinds of loves and hates can develop and others are foreclosed". Shafer (1976) suggested similarly that emotions are actions.

Restraint was a hall mark of the accounts therapists gave to me in the interviews. Therapists sought to give space to the patient, to be less directive and allow the focus of attention to be on the patient with as little intrusion as possible. However, this was not conveyed as being a blank screen. Rather they saw themselves as quite passionately involved with patients but having to hold on to an immense amount of their passionate feelings.

Mike spoke of the need to hold on to the agony of the patient, Mary talked of a patient's dishonesty as "a blow in the stomach", addressed but not retaliated for. Peter's 'rehab therapy' was long-standing with limited gains and Paul talked of tolerating much goading and denigration. Amanda had to witness the effects of severe assault by the patient on her own body. Jo referred to the need to throw open the windows *after* a particularly deadening sessions to enliven herself again. She also comments on her over-restraint when a flower pot was thrown at her by a patient after which she failed to react. Jo described refraining from physical contact with patients. Amanda described how she would look to meet aggression with a thoughtful response.

Expressiveness was also in evidence. Mary could be quite direct as could her supervisor. Jo would speak firmly when 'head and heart' came together. Paul described retaliation towards his patient as an expressiveness he was unable to monitor and check in time. Maria challenged a patient with "you're doing it to yourself". Paul described a need on occasions to tell a patient to "cool it" when their expressiveness was threatening the therapy.

The hazard might be expressed as the danger of intrusion by expressiveness over against the danger of a felt lack of therapist presence if they were too restrained. Restraint was something informants practised and actively fostered in themselves.

2.4.4 Therapists were involved in a process of 'dialectical tacking' between supporting culture and promoting counter-culture.

In the interviews the therapists described a tension that I have conceptualised as between supporting culture and promoting counter-culture. This tension overlaps with the previous section concerning 'being with' and doing to' but also goes beyond it in ways that I describe.

I am using the term culture in two ways. Firstly, it applies to the internal world of the patients as described in the interviews. The therapists described working to gain a 'feel' for the culture within the mind of their patient. Secondly' it applies to the contexts in which the therapists were practising about which they had important things to say.

With regard to their patients the therapists reported having to weigh up in their own minds and with the patient what constituted appropriate therapeutic ambitions at each point in the therapy, tacking between the ambition of radical change in the creation of a counter-culture within the patient and the ambition of promoting an acceptance of aspects of the inner culture.

I found support for this in the literature from the point of view of changes within the culture of therapist ambitions. Sandler and Drehr (1996) set out how wide the variations in therapeutic ambitions have been over the years. Holmes (1998) argued that there had now been a movement away from the therapeutic aim of radical change in the personality of the patient to an aim of promoting a shift in the patient's psychic equilibrium. The creation of the capacity for a self-reflective internal culture in the patient was valued. This was seen as more important than the achievement of insight in its own terms, Holmes argued.

Storr (1979) suggested that neurosis was a matter not of having a psychopathology but of being overwhelmed by it and not being able to make effective use of it. Progress is found in not feeling at the mercy of one's pathology but being able to make creative use of it.

Alexander (1954) argued for therapy as a 'corrective emotional experience' that addressed the deficits in a patient's internal culture. This met with the suspicion in the wider psychoanalytic community at the time that it would lead to an idealisation of therapy. Winnicott (1963b) described the need to 'fail' as a substitute parent to the patient and for this to be worked through. Malan (1979:141) wrote that the aim of therapy was not to make up for what the patient had not had but "to help them work

through their feelings about not having it". And yet I find it hard to argue that corrective provision is not part of therapy.

Holmes (2001) suggested change in the patient involved shifts in the patient's focus between culture and counter-culture which he described as being in three stages:

- The patient develops what can be a painful awareness of how past experiences are affecting them in the present. He refers to this as "getting in touch with one's ghosts."
- The patient attempts to expel or exorcise the 'ghosts' which appear to be alien inhabitors. This involves feelings of anger to parents and of protest about what was endured along with a hope of emerging anew and unscathed by the past.
- The patient becomes aware of the limits to the ambitions of the second stage. The past can not be shed like a skin and our parents were themselves influenced by their past. History can not be re-written and the very subjective sense of being 'I' is based on the reality of what has happened. 'I' would not exist if the story were different.

Most informants saw themselves as fostering an internal culture of integration in the patient. This involved offering a quality of relationship (Jo), valuing what was often despised and belittled in the patient (Peter), showing them kindness (Amanda) and effectively destabilising a patient's preferred but problematic position in relationships (Paul). Time was given to these processes in contrast to many other therapy "packages" (Jo) and the ability to reflect and therefore gain some critical distance was prized (Maria). This could be viewed as a radical agenda. Each idea has a contrast with someone or an aspect of culture implicit in it. In the broadest of terms informants might be understood to imply a contrast with a society that is too impersonal and mechanistic, prone to short term 'fixes' and offering little space in a hectic world for thoughtful reflection. Versions of humanity are evidently in conflict. One source of conflict was voiced for example by Maria, as being with a more biologically orientated psychiatry.

A subversive attitude to 'objective' knowledge was evident. Peter stressed the value of not-knowing and the way our theories are tools rather than certainties. Martin described the follies of dogma and wanted to hold perspectives together and avoid over-privileging any one. Maria preferred to limit herself to experiential knowledge. Mike valued avoiding premature conclusions.

There was evidence of tensions for informants between an individual focus and a more social, relational and integrative view. Agency (with its implicit sense of autonomy) was valued by some informants as a capacity to be fostered. Conversely integration was also a prized capacity. Paul talked of the need for "social interest", Peter of the need for his patient to let others in and to integrate the unwanted and unvalued parts of ourselves, Mary of the need to face reality and the personal and social consequences of not doing that. The whole context of NHS psychotherapy was relational. It operates in a context (the NHS) to which patients had an association and attachment and took place within a relationship with a therapist who was a participant. At the same time the patient was an individual.

Tensions existed very visibly within the world of psychodynamic psychotherapy with informants seeing themselves as in a counter position to an aspect of accepted practice. Paul was clearly wary of longer-term therapies and offered a significantly different model. Jo talked of "hypocrisy" and "crap" associated for her with some aspects of practice, in particular any attempt to be an opaque or unresponsive therapist. Martin felt the need to push forward a biological perspective which might otherwise be neglected. Mike talked of the true spirit of psychotherapy with its implication of other types of practice. Mary took a more confrontative style and talked of the South Trent's culture being more open than many London trainings.

2.4.5 Therapists were involved in a process of 'dialectical tacking' between employing the psychodynamic model in a way that was 'soft-edged' and in a way that was 'hard-edged'.

In the interviews I observed the therapists to be managing this tension between employing the model in a pragmatic and adaptable way and staying firmly within the perceived orthodoxy of the model.

In 1910 Freud (SE,Vol:X1) wrote a paper in which he attacked what he referred to as "wild analysis" in which psychoanalytic understanding and technique were misapplied by practitioners. In his subsequent paper 'On beginning the treatment' Freud (SE,Vol:X11:134) noted that the therapy setting was stressful in its relative deprivation and commented:

> I know that many analysts do it differently, but I do not know if it is the passion for doing it differently, or an advantage they have discovered in it, that has a larger share in this deviation.

In that quote Freud captured the dilemma for the therapist as to whether an innovation in practice might constitute a clinically useful development. Dialectical tacking would represent a 'testing out' of this, at least in the mind of the therapist. Without such tacking the strengths and weaknesses of the model are not explored.

Fairbairn (1958:6) described the risks of idealising a form of practice and suggested:

> A complete stultification of the therapeutic aim is involved in any demand whether explicit or implicit, that the patient must conform to the nature of the therapeutic method rather than the method must conform to the requirements of the patient.

Steiner (1996:1082) commented on the limits of theory, how " theory always lags behind practice and leaves us perpetually dissatisfied and frustrated with its

inadequacies." He reported how he found theory to be "not much use to us when we are actually in a session trying to understand what is going on ". Overall he felt "such disappointment with theory is a healthy state of affairs and leaves us aware that a good theory is a fine servant but a poor master".

Bollas (in Molino,1997:7) feared the effect of an undue reliance on previous practice and argued for re-invention as a necessity:

> Each psychoanalyst must, no matter whether he or she does it consciously, reinvent psychoanalysis for themselves. It is those analysts who show the re-invention that sustain a level of creativity that is essential to the development of thinking.

In the interviews the therapists described their attachment to the practice of psychodynamic psychotherapy as involving a combination of personal and professional experiences and as firmly integrated within them. There were several references to developmental changes in the nature of their attachment to the model. Amanda felt that she needed more time as a therapist before she would be able better to evaluate the model:

> I think I am at a stage in my development as a therapist that is still fairly new in that I think I am quite enamoured with the psychodynamic model and I need a bit more experience post-qualification in order to take a more objective view of it.

Other therapists expressed a sense of their development mainly in the form of a greater sense of freedom within practice, freedom from a pressure to 'know' and freedom from a pressure to do it a certain way (though this latter pressure continued to be felt to some degree as I will come on to). Jo talked of a sense of finding an analytic freedom and becoming herself as a therapist. Mary described how she used to worry more about doing it the correct way but had now learnt there was not always a correct way and that "it is OK not to know".

Paul voiced the need for a soft-edged approach and warned against the danger of an idealisation of the model:

> there is quite clearly a spectrum from hard analytic to soft analytic and I would be at the softer end of that spectrum.....some people idealise the model, thinking that practising within it is a good in itself. There are other people who are much more opportunistic.....some people think that there is a right way to practice therapy and, with that patient, if you don't practice that way then that's wrong whereas I think that's a funny way of putting it. I can see a question which would be 'is there a right or better way to help patients with particular kinds of problems'? That is a research question and you could tease that out. You might come up with the answer that this way is the best way but you might actually find that a lot of it is, not exactly mumbo jumbo, but.... isn't that crucial to the success of the project.

Several therapists pointed to a pressure, experienced as punitive, to be harder-edged, to conform to what they conceived as the model, to do it 'by the book'. Jo felt this and it troubled her, not enough to feel "a square peg in a round hole", but her practice had left her wondering at times "if I'm still [behaving as] a psychotherapist.". She talked of "hypocrisy", "dishonesty" and "crap" that can be part of accepted practice. Maria felt the model "can become quite punitive if we let it" such that she might practice in a way that left her feeling "God that was not very dynamic .....you know we end up punishing ourselves thinking "Oh God am I doing psychotherapy here ?" Martin described his belief that particular understandings always get pushed to the point where they fail, where in a sense they become too hard-edged.

Jo and Mary alluded to the danger of being "wishy-washy" within the model as a counter to the danger of being too hard-edged. Jo described herself as "eclectic within the model" and Maria preferred not to think in terms of models but to allow herself to see what emerged.

Mary saw a balance to be struck between open and closed systems of understanding both of which have dangers and she related this to the culture of South Trent Psychotherapy Departments:

> I'd hate to think I was narrow-minded and was not open to all sorts of ideas. I try not to restrict myself to one view because I think that's dangerous.....So I think there is an open-mindedness [in her Psychotherapy Department] which I suppose..... is something that I think is positive about South Trent in contrast to quite a lot of the London trainings. But on the other hand I think the danger of that is that sometimes I think that it can get too woolly ..... I suppose it's something about boundaries and whilst I think it is important to be open to ideas there is something about having something that defines what you are doing and I think you can be too open to other ideas so that you are not clear what you are and what you do think. I sometimes feel that's a danger here. I think a worse danger is people being very closed ..... that is one of the features of South Trent that there is a pretty open tolerance of difference.

I have found it difficult to locate therapists in a simple way within this tension. Perhaps Paul might be said to characterise the pragmatic spirit and Mike the more classical spirit of psychotherapy. But Mike's attempts to stay open to the patient did not lend itself to the description of being called hard-edged. Amanda's preferred self is not hard-edged but more egalitarian and soft-edged. Maria described being very practice-led rather than theory-led but I felt might be clearer about the model's frame than her words suggested. Though a therapist might describe their theoretical stance in harder-edged terms, their practice may not simply follow. This applies equally in reverse. I saw evidence of this in the interviews.

2.5 The clinical reasoning of the therapist constituted a 'hazardous journey'.

The metaphor of a 'hazardous journey' summed up well for me my sense of the process described by the therapists in the interviews. Stake (1994:241) had referred to the "hazardous passage" that research faced in its progression from writer to reader. From this grew my finding that the clinical reasoning of these therapists was experienced (in my terms) as being a hazardous journey because of the combination of the findings I have already described. These findings can be subsumed under three main concepts which collectively suggested this metaphor.

'Situated' Knowledge

I observed the therapists that I interviewed were working with the complexity of employing *'situated knowledge'* (Haraway, 1988) within which 'fact' and 'value' had been intertwined and which offered "truth without certainty" (Christopher,1996) and for which a simple correspondence between theory and 'reality' could not be claimed. Such knowledge involved an amalgam of theory, experience and values, held and developed within a personal and professional context and within a particular culture.

Intersubjectivity

I observed the therapists engaging with the complexity of therapy as an intersubjective encounter. Their clinical reasoning took place within the context of an engaged relationship. In particular the therapist's personality was identified as the main therapist tool and it provided both a resource and a limit. The quality of relationship was seen as crucial (though not sufficient in itself).

Dialectical Tacking

I observed in the interviews the therapists reasoning clinically in a way that involved a process of dialectical tacking principally between their professional knowledge base, their experience with the patient and their personal beliefs and experiences.

Overall I found that informants were describing a sense that they were working at the hazardous and stressful edge of an integrated sense of their identity, their personality, their capacity to relate to the patient, and their understanding. Painful enactment's were described that took place on this 'edge', on the lived border between people. The therapists described the demanding task of facing limits and 'tolerating the intolerable'. These included the limits of what life might have offered to someone and the limits to change, the limits of what the therapist (and/or the approach) could offer and the limits to ongoing understanding.

McLeod's (2001:10) description of the hazards involved in qualitative research fitted well I would argue with the experience of therapy described by the therapists in the interviews:

> Qualitative enquiry [and psychotherapy] generates uncertainty, ambiguity and a sense of the unknowability of things, a loss of boundary between self and other. These are experiences that cannot easily be contained within a set of standardised research procedures, or, to put it another way, *should not* be so contained. It is willingness to enter fully into the process of the enquiry, a willingness to draw upon (or risk) one's integrity as a person, that gives the best qualitative research it's 'edge'.

Discussion

In the previous section I set out my findings from the interviews in two stages, my initial findings and then my core findings. In this chapter I discuss these findings and their implications. I am arguing that while they are specific to the eight therapists I interviewed, they can usefully be explored for their implications for the practice of NHS psychotherapists more generally.

This research was motivated in part by my experience of a lack of an adequate conceptualisation of the process I have termed 'clinical reasoning'. I found that professional knowledge is usefully understood as only one part of the process of clinical reasoning and needs to be set alongside the therapist's personal beliefs and experience and their experience with the patient. There are a number of areas I have identified for discussion and for consideration of their implications which I have now outlined.

Know thy narratives.

There is an implication for practice in my finding that therapists organise and employ their clinical reasoning *implicitly* in the form of narratives. I argue that therapeutic practice would benefit from the therapist being more *explicitly* aware of the library of stories that inform their clinical reasoning.

Within our postmodern culture therapists encounter a *plurality* of competing visions of what it means to be a person. Object Relations Theory itself represents a community of theories that have common themes but much diversity and this was in evidence in the interviews. Therapists have to *choose* from within this plurality of competing visions. The choice is made as much unconsciously as consciously between a plurality of competing visions/narratives about what it means to live the 'good life' psychologically, about how psychological problems arise, and about how they are best treated.

In the interviews the therapists spoke to their choices with regard to two particular patients but in a way that suggested to me that it was quite reasonable to assume they were articulating from among their core narratives. They described how their choices had emerged from within the matrix of personal experience, professional training, the professional culture that had fostered them and from within the socially available discourses and practices of our culture. Their narratives represent a *synthesis* of what is and has been culturally, professionally and personally available and their synthesis was like a personal signature on their practice.

Therapist stories are inevitably conveyed on some level to patients (McLeod,1997) but if they are left at the implicit level they are not open to examination. Phillips (1995:2) put this in an interesting form :

> To walk into a psychoanalyst's consulting room, like being born into a family, is to walk into a very elaborate family of stories about who one is supposed to be. But if analysts can help the patients discern the family stories they have inherited, who can help the patients, and the analysts, with the analyst's stories?

Within a culture of competing stories the therapist is in a position of having to defend their choices. Phillips (1999:35) commented:

> Since any person's life can be seen from many perspectives, and since the life story can be told in many ways, one must choose one's narrative approach and be prepared to defend it.

The implication for practice is that therapists would usefully become more aware of their preferred stories (and their rationale for them) with which they inform their clinical reasoning and that they tell to their patients directly or indirectly. This involves a process of making the implicit more explicit. It can also be thought of as 'excavating a tacit dimension' (Mattingly and Fleming,1994). When such therapist stories are better known to the therapist, explicitly rather than implicitly, their effect

on the therapy can more easily be reflected on. Such a requirement would meet Haraway's demand (1988) for an "embodied objectivity". One of the outcomes of this research has been an exploration and opening up for examination of the narratives of eight NHS therapists as a contribution to this task of making therapist narratives more explicit.

Reflexivity requires a frame.

My findings indicate how reflexivity is the key therapist skill. Narratives are employed in therapy by both patient and therapist and this may be done in a reflexive way or a thoughtless and defended way. However reflexivity has to start from 'somewhere'. A framework within which to be reflexive is required. I have found that the concept of the therapist tacking principally between professional knowledge, their experience of the patient, and their personal experience and beliefs has provided one such framework. Therapeutic practice would be helped, I argue, by there being a developing understanding of such frameworks within which therapists reason clinically.

The subjectivity of the therapist.

The personal therapy undertaken as part of a therapist's training is intended to make a contribution to the therapist's self-reflexive ability through helping them to become better acquainted with their own subjectivity, their situated story, their values and morals, their relational patterns and their expectations of others. This is designed as one contribution to safeguarding the patient from the unthoughtful imposition of the therapist's internal world upon the patient. Supervision offers to the therapist another opportunity for reflection on their participation in the therapy. Personal therapy and on-going supervision also make their contribution to making more tolerable for the therapist what is intolerable within the intersubjective encounter and enactments of a therapy.

However, personal therapy or supervision do not offer a 'neutral' vantage point from which to view 'reality'. Rather I argue again that choices are made and the therapist, along with their personal therapists and their supervisors, employ "embodied

objectivity" (Haraway,1988). I question the extent to which the subjectivity of the therapist has been, and to some degree, can be taken on board within a therapy. Benjamin's critique (1995) that therapists collapse subjects into objects was to some extent borne out in the interviews with regard to the subjectivity of the therapists themselves. The subjectivity of the therapist was notable paradoxically for both its presence and absence. The tone of the therapist's account conveyed a sense of their perceived objectivity.

I am not making here a broad criticism of therapists as if they are adopting positions that are unhealthily 'defended' (Holloway,2000) though inevitably defences are in operation. What I am reflecting on here might relate to O'Hear's (1991) quote of Newatt that "knowledge is a ship on which we are afloat and which we can therefore only change plank by plank". This could be paraphrased as 'a therapist's clinical reasoning is a ship on which they are afloat in the therapy and which, therefore, they can only change plank by plank.' The therapists generally started, I suggest, with a presumption of the objectivity of their perspective in relation to the patient and changes were managed as much as possible. Perhaps this is an inevitable process and an expression of what is meant by "embodied objectivity" (Haraway,1988). Reflexivity has to start from 'somewhere'. The implication for practice is that therapists could usefully be more aware of the subjective element of the 'somewhere' from which they start and which shapes for them their encounter with the patient. Such awareness would allow for a clearer tracking of the intersubjectivity of the encounter.

Secure and exploratory

The concept of clinical reasoning implies a necessary skill in the therapist for it to be a creative process. An implication of my findings is that such creativity requires a capacity to be attached securely to a model and able to explore beyond it.

Holmes (1993,2001) writing from within the perspective of attachment theory described a dialectic between security and exploration, intimacy and autonomy, closeness and separation, attachment and loss, and attunement and challenge. Bowlby (1988) described how a secure base for an infant allows for exploration *beyond* that

base. A lack of capacity or opportunity to attach may result in clinging behaviour or avoidant behaviour.

I argue that these dialectics can be applied to the practice of therapists in terms of their attachment to the model and the narratives that inform their clinical reasoning and practice. In these terms, then, a secure attachment to a conceptual approach would allow a therapist to feel rooted and grounded in that approach and therefore secure enough to be able *to explore beyond it.* An enmeshed attachment pattern would see a therapist too insecure and needing to cling to their conceptual approach such that they would be unable to gain any critical distance in their practice or make any innovations. An avoidant attachment pattern would see a therapist unhealthily distant from a commitment to an approach.

The therapist, according to this view, will be able to reason clinically in more adventurous ways when, paradoxically, they feel more secure in their conceptual approach. Roth and Fonagy (1996) similarly suggested that outcomes of therapy are best if the therapist is firmly rooted in their model and also flexible to particular patients needs.

Phillips (1995) described Freud's two projects as:

- an enlightenment project that involved the pursuit of objective knowledge which would constitute norms (such as of mental health) against which a person could be measured.
- a postmodern project that questions norms, acknowledges perspectives and the situatedness of all knowledge and asks what we use our knowing to do.

A combination of the perspectives of Holmes and Phillips leads, I argue, to a way of conceptualising the 'modern' and 'postmodern' therapist. The 'modern' therapist leans towards an attachment to their model of practice that has a secure sense of its firm objectivity, a sense that it is 'normative'. The 'postmodern' therapist questions norms and objectivity and leans away from the 'normative' and towards varied practices, specific to the situation, practices that go beyond, *if necessary,* the accepted

model. These two therapists, the modern and the postmodern, are 'straw' figures in that the therapists I interviewed and whom I meet in my NHS practice do not sit neatly in such camps. However these two therapist figures illustrate the tension for therapists to hold and the dialectical tacking that is required of them.

An implication of what I am arguing is that therapist training and continued professional development needs to provide for a therapist a secure base within a model and its theory. However, it further needs to question how this base is used and with what consequences. Phillips (1997) applied this to therapist training:

> A psychoanalytic training should not only teach people theory, it should be showing people what they might be using theory to do, and noting the ways in which people are inclined to use theories" (p142) There is a sense in which we are producing pictures and metaphors and analogies of what we think of as internal space. All these pictures have consequences attached to them (p146).

A lack of difference

Within the psychodynamic model the therapists described their own versions in terms of preferred narratives and in this regard they displayed considerable variation. However, overall, I was left with a question about the *lack* of differences between the therapists. There was a strong apparent consensus about a 'normative' psychodynamic psychotherapist in the interviews. I was left wondering what had happened to their wider ambivalence to the model and to other identities within themselves that might compete with their 'psychodynamic identity'. I found evidence of substantial difference only in Paul's account.

In my experience of NHS psychotherapy within the South Trent Region there has been an emphasis on the importance of keeping together a critical mass of psychotherapists, as it were, else it may become impossible to avoid being pulled out of shape. It is perhaps this sense of a necessary shape (or purity of model) that I was detecting in a relative absence of difference. It is as if the principle hazard is that of 'shapelessness',

of loss of coherence and frame to practice, of practice disintegrating into something chaotic and unmanageable in the face of patient distress and projection.

NHS Psychotherapy in the South Trent region is conceivably at a stage of consolidation and maintenance, which McLeod (1998:298) referred to as the 'professional service stage'. At such a stage the initial innovative creation of a service has taken place and there is more an emphasis on 'holding it together'. Perhaps this leads to some suppression or restraining within the therapist of alternative identities and ways of working. Peter pointed to this when he talked of theory as holding him while he explores and lives with the unknown in the therapy. This suggests to me that the model is needed as a container whose firmness makes possible the exploring and 'tolerating of the intolerable' that takes place in therapies. It contains the therapist personally and professionally while in a potentially very difficult intersubjective encounter. The model provides the conformity while the invention is to some extent in the practice within the model.

Unarticulated reinventions

In my mind I have combined what I have seen as the implicit nature of therapist narratives and my hypothesis about a relative silence about wider differences in the therapists. I suggest that differences are being underplayed and re-inventions in the form of fresh syntheses are being insufficiently owned and articulated and would helpfully be made more explicit. Several therapists referred to the pressure to 'do it right' rather than own their approach.

Within each therapist that I interviewed some degree of reinvention of psychotherapy had taken place involving a synthesis of their personal life experience and professional trainings within the context of a professional setting and culture. This synthesis I found could be expressed in a division of the informants accounts into their narratives about living the good life psychologically (their psychodynamic narrative), about the origins of psychological problems (their developmental narrative), about how to proceed in therapy (their treatment narrative).

Bollas (in Molino,1997) argued that reinvention was essential to the future of psychotherapy. Therapists, he argued, need to be creators of theory and practice and not just passive absorbers of it and they needed to avoid being crushed by their own institutions:

> Each psychoanalyst must, no matter whether he or she does it consciously, reinvent psychoanalysis for themselves. It is those analysts who show the re-invention that sustain a level of creativity that is essential to the development of thinking" (p7). Psychoanalysis must survive "the psychoanalytic movement". If it survives psychoanalysts and their schools, then it will grow and develop. But this remains to be seen (p50).

Generalising from these interviews I would argue that psychodynamic psychotherapists have more differences and variety in their practice than they choose to acknowledge. I would suggest that the problem may not be a lack of reinvention in the practice of therapists but a danger that actual reinventions are not being seen and shared. The implication of this is that therapists need to find ways of having more open dialogue between themselves about their *differences* in practice.

Critical realism and social constructionism

I found that the therapists' accounts located them as practising within the individualist ethos of our culture. However I felt there was an ambiguous and ambivalent relationship between therapy and this dominant individualist ideology of our time. The therapists perhaps shared and rejected the culture's aspiration that we be 'autonomous, bounded and masterful individuals'. There was a clear limit to the ways in which the therapists thought in terms of the social construction of identity (beyond the family). Conversely, there were references in the interviews to psychotherapy as a counter-culture to the paradoxical neglect of the individual. So a further implication of my findings for practice is that social constructivist ideas about the formation of a sense of identity could usefully be integrated more into practice.

I did not ask the therapists during the interviews whether they would describe themselves as 'critical realists' (O'Hear,1991). However their accounts implied that they took such a view, as I do myself, that there is a real world even if we can not know it with certainty. However, in a spirit of postmodern reflexivity it is important, I argue, to ask what the therapist might use their 'critical realism' to do for them. Critical realism can then be thought of as a valid ontology and also as a *containing belief.* This, I argue, relates again to Newatt's notion of knowledge as a ship on which we are afloat. A critical realist perspective allows a therapist to start from an assumption of the validity of their perspective which I have argued above is both a necessary and inevitable starting point.

One of the dangers of a critical realist 'perspective' is that the *social construction* of knowledge might be underplayed by therapists through not exploring beyond the model. While the interviews gave evidence of therapists working within postmodern epistemologies of practice, they were much lighter on the social construction of reality. This was in evidence in the way that the therapist narratives leaned towards the clinically individualist and tended to focus on the 'self' as if it were a spatial entity.

Rustin (1991) argued for a realist position regarding the 'deep structures of mind' postulated by psychodynamic psychotherapy. Fonagy and Target (2003) argued that Freud's concept of non-conscious mental functioning represented his core theory and had commanded significant support (along with its relevance to psychological problems and the value of becoming more aware of what is not conscious). However, they criticised Freud for being *too specific* about the contents of the non-conscious conflict, theory which they suggested was at a different level, based on clinical observations. Psychodynamic theory is then open to endless revisions and updating of this content in the form of multiple theories, all of which are based chiefly on what they called "enumerative inductionism" which they saw as the main therapist epistemology.

Perhaps therapists can be critical realist when it comes to these deep structures but explore more the socially constructed dimension of non-conscious conflict, examples of which I gave in the chapter on the use and misuse of professional knowledge. The question of how therapy orientated around social constructivism might differ from a psychodynamic therapy needs to be the subject of another piece of research. My interest is more in the useful clinical integration into the practice of psychodynamic psychotherapy of ideas about the social construction of identity.

Summary

In this chapter I have argued for the importance of therapists knowing their narratives in a more explicit way and their rationale for them, and for the further development of frameworks for reflexivity. I have argued that the subjectivity of the therapist could usefully be taken more account of in practice and for the importance of their being securely within while exploring beyond their model of practice. I have questioned whether 'reinventions' go unnoticed to an unhelpful degree and whether ideas which draw on the social construction of identity could find more of a place within the clinical reasoning of therapists.

In the final chapter I have drawn together the threads of the thesis and the implications for practice. I have considered too the limitations of my research.

CONCLUSIONS

Conclusions

I can now look back on a journey that has taken me from a foreshadowed problem to an expounded argument in this thesis. I set out to explore the question 'what is professional knowledge in therapeutic practice?' I had not found an adequate way of conceptualising the thinking that the therapist undertakes when with a patient. I was unclear about the implications for therapists of the felt absence of a comfortably simple correspondence between their theory and 'reality' and of the gap between theory and actual practice. I felt it was an area under-represented in the literature and containing many hazards for therapists in their practice. This enquiry expanded in directions that have been very enriching to pursue.

The central finding of this thesis is that, rather than relying on professional knowledge conceived as conventional psychodynamic theory, the therapists engaged in a largely intuitive process I have termed 'clinical reasoning' which was practice-based, reflection-in-action that involved tacking principally between their professional knowledge base, their experience with the patient and their personal beliefs and experience. Such a process, I argue, constitutes a 'hazardous journey' in a postmodern climate in which the value of a psychodynamic perspective cannot be taken for granted.

I found that an understanding of the hazards for these therapists in their clinical reasoning could be organised around three themes :

- therapists employed 'situated knowledge' to inform their clinical reasoning, held in the form of narratives. Such knowledge could be thought of as if it were a map that offered 'truth without certainty' and needing to be read through the eyes of a 'critical realist'.

- therapy was an intersubjective journey that involved both parties, therapist and patient, in an intimate and uncertain exposure of their personalities. Maps only helped to a degree as they had also to be re-created as the encounter progressed. It was very easy to become lost on this intersubjective journey.

- therapist accounts highlighted hazards which had to be negotiated in practice and a course divined by what I have referred to as a process of 'dialectical tacking'.

The therapists I interviewed described their practice in ways that made clear to me that they employed postmodern epistemologies of practice which involved them in a tacking between the normative and the particular. An interweaving of Hamlyn's (1970) four criteria epistemological criteria underpinned their practice. 'Pragmatic rationality' (Bernstein,1983) appeared to have replaced a 'simple' correspondence with 'reality'. A 'correspondence with experience' was particularly valued.

Implications

In the previous chapter I described a number of implications of my findings for practice. The first of these highlighted the value of therapists being more aware of their own library of stories that shape their practice. This would promote a greater capacity for reflexivity by clarifying the 'somewhere' in which the therapist's reflexivity is 'situated'.

The second implication was that the training and continuous professional development of the therapist needed to provide both a secure base for practice and question and problematise that base. This would promote a healthily secure *and* critical attachment to the professional base.

The third implication for practice focused on the need to create space within the community of therapists for therapists to own their differences, their particular syntheses and reinventions within practice so that it becomes possible to learn from them. This would prevent potentially valuable changes being 'lost'.

The fourth implication for practice was that within the training and continuous professional development of therapists time needed to be set aside to explore whether and how social constructivist views of identity could be integrated into practice.

The overarching implication central to this thesis is that there is a need to promote an understanding of the ways in which therapists *think* when with a patient, the frameworks within which their reflexivity operates. My findings have offered one such framework. The idea of tacking I believe involves a helpful movement away from the notion of pre-existing, text book theory applied in the therapy room in the manner of flat-packed furniture that is unpacked, assembled and employed (in accordance with the written instructions) by the therapist in the therapy.

Limitations

There are areas that I had initially hoped to explore more of in this study but which I found to be beyond its scope.

I had hoped I would be able to generate in the interviews more specific examples of the process of a negotiation of understanding between the therapists and their patients so as to explore the process of how therapist narratives evolve and come to be shared and/or co-constructed. However I found I had not tackled this directly enough in the interviews perhaps in recognition that it would have overloaded an already crowded interview agenda.

I set out with a view that I might have explicit things to say about the culture of South Trent Psychotherapy in the light of the interviews. Again this proved a step too far for this particular research though I did ask quite specific questions within the interviews. I have found it did not remain a central focus. However, given the argument that the individual therapist's clinical reasoning is fostered and nurtured within a community of therapists a further study would be particularly interesting, one that explored the distinctive culture of NHS psychotherapy in the South Trent Region, its particular communal narratives as well as its points of difference.

A line of enquiry that I did not attempt because it was clearly a project in itself concerned whether and in what ways the gender of the therapist shapes and influences their clinical reasoning.

Strengths and limits tend to be two sides of the same coin. A strength of this research is that it has generated understandings within a context, situated understandings in other words, based on the accounts given by eight practising NHS Psychotherapists. Conversely I can not offer findings that are 'typical' or 'normative' though I have argued that they offer significant pointers to what is more general and normative. As such the findings need to stand or fall by whether they are experienced as both clinically significant and plausible, and also theoretically cogent.

Finally.....

A combination of metaphors that I have particularly valued is that the clinical reasoning of the therapist constitutes a 'hazardous journey' that is undertaken along 'lived borders' (Saukko,2000). The tacking that the therapist undertakes in their clinical reasoning involves a journey along a number of lived borders. I have already described the border between professional knowledge, the experience of the patient and the therapist's own beliefs and experiences.

Additionally and as part of those there are borders between the 'self' and the 'other', the known and the unknown, the found and the constructed, the secure and the exploratory. This I believe is where both the stress and the creativity lies and it is why clinical reasoning constitutes such a necessarily hazardous journey. I argue that these hazards are intrinsic to the creativity of the process of clinical reasoning rather than being avoidable. The saying applies equally to clinical reasoning as it does to ships:

> "Ships in a harbour are safe. But that is not what ships are built for" (Shelton,1989).

REFERENCES

Abramson, P. R. (1992). A Case for Case Studies : An Immigrants Journal. London, Sage.

Aggleton, P. (1990). Health. London, Routledge.

Alasuutari, P. (1995). Researching Culture: Qualitative Method and Cultural Studies. London, Sage.

Alexander, F. (1954). "Some quantitative aspects of psychoanalytic technique." Journal of the American Psychoanalytic Society. **2**: 685-701.

Argyris, C., and Schon, D.A. (1981). Theory in Practice : Increasing professional effectiveness. San Fransisco, Josey-Bass.

Aristotle (1985). Nicomachean Ethics. Indianapolis, IN, Hackett Publishing.

Atkinson, P., and Hammersley, M. (1994). Ethnography and Partcipant Observation. Handbook of Qualitative Research. N. K. Denzin, and Lincoln, Y.S. London, Sage.

Bakan, D. (1966). Against Method. New York, Basic Books.

Balint, A., and Balint, M. (1939). "On transference and counter-transference." International Journal of Psychoanalysis. **20**: 223-230.

Bannister, P., et al (1994). Qualitative Methods in Psychology. Buckingham, OUP.

Banton, R., Clifford,P., Frosh, S., Lousada, J., and Rosenthal, J. (1985). The Politics of Mental Health. Basingstoke, Macmillan.

Barker, C., and Pistrang, N., and Elliot, R, Ed. (1994). Research Methods in Clinical and Counselling Psychology. Chichester, John Wiley and Sons.

Becker, H. S. (1968). Social observation and social case studies. International Encyclopedia of the Social Sciences. D. L. Sills. New York, Macmillan and Free Press.

Benjamin, J. (1995). Recognition and Destruction : an Outline of Intersubjectivity. Like Subjects, Love Objects. New Haven, Yale University Press.

Berger, M. (1983). "Studying enrollment decline (and other timely issues) via the case survey." Educational Evaluation and Policy Analysis. **5**: 307-317.

Bergin, A. E., and Garfield, S.L., Ed. (1994). Handbook of Psychotherapy and Behaviour Change. Fourth Edition. Chichester, Wiley.

Bernstein, R. (1983). Beyond Objectivism and Relativism : Science, Hermeneutics and Practice. Philadelphia, University of Pennsylvania Press.

Bhaskar, R. (1978). A Realist Theory of Science. Brighton, Harvester.

Bhaskar, R. (1979). The Possibility of Naturalism. Brighton, Harvester.

Bickhard, M. H. (1980). Cognition, Convention and Communication. New York, Praeger.

Bion, W. R. (1959). Attacks on Linking. Second Thoughts. London, William Heinemann.

Bion, W. R. (1962). Learning from Experience. London, William Heinemann.

Bion, W. (1967a). Notes on memory and desire. Melanie Klein Today. E. Bott Spillius. London, Routledge. **2.**

Bion, W. R. (1967b). Second Thoughts. London, Maresfield Library.

Bion, W. R. (1970). Attention and Interpretation. London, Karnac.

Bion, W. R. (1974). Brazilian Lectures 1. Rio de Janeiro, Imago Editora.

Bion, W. R. (1975). Brazilian Lectures 2. Rio de Janeiro, Imago Editora.

Bion, W. R. (1988a). A Theory of Thinking. Melanie Klein Today. E. B. Spillius. London, Routledge. **2.**

Bion, W. R. (1988b). The differentiation of the psychotic from the non-psychotic personality. Melanie Klein Today. E. Bott Spillius. London, Routledge. **Vol 1.**

Bion, W., R. (1991). A Memoir to the Future. London, Karnac.

Bloch, S., and Chodoff, P., Ed. (1993). Psychiatric Ethics. Oxford, Oxford Medical Publication.

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

Booth, W. (1991). The Rhetoric of Fiction., Penguin Books.

Bowlby, J. (1969). Attachment and Loss. London, Hogarth.

Bowlby, J. (1973). Separation, Penguin.

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

Bromley, D. B. (1986). The Case Study Method in Psychology and Related Disciplines. Chichester, Wiley.

Bruner, J. S. (1986). Actual Minds, Possible Worlds. Boston, Harvard University Press.

Bruner, J. S. (1990). Acts of Meaning. Cambridge MA, Harvard University Press.

Bruner, J. S. (1990). "Loyal opposition and the clarity of dissent: commentary on Donald Spence's 'The Hermeneutic Turn'." Psychoanalytic Dialogues **3**: 11-19.

Bruner, J. S. (1993). The Autobiographical Process. The Culture of Autobiography : Constructions of Self -Representation. R. Folkenflik. Stanford.CA, Stanford University Press.

Buber, M. (1937). I and Thou. Edinburgh, T and T Clark.

Burawoy, M. (1979). Manufacturing Consent: Changes in the Labour Process under Monopoly Capitalism. Chicago, University of Chicago Press.

Cameron, D. e. a., Ed. (1992). Researching Language : Issues of Power and Method. London, Routledge.

Campbell, D. T. (1975). "Degrees of freedom and the case study." Comparative Political Studies. **8.**: 178-193.

Carnap, R. (1953). What is Probability? Mathmatical Thinking in Behavioural Sciences. D. M. Messick. San Francisco, Freeman.

Casement, P. (1985). On Learning From the Patient. New York, Guildford.

Casement, P. (1991). Further Learning from the Patient. Tavistock, Routledge.

Cavell, M. (1994). The Psychoanalytic Mind. Cambridge MA, Harvard University Press.

Chalmers, A. F. (1982). What is this thing called science? Milton Keynes, Open University Press.

Christopher, J. C. (1996). "Counseling's inescapable moral visions." Journal of Counseling and Development. **75**: 17-25.

Clarkson, P. (1993). On Psychotherapy. London, Whurr Publishers.

Clarkson, P., et al, Ed. (1994). The Handbook of Psychotherapy. London, Routledge.

Cochrane, A. (1987). "What a difference the place makes: the new structuralism of locality." Antipode. **19**: 354-363.

Coltart, N. (1986). 'Slouching towards Bethlehem'.....or thinking the unthinkable in psychoanalysis. The British School of Psychoanalysis : The Independent Tradition. G. Kohon. London, Free Association Books.

Cook, T. D., and Campbell, D.T. (1979). Quasi-experimentation : Design and Analysis Issues for Field Settings. Chicago, Rand-McNally.

Corwen, M. D. (1995). "Cultural issues in bereavment therapy : the social construction of mourning." In Session : Psychotherapy in Practice. **1**(4): 23-41.

Craib, I. (1987). "The psychodynamics of theory." Free Associations. **10**: 32-57.

Crotty, M. (1996). Phenomenology and Nursing Research. South Melbourne, Australia, Churchill Livingstone.

Cushman, P. (1990). "Why the self is empty : towards a historically-situated psychology." American Psychologist. **45**: 599-611.

Davis, M., and Wallbridge, D. (1981). Boundary and Space : An Introduction to the Work of D.W.Winnicott., Penguin.

Dennett, D. (1991). Consciousness Explained. Boston, Little, Brown.

Denzin, N. K., and Lincoln, Y.S., Ed. (1994). Handbook of Qualitative Research. Thousand Oaks, CA, Sage.

Dooher, J., et al., Ed. (2001). Case Studies in Practice Development., Quay Books.

Dreyfus, H. L., and Dreyfus, S. E. (1986). Mind over machine : The power of human intuition and expertise in the era of the computer. New York, The Free Press.

Dryden, W., and Feltham, C., Ed. (1992). Psychotherapy and its Discontents. Buckingham, OUP.

Dryden, W., Ed. (1996). The Handbook of Individual Therapy. London, Sage.

Dutton, R. (1995). Clinical Reasoning in Physical Disabilities. London, Lippincott Williams and Wilkins.

Eckstein, H. (1975). Case Study and Theory in Political Science. Handbook of Political Science. F. I. Greenstein, and Polsby, N.W. Reading, Massachusetts, Addison Wesley. **VII**.

Editors (1995). "Protection of patient's rights to privacy." British Medical Journal **311**: 1272.

Edwards, D. (1995). "Two to tango: script formulations, dispositions, and rhetorical symmetry in relationship troubles talk." Research on Language and Social Interaction **28**: 319-350.

Eisner, E. W. (1981). "On the differences between scientific and artistic approaches to qualitative research." Educational Researcher. **10**: 5-9.

Eisner, E. W., Ed. (1985). Learning and Teaching the Ways of Knowing. Chicago, University of Chicago Press.

Eliot, T. S. (1960). Selected Essays. New York, Harcourt, Brace and World.

Embleton Tudor, L., and Tudor, K. (1994). The Personal and the Political : Power, Authority and Influence in Psychotherapy. The Handbook of Psychotherapy. P. Clarkson, and Pokorny, M. London, Routledge.

Enns, C. Z., McNeilly, C.L., Corkery, J.M., and Gilbert, M.S. (1995). "The debate about delayed memories of child sexual abuse : a feminist perspective." The Counseling Psychologist. **23**: 181-279.

Erikson, E. (1958). The nature of clinical evidence. Evidence and Inference. D. Learner. Glencoe, Ill, The Free Press of Glencoe.

Erikson, E. H. (1976). "Psychoanalysis and ethics - avowed and unavowed." International Review of Psychoanalysis. **3**: 409-415.

Erwin, E. (1997). Philosophy and Psychotherapy. London, Sage.

Fairbairn, W. R. D. (1940). Schizoid Factors in the Personality. Psycho-Analytic Studies of the Personality. London, Routledge and Kegan Paul.

Fairbairn, W. R. D. (1943). The Repression and Return of Bad Objects. Psycho-Analytic Studies of the Personality. London, Routledge and Kegan Paul.

Fairbairn, W. R. D. (1944). Endo-Psychic Structure Considered in Terms of Object-Relationships. Psycho-Analytic Studies of the Personality. London, Routledge and Kegan Paul.

Fairbairn, W. R. D. (1952). Psychoanalytic Studies of the Personality. New York, Basic Books.

Fairbairn, W. R. D. (1958). "On the nature and aims of psycho-analytic treatment." Int. J. Psycho-Anal. **39**(5): 1-12.

Fenichel, O. (1940). "Problems of psychoanalytic technique." Psychoanalytic Quarterly.

Fessler, R. (1983). Phenomenology and "the talking cure" : research on psychotherapy. Duquesne Studies in Phenomenological Psychology. A. Giorgi, Barton, A., Maes, C. Pittsburgh, Duquesne University Press.

Fleming, J. (1953). "The role of supervision in psychiatric training." Bulletin of the Menninger Clinic. **17**: 157-159.

Fonagy. P., a. T., M. (2003). Psychoanalytic Theories. Perspectives from Developmental Psychopathology. London, Whurr.

Fonagy.P. (2001). Attachment Theory and Psychoanalysis. New York, Other Press.

Foucault, M. (1973). The Birth of the Clinic. London, Tavistock.

Foucault, M. (1988). Technologies of the Self. London, Tavistock.

Frank, J. (1974). Persuasion and Healing. A Comparative Study of Psychotherapy. New York, Shocken Books.

Freud, S. (1900). The Interpretation of Dreams. The Standard Edition of the Complete Works of Sigmund Freud. J. Strachey. London, Hogarth. **4-5**.

Freud, S. (1905a). Fragment of an Analysis of a Case of Hysteria. Standard Edition. J. Strachey. London, Hogarth. **7**.

Freud, S. (1905b). Three Essays on the Theory of Sexuality. S.E. J. Strachey. London., Hogarth. **7**.

Freud, S. (1916-17). Analytic Therapy. S. E. J. Strachey. London, Hogarth. **17.**: 448-463.

Freud, S. (1923). The Ego and the Id. S.E. J. Strachey. London, Hogarth. **19**.

Freud, S. (1927). The Future of an Illusion. S.E. J. Strachey. London, Hogarth. **21**.

Freud, S. (1930). Civilisation and its Discontents. S.E. J. Strachey. London, Hogarth. **21.**

Freud, S. (1933). Dissection of the Personality. S.E. J. Strachey. London., Hogarth. **22.**

Freud, S. (1937). Analysis Terminable and Interminable. S.E. J. Strachey. London, Hogarth. **23.**: 209-253.

Freud, S. (1957). On wild analysis. S.E. J. Strachey. London, Hogarth.

Freud, S. (1957). On beginning the treatment. S.E. J. Strachey. London, Hogarth.

Frosh, S. (1986). "Beyond the analytic attitude : radical aims and psychoanalytic therapy." Free Association Books. **7**: 38-59.

Gadamer, H. (1975). Truth and Method. New York, Continuum.

Gay, P. (1988). Freud, a Life for our Time. New York, W.W. Norton.

Geertz, C. (1983). Local Knowledge : Further Essays in Interpretative Anthropology. New York, Basic Books.

Gellner, E. (1985). The Psychoanalytic Movement., Paladin.

Gendlin, E. T. (1962). Experiencing and the Creation of Meaning. New York, Free Press.

Gergen, K. J. (1994.). Towards Transformation in Social Knowledge. London, Sage.

Giddens, A. (2001). Sociology. Oxford, Polity.

Glaser, B. J., and Strauss, A. (1967). The Discovery of Grounded Theory. Chicago, Aldine.

Glaser, B. J. (1978). Theoretical Sensitivity: Advances in the methodology of grounded theory. Mill Vale CA, Sociology Press.

Gomez, L. (1997). An Introduction to Object Relations. London, FAB.

Greenberg, J. R., and Mitchell, S.A. (1983). Object Relations in Psychoanalytic Theory., Harvard University Press.

Greencavage L.M. and Norcross, J. C. (1990.). "Where are the commonalities among the therapeutic factors ?" Professional Psychology : Research and Practice. **21**(5): 372-378.

Grosskurth, P. (1986). Melanie Klein : Her World and Work. London, Hodder and Stoughton.

Grotstein, J., and Rinsley, D., Ed. (1994). Fairbairn and the Origins of Object Relations. London, Free Association Books.

Grunbaum, A. (1984). The Foundations of Psychoanalysis. Berkeley, CA, University of California Press.

Guntrip, H. (1971). Psychoanalytic Theory, Therapy and Self. New York, Basic Books.

Guntrip, H. (1975). "Analysis with Fairbairn and Winnicott : (How complete a result does psycho-analytic therapy achieve?)." International Review of Psychoanalysis. **2**: 145-56.

Habermas, J. (1968). Knowledge and Human Interests. New York, Beacon.

Hamlyn, D. W. (1970). The Theory of Knowledge. Garden City, NY, Doubleday Anchor.

Haraway, D. (1988). "Situated knowledges : the science question in feminism and the privelege of partial perspective." Feminist Studies. **14**: 575-599.

Harre, R. (1979). Social Being. Oxford, Blackwell.

Harrow, J. A., Ed. (2002). Towards a Theory of the Self : Farbairn and beyond. London, Karnac.

Hattie, J. A., Sharpley, C.F., and Rogers, H.J. (1984). "Comparative effectiveness of professional and paraprofessional helpers." Psychological Bulletin. **95**: 534-41.

Health, D. o. (2003). Confidentiality. NHS Code of Practice.

Heimann, P. (1950). "On countertransference." Int. J. Psycho-Anal. **31**: 81-84.

Heimann, P. (1989). About Children and Children-No-Longer. London, Tavistock/Routledge.

Hinshelwood, R. D. (1986). "A 'dual materialism'." Free Associations. **4**: 37-50.

Hinshelwood, R. D. (1999). "Counter-transference." Int J. Psychoanal. **80**: 797-818.

Hobson, R. E. (1985). Forms of Feeling : the Heart of Psychotherapy. London, Tavistock.

Hogan, R. A. (1964). "Issues and approaches in supervision." Psychotherapy: Theory, Research and Practice. **1**: 139-141.

Holloway, W., and Jefferson, T. (2000). Doing Qualitative Research Differently : Free Association, Narrative and the Inteview Method. London, Sage.

Holmes, J., and Lindley, R. (1989). The Values of Psychotherapy. Oxford, Oxford University Press.

Holmes, J., Ed. (1991). Textbook of Psychotherapy in Psychiatric Practice. *Edinburgh, Churchill Livingstone.*

Holmes, J. a. L., R. (1991). The Values of Psychotherapy. Oxford, Oxford University Press.

Holmes, J. (1992). Between Art and Science: Essays in Psychotherapy and Psychiatry. London, Routledge.

Holmes, J. (1993). John Bowlby and Attachment Theory. London, Routledge.

Holmes, J. (1996). Attachment, Intimacy, Autonomy. Using Attachment Theory in Adult Psychotherapy. London, Jason Aronson Inc.

Holmes, J. (1998). "The changing aims of psychoanalytic theory." International Journal of Psychoanalysis. **79**: 227-240.

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

Hunter, V. (1991). "John Bowlby : An Interview." Psychoanalytic Review. **78**: 159-165.

Jablon, M. (1987). "Psychotherapists' perceptions of their professional development and supervision." Dissertation Abstracts International. **47**(SEBC. 4302.).

Karasu, T. B. (1986). "The psychotherapies : benefits and limitations." American Journal of Psychotherapy. **40**(3.).

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

Keller, E. F., and Grontkowski, C.R. (1983). The Mind's Eye. Discovering Reality: Feminist Perspectives on Epistemology, Metaphysics, Methodology, and Philosophy of Science. S. a. H. Harding, M.B. Boston, D. Reidel.

Kennedy, R. (1998). The Elusive Human Subject. A Psychoanalytic Theory of Subject Relations. London, Free Association Books.

Kermode, F. (1985). "Freud and interpretation." International Journal of Psycho-Analysis. **12**: 3-12.

Kernberg, O. F. (1975). Borderline Conditions and Pathological Narcissism. New York, Jason Aronson.

Khan, M. (1981). The Privacy of the Self. London, Hogarth Press and the Institute of Psychoanalysis.

Kirschener, S. R. (1996). The Religious and Romantic origins of Psychoanalysis. Cambridge, Cambridge University Press.

Klauber, J. (1981). Difficulties in the Analytic Encounter. London, Jason Aronson.

Klein, M. (1935). A Contribution to the Psychogenesis of Manic-Depressive States. Love, Guilt and Reparation. London, Hogarth.

Klein, M. (1940). Mourning and its Relations to Manic-Depressive States. Love, Guilt and Reparation. London, Hogarth.

Klein, M. (1946). Notes on some Schizoid Mechanisms. Envy and Gratitude and Other Works. London, Hogarth.

Klein, M. (1950). "On the criteria for the termination of psychoanalysis." London International Journal of Psychoanalysis.

Klein, M. (1952). Notes on some schizoid mechanisms. Developments in Psycho-Analysis. J. Riviere. London, Hogarth.

Klein, M. (1955). The Psychoanalytic Play Technique, its History and Significance. Envy and Gratitude and Other Works. London, Hogarth.

Klein, M. (1975). Envy and Gratitude and other works, 1946-63. New York, Delacorte Press.

Kohut, H., and Wolf, E. (1978). "The disorders of the self and their treatment: an outline." International Journal of Psychoanalysis. **59**: 413-424.

Kuhn, T. (1962). The Structure of Scientific Revolutions. Chicago, University of Chicago Press.

Kvale, S. (1992). Postmodern Epistemology in Practice. Postmodernism and Psychology. S. Kvale. London, Sage.

Kvale, S. (1996). InterViews. An Introduction to Qualitative Research Interviewing. London, Sage Publications.

Laing, R. D. (1977). Conversations with Adam and Natasha. New York, Pantheon Books.

Lakin, M. (1988). Ethical issues in the Psychotherapies. Oxford, Oxford University Press.

Lasch, C. (1984). The Minimal Self - Psychic Survival in Troubled Times., Picador.

Llewelyn, S., and Hume, W. (1979). "The patient's view of therapy." British Journal of Medical Psychology. **52**: 29-36.

Loganbill, C., Hardy, E. and Delworth, U. (1982). "Supervision : A conceptual model." Counseling Psychologist. **10**: 3-42.

Lomas, P. (1993). The Psychotherapy of Everyday Life. London, Transaction Publications.

Luborsky, L., Singer, B. and Luborsky, L. (1975). "Comparative studies of psychotherapies : is it true that 'everyone has won and all must have prizes'?" Archives of General Psychiatry. **32**: 995-1008.

Luborsky, L., Popp, C., Luborsky, E. and Mark, D. (1994). "The core conflictual relationship theme." Psychotherapy Research. **4**: 172-183.

Macaskill, N. D. (1982). "The theory of transitional phenomena and its application to the psychotherapy of the borderline patient." British Journal of Medical Psychology. **55**: 349-360.

MacIntyre, A. (1981). After Virtue : A Study in Moral Theory. London, Duckworth.

Mair, K. (1988). Changes. 6(3): 82-84.

Mair, K. (1992). The Myth of Therapist Expertise. Psychotherapy and its Discontents. W. a. F. Dryden, C. Buckingham, OUP.

Malan, D. H. (1979). Individual Psychotherapy and the Science of Psychodynamics. London, Butterworths.

Malinowski, B. (1922). Argonauts of the Western Pacific. London, Routledge.

Marcuse, H. (1966). Eros and Civilisation. Boston, Beacon Press.

Masson, J., Ed. (1985). The Complete Letters of Sigmund Freud to Wilhelm Fliess 1987-1904. London, Harvard University Press.

Masson, J. (1992). The Tyranny of Psychotherapy. Psychotherapy and its Discontents. W. Dryden. Buckinghamshire, OUP: 7-29.

Masterson, J. F. (1976). The Psychotherapy of the Borderline Adult. New York, Brunner Maazel.

Mattingly, C. (1991). "The narrative nature of clinical reasoning." American Journal of Occupational Therapy: 45-98.

Mattingly, C., and Fleming, M.H. (1994). Clinical Reasoning. Forms of Inquiry in a Therapeutic Practice. Philadelphia, F.A. Davis Company.

McLeod, J. (1997). Narrative and Psychotherapy. London, Sage.

McLeod, J. (1998). An Introduction to Counselling. Buckingham, OUP.

McLeod, J., and Lynch, G. (2000). "'This is our life' : Strong and weak evaluation in psychotherapy narrative." European Journal of Psychotherapy, Counselling and Health. 3(3): 389-407.

McLeod, J. (2001). Qualitative Research in Counselling and Psychotherapy. London, Sage.

Meares, R. A., and Hobson, R.E. (1977). "The persecutory therapist." Br. J. med. Psychol. **50**: 349-360.

Mendez, A., and Fine, R. (1976). "A short history of the British school of object relations and ego psychology." Bulletin of the Menninger Clinic. **40**: 357-382.

Miles, M., and Huberman, A. (1994). Qualitative Data Analysis: A Source Book of New Methods. London, Sage.

Miller, G. a. S., D. (1995). "Troubles talk and counselling discourse: a comparative study." Sociological Quarterly **36**: 725-747.

Mishler, E. G. (1986). Research Interviewing : Context and Narrative. Cambridge, MA, Harvard University Press.

Mitchell, J., Clyde. (1983). "Case and situation analysis." The Sociological Review. **31**: 187-211.

Mitchell, S. A. (1988). Relational Concepts in Psychoanalysis. London, Harvard University Press.

Mitchell, S. A. (1993). Hope and Dread in Psychoanalysis. New York, Basic Books.

Mitchell, S. A. (1998). "The analyst's knowledge and authority." Psychoanalytic Quarterly. **LXVII**: 1-31.

Mitchell, S. A. (2000). Relationality. London, Analytic press.

Molino, A., Ed. (1997). Freely Associated : Encounters in Psychoanalysis. Bristol, Free Association Books.

Moran, D. (2000). Introduction to Phenomenology. London, Routledge.

Murray, M. (2003). Narrative Psychology. Qualitative Psychology : A Practical Guide to Research Methods. J. Smith, A. London, Sage.

Nagel, T. (1974). What is it like to be a bat ? Mortal Questions. Cambridge, Cambridge University Press.

Nagel, T. (1986). The View From Nowhere. Oxford, Oxford University Press.

Nagel, T. (1995). Other Minds : Critical Essays. Oxford, Oxford University Press.

Neimeyer, G. J., Ed. (1993). A Constructivist Assessment Casebook. London, Sage.

O'Hear, A. (1991). What Philosophy Is : an Introduction to Contemporary Philosophy. Harmondsworth, Penguin.

Ogden, T. H. (1989). The primitive Edge of Experience. New York, Jason Aronson.

Ogden, T. H. (1992). "The dialectically constituted/decentred subject of psychoanalysis. ". The contributions of Winnicott and Klein." International Journal of Psycho-Analysis. **73**: 613-626.

Ogden, T. H. (1994). "The Analytic Third : Working with intersubjective clinical facts." Int. J. Psychonal. **75**: 3-19.

Ogden, T. H. (2003). "What's true and whose Idea was it ?" Int. J. Psychoanal. **84**: 593-606.

Ong, W. J. (1982). Orality and Literacy - the Technologising of the Word. London, Methuen.

Osborne, J. W. (1994). "Some similarities and differences among phenomenological and other methods of psychological qualitative research." Canadian Psychology **35**: 167-189.

Parker, I., Ed. (1999). Deconstructing Psychotherapy. London, Sage.

Patton, M. Q. (1990). Qualitative Research and Evaluation Methods. Newbury Park CA, Sage.

Pedder, J. (1982). "Failure to mourn and melancholia." British Journal of Psychiatry. **41**: 327-37.

Phillips, A. (1995). Terrors and Experts. London, Faber and Faber.

Phillips, A. (1997). Encounter with Adam Phillips. Freely Associated: Encounters in Psychoanal. A. Molino. Bristol, Free Association Books.

Phillips, J. (1999). The Psychodynamic Narrative. Healing Stories. Narrative in Psychiatry and Psychotherapy. G. Roberts, and Holmes, J. Oxford, OUP.

Pilgrim, D. (1992). Psychotherapy and Political Evasions. Psychotherapy and its Discontents. W. Dryden. Buckingham, OUP: 225-243.

Platt, J. (1988). "What can case studies do?" Studies in Qualitative Methodology. **1**: 1-23.

Pletsch, C. (1985). Subjectivity and Biography. Introspection in Biography. S. H. a. P. Baron, C. Hillsdale, NJ, Analytic press.

Polanyi, M. (1966). The tacit dimension. Garden City, New York, Doubleday.

Polkinghorne, D. E. (1992). Postmodern Epistemology in Practice : How is theory used in practice. Postmodernism and Psychology. S. Kvale. London, Sage.

Popper, K. (1974). Replies to my Critics. The Philosophy of Karl Popper. P. A. Schlip, Open Court.

Potter, J., and Wetherell, M. (1995). Discourse Analysis. Rethinking Methods in Psychology. J. A. Smith, Harre, R. and van Langenhove, L. London, Sage.

Prodgers, A. (1991). "On hating the patient." British Journal of Psychotherapy. **8(2)**: 145-154.

Reason. P. and Rowan, J., Ed. (1981). Human Inquiry : A Sourcebook of New Paradigm Research. Chichester, Wiley.

Rennie, D. L. (1994). "Client's deference in psychotherapy." Journal of Counseling Psychology. **41**: 427-437.

Rice, M. (2000). Cover Story. Observer.

Richards, B. (1984). Schizoid States and the Market. Capitalism and Infancy. B. Richards. London, Free Association Books.

Ricoeur, P. (1984). Time and narrative. Chicago, University of Chicago Press.

Ricoeur, P. (1991). A Ricoeur Reader : Reflection and Imagination. M. J. Valdes. Toronto, University of Toronto Press.

Riessman, C. K. (1993). Narrative Analysis. London, Sage.

Rogers, C. R. (1957). "The necessary and sufficient conditions of therapeutic personality change." Journal of Consulting Psychology. **21**: 95-103.

Rorty, R. (1979). Philosophy and the Mirror of Nature. Princeton,NJ, Princeton University Press.

Rorty, R. (1991). Objectivity. Relativism, and Truth. Cambridge, Cambridge University Press.

Rosenfeld, H. (1964). Psychotic States. London, Hogarth.

Rosenweig, S. (1985). Freud and Experimental Psychology. A Century of Psychology as Science. D. Koch. New York, McGraw-Hill.

Roth, A., and Fonagy, P. (1996). What Works for Whom ? London, Guildford Press.

Rowe, D. (1995). Guide to Life. Glasgow, Harper Collins.

Rustin, M. (1987). "Psychoanalysis, philosophical realism, and the new sociology of science." Free Associations. **9**.

Rustin, M. (1991). The Good Society and the Inner World : Psychoanalysis, Politics and Culture. London, Verso.

Rutter, M. (1981). Maternal Deprivation Reassessed. Harmondsworth, Middlesex, Penguin.

Ryle, A. (2003). "Something more than the 'Something more than interpretation' is needed : A comment on the paper by the Process of Change Study Group." **84**: 109-118.

Sacks, H. (1984). On doing "being ordinary". Structures of Social Action: Studies in Conversation Analysis. J. M. Atkinson, and Heritage, J. Cambridge, Cambridge University Press.: 513-529.

Salzberger-Wittenberg, I. (1970). Psycho-Analytic Insight and Relationships: A Kleinian Approach. London, Routledge and Kegan Paul.

Samuels, A. (1992). Foreword. Psychotherapy and its Discontents. W. Dryden. Buckinghamshire, OUP.

Sandler, J. (1976). "Countertransference and role-responsiveness." Int. Rev. Psycho-Anal. **3**: 43 - 47.

Sandler, J., and Dreher, A.U. (1996). What do Psychoanalysts Want ? : The Problem of Aims in Psychoanalytic Therapy. London, Routledge.

Sarbin, T., Ed. (1986). Narrative Psychology : the Storied Nature of Human Conduct. New York, Praeger.

Sass, L. (1988). "The self and its vicissitudes : an 'archaeological' study of the psychoanalytic avant-garde." Social Research. **55**: 551-607.

Saukko, P. (2000). "Between voice and discourse : quilting interviews on anorexia." Qualitative Inquiry. **6**.(3): 299-317.

Savege Scharff, J., and Scharff, D.E. (1998). Object Relations Individual Therapy. London, Karnac.

Sayer, A. (1984). Method in Social Science: A Realist Approach., Hutchinson.

Schafer, R. (1976). A New Language for Psychoanalysis. London, Yale University Press.

Schafer, R. (1980a). "Narration in the psychoanalytic dialogue." Critical Inquiry. **7**: 29-35.

Schafer, R. (1980b). Narrative Actions in Psychoanalysis. Worcester, MA, Clark University Press.

Schon, D. (1983). The Reflective Practitioner : How professionals think in action. New York, Basic Books.

Schwaber, E. (1990). "Interpretation and therapeutic action." International Journal of Psycho-Analysis. **71**(2): 229-240.

Seabrooke, J. (2004). A World Growing Old, Pluto Press.

Searle, H. (1960). The Nonhuman Environment. New York, International University Press.

Segal, H. (1957). "Notes on symbol formation." International Journal of Psycho-Analysis. **38.**: 391-397.

Segal, H. (1964). Introduction to The Work of Melanie Klein. London, Heinemann.

Shapiro, D. A. (1989). Outcome Research. Behavioural and Mental Health Research: A Handbook of Skills and Methods. G. a. W. Parry, F. Hove, Lawrence Erlbaum Associates.

Shelton, P. a. C., T., and Cervenka, H. (1989). "Ships in a harbour are safe." Journal of Social Work Practice. **4**(1): 88-96.

Shotter, J. (1993). Converstaional Realities. Thousand Oaks, CA, Sage.

Silverman, D. (1993). Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction. London, Sage.

Silverman, D. (2000). Doing Qualitative Research. A practical handbook. London, Sage.

Skovholt, T. M., and Ronnestad, M.H. (1992). The Evolving Professional Self. Stages and Themes in Therapist and Counselor Development. Chichester, Wiley.

Smail, D. (1987). Taking Care : An alternative to therapy. London, Dent.

Smith, L. M. (1978). An Evolving Logic of Participant Observation, Educational Ethnography and Other Case Studies. Review of Research in Education. L. Shuman. Itasca, IL, Reacock. **6.**: 316-377.

Spence, D. P. (1987). The Freudian Metaphor : Towards Paradigm Change in Psychoanalysis. New York, Norton.

Spence, D. P. (1993). "The hermeneutic turn: soft science or loyal opposition?" Psychoanalytic Dialogues **3**: 1-10.

Spillius, E. B. (1994). "Developments in Kleinian thought : overview and personal view." Psychoanalytic Inquiry. **14**(3): 324-364.

Spinelli, E. (1994). Demystifying Therapy.

Spradley, J. P. (1979). The Ethnographic Interview. New York, Holt, Rinehart and Winston.

Stake, R. E. (1994). Case Studies. Handbook of Qualitative Research. N. K. a. L. Denzin, Y.S. London, Sage.

Steiner, J. (1996). "The aims of psychoanalysis in theory and practice." Int. J. Psycho-Anal. **77**: 1073-1083.

Stern, D. N., Sander, L.W, Nahum, J.P, Harrison, A.M., Lyons-Ruth, K., Morgan, A.C., Bruschweiler-Stern, N., and Tronick, E.Z. (1998). "Non-Interpretive Mechanisms in Psychoanalytic Psychotherapy. The 'Something More' Than Interpretation." Int.J.Psycho-Anal. **79**: 903-921.

Stoecker, R. (1991). "Evaluating and rethinking case study." Sociological Review.(0038-0261): 89-112.

Stolorow, R. (1988). "Intersubjectivity, psychoanalytic knowing and reality." Contemporary Psychoanalysis. **24**: 331-338.

Stoltenberg, C., and Delworth, U. (1987). Supervising counselors and therapists : A developmental approach. San Francisco, Jossey-Bass.

Storr, A. (1979). The Art of Psychotherapy. .London, Secker and Warburg and William Heinemann Medical Books.

Storr, A. (1997). Feet of Clay : A Study of Gurus., Harper Collins.

Strauss, A., and Corbin, J. (1990). Basics of Qualitative Research : Grounded theory proceedures and techniques. London, Sage.

Strenger, C. (1989). "The classic and romantic visions in psychoanalysis." International Journal of Psycho-Analysis. **70**: 595-610.

Strupp, J. H., and Binder, J.L. (1984.). Psychotherapy in a New Key : A Guide to Time-Limited Dynamic Psychotherapy. New York, Basic Books.

Sutherland, J. (1968). "The consultant psychotherapist in the National Health Service." British Journal of Psychiatry. **114**: 509-515.

Symington, N. (1985). "Phantasy effects that which it represents." Int J. Psychoanal. **66**: 349-357.

Symington, N. (1986). The analyst's act of freedom as agent of therapeutic change. The British School of Psychoanalysis. The Independent Tradition. G. Kohon. London, Free Association Books.

Symington, J., and Symington, N. (1996). The Clinical Thinking of Wilfred Bion. London, Routledge.

Szasz, T. (1979). The Theology of Medicine. Oxford, Oxford University Press.

Taylor, C. (1971). "Interpretation and the science of man." Review of Metaphysics **25**: 3-51.

Taylor, S. J., and Bogdan, R. (1984). Introduction to Qualitative Research - The Search for Meanings. New York, John Wiley.

Taylor, C. (1989). Sources of the Self : The Making of the Modern Identity. Cambridge, Cambridge University Press.

Tuckett, D. (2003). "Building a more secure base for psychoanalytic Psychotherapy: conflicts in sharing the data." British Journal of Psychotherapy **20**(2): 177-188.

Valdes, M. J., Ed. (1991). A Ricoeur Reader: Reflection and Imagination. Toronto, University of Toronto Press.

Van Maanen, J. (1988). Tales of the Field : On writing ethnography. Chicago, University of Chicago Press.

Viderman, S. (1979). "The Analytic Space." Psychoanalytic Quarterly. **48**: 257-291.

Warnke, G. (1987). Gadamer : Hermeneutics, Tradition and Reason. Cambridge, Polity Press.

Wason, P. C., and Johnson-Laird, P.N. (1972). Psychology of Reasoning : Structure and Content. Cambridge MA, Harvard University Press.

Weinstein, D., and Weinstein, M.A. (1991). "Georg Simmel: sociological flaneur bricoleur." Theory, Culture and Society. 8: 151-168.

Weldon, F. (1993). The Case Against Therapy. The Times: 1-6.

Winnicott, D. W. (1947). Further thoughts on babies as persons. The Child, the Family and the Outside World., Perseus.

Winnicott, D. W. (1948). Paediatrics and Psychiatry. Through Paediatrics to Psychoanalysis. London, Hogarth.

Winnicott, D. W. (1950). Aggression in relation to emotional development. Through Paediatrics to Psychoanalysis. London, Hogarth.

Winnicott, D. W. (1951). Transitional Objects and Transitional Phenomena. Playing and Reality. London, Tavistock.

Winnicott, D. W. (1954). Metapsychological and clinical aspects of regression. Through Paediatrics to Psychoanalysis. London, Hogarth.

Winnicott, D. W. (1956). Primary maternal preoccupation. Through Paediatrics to Psychoanalysis. London, Hogarth Press.

Winnicott, D. W. (1958). Through Paediatrics to Psycho-analysis. London, Hogarth Press.

Winnicott, D. W. (1960a). The Theory of the Parent-Infant Relationship. The Maturational Process and the Facilitating Environment. New York, International Universities Press.

Winnicott, D. W. (1960b). Ego Distortion in Terms of True and False Self. The Maturational Process and the Facilitating Environment. New York, International Universities Press.

Winnicott, D. W. (1960c). Counter-transference. The Maturational Process and the Facilitating Environment. New York, International Universities Press.

Winnicott, D. W. (1963a). Communicating and not communicating. The Maturational Proces and the Facilitating Environment. New York., International Universities Press.

Winnicott, D. W. (1963b). Dependence in Various Settings. The Maturational Process and the Facilitating Environment. New York, International Universities Press.

Winnicott, D. W. (1965a). The Maturational Process and the Facilitating Environment. New York, International Universities Press.

Winnicott, D. W. (1965b). The Family and Individual Development. London, Tavistock.

Winnicott, D. W. (1965c). The effects of psychosis on family life. The Family and Individual Development. London, Tavistock.

Winnicott, D. W. (1967). The location of cultural experience. Playing and Reality. Middlesex, England, Penguin.

Winnicott, D. W. (1970). Creativity and its origins. Playing and Reality. London, Tavistock.

Winnicott, D. W. (1971). Playing and Reality. London, Tavistock.

Winnicott, D. W. (1988). Human Nature. New York, Schoken Books.

Wolff, H. H. (1971). "The therapeutic and developmental functions of psychotherapy." Br. J. Med. Psychol. **44**: 117-130.

Yin, R. K. (1984). Case Study Research : Design and Methods. Beverly Hills CA, Sage.

Zukar, G. (1979). The Dancing Wu Li Masters. New York, Bantam.

APPENDICES

APPENDIX A

SEMI-STRUCTURED INTERVIEW SCHEDULE

Introductory question concerning the length of time the therapist has worked as an NHS Psychotherapist and an estimate of the number of patients seen for therapy in that time.

A request to choose two patients who the therapist has seen for therapy (or perhaps for assessment) :

° a patient regarded by the therapist as at the mentally healthier end of the spectrum.

° a patient regarded by the therapist as at the mentally more disturbed end of the spectrum.

A selection of questions to open out the therapist's understanding of the two patients in succession, their interventions and the outcome of the therapy :

° what was it about the patient that seemed so healthy / disturbed ?

° around what ideas and metaphors did you organise your thinking about them ?

° what did the patient need help with in therapy ?

° how did you negotiate your understanding with the patient ?

° what was the nature of the relationship between you ?

° did you feel you helped this patient and if so how ?

° what theory was most helpful in thinking about them ?

Broadening out from these specific patient examples to wider questions about their practice :

- what understanding about what it means to 'live the good life' do you bring to your therapies ?
- what do you think you teach your patients ?
- what status do you give to your understanding of the patient ?
- what do you feel you know as a therapist ?
- how do you decide what your patient needs ?
- what do you regard as the limits of the psychodynamic approach ?
- how has your practice changed over time ?
- what was the contribution of your training to your current practice ?

APPENDIX B

CONSENT FORM

I consent to being interviewed by Nigel Runcorn for the purposes explained to me. I understand the interview will be taped and transcribed, that all material will be treated in a confidential manner and its future use will be discussed with me along with the understanding gained from it. I understand I can withdraw myself and this material from this process at any time.

Signed:

Date:

APPENDIX C

LETTER TO POTENTIAL INFORMANT

Dear

Following our conversation I am writing to ask if I could interview you as part of my PhD research which I am engaged in through Derby University. I am looking at the issue of how psychotherapists use their professional knowledge in practice. I am interested in how therapists structure their understanding, what status they give it and in particular how understanding is negotiated with a patient. I am very aware of these in my practice to the extent that I would like to explore how others handle them.

I would like to ground these questions in specific examples so I would be asking you to explore this area by talking about two of your patients, one who you regard as more healthy /less disturbed and one who you regard as less healthy / more disturbed. The confidentiality of all the material will be carefully preserved by me. However, I need, at times, to share parts of interviews with my supervisor(s) from the university . The focus of the research is on therapists and the way therapists use their professional knowledge. Nothing would be used in attributable form at any point and I envisage patient material as such appearing in a very limited way and well anonymised.

If you were to participate I would be happy to consult with you about the way material could be used in the final paper and accept your wishes. You would be able to withdraw yourself and therefore your patient material at any point in the process.

The interview would last up to an hour and a half and requires no preparation as such.

I am happy to offer more information if it would help your decision whether to participate. At the start of the interview I would ask you to sign a form indicating your consent to the interview and its uses as described to you.

Thanks for your time in considering this.

Yours Sincerely

Nigel Runcorn
Social Work Specialist in Psychotherapy.