Back to the Beginning:

An exploration of the treatment and effects of therapeutic regression to dependence in psychotherapeutic practice

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We shall not cease from exploration

And the end of all our exploring

Will be to arrive where we started

And know the place for the first time.

T.S. Eliot, "Little Gidding"

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The author of this study has published two articles addressing similar themes:

Price, L. (2007) The Dark House of Infancy: An Exploration of Regression to Primitive Pre-Verbal States for Clients in Integrative Psychotherapy. *The British Journal of Psychotherapy Integration*, *4:1*, 81.

Price, L. (2009) From Theory to Therapy: An Exploration of the Relevance of Winnicott's Theories in Regression to Dependence. *The British Journal of Psychotherapy Integration*, *6:1*, 29-39.

Abstract

This research builds upon and explores an enigmatic set of experiences which theorists in the Object Relations tradition have characterised as regression to dependence, a return to a primitive, pre-verbal relational process presenting in some clients in psychotherapy. This research is a study of the concept of regression to dependence, its manifestation within the psychotherapy process, and facilitation within the therapeutic relationship.

The Psychoanalytic theoretical positions on regression to dependence are explored, together with the Relational/Developmental perspective which recognises regression and its importance within psychotherapy. This exploration seeks to understand the experience of regression to dependence, how regression to dependence can be effectively worked within Integrative Psychotherapy, and makes recommendations for Integrative practitioners and theorists related to effective facilitation of clients, showing how the Relational/Developmental approach can effect repair.

The study employs a qualitative methodology. A heuristic study was undertaken in which eleven practicing psychotherapists were interviewed and data was collected via semi-structured interviews. Most participants were interviewed twice, with a view to collecting data on both their personal experience as a client in psychotherapy and also their experiences as practitioners when working with clients who were experiencing regression to dependence. The transcripts from these interviews were analysed for emergent themes. The themes are discussed in the context of and with reference to the Psychoanalytic theoretical position and the Relational/Developmental perspective. An account is offered of how these experiences have come to be understood as recollecting difficulties in early infantile relationships. Reflections are made on the essence and qualities of a therapy that can facilitate regression to dependence in order to promote healing. Recommendations are made for the practice of Integrative Psychotherapy and the training of Integrative Psychotherapists in order to prepare them for this work. These recommendations for therapists include; having sufficient preparation, knowledge and understanding to be able to recognise and work with a regressive process emerging in the client; having an understanding of the need to facilitate this process for some

clients; and to be aware of the need for particular adaptations in the therapeutic stance in some circumstances, and the difficulties which may arise. Recommendations are also offered regarding the support needed for the therapist whilst working with this process, which include the need for ongoing personal therapy, and supervision.

The researcher's personal story is an intrinsic part of the research, and as an integral part of this study is in accordance with the heuristic and autoethnographic styles, and with the practice of Integrative Psychotherapy, where the use of self is seen as a crucial clinical tool in the therapeutic process. Throughout this study reflexivity has been used regarding the personal experiences of the researcher as client, therapist and researcher.

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Chapter One

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Introduction

"The teller of chaos stories is, pre-eminently, the wounded storyteller, but those who are truly living the chaos cannot tell in words" (Frank 1995, p98).

I first came across the above quotation in a book by Kim Etherington (2003) about trauma. It caught my attention because I felt it described my experience. As a client in Integrative Psychotherapy I initially struggled to understand and articulate the process I was in and to put words to my experience. After a particularly painful experience during psychotherapy training one of my tutors comforted me and told me that I would need to establish a narrative for my experiences. This experience, and my reflections upon it over time, gave me some insight into the processes that might be occurring and into the need for narrative as a frame for experience, leading to my exploration and study of theories which I consider described these processes, resulting in the development of my clinical work and informing my initial and on-going research. This process has taken me many years to establish personally, but my tutor's words contained truth for me. Having a narrative for me has given meaning, and meaning has given understanding and a framework within which to conceptualise the experience. I recognised that part of my interest was to explore and gain insight into the 'lived experiences' of others and place them with my own experiences so that I could understand and inform myself. I also wanted to identify and understand those theories which seemed to offer explanation for these experiences and through this be able to support more effectively and offer healing to my clients (Etherington 2003, p10).

I consider that as the field of contemporary psychotherapy has developed 'the baby has been thrown out with the bath water', meaning that the importance of concepts from analytical exemplars, such as Winnicott, have been largely overlooked in the move to embrace relational concepts. I aim to re-establish the importance of these 'archived' aspects of theory in order to illuminate the processes emerging from this study. As a result of my own training and personal psychotherapy I came to understand some of my

disturbance as resulting from early childhood experiences. This fitted very well with my prior beliefs that my feelings and behaviour as an adult resulted from the family circumstances in which I was brought up. In my clinical work there were echoes of this, and my concern was how best to deal with these troubling and hard-to-understand experiences which may occur in therapy and which have been conceived of as representing a return to difficulties experienced in the mother/infant relationship (Winnicott 1965; Balint 1968; Van Sweden 1995; Erskine 2011). My personal and professional experiences resonated strongly with this theoretical construct, developing my interest further.

This thesis is particularly concerned with addressing the work with clients presenting with such symptoms. In writing the chapters in this thesis I have started with the theory because I wanted the reader to have an understanding of this theoretical concept in order to make sense of the data from participants. This is the same position that I will advocate later in this chapter for therapists to adopt, that is, an understanding of theory being necessary to fully understand clients. As Participant C, in relation to her own therapy which was undertaken as a requirement of Psychotherapy training, stated:

> I'd got the theory to support me and I realised that I could understand what was happening.

Understanding one another needs a shared language; in this case the language of both theory and experience, helping to develop a narrative, a story through which the experience can be understood. Winterson (2011, p40) describes the use of story as a means of sharing a reality and an experience, and how she has used stories as a means of personal healing. "I had no one to help me, but T.S. Eliot helped me. So when people say that poetry is a luxury, or an option, or for the educated middle classes, or that it shouldn't be read at school because it is irrelevant, or any of the strange, stupid things that are said about poetry and its place in our lives, I suspect that the people doing the saying have had things pretty easy. A tough life needs a tough language – and that is what poetry is. That is what literature offers – a language powerful enough to say how it is. It isn't a hiding place. It is a finding place." Personally, I have found that the shared experiences and the words of others when I was unable to find my own words have helped me to feel connected to others who understood what I was experiencing. It is

also necessary to recognise that there can be some loss in the use of words, as we can only use words that exist, and these are not always sufficient to describe the experience.

This thesis is based upon data collected via an interview study with participants who are practicing psychotherapists and therefore the reader should bear in mind that my participants are commenting from two perspectives, that of being a client in this process, and that of being a therapist working with clients in the process. I have clearly identified the perspective they are speaking from as their comments appear within the work. Initially, I considered trying to present these different types of data in separate sections of the thesis, however, I found that this resulted in a disjointed feel to the work and it occurred to me that this disjointed feel also mirrored the experiences I am describing.

When I began to write up this research I expected that I could present my participants' data in the normal style for a thesis, that is, in the findings sections. It soon became apparent to me that this was not possible. When I had conducted the interviews I had focused on both the participants' experiences as clients in their own therapy and as therapists in their clinical practice. I imagined that all of the data would form a cohesive whole. This was not the case. It was not possible to use the two strands of data together. Then I tried to separate the data into two sections, but this seemed to involve two sets of explanations about the points of data. At this time my tacit knowledge was emerging regarding the absence of theoretical understanding to explain the phenomena, so I made the decision to lead each of the findings chapters with the theories that resonated with the participants' descriptions of their experiences. In the process of doing this I intended to highlight the theoretical understanding of some of my participants, not wanting to lose their theoretical voice. I took the unusual decision, therefore, to use the participant data to illuminate points of theory, demonstrating the participants' theoretical stances and highlighting their experiences. This resulted in participant data being placed throughout the work as appropriate. Where participant data appears it is clearly identified as such.

When my participants are speaking from their personal experiences as clients, readers will notice a sparcity of language and description. During the live interviews I did not notice this, because there was richness in the experience and a shared understanding, so

it felt to me as if there were many words. When the participants are speaking of their experiences as therapists readers will notice that they speak articulately and often apply theory. This has become clear to me in the writing up of the work where I have been able to see the difference between the participants' use of words. I want to draw the reader's attention to these changes in the participants' language, which I formulate as indicative of the loss of language that is described by theorists, practitioners and participants when in contact with regressive processes in order to be able to share in this experiencing, in the way that a poet will give an experience that is more than the written word by developing rhythm and stanza. I consider that part of the role of the therapist is to help the client to find words to describe and give meaning to their experience. This then forms part of the client's narrative for life, self-history and story, which gives a sense of identity and continuity from their earliest existence. This self-history then forms part of self-experiencing and gives a sense of cohesion as an individual which helps the infant (client) to have a sense of going on "being", that is, a sense of the continuity of existence. This is in accordance with Stern's (1985) stages of development. Stern (1934 – 2012) was a psychiatrist and psychoanalytic theorist who specialised in infant development and mother/infant bonding. His research with mothers and their infants has influenced how the relationship between the therapeutic couple has been viewed, and has elaborated on Object Relations theories, by identifying the senses of self and describing their organisation and relationship. Stern suggests there are four interrelated senses of self which develop over our lifespan. He identifies the mother or primary care giver as having a key role in supporting the development of the sense of self. He proposes that any disturbance, misattunement by the care giver, or trauma can create later difficulties and psychopathology. There are two aspects of Stern's work that are particularly relevant to this study of regression to dependence. The first is his theory and observations which offer a dynamic account of the growth of the sense of self. He gives some account of the experience of the adult client who, although appearing to be functioning well in some aspects of their lives, has a need to regress in therapy in order to heal early relational wounding, so developing a previously damaged aspect of self.

The second aspect of Stern's (1985) work that is relevant to this study is the role he ascribes to the mother or primary caregiver; that of a "soothing vitality affective mother". He argues that it is the live response of the mother that brings a vitality affect

to the infant, so defining and helping them to know a sense of self and emotional relatedness. He relates this to therapy and describes "now moments" as being akin to the vitality affect in the early relationship. It could be argued that these "now moments", which Stern describes as occurring in therapy, provide healing during the process of regression, so enabling the aspect of the sense of self, which was damaged or arrested, to repair and grow.

The reader will see that I have frequently used the words of others, often literature quotations, which have spoken to me at a level that I have been unable to express with my own words. The developmental phases that Stern (1985) identifies recognise the value of the development of the verbal, but also the loss of the level of experiencing which is beyond words. I often find that my own words feel inadequate to the task of describing feeling states or experiencing, especially when I am writing about pre-verbal states. The words of others, often when they have captured an ethereal or spiritual dimension, can speak for me in ways that I feel inadequate to do. In Chapter 5, The Facilitating Therapy, I have discussed how establishing a narrative gives expression to hitherto unexpressed experiences, and allows shared understanding, enabling the client to have a voice which may reach back to their earliest existence. Winterson (1985, p xv) expresses it thus; "Once you can talk about what troubles you, you are some way towards handling it. I know from my postbag that *Oranges* (her novel) has given a voice to many people's unspoken burdens. And when you have found your voice you can be heard."

As I have indicated, my interest in psychotherapy began with the need to understand myself and my own story. It feels important then to identify some of my own story and its impact upon me and my work.

Prior to entering therapy I had what I would call a set of behavioural and psychological 'symptoms'. My anxiety was so severe that at times I feared madness, believing that only madness could account for my inability to control (at times) my behaviour, thoughts or emotions. I was unable to tell a story of my life which was cohesive and comprehensible. This resulted in feelings of shame and distress. From my early adulthood I recognised that my family was dysfunctional, containing high levels of criticism and shaming. I was a late and unexpected arrival and my mother was

depressed; this depression was intensified by grief when my older sister died unexpectedly in a car accident. She was passive in the face of my domineering father who, I now believe, suffered from unresolved Post Traumatic Stress Disorder as a result of his experiences in the Second World War, compounded later by the loss of my sister who was the apple of his eye. My mother also had chronic anxiety and a great fear of abandonment. She was unable to meet me emotionally as an infant, and unable to protect me from my father. As an adult, I now recognise that I sought a relationship that would complete me, that is, one which would fill my 'hole in the soul' (Tomkins 1963), which was caused by an absence of a cohesive self. I sought completion in friendships, in romantic relationships, in marriage, in becoming a parent, and in God, all unsuccessfully. The process of therapy for me involved the emergence of a story which would give meaning and narrative to my self, accounting for my psychological damage. Having such a story gave me a framework upon which to hang my experiences, helping me to apply theory, and to understand some of my behaviours and psychological processes. Having a story gave me a map with which to find my way in the world, and a template to build on in future work, and also made it possible to have a shared understanding with others.

Etherington's (2004, p75) work resonates with my experience. In her writing on the benefits of narrative enquiry, she uses an ontology which is partly based on psychological and socially constructed concepts. She uses the following quotations "we live storied lives and our world is a storied world" and "telling and re-telling one's story helps a person create a sense of self" identifying that "narratives…portray how people experience their position" and that "in peoples' stories we hear their feelings, thoughts and attitudes," and how the narrative "helps us to understand how they understand themselves." I concur with this understanding of narrative, but my assertion is that the formation of a core narrative originates in infancy, and where this does not happen because of a failure in the early mother/infant relationship, then a person's life can be without cohesion. My intention then is to use the Object Relations understanding of the development of a human being, to show how the process of regression to dependence enables the re-experiencing of aspects of the early infant relationship, and how the application of a narrative within the psychotherapeutic relationship helps a client to develop a sense of self and therefore find repair. Holmes, (2008, p3) writing from an

attachment perspective, considers that our narrative and our identity are inseparable. He identifies that attachment-informed research suggests that "people who know their story, and who can tell it coherently, are at an advantage", and more able to cope with life. This research tries to balance the psychoanalytic tradition which uses a more medical model of health and healing, and a post-modern model which relies upon social construction and a narrative formulation. My intent is to integrate the two, and to offer such integration as a model for practitioners to use. This is evident in my choice of theorists, which spans both traditions, and my choice of language which does the same.

Johns (2009, pp234-235) identifies how received knowledge has both helped and hindered her in her work as a psychotherapist. In writing about her own development from childhood she describes the growth of her understanding and some of her ways of being with her patients. She also relates her experiences of being a supervisee of Winnicott, and identifies his oblique approach. She describes her difficulties with integrating theory and how she decided to learn psychotherapy from her patients. She identifies her own approach as developmental, considering the reconstruction of received history as a crucial aspect of clinical work, together with the management of regression and the development of meaning. She draws a parallel between infant development and the development of a practitioner and the process of 'becoming oneself' as a practitioner. The process of writing up this research study has led me to develop and become myself as both practitioner and researcher; researching and writing led me to an exploration and questioning of my beliefs and experiences, and has enabled me to find ways of articulating them to others.

I turned to psychotherapy in the hope of discovering, understanding and making meaning of my story. As a result of this therapeutic relationship I understood how I came to be this way, and I experienced, over a long period of time, a painful but reparative relationship with my therapist which had the qualities which my early relationships had lacked. As I grew up (therapeutically), I was able to apply my new-found security to effectively offer repair to my clients, just as a secure person is able to parent more effectively. My history then has led to my research. Applegate (2002) offers his thoughts on this issue; reflecting upon the subjective experiencing associated with theoretical constructions he writes of his increased awareness that his theoretical

choice as a clinician "was in fact predetermined in convoluted and surprising ways". He considers that his psychological development resulted from this early environment, leading to his search to understand himself, and finding in psychoanalytic theory the answer to his conundrum. His preoccupation with Object Relations theory, and Winnicott in particular, revealed a shared interest in understanding early relationships which Applegate posits as arising from some aspects of their shared history. I feel that I too would have been understood by, and connected to, theorists such as Winnicott, Little and Van Sweden, who may well have had a shared history with me.

The term 'Integrative Psychotherapy' refers to an approach which combines various theories from different psychotherapy traditions. It is an evolving process in which different conceptual models of human psychology are intertwined into a cohesive unity, forming a structure for practice. Integrative Psychotherapists do not necessarily integrate the same theories or philosophies. Zalasiewicz (2006, p62) sees the Integrative practitioner as "open-minded, curious and questioning, able to hold more than one theoretical perspective at a time and welcoming "internal ambiguities, contradictions and paradoxes" (Shafer 1976, pp50-51)".

My model of integration is a theoretical integration, which relies upon an overarching Relational/Developmental philosophy as a structure for integration. This philosophy places the infant/caregiver relationship as the primary relationship, creating an organising matrix that frames the intrapsychic world, and also influences all subsequent relationships. This intrapsychic process, then, has been created in an interpersonal context. The therapist's role is to create a context of safety, offering attunement, presence and themselves in order to become a transformational object in this developmental perspective. The relationship is considered to be of prime importance, and the theory is accessed as a means of understanding the client, their experiences, their ways of relating, and the processes occurring in the therapeutic relationship. This model of integration takes into account views of human functioning which fit within Relational\Developmental philosophy, including Psychoanalysis, Object Relations theory, Attachment theory, Transactional Analysis and Gestalt Psychotherapy. An understanding of Human Developmental Psychology enables a view of where development has occurred, or where such development has been hindered. The resulting

process of psychotherapy can enable aspects of the client's self which may have been defensively disowned to be reintegrated.

As Integrative Psychotherapy considers the therapist to have an important part to play within the relationship, I consider then that I, together with the participants, have an important part to play within this research, and that my responses, feelings and thoughts are intrinsic to the research process.

Modern Integrative Psychotherapy has an important relational tradition, but my experience is that many Integrative Psychotherapists have little or no detailed knowledge of the issues raised within this study. This may be because, although training has focussed towards the relationship and therapeutic repair, aspects of theory which have relevance to some complex clients have not been taught to trainees, or have been lost or put into the background. Although there is a body of research from the Psychoanalytic tradition, this can alienate some Integrative Psychotherapists as it does not generally take into account the experiences of clients in the here and now and can be written from an 'omnipotent viewpoint', that is, from the position of an expert, rather than the relational stance held by Integrative Psychotherapists. I consider that there is a gaping hole between the theories that seem to describe this process and the therapist's and client's viewpoint where the work actually happens. As a practitioner seeking to understand the regressive processes being experienced by my clients, my Integrative training was very helpful in enabling me to use and extend my Relational/Developmental framework to apply theory in practice. My aim then is to inform the profession as a whole, but also to bring to the attention of Integrative and Humanistic therapists this area of client work which seems to be disregarded or misunderstood.

The research question for this study has emerged from my own search for understanding, originally personally, and then professionally. I wanted to develop my understanding of my own experiences and those of my clients, and I wanted to ascertain if these experiences were shared by contemporary therapists and their clients. In my personal therapy, I began by looking for resolution of troubling symptoms. I ended up finding an experience of love and intimacy, and I hoped to offer this experience to my

clients. What I was seeking to understand was both the experience itself, and the ways in which this experience can be understood.

My Methodology chapter describes the process of my research from identifying a question, through conducting the interviews and on to analysing the data. I identify my heuristic methodology which recognises and names my internal bias and my rationale for using such methodology within a socially constructed world view.

My Literature Review offers an overview of the relevant literature and theorists. However, as part of my contention within this thesis is that theory and experiences should be integrated and understood together, detailed theoretical concepts are more fully developed within the relevant chapters together with some of the participants' descriptions of their experiences that are relevant to the theory. Some of these excerpts may appear again in the individual chapters; however I have used them to demonstrate the theoretical thinking of the participants. Therefore, the chapters on Regression to Dependence, Terror – a Sickness of the Spirit, Shame in Regression to Dependence, the Facilitating Therapy and A Question of Boundary follow a theory-led format.

Some of the theories that have been outlined are no longer widely known, yet I consider that they are important for practitioners in order to understand the phenomena that they may experience. I have also tried to show the reader theoretical ideas and concepts from their beginnings in Freud, Ferenczi, Balint, Winnicott, then moving through to more current theorists and finally to the beliefs and ideas held by my participants. As my participants are all practicing psychotherapists who, in addition to detailing their experiences as clients also hold theoretical positions and understanding which they relate to both their personal experiences and clinical work, I have chosen to include their voices as appropriate within theoretical sections of this work. The structure of this thesis leads with theory in order to enable the reader to apply theoretical concepts to the data, and to enable them to form a structure within which to understand the experience.

The participants have identified, both implicitly and explicitly, how their experiences and insights into their own inner world have helped them to understand their clients and facilitate their therapy effectively and compassionately. There are precedents for this, for instance, Margaret Little (1990) wrote about her experience of her personal work

with Winnicott to teach others through her writing. Yalom (1980, 1999, 2001) wrote of his experiences from personal and professional perspectives, while Freud also used his own analysis to inform his work with patients and to develop Psychoanalysis itself. Contemporary theorists and writers (Etherington 2004; Palmer 2008) also recognise the connection between therapists' personal experiences and the influence of this upon their clinical work, or from Shaw's (2008) perspective, upon their potential research.

Throughout this work I have referred to my personal and professional experience, and I mention in detail my experiences as a client. I have chosen to give no clear examples from my clinical experience for the protection of my clients, both past and present. I have learned much from them, and I want to honour this by fully protecting them and our relationship from any possible exposure.

In summary

This chapter has set the context for this study which is grounded in theory, clinical practice and experience. I have stated my position as a researcher regarding my own experiences, both personally and clinically and how my personal process has influenced me in all aspects of the research. I have also highlighted some theoretical constructs which have resonated for me. This research has been undertaken to identify the experiences of clients who have engaged in the process, and to illuminate theoretical constructs which may be considered as addressing these experiences. I am mindful though, that theories themselves are not the therapy, they are conceptual ways of thinking about things. Mitchell (1988, p15) highlights this point: "Theories are not facts, observations or descriptions – they are organizational schemes, ways of arranging and shaping facts, observations, and descriptions".

The following chapter will overview the literature and theoretical constructs which are relevant to this study.

Chapter Two
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Literature Review

Introduction

In this chapter I review the literature that I consider relevant to the study of the experiences of clients in the process of regression to dependence. My intention has been to ground the study in historical, theoretical and professional contexts which resonate with my theoretical orientation as a Relational/Developmental Psychotherapist. Much has been written about the relationship between developmental theory and how psychotherapy clients present with symptoms which can be seen to echo early infant development, as Winnicott (1958/1984) described "through paediatrics to psychoanalysis". I have focused on those writings which relate directly to the process which I am describing and to my position in relation to this process. As an attempt to understand my own experiences, I have been engaged in extensive reading for a number of years. This reading, the insights I have gained and my personal and professional experiences, have now become part of my way of the seeing the world. This integration of theory then could be seen as a prior understanding which was carried into the interview process and which guided and influenced my research.

The participants in this study are practicing clinicians and they will be introduced further in Chapter Three – Methodology. My aim is to connect theory and practice, and to find suitable words for the experience, as a parallel process to the way that we are helping the client to find words for their early experiences. As I consider that current day practitioners are theorists themselves, I have included some of the theoretical constructs of my participants where they connect with studied works or where their experiences as clinicians illustrate points of theory. Shaw (2008, p10) concurs that practitioners are actually researchers in their day-to-day work. He highlights the importance of the "therapist's body language, the countertransference that is felt in the body, seeing it as a valuable tool which can be shared in the therapeutic encounter".

I have therefore used some of my participants' quotations to highlight their theoretical understanding and I have identified that these are the participants' words within the review.

Much of the literature I reviewed comes from the Psychoanalytic tradition, and I used such theory to understand the clients' processes, I did not address the traditional analytic stance, but rather the application of such theory as it applies to my model of integration which has a cohesive philosophical and theoretical base, whilst holding a relational stance. Integrative Psychotherapists use a variety of theoretical sources which fit together under the umbrella of their philosophy. The sources I have used are compatible with an overarching Relational/Developmental philosophy, which was the stance of my training organisation, and is now integrated into my own stance as a practitioner. In the process of undertaking this research I have reviewed literature from a variety of sources beginning with Freud and moving towards more contemporary writing. As an Integrative Psychotherapist I regret that there is a lack of literature emerging from Integrative sources. I recognize though that this is the nature of integration, that theorists and theories develop and change, and new theories emerge becoming theorised as a new therapy rather than being integrated. I have explored and critically reviewed theories of human development, Psychoanalysis, relational psychotherapy, Object Relations, theories of trauma, shame process and research theories.

My initial search involved reference to the origins of psychotherapy, Psychoanalysis, its understanding of the mind and its development into Object Relations theories. The data arising from this study then led to me looking at later contemporary constructs of trauma theory, shame theory and relational theories.

I accessed relevant Internet data bases, (Psychinfo, Biomed, Ingenta, Psychotherapy Research, Psyche Matters) using key words such as regression, regression to dependence, pre-verbal, primitive emotional states, pre-verbal/child development and child development/Integrative Psychotherapy. I also followed references from books that addressed aspects of the pre-verbal to find new theorists writing on associated subjects. Overall the largest body of research in relation to regression came from the analytic tradition. Both trauma and shame have their own branches of theory and the

therapeutic relationship itself is widely written about from a variety of theoretical orientations.

Although my review has a broadly chronological theme, there is a relationship between the theorists in that, to a greater or lesser degree, the work of the earlier ones has had an influence on the work of the later ones. I begin with Freud and his monadic (the mind as a self-contained unit) understanding of the development of the self, then moving into Object Relations theory where the individual is seen to develop in relation to its early environment, the care taker, (Winnicott 1965/1984: Fairbairn 1952: Mahler 1968; Mahler et al. 1975) and others. Once the influence of this dyadic relationship is acknowledged, then theorists move towards the construction of the importance of such a relationship and the consequences when it is considered as insufficient for optimal development. I will then review some theorists' responses to the return to earlier developmental stages within the psychotherapeutic relationship (Guntrip 1969; 1971; Balint 1968). The effects of shame within the dyadic relationship are then considered, looking at the work of Erikson (1950), Nathanson (1987) and Bradshaw (1988). The relational trend in psychotherapy in contemporary writing has largely overlooked theories of regression in favour of more short term solutions as seen in Cognitive Behavioural Therapy (CBT). This approach, and other short term therapies which look to symptom relief, or concentrate only on the repair that is possible with the here and now relationship as in Person Centred therapy, do not recognise the transferential component of early developmental processes within which regression can occur.

Because of the differing language and understanding in the various schools of psychoanalysis/psychotherapy, I have used the language common to each group when talking about concepts pertaining to that group, i.e. analyst/therapist, patient/client. My theoretical orientation would use the word 'client' to describe the recipient of the therapy; however, as a 'client' myself I struggle even with this word as it does not seem to fit the depth of my experience of the therapeutic relationship. I have also used the words appropriate to the authors writing to represent the relationships as they saw them, i.e. mother/infant, whilst recognizing that today's society has a variety of different caregiving relationships and that not all children have the traditional two parents. Mother/infant should be understood as also referring to care-giver/infant.

I will begin this review by looking at the historical developments of psychotherapy to identify the roots of psychological understanding and the progression to current understandings of human development and environmental provision in relation to the emerging themes of regression to dependence, terror, shame, boundary, and on the psychotherapeutic relationship itself. All of these themes have emerged from my initial reviewing of the literature and from the data.

Historical perspectives

Freud (1856 – 1939) considered that psychological conflicts, unresponsive to reason or re-assurance had to be understood as products of unconscious motivations. His construction of human behaviour was derived from instincts based on the needs of the individual, seeing psychological disturbance as resulting from psychological conflicts. His focus was on the oedipal period where the importance of the father's presence within the parental group is first seen to be important. The role of the analyst was as an opaque mirror allowing the patient to see only themselves and using free association to explore unconscious processes (1900; 1905; 1915; 1933; 1940). As an Integrative practitioner this stance seems to me to be cold and harsh, and counterintuitive to the concept of relationship, a position which Ferenczi also held. Ferenczi (1873 – 1933), a student of Freud, was interested in working with patients found unsuitable for analytic treatment by other analysts, developing techniques to explore regression in psychotherapy. He begins to identify the importance of relationship when working with certain types of client presentation and we begin to see the change of focus from processes occurring within the individual towards an understanding that the therapist's self is an important factor in healing and growth which is of relevance to this study.

Ferenczi considered (1923) that analysis needed to be more than an intellectual reconstruction; it needed to be an emotional reliving. He believed that the problems of childhood developed as a result of poor parenting, viewing the attitudes of parents towards their children as potentially traumatising. In his view love was essential for a child's healthy development and that the child would be affected by its parent's lack of sincerity. He accepted Freud's view that the analytic situation brought about a repetition of early parental relationships through the transference occurring, and as such then the patient also needed love, acceptance and sincerity from the therapist. Ferenczi

considered that Freud's recommendation to analysts for passivity and non-reaction, being a mirror to reflect the patient's reactions, could actually repeat childhood trauma. He considered that, by offering a different attitude of love, then childhood trauma could be repaired, and that the emotional reliving of such childhood trauma within the therapeutic relationship was necessary to effect repair (Thompson 1988). Ferenczi considered the failure of analysis as a failure of the therapist to adapt sufficiently, rather than the resistance of the patient as it would be viewed by Freud. Ferenczi advocated appropriate relaxation of the analytic technique to allow resistance to reduce, recognising that object relatedness demands adaptation. Ferenczi believed that the infallibility of the doctor, a position held by many analysts at the time, and a development occurring because of the application of a medical model upon psychotherapy development, repeated the childhood situation of mother's infallibility. He therefore recommended that the real personality of the analyst was an important factor which could positively influence the therapy. Ferenczi considered that where there is a trauma there is always a split in the personality whereby part of the personality regresses to the pre-traumatic state. He believed that no analysis was complete unless it had penetrated to the level of the trauma, a position that Winnicott would later also hold. He recommended that the analyst be more involved than in classical analysis considering that there needed to be a contrast between the analytic encounter and the client's experience of infancy. Only with this contrast can the patient be helped to heal from the trauma rather than repeat it. Some writers consider that the difference between the approaches of Freud and Ferenczi was due to their differing client populations holding the opinion that Freud's theory was effective in individuals who had benefited from good mother/infant relationships whereas Ferenczi (1931; 1933; 1988) worked with those patients who had insufficient mother/infant relational bonds and therefore the stance of the analyst needed to change to reflect this. This concept resonates with me as a practitioner because in my own client population my therapeutic stance and boundaries adapt to accommodate the needs and level of disturbance of the client.

Ferenczi's experimental work with these patients was followed by Klein, Balint, Winnicott and others who started to construct theories about the mind using information gathered from infant observation. This began to change the focus of understanding of theorists away from drives and towards needs. Greenberg and Mitchell (1983) have

distinguished between Freud's theory of mind and an Object Relational theory of mind, seeing that in the former instinctual drives require discharge of energy and are based on the pleasure principle, whereas relational theories view physiological needs within a relational context where disturbances in mother/infant relationships result in psychopathology. Mitchell (1988) explains how theoretical traditions from Object Relations, Self-Psychology and other interpersonal theories complement each other and can be seen as being within a multi-faceted relational matrix. He makes an important point, that the basic features of an integrated relational approach were not constructed from previous theoretical traditions which were applied to clinical work; rather they were discovered within the practice of psychotherapy.

An early theorist who was interested in these processes occurring within the infant was Klein (1882 - 1960) who was a contemporary of Freud, but considered the relationship with the mother to be the formative one, the source of psychological disturbance being in the dyadic relationship and was thus part of the Object Relations movement. 'Object' in Psychoanalysis is a word referring to someone or something having significance for the self. Balint (1896 - 1970) defined 'object' as having two different meanings; one as a verb as in 'to object to …' something to resist, and one as a noun where 'object' is the 'target' of instincts and drives (1960). In Object Relations theory then the 'object' is representative of the 'other' which is internalised and carried into adulthood influencing and predicting behaviours in social relationships and interactions. Such objects are considered to be originally comprehended in the infant mind by their functions, and are termed 'part objects'. Klein considered that a person's inner world was stocked with 'part objects' such as experiences of the breast and the nipple. These inner objects then, for Klein, were partial maps of reality.

The movement from Freudian thought to Object Relations thought indicates a move in the understanding of human motivation; Freudian theory seeing instinctual drives being the motivating force for human behaviour, whereas Object Relations theory views the need for relationship as the motivating force.

Object Relations and Attachment

Object Relations theorists considered that the interpersonal relational constructs made by the individual, and the mother-infant relationship were key to understanding the

nature and direction of psychological growth and the role of the pre-oedipal period in the developing self. Fairbairn (1952), Mahler (1968), Mahler et al. (1975) and Winnicott (1958/1984; 1965/1984) based their Object Relations theories on the understanding and observation of infant and child development. Fairbairn recognized the part that dependency plays in the child's development, starting from early infantile dependency in a state of merger with the parent, moving to a state of mutual dependence. Fairbairn described splitting in the child as defence against an inconsistent and unsatisfactory mother, resulting in large segments of the self being cut off from consciousness in a fragmented inner world, thus forming the development of psychopathology. In this construction the same mechanisms which were once responsible for the splitting of experience of the mother in childhood, led into relationships being characterized by infantile dependence, avoiding the pain of abandonment. An important factor when thinking about Object Relations as a theory is that the key theorists do not all hold a cohesive position. Each comes from a subtly different focus and is interested in different aspects of the relationship, the cohesion coming from their acceptance that the mother/infant relationship is the key factor in the human development of the self. While Fairbairn viewed the mother/infant relationship by constructing it from the ways he saw adult clients behaving, Mahler based her understanding on actual observation of infants. Her interest was in monitoring the effects of early bonding between mother and baby, observing the early stages of development when there was no differentiation between mother and infant, being part of the same symbiotic interpersonal system. She refers to this stage of development as the infant's psychological birth, and documents the stages of development between separation from the symbiosis of mother-infant relationship, to individuation and shows how they develop from the child's early object relations (Mahler et al., 1975).

Suttie (1898 - 1935) ascribes the motivation for human behaviour as a search for attachment and so adds to the body of theorists who value the importance of the dyadic relationship in the formation of the self. He was a critic of Freud's theories and concentrated on the concept of love believing that an infant was born "with a simple attachment to the mother, who is the sole source of food and protection" (1935, p31). Although not identified as an Object Relations theorist, he based his theory of love on the attachment relationship between mother and infant.

Ainsworth (1913 – 1999), developed her interest in the dynamic of the mother/infant dyadic relationship. In her seminal work (1969) she considered and reviewed literature relating to the infant/mother relationship. Moving from Canada to work at the Tavistock Institute in London, she was particularly interested in the effects of maternal separation on infants, developing a technique for assessment called 'strange situation'. She was interested in looking at what happened to infants when they were faced with challenging situations, noticing how their behaviour was different according to the nature of their relationship with the mother and that this relationship was observable and predictable. This work influenced Bowlby's development of attachment theory, and the understanding of Object Relations theorists.

In his 1988 work Bowlby described the applications of attachment theory developed during his previous writings (1969/1982;1973;1980). He propounded a model of the development of the attachment bond between infant and primary caregiver, seeing the infant leading the relationship, and the mother/caregiver sensitively responding. The mother's response to the infant's cues (her attunement) leads the infant to adapt either towards, or away from, cooperation with her. Those infants receiving attentive loving care will view themselves as loveable, developing secure attachment behaviours while those whose comfort-seeking behaviour is dismissed or rejected will see themselves as unlovable and will develop insecure attachment behaviours. He discussed the contention that negative early attachment experience can result in adult psychiatric disorders. Fragmentation or lack of internal communication within the personality of the infant occurs when the mother's responses are determined by the acceptability, or non-acceptability, of the infant's displayed emotions. This fragmentation means that the process by which internal working models are updated becomes resistant to change. Bowlby sees therapy as providing a secure relationship in which the client can investigate their representational models, and experiment with difficult feelings and memories from the earlier attachment relationships, with the potential to reinterpret, and subsequently update the working model.

Attachment theory has given a scientific authority to the study of the bond that develops between infants and their caregivers, explaining the effect that breaks and disturbances in this bond have on the development of psychopathology. Attachment patterns are seen

to develop in childhood and have influence throughout an individual's life and relational history. Life events which break or disturb attachment bonds, such as loss or bereavement can have neurochemical, physiological and psychosomatic components (Marrone 1998). Although Attachment theory is often seen as part of Object Relations theory, Attachment theorists have developed styles of therapy related to this scientific study. From my perspective I consider some of the therapy based upon attachment theory is too tightly governed by a simplistic protocol and is insufficiently sensitive to the needs of the client because it defines the client according to their attachment, not viewing the client as a whole. Although it offers an understanding of the relationship between the person and the object, it overlooks the complexity of the object itself.

The purpose of such understanding of a client's early relationships is to identify the meaning the client makes of their current relationships both internal and external, in order to develop the client's insight and awareness and in the new, significant relationship between therapist and client to be able to offer a degree of repair. This repair was a focus for Guntrip who regarded the self as the fundamental psychological concept and considered that the process of therapy through the personal relationship was aimed at helping the patient to grow and develop highlighting the importance of the therapeutic relationship in offering a relational repair.

Guntrip (1969, pp85-86; 1971) synthesises Object Relations concepts from Klein, Fairbairn and Winnicott. He developed the concept of splitting as a major developmental dynamic occurring in the early stages of infant life, when the child is able to recognize, in a primitive sensory way, that which is environmentally good or bad. He considered that security for the regressed ego could be found in the therapeutic relationship. In commentating on Fairbairn's work, he recognises the developmental stages from an infantile kind of dependence through a transition, a stage extrapolated by Guntrip, to a final stage of mature dependence, seeing interdependence rather than independence as a mature characteristic (Klein 1987, p 419). My experience as a clinician indicates that dependency develops, is supported and sustained and gradually moves to an appropriate mature interdependence.

These Object Relations theorists make the assumption that there are significant similarities between the mother/infant relationship and the therapist/client relationship,

and so use the dynamics of the mother/infant relationship as a template in order to identify the sources of pathology and using them to identify the means of repair. Object Relations application to therapy places emphasis on relational pathology and subsequently on the relationship between therapist and client, where the patient's early object relational failures can be transformed by the substance of the relationship. All of these theorists have looked at Object Relations from a white male perspective and Hockmeyer (1988) offers a useful challenge to these cultural constructs which underpin Object Relations.

Hockmeyer (1988) explores the use of Object Relations theory and its implications for Feminist theory. Citing the work of Chodorow, Dinnerstein, Keller and Gilligan she attempts to show inconsistencies between the assumptions of Object Relations theory and Feminist theory. She concludes that there is a difficulty for Feminist researchers in "identifying, owning, and confronting their own anger over the power politics of misogyny" (p26), because of a fear of anger. She sees Object Relations theory as problematic for Feminist theorists because of its androcentric bias, but recognises its attraction for women in the valuing of feminine qualities. I consider that whilst Object Relations theories may have developed from a male dominated view of the world, modern understanding is able to value the roles of both male and female and so, for me, this does not contradict my understanding of Feminism or Object Relations.

Having looked at how the mother/infant and therapist/client relationships can be seen to have conceptual correlation, then the metaphor of the baby is a means of understanding and having a shared language for the process which therapist and client are experiencing. This begins to bridge the gap between conceptual knowing and application to practice.

The metaphor of the baby

Mitchell (1988, p127) identifies that "psychoanalytic experience has shown that the scattered and complex fragments of the analysand's background are often powerfully integrated and illuminated by viewing them in terms of infantile experiences". Mitchell recognises that viewing obscure and puzzling presentations in the client as if the client was a child can help to organise fragmentary experiences into "coherent, understandable patterns" identifying this as "using the metaphor of the baby". He highlights the

difference between Freud's baby and the modern baby; Freud's baby being riddled with conflict, the modern baby being a relational baby, where conflict only arises when there is a lack of parental provision. This is important to theories of developmental-arrest, as in Winnicott's "deficiency disease". Mitchell (1988, p139) accounts for this shift in understanding of the baby by seeing it as a product of scientific advance coming from the field of infancy research. He considers that the risk in perceiving human dynamic issues through the lens of the baby is that such dynamic issues may no longer be seen as an expression of basic human relational needs. Mitchell identifies the differing formulations of human motivation between drive theory and relational theory, and how this results in 'wishes' for drive gratification now being replaced by the idea of 'needs' for developmental provision. Having reached the concept of these needs, the work of Winnicott, Balint and other Object Relations theorists begins to offer insight and understanding into the application of these conceptualisations.

The contributions of Balint and Winnicott in the understanding of infant development and psychotherapeutic theory

Balint (1968) and Winnicott (1958/1984) identified a group of patients who required assistance to deal with the early stages of emotional development before, and up to, the development of personality as an entity. These are the patients whose reparative need is in the dyadic relationship and who need "management" according to Balint (p87) and the "mother actually holding the infant" according to Winnicott (p279). These theorists are recognising regressive experiences where 'talking therapy' is neither useful nor therapeutic.

Both Balint and Winnicott believed that in therapy it is possible to have an experience that partially repairs the infancy experience, known by some theorists as the reparative relationship. The analyst's task is simply to be in tune with the patient. A new beginning occurs because the patient feels they are in the presence of a safe object.

Balint (1959; 1968) focused on "two-person psychology" based on his analytical experiences with patients. This enabled the interaction between caregiver and infant to be at the centre of developmental theory (Van Sweden, 1995). The relational two-person

model places emphasis on the involvement and responsiveness of the analyst and continues the shift from the earlier Psychoanalytic view, with the therapist becoming an 'object' to be used by the patient/client. Balint (1959; 1968) focused on what he saw as the primitive area of the personality, 'the basic fault' which he encountered in his work with patients who were unable to respond to traditional psychoanalytical methods. Proposing a flexible technique which recognized the value of regression to progression, and focusing on the relationship and the object relations of the patient, Balint described the concept of regression and the progression which occurs as a result of mental regression. He considered that the source of some patient's difficulties was not in the oedipal period, but the dyadic, mother/baby relationship, and developed his theory of primary love and new beginnings, necessitating a change in therapeutic stance, as Ferenczi had suggested, from one of abstinence to one of presence, from withholding to appropriate, therapeutic gratification. Balint viewed the biological basis of the primary love relationship as the instinctual interdependence of the mother and infant. He considers the infant at birth and prior to birth to be in a state of intense relatedness to its environment (the mother), a state of harmonious mix-up which they interpenetrate, with birth changing the environment and beginning the process of separation.

Balint (1959; 1968) used the term 'regression' to denote the emergence of what he viewed to be primitive forms of behaviour and experience, seeing it as an intrapsychic and interpersonal phenomenon, having at least two aims: ratification of instincts or drives, and the recognition of self by an object. He believed that interpretations were not as important as the maintenance of the object-relationship and that the return to primitive features in the relationship required the analyst to be tolerant and indestructible. Balint considered that mild forms of gratification were necessary to effect these conditions, including touch, and telephone contact between sessions, which resembled the original relationship of primary love. He differentiated between those patients who needed the co-operation of the therapist to help them reach areas of the self and those for whom the regression did not have the same effect and was not in the service of progression, having only gratification as a result. Winnicott and Balint emphasized the importance of the mutually shared, non-verbal aspects of the regressive experience, and the necessity of interpreting only after the patient has emerged from the regression (Stewart, 2003).

Winnicott (1958/1984) became an important figure in the Independent Group of British Psychoanalysts, having first discussed the concept of regression to dependence in 1949. He asserted that early maternal deprivation made regression necessary in order to search for the true self (Winnicott 1958/1984). He described the development of 'True self' and 'False self' as central to his understanding of development of the self, seeing the threat to the self arising from maternal failure, resulting in the withdrawal of the true self, and the internalized rejecting aspect of the mother developing into a false self (Winnicott 1960; 1965/1984).

Winnicott observed the infant's absolute dependence on the mother, which she facilitates with her state of primary maternal preoccupation, as mother-infant unity, the primary basis of subsequent two-person relationships. As the mother is the source of instinctual satisfaction, she provides two functions; holding and supplying. He concluded that the mother facilitates the creation of the object which leads to a growth of the infant's ego. If the mother is insensitive to the infant, Winnicott (1960; 1965/1984) considers that the infant's vital self withdraws and a compliant false self emerges, leading to psychopathology. Winnicott also described transitional objects, the development that leads to the infant investing soothing in objects which are symbolic of the maternal relationship.

Wynn (1996) in her exploration of the early mother-infant relationship views the newborn infant as an active co-participant in relation to its mother and the world. Identifying how there is an interweaving enabling mutual development of the relationship she writes in defence of Winnicott arguing that his work opens up the importance of the mother to the developing social life of her infant.

Winnicott (1965) maintained that regression to dependence is necessary to resolve the trauma caused by maternal failure. He considered that the patient's psychopathology was due to disturbance in the early maternal relationship and that in order to reach these levels of development, the patient needed to regress within analysis, which offered a new environmental provision tolerant of regression. Winnicott saw regression as representing the hope that aspects of the environment that failed originally could be re-lived with a new outcome. He considered that the process of regression to dependence required the analyst to be reliable, non-defensive and aware of the risks involved.

Winnicott gave no account of his management of patients, possibly because of his concern about how this would be received by his contemporaries, but maybe also because it is very difficult to be specific about relational responses to clients within the context of regressive work, as I have experienced in writing this thesis. Without the context of actually being in relationship it is difficult to articulate what our responses and our moment-by-moment experiencing might be, but the perspectives and experiences of the participants can help to illuminate this. Margaret Little (1990) gives us a glimpse of Winnicott working in a relational way through her description of him holding her hands, or her head at appropriate times in her analysis.

Goldman (2013, p5) draws upon Winnicott's work to elucidate understanding that Winnicott "was deeply attuned to the relationship between these two currents: the extent to which aliveness is accessible and sustainable, at any given moment, is related to how one uses dissociation." He identifies the importance of Winnicott's formulations and their theme of aliveness. Goldman considers that at the heart of Winnicott's work is an understanding of "a vital spark", an urge towards life, and the consequence of the threat of loss of such aliveness in annihilation. He highlights that Winnicott's term "going-on-being" was his "way of communicating what it means to be alive at a time before the infant becomes a subject capable of knowing anything about what time means." Goldman offers detailed explication of Winnicott's description of normal dissociative process and the importance of the other in the integration of dissociated experience, elucidating the concept of the false self and how the repetitive search for an experience that could not be processed in the past can remain unprocessed through dissociation. It is my contention that having virtually discounted the theories of regression in general psychotherapeutic practice it is now time to review and revisit these aspects of the therapeutic work, bringing them up to date with current attitudes regarding the relationship, yet valuing their insights into the heart of a human being.

Newman (2013, pp67-68) amplifies aspects of Winnicott's theories, identifying the construct of developmental arrest and details the anatomy of the false self, seeing it as a principal way that the psyche defends against anxiety, depressive feelings, and tension. He identifies the consequences of affect management and the importance of this aspect in therapeutic work. In his conclusions Newman identifies how "analysts are

continuously processing which dimension of need is in the forefront", and how some patients considered to have a clearer false self adaptation may need their defences to be understood, their fears addressed and for their therapist to be available to offer affect management in order for a degree of safety to allow the patient to "feel safe enough to mobilise more positive longings".

Stewart in his paper (2003) compares and contrasts the theories of infantile development and the work on the use of therapeutic regression in the work of Winnicott and Balint and the independent tradition. He describes the British Independent Group's tradition and philosophy and their leaning towards an experiential and flexible technique. Stewart sees that the aim of analysis is to provide a setting in which the patient can reach understanding, of self, of the relationships of the past and present, and to be able to reintegrate parts of self which have been split-off or sequestered (Guntrip 1971), or as Winnicott (1965) might have described them - dissociated parts of self. Stewart considers that work on this area of analysis has not received the recognition it deserves because of the adaptation of technique that it requires, and the necessity of the therapist living without knowing for long periods.

Klein (1987) has collected major contributors to Object Relations theory considering how the various constructs of the inborn need for relationship have their roots in infancy, exploring how the understanding of the infancy narratives impacts upon the adult patient in psychotherapy. She outlines the course of development as involving a transfer of functions: at first the requirement is for care and nurture, later comes the need for support and encouragement followed by mutual consideration and acknowledgement of the other's needs and a shared responsibility for goal setting. Klein considers that the primitive self is a sensory experience not a conceptual one. Before the differentiation of 'me' and 'not me' mother and infant are one. The baby has to (e)merge, to cease to merge, and as the baby (e)merges so does the mother with body imagery seen as the forerunner of self imagery. This conceptualisation has correlations with the formulations of Bick (1968) and Tustin (1972; 1981; 1984) who viewed the infant's skin as a container binding together the most primitive parts of self and differentiating 'me' from 'not me'. This is the container then for the rudimentary self prior to the development of an internally felt sense of self. Bick considered it to be

observable in relation to dependence and separation in the transference, viewing the stage of primal splitting and idealization as resting on a previous containment of self and object by their individual 'skins'. Tustin (1972) explores the infant's experience of the mother as skin, container, and organizer, considering that the psychological skin formation occurs when the infant has internalized nurture.

Winnicott (1965/1984) would recognise this conceptualisation as he highlights the boundary of the skin as the identifier of 'me' and 'not me', a construction that Bick (1968) also placed upon the skin as representative of that boundary. Winnicott considered that ego development starts from absolute dependence on the mother for support. The strength of the ego is dependent on the mother's ability to meet the absolute dependency of the infant. The origin of the word 'infans' means 'not talking', and because of this pre-verbal state the infant is dependent on maternal empathy rather than understanding or on what can be verbally expressed.

Manolopoulos (2006, p83), using the thinking of Winnicott, focuses on the splitting and integration processes in instances of pre-verbal trauma. He highlights that where there is a splitting between psyche and soma, mind and body, time is not allowed to go on and give an experience of 'going on being'. He considers that when "primary experiences and affects are alienated (McDougall 1989)" then in "analysis we need to speak for those who no longer speak". This highlights the occurrence of a co-construction which establishes meaning, and feelings are put into words which bring in the split-off elements of trauma, so establishing a narrative and eventually consigning them to history.

Stern's (1985; 1995) works created a bridge between psychoanalysis and developmental models of psychology. His work was based on the observation of infants and most prominently considered the areas of motherhood and infancy. In his (1985) writing he formulated the sense of self and self-esteem as emerging out of contact-in-relationship, the infant starting to experience a sense of the emergent self from birth. Stern considered that there is no confusion between self and other from birth, the infant being pre-programmed to be responsive to external situations. He disagreed with the symbiotic phase, as identified by Mahler et al. (1975), viewing the development of a core sense of self as occurring from two to six months, when the experience of a sense

of oneness with another is possible. Stern questioned the notion of developmental phases, believing that as subjective life develops the infant seeks inter-subjectivity and new levels of relationship. He described domains of differing senses of self and self-experience as operating simultaneously. These senses of self are considered to function throughout life, continuing to grow and co-exist. The understanding of these senses of the self has contributed to the knowledge base of the developmental processes observed in the therapeutic relationship. Understanding the process of infant development enabled Kohut (1971; 1977) to view the unconscious process between therapist and client as part of the client's developmental history and present day relational story, and in understanding this story offered the opportunity of repair.

The influence of Kohut

Heinz Kohut (1971; 1977) added significant Object Relations theories, developed from his work with narcissistic disorders. He considered that relatedness was the essential factor in psychological survival and that infants need adults for physical and psychological survival, as the sense of self which starts of as "vague and undifferentiated, becomes transformed into a central organizing force in the psyche" through positive parental responsiveness and affirmation (Kohut 1977, p99). Kohut described parents, and other significant objects in the child's life as 'self-objects' which gradually become incorporated in the child's psyche through the process described as 'Transmuting Internalization', supplying psychological functions which the child absorbs. These can be positive (praise), or negative (shame). The child learns to see their goodness, or badness, through their mother's eyes, tendencies which become incorporated into the child's internal representation of their world. Kohut's overall approach is concerned with the process of psychotherapy itself. The nature of the therapeutic relationship must reflect an opportunity to repair the self through 'transmuting internalization' of the therapist's positive responses. Kohut (1977, p123), recognizing the group of patients who need regression to dependency states "The deepest level to be reached is not the drive, but the threat to the organization of the self, the experience of the absence of the life-sustaining matrix of the empathic responsiveness to the self-object." This threat to organisation might have been seen by Winnicott (1958/1984, p149) as the threat of a return to "the state of primary unintegration".

Building on this understanding of the client's history being re-enacted within the therapeutic relationship, Steele et al. (2001) identify the phenomenon of dependency occurring in the treatment of complex traumatic and dissociative disorders. When such traumatic events are re-visited in psychotherapy then dependency becomes a pervasive component of the therapy. They quote from Dalenberg (2000, pp189-190) "as we encourage deep and at times regressive and dependent relationships to develop, to facilitate transference and therefore deeper change, we also implicitly agree to honor the depth and felt life-saving quality of that attachment".

Fosha (2003, pp227-228) identifies that receipt of empathically attuned caregiving results in the child experiencing himself as an individual enabling him to modulate emotion, to have flexible responses and to have resilience. She identifies that the empathically attuned care which is ideal in the mother/infant relationship can be supplied in the therapeutic relationship with dyadic affective processes of attunement, empathy and repair. She recognises that "the processing of emotional experience solidifies, rather than taxes and erodes the attachment bond". She recognises that the opposite is also true, that fear constricts the range of tolerance and exploration of emotion. In the absence of such "dyadically constructed safety" energy will be devoted to defence mechanisms to enable the infant to psychologically survive. Winnicott's (1965/1984) description of the false self can be seen as such a defence mechanism, where the vulnerable true self, because of the risk of annihilation, is split off, sequestered and protected by the false self. The false self hides the true self by complying with the environmental demands, and in extreme circumstances may completely isolate the true self. Splitting is a complex subject, and as such I am limiting it, in this thesis, to my understanding of splitting which relates largely to Winnicott's meaning, where spontaneous and creative aspects of self are split-off or isolated from the rest of the personality. This isolation of an aspect of self could also be seen as dissociation, a defence mechanism of primitive origin.

Theoretical concepts of splitting

The word 'splitting' has different meanings to describe different conceptualisations. In Kohut's (1977) work the split is considered to be a 'vertical split' which preserves the self-esteem by isolating feelings of limitation and low self-esteem from the other

aspects of the self. Klein (1987) describes the theoretical concept of repression, 'a horizontal split' which separates the adapted self which is acceptable to the environment from the individual's natural self-assertion which is disapproved of by the environment. This split has connection with the shame process which will be developed further in the chapter on shame.

Guntrip (1971, p172) describes what he sees as splitting of the ego; "Here, in this complex pattern of ego-splitting or loss of primary psychic unity, with all the weakness and internal conflict it involves, is the root cause of personality disorders in later life: and the most vulnerable part of the self is the most hidden part, cut off from all human relationships in the depths of the unconscious." According to Klein (1987) Guntrip has developed this construct through lack of knowledge of the development of the infant, basing his understanding only on what he saw of adults in the consulting room. Klein considers that this led to Guntrip misunderstanding ego development.

The splitting off of aspects of the self in early infancy could be seen to result in "walled off" separate self states, which are thus avoided in order to maintain functionality, and to manage adaptation to the demands of the environment. This self state can also be retreated into in regression.

I will now move on to explore application and conceptualisation of the regression process and the re-emergence of these infantile self states.

Theorists' responses to the concept of therapeutic regression

The Shorter Oxford English Dictionary (1983 p1783) defines regression as "a re-entry to or into the place of issue or origin, to return to a subject or place, or into a former state". The kind of acting out of emotions and thoughts which cannot be described verbally are remainders of pre-verbal experiences, and become accessible when the patient/client re-experiences the thoughts and feelings of a pre-verbal time. This is known as regression by most writers, although some Psychoanalytical theorists call it dependence. These terms can be viewed pejoratively by some clinicians and authors because of the perceived negative impact on the therapy. Van Sweden (1995) identified several writers (Heimann and Isaacs 1952, Ornstein and Ornstein 1981, Gaddini 1990)

who linked regression and progression in the analytic encounter, thereby confronting the traditional analytic belief that regression was actually resistance to Psychoanalysis and therefore resistance to change and growth. The British Object Relations Group supported therapeutic regression as a necessary part of the therapeutic process for patients/clients with more severe problems (Balint 1968; Kernberg 1975; Kohut 1971; Searles 1965).

Regression in psychotherapy is considered to lead to a primal, two-person relationship with dependence and attachment to the person of the therapist. Bowlby (1969/82; 1980; 1988); Kohut (1971; 1977; 1984); Winnicott (1958/1984; 1965/1984) and Stern (1985) considered that techniques developed from observations of infants and their caregivers could also be applied to regressive experience in the psychotherapeutic arena, allowing the therapeutic second chance to be offered. Stern (1985) developed an hypothesis that several senses of self existed in pre-verbal terms. His application of this in therapy differentiated between the observed infant and the infant reconstructed in the course of clinical practice. Gill (1982) considered that childhood traumas were acquired experientially, so must be transformed experientially through relationship with the therapist.

Van Sweden (1995) explores the nature of regression to dependence, tracing the development of the understanding of both regression and dependence through the work of Freud, Ferenczi, Klein, Balint and Winnicott. This process of regression to pre-verbal states within the dyadic relationship, that is, regression to dependence, he sees as regression to the developmental stage where dependence was originally appropriate in order to offer repair of ego deficits and restoration. Van Sweden cites Winnicott's treatment as addressing establishment of a holding environment which facilitates the mother-infant transference, allowing the regression to dependence to be experienced. He looks at those analytic interactions which impede ego integration, and at the related opportunities provided by regression to dependence. Van Sweden recognizes that clients experiencing acute dependence may need daily contact as their ego development is pre-oedipal, and the analyst's posture is one of a mother to a developmental infant, offering ego integration and discovery of the true self. He recognizes that in this process much of the analysand's communication is pre-verbal and therefore increased emphasis is given

to the countertransference of the therapist. The task of the analyst is to assist the analysand to find words and narrative in order to express emotional states. Balint (1959, p72) saw that "Both the baby and the regressed patient in the end have no choice but to speak the language of the adult on whom they are dependant, the baby for his life, the regressed patient for his restoration".

Eshel (2013) uses the terminology of Nano science and Nano technology and applies it to Winnicott's concepts of a return to the earliest states as necessary to allow the possibility for new opportunities for correction and forward development. She describes how in physics a new paradigm opens up when the existing paradigm no longer fits. Eshel considers that Winnicott theorised about a period in infancy that Freud took for granted, quoting from Fulgencio (2007, p447) who maintained that the Freudian model "does not hold true in the more primitive phases of emotional development". Eshel suggests that Winnicott has addressed the question 'how can I, the clinician in the healing process, cause structures and processes that operated in infancy *to begin functioning and allow progression"*(p39). She considers that Winnicott's idea of a return to earlier stages in order to begin again, shares the same concept as Nano technology, that is, in "going back to the bottom, to the elemental early states and processes of psychic development, and to early mothering techniques" formative developmental processes can be initiated, a comparable concept to Balint's (1968) theory of regression to progression. From this construction then (p40) "this can occur only at this primary level because working in a regressed state opens up new possibilities of re-experiencing and correcting "the original environmental [maternal] failure situation" and of reliving the traumatic not-yet-experienced early breakdown. The analytic lived experience of holding and handling "can actually alter the patient's past [making possible] the growth that might have taken place in the very early stages in the context of human care" (Winnicott 1988), so making changes which can repair the damage of acute and chronic trauma. Eshel highlights Winnicott's assertion that the patient must return to a point prior to the disruption of psychic growth. The purpose of such a return is to enable a repair, and such a repair is possible through the conduit of transference.

Transference within the therapeutic relationship

Such a repair is considered to be made possible by the unconscious process of transference occurring within the therapeutic relationship. This mode of relationship is extensively explored in the works of Heimann (1950), Langs (1976), Racker (1982), Cashdan (1988), Maroda (1991) and Clarkson (1992). Clarkson (2003 p10) cites Laplanche and Pontalis (1988) considering that "in the transference, infantile prototypes re-emerge and are experienced with a strong sensation of immediacy".

Clarkson (2003 p11) offers this definition of transference and counter-transference "the transference/countertransference relationship is the experience of 'distortion' (Freud's word) of the working alliance by wishes, fears and experiences from the past transferred (carried over) onto or into the therapeutic partnership". In her writing on the therapeutic relationship she identifies the five facets of relationship and acknowledges aspects of the developmentally needed relationship which has the potential to offer repair of failure in environmental provision in infancy and the transference/countertransference relationship which is the vehicle in which the repair is enabled, seeing it as "one of the most potent forms of changing human relational patterns" (p82).

Erskine (1991) offers a critique of transference from a transactional analysis perspective considering that there is a distinction between Berne's theories of ego states and how they are applied in relation to transference. He considers that the use of Berne's theories, developmentally, relationally and intrapsychically can lead to repair within the therapeutic relationship.

Novellino (1985, p204) understands the function of transference to be the projection onto the therapist of the unsatisfied childhood need of the patient where the therapist is experienced as the possible satisfaction of the need as well as its frustration. Erskine (1991) cites Trautmann (1985, p190) in her summary; "Therapy is effective when the internal parental influence or dialogue is externalised (transferred), allowing for the resolution of childhood impasses and traumas, and the emergence of a stronger, uncontaminated, more integrated adult. The specific approach used to effect this resolution depends on the level of childhood fixation: the more symbiotic the child, the more actively the therapist needs to take on the transference relationship".

Levy and Scala (2012, p400) discuss the concept and use of transference within psychotherapy. They offer an historical overview and review empirical evidence with a definition of transference as "a tendency in which representational aspects of important and formative relationships (such as with parents and siblings) can be both consciously experienced and /or unconsciously ascribed to other relationships" (Levy 2009), and conclude with preliminary findings that this conceptualisation indicates that transference is both a cognitive-information process and a dynamic process related to attachment and defensive processes and allows the re-emergence of early experiencing which requires the creation of a narrative in order to make meaning.

From 1990 onwards therapists, social researchers and others became interested in narratives, narrative therapies, and narrative studies of lives. They were interested in how people constructed their lives through social contexts. From a non-medical perspective narrative ideas aim to understand a client/participant/social group in the context of their environment. This developing tradition in psychotherapy has informed therapeutic theory and practice. Zilber et al. (2008) explore embedded narrative and acknowledge that narrative psychology recognises the importance of context in understanding and interpreting identity stories. They highlight that narrative theoreticians emphasise that identity stories are constructed intersubjectively (Gergen & Gergen 1987). Object Relations construct the self as occurring in the intersubjective field, and human development theories place the development of self in early infancy. These theories and narrative theories can be seen as fitting together in combining the client's history, the here-and-now and the therapeutic response to their story.

The importance of narrative in the development of self

Etherington (2000) highlights the importance of narrative in helping clients to understand their development and history. In constructing the client's narrative, therapist and client can develop a shared language which enables the client to feel understood and to make sense of their early life and current relationships.

Erskine (2007, p5) sees the necessity within the therapeutic relationship for the recreation of narrative in both verbal and non-verbal ways. Through empathic attunement, validation of the client's experience together with an understanding of their developmental state "is essential in forming an emotional connection that facilitates a

communication of pre-verbal experience." Wosket (1999) also recognises the importance of narrative as she relates her experience of helping her client to reconstruct the reality of her life. She quotes from Lynch (1997, p127) "in permitting and enabling clients to articulate their experience, therapy can potentially allow the telling of stories which have been suppressed".

Having discussed the nature of regression I will now identify and discuss some reservations regarding the process.

Reservations regarding regression to dependence

Van Sweden (1995, p103) identifies the objections of some analysts to the process of regression to dependence. There is some concern about the inability to remember early infancy, although I, along with many Integrative practitioners, consider remembering to be less significant than the person's perception of their infancy together with aspects of early relationship constructed through the transference.

Other objections fall into two categories, theoretical and clinical. From the analytic approach there is a theoretical belief that resolution of the Oedipus complex results in the consolidation of earlier stages, assuming good enough mothering up to the point of development of the ego and that a nurturing mother has been internalized (Khan 1969). Clinical objections include concern regarding the potential for increased demands on the analyst and increased demands on the patient, together with the fear of working with pre-verbal stages where the anxiety may become so acute that the patient may begin to decompensate, that is, previously held defensive structures begin to break down, significantly reducing the patient's functionality.

In his 2008 article Spurling explores the idea of regression and its necessity or otherwise. In seeking to understand the concept of regression from a psychotherapeutic perspective he identifies a number of factors – the belief by some analysts, Winnicott (1958/1984); Van Sweden (1995); Bollas (1987); Newman (2013) and others, that regression is a necessary part of a full analysis; a seeming contradiction about whether regression is positive or negative in the therapeutic process; and how some theorists believe that normal analytic technique must be adapted in order to deal with regressive phases. The main thrust of Spurling's paper is a detailed investigation of these stances.

Writing from a psychoanalytic perspective he takes issue with the belief that the normal analytic stance should be varied. Spurling highlights the model of the dyadic relationship where the analyst is an image of a devoted mother, and he takes issue when this model is an exclusive metaphor for the therapy seeing that it denies the analyst's own subjectivity. He concludes that the concept of therapeutic regression seems outmoded, but that an investigation of its usefulness can identify what is therapeutic in therapy. The aim of my research questions was also to ascertain if the process of regression to dependence was seen to be therapeutic.

Bollas (1987) wrote of "ordinary regression to dependence" and of the relevant conflicts in the therapeutic world. He considered that Balint, Winnicott, Khan and others described dramatic realizations of regression to dependence without looking at ordinary manifestations. In his chapter on regression to dependence Bollas describes analytic space and setting, "like being held by the mother" (p259) as the necessary conditions for regressions to occur. The proximity and attentiveness of the analyst, and the security and containment provided in the analytic space, act as an invitation to regress. The analyst must understand this need, be attuned to the process and understand the phenomenon. Bollas describes the suspension of interpretation, the dismissal of residual guilt and the silence that can be involved while the deeper parts of the self begin to emerge. The patient can have alteration in state of mind to a place of musing to sensory awareness, olfactory sensations and perceptions, intense feelings and discoveries. Bollas (1987, p4) terms the mother as a "transformational object", considering that the adult's 'search' for transformation constitutes in some respects a memory of this early relationship. The patient knows the object-setting through which he developed, and it is a part of him, but it has yet to be thought, (Bollas 1987, p230). He describes the re-enactment of this relationship within the transference/countertransference relationship as the 'unthought known'. He considers that the process of regression to dependence "may repair a previously damaged capacity to receive news of the self in this manner" (pp271-272). This seems to have resonance with the idea of restoring contact with the true self, that is, that aspect of an individual which appears as soon as there is mental organisation which, with a healthy facilitating environment, results in "the sense of being real" (Winnicott 1965/1984, p149). Bollas (2013, p1) describes working with patients in the process of breakdown and the difficulties for the analyst when patients

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tip into psychosis. He makes an interesting statement though, about regression to dependence, "if the analysand regresses to dependence in a rather ordinary way – lessening defences, opening up the self to interpretive transformation, abandoning disturbed character patterns – the self will usually break down in a slow and cumulative way". Fosha (2008) also recognises the fundamental need for transformation in humanity, seeing this as a motivational force whereby the client has to surrender some psychic organisation in order to reach something more primal. She uses the term 'transformance' to denote this surrender, seeing it as the opposite of resistance to the therapeutic process.

Erskine (1993) highlights how, in regression to dependence, fixated, contact-interrupting defences which interfere with satisfaction of current needs and healthy interpersonal and intrapersonal contact, can be dissolved through the therapeutic relationship (Cullwick 1998). Valentine (2001) discusses the difficulties of working with the regressed or borderline patient, using clinical material and research on the mother/infant dyad to offer theoretical explanations and guidance for psychotherapeutic practice. She considers the therapist should be empathically engaged with the patient's internal and external world and argues that regressive periods can be seen as containing the potential for the patient's evolution of self. In his (1994) formulation, Hedges sees this potential for evolution in the primitive strivings in early development for the lost connection with the mother. He writes of the search for the "lost mother of infancy", considering that the infancy experience is re-experienced through the therapeutic transference which he views as a living record of failed attempts for connection which remain imprinted in the psyche, creating a perpetual search for the mother who was lost. I recognise this concept from clinical practice when clients present who have a history of failed relationships where their expectation of a partner has included an unconscious desire to find a partner who will transform their emotional state. The therapist's task over time is to identify and elucidate this primordial love. As the early developmental period comes into focus the client begins to 'remember' their failed attempts at maternal connection through the therapeutic relationship. In this period, the therapist will need to be able to tolerate the clients' acting out behaviour as appropriate.

Participant D, an Integrative Psychotherapist of some thirty years' experience, puts her understanding of this process as follows:

> I think that what happens in regression is that an immature defence system has been triggered….. the patient is either reaching back to a time when the trauma happened, or before the trauma happened, and I think she's certainly gone back into the time of the abuse when, as we're beginning to put the thing, pieces together…
>
> I agree with the writers who say that, until you've reached that place where misunderstanding, or that something could not be understood has been repeated again, …….I think what we try to do is, when reaching that place, that we try to understand it in a way that it can be lived with,

Participants working as therapists have clearly found the formulations of these phenomena by authors in this tradition to be useful and intelligible in relation to their everyday experiences as therapists, giving them a map with which to interpret and work with these experiences.

Data from participants has included references to traumatic experiences. Some theorists connect early infantile environmental failure with the experience of trauma. Participants have identified a 'life or death' component to their experiences. Theorists also recognise that in the phase of early infancy such life or death issues are a fear, a feeling and a reality. This has led me then to consider theories around trauma as applicable to this work.

Concepts from trauma theories

Trauma theory has been of great interest to theorists since the 1910s. Because of the nature of my own experience physiologically and psychologically, those experiences reported by my clients, and the resonance in the data from my participants, I researched the work of trauma theorists who linked experiences in childhood with traumatic sequelae. Steele et al. (2001) write on the manifestation of dependence in the treatment of trauma. They discuss the psychotherapeutic positions on the therapeutic use of dependency, and the links between dependency and attachment, considering that in recovery from trauma the needs of the client must be met, including emotional and physical safety, and the attainment of a secure attachment to a consistently responsive

and caring therapist. In their 2001 paper Steele et al. attempt to normalize dependency whilst being mindful of potential difficulties. They recognize the interchangeability in the literature between dependency and regression, symbiosis, attachment, helplessness, passivity, lack of autonomy and an infantile developmental phase of oral and symbiotic needs.

Participant A identifies his experience of the relationship needed to address and repair traumatic wounds:

> But for some people who don't have a foundation of security you cannot go to that wound and fix the wound because there's no security. I'm thinking right away of two clients, one was a young woman whose… her trauma was sudden death of her father and her mother going crazy, which we could not repair because there was already a lack of security, emotional security with that mother before that, although she kept going back to that scene. I needed to go back and be that good mother before we could come back and deal with that.

Adams (2006) makes the link between failed dependency and chronic shock, a lack of containment. She explores the manifestations of chronic shock and annihilation anxiety together with various primitive defences, noting how they exist with high functioning patients, and using clinical material from one psychotherapy group. Within the work she identifies the primitive nature of the defences used by such patients. She makes a link between cumulative trauma and failed dependency. She writes in depth about the use of omnipotence, bringing in the development of a psychic skin and identifying the development of a gap or hole in the fabric of experience. In her 2009 work Adams identifies how, in primitive ego states, terror of intimacy and the need for human contact in dichotomy can result in the experience of annihilation anxiety and dissociation.

In the experiencing of trauma, the themes of life and death emerge frequently; many traumas carry a risk of death, road accident or physical attack. Trauma occurring as a result of pre-verbal experiencing also carries this connection. Infants who are separated from parents are at risk of death, those who are separated emotionally or psychologically are considered by some theorists to face annihilation anxiety or death of the self. Kalsched (1996), applying Jungian theory shows how, as a result of cumulative

or acute trauma in early childhood, defences that developed to protect the individual can become malevolent and destructive resulting in a repeated inner traumatisation. He considers that traumatic anxiety threatens a total annihilation of a human being. He sees that these primitive defences, because of their primitive nature, can result in psychopathology. Hurvich (2000), recognising these primitive defences, explores the fear of overwhelm as it relates to psychoanalytic theories of anxiety. He recognises that the experience or expectation of overwhelm can involve anxiety, terror and panic associated with conscious memories. This can be experienced as psychic disorganisation of ego functions and of the self (Frosch 1967; 1983) which can result in "temporary or long-lasting structural decrement". Hurvich lists a number of descriptors from various writers for this sense of overwhelm, noting that frequent expression of these fears can reflect ego function weakness and the residue of trauma.

Participant A identifies how clients experience such overwhelm:

> In psychoanalysis to lose here-and-now focus, to go back and be overwhelmed by affect, is described as a psychotic experience, meaning its affect flooded, it's flooded with fantasy, and emotional memories…

and has this suggestion for Winnicott's paper (1963) "Fear of Breakdown":

> It should have been written as 'The Fear of Psychosis'. He said that everybody who fought him and resisted using the couch, when they eventually DID use the couch two or three years later and they regressed, they regressed to a psychotic experience that they once upon a time had….

Theorists including Winnicott (1971), Borgogno and Vigna-Taglianti (2008), Adams (2009) and Symington and Symington (1996) link pre-verbal infantile environmental failure and the experience of trauma experienced in infancy and continuing into adult life. Little (1990) describes her experience of regression during her therapy. She identifies feelings of anxiety and disorganisation, formulating infantile roots for the experience.

Hurvich (2000) identifies and critiques the experience of the fear of overwhelm and concepts of traumatic anxiety. He reviews psychoanalytic concepts of anxiety and traumatic overwhelm, emphasising the clinical manifestations of these phenomena.

Solomon and Siegel (2003) have collected the work of researchers and clinicians who consider traumatology from biological, developmental and social aspects. Drawing from a multi-disciplinary theoretical base, they explore the influence of life experience on brain development, the role of emotion, the influence of the body upon the mind and the effects of traumatic experiences.

Van der Kolk and Fisler (1995, p9) review the literature regarding stressful and traumatic events, and the evidence for dissociative processes resulting in Post Traumatic Stress Disorder. Their discussion suggests that there are critical differences in the ways that people process traumatic memories, seeing the nature of traumatic memory as dissociated and, therefore, stored without a coherent narrative. The authors highlight that their research subjects "remembered" the trauma "in the form of somatosensory flashback experiences" through a variety of sensory modalities. Their study supports Piaget's notion that memories remain unintegrated when they cannot be processed linguistically. They draw a distinction between those who have suffered adult onset trauma and those with childhood onset trauma, in the latter case abuse was remembered in olfactory and kinaesthetic sensations which they see as supporting the notion "that childhood trauma gives rise to more pervasive biological dysregulation, and that patients with childhood trauma have greater difficulty regulating internal states than patients first traumatised as adults" (Van der Kolk and Fisler 1994).

Van der Hart et al. (1993) cite Janet (1904; 1919) in his observation that the lives of traumatised individuals appear to have had the evolution of their lives arrested by the trauma "they are 'attached' to an obstacle which they cannot go beyond. The happening we describe as traumatic has brought about a situation to which the individual ought to react. Adaptation is required, and adaptation is achieved by modifying the outer world and by modifying one's self. Now, what characterises these 'attached' patients is that they have not succeeded in liquidating the difficult situation" (Janet 1919, p660). They acknowledge, with Janet, that putting the event in words, establishing the narrative, reconciles the experience and restores continuity in personal history, that is, integration of the traumatic event has occurred. This has echoes of Winnicott's (1965) concepts of impingement upon the developing self, resulting in reaction by the infant and subsequent difficulty in moving beyond the phase when this occurred; Winnicott saw

this trauma occurring in early infancy. Such 'catastrophic psychic trauma' is considered by Tarantelli (2003, p915) to be the reaction of the psyche to an external event in which the person is helpless to resist and where there is no possible defence. She formulates that such an experience produces "a radical break in being which disarticulates the psyche and causes a headlong descent to the most primitive levels of psychic functioning." Looking at the experience of trauma in adulthood she formulates that the complete helplessness produced by the trauma results in a death experience, so echoing the theories of Winnicott's (1989, p93) 'phenomenal death'.

I will now critique aspects of the therapeutic relationship which make it a suitable vehicle in which to offer repair.

Contemporary concepts on the therapeutic relationship

Psychotherapy began as a medical speciality, with the treatment, rather than the relationship, being paramount. In his discovery of transference, Freud understood that the interaction between patient and analyst was crucial, and that in order to develop this transference and interpret it correctly, the analyst should be a blank screen, reflecting the patient, believing that the patient needs optimal frustration to reveal inner conflicts. This resulted in the analyst responding only by giving interpretations. Elkins (2007) considers that the application of the medical model upon the practice of psychotherapy has caused intrinsic problems which have not been resolved. He considers that the medical model does not fit the process, it dominates the field because of questionable ties with medicine, science, and health insurance, and it does not account for the majority of clients who are not mentally ill.

Carl Rogers (1902 - 1987) was an American psychologist. In his early career he trained to be a Minister of Religion. In the 1930s his interest was in child maltreatment and 'problem children'. He borrowed his conception of the person, which informed his later work, from the ideas of Combs and Snygg (1949) who coined the term 'phenomenal field'. Rogers' work had a great effect on the psychotherapeutic world, particularly in the 1960s. He proposed a radically different style of therapy from that of non-responsive psychoanalysis. He believed that the therapeutic attitude needed to involve

empathy, unconditional positive regard for the client and genuineness. This style of psychotherapy came to be known as person centred psychotherapy where the unconscious aspects, the transference/countertransference, were not worked with. His techniques were criticized by many psychotherapists, who were concerned that the therapist's responses could result in the acting-out of countertransference, causing confusion for the client.

Kohut (1971; 1977) and Gill (1982) considered that the traditional unyielding stance of psychoanalysis was rejecting to the client and could repeat the wounding received in infancy. They recognized the need for engagement, involvement and non-defensiveness by the therapist, and upheld the importance of working with the relationship between therapist and client in all its aspects including transference/countertransference, so uncovering unconscious processes (Kahn 1991). He describes this rapprochement between the traditional stance of psychoanalysis and the relational component seen in Kohut and Gill, where genuineness, non-defensiveness, spontaneity, respect, empathy and understanding meet knowledge of unconscious processes and needs, calling it the new relationship in the therapeutic world. Josselson (1992) writes about the essence of relationships through all the important relationships in a person's life, seeing the positive aspects of relationship and their meaning for humanity.

Clarkson (2003) identifies in detail aspects of the therapeutic relationship and acknowledges the presence of five forms of relationship occurring within the therapeutic relationship. She describes two of these forms which are of direct relevance to this study; these are the developmentally needed relationship, and the transference/countertransference relationship. Wosket (1999) describes her self-development into a relational therapist. She highlights the nature of the therapeutic relationship and the therapeutic use of self. The therapeutic importance of the relationship is also shown by Adame and Leitner (2010) as they consider Buber's (1958) work. They note that genuine dialogue is a process of healing through meeting, which re-establishes relations with the world that have previously been injured in relationship. The debate on common factors indicates aspects that may be critical to psychotherapy outcomes. Wampold and Budge (2012, p618) present a model that identifies how specific treatment and common factors work together to make

psychotherapy effective. They identify that the importance of the relationship, the creation of expectation and therapeutic actions come together to improve the quality of life. They conclude with the contention "that attachment – belongingness, empathy, and expectations provide the neurological and social contexts for establishing a real relationship, therapeutic creating expectations, and participating in healthy actions that all contribute to positive outcomes within the psychotherapy process". Highlighting the importance of relationship to the practice of psychotherapy, Wachtel (2008) recognises the movement towards relationality from the psychoanalytic perspective and he identifies how relationality can effect psychological change; the enactment of aspects of the patient's history being a two-person phenomenon. In discussing the corrective emotional experience, he identifies the importance of experience over insight. Mitchell (1988) describes relational-model theorists and their integration of aspects of psychoanalytic theory relating to drives, with relational theory based on attachment and need, seeing that drive theories develop intrapsychically and relational theories, which are need based and interpsychic, overlap considerably.

Relational needs

Erskine (1998) uses the work of Object Relational and other developmental theorists to describe the process of contact, and its importance in both the mother/infant relationship and within the therapeutic relationship. He considers that relationship-orientated psychotherapy meets the need for relationship through contact, encouraging an awareness of self and other. He cites Stern's (1985) research, together with Erikson (1950), Mahler (1968) and Bowlby (1969; 1973; 1980) who recognized the significance of the early infant relationships, through which experiences of self and other emerge, seeing that the sense of self and self-esteem grow out of contact-in-relationship. Erskine (1998) considers that the therapist's self is used to assist the client to develop and integrate, obtaining satisfaction of relational needs, interpersonal connection and construction of meaning. Erskine and Trautmann (2002) describe the process of Integrative Psychotherapy whereby the client's childhood needs, their experience process, and interventions, including touch and holding, as dictated by the client's developmental age in regression are appropriately addressed within the therapeutic relationship.

In Erskine's (1993; 1994) works, he identifies the necessity for the therapist's attunement to the client's presenting developmental stage, and to respond appropriately to provide a reparative and emotionally nurturing relationship. Erskine recognized that in an atmosphere of affective attunement the needs and feelings of the client can be expressed and responded to, these needs may be emerging from archaic stages or from the current relationship. Erskine (2011) describes the therapeutic response when working with clients for whom contactful, sensitive and attuned parenting has not been consistently or dependably available. He considers that such clients, whilst requiring the usual needs present in a here-and-now relationship, also present with the unmet relational needs of past insecure attachment. Erskine considers that therapeutic presence, attunement and involvement should be engaged with the archaic needs, this does not mean that they must be satisfied, but they must be acknowledged, explained and validated.

Participant A gives his understanding of the process of repair through regression:

> The regression is reparative when we almost relive it, if we fully relive we go into it and relive the same old self-protective pattern that happened in the original neglect or trauma.

> In a re-experiencing or in a supportive therapeutic regression we do almost the same thing, let's pick a number – 80 – 85% - we do 80 – 85% and then there's that therapeutic twist, it would be like the child who is about to be beaten, takes the stick and breaks it and throws it out the window, or the child who's about to be raped screams for help, or a kid fights back.

He describes how the search for relational needs belonging in infancy can still be searched for, but not met in adult life:

> For whom is this necessary, for the client who avoids it…..they're starting to regress in other relationships, the client who's caught in that transference of everyday life, regressing with their husband, they become that whimpering, crying, suffering little baby with the husband, 'cos he doesn't know what to do with them, he's got his own needs.

Clarkson (2003) discusses the intentional provision by the psychotherapist of a corrective, reparative relationship where the original parenting was deficient and describes the phenomenon of regression as enabling parts of the psyche belonging to earlier developmental stages to be cathected, that is, to be invested with emotional energy. She considers that only those, such as Kohut, who view the human being as having a directional tendency to grow and develop, are usually associated with this reparation. Clarkson distinguishes between healthy regression and fixation, and the potential for corrective emotional experiences. She lists various presentations of regression; spontaneous, inside or outside the session, facilitated, induced, recognized and contracted, and expounds the replenishment of the original deficit by gratification, presence, intuition, receptivity, touch, structure and self-object transferences.

As I had experienced extreme difficulty with feelings of shame emerging in my own therapy as a result of the regressive process, and I had recognised it occurring within my clinical work, I was curious about its presence as a part of regression and I asked participants about it in their interviews. Their responses were largely in accord with my own experiences, and are detailed in the chapter on shame. I now offer an overview of the literature on shame as it relates to developmental processes.

Developmental concepts from shame theory

Shame has been recognised "since antiquity" (Gilbert and Andrews 1988) and there are powerful words used to describe the feeling of shame which emerge from poetic and theological imagery which seem to link with the biblical description of Adam's sin and the resulting experiences of shame when separated from God, or the dualistic view of good or evil where to sin results in the ultimate punishment of Hell. Evans (1994) sees shame in this way, calling the experience of shame "a descent into Hell." Kaufman (1992) cites Tomkins' (1962/63) view of shame as "a sickness of the soul". Many theorists write of shame as a powerful emotion that is all encompassing, Bradshaw (1988) calls shame the "master emotion" and uses Winnicott's 1967 term "false self" to describe a carapace over the perceived shamed "true self".

As the focus of this work involves understanding the early stages of development where shame is considered to emerge it is not unexpected that it would be seen in the literature

on human development. Erikson (1950) places shame as a stage of psycho-social development where, based upon the environmental response, the infant learns a self position of shame or acceptance, whilst Nathanson (1987, 1992), a theorist interested in the study of emotion and affect, has made a particular study of shame. Nathanson acknowledges himself as a painfully shy person and recognises that shame has been an ignored emotion. He explores the hidden nature of shame, looking at its biological connections, and identifies what he calls a "psychology of shame." He identifies shame as part of human emotion, citing Darwin in his identification of an evolutionary display of emotion. His writing on the nature of emotion (1992) describes the shame process from a physiological and psychological perspective, usefully linking infant development with the onset of shame. Draghi-Lorenz, Reddy and Costall (2001) also site shame emerging from an early period of infancy.

Participant B identifies her understanding of this link:

> I can't think either in my own work, or my work with clients where shame hasn't been needed to be dealt with, and that sometimes there can be many layers, multiple layers of shame through a person's psychological self, or the bit that goes with that - their history, back to their beginning… where regression is part of the appropriate psychological treatment it's going to be 'being'…

Winnicott's (1967) role as a paediatrician and psychotherapist led him to consider that the importance of the mother's face and her expression directed towards her child is vital in the development of a healthy sense of self. He considers that if the child sees disgust or disapproval the child then ascribes these characteristics of shame to its developing self, so the child is dependent on the mother's facial expressions to establish its own sense of self. In a similar way the facial expressions of the therapist can also have an effect in the therapeutic relationship. Jacobs (1995, p87) highlights this potential for shame in the therapeutic dialogue, "there are elements of the therapeutic situation which lend themselves to evoking shame in the patient whose self-image is laced with shame" and links life or death feelings with the experience of shame. She concludes by highlighting the transformative power of the therapeutic dialogue to resolve shame issues and considers that the resolution of internalised shame is one of the greatest gifts of psychotherapy. Simon and Geib (1996) conceptualise shame as an

intrapsychic event and also as an interactive occurrence meaning that potential for shame is present in any relationship. They discuss how therapists can become instruments of shame and the importance of awareness because of the power dynamics. The client enters therapy from a place of vulnerability and the therapist's words and behaviour can have a powerful impact. They highlight that if shame is generated by the environment, causing disconnection, then being received and known and thus connected is the antidote.

Bradshaw (1988) uses the phrase 'toxic shame' as distinct from healthy shame which he views as enabling the infant to experience his own limits, whereas toxic shame can become a state of being where the belief is that one's self is defective. He positions toxic shame as occurring before the infant has developed sufficient ego boundary. In these early stages of ego development the outcomes of toxic shame are seen by Lewis (1971) as emotional distress and feelings of isolation, which ultimately affect the ability to trust one's self. This situation arises as a result of, at one end of the spectrum, a lack of empathy, misattunement and cumulative trauma (Khan 1963) and at the other end all types of abuse. Kauffman (1994) concurs with this understanding. So shame can be seen as either a normal human emotion or as a destructive force which Agazarian (1994) describes as the anguish of shame which results in the loss of an aspect of the self which is needed for intimacy. Aspects of this anguish are considered by Hyams (1994) to be internal "dark forces" which lead to inner conflict. She highlights that internal conflicts relating to disowned aspects of self can be projected into the outside world and accounts for hate and prejudice. Hyams links infancy experiences of shame, which she refers to as toxic shame, to the internal conflict which continues to be experienced in adulthood. The infantile origin of shame and its persistence into adulthood is described by Evans (1994), who views shame as a defence against the abuse of power in the infant/caretaker relationship, and proposes that a dialogical relationship, which has three main characteristics of inclusion, presence, and attention to the space between, can be reparative. The connection between child abuse and traumatic relationships, and the experience of shame in early infancy is recognised by Fosha (2002) and Soloman and Siegel (2003). Fosha (2002) also recognises the pathogenic effects of relational trauma which can be experienced within the internal dynamic of self with one's self. I

recognise this from past experience when I would shame myself for my needs, so suppressing them.

Participant B recognises the traumatic potential of shame:

> Well, I think there are some levels of trauma, particularly with shame…I think shame is a trauma, that causes a separation in self,

The development of shame as a response to rupture in relationship is recognised by Erskine (1998, p112). Looking at it from a Gestalt therapy perspective he described the belief often presented by the client, "Something is wrong with me." He described some family systems which shame children for their needs and emotions, and the value of an affective response by the therapist. He also considers (1995) that shame can be regarded as a self-protective process in which becoming confluent with either the external humiliation or with internalised criticism averts the potential for abandonment. Erskine concludes with a description of the therapeutic situation in which the therapist needs a commitment to contact-in-relationship, patience, and understanding of shame and the defence of self-righteousness.

Participant G describes how she would try to contact her client who she sees to be experiencing shame:

> …trying really hard to make sure they hear me, because in their shame they don't hear the support that I'm offering, so I have to often get right down there and try and make the eye contact, which could be seen as intrusive, but there's a thing about trying to find the person…

The theorists I have referred to are writing about the aspects of shame which relate to shame 'just for being'. This is different in its context, nature and presentation from the shame that we might be experiencing if we can't do something, if we make an error, or when we feel less capable, maybe because of aging or illness. Shame which has developed in infancy and has left a lasting mark on the psyche can be addressed within a reparative relationship, whereby a person shamed interpersonally, that is, in infancy, can have reparation interpersonally, within the therapeutic relationship. Shame which could be considered normal and healthy would not be addressed in the same way; the therapeutic task would be to accept the feelings of the other, acknowledging the shared

humanity of such feelings. Shame is a human emotion and has an essential function which it would not be therapeutic to attempt to heal, even if that were possible.

Having considered the interpersonal relationship developing between therapist and client and how it can be the catalyst for healing, I will now explore concepts of boundary where the 'edge of the therapist' meets the 'edge of the client'.

Concepts of boundary within the psychotherapeutic relationship

The two main professional organisations governing counselling and psychotherapy are the British Association for Counselling and Psychotherapy, and the United Kingdom Council for Psychotherapy. Both organisations have codes of conduct for their members to adhere to. These are The Ethical Framework for Good Practice in Counselling and Psychotherapy – BACP (2010) and UKCP Ethical Principles and Code of Professional Conduct (2009). The BACP information sheet for prospective clients identifies both implicit and explicit rules which are embedded in all therapy. It also recognises that specific boundaries may be negotiated at the start of therapy. This document identifies the difference between therapist orientations and the effect of such orientations upon the boundaries that the therapist holds, more humanistic therapists may use touch and self disclosure, while more psychodynamic therapists may not.

Both the UKCP Code and the BACP Framework offer a guide with the aim of protecting clients and advising clinicians. However, theorists have considered the impact of such rules upon the therapeutic relationship. Gutheil and Gabbard (1993, p1) recognise that whilst clear in theory, defining boundaries can prove "slippery on closer observation." Wosket (1999) makes a distinction between boundary violations and boundary crossing, seeing boundary crossings as potentially in the interest of clients, whereas boundary violations are not.

Participant A identifies his approach to boundaries associated with touch in his client work:

> I try to have a very clear contract with the person that if I touch you, you have the right at any point to say stop and I stop immediately.

In identifying any boundary we must identify what is contained within. In a therapeutic setting we should then consider the therapeutic frame. Milner (1952) and Young (2005) have identified aspects of the therapeutic setting and historically boundaries have been seen to contain it. Authors such as Mair (1992), Smith and Fitzpatrick (1995) and Johnston and Farber (1996) have all written on the significance of boundary transgressions. Pope and Keith-Spiegel (2008) identify the significance of considering how any boundary adaptation is perceived by the client, as does Totton (2012).

Ferenczi (1953), Balint (1968), Winnicott (1965) and Van Sweden (1995) have all identified the need for adaptation of boundary in order to work with regressed clients, whilst Little (1981) describes the permeability of the therapist's personal boundaries in the interests of the regressive process. The importance of this dependent phase of human development and the impact of boundary is recognised by Weiss (2002) who critiques cultural understandings of dependency and places dependency as part of the developmental process. Weiss also notes that professional boundaries can be seen to protect the therapist rather than the patient and the countertransference involved in this.

I have identified the changes to normal therapeutic boundaries in order to address the needs of the client in regression to dependence. Revisiting pre-verbal states can mean that other means of communication which are appropriate in early development become important. Infants are tactile and communication is often through physical contact. It is important then to consider the relevance of touch in relation to regression to dependence and therapeutic boundary.

Touch

Touch is a contentious issue in the psychotherapy world. Traditionally, analysts would not touch their clients because they believed it would have an effect upon the transference, and would negate their position of the blank screen. In modern psychotherapy there are polarities of opinion regarding the use of touch. Those who work with regression to dependence often see it as a means of non-verbal communication, while others hold the psychoanalytic view, or may have a fear of litigation. Two of my participants had ceased to use touch with clients because of complaints made against them. They were unwilling to talk about this at interview.

Participant E highlights the issues which are important for consideration:

> How can you do a serious early childhood or traumatic therapy without touch? Now
> how much touch, when is that touch initiated, what is the quality of the contract for the
> touch, what is safe touch versus non-safe touch, those are all the issues that have to be
> decided on, on an individual basis.

The Gestalt therapists Polster and Polster (1974) valued the therapeutic use of touch as
being a central contact function, and a powerful means of establishing contact with the
client, so as to complete unfinished development. Hoffman and Gazit (1996, p115) do
offer this warning, "Before initiating physical contact, due consideration should be
given to the patient's history, values, religious beliefs, dynamics, transference and
countertransference elements, timing and its impact on the therapeutic process."

Participant C identifies the importance of the freedom to use touch in her clinical
practice:

> I want to be free to touch a client if I feel that's right, there are some clients I would
> never touch from the start to finish of therapy, but if somebody said to me, 'if you work
> here you can't touch', I think I would say, 'well, I'm sorry, I can't work here,'

Durana (1998) explores the arguments for and against the use of touch in
psychotherapy, considering the ethical and clinical guidelines for the appropriate,
sensitive and skilful use of touch. Eiden (2002) also explores the therapeutic use of
touch and describes the origins of the analytical 'no touch' rule, held because of fear of
sexualisation of the therapeutic relationship. Eiden pointed out that although Winnicott
considered that the infant learns to accept the body as part of the self, Object Relations
therapists pay attention to the infant's needs and drives and are disinclined to use touch.
Eiden described the fear that transference could be interrupted by providing
gratification, and outlined the analytic psychotherapist's belief that touch could inhibit
the process of internalization. He links the experience of the body with the development
of self, viewing therapeutic touch as offering an experience of nurture and support in the
development of the core self, describing the 'metaphorical holding' space (Winnicott
1958) as insufficient for some clients. When Winnicott (1965/84) described the
importance of the concept of holding he was referring to the mother's ego supportive

function, allowing itself to remain unintegrated and relaxed in a state of 'alert inactivity'. This holding was a psychological support and does not refer to physical holding. However, he viewed the ego as essentially a body ego (p223) seeing that for the development of the psyche-soma physical skin contact is required.

Maroda (2004), in her chapter on physical contact, looks at the touch taboo, describing the current objections concerning touch from the analytical circles which focus on the intrapsychic rather than the interpersonal. She quotes from Goodman and Teicher (1988) who provide an overview of the literature available at that time on physical contact. Maroda explores the therapeutic use of physical contact and the potential for the therapist to act out, and advises caution and careful observation of the patient's responses subsequent to physical contact, and describes her decision to use physical contact whilst being aware of the dangers. She writes of her decision not to use touch with a particular patient and the subsequent feeling that she had failed to respond appropriately to their developmental need. Maroda thoroughly explores the area of controversy, and develops a therapeutic style of minimal, appropriate, therapeutic touch.

Leijssen (2006) highlights the intimacy involved in touching an other, and that some psychotherapists are afraid of transference issues and re-traumatisation if touch is used. Citing Milakovich's (1998) research that there is no statistical association between sexual experiences with therapists and therapists' practice of using or not using the body in therapy, she points out that touch can be seen as an expression of a genuine, caring relationship, and also as a means to meet developmental need. Leijssen uses a powerful quotation as an example to illustrate that bodily trauma can be healed through bodily contact –"the only way they survived is that their souls left their bodies and they don't know where they went. Through kind, gentle touch they gradually come back into their bodies…to talk about it is not enough because the predisposition for reoccurrence of the trauma is so plainly embedded in the tissue" (Bingham Hull 1997, p6). Leijssen recognises that attention to the body gives access to the past seeing that body-oriented interventions can trigger strong affective or traumatic memories. She highlights the importance of the body, together with the verbal and cognitive, as necessary for change because "we know for sure that human life is existence in a body and a bodily experience" (p144).

Professionally, I have encountered a significant number of clinicians who are afraid to use touch because of the possibility of complaint or litigation. I am struck by the incongruence that bodily-orientated therapies, such as physiotherapy and osteopathy, which operate within one-to-one relationships, do not seem to have this dilemma. Wosket (1999) cites Hunter and Struve (1998) in their assertion that most clinicians avoid the potential of litigation by avoiding the use of touch. This could be problematic when working with regression to dependence because pre-verbal experiencing and pre-verbal communication potentially involves touch as a means of relational repair.

Pre-verbal experience: the neuro-scientific connection

In 1981 the United Kingdom Council of Psychotherapy created a forum to explore the inter-disciplinary field of neuroscience. Exponents of neuroscience formulated psychological phenomena as emerging from the complex interaction between systems in the body and those in the brain. Affective neuroscience integrates aspects of human functioning into its conceptual models. Some scientists and clinicians make direct links between brain processes and psychological theories. Their formulation recognises the role of relationship processes in human development. I will aim to give a critique of this perspective from some key theorists.

Schore (1997) considers that a rapprochement between psychoanalysis, the study of the unconscious mind, and the biological sciences is necessary, and sees the potential for bridging the relational and intrapsychic realms of the unconscious mind. He states (2003 p9) "I want to suggest that an integration of current findings in the neurobiological and developmental sciences can offer a deeper understanding of the origins and dynamic mechanisms of the system that represents the core of psychoanalysis, the system unconscious." Carroll (2001) considers that the fields of psychotherapy and neuroscience are undergoing a paradigm shift. Developing neuroscience has impacted upon trauma psychotherapy by the re-definition and differentiation of trauma. In his (2001) paper Schore looked at the neurobiology of infant trauma, the neuropsychology of disorganized/disoriented attachment patterns and the impact upon enduring right hemispheric function. Schore agreed with John Bowlby (1969) that developmental processes were best "understood as the product of interaction of a unique genetic endowment with a particular environment". This offers an integration of contemporary

biology with developmental theory. Schore's (2004) paper presents an overview of Kohut's work and applies a developmental neuro-psychoanalytic perspective to the psychopathogenesis of severe deficits of the self system. He describes the aetiology of post traumatic stress disorder and borderline states using a model of self-psychology and the neurobiology of infant trauma. Schore considers the neurobiology of regulatory structures resulting from psychotherapeutic change. Kling and Steklis (1976) found that orbitofrontal lesions disrupt behaviours of 'social bonding'. In Schore's construction clients who experienced neglect and parental failure in infancy may have a reduced capacity to adapt to new relational experiences. Their therapy will involve developmental repair through therapeutic regression and corrective emotional experiences, which can directly affect their ability to develop new attachment relationships. Siegel (2003, p1) makes the connection between neuroscience and attachment patterns, considering that "trauma during the early years may have lasting effects on deep brain structure." He identifies that early experiences "influence the fundamental processes of memory, emotions, and regulation".

Wilkinson (2010, p3) states "It is much more than merely the young person's brain that is the outcome of successful affect regulation and the development of emotional competence in the earliest years. Rather it is the development of an ever-increasing neuronal connectivity resulting in the complexity that is mind, which in turn gives rise to varied but interlinked self states. Ultimately it is on issues around attachment and affect regulation that a person's capacity to experience a sense of self that is 'simultaneously fluid and robust' depends (Bromberg 2006, p32)". Schore (2001, p5) conceptualised the attachment relationship as directly influencing the infant's "capacity to cope with stress" and that a deeper understanding of the complexity of normal development would be achieved by integrating developmental psychology, psychoanalysis, biology, and neuroscience. Gerhardt (2004) connects the relational aspects of infant development with her understanding of the influence of neuroscience, exploring the social aspect of the baby's brain being formed through relational interactions, and the consequences of babies being neglected or abused. She considers that this information has a direct application to psychotherapy.

It can be seen from the above references that these theorists embrace neuro-scientific research outcomes as evidence for theories of human development. However, as in reality we understand very little about brain processes, these links are conceptual rather than factual, and are extrapolations of processes rather than evidence, and are not the focus of this research. Within this chapter I have explored and critiqued literature which was relevant to this study and the themes which emerged from the participants' data. I have explored the historical origins of psychotherapy and critiqued literature which relates to early human development. As a result of the emerging themes, literature on primitive defences, trauma, the therapeutic relationship, shame and issues of boundary have also been included. Prior to starting this Literature Review I had an idea of some of the literature that would inform this study. As I have conducted this review I have found more areas of interest which had direct connections to my original question and the emerging themes within the study. Likewise, subsequent to my interviews, my prior reading of the literature informed my understanding of the data. A further development of these theories and concepts is presented in the themed chapters four to eight.

The following chapter presents my methodology for this study and demonstrates the process of my research to address the driving research aim of this study: to explore the treatment and effects of therapeutic regression to dependence in psychotherapeutic practice.

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Chapter Three

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Methodology

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Introduction

"What I do is me, for that I came." (Gerard Manley Hopkins 1968)

The above quotation is meaningful for me as I consider myself to be an essential component of this research. I have already described what I now identify as regressive experiences which resulted in me feeling panicked and crazy. Beginning psychotherapy for me was a way of seeking to find order out of this chaos. In this chapter I intend to identify how my understanding of this personal search for narrative has resulted first, in my undertaking of this Doctoral research, secondly, how it has influenced the manner in which I conducted the research, that is, in a way that recognises that I am intimately connected with this project, and thirdly, how my participants and their clients have searched for such understanding, and healing through psychotherapy, convincing me of the need for reflexivity within the research process to form an important aspect of my methodology. I will initially examine my choice of qualitative research, my heuristic style of research, my philosophy for this research and then explain my research process itself, introduce my participants and the rationale for their inclusion.

Quantitative and qualitative research concepts

"A useful working definition of research is: a systematic process of critical inquiry leading to valid propositions and conclusions that are communicated to interest others." (McLeod 1994, p4)

McLeod makes some suggestions about the purpose of any research in counselling. He considers that research can a) assist the profession to gain a wider perspective of the field generally, b) demonstrate efficacy of the work of counselling, adding rigour and accountability, c) develop new ideas and approaches, d) develop the application of counselling into new fields of research, and e) aid personal and professional development (McLeod 1994). I consider that these suggestions also apply to the practice of psychotherapy. .

There are two distinct research traditions - Quantitative and Qualitative. Ponterotto (2005) associates quantitative research with the natural sciences, seeking to explain the natural world through scientific means. Qualitative research is associated with human sciences seeking to understand meaning of social phenomena. Gergen (1985) described the qualitative, social constructionist paradigm as emerging from a post-modern critique of the traditional, quantitative paradigm which Creswell (1994) views as dominating science since the time of the enlightenment. Ponterotto (2005) attributes the beginning of constructivism/interpretivism to Kant (1724 - 1804) who considered that human perception was not only dependant on the perception of the senses but also on what went on in the processes in the mind. An important theme in qualitative research is the attempt to understand the meaning of experience of participants or researcher. Intuitive and felt knowledge are relied upon and are not quantifiable in the traditional ways (Lincoln and Guba 1985; Merriam 1998). Quantitative research holds a positive, empiricist view, assuming that it is possible to discover a knowable, objective reality. It is analytical, measuring variables, being deductive and reductionist. The researcher withholds his/her own values and is distant and independent in order to maintain objectivity. The outcome of the research is determined by the researcher, who seeks validity and reliability from the 'subjects' of the research. Much of qualitative research holds a more post-modern, social constructivist position. No assumption of single objective truth is made, but multiple realities can be held through use of an evolving design which seeks authenticity. It is descriptive, drawing out meanings and allowing concepts and theories to emerge. The researcher interacts with respondents, owning their values and biases, thus minimizing the distance between researcher and respondent, who are considered to be co-informants, forming the emergent categories of the research.

McLeod (2006) has seen the increasing influence of qualitative research in the fields of education, health care and social sciences in recent times. Dalos and Vetere (2005) considered qualitative research methodology to be more concerned with human experience and the construction of reality, understanding the human behaviour and valuing subjective experience. Rawson (2006) considered that qualitative research and psychotherapy are related in both form and content and therefore qualitative research suits better the requirements of psychotherapeutic practice. As a researcher I agree with

this construct and will detail how this idea has informed my thinking later in the chapter.

Applying qualitative methods to psychotherapeutic research

Frank (1989) contends that the failure of traditional experimental research to deliver clear evidence of the differential effectiveness of competing schools and treatment approaches lies in its search to establish facts "whereas psychotherapy transpires in the realm of meaning" (p144). He argues that unlike facts, meanings cannot be confirmed or disconfirmed by the objective criteria of the scientific method. Since traditional scientific methods can deal only with facts, slippage that occurs between the essentially different activities of mining for facts and delving for meanings may account for the relatively disappointing findings of psychotherapy research using conventional methods (p63). He acknowledges that qualitative researchers are more likely to ask: "How can we hope to know a final truth about an activity that has at its heart the impenetrable mysteries of the human condition and which has the primary purpose of uncovering each individual's unique and subjective truth about their own experience?" Given that my aim was to understand the experiences of my participants, qualitative research was the obvious choice.

McLeod (1994, p77) identifies that qualitative researchers "adopt a philosophical stance that human knowledge is contextualised and local". Because different researchers have been impacted by various traditions he sees that there has been a development of idiosyncratic styles of data collection and analysis. My aim was to acquire individual and personal data to be collected in the form of interview. McLeod (1994, p79) acknowledges that the research interview "is a flexible way of gathering research data that is detailed and personal. The presence of the interviewer enables on-going monitoring of the reliance of the information being collected, and enables the researcher to check out his or her understanding of what is being said." As my skill and experience as an interviewer developed, I recognised the conversational nature of the dialogue, rather than a question and answer session. The interviews felt very intimate and I sensed a degree of relief in both of us that we were able to speak about these issues with mutuality. I believe that my more relaxed style influenced the responses of the

participant. The participants were sharing their very personal experiences and stories, needing to feel my acceptance and see congruence between me as a person, my research and the way I conducted the interview.

Feminist researchers have grappled with issues of masculinity, power, and authority in knowledge creation. Doucet and Mouthner (2006) cite Code (1981; 1991) as playing her part in exposing masculine bias in science. They describe the movement to define the relationship between Feminism and epistemology. They highlight the concept of reflexivity and the role of the researcher in constructing knowledge. Because of the emphasis in Feminist methodologies of the use of self and because of my personal heuristic frame for this research it feels important to mention the impact that Feminist research approaches have had in the field of research generally, and how this impact is a part of my understanding of qualitative research.

Feminist research

Etherington (2004, p27) considers that "Feminist research approaches … and their emphasis on equality, challenged researchers to make transparent the values and beliefs that lay behind her interpretations, lower the barrier between researcher and researched, and allow both sides to be seen and understood for who they were and what influenced them." She considered that "reflexive feminist research encourages us to display in our writing the full interaction between ourselves and our participants so that our work can be understood not only in terms of what we have understood, but how we have discovered it" (p32). On reflection I believe that I have only partially succeeded in this because I have been developing within the process of researching. My early history and my defensive styles that I have already identified have made me fearful of chaos and needing to control. This has had its impact in all areas of my life including within this work.

Qualitative research values subjective, personal meaning and definition, commonalities and empowering the oppressed. Feminist research, in its challenge to traditional social science research, seeks to reduce the power imbalance between research and subject. In exploring the field of Feminist research I have recognised the ways in which mutuality and shared experiences can influence and develop the research process and I have aimed to develop these themes within my research. Finch (1984) coming from a Feminist

perspective also considers the importance of mutuality between interviewer and interviewee, which is enhanced by the informality of one person talking to another. McLeod (1994, p80) cites Mies (1983) and his description of this approach as "conscious partiality" where "the researcher should be willing to be known by, and identify with, the informant". Oakley (1981, p41) identified that rather than an objective and standardised approach to interviews the best way of finding out about peoples' experiences was in a non-hierarchical setting where the interviewer was able to use him/herself in the relationship. Whilst I did not consider myself to be undertaking Feminist research many of the concepts of Feminist research influenced and informed me. I wanted that level of sharing and mutuality which I believe was achieved by my willingness to share myself and my own experiences. Doucet and Mauthner (2006) question whether there are specifically Feminist methodologies and epistemologies, or simply Feminist approaches. They highlight the divide between traditional mainstream epistemology and Feminist epistemology. Hockmeyer (1988) considers that there are inconsistences between the inherent assumptions of Object Relations theory and Feminist theory. She recognises that the attraction of Object Relations theories for women is in the valuing of feminine qualities. The development of Feminist thinking now embraces and values the differing qualities of male and female, and seems to me to represent more understanding and less of a conflict.

The interview process develops

Initially I was anxious about the process and I felt more secure with a question and answer process. I wanted to get it 'right' and be understood by my participants. My default position is to be intimidated by those I consider more knowledgeable than I am. In my first interviews I felt defensive about my project, wanting to convince the participant of my validity, and to avoid experiencing shame. In my later interviews I felt more confident in my understanding of my topic and was able to value my subjective experience and consequently engage with their subjective experience. As I became more experienced as a research interviewer I relaxed into the process and I noticed there was more mutuality in the engagement and the participants appeared to be more relaxed with me and more reflective. My intention in choosing a qualitative methodology was to use an approach that would enable me to be transparent about my own beliefs and biases believing that it was impossible to do any other. I had lived the experience that I was

exploring, it had become part of me, I could not leave it behind, but I hoped that my experience would enhance my enquiry, adding a layer of depth to the data. Roberts (1981, p16) comments that 'Feminists, in stressing the need for a reflexive sociology in which the sociologist takes her own experiences seriously and incorporates them into her work, expose themselves to challenges of a lack of objectivity."

Feminist researchers originally identified a clear male/female divide in terms of ways of relating, and how this impacts on research, although current Feminist research places more emphasis on duality. Current Feminist researchers do not have the same difficulties in validating their research findings and have successfully challenged mainstream ways of collecting data. Skeggs (1994, p77) distinguishes Feminist research from non-Feminist research because it "begins from the premise that the nature of reality in Western society is unequal and hierarchical". My experience of the world of psychotherapy recognises this divide, but the divide could be seen as between a medical model (male) and a socially constructed environmental model (female). I also recognise, though, the value of understanding both the medical model and the socially constructed model, and that if they are equally valued then they each have important aspects to offer to psychotherapy theory, research and practice. It has previously been considered that data collected by empirical means was valid and social research less valid. I can agree with Roberts that there has been, and to some degree still is, a failure from those championing the medical model to see how their own work is affected by their experiences. I have also observed a degree of self-righteousness and arrogance in those who hold tightly to such certainty, which evidences to me their need to be 'right'. Elkins's (2007) work identifies the limitations and failures of the medical model when applied to the psychotherapy process. In my view he correctly identifies that there is a continuum, at one end is psychotherapy practice relating to self-development, and at the other mental illness. Most therapists are working somewhere between the two. For me psychotherapy spans this continuum and so working relationally, and yet possibly holding a diagnosis for the client can jar and conflict.

Etherington (2004, p27) when writing about narrative research recognises that the inclusion of the researcher's story makes "transparent the values and beliefs that are held, which almost certainly influence the research process and its outcomes". Hiles

(2001) recognises the demands of the heuristic research process "involving discipline, self-commitment, rigorous self-searching and self-reflection, and ultimately a surrender to the process" and in which the self of the researcher is an important aspect. I wanted to learn to be as transparent as I could, and to document as much about my experiences as was possible, although this was initially very difficult for me as historically I have hidden my vulnerability in order to stay safe. I have tried to be open about my own story as it is relevant to this work, recognising the co-construction of human knowledge (Walsh 1996). I did fear being accused of a lack of objectivity in my work, not only from male colleagues, but from any colleagues. I imagine that this is largely my own fear of self-accusation.

Reflexivity

Reflexivity is the ability to observe the world and the responses to it, and how this knowledge is then used to inform actions. We are viewing the world and what happens, learning from observation and allowing that observation to inform and guide our actions (Etherington 2004). Etherington (2001) cites Wosket's (1999) consideration that reflexivity requires "an ability to reflect on our selves, which in turn requires an awareness of our selves as active agents in our process."

My attitude to reflexivity between research and practice is evident in my decision to undertake this research. I had observed the processes occurring between me and my clients, I had reflected upon this, and had identified and applied relevant theory and I had decided to undertake research to discover the experiences and attitudes of others. The completion of this work will be the translation of the results of my research into findings that I and others will use to inform practice. Reflexivity is the use of self. My way of being as psychotherapist relies upon the use of myself therapeutically, and, at times I use myself as a tuning fork, able to pick up the vibrations occurring between myself and the client and then interpreting and using this information to feed into the therapeutic process, aiding the client's development. Enactments are a factor in psychotherapy approaches which recognise psychodynamic processes. Enactments are seen to arise where unconscious historic relational templates develop in the relationship with the therapist based upon the client's (and sometimes the therapist's) history. This unconscious re-experiencing is known as transference, which I will explain further in

Chapter 4 (Regression to Dependence). Such enactments occur when "the therapist unconsciously participates in a re-experiencing of the patient's dysfunctional attachment patterns" Pagano (2012, p206). He recognises that the therapist's self-awareness and reflection can use such processes in order to understand the client's story, but he also highlights that unconscious enactments are often difficult to see and use.

The use of self in the therapeutic relationship has been considered extensively in recent times and has highlighted the therapist's contribution to psychotherapy process and outcomes (Andrews 1991; Baldwin and Satir 1987; Lambert 1989; Real 1990; UKCP 1997 and Wosket 1999). This therapeutic use of self involves the use of all aspects of the therapist's self in the interest of the client and the therapeutic relationship. Wosket (1999) would describe this as the extension of aspects of the therapist's personality into the therapeutic process.

Feminist reflexivity also advocates for "the full interaction between ourselves and our participants" to enable what is discovered and how it is discovered to be transparent and for both to inform the body of knowledge (Etherington 2004). Within this project, my aim has been reflexivity; however, I have struggled somewhat with this, because of my personal struggle with chaos. Historically I have had an inherent fear of chaos, and to defend against my own chaos I tried to organise, be linear and chronological. Writing reflexively is a multi-layered process that I have struggled to organise and achieve. My inner process tends to cogitate and churn-out, writing the in-between stages seems too difficult, like showing the working for a maths equation, I have always struggled with this because it becomes too messy and ends up with a mistake. My fear in trying to organise this research was that in trying to show my working processes, I might confuse myself and make so much mess that I might lose the answer. I am also aware of my shame process in which I fear exposure and the negative judgement of others. I have done my best with what I have and I have aimed to share my own processes and subjective self with the reader whilst undertaking this work. The self is an analytic tool – this is how I have used myself as a researcher.

Hollway and Jefferson (2000) conducted their research by using their psychodynamic theoretical orientation to inform the work. They adapted techniques from psychodynamic theory to gather knowledge and to provide data analysis. They explore

the conscious and unconscious aspects of the research relationship, and they place emphasis on the importance of the centrality of the participants' responses. They introduce narrative interview methods using free-association and interpretation.

I also wanted a research process which was congruent with my therapeutic stance. I view my theoretical orientation from a Relational/Developmental perspective, which includes Object Relations to inform data analysis. I decided to use this understanding to develop the relational component of my research, and to aid me in data analysis. This stance would then highlight my personal reflexivity, and the importance of the relationship between me and the participants. In thinking of my identity as an Integrative Psychotherapist, it is of great importance that some of my knowing comes from the experiencing of self and other. The training of Integrative Psychotherapists involves extensive personal psychotherapy in order to develop the knowledge and use of the self. Involving myself in the research process is congruent with my personal beliefs and practice. In applying my philosophical and theoretical stance, I would need to consider my personal experiences as well as the experiences of the participants. This would include having regard for the regressive process and ego state of the participant which they (and I) may experience as a result of the dialogue. I would need to have regard for the possibility of an absence of words within the dialogue and the need for interpretation at times for the participant - giving them words either in the interview or later. I also recognised that there may be a need to extrapolate meaning from my felt sense. I was attentive to the reflexive processes of my participants, and was interested in Wosket's (1999) comments on Rennie's proposal that research methods should be developed to access the reflexive processes of the participants in order to present their experience of therapy in its spoken and unspoken entirety.

When I introduced my research to the following participants G, F and I, they made a clear link between their personal journey as clients, and the way in which they work with their clients now:

> I made a decision not to begin working with clients……until all the kid in me stopped being so scared, until she had got enough self-support….

I want to talk about how I experienced being worked with (with) my therapist (X) ….. I feel it is important to experience therapeutic regression, because it is only by going to those places that you can know regressive work….

…it feels like it's useful to think about my own experiences before I think about talking about the way that I've worked with clients.

Participant I, in connecting her own experience and her work as a therapist, seems to echo the human development perspective, which is that internalising good objects as children means we have the capacity to be a good object for our own children, and of course the opposite is also true; internalising bad objects increases the likelihood of being a bad object for our own children, parenting as we have been parented (Zucker 1998). Participants made clear links between their own experiences as clients and that of their own clients.

When I asked participant D to talk about her experiences of regression as both a patient and a therapist she replied, "I guess some of those questions will overlap."

I asked the participant H if her own experience informed how she worked. She told me that it did and how this helped her to work with a particularly damaged client because she was able to tolerate the chaos that was experienced by herself and her client, having experienced chaos personally and survived, recognising that healing could result:

…she went back to that pre-two period …where she couldn't walk, she was lying on the floor…and I sat by her for seven and a half hours, I would not call the ambulance which would have been a real problem [for her] …. [it was] terrifying, but I knew I had to do it.

The participant considered that she had had "the balls to stay there." I asked her if she could have done what she did if she had not had her own experience. She replied, "I don't think I could."

Choice of method

I identified that my process and my research are inextricably linked and so a heuristic methodology might be the appropriate choice as it situates the researcher within the research. My endeavour was to capture both the conscious and unconscious processing

of the participants because the regressive process itself is invested in exploration of both the conscious and unconscious experience, therefore I was seeking a research method that was congruent with myself as researcher and the subject under study. McLeod (1994) cites from Mearns and McLeod (1984) in recognising that if the relationship, in this case between researcher and participant, is "characterised by the 'core conditions' of empathy, acceptance and congruence then people will collaborate more effectively" (p186). I recognised that I was an intrinsic part of my research, in fact my research was a product of me and I wanted this to be transparent, but I have had to learn how to do this. Whilst my interest was based upon a professional approach, the topic was interwoven with my personal experiences and interests. There was a connection between my client work, my theoretical understanding and my personal experiencing. I expected that this personal connection and knowledge would help me to understand the experiences of others (Moustakas 1990).

Having recognized that my process and my research were inextricably linked, I needed a method, which would enable me as researcher to be situated within the research. I chose an heuristic approach as my purpose was to inquire into the essence of the person within the experience, capturing the richness and texture that individual experiencing and meaning-making can offer.

Interpretive Phenomenological Analysis (IPA) focuses on the lived experience, but it is particularly focused on the person's conscious perception or account of their experience. However, the data from IPA can be more cognitive in orientation. IPA, like grounded theory, is a suitable method if the aim is to extract a framework or structure of the experience (McLeod 2011), however, the aim in this research was to explore the conscious and unconscious experience of participants and give voice to it, capturing the essence of the person in the experience, and not just their conscious perception or meaning-making of it. This is particularly true as the participants may not have been able to articulate their meaning-making or perception of the experience because of the very process of the experience itself.

In IPA the researcher is looking for themes that are running through all of the data, themes that are not common can be lost (Smith et al. 2011). The aim of my research was to capture the range of uniqueness of experiencing within the data, and not to lose any

because of a lack of commonality. It was also important to me to be transparently present and to have a voice within the study. In IPA the researcher interprets the interpretation being made by the participant, employing a double hermeneutic, so the findings are arguably more influenced by the researcher than with the heuristic method, and as the IPA researcher is essentially the filter of the data, their bias is not easily identified, whereas in a heuristic method the researcher declares their bias and gives voice to their own experiencing. Because of these considerations a heuristic method was judged to be the most suitable choice.

A further possibility would have been to adopt a similar approach to Nollaig Frost (2011) who combines core approaches to qualitative research. She illustrates a number of ways to do this. A possibility for this study would have been to have combined exploration of the human experience of regression via a heuristic or IPA method with a phenomenological or grounded theory analysis of the data to elucidate either the essence of the experience itself (bracketing the experiencer's view), or to have developed a conceptual framework of the experience via grounded theory. This may be a possibility for future research, however my aim in this study was to be able to enter into an immersion of the experience without any detraction from this, which may have been created by employing an additional method. I was mindful that the experience of regression to dependence is an experience of immersion and it was appropriate to employ a single method which mirrored this process.

Application of the heuristic research style

Moustakas (1990, p38) considers that heuristic research successfully aids the discovery of the processes of internal searches by which one discovers the nature and meaning of an experience. The aim of heuristic methodology is to understand "the heart and depths of a person's experience." The self of the researcher is always present in the process and the development of self-understanding and meaning emerges through the researcher. Moustakas describes the processes involved in understanding the meaning and nature of the experience through a series of stages. These stages are identified as follows: immersion - he describes this as being open and receptive to the nature of discovery. He describes his search within his knowledge and experience for "deepened and extended awareness that would further illuminate structures and essences of heuristic discovery."

Moustakas sees the heuristic process as a means of knowing, using the self of the researcher to add insight and elucidation which is then a process for further discovery and illumination. It is a cyclic process in which not only is knowledge extended but also the self of the researcher is illuminated. He considers that "from the beginning and throughout an investigation, heuristic research involves self-search, self-dialogue and self-discovery; the research question and the methodology flow out of inner awareness, meaning and inspiration." He describes his immersion process "When I consider an issue, problem, or question, I enter into it fully. I focus on it with unwavering attention and interest. I search introspectively, meditatively, and reflectively into its nature and meaning" (p11). He adds that "in the process of a heuristic search, I may challenge, confront, or even doubt my understanding of a human concern or issue; but when I persist in a disciplined and devoted way I ultimately deepen my knowledge of the phenomenon. In the heuristic process I am personally involved. I am searching for qualities, conditions, and relationships that underlie a fundamental question, issue, or concern". "In heuristic investigations, I may be entranced by visions, images, and dreams that connect me to my quest. I may come in touch with new regions of myself, and discover revealing connections with others" (p11).

Polanyi (1891-1976) contributed to the philosophy of science and social science. He identified the importance of tacit knowing whereby ideas and concepts which are known tacitly rather than explicitly emerge within the participant and the researcher. He considered that "we know more than we can tell" (1967/1983, p4). His argument was that intuitions, guesses and hunches have their motivations in what he calls 'passions' which are not formally known, terming this pre-logical phase as 'tacit knowing' which would include a range of conceptual and sensory information from a variety of modes which together can made sense of something. These bits of tacit knowledge could be brought together to form a new model or theory. Moustakas (1990, p20) highlights the importance and value of tacit knowing, "underlying all other concepts in heuristic research, at the base of all heuristic discovery is the power of revelation in tacit knowing". Douglass and Moustakas (1985) in emphasising connectedness and relationship, also recognise the value of intuition and tacit understanding.

Moustakas (1990, p13) acknowledges that the beginning of the heuristic journey is with something from within his own life experience. He considers that he is "creating a story that portrays the qualities, meanings, and essences of universally unique experiences." He identifies that he is "not only lifting out the essential meanings of an experience," but is "actively awakening and transforming" his own self. My reasons for conducting this research were clearly based in my own experiences and whilst I wanted to explore the experiences of others, seeking to understand the ways that therapists worked with this process and be able to offer this back to the profession, I also recognise that I expected some transformation within myself as a result. Rogers (1969) as cited in Moustakas (1990, p17) "has summarised the essential qualities of discovery in terms of openness to one's own experiences, trusting one's self-awareness and understanding, an internal locus of evaluation, and a willingness to enter into a process rooted in the self."

Through my personal engagement with psychotherapy I came to understand my pre-occupation with finding the right answer as a manifestation of defence mechanisms. Being able to get to the right answer enabled me to feel in control and avoided the discomfort of not knowing. My first career in the Civil Service was perfect for me in the sense that there is always an answer. There was a set of codes and if I studied hard enough I would find the answer which then was incontrovertible. By the time I entered professionally into the field of counselling and psychotherapy I had changed significantly, but this defence remained and as I started to think about research for my Master's Degree I took this position into that project with me. Therefore I wanted to gather incontrovertible data which was evidence based and could be seen as scientific and 'right' even when I began my thesis for my Masters, and having chosen a heuristic methodology I still wanted to be 'right'. This position is very black or white with no tolerance of ambiguity. It began to conflict with the values I placed upon more experiential ways of knowing and my understanding of reflexivity. Etherington (2003) would recognise this process. Over time, I moved away from this tightly held position and recognised that being 'right' is subjective and for me the important facts are those which belong to the individual's subjective experiences. These are the truths that the individual uses to make meaning of experiences. I had moved from wanting scientific methodology to a socially constructed one.

As an experienced practitioner I have come to realise that how an individual makes sense of their story affects their experience of living life. When an individual is fearful of their internal chaos and anxiety, often because chaos and anxiety has not been tolerated or managed in their infancy, they seek to control it or diminish it. In their attempts to control they are unable to manage ambiguity, seeking to find the answer, and to excise chaos and anxiety from their lives. This eventually fails and can result in a breakdown in these defences. It is at this point that clients often present for therapy. Part of the therapeutic task is to provide a framework for understanding in which the chaos and anxiety can be explored and tolerated. This is how I understand the process I experienced, that moving from a scientific methodology where there would be a 'right' answer, I was moving towards a socially constructed methodology which lets go of certainty and embraces ambiguity. I wanted this change to be reflected in my research methodology. I was not aware at the beginning of my research that my work would take on an autoethnographical nature. Autoethnography is a form of self-reflection and writing that explores the researcher's personal experience and connects this autobiographical story to wider cultural, political, and social meanings and understandings (Ellis and Bochner 1992). My personal story is connected to my professional experiences and as such aids understanding of the subject of this study.

Intuition

When I started this project I already had personal experience, clinical experience and theoretical knowledge. I also had tacit knowing and intuition. All of this knowledge indicated to me that there would be an abundance of stories held by the therapists about their experiences. I also sensed, because of my own experience in therapy and with clients, that shame would be an important factor. This tacit knowing helped me to prepare for the possibility that participants (and I) might experience shame, finding strategies that would manage it, such as sharing my own shame experiences with the participant. I also expected that in talking of regression, some regression might occur, and I addressed this by inviting the participants to think theoretically about the processes they were describing. I also ensured that I did a full debrief at the end of each interview. Moustakas (1990, p23) comments "From the tacit dimension a kind of bridge is formed between the implicit knowledge inherent in the tacit and the explicit

knowledge which is observable and describable. The bridge between the explicit and the tacit is the realm of the between, or the intuitive." Both Polanyi (1969) and Moustakas (1990) recognise that intuition leads to discovery and deeper knowledge.

Indwelling

"Indwelling refers to the heuristic process of turning inward to seek deeper, more extended comprehension of the nature or meaning of a quality or theme of human experience." "The indwelling process is conscious and deliberate, yet it is not lineal or logical" Moustakas (1990, p24).

I feel that I have been indwelling this project for many years, again based on my own experience and that of my clients, yet the process of actually beginning the research uncovered aspects that I had not experienced before. Studying the data led to my experiencing of the data, putting me in touch with my own experiencing so that my experience added to that which was being described by the participant. When I was writing the chapters, particularly around regression itself I found that I would quickly grind to a halt and be unable to articulate the concepts I was trying to describe. Indwelling in this project has resulted in a widening of my understanding of the phenomenon I was exploring. From my initial view of the therapeutic encounter as the only focus of exploration I now see that the initial encounter described to me was like a pebble dropped in a pool with ripples extending outwards and having effect upon the encounter with my participants and then individually on me as researcher. Through the process of this research I have encountered many of the facets of the experience implicitly or explicitly described to me by participants. I have felt shame at the idea of exposing myself personally and professionally to others in my intended audience, I have been regressed and unable to articulate my meaning, I have experienced chaos and been unable to organise my thoughts or words, I have experienced the terror of lack of comprehension and fear of madness, I have felt too little for the task at hand.

Focusing

Gendlin (1981, p30) uses the word 'focusing' to describe the edge of awareness. This focusing can mean "reaching beyond conscious competence to aspects of yet unfathomed capability."

Focusing is an essential process in heuristic enquiry. This process has been perfected and advanced as a therapeutic strategy by Gendlin (1978). Moustakas (1990, p25) identifies "Focusing is an inner attention." Douglass and Moustakas (1985, p51) conclude that the focussing process enables the researcher to identify qualities of an experience that have remained out of conscious reach primarily because the individual has not paused long enough to examine his or her experience of the phenomenon. Through the focusing process, the researcher is able to determine the core themes that constitute an experience, identify and assess connecting feelings and thoughts, and achieve cognitive knowledge that includes "refinements of meanings and perception that register as internal shifts and alterations of behaviour."

I found it easy to be focused on this subject as it is a major part of my personal and professional life. Seeking to understand this process has been a focus of my attention for many years. During the process of data collection in particular I was aware of an inner and an outer concentration on the topic, which resulted in dreams and waking thoughts which would connect themes together, or identify other avenues to explore. One of my dreams during this time involved the role of the therapist in emotional regulation of the client. I dreamed that my own therapist operated like a damper on a piano which would absorb the resonance of the string as the hammer hit it. This is how I experienced my therapist in regulating my disturbed emotion and how I understood that part of my role as a therapist for some clients is that I would be able to absorb some of their unwanted resonance. This could be viewed as regulation by the mother/therapist of the infant/client's unregulated emotion (Fosha 2003). Ultimately, this is the process by which self-regulation is developed.

In the course of this project I recognised how in analysing the data I was actually resonating with the experiences which formed part of the data, so when I was writing about terror I was resonating with the terror, when writing about shame I was experiencing shame, and when writing about regression I was regressed. As a result of my dream I recognised the need to absorb and regulate myself, rather than to resonate and become dysregulated. The dream and this whole experience was part of my heuristic process of immersion and indwelling. This understanding through reflexivity influenced me as a practitioner and as a researcher.

Internal frame of reference

Moustakas (1990, p26) considers "Heuristic processes relate back to the internal frame of reference. Whether the knowledge derived is attained through tacit, intuitive, or observed phenomena - whether the knowledge is deepened and extended through indwelling, focusing, self-searching, or dialogue with others - its medium or base is the internal frame of reference."

When I began to try to understand the data from my research, and indeed to write this chapter I found myself struggling to frame what I wanted to express. The more I have thought about this process, the more I have come to understand that the nature of the regressive process itself seeks to understand by framing the experience in ways that it is possible to articulate the experience. I found illumination in the form of Hollway and Jefferson (2000) in the way that they had understood data through psychodynamic theory. I have understood how my striving for understanding through articulation is a parallel process to that of my participants and originally to that of my clients.

Moustakas (1990, p27) "Six phases of heuristic research guide unfolding investigations and comprise the basis research design. They include: the initial engagement, immersion into the topic in question, incubation, illumination, explication and culmination of the research in a creative synthesis."

Initial engagement

In this phase the task is to find the area of interest for the researcher. I have previously identified how much my interest and engagement developed, recognising how much "personal power" the subject held for me. "During this phase the researcher looks for areas of tacit knowing and intuition" (Moustakas 1990, p27).

Immersion

"The immersion process enables the researcher to come to be on intimate terms with the question – to live it and to grow in knowledge and understanding of it." "Virtually anything connected with the question becomes raw material for immersion." "Primary concepts for facilitating the immersion process include spontaneous self-dialogue and self-searching, pursuing intuitive clues or hunches, and drawing from the mystery and

sources of energy and knowledge with the tacit dimension" (Moustakas 1990, p28). My initial immersion in the question continued to take place during and after my early interviews and my connection with the material would lead me to theoretical reading in between studying the data. I felt quite energised by the work I was doing. At times I was very busy teaching, and working hard with clients, and my research was far from my mind. It was during these periods that my dreams and fantasies took me back to reconnect with the material, usually with new understanding emerging from these periods of absence.

Incubation

"Incubation is the process in which the researcher retreats from the intense, concentrated focus on the question." In this phase there is a detachment from the intensity of involvement with the question. However, Moustakas (1990, pp28-29) recognises that "on another level expansion of knowledge is taking place." "The period of incubation enables the inner tacit dimension to reach its full possibilities". In this period I had collected the majority of the data, and was reading and re-reading the words of the participants. Transcriptions of the recordings, and reading the transcriptions enabled me to see things beginning to emerge from the data. During this process I had taken a new post and I needed to focus my attention in that area. This meant that I came away from the data for quite long periods during which time I think that my understanding and 'tacit knowing' was developing.

Illumination

Moustakas (1990, pp29-30) considers that the process of illumination occurs naturally when the researcher is available to tacit knowledge and intuition. This is more than reflectiveness, this process contains a degree of mystery requiring "tacit workings to uncover meanings and essences." "Illumination opens the door to a new awareness, a modification of an old understanding, a synthesis of fragmented knowledge, or an altogether new discovery of something that has been present for some time yet beyond immediate awareness."

It was during this period that I came to recognise my own terror, seeing the amaranthine ways that it permeated my being and affected my everyday life.

When I returned to concentrate on the data after the period of incubation, I developed individual depictions for the participants. Through reading and re-reading their transcripts I was able to identify the key words and phrases which depicted the essence and meaning of their experience.

Explication

Following illumination the heuristic researcher enters into a process of explication. "The purpose of the explication phase is to fully examine what has awakened in consciousness, in order to understand its various layers of meaning". As a result of this explication the researcher pulls together that which has been discovered and organises it into a comprehensive depiction of the meaning and nature of the experience (Moustakas 1990, p31).

In this phase of the research I extracted key themes from the individual depictions which have now formed chapters in this thesis. Although the discovery of these themes was a guide to me, as the process continued I found myself returning to the participants' actual words in the transcripts rather than the depictions themselves. I discovered that returning to the transcripts after a period of time gave me additional insights into participants' meanings.

Creative synthesis

The researcher is now fully aware of the body of data and its parts and themes. The creative synthesis is derived through the means of tacit knowledge and intuition. My creative synthesis involves the meaning that I have made of this whole process. I have tried to use my reflexivity to inform me and my work. The whole process has been all encompassing; I have understood things at many levels:

First, at the level of an individual who is damaged and who has experienced that inner chaos, the 'unthinkable anxiety', and who has been desperate to find a means of surviving in life. I have also experienced the 'fear of falling' and finding myself caught by a safe, attuned and containing other.

Secondly, as a clinician I have used my understanding derived from this research to inform my practice. I have seen the themes which have emerged from the data also revealed in my work with clients.

Thirdly, I have used my reflexivity to help me to interpret the data in a meaningful way.

Finally, I have been able to transmit my increased understanding to my students, to other professionals and to elucidate the conclusions of my research which I intend to use to widen my scope for sharing and dissemination.

Validation

Moustakas (1990, p32) considers that "validity in heuristics is not a quantitative measurement that can be determined by correlations or statistics. The question of validity is one of meaning." He considers that because the primary researcher is the only person who has engaged in the research process "together with the participants" that he/she is the only person capable of drawing meaning and essence of this experience.

Moustakas (1990) cites Bridgman (1950) and his emphasis on the subjective bases of validation, the dependence of validity on the judgement and interpretation of the researcher. Moustakas (1990) highlights the need for the heuristic researcher to repeatedly return to the data looking for significance and meaning. He quotes Polanyi (1969, p30) "certain visions of the truth, having made their appearance, continue to gain strength both by further reflection and additional evidence. These are the claims which may be accepted as final by the investigator and for which he may assume responsibility by communicating them in print." Moustakas (1990) cites Polanyi (1969) and his emphasis that there are "no rules to guide verification that can be relied on in the last resort; the scientist must make the ultimate judgement. The synthesis of essences and meanings inherent in any human experience is a reflection and outcome of the researcher's pursuit of knowledge. What is presented as truth and what is removed as implausible or idiosyncratic ultimately can be accredited only on the grounds of personal knowledge and judgement"(p120). Moustakas (1990) identifies that heuristic research is a demanding process requiring focusing on one's own experience, using a high level of reflexivity in self-dialogue, and looking in great depth at the meaning and essence of the experience being investigated. As I was re-reading the explication of my

methodology above, I saw in how linear a fashion it is written. In reality, this was not a linear process, rather it was a working in and out of various thoughts, feelings, ideas and knowings which would emerge and change in a seemingly random fashion. It is only now, having completed my research that the whole process is becoming clearer to me.

Use of self

Wosket (1999) has identified how the role of the self has been 'de-emphasised' by traditional research methods with 'individual characteristics' of the researcher aimed to be eliminated in order to produce objectivity and repeatable results.

This research also represents an aspect of my search to bring meaning out of my own chaos and that of my clients. Since undertaking my Masters into this area I can observe how my beliefs and understandings have changed from then to now, and I am aware that this is a continuing process. When I completed my Masters dissertation I was aware that my stance was different from when I started and that I had learned a lot in the process of research. I now recognise that the same personal and professional development has occurred as a result of this doctoral research.

Wosket, (1999, p66) writes of the implications of studies that are flawed. "Flaws become a problem only when the researcher claims that the study is flawless when it is not. It is the deception that renders the work invalid. All studies are flawed in some way. As long as the researcher is able to identify and name the flaw, the data from the research and its conclusions can be seen as valid.

Another area of learning has been my psychotherapy clients, my supervisees and my students who have presented me with a rich variety of their own and their clients' stories. In learning with them and from them I have understood more and paradoxically often feel that I know less about how human beings are. The chaos of not knowing will always outwit the human endeavour to bring control and I am mindful of the quote from Jurassic Park, when the scientists believe that they have nature made safe and contained - "because the history of evolution is that life escapes all barriers. Life breaks free. Life expands to new territories. Painfully, perhaps even dangerously. But life finds a way." Our illusion of control and understanding is just that and the ways that I think about clients' stories is just a framework for understanding and is not a template for the truth.

Search for a meaning

Often clients enter therapy reporting feelings of chaos. They may describe behaviours, feelings and experiences which are outside of their understanding. This generates fear and feelings of lack of control. The client is initially looking for a remedy to take away these feelings, finding a way to understand these processes so that they have meaning and context can result in their reduction, but can also introduce the client to the message their body is expressing and help them to begin the journey of self-discovery and self-understanding. Arriving at some shared meaning helps the client to have a framework and a language to think about and share their experiences. Etherington (2004, p9) recognises that the act of forming stories in order to share meaning creates "coherence through ordering" experiences, providing an opportunity for "reclaiming ourselves and our histories." Seeking to understand the process that I had experienced and that I see frequently in the therapeutic relationship, and finding a shared meaning for it which is understood by other professionals and theorists, has helped me to find and articulate the necessary language to help others to find theirs. It will be evident to the reader by now that my own need to order the chaos that I have experienced is an intrinsic part of this research and I believe that it is necessary for clients to be able to tell their stories (Holmes 2008).

The value of story telling

The participants in my study are all practicing psychotherapists who have identified as Integrative, that is, they have studied one main theory, such as Psychoanalysis, and integrated theories from other orientations, or they have trained using an Integrative orientation which contains a Relational/Developmental perspective. They are describing their experiences from a perspective of having already established a narrative for them and they have understood them through the lens of their theoretical background. When clients have a means of understanding their process it changes their perception of the experience, reducing fear and developing a shared language to engage with their therapist and with others who understand. This results in a marked difference between clients' initial presentation and later experiences. This also accounts for the difference between the case studies that theorists present as the general client population and those who have found some resolution to their archaic pains, such as my participants and me

(Etherington 2003). Also, there are many factors which add to clients' trauma such as a lack of environmental support during these times. My participants, regardless of their particular stories, had additional support from their training colleagues, their tutors and from reading theory, to which the average client has no access.

Etherington (2003, p9) writes powerfully about the impact of trauma upon people's lives and how the experience of chaos as a result of trauma can leave people "speechless, voiceless and silenced." Yet the human spirit still seeks to communicate with the other through whatever means are available. She talks of those who, in facing their suffering, have "found a voice with which to narrate their stories." Clients, and therefore also participants, enter therapy often voiceless and unable to word their experiences. The therapeutic process helps to find words and story. She makes the point that "By writing stories we become agents in our own lives. We claim a voice that previously may have been silenced by potentially marginalising traumatic experiences which are culturally denied." I would assert that developing therapeutic stories with the client in therapy has the same effect, and that clients who enter therapy in confusion and fear, without a clear sense of self, can develop into clients leaving therapy with a clear sense of their own story, in appropriate control of their lives and with a sense of love and attachment which may have been missing for a lifetime.

Wilkinson (2010, p132) also recognises the importance of the establishment of a coherent narrative resulting from adequate regulation of emotional arousal. Wilkinson sees the co-construction of narrative as an "integral part of therapy for patients who have experienced early severe relational trauma." She argues that such co-construction may be vital in both assisting the patient to come to terms with their internal world and also in mourning the loss of what didn't happen and establishment of a narrative which helps to develop meaning and a sense of self.

Finding the research topic

Almost at the end of my Masters research I realised that my search to understand regression was specifically about regression to dependence. I recognised that this was the process that I had been engaged in as a client and the process that some of my clients were engaged in, too. I hoped that by developing my understanding of the experience I would ultimately be able to apply my research to practice, and also inform

the profession. I wanted to know how other clients and therapists viewed, understood and experienced regression to dependence. I identified the research topic that I wanted to work on as regression to dependence: the experience of regression to dependence in the adult client in psychotherapy. I chose the word 'experience' because I thought it would enable participants to speak widely about anything that they considered experience. I wanted to explore regression to dependence with and through the participants, rather than exploring regression in its entirety.

Seeking ethical approval

As a researcher at De Montfort University, Leicester I was required to apply to their Ethics Panel for their approval. I had already ensured that in using therapists I would be able to address some potential concerns such as; that the participants would be able to give informed consent, and that they would be able to access support should they be adversely affected as a result of the interviews. I was required to indicate that my research would be conducted in an ethical and professional manner. Having seen the proposal for the research the ethics panel gave their approval for me to proceed.

Research questions

I started with a list of eighteen questions which I hoped would elicit useful information. I used these questions in a semi-structured way, adapting them as I felt appropriate according to the information given by the participant.

1. Have you had experiences as a client and therapist working with this client group that you would identify as regression to primitive, pre-verbal emotional states?

2. Thinking about when you were a client, could you tell me about your experiences?

3. How did your therapist respond to you during these times?

4. What did you feel was beneficial to you?

5. What was difficult or unhelpful?

6. What was your experience of holding/being held (literally or symbolically)?

7. Did you have/use any transitional objects during this time?

8. Do you believe that this experience was necessary for you

9. Who/what supported you through this experience?

10. Could you now tell me about your experiences as a therapist when working with this client group?

11. What do you see as problems for the therapist?

12. What do you see as problems for the clients/patients?

13. Why might this experience be necessary for your clients/patients?

14. Did you offer any transitional objects? And if so, did they help?

15. What was your experience of holding clients/patients (literally or symbolically)?

16. Who/what supported your client/patient through this experience?

17. How do you feel about these experiences now?

18. Is there anything else that I have not asked that you would like to tell me about these experiences?

Participants, requirements and rationale

I was looking for participants who were practising United Kingdom Council for Psychotherapy (UKCP) registered psychotherapists who could identify as Integrative. The UKCP is a professional body who register psychotherapists from a variety of orientations but who have all attained a high level of training, that is, Masters level. As I was looking for well-trained and experienced practitioners to be able to address the kind of therapeutic practice that was of interest to me I considered a starting point to be UKCP registration. I wanted to conduct an in depth study which would allow for the multi-layered experiences of the participants to fully emerge. I knew that the topic would generate intimate and complex stories which would yield sufficient data. I was interested in case study research where only one participant generates data, but I did not consider that this would produce sufficient themes for my purposes. There was a part of me that wanted to execute a study with many participants in order to provide 'proof' of my hypotheses, but another part of me values experiential and subjective 'proof' more. Looking at the work of Etherington (2000; 2003), Speedy (2007) and Cooper (2008), I decided that my participant numbers should be around a dozen, because I believed that

this would give me sufficient data to encompass the breadth of the subject, whilst allowing an in-depth immersion in the topic. I anticipated inviting between ten and fifteen participants into the research and these would be practicing psychotherapists who work with regression to dependency and have received long term psychotherapy pursuant to their psychotherapy training and have had an experience of a developmentally needed regression to dependency, subject to ethical approval and informed consent. I was looking for participants who had enough experience to work with the sort of clients at the centre of this study. I also wanted them to be of a high level of training so that they would be able to apply theory and articulate it. I obtained my participants through word of mouth, which could be considered to be a form of snowball sampling. I told people in various therapeutic settings what I was doing, as I was looking for participants who could work with regression to dependency and who would understand the concept. The world of psychotherapy is small, and when people are particularly skilled in particular areas it is often known by other members of the profession.

Initial invitation and discussion

Having generated a list of names I contacted the potential participants and sent them details of my research. I then arranged a discussion time to explain in full the concepts I wanted to research and to ascertain whether or not the potential participants had the relevant experience. Seventy–five per cent of the people whose names I was given agreed to look further at my information. They all went on to become participants.

Participant profile

In order for the reader to have a sense of my participants I will now briefly describe them.

The age range of participants' was from 30 – 70, three were male and eight were female (including one who withdrew after interview). Their cultural backgrounds included Western European (British), Western European (Other) and American.

Participant A was a practitioner, writer and trainer who had studied a wide spectrum of theoretical training. Participant B was a practitioner and trainer in psychotherapy and other health related fields, having worked within the NHS for many years, and had an

interest in spirituality and its links into psychotherapy. Participant C, also having had an NHS background in nursing, was a skilled clinician with an interest in body orientated therapy. Participant D was an experienced trainer and NHS professional who specialised in working with those with personality disorders. Participant E was an established clinician who originally trained in Psychodynamic Psychotherapy and then in a Relational/Developmental approach, working in the NHS and in private practice. Participant F was a clinician and supervisor in private practice. Participant G was a practitioner, lecturer, author and academic in the field of education and psychotherapy. Participant H was an established clinician, trainer and academic. Participant I was a practitioner, supervisor and trainer who had a background within the NHS and worked in private practice with long term clients. Participant K was a private practitioner who specialised in working with couples with relational issues and in long term psychotherapy with individuals.

I chose these particular participants because they were sufficiently experienced to have encountered the issues that I was interested in, they were theoretically knowledgeable and all of them had an interest in working at depth in psychotherapy.

Changes in interview methods

In my first interviews I was very anxious, not knowing how to elicit the sort of information I was seeking. Initially I asked all of my questions and the participants answered if they could. What I noticed after the early interviews was that participants could be encouraged to just talk, using my questions as a fall-back only. This resulted in material that had more flow and greater richness. Through all the interviews I held a boundary around the interview itself, what was pre-interview and what was post-interview. On reflection I now believe that my interviews actually started when I arrived and ended when I left, as some of the conversation before and after the interview itself was pertinent to the area of study. I believe I had drawn such a boundary around the interview itself through a misguided sense of ethics and a fear of getting it wrong, but in fact I could have asked the participants for permission to record from the beginning. For instance, post-interview and post-recording I was given information regarding a legal complaint made against two participants which contained valuable data concerning

boundaries and touch that I was unable to use. There was also a conversation with one participant regarding her shame when faced with peers talking around this area.

"Through exploratory open-ended inquiry, self-directed search, and immersion in active experience, one is able to get inside the question, become one with it, and thus achieve an understanding of it" Moustakas (1990, p15).

Initially I was asking participants about their own experiences as clients, and then I chose a point to move to talking about their experiences as therapists with clients. Later, when I had moved to a more relaxed questioning style I noticed that the participants talked about their own experiences and then spontaneously made the link from this to their work with clients.

Double interview rationale

During the process of my Masters study I was frustrated to find that what seemed obvious to me at the time of interview required explication later. I had set up single interviews only with no facility for revisiting. Therefore I was unable to ask any supplementary questions and gain further understanding. When I embarked on this project I knew that I wanted to have the potential to have a second interview where I could ask further questions, allowing sufficient time for the participant to talk at their own pace. I interviewed eleven participants in all, aiming to obtain twenty-two interviews in total. I successfully completed eleven first interviews, but only eight second interviews, as three participants gave only one interview each for personal reasons, one participant completed two interviews, but withdrew at the time of writing up. Having undertaken the double interview process I feel that it did elicit the information I was looking for, and allowed me enough time between interviews to immerse myself in the data prior to re-interviewing. It did result, however, in a lengthy interview process which was hampered by the difficulty of getting busy people to arrange appropriate interview times.

One participant withdraws

Seventeen interviews were actually conducted with ten participants. The original aim was to achieve twenty-four interviews – two with each participant. I successfully recruited eleven participants to the study; one withdrew after interview, and three

participants were available for only one interview each. One of those participants was interviewed, but the recording failed meaning that only a very limited amount of data was available. I was very impacted by this interview and remember the content, so it was very frustrating not to be able to offer data from it. This study then became smaller than intended. An important participant withdrew after both interviews were completed and the data from this participant, and also that from the participant whose recording failed, has remained like a ghost within the work, influencing me and my thinking, but unable to be seen. This reminds me of how some clients bring their history into the therapy with them and it remains like a ghostly presence until it becomes possible to name and give meaning and narrative.

Mutuality and motivations of participants

When quoting from one of her participants Etherington (2004, p43) highlights the impact on the participant of the researcher and the researcher's agenda, "I am convinced that what I say to you now is very much influenced by who I think you are at this moment in time, and what you might want to hear from me". Some of my participants demonstrated this concept very clearly. One participant said at the start of the interview prior to recording "let me know if what I'm saying isn't what you're looking for", another seemed very concerned that she would get it right for me. My stance from early on in the process was an attempt to negate any hierarchical perceptions of the participants. I didn't feel 'one-up', quite the reverse, and I allowed this to be evident in the research process by the sharing of fears and failures. I feel now that this aspect of the interview was key, yet at the time I did not see it as forming part of the research itself. On studying the data, I did observe that the participants gave a largely positive view of regression. I think that there is a number of reasons for this: the participants are remembering experiences through hindsight having established a personal narrative for them and having made meaning from them. They have developed a language to talk about them and the feelings associated with them have been attenuated by personal therapy. When talking about their client work, they were more likely to talk about the difficulties with regression for themselves and their clients.

Participants' capacity to articulate

Hollway and Jefferson, (2000, p30) identify that Feminist research has criticised the inequality of the power balance and the objectification of the participant which results from the idea of the detached scientist and the subject of his research. I have sought to enter into a dialogue with my participants in which both are affected by the outcome. It is important that the researcher does not make the meaning for the participant, but addresses the meaning that they make of it. Feminists have stressed the importance of achieving symmetry of the interview pair. I used a semi- structured interview style as a guide for my participants, but I quickly revised my style after the first couple of interviews as I found that my participants gave me much more when I allowed them to talk about what was important for them, and I only prompted them when they dried up. I had given them a list of my questions at the beginning of the interview so that they were able to see what direction my interview would take. But after that I asked spontaneous questions as the need arose. I noticed that some participants were much more able to flow in their stories and this seemed to relate to two main points: their personality style and also how used they were to thinking and articulating from a theoretical perspective. Those who were in positions of trainer or writer were easily able to move from the experience to the appropriate theory or theoretical description of the experience, whereas those who worked more intuitively and were less used to thinking from a theoretical perspective struggled more with descriptions of the experiences. These two facts are also relevant to clients within the experience of regression to dependence itself. Those who have some understanding are less scared of the experiences, as with my participants, whilst those who are 'off the street' tend to be very frightened of their experiences. The provision and working through of a narrative helps, as it does when a mother is able to supply words for a child's experiences, connecting the pain with the experience. In this way the child learns to apply cause and effect through their experience and begins to organise their world. In looking at the work of Axline (Dibs 1964) and play therapy, the action or experience of the child is named by the therapist, acknowledging the child's self-agency and developing a story through language. When therapists help their client to understand a cause for their inner pain, such as a lack of attunement in infancy, and link it with the pain of misattunement and misunderstanding experienced in the here and now, the client is able to

acknowledge, understand and make sense of their pain which has previously seemed to come 'out of the blue' and be 'over the top' in relation to their current experiences.

When I began this research I wanted to ask therapists about their experiences both as clients and as therapists. I wanted to find people who could talk about their experiences in an articulate and theoretical way. I wanted them to have reflected on their process and for it to be largely processed and resolved and able to view their experiences both subjectively and objectively so that they were able to express their experiences without re-traumatisation or overwhelm and be able to apply reflexivity to them (Etherington 2003). It was important for them to have had a genuine engagement with this material, and that they had significant experience and understanding of the process itself. I specified that they should be Integrative so that they would be speaking in a common language. Most of my participants had other core training, but had integrated other approaches in order to be able to work with their clients more effectively. My participants are all experienced psychotherapists. All have expertise in clinical work, some have teaching, lecturing and writing experience. This has made a difference to how they are able to articulate their stories. Those who are used to teaching are able to think more theoretically about the experience, those who are clinicians are working and speaking more from instinct and are less able to articulate. Etherington (2003, p11) recognised this process when searching for participants for her 2003 publication, saying of her participants, "these people would have already begun to process their childhood trauma and would probably be at a stage where they could stand back enough to have a reflective grasp on their lives, whilst also being able to relocate themselves back inside their stories in order to write about them without becoming overwhelmed. These were ethical issues as well as literary ones". These issues were relevant to my research and the participants I chose had processed their experiences and were able to reflect upon them without overwhelm.

Reasons for entering therapy

My participants' reasons for entering therapy were varied. Some had sought therapy because of distressing personal symptoms, and some sought therapy because it was a requirement of their training. From the participants' perspective and from mine as

researcher these initial differences seemed to have no bearing on the level of their experience, or the level of their distress upon encountering regression.

Support of training structure

As the participants were all therapists the majority of them had the support of a training structure around them while they were in periods of distress and disorganisation. Trainers develop relationships with students as do training groups; both have knowledge and understanding of psychological processing, relational styles and theory and are able to offer support and understanding to trainees in the midst of their personal therapy. They also had the benefit of theoretical understanding, which many clients do not have. From my own experience this theoretical understanding helps to give a framework and form a narrative which relieves some anxiety about this process. This could be compared to the difference between facing a medical operation in the near future with all its uncertainty, and the operation having been some time ago with a successful outcome.

Difference between published accounts and the accounts of my participants

I consider that a differentiation can be made between published accounts and those from participants in the regression research. Margaret Little (1990) in describing her experience as a client sounds rather like my participants, whereas theorists presenting case studies of their clients describe processes which are much more chaotic, for example in the work of Adams (2006: 2009). Clients, who are experiencing some quite dramatic symptomology, may have little inner strength and be without external support and understanding. On reflection this means that the data available to me might have been somewhat different if I'd been able to interview clients who were not therapists.

Added value for participants

Participants described a value in thinking about the experience in a reflective way and with some distance from the actual events being described. As I was leaving a second interview the participant commented that she had not initially considered the benefits of sharing this story with me, but now recognised that looking at her experience from a

point of distance enabled her to think more clearly about it, and also gave further rationale for the way that she worked with clients.

Other participants told me that they valued being able to think theoretically with the researcher whom they experienced as being non-shaming, meaning that they could describe events and experiences that they may have hesitated to do in a different setting with a different researcher. I believe they found it easy to talk to me because I engaged in a dialogue with them, sharing my own experiences and difficulties. Finch (1984) recognises this in her article regarding interviewing women. She is describing the informality of women talking to women and how this avoids objectifying them, and also avoids a hierarchical relationship. From my perspective in interviewing both men and women I think the mutuality was brought about by the shared struggle to understand the issues being discussed. The potential benefits of research participation are also recognised by Wosket (1999), who considers that this negates the one-sided or exploitative nature of traditional research. She also recognises the value of subjectivity in the research process.

Experiences of the researcher

Shame and exposure in the interview

Initially, I was very anxious and fearful of appearing incompetent; some of my participants I considered to be more experienced than I and more professionally knowledgeable. I took this into the interviews and I was aware of my own shame process. It seemed also that the participants experienced shame, as prior to, and subsequent to recorded interviews, it became clear that they were fearful of getting it wrong for me, and wanted to give me the data I was looking for, showing me the positives of an experience that they practice and believe in. Shame was also evident at times within the interviews, as seen when asking Participant C about her own shame process she lost track of the question I'd asked and asked me "What was the rest of the question, please."

Fear of shame in the profession

There is a fear of shame in the profession, fear of being seen to be unethical or anti-therapeutic which has been in evidence since Freud. When people understand things differently, they are often seen as 'wrong' and not following the 'true path'. Johns (2009, pp234-235) identifies the need to stay safe within one's group because of fear of rejection. She draws this parallel between "Psychoanalytic establishments [who] may come to enact the role of the narcissistically damaged mother who demands loyalty and that the infant share her point of view". From this perspective "those who find independent points of view do so at the expense of loneliness and isolation". She considers that "owning oneself in one's work" is possible through the process of gaining independence and authenticity and dealing with the identifications that have been part of one's journey so far. I have also experienced shame and fear of shame when speaking of myself working in these ways which may differ from more usual ways of working and I have enlarged upon this in Chapter Nine.

Psychotic experience

One participant recognised the level of chaos and sometimes psychotic material which presents when working with this very early development of the self. She described to me her own experiences as a client, and also as a therapist. She considered that her ability to work within this area was recognised by her clients who allowed these aspects of themselves to come to the fore. After both of my interviews with this participant I left in a very disoriented state. I felt disturbed to my core and in a desperate need to return home. I recognised later that the parts of me which easily lose touch with reality had surfaced. Even though I was prepared for this in the second interview I was unable to prevent it from happening. Wosket (1999, p5) writes of her own experience of the effects of unconscious processes in a research interview, "I gained my first powerful experience of countertransference not in a counselling interaction, but in a research interview where I reacted punitively to a research participant who pushed one of my defensive buttons". There are many examples that can be seen from researchers and theorists which reflect the experiences of researchers and their emotions when conducting research interviews such as in the work of Etherington (2000; 2004), Ellis and Bochner (2000), Josselson et al. (2003) and Speedy (2007).

Terror

Two participants particularly focused on their experiences of terror within their therapy. In both cases I experienced terror myself, once during the interview and once immediately afterwards. The latter interview took place in a setting which I found particularly fear provoking because the street where the participant lived was unusual in that it had rear entrances and fences backing onto the street, which meant that there were no people around, or any sign of them. It was dark and to get to my car I had to walk past two large, barking and slavering dogs (Cerberus came to my mind) which were not restrained by the wall they were standing on and I feared they would attack me. I was also afraid of some unseen assailant emerging from the darkness. I experienced nightmares subsequent to these interviews which were reminiscent of my night terrors, but were without form and were experienced mainly as feeling.

Maternal need

While interviewing one participant I experienced through her description of her work with clients, her capacity to nurture, and an invocation of my own need for a mother. This felt both powerful and poignant and when I left I wanted to seek some closeness with another person.

Making judgements

Like Etherington (1996, p342) I acknowledge that my therapeutic training has added to the depth and quality of my interviews. She recognises that this could also be problematic because it was difficult "to hear subjects talk about resigning themselves to their condition without exploring their feelings and challenging their blind spots and assumptions". I became aware that at times in my interviews and when reading the transcripts I was making judgements about my participants' experiences, things like, perhaps their therapy hadn't been fully addressed, or that their ways of being with clients were not correct. I was uncomfortable with these thoughts, and I have wanted to ensure that I do not apply my assumptions and perceptions onto another's experiencing.

Conclusion

In this Methodology chapter I have aimed to show how my personal interest in the topic has led me to undertake this research. I have shown how I have considered my choice of

methodology using my beliefs about human beings, psychotherapy and my personal experience, and how I have used this reflexivity to develop my understanding and the research process itself. I believe that being a client who has received the sort of therapy which is at the centre of this work, a professional practitioner involved in this work and a researcher who is interested in this subject I have a unique position from which to explore and experience this phenomenon. Howard (1986, p63) considers that "experienced clinicians, by dint of their role, are the true torchbearers of research". Shaw (2008, p10) highlights the importance of the practitioner being the researcher, and how practitioners are actually researchers in their day-to-day work. He highlights the importance of the "therapist's body language, the countertransference that is felt in the body, seeing it as a valuable tool which can be shared in the therapeutic encounter".

 McLeod (2001) highlights the gap between psychotherapy research and practice. In his 2001 paper he considers that there is a crisis in the relationship between research and practice. He considers that much of this research has been dominated by scientific perspectives which objectify the client and therapist, and risks misunderstanding the phenomenon. Elkins (2007) discusses the limitations and failures of the medical model in psychotherapy. He aims to show that it does not describe the process of psychotherapy, but continues to dominate the field because of its ties with science, considering that it obscures the interpersonal nature of psychotherapy. He asks why the medical model persists when the majority of clients are not mentally ill, but struggle with living. From my perspective the relationship with the client, whilst being shown by evidence to be the key factor in client well-being, cannot be fully understood by the use of quantitative medical/scientific methodologies.

My hope is that the results and conclusions of my research will impact upon the way I work as a practitioner, the way that I work as a trainer and my ability to pass on this knowledge to other professionals. I would echo this quotation from Ross (1996, p552) "Research and scholarship engender humility in us. This is a function of knowing just how fragile are the foundations of our profession. We then behave with real vulnerability in our relationships with clients. Indeed, our ethic demands that we do our best for the client, best that can only be demonstrated by concern for questioning assumptions and refining techniques and theories".

My aim is to disseminate the outcomes of my research to practitioners, who I hope will view me as a fellow practitioner hoping to help them to apply my findings to their clinical practice. Toukmanian (1996, p64) considers that "The problem is further compounded when practitioners perceive researchers as primarily interested in methodology and theoretical formulations, and only marginally interested in the practical application of research findings to clinical contexts'. In telling my personal and professional story I hope to enable the reader to see me primarily as a practitioner aiming to develop my work with clients.

On the following page I have set out a table of themes and points of discussion. I have sited it here to introduce and provide an overview of the following five chapters which individually represent one of the themes which emerged from the participant data in this study. These specific themes were elicited by heuristic analysis of the data from participants and are the subjects of the individual chapters numbered from four to eight. Chapter Four addresses Regression to Dependence, Chapter Five addresses the Facilitating Therapy, Chapter Six addresses Terror-A Sickness of Spirit, Chapter Seven addresses Shame in Regression to Dependence, and Chapter Eight addresses A Question of Boundary. Theories, relevant literature and the points of discussion arising within these themes are contained within each specific chapter, together with participant data.

Table of themes and points of discussion

Themes	Points of Discussion
Regression to Dependence	- Seeking answers in theory - Historical perspectives - Transference - Infant development - Attachment - Trauma and cumulative trauma - Regression.... to Dependence - Regression and progression
The Facilitating Therapy	- Remembering and re-experiencing - The therapeutic setting and the holding environment - Affective attunement - Relational needs - Touch as therapeutic intervention - Establishing a narrative - Transference within the therapeutic relationship - Countertransference - Secure attachment - Ego boundaries - The use of transitional objects - Malignant regression - My experience of the facilitating therapy as a client - Real infants, therapeutic infants
Terror: A Sickness of Spirit	- Terror in infancy – terror in therapy - Annihilation anxiety - Primitive defences - Cumulative trauma - The therapist as transformational object - Countertransference as means of repair
Shame in Regression to Dependence	- Shame as normal human emotion, or as a destructive force - Shame and the therapeutic relationship - Metaphor and shame - Use of creativity
A Question of Boundary	- The therapeutic frame - Crossing boundaries - Regression and boundaries - Movement of ego boundaries - Adaptation of techniques - The real relationship - Boundaries and touch - Fear of litigation - The importance of supervision

<p style="text-align: center;">Chapter Four</p>
<p style="text-align: center;">-</p>

Regression to Dependence

"The advantage of a regression is that it carries with it the opportunity of correction of inadequate adaptation-to–need in the past history of the patient, that is to say, in the patient's infancy management" (Winnicott, 1958/1984, p261).

Introduction

The above quotation refers to the concept of regression to dependence, whereby it is seen that such regression allows for the possibility of a repair of environmental failure in infancy. This thesis considers therapists' accounts of their experience as clients and as therapists using a Relational Developmental theoretical perspective, which seeks to repair early environmental failures, seeing such clients as having sustained psychological damage very early in their infant development resulting in a variety of relational difficulties. Such clients may present with feelings of alienation, fear of emotional dependency, have difficult intimate relationships, fear of abandonment and being alone, feeling that life has no meaning, or feeling panicky and anxiety ridden, feeling that they are living behind an emotional façade. It was with these clients, whose struggle I recognised both personally and as their therapist that I found myself challenged to find ways of working effectively. This challenge resulted in my search for a supervisor who would help me to understand and develop theoretical and clinical strategies to manage the process, ultimately leading to Masters and now Doctoral studies.

This selection of participants' quotations begins to illustrate these experiences:

Participants C and I describe some of their experiences which brought them into therapy. Similar experiences have been frequently described to me as a practitioner. They describe their experiences in terms of physiological or psychological symptoms which were difficult for them to understand, and felt scary or alien:

> …in nursing and things like that I would be terrified a lot of the time, I would just be petrified…

> I just went into complete collapse, there was a whole lot of things happening in my life …that was like the crash point, but there was a whole lot of other stuff, that everything had just got too much, and I …suddenly just couldn't stop crying. I think I was anxious long before I got to therapy, I was very anxious…

> …literally feeling that my body doesn't, isn't together, that my arms and my body don't function together, that my legs don't function together,

The above participants seem to be describing a sense of disintegration and collapse which could be considered to echo theorists' descriptions of a return to an unintegrated state (Winnicott 1958; Van Sweden 1995).

Participants B and I below describe how as therapists they identify clients whose work will take them into areas of regression to dependence:

> … the thing that kind of stands out most predominant is the difficulties with object constancy… and the terror that then follows on and the inevitable polarisation of experience, I can't say that I've noticed boundary issues, I would say I've always noticed object constancy, I've always noticed a kind of really early shame,

> I'm not sure whether I do see it often to start with, my sense is that some of the clients that I've worked with in this way have come with a thick defence to start with, but that within that adult defence I've noted some 'kid' bits that don't quite add up to the adult defence...pettiness, kidishness, tantruminess…that hasn't quite fitted with the, the grown-up presentation, but I'm not sure I've always spotted it right from the outset.

> A hunger in certain clients that, that is evident from the beginning, that's little, and hungry from the beginning, and actually as those words come out of my mouth, that lets me know that this might be the level of work that we'll be doing,

Participant A uses a pictorial way of understanding his client, describing how he views their psychological damage, seeing it as their 'basic fault' (Balint, 1968):

> In my mind, it is MY impressionistic painting of the basic fault…

Participant H tells her client's story and how this was experienced within the therapy session:

…probably the most damaged client I've ever worked with…she was in and out of care up to the age of two, her mother was a prostitute, her primary attachment figure were cats, and she was taken into care at the age of two, underweight, not able to walk, with urine scalds down her legs, and into foster care after foster care placement where she was sexually abused and physically abused…so she's never known who her father was, never [known]who her mother was really, and very, very fragmented, and one day she completely collapsed, she went back to that pre-two period really where…she couldn't walk, she was lying on the floor…I could see her, it was like a domino run, going through all the shame, right down til all the dominoes were laid flat and she was collapsed…and I sat by her for seven and a half hours; I would not call the ambulance which would have been a real cop out, so I just sat by her, she's multiple dissociative identities of, whenever anybody came out and found a voice I would speak to it, soothe it, calm it,…terrifying, but I knew I had to do it, so I just sat there. Eventually she got up, eventually…she was…well, in a difficult place still, barely present. I managed to get her into my car and took her home….and after that she began to trust me…I think she knew she'd shown me the length and depth of her damage… I suppose to put it bluntly, having the balls to stay there.

Participant H relates how her client conceptualises her inner world:

'…it feels as though there's a part of me not yet born, that's left behind'

and she identifies how she understands it:

She's come up with that idea herself, and sometimes she's lost in a kind of speechless, nowhere land, you know, just, just not present, and it's felt as though there's something in there that's been more foetal, pre-verbal…

In this chapter I will identify aspects of theory, moving through historical perspectives towards more contemporary theorists, which are relevant to these issues raised by participants. I will apply theoretical constructs to illuminate the experiences described by the participants. I will explain the place of transference in Integrative Psychotherapy and describe theoretical understanding of ideal infant development which supplies a good environment in which the innate potential of the infant can develop. I will also introduce theoretical understanding of the influence of such environmental failure upon infant development, and the potential for trauma as a result. Having explored infant development I will then describe what I mean by 'regression' itself, and 'regression to

dependence', and how this is considered to offer the prospect of psychological progression.

Seeking answers in theory

My Integrative theoretical orientation owes much to Object Relations theory and it was into this field that I first looked for answers. How to more effectively help such patients/clients is an important question for me and a question that has occupied the thoughts of practitioners and theorists for many years. The original psychoanalytic position presented by Freud viewed the mind as monadic, that is, a unit operating and developing by and of itself. Later relational theorists viewed the development of the mind as occurring in the relational matrix. Mitchell (1988, pp17, 19-33) considered that the "mind has been redefined from a set of predetermined structures emerging from inside an individual organism to transactional patterns and internal structures derived from an interactive, interpersonal field". He writes that "the individual mind is a *product* of as well as an interactive participant in the cultural, linguistic matrix, within which it comes into being. Meaning is not provided a priori, but derives from the relational matrix. The relational field is constitutive of individual experience". He explains that "for Kohut, as for Winnicott, the establishment of reflexive stability is the central motivational thrust in human experience, and relations with others and the roles they play in this pursuit is the primary context for human experience".

As a paediatrician Winnicott (1975, pp170-171) observed similar processes occurring between mother and infant, and between himself and his psychotherapy patients. When studying human relationships he stated that the "paediatrician and the psychiatrist badly need each other's help", feeling that "those who care for infants…can teach something to those who manage the schizoid regressions and confusion states of people of any age." "I am saying that the proper place to study schizophrenia and manic depression and melancholia is the nursery".

Those practitioners using Object Relations theory to understand the experiences of their clients view that the troubling symptoms experienced by some of their clients have their roots in their early infantile relational experiences. Erskine and Trautmann (2002) describe the process of Integrative Psychotherapy referring to the integration of theory with a perspective of human developmental tasks and needs. The theoretical foundation

focuses on child psychological development, the understanding of attachment patterns and the lifelong need for relationship. In this formulation of the therapeutic process it is considered appropriate for the therapist to use his or her self experiencing to assist the integration of developmental process through the client's childhood needs, their experience process, and interventions, including touch and holding, as dictated by the perception of the client's developmental age regression. The rationale for this is further supported by reference to Fairbairn's (1952) argument that the need for relationship is a primary motivation in human behaviour and the disruption of contact results in needs being unmet. Developmental research shows that the sense of self and self-esteem emerge out of contact-in-relationship (Stern 1985). Other theorists (Erikson 1950; Mahler 1968; Bowlby 1969; 1973; 1980) wrote of the significance of the early infant relationships, through which experiences of self and other emerge.

Interest in the nature of human relatedness led Bowlby (1969; 1973; 1975) to understand that the nature of human beings is to be drawn together. He considered that for the infant to survive its need for its mother to supply the physical and emotional needs was primary. It is this intersubjective view of the mind that underpins Relational/Developmental psychotherapy, and therefore this thesis, but I am mindful of Mitchell's (1988, p22) point that "current thinking about infants, like all psychoanalytic ideas, is a blend of facts and theories and is presented here as an example of a way of thinking, a conceptual strategy, not as incontrovertible truth". Mitchell (1988) recognises Bowlby's contribution, but highlights that 'biological, physiological and psychological' primacy of the early relation of the child to its caretakers has emerged from another field entirely – infancy research, and it is from this field that Winnicott, a paediatrician and psychotherapist, finds his experience and understanding. These, along with other Object Relations theories are used to underpin the stance within this work.

The group of patients which are the focus of this study was identified by Winnicott (1958/1984, pp279-280), who emphasised that the therapist must specifically address "the early stages of emotional development before and up to the establishment of the personality as an entity". He considered that the treatment techniques developed by Freud and Klein were ineffective because of the level of maternal deprivation experienced by such patients. This resulted in an inability to benefit from traditional

Psychoanalytic technique because they would require the ability to identify thoughts and feelings and verbally communicate them to the analyst. These theoretical constructs seem to describe the clients I was seeking to help and also connected with the experiences described by my participants.

Participants E and B describe aspects of their regression which left them wordless and lost:

> …an overwhelming…sense of a kind of lostness and disconnection…of regressing to a kind of wordless state…

> …I couldn't find the language, though…and I know I knew, but I didn't have the language for it…

Theorists such as Ferenczi, Balint and Winnicott had encountered such clients and concluded that treatment was possible for these patients, but would require different techniques to enable the patient to come to 'a regression in search of the true self.' It should be noted that at this time therapy was not relational in the way that it would be understood now, that is, where the self of the therapist and the relationship between therapist and client play an important part within the therapeutic relationship. The Object Relationists were advocating a move away from the traditional analytic techniques which were prevalent at the time, but even with these adjustments which were suggested for particular clients, the therapy would still have been much more formal than would be recognised by many therapists today.

In his seminal work on regression to dependence Van Sweden (1995) identifies the following four premises which lie behind his theoretical stance: a) that in working with clients with pre-oedipal disorders of maternal deprivation a change from aspects of the usual analytic stance of abstinence and interpretation is necessary: b) that the early months of life are the main focus of the therapy, and that the transference relationship is the vehicle through which these early experiences are replicated and worked through: c) that complex defences have developed resulting in a high functioning client which may mean that these deficits are missed in the therapy: d) that the therapist's response, survival and containment of the return of the client's primitive experiences within the therapy can result in progression, enabling a second opportunity to achieve ego

integration. As an Integrative Psychotherapist I would agree with this stance, but my way of being with a client would be different from that described by Van Sweden, as I do not practice as an analyst, I do not hold an analytic stance with any of my clients. When working with regression to dependence, I may adjust the boundaries of my usual therapeutic stance, particularly those around contact outside sessions and touch. It is important to recognise that there are other theorists holding different positions. Whilst Mitchell (1988) would recognise the importance of Object Relations theory in understanding human development and the connection between the client's infancy experience and their needs of their therapist, he would take issue with the concept of seeing a client as having past omissions and developmental gaps repaired. He believes that this is a distortion which omits the adult relational needs of the client. He cautions against the highlighting of regressive needs above other aspects of the relationship. I think this is an important point, however in looking at the relationship overall and over time, the regression to dependence relationship has phases of intensity, but at any one time all relational facets may be present to some degree. It is important not to forget the importance of the person to person relationship (as opposed to the transferential one) and the normal relational needs which present in any relationship. In my experience, rather than seeing a regressive phase which is clear and distinct, which clients approach and then move away from, I have experienced an overarching movement to deeper levels of regression over the course of therapy but also that clients may move in and out of regressed states within any session. Clarkson (2003) identifies five facets of the therapeutic relationship, these are: a) the working alliance; b) person to person; c) transference/countertransference; d) developmentally needed; and e) existential. She considers that all of these facets may be present at any time. The regression to dependence process has a focus in the transferential/countertransferential and developmentally needed facets, but will also involve the working alliance, the person to person and possibly the existential.

Before exploring further the process of and rationale for regression to dependence it is necessary to look in detail at some history of the development of psychotherapy, and then at how psychotherapists understand and are informed by aspects of developmental psychology.

Historical perspectives

Freud (1900; 1905; 1915; 1933; 1940) formulated that psychopathology developed from conflicts as the individual moves from the dyadic relationship between mother and infant, to the triadic relationship of the mother, father and child, 'three-person psychology'. He considered that instinctual drives were the motivation for individuals, only incidentally moving them towards others. The analyst's role was to be non-judgemental and emotionally uninvolved, viewing themselves as mirrors on which the unconscious ideas and beliefs of patients would be revealed. Patients were helped with their psychological difficulties by bringing the drives that were in the unconscious into consciousness, therefore allowing the patient to understand and work through their issues. The therapeutic task then was to help the patient to become aware of these unconscious processes, making them conscious and under the command of the will, and therefore available for change. To achieve this the analysand must be able to recognise and verbally communicate thoughts and feelings to the analyst. Any emotional impulses would be spoken rather than acted out, with behavioural acting out being seen as resistance to the analytic process, this then requires a high degree of sophistication in the psychological processes of such clients. This meant that more disturbed and distressed patients who acted out and who were unable to verbalize their experiences were considered un-analysable. There were other theorists however who were willing to try to work with patients who did not fit these criteria.

Ferenczi, (1931; 1933; 1988) a student of Freud, was known for working with such patients. He, and other Object Relations theorists, have sited the roots of psychological disturbance within the dyadic relationship, considering that patients who were not available for interpretive Psychoanalysis could still be effectively worked with if there were changes to the way in which the therapy proceeded and in this way started to move away from the analytic stance to what I consider to be a more client-led model. He believed that in order to heal, some patients needed to regress to a former developmental state, prior to the time when they were psychologically damaged, whereas Freud would have viewed these regressions initially as resistance to analysis.

The therapeutic dyad being used to reveal unconscious processes enables both client and therapist to identify deficits within early relationships, and through the therapeutic

process have the potential to allow relational deficits to be responded to and repaired. Thompson (1943, p64) cites Ferenczi's understanding of this process "With patients in whom a severe depression dominates the clinical picture from the start the regression is likely to go further, and demands may be too primitive for the ego to mediate", considering that the inability to work with such patients was more to do with the lack of skill on behalf of the therapists rather than the patient's incurability. Thompson identifies Ferenczi's understanding of therapeutic repair "the patient is ill because he has not been loved, and that he needs from the analyst the positive experience of acceptance, i.e. love". Van Sweden (1995) also highlights Ferenczi's perception of the relationship in regression (1931, p137) as "like that of an affectionate mother" and thought that "adult patients, too, should be free to behave in analysis like naughty (i.e., uncontrolled) children" (p132). He considered it necessary to focus the analysis upon the child ego state within the adult, considering that the analyst's presence was important within the relationship and that the process between therapist and client would enable past traumas to be re-lived emotionally within the therapeutic relationship. The traditional unyielding stance of psychoanalysis was considered by Kohut (1971; 1977) and Gill (1982) to be experienced by the client as rejecting and could repeat the wounding received in infancy.

Klein, (1957; 1959) a contemporary of Freud, considered the relationship with the mother to be the formative one, and that the source of psychological disturbance was in the dyadic relationship. This stance was also held by other influential theorists such as Winnicott, Fairbairn, Guntrip, Balint and Kohut. These theorists (known as The British Object Relations School) viewed the dyadic relationship as developmentally key and the therapeutic relationship as fundamental to the successful outcome of therapy. Balint (1959; 1968) placed high importance on the value of the regressive experience seeing that in the therapeutic setting it offered an opportunity for reparation. Both Klein and Winnicott were in a position to observe the behaviour of infants, and drew conclusions about their internal experiencing as a result of these observations. Through his experiences as a paediatrician Winnicott highlighted similar behaviours in his adult patients who were in distress to those that he saw in distressed infants. This was a move away from Freud's understanding of the infant living in a completely narcissistic state and unable to distinguish the other as separate, towards a model of psychology which

focuses on the dyadic, intersubjective relationship between mother and infant. This relationship, once formed, is considered to be carried with the individual into adulthood.

In his paper on True and False Self (1960, p141) Winnicott comments that "experiences have led me to recognise that dependent or deeply regressed patients can teach the analyst more about early infancy than can be learned from direct observation of infants, and more than can be learned from contact with mothers who are involved with infants since what happens in the transference (in the regressed phases of some patients) is a form of infant-mother relationship." He considered that "it is possible to establish a clinical link between infant development and the psychiatric states, and likewise between infant care and the proper care of the mentally sick" (Winnicott 1958/1984, p158). His observations of what he considered to be normal infant development led him to believe that "The mental health of the human being is laid down in infancy by the mother, who provides an environment in which complex, but essential processes in the infant's self become completed."(p160).

'Two-person psychology', the psychology of the in-between of relationship, the intersubjective, was the focus for Balint (1968) based on his analytical experiences with patients, putting the interaction between caregiver and infant at the centre of developmental theory, and identifying the possible source of some adult clients' difficulties as being the experiences of their early infancy (Van Sweden, 1995). When attempts to connect in infancy fail, Hedges (1994, pp4-5) considers that they remain "imprinted on the psyche". He views these infant scenarios as reappearing "in the psychoanalytic relationship as replicated transference modes of interacting that pervade our character and body structures." It is these theorists, in making the link between infancy and clients in therapy that form the underpinning for this theoretical stance and so allow for the concept of therapeutic relational repair.

The following participant, D, describes her experience of regression in therapy:

> "…but in my analysis feeling that all of life was draining away from me was… a very terrifying place because I thought I would lose contact with my analyst"

Participants C and G describe how their understanding that the source of their difficulties seems to relate to their childhood experiences has been gained through the therapeutic process:

> …well I wouldn't have known that it was going to be regression when I went into the therapy, I thought I was perfectly adult. I didn't know what therapy was anyway, but I realise looking back now and at the time I knew I was very anxious. It reached a point where I would just walk through the therapy room door, and I could just feel myself becoming two or younger… not a nice feeling, tremendous, I definitely needed to go there because I think I was there most of my life, but totally unaware…

> It wasn't something I did, it just happened.

> Well, I recognise that if I was in situations where there was a lot of anger around me I completely dissociated… in terror, which was about my dad's rages…and I wouldn't be present, but I would look like I was, and that happened to me at work, and you know, all over the place really, and I think I spent a lot of time dissociated in a way that I don't any more… without…and it was around rage as if there was anger around, and I would sometimes dissociate in the train,

It is clear from these extracts that the participants understand their experiences through the construction of the infancy narrative. Their therapists are likely to have held this view of the phenomena, and their own training would have also supported this view. Clients who are not therapists may not hold this perspective until it is introduced to them through therapy (Stern 1985). Other theoretical orientations may view these experiences differently and I will comment upon this further in the conclusion of this chapter.

Transference

"Those who do not remember the past are condemned to repeat it." (Santayana 1905)

If we accept the Object Relationist stance in asserting that the way that infants develop and behave and the way that regressed patients behave have similarities, then knowledge and understanding of developmental theory can be seen to supply important information for the therapist. The early relationship with the mother, or primary caregiver, recognised as the key relationship for infant development, can be seen as a

model for the sort of setting and the type of relationship required to address issues which stem from this period. It is this developmental theory which is the basis for working with regression to dependency and it is the concept of transference and countertransference which means that a new experience between therapist and client is possible.

Transference was initially seen as a defence against remembering when it was first described by Breuer and Freud (1895; 1955). Later (1905), it came to be seen as one of the main elements of Psychoanalysis, where it was recognised that some patients' communications were in response to archaic relational conflict rather than as a response to some current environmental situation. Transference can be defined in this way: "The transference/countertransference relationship is the experience of 'distortion' (Freud's word) of the working alliance by wishes and fears and experiences from the past transferred (carried over) onto or into the therapeutic partnership"(Clarkson 2003, p11). Jacoby (1984, p17) views transference thus, "In his relationship to the analyst the patient repeats and relives the love, hatred, aggression and frustration he experienced as an infant in relation to his parents." In this formulation patterns of relating which originated in childhood are seen to be repeated by the client in their significant relationships, including the therapeutic relationship. Maroda (2004) defines transference as the conscious and unconscious responses, affective and cognitive, of both therapist and client. Levy and Scala (2012, p400) define transference as "a tendency in which representational aspects of important and formative relationships (such as with parents and siblings) can be both consciously experienced and /or unconsciously ascribed to other relationships" (Levy 2009).

Further insight into the process of transference within the therapeutic relationship can be found in the work of: Heimann (1950); Langs (1976); Racker (1982) and Cashdan (1998).

Participant C acknowledges how important the therapist has become to her, and the significance of the relationship:

> …I also couldn't bear the idea of her having other clients…I just convinced myself I WAS the only one, and she only had the others because she'd got to earn a living, and that way I could just tolerate it…

Without the understanding of early infancy narratives and infant psychological development, this extract could convey something akin to romantic jealousy, however, from my theoretical perspective romance and romantic encounters also have their roots in early infant relationships and, like me, Clarkson (2003) would recognise this as a transferential relationship. She identifies the transferential/countertransferential (the experience of the therapist) relationship to be the unconscious wishes and fears transferred onto or into the therapeutic partnership. Therefore, the client will eventually bring their wishes and fears for relationship into the therapeutic arena for re-enactment and resolution.

From this formulation of relationships Participant I below could be considered to be experiencing a re-enactment or a reprise of a significant relationship which is now transferred into her relationship with her personal therapist. It could also be considered that the historic relationship with her parents who shamed her for her needs was transferred into the therapeutic relationship:

> …but also me seeing in the transference that she was irritated with me, angry with me… me seeing all of that and working to break that, that transference, 'cos that was always there, I would always see her irritation, I would always see her annoyance at me…

It is considered by therapeutic approaches which recognise and work with the transferential aspects of the relationship that the client may be able to tell the unconscious components of their story through the unfolding of the transference. The therapist's task then is to understand their part in the story. The emergence of transference within the therapeutic relationship and the potential re-enactment of the mother/infant relationship within the therapy then has the potential to be beneficial in the client's development. From this construction the client presents their story into the relationship in a 'live' way and this allows the possibility for whatever failed in the early relationship to be seen and repaired in the current therapeutic relationship. Theoretically then an understanding of the processes involved in that early infant relationship is necessary. The therapist's response, their countertransference, will be explored later in this chapter after I have presented theories describing the type of infancy relationship which can be considered as enabling an infant to develop their full potential.

Infant development

The good enough mother

The theory of the ideal parent/infant relationship sees the infant, with its inherited potential, ready to meet a facilitating environment which is responsive to it, initially totally, then appropriately, given the rate of development of the infant. In this ideal setting the infant is not challenged with more than the level of its development can tolerate, allowing the infant to develop a "continuity of being" (Winnicott 1960, p47). The alternative to this is reacting, and reacting interrupts the "continuity of being" and annihilates. The mother, who is the facilitating environment, recognises the infant's needs and level of development through her attunement, and only allows such stimulation as is tolerable to the infant. In this setting the infant is able to process such experiences as occur, and to make meaning of them. Winnicott describes it as "the ego-support of the maternal care enables the infant to live and develop in spite of his being not yet able to control, or to feel responsible for, what is good and bad in the environment."(p37). He considers that "infants come into being differently according to whether the conditions are favourable or unfavourable."(p43). A key point is that while the infant's inherited potential is a fact, this potential can only develop when linked to maternal care. Where dependence is adequately met, the child achieves healthy interpersonal relationships and is resilient enough to deal with personal conflict.

Mitchell (1988) cites Bion's (1957) characterisation of the mother's holding functions in relation to the infant's inchoate experience, using the metaphor of the 'container'. Mitchell (1988) also identifies the importance of the development of the self in both ego psychology and, of course, in Winnicott's and Kohut's work.

Maturational developments depend on environmental provision. The facilitating environment makes possible the steady progress of maturational process. The environment does not make the child, but allows the child to develop up to its potential.

Winnicott (1960, p89) describes the early stages of emotional growth:

- The individual inherits a maturational process which meets with a facilitating environment which is adapted to the changing needs of the individual.

- The individual proceeds from absolute dependence to relative dependence going towards independence. In health, development takes place at the appropriate pace.

- The facilitating environment – described as holding, moving into handling and then to object presenting.

- In this environment the individual undergoes development – integrating towards in-dwelling and then object relating.

In absolute dependence, where the mother supplies the auxiliary-function, the infant has not separated out the 'not me' from the 'me', seeing that the mother's "primary maternal preoccupation" enables her to know about her infant's earliest expectations and needs, and makes her personally satisfied in so far as the infant is at ease through it, the mother knows how to hold her infant and the baby can then start existing and not purely reacting (Winnicott 1974, p341).

The true self is its own source of action, a notion which is closely linked to the philosophical theory of the transcendental ego. This is the radically anti-deterministic view that the person has within him/ her, a source that cannot be explained by antecedents alone. Freedom then is the capacity to act from this source. Winnicott's theory is that the mother, through her spontaneous responses, is able to bring this source of creative activity to birth (Symington 1986).

The self-regulating process between infant and mother is described by Lewis (2004, p5) "The parent or caretaker is the auxiliary ego for the infant during its prolonged period of total dependence. The parent senses the inner needs of the infant and gratifies them; the parent is the buffer between the external world and the infant. Sudden noise, temperature change, positional change are avoided or tempered by a reasonably attuned parent". "Reasonably attuned" covers a broad spectrum: there is a tremendous range of what constitutes adequate empathy as a particular mother and infant get to know each other. This question of the parent as auxiliary ego is well covered in the literature of ego psychology. The parent is not just gratifying the infant: she or he is really helping it to organise itself. This positive and specific function of helping the infant to control and modulate its movement and feeling is taken for granted in a reasonably healthy

mother/infant dyad. The biological aspect of this relationship is addressed by Bowlby's (1969) theory of attachment. Attachment theory recognises the search for relationship for protection and support. An infant seeking proximity is seen as a response to a distinct biological motivational system involving intense emotion. Bowlby and subsequent Attachment theorists consider that the patterns of affectional bonds occurring throughout life depend on the way that their attachment was formed in infancy.

I will now explore what happens from this construction of infant development when an ideal attachment bond does not develop and when an ideal facilitating environment is not available.

Failure of the facilitating environment

Winnicott's (1988, p131) formulation of infant development identifies that in the earliest stage of development disturbing happenings are unable to be experienced or integrated by the infant because they "have not yet reached a stage where there is a place to see from". Tarrantelli (2003, p916) cites Blanchot's (1986, p28) identification of the same process as "a non-experience…which…cannot be forgotten because it has always already fallen outside memory." Little (1990), in giving her personal record of her analysis with Winnicott, describes her regressive return to disorganisation and anxiety that she experienced during her therapy, clearly outlining the infantile roots of this experience. She concurs with Winnicott's assertion that environmental provision is necessary to manage these experiences within the therapeutic relationship. Erskine (2007) also recognises the impact of pre-verbal trauma, whether acute or cumulative, on the individual which may not be available to consciousness because of the pre-verbal origins, yet surfaces at points, usually times of stress, throughout adult life.

Lewis (2004) asserts that parents with their own unmet developmental needs can fail to help their infant to develop self-regulation. He describes dissonance being laid down in the cells, autonomic nervous system, and energy centres of the infant. He identifies this dissonance as the basis of falling anxiety and premature ego development which from a relational and developmental perspective could be formulated as a fear of letting go, and a split into thinking to avoid feeling. This has emerged in client work when the client experiences a desire to let go of control and 'rest' with the therapist in order to

experience dependence. When this emerges in therapy a fear of falling, or of being dropped, can be manifested. For me as a client this manifested as a fear that my therapist couldn't 'hold' me. Bion (1962, p116) posits that where the mother is an inadequate container for the child's indigestible feelings he remains in a state of "nameless dread". This could then be seen to lead to psychopathology, where it may remain to re-emerge in adulthood.

The argument that the ruptured strivings for human contact in infancy can be manifested in adulthood and in the therapeutic relationship is constructed by Hedges (1994, pp5-6). He identifies this as the continued search for the lost mother of infancy, the empty place where the needed love and acceptance were never received, which has left "its own definite and indelible mark on personality". This "living record of failed connection" leaves them searching for a relationship to fulfil the need and complete them, a stance taken by both Freud, (1953) and Van Sweden (1995). This search for that lost mother of infancy then continues into adult life and is the premise of this study.

Participant C describes her experience which she formulates as the re-emergence of infantile trauma into her adult life:

> …triggering a very scared child inside of me… and from that place of scare, you know, completely losing touch with what was happening in the moment, and re-experiencing quite strong emotions, that I couldn't put words to, or understand or explain, and often quite strong physical reactions, like my arm shaking and not knowing why my arm was shaking, or my leg twitching up and down for…my body was remembering, I would realise that my body was remembering things that I didn't know what they were…

Bodily and psychosomatic manifestations are interpreted by some theorists as residue of traumatic experience. Hedges (1994) considers that infantile emotional pain can be ascribed to various aspects of the body, and trauma theorists such as Solomon and Seigel (2003), Etherington (2003) and Ogden et al. (2006) recognise the connection between the body and traumatic experiences. Winnicott's (1958) construction of the infant's developing mind sees the infant experiencing from a body/mind perspective where experiencing is both 'think' and 'feel'. It is also important to identify the essential role of the body in dyadic regulation (Ogden et al. 2006). Based on his experience with mothers and their infants Winnicott theorised about the development of

the mind from the psyche-soma (the whole of a person, mind and body), seeing that the early psyche-soma proceeds in its development "provided its continuity of being is not disturbed; in other words for the healthy development of the early psyche-soma there is a need for a perfect environment". This is considered to be an absolute need whereby the environment adapts to the needs of the infant and when there is a failure to adapt the infant "must react", so disturbing its development. Initially these needs are physical, but eventually become emotional, psychological and social. Over time, if the infant's needs have been adapted to sufficiently, the infant's mental activity becomes able to allow for any deficiencies. Winnicott (1949) considers that it is also important that this initial perfect adaptation should become a graduated failure of adaptation according to the infant's capacity to allow for it by mental activity or understanding. He considered psychosis as "an environmental deficiency disease", and that when the infant's environment is not responsive to its needs then there can "develop an opposition between the mind and the psyche-soma" whereby the infant starts to care for itself in ways which should be the function of the environment, thus Winnicott considers that the infant prematurely takes over this function, placing a strain on "mental functioning" and "self disorder" (Winnicott 1965, p56). The infant's self, identified as "inherited potential which is experiencing a continuity of being" known as the True Self (Winnicott 1960, p280) which begins to have life through the strength given to the infant's weak ego by the mother's implementation of the infant's omnipotent expressions (p145). This means that the mother's preoccupation, a sort of sensitive attunement, with the infant and its needs, enable it to develop a sense of its own continuity over time, as Winnicott says, a sense of 'going on being'. The mother's implementation of the needs of the infant results in the development of a sense of 'I-ness' which will become the True Self. He considers that the holding environment has the function of reducing the number of impingements to which the infant must react, and must provide for physiological needs. As physiology and psychology have not yet become distinct the environmental provision should be reliable, but not in a mechanical way, being based on the mother's empathy and attunement and therefore adaptive to the needs of the infant. Holding protects from physiological insult, takes account of the infant's skin sensitivity to touch, temperature, auditory sensitivity, visual sensitivity, sensitivity to falling and of the infant's lack of knowledge of the existence of anything

other than the self. It follows the minute changes of the infant's growth and development. Holding includes especially the physical holding of the infant which is a form of loving, maybe the only way that the mother can show the infant her love. The basis for instinctual satisfaction and for object relationships is the handling and the general management and care of the infant. Symington (1986, p313) identifies that, from Winnicott's perspective, if mother has not responded to her baby appropriately it puts up a protective screen to protect the true self. The primitive fears of invasion, annihilation and breaking to pieces are felt. The true self does not become a living reality unless the mother repeatedly meets and affirms it.

In this view, the mental health of the individual in the sense of freedom from psychosis or liability to psychosis is laid down by this maternal care, "It is in the years of one and five that the foundations of mental health are laid and here too, is to be found the nucleus of psychoneurosis"(Winnicott 1958, p 7).

Hedges (1993) uses the phrase the 'organising experience' in relation to the process occurring within the infant within the first few months of life, maybe even in the womb. This phrase has also been used by Yorke (1986) and by Stolorow and Atwood (1992) to designate a state of psychological organisation. When the infant fails to organise mental activity because of the absence of a present and attuned mother, it organises around aspects of itself, becoming aversive to contact with the primary nurturing object, that is, the infant fails to attach to a mother who is unavailable. This phenomenon is referred to by Grotstein (1994) as an early massive dissociation of the personality, and he quotes a variety of other theorists describing this period as 'infantile catastrophe' (Bion (1962; 1963), 'failure to go on being' (Winnicott 1952), 'annihilation anxiety' (Mahler1952; 1958; 1968; 1972) and 'black hole anxiety' (Tustin 1966; 1972) and (Grotstein 1990). He also describes this as Balint's 'Basic Fault' (1968). An increased understanding of infantile development has enabled increased understanding of this early process.

Attachment

In his 1988 work Bowlby described the applications of attachment theory developed during his previous writings (1969/1982; 1973; 1980). He propounded a model of the development of the attachment bond between infant and primary caregiver, seeing the infant leading the relationship, and the mother/caregiver sensitively responding. The

mother's response to the infant's cues (her attunement) leads the infant to adapt either towards, or away from, cooperation with her. Those infants receiving attentive loving care will view themselves as loveable, developing secure attachment behaviours while those whose comfort-seeking behaviour is dismissed or rejected will see themselves as unlovable and will develop insecure attachment behaviours.

From an attachment theory perspective chronic misattuned dyadic interactions can result in disorders of attachment. Attachment theory describes the nature of significant relationships between humans from their development in infancy through to later life (Bowlby 1969).

Trauma and cumulative trauma

Having explored the results of environmental failure upon the developing infant it is evident to me from this construction of human development that where provision fails and deprivation results, trauma could be experienced by the infant. Winnicott (1958/1984) described maternal failures as 'impingements' upon the infant's experience, affecting its sense of 'going on being'. He sees that frequent and serious impingements can lead to failure to develop a sense of being real and a fear of annihilation with most impingements occurring because of misattunement between mother and baby. In Winnicott's view, during infancy the ego is too immature to manage the 'primitive agony' of serious and frequent impingement leading to the development of a False Self defence and 'self disorder' (1989, p91). He coined the term 'false self' to describe a defensive organisation in which the protective functions of the mother, which are unavailable to the infant because of misattunement, are instead taken over by an aspect of self. The taking over of this function allows the infant to adapt to the environment whilst protecting and hiding the source of personal impulses, viewed as the 'true self'. The 'true self' then could become sequestered to avoid the risk of annihilation when impingements are too severe and too frequent. While being protected by the 'false self', opportunities for 'true self' living were limited by the actions of the 'false self'. He considered that the 'true self' was the source of spontaneity and real impulse, and for this aspect of self to function at its fullest someone else would need to take over once again functions which defend the 'true self' (we will see later that this role is within the domain of the therapist). In the regression the client returns to a

developmental phase which is incomplete, and this has previously been managed by the development of defences to compensate for this incompleteness.

Trauma can take the form of easily identifiable events, such as abuse or physical neglect, but also can involve repeated less discrete but more pervasive accumulations of misattunements which are traumatising to the young infant who does not have the psychological reserves with which to manage overwhelming and painful emotions. This is known by some theorists as cumulative trauma. The concept of cumulative trauma is identified by Khan (1963) as resulting from the lack of fit between child and parent, and as a specific traumatic childhood experience based on continuous environmental failure (misattunements) from a caretaker in infancy (Lourie 1996), leading to psychopathology. Fosha (2003, p226) also recognises the impact of cumulative trauma "the sequelae of trauma and neglect not only become evident in the dramatic disturbances of PTSD, but also make themselves known and felt in the havoc wreaked on social relationships and the devastating ruin of a baseline of well-being". Lourie (1996) sees the result of these failures as having an impact on the child's developing relationships into adulthood with both themselves and others. To manage these feelings requires the development of defences, initially to protect against the effects of further failures. She considers these defences from the perspective of bodily armour which was donned in infancy and remains so into adulthood.

Hurvich (2000, p82) quotes Rothstein (1983) regarding the unconscious presence of the early traumas of infancy, "the primal traumas and therefore the primal danger situations are derived from pre-verbal memory traces of experiences of mounting tension that never become conscious in the true sense and are in a state of primary repression. The infantile ego's experience of these primal traumas is influenced by its 'basic core' (Weil 1970) and by the quality of its caregiving environment". Hurvich also acknowledges the mother's role as the protector against over-stimulation, citing among others Khan (1963), Searles (1965), and Winnicott (1958).

When the facilitating environment does not appropriately match the needs of the infant, the resulting psychic disturbance is described by Balint (1968, pp19-22) as "the basic fault". He considers that this fault which develops in infancy can remain for the whole of a person's life "it is a fault, something wrong in the mind, a kind of deficiency which

must be put right. It is not something dammed up for which a better outlet must be found, but something missing". His theory of "new beginnings" required the patient to be capable of regression, that is, a return to the area of the "basic fault" in order to re-emerge with the capacity for a mature object relationship. Winterson (2011, p145) identifies that "the past is so hard to shift. It comes with us like a chaperone, standing between us and the newness of the present – the new chance".

The words of Participants I and E describe their experiences prior to regressive therapy:

> Now I could see that sort of forever being on the edge of relationship, forever getting a bit of relationship, seeing the possibility of that opening up slightly more, and then feeling short-changed, feeling like I couldn't quite have enough,

> …an overwhelming….sense of a kind of lostness and disconnection…and then feeling intense pain (of need).

Winnicott conceptualised similar experiences in his 1974 paper entitled "Fear of Breakdown" where he described the ego's inability to encompass intense emotional experiences, a view with which Erskine (2007) concurs. Psychosis is seen as "the defensive organisation designed to protect the self" resulting from failures in the infant care process. He described the infant in a place of psychotic anxiety with feelings of annihilation, going to pieces, falling for ever, having no relation to the body, having no orientation in the world, and complete isolation without means of communication. In his view, these horrors surface in later life as psychotic or borderline-state anxieties in which one's very being seems threatened. Rather than its present-day association with schizophrenia, psychosis is used in its original sense to denote a loss of contact with reality, strange experiences and a sense that personality is fragmented or dislocated in some way.

Participant D gives us this example:

> …to the regression that I experienced as being in such a deep, dark place that it was, it still is, quite hard to talk about it… I built myself a couch on the couch, and got a blanket and for about two to three days just stayed in a crazy place….I was in and out of consciousness all the time…..I felt feverish, sick…

Winnicott viewed the infantile ego as too immature to manage the 'primitive agony' of serious and frequent impingement (1989, p91), resulting in the development of a False Self defence and 'self disorder', at worst the complete disorganisation of the self as seen in psychosis, the "unthinkable state of affairs that underlies the defence organisation"(1974).

This 'psychotic' anxiety concerns survival and identity, and relates to the earliest experiences of the infant. Participant H describes her experience:

> …in the most vulnerable place, not being able to understand it and not have words for the experience, really, so it becomes like a psychotic experience, because you can't, you can't, don't have a frame for it…

Little (1990) described such experiences as resulting from 'pockets' of psychosis which can be experienced in the regression to dependence process, as in her 1981 quotation from Santayana "the suppressed madness in a sane man". When clients are in this phase they may be considered to be experiencing the terror and rage of early maternal failure, and the therapist's task is to provide a holding environment to allow the experience and expression of these emotions. Winnicott describes **'**unthinkable' or 'archaic' anxiety being aroused by trauma "against which an individual has no organised defence, so that a confusional state supervenes." It can be experienced as annihilation, total destruction, falling forever, being isolated through having no means of communication, being unconnected to the body, or being lost in space (Winnicott, 1956/1984; 1962/1984). Integration can then be promoted in an environment where needs can be acknowledged, validated and appropriately met. He identified how the transference relationship becomes real for the client, "In so far as the patient is regressed (for a moment or for an hour, or over a long period of time) the couch *is* the analyst, the pillows *are* breasts, the analyst *is* the mother at a certain past era" so recognising this psychotic aspect of the regression (1984, p288).

Little (1990, p83) considers that the value of regression to dependence is identified thus "it is a means by which areas where psychotic anxieties predominate can be explored, early experiences uncovered, and underlying delusional ideas recognised and resolved, via the transference/countertransference partnership of analyst and analysand, in both positive and negative phases". In a conversation with the author Richard Erskine, he

described to me how he views clients' regression as a need "to tell their story at the emotional, physiological level of the narrative", seeing it as a form of non-verbal early communication of those neglectful and traumatic experiences.

In my psychotherapy practice, and in my colleagues' practices, clients frequently present with chronic anxiety as the motivation for attending therapy. This anxiety is often spilling out into every part of their life, at times reaching its culmination in chronic panic attacks, whereby the fear has been described to me as of death, collapse and/or annihilation. Cognitive therapies aim to change thinking about these outcomes, but in my experience these fears appear again in a slightly different form. It seems clear to me that whilst short-term therapy for these issues may address symptoms it does not holistically address a person's life issues.

In facilitating clients to revisit early developmental stages clients inevitably re-experience any psychological trauma which occurred as a result of an environmental deficit. The following participants, B and E, describe the wordless experiences of pre-verbal regression:

> "I couldn't find the language though I was in terror at times though I couldn't… move it in any way forward

> "…it was utterly…and all consuming

> "And I know I knew, but I didn't have the language for it"

> "…of regressing to a kind of wordless state"

> "…helping me make the history and not lose the thread with me, and it was all on this, on the regressive pre-verbal, really pre-verbal, you know we're talking about early…we're talking the first few months, your birth to the first few months,"

In similar vein, Laing (1960, p99) described this psychosis as "simply the sudden removal of the veil of the false-self which had been serving to maintain an outer behavioural normality that may, long ago, have failed to be any reflection of the state of affairs in the secret self". Participant K describes her transferential expectations of her therapist's response:

> …in the regressed state I wouldn't be….my method of communication would be very different, and I expected her to know, and she didn't always know….

The participant describes the experience of the need for her therapist to offer the desired response – to intuit her need and address it. Actually, it is not necessary for the therapist to meet this need, but to acknowledge the client's protest and respond empathically.

Within the therapeutic regression to dependency process the regressive pull is in the interest of progression, i.e. for the individual to master that incomplete developmental phase. Kohut (1977, p178) identified the single "original development tendency" which is reactivated in the therapy, allowing the client to search for the developmentally needed, reparative relationship.

Having explored theoretical concepts about human development and the need for relationship. I will now define my understanding of regression, and regression to dependence.

Regression….

The Shorter Oxford Dictionary's definition of regression is "a return to a subject: the action of returning to or towards the place or point of departure: return to or into a state or condition: reversion to a less developed form." The term 'regression' can refer to experiences of regression or shock occurring spontaneously in a client's life, or spontaneously within the therapeutic relationship which the therapist has not facilitated, but should respond to. It can also refer to the regression occurring as a result of the therapist's facilitation in order to allow the client to connect with earlier developmental aspects of their experience for healing purposes (Clarkson 2003).

Regression is a well-documented experience in therapy (Balint 1968; Bollas 1987; Erskine 1998). I would view regression occurring in everyday life in some cases, for example, individuals returning to study in later life may both remember and affectively experience feelings as if they were children in school once more, likewise a job interview can bring with it the experience as if the individual is back in the headmaster's office, and attending a party can reconfigure the experience of being on the playground. Clients can bring into therapy stories of difficult experiences in their everyday life of which they have no understanding. They bring with them such

experiences for exploration and also bring with them their conscious or unconscious representations of historic stories that can re-emerge in the therapy room in differing ways. Many therapists will work with these stories to express affect, to understand their meaning, offering empathy and support.

In this setting the client's history can become re-enacted, allowing for the possibility of a different experience and so providing the opportunity for relational repair where the client can experience both emotional and physiological effects. If managed correctly the client can feel understood, supported and often healed by the interaction between themselves and the therapist, and some new insight may be gained from this revisit which reframes the experience through the eyes of an adult. So, for example, an individual might have experienced physical or sexual abuse as a child and have felt blamed and shamed by themselves and others. Having viewed this with an empathic other, the support and concern that was not available at the time of the original incident(s) can be offered by the therapist.

This conceptualisation of regression considers that the client's need is to experience the developmental stage prior to that in which ego damage occurred in order to offer repair, and progress into later ego development (Van Sweden 1995, p197). He quotes Winnicott's view of regression within the therapeutic relationship "the patient regresses because of a new environmental provision which allows of dependence". "The regression represents the...individual's hope that certain aspects of the environment which failed originally may be re-lived, with the environment this time succeeding instead of failing"(Winnicott et al., 1989, p128).

....to Dependence

"Regression is a flight backwards in search of security and a chance for a new start. But regression becomes an illness in the absence of any therapeutic person to regress with and to" (Guntrip 1969, p86). He is describing the needed regression to dependence which is at the heart of this thesis.

The way that the concept of dependency within psychotherapy is viewed by some theorists is highlighted by Weiss (2002). He explains that some theorists writing on dependence tend to see it as pathological, and that this stems from the idea that

dependency is something to 'get over' in order to become truly independent. He cites Guntrip's (1969) recognition of mature dependency as "what makes the experience of independence possible, and that independence without a mature dependence is only pseudo independence", which Weiss sees as self-sufficiency (Weiss 2002, p8). This concept suggests that independence naturally emerges through satisfactory resolution of dependency needs. Weiss highlights that therapists may respond from three potential positions: a) they may withhold gratification of dependency needs: b) they may attempt to respond literally: or c) symbolically. Their response will depend upon their theoretical understanding of the process (p11). He also considers that "the more wounded the patient the more likely he is to experience his needs in literal rather than symbolic terms", which echoes Winnicott's understanding of the loss of the 'as if' within the transference (1984).

Some clients enter therapy with obvious dependency issues, some clients are so extremely independent that they cannot acknowledge any need of another and present with an extreme self-reliance and almost pathological independence. In either circumstance the issue emerges from an environment where appropriate dependency does not develop, but remains in the psyche and in adult relationships as a searched for relationship or as a confusing aversion to such relationships. Guntrip (1969, pp85-86) recognises that this process usually takes a long time before the patient can reveal the passively dependent ego because of the anti-libidinal defence of independence. This means that when the patient understands and accepts the regressive process they are able to allow it, and "find security for their regressed ego in the psychotherapeutic relationship." Participant K identifies her experience of this as a therapist:

> … taking your coat off at the door…there's a lot of clients who do that, so they actually are functioning very well…on the other side of the door, and then they walk through the door and they just lose it…the whole attachment pattern is about learning dependency, not learning independency, that the important phase is actually learning to be dependent, or allowing dependency….I would see it as fitting into the overwhelm abandonment

Steele et al. (2001) identify an evidence base which demonstrates that dependency increases where there are insecure attachments which developed in traumatic parental

environments. Clients with these attachment styles can present with dependency issues which can be extreme and contradictory. They describe this traumatically induced dependency as a "manifestation of the attachment emotional system" but also "closely related to a defence" that is the struggle of the client to stay with the other, to cling on demonstrates the dependency relationship but also defends against loss of the other. Bornstein (1993) notes that every theory of personality includes a conceptual model of dependency, that is, a philosophical/theoretical understanding of the presence of dependency in adulthood. Humanists and behaviourists see dependency as a defensive behaviour resulting from a failure to self-actualise, while the psychodynamic view links dependency to events in the oral period, linking personality development to feeding, Freud (1905/1953). The psychodynamic view of 'fixation' means that conflicts which are unresolved remain fixated into adulthood, for example, someone who is orally fixated may remain inappropriately dependent into adulthood and manifest oral need for food, smoking, etc. In Psychoanalytic theory oral fixation is seen on a continuum. This is considered to be out of awareness by repression, denial and other ego defences. Bornstein (1993) also notes that these defences keep dependency needs out of awareness unless under extreme regression. Steele et al. (2001) also offer insights from Akhtar (1999) regarding the difference between wishes and needs, a frustrated wish for another to depend on to avoid the pain of mourning what didn't happen in infancy may lead to an internal shift in the dynamics of the client, whereas a frustrated need for dependency may lead to a fragmentation of the self. This resonates with Balint's (1968) benign or malignant regression.

Regression is seen by Balint (1968) as a demand for a certain kind of relationship, namely the early relationship into dependency, seeing that this need occurs when there is a mismatch between the infant's needs and the environmental provision. He considers that an individual develops more or less normally to the point when he experiences trauma, from that point on any further development is fundamentally effected by the method chosen to cope with the effects of that particular trauma. These effects are the defences developed by the infant to enable the primitive ego to survive the trauma, and are described more fully in the chapter on Terror. The aim of facilitating regression to dependence then is to relationally re-experience with the client their development prior to the time when the trauma had occurred, thus allowing the possibility for undoing the

primitive defences. In his foreword to Hedges' work Grotstein (1994, p xxi) posits that "all emotional illnesses spring from failures or disorders of bonding and/or attachment in some measure". The task of psychotherapy is then "to help establish anew, or to restore the conduit of attachment and bonding." Van Sweden (1995) describes regression to dependence as a "second opportunity for ego integration and developmental progression", an opportunity which had been unavailable to clients who have experienced maternal deprivation in early life, thus leaving lacunae in their ego integration which then impacts their later relational capacity.

The Object Relations movement and the Attachment theorists emphasise the infant/caretaker relationship where the infant is seen as appropriately dependent on the mother, but de-emphasise practical oral activities seeing the actual relationship between mother and infant as a dependent one from an emotional perspective, and rather than physical deprivation of the breast emotional deprivation being the precursor of dependant personality traits. I would suggest that both biological dependency needs and emotional dependency needs have some correlation in the development of dependent personality traits and subsequently can become a factor in their repair. This work does not consider specifically or in detail those with dependent personality traits, whereby help is sought from anyone who seems able to provide it, but rather addresses those dependency needs which are related to relationship and attachment, where the dependency is focused upon a particular individual for support, attention and reliability. Steele et al. (2001) note that dependency increases in insecure attachment relationships where there is trauma or neglect. So we can conclude from these relationship focus models that environmental failure in the normal developmental period where dependency is appropriate, results in a potentially life-long search, either consciously or unconsciously for that solid, reliable, transformative other who can bond with the individual and offer the potential for that individual to grow through dependency into the relational interdependency of adulthood. Steele et al. consider that Bornstein (1995) clearly links dependency with attempts to develop a secure attachment relationship. In Integrative Psychotherapy the aim is to develop an inter-dependence whereby individuals are supported by trusted persons whose help they can access when in need.

The process of regression can be seen to offer a chance to re-enter these developmental stages and to learn new ways of relating. Participants E and B describe their understanding of the source of their regression:

> …it's not falling back on something that was once there and got lost, or was there, but not adequate, it's like going…back to…something needed which hadn't really existed.

> It was on a continuum, so regression back into that utter kind of core…even earlier than core experience was that it was present in me…

Bromberg (1991, pp416-417) recognises the need and the value of regression for some patients "…the deeper the regression that can be safely allowed by the patient, the richer the experience and the greater its reverberation on the total organization of the self."

Participant D relates her view of her role in her client's regression:

> [We are] lending ourselves to the patient to use us when they regress, but that's all it is, it isn't that 'I know better about where you need to go and I've got an idea about how this is all going to turn out', but 'I'm prepared to lend you me so that we can find out together', otherwise we've got another independent problem, or another dependency problem.

Regression and progression

Balint (1959) considered that making a 'new beginning' meant going back - regression, to something 'primitive' to a point before the faulty development started, and finding a new way of relating - progression.

Winnicott (1958/1984), Balint (1968) and Van Sweden (1965) are among the theorists who view this return in terms of a therapeutic experience and a theoretical concept. The process of regression to dependence aims to treat clients whose psychological damage relates to early emotional development prior to the development of self (Winnicott 1958/1984, p280). He recognised in these clients the "very early development of a False Self [and, in order] for treatment to be effective, there had to be a regression in search of the True Self". Given this premise then treatment involving regression to a state prior to the development of the false self is appropriate.

Van Sweden (1995, p210) recognises the paradox of the regression to dependence process, "Paradoxically, the way to progress is to regress; in this case, further developmental progression can only occur through the regression-to-dependence process. The greatest reward of this progress is that the analysand is finally able to relinquish a life of futility and hopelessness and to move toward the creation of a new life that is emotionally rich, full of vitality and hope." This concurs with Winnicott's (1963) thinking. These dependency needs, when revived in the therapeutic relationship, offer the opportunity for a corrective experience and also an opportunity to understand them from an adult perspective, rather than helplessly as a child would.

This chapter has identified the importance of regression to dependence and how this can result in progression for the client. It is important to mention however that when the therapeutic relationship becomes 'significant' the regressive processes which occur as a result of the transference can result in the re-experiencing of frightening feelings and their subsequent defences. This process is developed further in the chapter on terror.

Conclusion

Within this chapter I have identified the experiences of participants which relate to the concept of regression to early developmental stages. Having explored theories relating to infant development I have identified how failures in an infant's early environment can result in relational difficulties and trauma, and the effects upon attachment patterns which then may continue into adult life. Unconscious processes have been identified as being present in the therapeutic relationship, and viewed as transference enactments which re-configure aspects of the client's early relational history. I have described my understanding of regression and regression to dependence, and identified the psychological hope that regression can result in the client being able to move on; to progress. "It is as if there is an expectation that favourable conditions may arise justifying regression and offering a new chance for forward development, that which was rendered impossible or difficult initially by environmental failure" (Winnicott 1984, p xxiii).

When the interaction between caregiver and infant is placed at the centre of developmental theory and the therapeutic relationship is formulated as a replication of the original infant/ caregiver relationship because of its dyadic nature, and its intense

focus on the client and hypnotic quality, then the potential for relational repair becomes possible. This repair can span a wide spectrum of therapeutic interventions, from the offering of a listening and non-judgmental space for a client to explore issues which are currently troubling, to a regression to, and re-experiencing of, traumatic events in early life. In a facilitative relationship these traumatic events can be identified, and a narrative of the client's experience can emerge. Erskine (1998) views these aspects of experience as "a form of non-verbal early communication of those neglectful and traumatic experiences." This view of the relational and communicative aspects of regression echoes Balint's (1968) view. Bromberg (1991, p416) considered that "Therapeutic regression refers to the raw states of cognitive disequilibrium allowed by an analytic patient as part of the progressive self-perpetuating restructuring of the self and object representations."

Winterson (2011, p172) writes about the consequences of her dysfunctional childhood, "This is the most dangerous work you can do. It is like bomb disposal but you are the bomb. That's the problem – the awful thing is you. It may be split off and living malevolently at the bottom of the garden, but it is sharing your blood and eating your food. Mess this up, and you will go down with the creature." Flanders Dunbar (1947, p45) had formulated such experiences thus, "…the delayed-action mines of childhood, planted either in shock of some single incident or in the steady friction of a conflict between mind and environment. Once these mines have been planted, they may become covered over with a thick, hard crust of oblivion, but they never cease to be dangerous unless the fuses can be drawn." It is my belief that regression to dependency occurring and facilitated within the therapeutic relationship is the process by which the mines are defused.

For a time in my personal therapy I became aware of an aspect of me that felt dead. I could see it as an aspect of my real self, or a sequestered infantile aspect of me. I felt as though I was taking a dead baby to therapy with me, and I had many dreams about carrying a dead infant in a bag. These dreams developed over a period of time, so that initially the baby was dead, then it was barely alive, but I kept leaving it outside the therapist's door where it would become frozen, until eventually it came into the room. I viewed this as a development in my ability to re-integrate a split. In almost every way I

was describing what I saw as the existence of the split-off, inert, infant ego. In Winnicott's (1958) view this split-off infant ego results from disruptions or deficits in caregiving in infancy. In other words, this had constituted too much impingement upon myself as an infant and had made this splitting-off necessary. Splitting is seen as an early defence to wall off experiences which are impossible for the infant to contain so that it can keep pain away from itself and continue to function. Over time, my therapy sessions needed to increase in frequency to contain my increasing levels of disturbance which included manifestations of psychotic anxiety during the sessions. These were always well contained and eventually my terror of my own 'craziness' was diminished by my therapist's acceptance and management of my behaviour. Throughout this period there was movement both towards intimacy and flight from it, but I gradually allowed my infancy needs to emerge and begin to be met despite my shame about them. These experiences then, rather than being unique or idiosyncratic, have turned out to represent a valuable source of insight in working with my clients. Careful reflection on their own experiences like this can enhance the empathic reach of the therapist in assisting clients with their troubles.

Kohut (1977, p178) considers that a person's strength depends on the organizing and integrating processes. Where these are split off and inaccessible a person may be lacking in integration without a reliable and intelligent ego able to work through the normal analytic process using words. Psychotherapy provides a supportive environment "until such time as their nuclear self becomes consolidated." In the next chapter I will explore the sort of supportive environment which may be seen to address these issues, and some theories which recognise and respond to these symptoms, offering comments and suggestions for the therapeutic response.

Chapter Five

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The Facilitating Therapy

"The best and most beautiful things in the world cannot be seen or even touched; they must be felt in the heart." (Helen Keller 1904, p203)

Introduction

The above quotation identifies the intangibility of "the best and most beautiful things". There are many tangible ways of offering a facilitating therapy, yet it is the intangible, the intuition, the tacit knowings that truly facilitate. It is hard to describe such things, and in writing about strategies and interventions, I do not want to present a formulaic set of rules which would heal no one. Ultimately, I believe that the source of the healing is the development of a love relationship. Participant B expresses her experiences of her therapist's love:

> …but it was utterly unconditional and she didn't want anything back, it wasn't a possessive love, it was a non-possessive love…

This quotation is in stark contrast to the relational experiences of some clients entering therapy. Hedges (2004, p8) describes how defensive patterns formed in early dyadic relationships can result in resistance to relationship, "Where love once was, or might have been, is now blocked." When a new dyadic relationship is formed with the therapist it is considered that these resistances can be re-experienced, understood and finally given up when it becomes possible to experience a new, formative relationship with the therapist.

These ideas have emerged at various times over the history of Psychoanalysis/psychotherapy. Ferenczi considered that love heals the patient so that they are free to develop a meaningful and anxiety-free relationship with the therapist which can then lead to the ability to have other anxiety-free relationships. Thus the therapist has taken the role that the mother originally would have taken in being a starting point for relationship. The purpose of psychotherapy then is to restore the patient to full membership of society. He states that the whole of the development of

Psychoanalysis seems to have been dominated by the unconscious purpose of utilising love in practice, while repudiating any such activity in theory (Suttie 1935).

Participant H, speaking in her role as therapist, comments on the nature of the repair that she believes she offers:

> Regulation, soothing, and there's also acknowledging the outward, exciting emotions as well as the 'ok, well let's contain the anxiety as well', so she's more able to discriminate between that which is anxiety-led, and that which is excitement-led, and it's all done within the therapeutic relationship, and she needs to come and talk to me because her father never got excited about anything, she could get excited with her mum, but only when nobody else was listening, so there's somehow a repeat about that with me…she's never been able to fully enjoy at an appropriate developmental level her feeling grand, she's always been over-contained, so to see that, "I've got a new job, I've been chosen", and coming to tell me…is not over-toppling the grandiosity…but catching up with herself.

Giovacchini (1990) considers that a client must feel secure in order to comfortably regress to the more infantile aspect of their psyches. The following Participants A and H describe their understanding as therapists of how the therapeutic relationship must provide the secure base to enable the client to tolerate regression to early traumatic experiences:

> My training was primarily to go to the wound. But for some people who don't have a foundation of security you cannot go to that wound and fix the wound because there's no security.

> I think learning to love this client, 'cos she's very lovable, I think that's a hell of an important dynamic and we don't talk about love enough, I think, in the therapeutic relationship. She's lovely and she's become very dependent on the therapy and that's very obvious…if I'm away she ricochets, she feels the loss again, it's like a mini death to her, like the loss of her mum and her dad…and she's aware of that, but still it happens so she's…depending upon me, not in a kind of, unhealthy way, but in a way that helps repair…some of those lost, or never developed self-functions…she's finding a secure base that's located in me and my therapy room.

The United Kingdom Council for Psychotherapy (2013) identifies the purpose of psychotherapy thus - "Psychotherapy aims to help clients gain insight into their difficulties or distress, establish a greater understanding of their motivation, and enable them to find more appropriate ways of coping or bring about changes in their thinking and behaviour". Those individuals considered in this thesis, however, cannot be helped by this alone "any more than a baby who has had a bad fall can be helped by being made to understand itself. From the point of view of the person giving help, there is no point in aiming at the capacity to understand intellectually (because it is not there)" (Klein 1987, p7). More is required than this. Whilst understanding and insight are important the ultimate objective of Relational/Developmental psychotherapy is reparative. Kohut (1977, p178) recognised the search for the developmentally needed reparative relationship and its reactivation in therapy naming it the "original developmental tendency", and so it is the therapeutic task to offer such a reparative relationship.

This chapter utilises participant data to identify how psychotherapy can facilitate regression to dependence, highlighting specific interventions which address the relational needs of regressed clients. As a result of this data points of discussion within the themes have emerged. I will use theoretical literature together with participant data to show the therapeutic relationship as a potentially secure attachment which has aspects of the mother/infant relationship. I will also identify malignant regression and how this occurs.

Remembering and re-experiencing

It is the therapeutic setting itself which is considered to induce the remembering and re-experiencing of the past, allowing the client to experience the therapist based on early experiences which may or may not be part of linear memory, but because of this re-experiencing occurring in the presence of the therapist, relational patterns can be re-worked and new patterns formed thus making a new beginning with new ways of relating being learned over time. In the Relational/Developmental formulation the client is considered to have returned to the experience of a former developmental state with the therapist appropriately responding

Participant I describes how it could be seen that the regressive therapy that she has received as a client has changed her intrapsychic process. She is able to use her experiences with the therapist to outweigh her learned beliefs from past experiences:

> I know and trust generally that what my therapist is saying, that if that isn't how she's feeling, then that's not how it is for her…so I'm less likely to have that transference, but actually even if I see it now, I give it less weight, that actually even if that is there, and even if that were truly there and somebody was irritated with me, I'd be more likely to say, 'well, I'm still gonna ask …something changed on that level…

This process of allowing the regression and the dependency to occur requires an adjustment in the therapist's behaviour and the management of the client, requiring in this phase a move away from interpretation towards the management of the client's transference and dependency. This management, and the consequent adjustment of boundaries, is considered further in the subsequent chapter on boundaries.

Participant D, speaking as therapist, describes her understanding of interpretation in regression, and how her therapist did not recognise this:

> …I was reading from Winnicott the other day about during regression the absolute need to keep interpretation to a minimum, because…the only thing that heals in regression is if the analyst can be where the patient is, so I really needed (therapist's name) to be more with me in that situation, than keeping me in my adult head…I wonder and I worry about interpretation in regression…whenever I find myself reaching for an interpretation, I think it's probably to protect myself from going into the place where my patient is…

If it is accepted that developmental needs that are unaddressed in the appropriate developmental stage remain searched for in adulthood, and that needs and needed relationships can re-emerge in the psychotherapeutic relationship, then it is possible to attempt to offer resolution and repair. In all cases, the therapeutic task is to attune to the client's ego state, matching the client's needs to the provision of care, support, understanding, acknowledgement and sometimes meeting the need. Gill (1991) sees such provision as providing a therapeutic re-experiencing.

Participant C values time and presence:

> …it was something about that constancy, and also just the holding was a very relaxed
> holding. That made me remember, when I was little my mother would come and say
> goodnight to me, but she would have to dash off, she wouldn't stay, she'd just come and
> tuck me up, and there was something about the level of holding I was getting, the
> person wasn't dashing off, it was a sort of relaxed, physically to be with, that was a
> calm, not an anxious person.

Both Kohut (1971; 1977) and Gill (1982) advocated for changes in the therapeutic stance because the traditional unyielding stance of Psychoanalysis could be experienced by some clients as rejecting and therefore could be experienced as a repeat of infantile wounding. They recognised the need for engagement, involvement and non-defensiveness by the therapist, and upheld the importance of working with the relationship between therapist and client, so uncovering unconscious processes (Kahn 1991).

The therapeutic setting and the holding environment

Bion (1962) considered the mother as container for the infant's projected overwhelm. He identified the mother's role in transforming that which the infant could not digest into more palatable elements which could be re-introduced to the infant in a transformed state. There is a link between Bion's description of the mother as container and Bollas's (1987, p259) description of the therapeutic setting which he describes as "like being held by the mother". He considers that there are necessary conditions for regressions to occur, these include the proximity and attentiveness of the therapist, and the security and containment provided in the therapeutic setting can act as an invitation to regress. He considers that the therapist should understand the need (not wish) to regress, be attuned to the process and understand the phenomenon. Winnicott (1965/1984) identifies that anxiety in the infant has its roots in being insecurely held, this is an important point for therapists in terms of establishment of the holding environment.

As in the maternal setting, the therapeutic setting can provide the dyadic regulators of physical comfort, warmth, quiet and the absence of interruption. The therapist should have an attitude of acceptance, encouragement and responsiveness.

Symington (1986) cites Winnicott's understanding of primary maternal preoccupation as enabling the mother to know the infant's expectations and needs. Through it the

mother knows how to hold the infant, and the infant starts existing and not just reacting. Winnicott theorises that the mother through spontaneous sources brings about this source of creative activity and that some analogous attitude needs to be present in the analyst in regard to their patient. In this particular matter, Bion and Winnicott are very close in their thinking. Just as a mother cannot learn how to mother from books or advice, when her baby spontaneously reaches out towards her in gesture or in action, neither can the therapist rely upon a mentor or a book in some difficult moments. However, a mother can be taught a lot: she can be shown how to hold a baby, how to feed the baby, how to wind the baby, how to bathe the baby and so on, but only she can know how to respond to the infant's look, noise, etc. This is also true for the therapist; theory and supervision offer teaching, but at some point the patient will demand that something comes spontaneously and uniquely from the therapist.

Participant B identifies this demand in her own therapy:

> I think that I pushed through her model of therapy and demanded that she be real with me…I demanded it, and when she did it she realised she had failed her own discipline, her own model.

This demand may come verbally, or the emotional intensity of the situation generated may place a responsibility on the therapist to act, the action may be to remain silent or to speak, but whatever it may be, the patient is wanting a gestural response that comes out of the therapist's true self, which by definition has no antecedent.

Bollas (1987, pp271-272) describes the suspension of interpretation, the dismissal of residual guilt and the silence that can be involved while the deeper parts of the self begin to emerge. The patient can have alteration in state of mind to a place of musing to sensory awareness, olfactory sensations and perceptions, intense feelings and discoveries. Participant K's quotation, when she recalls her experience of therapy, illustrates this point:

> The first thing I think about is the room, and that's quite surprising, because my picture now is of the room actually without (the therapist) in it, and the view outside the room, because I used to stare outside the room a lot, so the trees outside the window…and the sort of silence, the wordlessness…

Bollas considers that the process of regression to dependence "may repair a previously damaged capacity to receive news of the self in this manner".

The regression to dependence process means that the client is in a less integrated state, and experiences elements of merger with the therapist. This recollects the original mother/infant relationship. In therapeutic contexts, the creation of a situation akin to the holding environment offers a sense of protection. This allows the client to access hitherto split-off primitive agony and rage resulting from the original maternal failure, and accounts for the sometimes extreme and troubling emotions sometimes experienced in therapy or when any interruption in the therapist client relationship is threatened. Because of the profound and overwhelming emotions it will often have to contain, the development of the holding environment must be firmly established through a series of therapeutic successes in order to gain maximum benefit. The therapeutic alliance is an aspect of the therapeutic relationship which holds both parties together even when the relationship at times becomes difficult. Depth psychotherapy involves working with negative aspects of the relationship and the client experiencing often painful feelings, and in order to sustain the client through this period client and therapist need to have established sufficient relationship to avoid the work being disrupted by negative experiences. Greenson (1967) described it as "the relatively non-neurotic, rational, and realistic attitudes of the patient towards the analyst".

The following participant, B, identifies the necessity of the therapeutic alliance so that there is sufficient trust to enable the regressive work to be successful

> They've got to have a knowledge of the way back, so that, that alliance elsewhere needs to be in a place, needs to be very clearly in place,
>
> so I need to have a way of assessing that I can get them into that other place, say I've got it wrong, or it's going to take them into distress, or memory, or whatever, I've got to have a knowledge of the way back…

Ellman (2007) identifies that as love develops in the therapeutic relationship the ruptures occurring as a result of transference are more easily recovered from, and the survival of these ruptures enhances the trust between the therapeutic couple.

Affective attunement

Van Sweden (1995) and Erskine (1993; 1994) specified that the therapist must attune to the client's presenting developmental stage and respond appropriately to provide a reparative and emotionally nurturing relationship, recognising that in an atmosphere of affective attunement the needs and feelings of the client can be expressed and appropriately responded to. This attunement will be based on verbal and non-verbal cues and is similar to that of mother/infant in the infant's pre-verbal phase. Affective attunement requires intuition, understanding and empathy which are developed through shared knowledge of the experiences of the client, the use of the unconscious material in the countertransference and the processing by the therapist of unconscious confused material, in short it means being totally in tune with the internal experiences of the client (Van Sweden 1995). Affective attunement using the countertransference allows communication of the therapist's understanding of the client's pre-verbal experiences. Erskine and Criswell (2012, p2) identify developmental attunement which he describes as "thinking developmentally, sensing the developmental age at which the client may need therapeutic attentiveness, and responding to what would be normal in a child of that developmental age". Kohut (1971; 1977) demonstrated empathy as one of the main requirements of the therapist in relationship. He recognized the need for engagement, involvement and non-defensiveness by the therapist, and upheld the importance of working with the relationship between therapist and client, so uncovering unconscious processes developing within the relationship, this engagement in the relationship was also important to Kahn (1991).

I have stated earlier that in formulating inchoate feelings as needs, a narrative is established which does help both therapist and client to have a sense of the direction of the work. However, just as in the mother/infant relationship, until the child achieves the ability to verbalise their needs, wants and desires, this necessity to tolerate ambiguity and live with not knowing seems to be echoed in the therapeutic dyad. Stewart (2003), in his review of Balint and Winnicott and their understanding of therapeutic regression, stated that work on this area of analysis has not received the recognition it deserves because of the adaptation of technique that it requires, and the necessity of the therapist living without knowing for long periods. This then is the focus of this work, that in order to effectively work within the dyadic relationship, offering the possibility of a

'new beginning' to the client in psychotherapy, requires a stance not only different from the Psychoanalytic stance of abstinence, but also different from that which is offered by most psychotherapies and many psychotherapists.

Participant G talks of her experiences in therapy and the ways that her therapist met her, which are outside the boundaries for many therapists, and how she responded to this:

> …..the key times, the critical moments were definitely those points of regression, it wasn't the regression itself, it was the moving through the regression, there was something about being met, and feeling safe enough in my own therapy….once things became unlocked they tumbled out, I couldn't stop them, I couldn't put the lid back on, and part of me didn't want to, I didn't know where it was going, I didn't know sometimes if I'd ever get better, if I'd ever feel normal, or the sense of normality I thought I'd had before, which I realise wasn't really normality at all, but I kind of knew I needed it out, so I think I trusted that process somewhere, even though I was often scared….She held me, she stroked me, she sang to me, she covered me up with a duvet, she stroked my hair, she read me stories, we played in the sand, we drew and painted, you know, finger painting, foot painting, we did all kinds of things that were beyond my life experience that needed to happen for me to be able to inhabit another (name) who'd never had a voice, never had a place, never had any form of expression, and all that was really moving work, the painting, really moving work, and very beautiful, and she handled the time boundaries brilliantly ……so there was always enough time for me to come back, and a couple of times she put me in another room, with a duvet on a sofa and just said, 'stay here 'til you're ready, and just let yourself out, and you know where the coffee and tea is if you need a drink before you go home, make it, but I'm working with somebody else', and I took that often, that option, two or three times, and stayed for at least an hour, I needed to feel safe enough to drive.

This participant described what she saw as a nurturing experience with her therapist in which she is attuned to her relational needs, some of which are met. Therapist and client have worked together to construct and make actionable their situation in these terms. She has described an experience which is significant developmentally both in her internal world – intrapsychically, and in her external relationships - inter-psychically.

Participants A and B while speaking about their work as therapists identify their attunement to their clients:

…the real thing is my capacity to be attuned to them and meet them where they're at which includes really respecting all of their reluctance and resistance to regressing. Oh, the other thing is identifying the regression when it's embedded and hidden amidst all of the adult stuff……..Yes, and so what I have learned is that when people are in that quiet regression to make comments like, I'm still here, I'm watching over you, I'm still listening even though you're silent, you don't have to, you don't have talk, so I make statements about my presence.. But I don't turn it into an enquiry…..if I know some people well I might say it's so important to be silent, or if you're quiet there's a safety…as a generality and then I watch with little body movements that signal agreement or disagreement or nothing…And if I see an agreement then maybe five minutes later I'll say it again so as not to abandon them

Participant B describes what she might do:

I might get hold of their face and turn it, and say, 'look at me, look at me, what are you seeing,' , I might, I might move quite clearly into body work with somebody, there is a specific move, and I think the way in which I would conceptualise it is that when I see a child who's distressed, or distraught….a little one, obviously there needs to be an appropriate attunement to what's happening, I don't expect them to deal with themselves, I see it as – that's the other, the other's responsibility, so I will specifically work there, it depends on what I'm getting though, age-wise,

An Integrative Psychotherapist working from a Relational/Developmental framework would keep in their therapy room various items which could be used in their therapy practice. This might include sand trays, books and paints. This is necessary because, from this conceptualisation, creative means would help to access and meet the clients' archaic needs.

I will now explore the theoretical understanding of relational needs.

Relational needs

Participant K describes her experience of being cared for by her therapist:

…she looked after me…and I don't really know what that means…I do actually think a lot of it is in the word 'look'….'cos it isn't about providing drink or tissues…'cos it's more than seeing, it's watched…watching me, just watching and waiting…you know, a

bit like watching a child sleep, you know, when it's…. you don't need to do it, it's not something the child needs…

As theoretical understanding has moved away from the internal world of drives as in Freud's understanding, into a world of relationship - the influence of the other - then theorists and therapists become part of the therapeutic encounter in a different way. They are viewed as relational partners rather than experts who provide knowledge and insight into their patient's inner world. They are therapeutic partners in a setting whereby their patient/client is experiencing deep and painful feelings and they may be sitting with the discomfort of being with their client who is without words. Therapists and theorists have formulated the therapeutic process as one of 'meeting needs' perceiving that these needs existed independently of and prior to the therapeutic process. This happens as a result of the theoretical stance whereby these inchoate feelings are located by developmental theories in early infancy and so a narrative starts to develop in turning these feelings into needs.

When these feelings are named as needs, the therapeutic partner can start to do something about them, i.e. either name them and/or attempt to act upon them. This narrative then forms part of the client's story and gives words and meaning to their inner experiencing. It also means that the therapist and the client can start to know rather than live with the discomfort of not knowing. For me this then has echoes of the early infancy dyad, where initially the infant experiences and protests, the caretaker is prompted to respond and because the source of discomfort may be unknown, then different things are tried in an attempt to resolve. Over time the needs of the infant become more recognisable based on the trial and success or failure of the previous experience - experimentation. The feeling for the parent in these early days is very uncomfortable. Their empathy can be aroused, but it may be difficult not knowing what the infant requires.

In establishing such an infancy narrative and re-enactment there is not only a narrative, but also a way forward and an agreed and understood treatment plan for the therapeutic work. That is, what the individual requires that can then be supplied initially by the other as in the early infant relationship. Erskine et al. (1999) argue that needs that can be met through relationship grow out of, and nurture, human interaction. As needs are

present in all relationships, both client and therapist will have them, but in the therapeutic relationship it is the client's needs that are at the core of the interaction. Needs are often out of awareness, only coming into awareness when they are unmet. The needs which arise in the therapeutic relationship must be met with the therapist's genuine affective response of spontaneity, warmth and care (Erskine et al. 1999).

Erskine et al. (1999) identify eight relational needs, although there could be as many relational needs as there are individuals, which should be acknowledged and addressed appropriately by the therapist. A contactful supportive relationship in infancy can result in the emergence and satisfaction of relational needs and the same is true of a psychotherapeutic relationship.

Contact in relationship includes the sensitive meeting of the other and results in the ability to authentically acknowledge oneself. If such contact is disrupted by insensitive attunement or neglect, then the relational needs which are appropriate at this time become problematic and cause pain. This can result in the infant putting them out of awareness to avoid the pain of dissatisfaction. These needs can then re-emerge in the therapeutic relationship, along with other relational needs that would be expected of any adult to adult relationship. The client who experiences regression to prior developmental stages will also experience relational needs for security, valuing, acceptance, mutuality, self-definition, making an impact, having the other initiate, and to express love. Clients have often described themselves as having experienced inadequate parenting and have been inappropriately responded to in their infancy, and therefore have present and past relational needs. Attunement and response appropriate for both must then be supplied (Erskine et al. 1999).

My metaphor for attunement is of an old TV set in which the required channel can be found by turning a knob, left or right, until some sort of picture is seen. As I remember this tuning in process one would make large movements first to locate a picture, and then increasingly fine movements to obtain the best picture available. My understanding of attunement has its origins in being a mother. With a new-born a mother has to guess, based on their knowledge of what infants need, what their infant may need at any given time. Over a fairly short period of time the mother starts to learn, 'tune in', to the signals given by her infant, and is more and more accurately able to interpret and

subsequently meet the need of her infant until such time that they are able to identify their needs. As a psychotherapist the process of getting to know the nuances of any individual client is similar to this process.

Clients are individuals with individual needs and the recognition of their individuality is important. Because of the level of damage they have sustained, many clients do not recognise their own needs and so cannot identify them to the therapist. In regression to dependence the moment-by-moment attunement of the therapist will identify nuances of behaviour which can help the client to start to recognise and acknowledge needs (Erskine 1998). The following Participants I and K identify below how unmet relational needs took them into therapy:

> …but I'm also aware of becoming increasingly aware that there were needs in me that weren't met, that weren't met in my relationship, there were gaps, I was constantly hungry for those needs to be met through my relationship, and they couldn't be, and a constant level of frustration around that, so I guess that was my sort of primary driver… for what I needed to do in therapy was to find out how to meet those needs, relationally… with someone other than my partner….Now I could see that (I was)sort of forever being on the edge of relationship, forever getting a bit of relationship, seeing the possibility of that opening up slightly more, and then feeling short-changed, feeling like I couldn't quite have enough…

> I suppose I make sense of it as taking me back to a neediness that hadn't been met, it was about unmet needs, so it took me back to a place of unmet needs…

It is clear from the above comments that these participants construct their experiences through the infantile need for relationship.

Participants E and H relate some of the ways that they as therapists attempt to meet the relational needs of their clients:

> "I know you have no hope where you are now and it seems the end, but I'm still here and I can hold the hope"…that's all I could do which seemed very…little to do at the time but in some way it enabled her to get through…

> Consistency is really important....and respecting of the level of needs, and trusting that they'll grow through that, consistency even to the point of sometimes, if they're really traumatised, of wearing the same clothes as when they last saw you, same

jewellery…Sometimes it feels like a real straight jacket and it's important, I think, for me, to trust that it won't be forever….So they're allowed dependency…and I said, "well, that's what children do, you know". So normalising as well is important I think, yes very important. It's so important just to be the same I think, to be the same person…

Participant D quotes her client, recognising the importance of the provision of gentleness:

…she'll say, "it's the softness that matters, it's the gentleness" and I think that is her first experience of something like that…

When the client is regressed to a former developmental stage, then in this view the appropriate intervention by the therapist can lead to a re-experiencing of a past interaction with a different outcome. Bringing insight and remembering is important to help the client to understand their difficulties and to cognitively apply themselves to change, but, both Gill (1991) and Erskine (1998) see the relational repair as being "transformed experientially", or a re-experiencing with "a therapeutic twist". Stewart (1992) describes his conviction that where an experience has been psychically traumatic, in order for change and psychic growth to occur, both intellectual knowledge and understanding of emotional states involved need to be brought into consciousness.

Participants B and H describe how they work with clients to identify how they must position themselves in order to address the client's developmental need, and how they begin the process of establishing a narrative for the experience:

So I…would encourage them to tell me all sorts of things about their life, and I'm listening for, and I do a lot of listening of, what is it, where is it, how do I complement it, how do I help them, how do I slow them down, how do I increase the richness of this, the resourcefulness of it.

…for the first two or three sessions, 'where's this gonna go, what are the developmental issues here, what's not being met historically, what are the issues with', I mean I've got a newish client now always experiences that kind of nameless dread of things emerging…in regulatory terms, a terrible, real difficulty with, with regulating, or affect and her anxieties…She, she gets very panicky at night, very panicky…once it's set up it gets repeated, so yeah, for her I think there's early stuff…we haven't got to the earliest, but I know it's early something, but we're getting some of the narrative.

Using the information gained, Participant B would then identify her therapeutic stance:

> … this is pre-verbal, because if you haven't got a sense of life-affirming given to you in those first few months of life it's going to be phenomenal to get it, so I go back to there with clients.

"But if we sensitise ourselves to think developmentally we begin to sense what a traumatised or neglected child of that particular age may require from a caring and contactful adult" (Erskine and Criswell 2012, p2).

Participant B identifies her considerations regarding working with regression:

> … looking at it from the 'now', and thinking with any client what is it that's preventing them, living as wholesomely and as holistically as possible in the 'now'. So that would be my kind of starting point with anybody, and from that then I'll have choices, from those choices, regression i.e. for me actively inducing a decent, or a change into child ego is one of the choices, and I guess the question's like anything in life is, what's going to be the most effective and ethically most appropriate i.e. have I got the competency to achieve, and with regression it would be very specifically to extend and more likely into the process of gratification, so it would me becoming an active component, or the continuance on of something that I felt was needed developmentally that hadn't occurred…

When infantile experiences re-emerge in therapy and become played out with the therapist they can be reparative when the experience is *almost* re-lived; if it is fully re-lived, it will be re-lived in the original way, using the same self-protective pattern and resulting in trauma. Clearly it must not have the same ending as the original event, but be similar enough to trigger the emotional processes belonging to the event.

One of the interpersonal needs originating in childhood is for touch. I will now identify therapeutic responses to the need for touch.

Touch as therapeutic intervention

Hedges (1994a; 1994b) considers that human contact, often manifested in some form of physical touch, even if token, is necessary to transform reflexive mental states into symbiotic bonding patterns. He, in fact, questions whether this transformation is

possible without touch. The foundation of human relatedness is now understood to be related to actual human contact.

Grotstein (1994) acknowledges that psychosomatic theorists such as Hofer (1978; 1981; 1982; 1983a; 1983b; 1984) and Krystal (1988, p xxi) recognise the importance of skin and of "the touch modality that contacts it." "The infant's senses in general and perhaps that of touch in particular, seem to be the conduit of earliest contact with the object."

When there is an experience of regression to early infantile experience then some theorists posit that the only form of contact with the infant is through sensory contact including touch. Little (1981, p144) recognises that, when dealing with the primitive layers of a patient, modification of boundaries may be necessary using non-verbal means "to carry interpretative effects….linking them with words to make the interpretation complete and to join up the primitive with the advanced layers." She describes work with a patient in emotional despair reaching out for her "I put my hand on his. He took a deep breath and burst into a storm of weeping, and great relief followed." She argues that emotional material at the primitive core of her patient "would not have been reached but for the body happening of his hand movement, accepted both verbally and non-verbally by me. It was the body injury that showed me the need for the body response."

Hedges (1994) considers that in order to reach the somatised psyche touch may be a necessary part of the therapy at this time. He holds the belief that some physical contact is necessary to help the clients remain in contact at the time of re-experiencing 'memories' of previous relational trauma.

Participant C, from her position as a therapist, echoes this belief:

> I daresay there are ways of not having contact and possibly it does meet a need that is often pre-verbal and that somehow the body contact actually seems to 'speak' in a way that face to face contact doesn't,

Infant research concludes that touch is necessary for infants' well-being (Spitz 1957). Psychotherapeutic research which looks at the infant within the adult client also suggests the necessity for touch when addressing early infantile need. Erskine (1994)

identifies the sense of unworthiness that can be experienced in the adult client resulting from a lack of physical touch in childhood.

Participant A, speaking as a therapist, describes his work with touch:

> I've worked, focusing a lot on physical holding, with this client group and allowing them to determine what they need from me physically, so a lot of experimenting with getting physical contact to feel right for them, and allowing them some freedom in being able to do that, using touch, to experiment what feels good, what doesn't feel good, allowing them to make some physical contact with me, to feel a sense of my physicality in the sense of my, my boundary, my solidness has felt important.

Erskine and Trautmann (2004) recognise that there is a link between use of touch and the increase in dependency in the client. Toronto (2001) and Durana (1998) recognise the therapeutic advantage in the use of touch. Polster and Polster (1974) consider that touch is a means of making contact and of completing unfinished business.

Participant B describes how her therapist used her own body to meet her:

> There was a terrific amount of risk taking and pro-activity on her behalf. She was unashamed about using herself physically as a mother would….physically so comfortable, and so comfortable in her own body, so I never had to go through that excruciating thing of thinking, 'I need someone to hold me', it was just so seamlessly done….

Participant C identifies her realisation of the difference between what is available in this relationship and the nature of her parental relationship. The fact that the therapist initiated physical contact seems to offer some repair:

> …it was good that she initiated it because it was something I'd not had with any physical contact as a child, I really thought that it was really strange when she suggested it, but the being held was really, was important because somehow it meant that my body which I hadn't felt before, and there was something about somebody actually saying 'I would like to hold you'…to feel connected, I think, as much as anything, this person's given me something because they understand, therefore, even if I'm feeling unloved, I know…so it somehow it affirmed…

Participant H describes how the use of touch enables her to feel connected and soothed:

> so the therapeutic touch was like…I remember it now, it was just so………it wasn't invasive, it was just like warm electricity going through me….it brought tears to my eyes because it was soothing, you know

Participant C identifies how her therapist actively reached out to her, she acknowledges the intensity of the experience:

> …she obviously recognised that need and at the point of very, very deep need went into the session I would need a hug before we started…It was something about that constancy, and also just the holding was a very relaxed holding. … Well, she was constantly reaching out to me…

Participant K told me of her first experience of touch with her therapist, and how she had a dream about being close to her therapist which precipitated it.

> …. remembering the impact of the first time, which was incredibly early on in the therapy, and because it was me actually saying I'd had a dream very early on of being held by her, and me saying, 'no, that's not gonna happen' you know… and then to be held was real, you know, …wow.

Sometimes clients will dream, or daydream, about encounters in therapy. Rennie (1992, p227), in his research on client reflexivity and change, identifies the 'reflexive moment' as a 'safety zone' where a 'course of action can be contemplated' seeing that reflexivity is "the form of consciousness in which a decision may be reached about a contemplated action and in which the decision may be converted to action". This is where the individual has a choice and I would view dreams and daydreams about the therapeutic encounter as means of reflexivity whereby the client incubates desires, wishes and needs, making choices about action.

My experience is that clients often picture what they need in a therapy session, but shame can be experienced which blocks identification of this need to self and to the therapist. Sometimes I ask clients if they picture how the session will be, and often needs can be associated with this. One of my own pictures, a sort of waking dream, was of being held in a way I saw a workshop participant being held by the facilitator. It was months before I was able to stutter out this need.

Winterson (2011, p9) writes of the power of stories, "I believe in fiction and the power of stories because that way we speak in tongues. We are not silenced. All of us, when in deep trauma, find we hesitate, we stammer; there are long pauses in our speech. The thing is stuck. We get our language back through the language of others. We can turn to the poem. We can open the book. Somebody has been there for us and deep-dived the words." Wosket (1999) describes a client using reflective writing to experiment with the possibility of disclosure of issues considered shameful as a means of experimentation with the possibilities. Such reflective writing can have the same distancing possibilities as the use of metaphor. She also advocates for the negotiation with clients around the use of touch, sharing dilemmas and exploring possibilities. I think of this as bypassing their defences against shame in the way that some clients use metaphor to create the "as if" experience which reduces their level of shame. Erskine (2001, p2) considers metaphors to be "an expressive communication that emphasises our emotional and developmental perspectives". Tomkins et al. (2005, p2) consider that metaphor helps the client to create new internal experiences based on the evolution of a chosen metaphor. The use of metaphors enables the client to gain some distance to see from a perspective which uses all of the client rather than them being engulfed in only the shamed ego state. They also identify that working with metaphor as verbal and non-verbal components. They highlight that clients will use metaphor to express "something abstract in more concrete terms, capture the whole, or the essence of an experience, or talk about something obliquely." Talking about issues that are perceived as shameful, in an oblique and metaphorical way can help to titrate shame, so that the client is able to tolerate exploring such issues.

Leijssen (2006) considers the use of the body in conjunction with verbal psychotherapy, seeing it as providing additional information and in order to improve awareness, to deepen experience, to release body memory and to explore new possibilities. She highlights the importance of the therapist's validation of the body and the use of touch. She notes that the therapist can also make use of the spontaneous bodily expressions of the client to understand their story.

Participants E, A, and H describe their ways of working with touch and holding:

I think there probably was a sort of a hostility, or a, almost an anger and a rage at having allowed herself to be vulnerable with me, having allowed herself to need and want a hug, and get a hug, and then kind of hated me for it, or hated herself for it or, maybe, 'cos I never had a chance to talk to her, maybe it just stirred up so much pain, that, that she just couldn't deal with that, or it was too shameful…

Although there are questions and physical response sometimes actual holding sometimes it might be that she needed to tussle with you with me and you know push me across the room and be pushed back…and there were other times when she seemed to be in a phase where err she regressed to where she was only communicating between herself and her hands and you know shutting me out completely and as she would say if you are more than two feet away you might as well not exist.

I think I learnt quite early on in my career how often physical holding was appropriate and good and learnt by the seat of my pants really just learnt not a very good metaphor but in this context but learnt just learnt how it worked basically by following what your clients needed.

…the symbolic holding is, you know, really, really important 'cos if you're not doing that the whole thing…. now whether or not you go for holding in terms of physical holding, I have used physical holding only if it felt useful for the client, and certainly with a number, well, the one I've just spoken about was another client, who was very, very badly abused with a kind of cultic context, not just holding, but actually smelling, primary scents sense, trying to differentiate good smells from bad smells, it was really an important part of our, of our work, so that she could hold in her sense memory that the scents sense of me in the world, still existing, and quite literally I would rip off an old shirt of mine and stuff it up my jumper, refuel it with my smell, and give it back to, you know, to her for the next week so that she'd got, she could smell me in the world, so holding in that sense was enormous….certainly with this, this client there was sight, sensory memories of bad smells, bad smells, smelling bad smells in the room and then inviting her to smell me, acute startle responses to the slightest noises, you know, out there or out there, and holding… working at those sensory levels I think it's really important, but it's meticulous and careful work really, and often working with gut feelings…

Participant B describes how she experiences her responses to the client and her understanding of how she titrates her responses to meet the needs of the client in the

moment having regard for their defences and her previously assessed understanding of their ability to tolerate such interventions:

> it would depend….upon how robust they were at what stages...different levels of their development…. what they were capable of….if I were to...move across and put my arm around somebody, I know I'm pushing them into something else, therefore they've got to have a level of allegiance with me elsewhere, cos I'm taking them into the bit that they might not have,

Touch is a controversial issue in the world of psychotherapy, yet I believe it to be an important intervention to be considered when working with regressed clients. Working with holding requires a concept in order to understand the experience, and a narrative is developed in order for both therapist and client to have a shared understanding.

Establishing a narrative

Etherington (2000, p9) recognises that "making a coherent narrative out of experiences of childhood trauma is perhaps one of the most difficult tasks we can set ourselves". Establishing a shared narrative with an other (the therapist) can give people a voice and words on which to hang their experience which has previously been wordless. Narrative is the client's story, their understanding of how they came to develop as they are. For the therapist narrative can help to develop a shared language for the client's experience. For the client having a narrative can help them to make sense of their early lives and of current experiences in the here and now.

Participants A and H, speaking as therapists, describe their ways of working with narrative:

> …I think what you're doing here is half reliving, or trying to tell the story of a little baby, but I wouldn't label it as birth trauma or I wouldn't label it as mother abandoned you. That's much more the old psychoanalytic way. I have done things that have looked like and felt like re-birthing and I don't say anything but it's some kind of emotional experience but they might say, yes it was like I was being born again. I say, well tell me about it, how was it for you, well I had to push, or struggle, I thought I was going to suffocate, what do you know about your birth

> …we couldn't do it in any other way, he wanted…me to use, 'do this', it was by request and…week after week there was agonies of pain, but he re-established ...his narrative

and he was ok...so he was utterly determined to resolve that…so he did, he was fantastic, it was like an operation without anaesthetic.

Giving a sort of narrative understanding, yeah, I think I might do that, but equally well I might not, 'cos it might feel, might be just too much information for where that person is and too over-defining, I prefer it that they're able to come back and say, 'I think I was in that place again', and then to talk about it….I do think that's really important, but I think it's got to be co-created, not over-defined by the therapist, I think it can rob a client of their real internal experience.

Stern (1985) highlights how narratives are constructed in therapy and he sees the clinical infant, that is, the perception of the client's infancy narrative reconstructed in the course of clinical practice, as a construct which is discovered and altered by both teller and listener in the telling. He identifies the competing theories around early life; "the early life narratives as created by Freud, Erikson, Klein, Mahler, and Kohut would all be somewhat different even for the same case material. Each theorist selected different features of experience as the most central, so each would produce a different felt-life-history for the patient". In this way Stern demonstrates how therapeutic narratives are not used simply to discover what actually happened, but also to create "the real experience of living by specifying what is to be attended to and what is most salient. In other words, real-life-as-experienced becomes a product of the narrative, rather than the other way around" (Stern 1985, p15). He recognises that the establishment of a narrative is an important clinical necessity.

At interview I asked Participant H about the importance of narrative and she offered a word of caution:

I do think that's really important [developing a narrative], but I think it's got to be co-created, not over-defined by the therapist, I think it can rob a client of their real internal experience… I love those moments when the client comes and says, 'do you know I've been really thinking about this… and it seems as though I've been in this place, you know, and does this make any sense to you?' and I say, 'well yeah, where are you with it?' so you know it's come out of something organically, but I'm not imposing it in an interpretive [way].

Transference within the therapeutic relationship

Participant I is describing an experience in her own therapy which illustrates the importance and nature of the therapeutic relationship to her. She has arrived for her therapy whilst the previous client is still leaving:

> ….but as I walked in the hallway the door opened and my therapist hugged the client and was really tender towards her, and, and the client left, and I was devastated by her, absolutely devastated that, they'd become like my parents that didn't notice that I'd really needed her to be there and be waiting for me and notice, and she really wasn't there and she really didn't notice me, and, and she said that she'd even forgot that I was coming, and that, that part of the therapy has been really difficult for me, being forgotten, not being noticed, makes me rage as to why it's still happening, how I can be so forgotten and so unimportant…

The participant seems to identify feelings that we may see in sibling rivalry, where there is competition for parental love, and indeed how this can be echoed in adult romantic attachments where there is a demand for exclusivity.

Cozolino (2006, p50) states that the brain should be understood as "not a fully formed structure, but as a dynamic process undergoing constant development and reconstruction across the lifespan." There is then hope for the 're-formation' of brain processes into more helpful patterning as a result of therapeutic intervention. Wilkinson (2010) calls early relational trauma "the old present" where she identifies how early relationships bring with them the patterns and emotions from past relationships. Hurvich (2000, p19) describes the experience in regression whereby the "distinction between past and present is lost, so that the past is experienced as if it is happening now (Schur 1953). There is a decreased ability to integrate experiences and a restriction or temporary loss of the sense of self" (Pao 1979).

The following quotation from Participant I describes the emergence of a different experience of herself:

> ...but I think that constantly working with that transference… allowed me then to free up around what I might need, that actually if I wasn't gonna get annihilated there for being vulnerable that actually I might be able to ask for stuff from her…

That I might be able to ask for reassurance from her, that I might be able to ask for… some affirming of me, that I might be able to ask for her to hold me, I might be able to ask for her to tell me how I appear, or to tell me how I come across, or just to tell me how I'm perceived.

Participant E told me:

The thing that touched me when I went to see her was she just felt like a warm, tender person and I think that was just the thing that caught me, and brought out that little boy who just needed that…and yet I guess it was stirring up a lot of intense emotion because I think it, it was mainly my relationship with my mother.

During regression to dependence the nature of the transference can lose it's 'as if' quality, because the client perceives the therapist in an authentic way where he/she is really the parent. Federn (1952, p26) considers that time does not exist in the unconscious. The psychotic aspect of regression to dependence is psychotic because at times the 'as if' aspect of the transference is lost, and the transferential relationship seen as reality. The therapist does not have to become the mother to the dependent infant, only to accept the developmental needs and to offer appropriate response. During this time therapeutic misattunements can cause the client to experience deep shame and pain, the effect of which should not be minimised (Clark 1993; Simon and Geib 1996), but as in all therapy these misattunements can be used to deepen the relationship, and with successful reparation can allow the client to feel loved. The therapist's occasional and unintentional failure for the client can eventually help the client to recognize the normal failures which are a part of life, and to become robust and resilient. In the dependency stage of early infant development the caregiver does not know what the infant's needs are, but makes an educated guess of what might be needed. When this is wrong then the infant protests and the caregiver learns more about the infant's needs. Similarly, the verbal and non-verbal protests of the client assist the therapist to correctly attune to their needs. When the therapist fails the client, the transgression may seem minor, yet to the client it can be experienced as an impingement which can engender pain or rage, getting the balance right is a tightrope to be walked by the therapist during these phases. Too many impingements can result in a return to the despair of childhood and if this is not recognised by the therapist, the client can terminate therapy. When my therapist failed me, usually by misattunements, I raged and felt let down once again, the

pain I experienced was overwhelming and immense, and my response was to return to my normal defensive patterns and to lose hope. Because I had learned that I had a right to protest about this to my therapist without adverse consequences I began to be able to address these feelings with him. I learned over time that these powerful feelings do not have to cause an end to relationship, or abandonment, but instead can develop the relational depth. There was also a sense of relief from my almost permanent feeling of being wrong when I was able to feel that he was wrong instead, for once my critical internal voice, normally directing feelings of wrongness and rage towards myself, was directed outwards towards a relational other that could contain them. Even these apparent failures, however, serve a valuable function in that, provided that the relationship is strong enough to contain any overwhelm, they are part of the process of developing healthy inter-dependence. As Winnicott (1971, p10) says of good-enough mothers: "as time proceeds she adapts less and less completely, gradually, according to the infant's growing ability to deal with her failure". The failure then is what prompts independence.

Countertransference

"The therapist is forced into shapes determined by the client's earliest relationships and is further influenced by the human tendency to repeat certain old patterns" (Kahn 2001, p115).

The above quotation refers to the phenomenon of transference. My intention is to look, though, at countertransference, which is the therapist's response to the client's transference. Currently and historically there are significant contributions to the body of knowledge on countertransference from varying perspectives. The scale of this research does not permit for a full exploration of this concept therefore I have only selected such literature as is relevant to the issue of countertransference in regression.

Countertransference is usually considered to be the therapist's feeling towards the client. It can be divided into pro-active, that which the therapist brings of their own history or process into the relationship, and re-active, the therapist's response to the client's transference (Clarkson 2003). Pro-active countertransference is largely problematic resulting from the therapist's unsolved conflicts. Here I am considering re-active countertransference as a response to the client's story, spoken or unspoken.

Participant A describes his countertransference which engenders parental feelings, and he explains how he uses these responses to inform him of the client's needs and ego state or history:

> … what I remember most of all, is holding them one series of memories, and it's often right, it's analogous with the feeling engendered in me, the nights I had to stay up with my own sick children when they had been young and they have a fever and I hold them all night long and I you know I never really get to sleep myself I'll doze for five minutes but they'll move or they'll cough or something like that and yet you know if you put them down the baby will wake up they don't sleep then you you can't lay down with them and you have to sit up and hold them all night and that's often the feeling engendered in me when I'm holding a regressed child.

Racker (1968, p2) describes it "as a technical instrument, that is, an essential means to the understanding of the psychological processes (and especially the transference processes) of the patient." He (1968, p15) sees it as the patient's transfer of "infantile and internal conflicts to current situations and objects which are out of place and inappropriate." That is, the client sees the therapist through the spectacles of previous relationships. For many therapists the process of transference and countertransference is an effective tool to understand the client's early relational history which becomes manifest within the current relationship. Young (2005) considers that transference and the therapeutic process itself are based on a mistake, that is, that the client experiences the therapist as someone else. He notes that many Psychoanalyst colleagues of Winnicott and Little considered that the relationship between them went beyond the appropriate boundaries. Working at the pre-verbal regressive level does involve an awareness of boundary and the potential for the movement of boundaries. In responding from the countertransference Winnicott met with the infantile aspects of Margaret Little and his countertransference response was to step outside the normal boundaries of the analytic frame. So countertransference then can be seen as the catalyst for movement of the analytic frame (Little 1990).

Young (2005) considers that "the frame must provide a bounded space in which it is bearable to do the work. Space – space for the patient to be safe enough to explore what is unsafe." He also discusses those theorists who have used the countertransference and subsequently stepped outside of the analytic frame with the aim of meeting the patient's

needs and effecting a repair. My belief is that countertransference is an important key to understanding the client and a guide to the relational stance needed to offer repair. When clients have experienced infantile, pre-verbal trauma their ways of being including transference and defences will operate on a more primitive level. Borgogno and Vigna-Taglianti (2008) consider that not only the patient but also the analyst is involved in primitive experiences. They consider that the unconscious relationship of transference and countertransference occur to "create the affective inter-psychic conditions that will enable the transmission of the emotional alphabet that is needed to master the lived experiences" and that this will be long-term therapy to allow such transference to be established "since such a patient is lacking a piece of experience connected to subjectivation (Botella and Botella, 2001) and consequently trauma for them would consist of the very fact that something that should have happened has actually not occurred." I would then assert that countertransference and the consequent meeting of relational needs is the means to relational repair. Participant I, speaking as a therapist, describes an instance of such countertransference feelings and her response to her client:

> a client that I was holding…there was nothing, no words going on, but I had a sense that his head was really tender, like a new-born, like how you would protect a new-born baby's head, and I put my hand on the top of his head, on the crown of his head, and something really changed in his body, his body *went* in that, and there was something really met in that, and he did, he was able to tell me a few sessions after that that had been really powerful.

Participant F describes an experience of countertransference:

> I feel an arousal or a fatherly tenderness.

If countertransference is viewed as an inescapable part of the imaginative work of being able to think one's way into the client's concerns then it can be viewed as a major vehicle for empathy; but it is more than empathy – Maroda (2004, pp67,70) sees countertransference 'as the sleeping giant'. She believes that the countertransference can be as important as the transference and that the therapist can be almost as important as the patient. She quotes from Benedek (1953, p208) "…the unfolding of an interpersonal relationship in which transference and countertransference are utilised to

achieve the therapeutic aim. This definition places the therapeutic relationship as the most important agent of the therapeutic process", a concept identified by Norcross & Prochaska (1986).

Participant H identifies how she uses her own feelings/experiences/perceptions as a therapist to stay with a regressed client:

> …it feels like a felt sense, just a hunch and not being too over-defining of it, but to be curious, just to hold in my doubts and uncertainties really, and tracking, observing eye contact if there is any, very often there isn't, observing my own counter-transference responses, observing body posture, and even doing just gentle feedback, even to say that 'it's me…I'm still here' so that they can be more grounded in present reality… but very delicately you know…

She illustrates her use of countertransference to understand her client's story:

> it was almost as though I was being induced into sleep, and I was struggling to a) stay awake, and b) understand what was going on, suddenly had this image, and they were holding so many different ways, and we would communicate in different ….this, but this image of this mother with a small child, with the mother unavailable, fast asleep, and I just said to her, 'did you, did your mum fall asleep with you and you were desperate to try to wake her up?' and, 'stop'…up came the memory, yes, she was a, she was a sherry drinker, you know, she recalled the clock falling on her knee and trying to wake her up…she was out of contact…

Reflecting upon the feelings I have as a therapist working with clients undergoing these kinds of regressive experiences has been a source of increasing insight and knowledge. My countertransference when working at these developmental levels usually involves maternal feelings and a desire to meet the infant ego in whatever way is necessary. This can be through eye contact, the expression of understanding, touch, physical holding or through silence. When clients are dealing with such a high degree of psychological damage that they need to revisit these pre-verbal times, then their needs become appropriate to their developmental age of the time. Clients who are regressed struggle to cope with cognition, thus, as Winnicott (1965/1984) advised, interpretation during these times is not useful and may be experienced as an impingement. My own experience has underscored the way that countertransference also involves an experience of one's own

infancy needs. Participant E illustrates how his personal work as a client now influences his therapeutic work:

> …she obviously regressed in the therapy to the point where we could only do the work as long as I was actually physically holding her and that gave a kind of security which enabled some very intense feelings of lostness. I can also remember occasions where I tried physical containment and it didn't work at all it wasn't the right thing for that client…Because I think holding and not being held are very much part of my stuff from very early in my life which means I am very acutely sensitive to it and probably quite good at you know at picking up the vibes and reacting to the clients need or where things went wrong in their lives.

If the therapist has not worked with these needs they may rely on the client to fulfil them, hence the need for a personal experience of this depth of work. Therapists may also experience the threat of chaos and psychotic process. This can be frightening for the therapist who has not met this in themselves.

Participant B identifies this experience in her own therapy:

> I stood for something that she'd not faced in her own life…I don't think she'd looked at it in herself. And I think I knew that, but I was still going to take the risk of showing, and watch what she did, and I think that frightened her…I think it opened up on her own need.

Participant A describes powerful feelings that can be engendered by in-depth psychotherapy, which can be psychological and physical. He is describing a powerful physical response in countertransference with a particular client:

> …it's like holding a child rather than an adult. I've held some beautiful, attractive looking people in my arms, but once they get into regression it's just like a little kid. Now, where have I gotten sexually excited, 'cos that's an important part of the question. Intriguing to me the people I have sat in a session with and started to get an erection with. Talking about everything later I discover they are a sexual abuse victim and they've kept it a secret. I'll give you one example and it has nothing to do with attractiveness. I was sitting with a very ugly woman who does not smell good to me, who is obese and aggressive. Yet each time I see her somewhere in that session, I start to get an erection. Its two years before we get around to the sexual abuse with her father

which was a very seductive abuse, not a painful abuse, not a rape, but a slow, easy, seductive abuse which is why this woman has never been married. In her adult life she has sort of been a virgin, as a child she wasn't, that's her fending people off. And yet I could pick up that energy and my body is picking it up and responding, because while she's fending me off she's also seductive…..And those are the wonderful countertransferential resonances. It's where we are resonating with them at a physiological level.

He is describing sexual arousal which he considers to be in response to his client's countertransferential story. He has identified his experience that this countertransference is often present where there has been sexual abuse. Maroda (2004) highlights that discussion of such sexual feelings towards a client is a controversial area. She cites Gorkin (1985; 1987) concerning different aspects of such countertransference, and Mann (1997) identifies the experience of either distaste for the client, which he describes as 'transference resistance', or a desire to respond to the client's unconscious process. Of course, either of these positions is problematic for the therapist and is controversial for the profession, but the participant is describing his therapeutic use of such feelings. This aspect of countertransference is complex and involved and is beyond the scope of this thesis, but could be explored in future study.

A high level of skill is needed in management and tolerance of these processes, and I feel particular insight was gained from having undergone these experiences in my own therapy. Nathanson (1992) considers that "It is axiomatic that therapists treat their own patients in a manner and style somewhat akin to the way they themselves were treated."(1992, p22). He considers that therapists minister to their clients as they were ministered to by their personal therapists. I would enlarge this to say that therapists who have not experienced repair of early infantile relationships can 'parent' their clients as they have been parented.

Therapists can make use of the way that their own awareness may develop as a kind of response to the patient's immaturity and dependence as they regress. In Winnicott's account, the good-enough mother is willing to let go of her identification with her infant as soon as the infant is capable of become separate. Because of maternal attunement and empathy the mother knows how the infant feels and is able to meet its needs for holding

and environmental provision. In the therapeutic relationship this attunement and empathy is present in the countertransference and skilful use of this enables identification of and adaptation to the client's needs and recognition as the client develops and as needs change.

As in the mother/infant relationship, when the therapist fails to attune to the needs of the infant/client they will experience this as an impingement or, as Khan (1963) would describe it, a psychological affront to their sense of self.

Participant G identifies her experience of misattunement which was worked through with her therapist:

> …I got full, in that sense I always felt that once we got beyond that sticking point of me feeling, 'it's the same pattern, being missed, and not being remembered, I'm not being thought about, I'm not being held, I'm not safe,'…once we got beyond that something different happened, then I allowed myself to really get into the work…

In order to meet the client's needs in regression the therapist must be reliable, non-defensive and aware of the risks involved. In this phase supporting and managing the client's experience is more necessary than verbal interpretation. This involves accepting the client's anger and rage without interpreting it as transference or identifying previous patterns, it is not the time to offer logic or teach self-support. The client needs their experience to be accepted, and for the therapist to offer necessary support within the session and sometimes outside of the session in the form of texts and phone calls or additional sessions. Winnicott (1974) believed that this process involved a frightening return to the earliest unintegrated state, which would involve a primordial fear of annihilation which can have a physical reaction in the startle reflex. The therapist must be able to stay grounded in reality, retaining their sense of identity whilst being able to experience the anxiety, fear of annihilation and loss of identity that the client faces. This requires the same qualities that a 'good-enough mother' provides.

The development and maintenance of such a relationship involves emotional effort for both parties. Clients can access powerful primitive emotions of rage and fear during the regression to dependence process, as can be seen in the participant's descriptions in the chapter on Terror, but my experience suggests that this is generally manageable.

Participant G identifies that her trust in the psychotherapy process being beneficial:

> I needed it out…so I think I trusted that process somewhere, even though I was often scared,

I consider that the question for the therapist in private practice is, "given my situation, the client's functionality, and practical facilities is this client containable and manageable by me?"

Participant E illustrates his concerns:

> …but certainly a fear that it would…that I would be unable to hold it with her, that it was so overwhelming, that 'was this a good idea' you know, 'should I be doing this' but I also knew it could happen to her even outside a therapy session, it wasn't necessarily the therapy that was triggering it, and it meant that the session would always go on longer than an hour, and it meant…and it was exhausting, physically and emotionally, mentally exhausting to stay with…

Some clients' levels of distress and lack of internal and external emotional support mean that additional support in the form of Mental Health Services may be required. The client's history, functionality and psychological style should be considered at assessment, although sometimes it is not possible to see the emergence of a high level of distress prior to beginning work. In a private practice setting the therapist's ability to work with high levels of distress must be considered, they must be supported by supervision, and elicit the support of other agencies if necessary. Participant E relates an experience with a client who was receiving support from Mental Health Services:

> … her consultant had formed the opinion that this was some kind of re-living of trauma, and was a dissociative episode, and not, not a normal psychotic breakdown, but she didn't enamour herself to the staff in those phases, but in sessions with me the whole room could get filled with this kind of sense of tension and terror.

Bollas (2013) addresses this issue with the recommendation that a team of supporters is assembled in order to deal with such crises. This may be possible for such a high profile practitioner, but would be much more difficult for most practitioners when they are unknown to local psychiatrists. The prevailing wind of CBT also has an impact here. Previously, when I have sought support from psychiatry for a client in crisis the

response has been for the psychiatrist to refer the client for a course of CBT which would divert the client from the issues of their internal life by attending "to a time-limited cognitive project. Just as a parent resolves a toddler's crying by diversion" Bollas (2013, p2). He considers that this action would forestall a 'necessary' crisis. I concur with this position, considering that to fail to address this emergence of what I consider to be the true self, leaves the client forever in a place of fragility and compromise.

Piloting distressed and regressed clients makes it essential for therapists to access supervision from practitioners experienced in this type of work in order to gain support, advice and assistance in recognising if it is appropriate to work with a particular client, to obtain help in understanding transferential aspects of the relationship and to ensure that the relationship remains ethical. Once all this has been considered then it is the combined efforts of both participants that bring 'the mother/infant emotional upheaval' to the foreground of the therapeutic relationship. When this is successful, integration of disconnected feeling states can occur. The provision of a containing environment, affective attunement and acceptance of dependence allow the regression to occur. Van Sweden (1995, p210) recognises that "these provisions support ego integration, encouraging developmental progression to take place." Winnicott (1958/1984) also identifies that given the provision of a safe setting and the facilitation of regression to dependence then the hidden self can become integrated into the total ego, there can be an unfreezing of the environmental failure and the expression of anger related to this. Subsequently there can be a return from regression to dependence with instinctual needs and wishes becoming realizable.

Bollas (1987, p230) considers that "patients convey their internal world through the establishment of an environment within the clinical situation, and they necessarily manipulate the analyst through object usage into assuming different functions and roles…This is so because the patient cannot express his conflict in words, so the full articulation of pre-verbal transference evolves in the analyst's countertransference." Maroda (2004) also recognises the regressions of both therapist and client and their immersion in the symbiotic phase of treatment whereby the work centres on the pre-verbal and the patient requires more of the therapist's self.

Participant E describes his regressive experience as a therapist (my words in parentheses):

> …but it's just more distant from that feeling, it's not so present, so obviously I don't… regress…times when you have the same feelings, but they're much more….
>
> (Powerful, I guess)
>
> …yes, cathected, or whatever words you want to use, that dominate how you're feeling
>
> (Do you ever have that feeling when you're working with a client, who's very regressed and infantile?)
>
> …I can certainly recall particular clients…in …the early twenty or more years I've been doing psychotherapy, in the early phase, funnily enough, maybe I should have come across those clients later…
>
> (Where the countertransference was one of your own…infancy experiences, then?)
>
> Yeah, I don't think you can go into the client's inner world, object world…without, to some extent, going into your own…
>
> (How painful was it?)
>
> Painful to me as a therapist?...I can't immediately answer that….what I can remember is a feeling of exhaustion.

My experience of working with regressed clients has involved being in touch with my pre-verbal experiencing, that is my connection with the infant part of me. As my need to be developmentally met has been addressed I am able to use such experiences as a diagnostic tool to guide the process of the relationship I am working in. In writing of Winnicott, Khan (1984, p xi) described that he "listened with the whole of his body" and that his "psyche and soma" were in perpetual dialogue and debate. Van Sweden (1995) recognized that in this process much of the analysand's communication is pre-verbal and therefore increased emphasis is given to the countertransference of the therapist.

In his chapter on the meanings and uses of countertransference Racker (1968) refers to Freud's 'third meaning' in the transference. "It is in the transference that the analysand may re-live the past under better conditions and in this way rectify pathological

decisions and destinies." Racker continues to look at the three meanings of the countertransference, seeing the third meaning as affecting "the analyst's behaviour; it interferes with his action as object of the patient's re-experience in the new fragment of life that is the analytic situation, in which the patient should meet with greater understanding and objectivity than he found in the reality or fantasy of his childhood." He also quotes from Heimann (1950) "the basic assumption is that the analyst's unconscious understands that of his patients." All of these theorists are seeing countertransference and the understanding which can arise from it as a means to interpretation which ultimately would result in the analysand obtaining insight, which is the main aim of psycho-analysis. My hypothesis would be rather that the countertransference can help us to understand the client's story, both subjectively and objectively, and this insight can then help us to respond to the client in ways which offer a relational repair. I must stress when I write this that I am thinking of the clients who are the subjects of this thesis, and not the general client population, where insight can be useful in bringing about change. In 'Interpreting the Counter-Transference' (1992) Hedges gives an account of his experience of countertransference and how his understanding and use of countertransference reactions has influenced his work. In Hedges (1994b) 'In Search of the Lost Mother of Infancy' he has further developed his understanding of countertransference as an indicator of the presence of pre-verbal material and as a guide to eventually engaging the relational components of the work, and on removing blocks to interpersonal relationship, therefore seeing the aim of such understanding as transformation through connections which may include physical contact.

Secure attachment

Theorists consider that clients who need to re-visit early developmental epochs will need to develop a long period of secure attachment with their therapist in order to create a safe, secure base in which to explore these painful experiences. In this process the infantile relational needs are believed to re-emerge and the developmental relational stance will require some gratification of these needs (Van Sweden 1995).

Siegel (2003) describes psychotherapy as a form of attachment relationship in which the client seeks proximity, is soothed, and develops an internal working model of security

based on the experience and subsequent learning of the nature of the relationship between the therapist and client, seeing that an effective change in brain function and in the attachment process can help the client to self-regulate. Stewart (2011) describes the possibility of developing a secure attachment after a successful long-term therapeutic relationship. Some attachment theorists (Roisman et al. 2002; Phelps, Belskg, and Cmic 1998) have called this 'earned secure' which describes the attachment relationships of adults who have had early traumatic relationships, but have created a narrative for their experience and have entered into a reparative relationship. The development of attachment, the understanding of object relational needs, working within transference whereby early relationships are reprised within the therapeutic relationship where the client can experience a new relationship and risk regression and dependency with a dependable other. Ultimately it is possible for previously held disorganised, insecure attachments to move towards more secure attachment relationships as a result of the therapeutic relationship. My participants have identified that this attentive, loving care, when provided within the therapeutic relationship through adaptation of technique, allows clients to rediscover themselves as worthy and loveable, and to develop secure attachment patterns. This attachment is considered necessary by Steele et al. (2001), seeing that in the treatment of trauma the client has a need for emotional and physical safety, and the attainment of a secure attachment to a consistently responsive and caring therapist is necessary to enable the client to recover from traumatic injury.

Ego boundaries

Winnicott (1965/1984) frames the provision of ego-support by the therapist as a reprise of the mother/infant relationship whereby the mother lends some of her ego to the infant. I have experienced this in my personal relationship with my therapist. In a regressed state I have needed protection from impingement, whether that is impingement in the form of interruption of my reverie or silence by my therapist or by some outside agency or event. I have also received ego support in the recognition that I might need soothing when such an impingement occurs. Both of these forms of support have enabled me to remain in my regressed state without needing to react, my therapist has done the reacting for me. There have also been failures in this aspect of my therapy, where my therapist has misattuned to my need in the moment and in a lack of spontaneous gesture in response to my action. On one occasion I remember playing

with my therapist's hand and my expectation was that I would be met in this. My therapist did not respond and I felt shame and reacted, resulted in a premature return from regression into shame for being regressed.

Winnicott considered that working with a regressed client may require the therapist to lend some of his own ego to the client. He views that a regressed and dependent client in some circumstances - such as where the client is unsafe to leave the therapeutic setting – unsafe to drive, etc. - requires a change in the therapeutic stance whereby the therapist takes appropriate responsibility for the client's actions, feelings, behaviours. He considers that when the client is regressed the therapist will need to 'take care' in the way that a caretaker would with an infant. Therapists may also, in the client's interest, need to allow their own boundary to move in order to accommodate the client's need. The client's need may penetrate the therapist in the same way that the infant's need penetrates the mother, though at times this may be uncomfortable for the therapist/mother. The therapist may also need, in the client's interest, to give the client more of themselves than they normally would – this too may be uncomfortable.

Giovacchini (1972, p301) comments on the propensity of even healthy patients to regress given certain circumstances. He considers that evidence can be found of "fusion during the transference regression. This should not be surprising because if one accepts the existence of a symbiotic fusion as a beginning developmental phase, one should expect its persistence in the context of more integrated superstructures. During regression it can become activated again."

Within this there can be an experience of the loss of self and of the client's inner world. Bollas (1987, p254) describes this process of mutual regression "only by making a good object (the analyst) go somewhat mad, can such a patient believe in his analysis and know that the analyst has been where he has been and has survived and emerged intact with his own sense of self." Little (1981) describes her work with 'borderline' patients, commenting that "the work shifts and changes continually and calls for a high degree of sensitivity, stability, and flexibility in the analyst." She recognises that this is a difficult task in which the analyst must face his own anxiety and inner processes, having freedom of imagination, the ability "to allow a free flow of emotions in oneself, flexibility of ego boundaries", may all be necessary in the treatment of the patient.

Participant I, speaking as a therapist, describes her reactions to some of her clients and how she responds to the countertransference:

> With love, actually, with feeling love for these clients…but also letting myself feel all the other things, too, letting myself feel all the countertransference stuff that's horrible…how do I meet it and how do I envisage meeting it…through touch, through look, through sensory experiencing more than the verbal word.

She describes her immersion into the client's world, by giving an example of how her inner boundary, her sense of separateness becomes subsumed into the client's world:

> … yes, the ecstasy and pain, it felt like, that…and I feel like I hit that ecstasy and pain place a lot with this client group.

Balint, in recognising that in a 'benign' regression there is a potential benefit for the client in resolving experiences of the past which have caused damage, he also recognises that the therapist "must accept and carry the patient for a while, must prove more or less indestructible, must not insist on maintaining harsh boundaries, but must allow the development of a kind of mix-up between the patient and himself" (1968, p145).

In this formulation the aim of addressing these early developmental needs is to help the client to "catch up" with other aspects of the self which have not be fixated by failed dependency and the primitive defences which have surrounded the experience. Transitional objects are indicators of the developmental stage that the client is in and can also evidence the development of the beginning of internalisation of a more secure relationship.

Dosamantes (1992, p361) in linking the pre-verbal dyadic couple with the therapeutic dyadic couple writes "while in a state of symbiosis, the dyadic couple blurs the boundaries between them and together they create the illusion of at-oneness with one another. In this merged state, words have little meaning for them, and communication transpires primarily through touch, sensation, and mental images."

The use of transitional objects

Winnicott wrote of transitional objects originally in his 1953 paper. He describes the movement between what could be called 'subject' and 'object', or 'me' and 'not me'. Initially, the infant experiences everything as himself, such as his thumb. Eventually the infant recognises an object such as a teddy bear or blanket. Winnicott describes an "intermediate area of experiencing". In this intermediate area the infant uses an object to represent the relationship that reduces anxiety.

A transitional object is any object (although usually a soft toy, comforting blanket, or some other item) which is in the infant's/client's possession and can be used symbolically to soothe in moments when the mother/therapist is not available because it is believed to represent the soothing power of that relationship. Winnicott (1953/1984) considers that the infant uses an object to describe the intermediate area of experiencing, the between. This object comes to represent the holding relationship between mother and infant in the time before the infant is fully able to have a sense of self and other. Litt (1986) identifies that Winnicott considered that such attachments represented an important aspect of ego development which ultimately led to the development of the sense of self. He introduced the terms 'transitional object' and 'transitional phenomena' to identify the area of experience between 'oral eroticism and true object relationship.' He described an intermediate area of experiencing in-between the infant who has not yet developed a sense of self, and the infant who has grasped the sense of self and other, a transitional area to which inner reality and external life impact, again a transitional area (Winnicott 1984, p230). The term 'transitional phenomena' describes the use of soothing acts in order to reduce anxiety. This transitional tendency develops at the point when the infant is moving out of oral eroticism towards recognition of 'me' and 'not me'. The point at which the infant begins to incorporate 'not me' into its soothing technique is described as 'transitional phenomena', when this consistently becomes one such object this is known as a 'transitional object'. Winnicott made clear that it is not the object itself that is referred to, but rather the possession, and the intermediate position between the subjective and the objective (p231). In using a transitional object the infant possesses it. The infant can then use the object in times of anxiety as a means of soothing. Winnicott considers that the root of symbolism in time is highlighted by the transitional object and shows progress towards experiencing.

Within the therapeutic relationship a therapist can also use this formulation of infant development in the period before the client has fully developed the sense of self and other. It is seen to support the client between sessions, enabling them to hold externally a sense of the relationship with the other.

Participant C describes her experience of receiving a transitional object:

> …..if she was on holiday for a month it was like I'd got something of her ….the scarf I used to keep under my pillow, the cardigan I'd put on at night and… To feel…to feel connected, I think, as much as anything, this person's given me something because they understand, therefore, even if I'm feeling unloved, I know…, so it's somehow it affirmed… At the beginning of therapy I had a stone I used to keep in my pocket, later on I had a scarf (and a cardigan).

> Yeah, it was just so, it was just like I needed this contact and to know this person wouldn't disappear…

Little (1981) describes how the attention to a client's physical needs made it possible to reach psychological material which may not have been possible otherwise.

When infants have experienced being shamed by caretakers for their needs or vulnerability, they can reject and disown those aspects of themselves. When these aspects of themselves are brought back to awareness through the process of therapy, they are often thought of with disdain and there is a process which needs to occur in which clients start to reclaim and integrate those previously unintegrated self-aspects.

Participant G describes how she used a transitional object in her therapy to give a symbol to her relationship with the infant part of herself:

> I still have a cushion from my therapist's room which I, which is my, you know, the baby, for me to, you know, talk to, love up, soothe, stroke or blah, and that was really important for me to be able to take that home after, when I actually made contact with her I was able to see her and recognise and acknowledge the deficit, and feel a kind of, you know to integrate her, I needed to have her in-between sessions…..and I've still got it, and I think I'll always have it.

This participant, K, is describing how phone texts from her therapist had become a sort of virtual transitional object which she could look at to evoke a sense of the relationship:

> …texts were a really important transitional object and I can remember once deleting them by mistake, and feeling completely bereft.

Winnicott (1960), Tustin (1990), Bick (1968) and Hedges (1994) in different ways consider the infant's skin as both a container of the internal world and a connector to the external world. Infants (and regressed clients) seem to find comfort in soft, warm items such as fabrics. The items that infants seem to choose have such characteristics, and the participants of this study have also largely described the finding and acquisition of such items to symbolise the soothing that they experience within the therapeutic relationship. These items seem to have their place for both infants and clients for a time in their development and are relinquished when they are no longer needed, as Participants C and B acknowledge:

> I would say….'when I've left here I can't hang on'….this was when I got things like phone calls…and transitional objects…..to take home….i can't remember exactly [when I stopped needing them] but I think there were things that I didn't need so much, I'd still got them, but I didn't cling on to them.

> …..she'd taken a photograph of herself ……she'd clearly kind of thought and felt herself back into it…..she kept the tape recorder running for three or four weeks….then she'd cut and edited snippets and threaded them all together….she did that, and that was lovely, and eventually I lost the tape….it was actually right to lose it in the end….the work was moving on and actually I didn't need it.

Participants G and D, from their perspective as therapists, describe their use of transitional objects with their clients:

> …I've given them things, what kind of things, from the Pound shop, these tiny little knitted teddy bears that just had a little heart on that said 'I love you' or 'look after me' and I remember buying a couple of dozen of them and quite a few of my clients have got one of those that was for, you know, at whatever point it felt right, and they were ready to receive it and able to use it, and others have chosen things like a stone .

…with my regressed patients, if it looks like they would benefit from having something of mine to hold on to, just something small, I know you have to analyse what's been imbued into this particular item that you might have given to the patient, and can make for complications, but on the whole I'd still rather be spontaneous and get it wrong than not reach out at all.

Having looked at how therapy can effectively be considered to facilitate regression to progression it is important to mention an aspect of regression which is neither helpful nor healing.

Malignant regression

Balint (1968) recognised that there could be negative aspects to regression. He considered that these negative aspects involved patients who, rather than needing regression to progress in their development, regress in order to avoid change and maintain their defensive structure, that is, those patients who demand caretaking from the therapist in order to maintain their fragile self-structure. In this construction the therapeutic task would be to challenge the regression rather than to facilitate it.

The following participants are referring to this possibility, that is that the client may come to rely upon regression as a means to get their needs met rather than as a means of progression to maturity. Participant C seems to echo Balint's position:

I feel the risk could be that it could just be staying there, so that I'm very careful, I don't just offer it…

She recognises that there was a potential for this within herself:

…I believe with myself that could have been a risk, but actually it didn't become a risk,

She also identifies how clients may fear that regression and dependence may become permanent:

…but I've experienced their fear of that,…….they won't get stuck like that for ever, but I can understand their fear.

Participant D illustrates the complications that can occur when working with regressive processes:

….this woman has been regressed now….this is her fourteenth year…the only thing that would meet her originally when she was in the three/four year old stage was for me to put my arms around her and hold her tightly, until she could feel her edges again…. I don't think I can really heal something, there's been too much destruction, and she's not sure she wants to live either, so I do sometimes think, and I did question her very gently over it, that maybe she's afraid of getting better…. because she's also afraid that our relationship would come to an end.

Participant E connects malignant regression with borderline style personality:

There's that other phenomenon you get with people who are called borderline…who seem to have an intense malignant dependency or…toxic dependency…whether that's real dependency or whether that's just some kind of … learned behavioural habit ….I think it's an apparent dependency which masks real dependency….two years into therapy when they regress to an earlier developmental stage… it's a sort of demand to be rescued.

Maroda (2004) notes that "the more disturbed the patient, the more difficult and traumatic" the therapeutic re-enactment (the out-playing of the story) will be. Van Sweden (1995) recognises where there is a high level of disturbance within the therapy it can be difficult to differentiate between benign regression and malignancy at this time. This is because at the heart of the regression it is difficult to see progress or identify the direction of the work.

I have reservations regarding the concept of malignant regression. Whilst there can be regression in the service of gratification, which would not be towards progression, the reasons for this search for gratification rather than progression can be found in the client's early history, and, with the appropriate therapeutic relationship, can be addressed by the acceptance of this need and the appropriate holding of boundary, resulting in a regression towards progression. A previous client of mine (I shall call him Fred) has progressed by being given minor gratification from me. Sometimes, when wants are not met there were hot protests. Overall his needs were such that without these minor gratifications to ease his anxiety he would not have been able to stay in therapy. Eventually, he was sufficiently supported to conceive of the idea of change and progression, at which point there was no further unhelpful regression.

My experience of the facilitating therapy as a client

Throughout this work I have reflected upon my personal experiences as a client and as a therapist, but in this section I want to describe my experience of the facilitation of my therapist. I have been hesitant to give detail because the relationship is intimate and therefore private. I consider that my gift as a therapist, supervisor and trainer is in sharing myself with the other, yet on the negative side of this, I can easily give myself away and open myself to those who do not value my offerings. Yet I believe that being open to share our experiences is essential. Winnicott describes the process of the psychological development of the self, and it is this description which has so closely matched my own experience as a client. My therapist, although highly trained, did not fully understand the regression to dependence process, yet he was able to stay with me through it because of his ability to live without knowing, to accept my experiences and to love me through them. The most important times for me were when he allowed his own spontaneity into the regressive process. Where he seemed to know how little I was feeling and would reach out to me. On one occasion I was experiencing a high level of distress and he needed to go to the toilet. He took off his jumper and gave it to me to hold until he returned. Not only was my panic contained by this gesture, but also I was able to see his understanding of where I was and his acceptance of that. There were many other instances like this where he facilitated my development. I was very dependent for a long period and he managed to tolerate this, attending to his own needs and yet continuing to support me. He made many misattunements and mistakes, but the relationship we had developed enabled quick recoveries and he was always ready to own his own errors and failings. Coming from a family where no one ever said sorry this was really important for me. I consider that he gave me the gift of himself. He taught me how to have an intimate relationship and how to be non-defensive and accepting of myself and my clients. Throughout this time I was functioning and practicing as a therapist. His support enabled me to work and function sufficiently and I saved my falling apart until my therapy sessions. I was a therapeutic infant.

Real infants, therapeutic infants

Stern (1985, pp14-15) highlights the difference between the infant observed by developmental psychology, and the infant reconstructed using theories about

developmental psychology in the course of clinical practice with adults. He describes this infant as a joint creation between therapist and client; the client an adult who became a client, and the therapist who has a theory about infant development. He considers that "this recreated infant is made up of memories, present re-enactments in the transference, and theoretically guided interpretations." Like Winnicott he considers that both clinical and observed infants are necessary to think about the development of the sense of self. He highlights how "the story is discovered, as well as altered, by both teller and listener in the course of the telling. Historical truth is established by what gets told, not by what actually happened."

Participant G recognises her expectation of her therapist's response:

> I trusted I would be responded to in a way that I hadn't experienced being responded to - as an actual child…

Bromberg (1991, p417) recognised that "the child in the patient is a complex creature; he is never simply the original child come to life again, but always an aspect of an aware and knowing adult. In this respect it is fair to portray the relationship between analyst and child as simultaneously real and metaphorical. Regression in one respect is a metaphor, but not only a metaphor. It is also a real state of mind." The powerful and overwhelming experiences of shame, rage, anxiety or loss of contact with reality experienced in therapy could usefully be formulated as a kind of reprise of much earlier traumatic incidents which have been experienced in the early parenting of the client.

Conclusion

In this chapter I have demonstrated how therapy in regression to dependence can facilitate repair by looking at the relationship itself and the particular setting and interventions which are facilitative. I have identified how the therapist's use of self within the transference relationship can both tell the story and change the story. I have written of the importance of the relationship between therapist and client, the development of a love relationship, and data from participants has been used which demonstrates aspects of this relationship. I have described the importance of re-experiencing, not just remembering, and have identified by what means the therapy is

facilitated. I have identified the importance of touch in regression and why this is important when working with nascent relational needs.

Clients who need regression to dependence have within them elements of chaos, the chaos which emerges prior to the development of self, and often the chaos present within their early environment. Order proceeds from love, and the therapist, in facilitating this therapy, offers love in the midst of relational damage and disturbance. Winterson (2011, p211) describes how her chaotic upbringing has led to hurt and damage, "And the people I have hurt, the mistakes I have made, the damage to myself and others, wasn't poor judgement; it was the place where love had hardened into loss." She recognises that she "would need to find the place where my own life could be reconciled with itself. And I knew that had something to do with love"(2011, p146). The therapeutic aim then would be to acknowledge this loss, and the effects of loss, but to repair with love. In clients with such early relational damage the theory helps to identify how this love can be offered in ways that address relational needs which originate in early infancy.

Bryce Boyer (1993) recognises that there has been a change in attitudes regarding the treatment of more complex patients because of increased knowledge of character structure, psychopathology and deeper understanding of early object relations and development. He notes that treatment of patients with primitive disorders, that is, relational disorders believed to have originated in infancy, demands heightened understanding of the interactions intrapsychically within both therapist and client. My aim has been to demonstrate how theory can heighten understanding, so making therapy effective with this client group. Stewart (2003), though, considers that this area of psychotherapy has not received the recognition it deserves because of the adaptation of technique that it requires, and the fact that the therapist goes with the client into unknown aspects of themselves, for however long it takes, and without the benefit of technique or interpretation to lead the way. Stewart sees this as the necessity of living without knowing. I would add to this the degree of difficulties for the client, the length of time and commitment needed by both therapist and client, and the costs involved. However, many clients who have reached this point in therapy recognise that it is their only hope. I know for myself that it has been well worth it.

I chose the quotation at the beginning of this chapter because it speaks to me of love. I have found this love in my personal therapeutic relationship and I offer it to my clients. Whilst the ways of being, and techniques of therapy, are referred to in this chapter, ultimately it is love that heals. In a loving parental relationship, the parent is keen to do what is in the best interests of their child, and in a therapeutic relationship the therapist's aim is to do good for their client. Ultimately, whilst I have talked about various theories I do believe that the relationship itself is the main agent for change. Wachtel (2008) identifies the importance of relationship to the practice of psychotherapy. He considers that psychological change is effected by relationship; this is also evidenced in contemporary research regarding important factors in therapy, one of which is the relationship between therapist and client (Norcross 2011).

Such a relationship is based upon the therapist's attunement to the states and needs of the client which can change moment by moment. Winnicott (1965), Balint (1959) and Van Sweden (1995) all discuss the importance of silence in regression; however, my participants did not mention the importance of silence in particular, they did however, describe the importance of their therapists' attunement to the client's moment by moment experiencing and that it was this attunement that was significantly different to their original infancy experiences.

Revisiting experiences which are believed to have occurred prior to the development of self can result in the re-emergence of terror and of shame, which is a reprise of the original nascent experience. The following two chapters address these areas of terror and shame as they have emerged within the participant data.

<p style="text-align:center">Chapter Six</p>

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Terror: A Sickness of Spirit

"This man is going about and carrying a sickness of the spirit which only rarely and in glimpses, by and with a dread which to him is inexplicable, gives evidence of its presence within" Kierkegaard (1849, p155).

Introduction

I have used the above quotation because it reminds me of my presentation when I first went into therapy, and echoes what I have seen in some of my clients. This life or death theme may seem unexpected in a work that relates to the early infancy period, however, pregnancy, birth and early infancy are times when the balance between life and death is most easily tipped. I can identify with these concepts from my own experience as I recognise them as the source from which my anxiety flowed. Kierkegaard (1849) sees this 'sickness unto death' as despair and in this way the self is lost. When I first identified this theme emerging from the data, I saw it as 'life or death' because of the potential for life or death of the self, and the references to life or death made by the participants. As I worked with it I identified with the terror present in the experiences being described to me. This again reminded me of my own experience of the confusing emergence of my 'sickness of spirit' which would surface at times of stress and anxiety, and of the fear of falling into the source of my dread, the loss of self, which various theorists have identified in different ways. I saw that to find self was life, to lose self was death and that terror was present when the scales were perceived to be tipping towards death.

Participant H describes a similar fantasy regarding her own psyche:

> I saw this huge, huge, great black lake and distant mountains, and the thought was at that moment, 'fxxx, that's my source' and the dread of that, the horror of it was just completely overwhelming in that moment, like it was a big, black, bleak, cold lake, where I didn't even know if things survived...

This is a recognisable theme; I am reminded of Steinbeck's (1952, p132) words "who in his mind has not probed the black water?" Some clients enter therapy with experiences such as the one described above. They function well most of the time, but live with the fear of panic or of overwhelm which can develop, seemingly from out of the blue. Prior to entering therapy myself, I was high functioning, caring for my children and in a responsible job, and many of my acquaintances would have been unaware of the fear that lived beneath my surface. I was always afraid that it would surface in the form of a panic attack, and sometimes it did. I expended vast amounts of energy in attempting to contain it. Had I sought medical help at this time I may have been prescribed medication for panic disorder; instead I chose the therapy route. Adams (2009, p132) notes that clients "oscillate between feeling just fine, and then inexplicably falling apart."

Participant H describes her experience:

> I've felt mad, mad and crazy…..images of something just out of my sight lines, there would be something there that was hostile, just there, just there, but I could never catch it, and it was quite crazy- making….

Little (1990, pp32,42-43), in her account of her analysis with Winnicott, describes the infantile and childhood roots of her difficulties. As an adult she sought psychotherapy and identified a number of difficulties; "apologising for existence, profound disturbance, fear of annihilation with a deep sense of longing, panic, fear of destruction, being bodily dismembered, driven irretrievably insane, wiped out, abandoned, relationship difficulties and terror."

This chapter contains participants' data pertaining to their experience of, and understanding of, terror occurring within therapy, both as client and therapist. I will explore some theoretical concepts which seem to provide a rationale for these experiences, looking at the development of primitive defences in relation to trauma, and how the therapist, the client and the therapeutic relationship may transform these experiences.

Terror in infancy – terror in therapy

Some of my participants have acknowledged the experience of terror as part of their presenting issues on entering therapy. Others would only recognise these feelings subsequent to entering into the therapeutic relationship and beginning to re-experience a significant relationship which has the same depth and quality as the infant/caretaker relationship. The development of this new relationship and the regressive process occurring during therapy can then stimulate old fears and the subsequent defences against the re-emergence of dependency which had originally failed. This is known as juxtaposition which "occurs when there is, for the client, a marked contrast between what is provided in the therapeutic relationship and what was needed and longed for but not provided in previous relationships" (Erskine et al. 1999, pp151-152). Hedges (1994) considers that such experiences and fears are always present when working with pre-verbal processes because the primordial terrors of life or death, which he sees (as does Winnicott 1974) as being present at the beginning of life, re-emerge in the regression. In order to manage these primordial terrors in infancy individuals develop means of protection against these terrors. Defence mechanisms can be categorised based upon how basic or primitive they are. Primitive defences are largely unconscious and may include denial, regression, acting out, dissociation and projection. I will discuss these in greater detail later on in the chapter. Kalsched (1996) offers insight into the development of primitive defences in individuals who have suffered early infantile trauma. He identifies the division that forms within themselves, describing how their original protector against further abuse in infancy also takes on a persecutory role and becomes part of a perpetual, internal re-traumatisation. He describes how these primitive defences allow the individual who has experienced unbearable pain to continue with an external life, and how this may mean that there is a disconnection between earlier traumatic experiences and current life. However, the "psychological sequelae of the trauma continue to haunt the inner world" (p13).

Participant H describes her understanding of core primitive developmental aspects of her regression:

> This was a real developmental stuff about separation, identity, about coming into the world, about that survival…that is the memory that most comes to mind.

In considering that the mother is the repository for indigestible feelings which are made digestible and returned to the infant in a palatable form, Bion (1962, p116) posits that where the mother is an inadequate container the child remains in a state of 'nameless dread'. Such a situation could then lead to pathology, remaining into adulthood to re-emerge.

Winnicott uses the terms 'unthinkable anxiety' (1952a) and 'fear of breakdown' (1974) to describe what he sees as a response to happenings in early infancy where the baby's psychological immaturity keeps it perpetually on the edge of 'unthinkable anxiety' which is normally kept away by the mother's holding function. Other theorists have similar ways of thinking about such processes experienced by clients, using terms such as 'psychotic anxiety' (Klein 1935), 'annihilation anxiety' (Hurvich 1989), and 'pre-verbal anxieties' (Symington and Symington 1996). People who have these experiences will find various different ways of describing them, but terror seems to be present in all of them. Theories of traumatology have some information to offer regarding the symptomology of the experiences, while some aspects of Jungian thought help to offer insight into the more hidden aspects of the psyche.

In the quotations below Participant H describes her experience of a fear that she couldn't understand at the time, which was not engendered by her current life circumstances, but which would emerge unbidden. She also identifies the vulnerability and the inability to articulate the experience:

> …that nameless dread of… that I can still feel sometimes…there'll be a surge of something… an anxiety which has no reason nor rhyme nor even a shape, it's just terror or anxiety…

> ...there was this thing in the water with, like a Moray eel that was all teeth and mouth and threat…the two images together were really aversive, and quite terrifying …levels of terror were quite huge,

Adams (2006, p143) describes some patients as carrying "anxiety and a vague sense of dread…struggling to overcome shock: shocking disappointments, shocking abandonments, shocking betrayals, shocking reversals in health and fortune. The substate of shock lives in their brains and bodies as a shadow imprint of their earliest

experiences." In this quotation Adams makes a link between the experience of dread and shock that she describes and the infant experiences of the patient. She identifies how the therapeutic relationship provides support to the client when they re-experience these frightening episodes. Participants C, D and H describe their experiences of clients' presentations and how they construct their understanding of clients who have experienced early relational deficit:

> I would say they all had a developmental need…it was a relational need and a safe containment. All of them have not had physical holding, or safe physical holding as children. …and I feel that they have reached the point of utter despair...not necessarily suicidality, but that feeling that they are just going to completely collapse...or not being able to cope at all... for the client I think they need to know that I'm gonna be there consistently…and because of their own fear of collapse they need to somehow trust me sufficiently to hold them, psychologically…I think if they are afraid of falling apart they need to know that somebody will stop that happening….

> ….one was very, very psychotic a lot of the sessions and so…I don't think I really held her while she was psychotic...she suddenly shouted 'don't leave me' and we explored that she'd actually gone back to early…when she was about…cos it was just this voice that came out of the blue…

> ….[when] clients come into therapy they may well be in a regressed state, so…they've got limited kind of resources, or something has pushed them back into a place…that's familiar, but they can't escape from somehow, so they may already be in a regressed state, in some way or another…I was thinking particularly of a client now that I'm currently working with whose mother died when she was sixteen, in her external life she's…got a doctorate, she's very functional, she's a lecturer…it was almost like the regression was right there in her body, she's very tall, but actually she doesn't use her whole height,….she's littler than she might be, she curls over at the top…

I have covered in an earlier chapter the contention of many psychotherapists that from the nascent period up to the age of five character styles and defences develop which are carried into adult life. This means that the early experiences of human beings leave their mark upon the psyche of the individual. If this is the case then, what happens in early infancy is of critical importance when trying to understand the ways of being of adult clients. We have already seen how the environment that the infant is born into is of key

importance to its development therefore the caregiver/infant relationship is pivotal to the successful (or otherwise) development of the infant. Caregiver/infant relationships all vary in their quality and style, the key issue seems to be that the environment that the infant is born into should take account of the needs of the infant. If this occurs the infant will move from an unintegrated, unformed self to the development of a sense of self and self-identity.

I will now introduce the writings of some theorists to describe what can happen when an ideal facilitating environment is not available. Borgogno and Vigna-Taglianti (2008) would see such non-availability as causal of pre-verbal trauma because of the potential for damage occurring to the ego as it is developing. Tustin (1994) also recognises the disruption to the infant's development resulting from a stress caused by discord which she considers develops into "an agony of consciousness beyond their capacity to tolerate or to pattern" (1994, p192).

In the earliest stage of development some theorists consider that disturbing happenings are unable to be experienced or integrated by the infant because they "have not yet reached a stage where there is a place to see from" (Winnicott 1988, p131). As the infant has not yet identified its self it is unable to experience happenings from a place of self. Tarrantelli (2003, p916) cites Blanchot's (1986, p28) identification of the same process as "a non-experience….which….cannot be forgotten because it has always already fallen outside memory." Kalsched (1996) understands that the young infant oscillates between painful, uncomfortable feeling states and satisfied, comfortable feeling states. The mother's empathy is required through empathic responses, comfort and naming of states by which emotional homeostasis is restored ultimately resulting in the development in the infant's psyche of the ability to contain internal affect. Little (1990) describes her regressive return to disorganisation and anxiety that she experienced during her therapy, clearly outlining the infantile roots of this experience. She concurs with Winnicott's belief that environmental provision is necessary to manage these experiences within the therapeutic relationship. Without this environmental provision in infancy anxieties concerning existence, survival and identity can remain, and emerge as feelings of 'inexplicable dread' within the psyche, emerging in times of stress, distress and in regression.

Participant H describes the effects of her mother's lack of attunement. Her mother did not identify with her or empathise, so that her experience of being touched was a painful one. She goes on to describe how she eventually experienced touch from her therapist:

> It was inappropriate touch….possibly quite violent or scary touch, my mother was quite rough and didn't appreciate….and I was, as a child, very colicky as a baby and had a lot of eczema, so that touch would be painful and irritating, so it was never soothing, so the therapeutic touch was like….I remember it now, it was just so….it wasn't invasive, it was just like warm electricity going through me…it brought tears to my eyes because it was soothing.

Clients who have apparently experienced early mishandling or other misattunement may present for therapy with a desperate need for relationship yet have a real fear of it, and they may fear touch and intimacy generally. Erskine (2007) would consider the above experience as an example of the impact of pre-verbal trauma. Such trauma, whether acute or cumulative, can be largely unconscious because of its pre-verbal origins, leaving the client without story or reason with which to understand the experiences and feelings occurring in their daily lives.

Writing from a body psychotherapy perspective, Lewis (2004) identifies the shock that the infant feels upon experiencing sufficiently unempathic parental holding and handling in early life. He describes his construct of cephalic shock as similar to the 'false self' of Winnicott considering that the absence of empathic holding leads to Winnicott's (1962) 'unthinkable anxieties'. Lewis (1981) describes the Moro reflex (startle reflex) occurring when the infant experiences a change in its equilibrium. He argues that rough mishandling "creates a chronic state of disequilibrium or shock….that is far beyond the shock that the infant can discharge via the Moro reflex" (Lewis 1981, p8). Little (1990) also recognises this phenomenon occurring with her adult clients, "There is the risk of repeated annihilation by stimuli to which the client may have to react to physically (startle reflex)" (1990, p88). I have experienced this personally and in my client work. Some clients enter therapy recognising that they are 'jumpy', others find that as the regression develops they can be easily startled by sudden noise or unexpected events.

Balint's (1968) way of understanding patients with a high level of psychic disturbance coins the phrase 'the basic fault' which he considers occurs in early infancy when the needs of the infant are not appropriately matched by the facilitating environment. He recognises that this fault which develops in infancy can remain for the whole of a person's life "it is a fault, something wrong in the mind, a kind of deficiency which must be put right. It is not something dammed up for which a better outlet must be found, but something missing either now, or perhaps for almost the whole of the patient's life" (Balint 1968, pp19-22). He is making the case for the possibility of a reparative relationship between therapist and client.

I will now look further at the experiences of participants and the theories that may illuminate them. The following theorists are attempting to describe and understand the experience of infants at a time prior to the development of identity or self, considering that through regressive experiences distressed clients may be revisiting these early stages.

Annihilation anxiety

Winnicott uses the word 'impingements' to describe happenings occurring to the infant which disturb the 'going on being' of the infant. These happenings are seen as a failure in the facilitating environment to protect the infant from disturbance by the external world. When such impingements occur the infant must react and this is seen by Winnicott as "resulting in annihilation of personal being." (1965/1984, p47). (I have previously identified this as the loss of self, resulting in the death of self.) This threat of annihilation can then be seen as the source of the terror which is experienced by clients who have not benefited from an appropriate facilitating environment.

Participant H describes her perception of the balance between life and death, the threat of annihilation:

> ....my own identity, which was like a battle for my own life really, it was a life and death....quite a profound experience.

She is describing experiences in her adult life, but these types of experiences are seen by theorists as emerging from the re-experiencing of an early infantile occurrence in later psychological states. Little (1990), writing about regression, recognises that in inchoate

development the infant is dependent and at birth integration has only begun and survival is not a certainty. Because at this stage of infancy there is seen to be no integration then there can be no organised defence against unwanted stimuli from the environment. She identifies a confusional state which is experienced as annihilation and that this "annihilation anxiety" will persist unless supported by "an environment which is capable of meeting all needs [which] can ensure survival and promote integration" (Little 1990, p87). Winnicott (1984, p47) places this early anxiety as against annihilation, the threat of loss of being, loss of self. If there are infrequent and minor impingements, these do not interrupt the development of the continuity of being. Too many impingements threaten the development of that continuity of being, and so the task of the holding environment is to reduce and minimize the number of impingements which result in loss of continuity of being by the infant having to react rather than just be. He describes the more acute deprivations of infancy as 'primitive agonies,' a nameless dread associated with the threatened dissolution of a coherent self. "To experience such anxiety threatens the total annihilation of the human personality, the destruction of the personal spirit" (Kalsched1996, p1). This results in the development of primitive defences which cause psychopathology because of their primitive nature. It is viewed that this trauma is a break in the continuity of 'going on being' and the primitive defences organise to prevent a repetition of 'unthinkable anxiety' or a "return to the acute confusional state that belongs to disintegration of nascent ego structure" (Winnicott 1971, p97). Adams (2009, p139) considers that the experience of annihilation anxiety and dissociation is not confined to those who have experienced overt trauma or abuse. She attributes work in depth therapy to revelations of covert primitive ego states which exist in parallel with mature functioning. She describes the dichotomy, terror of intimacy and a need for human contact. She describes "intense waves of feelings" and "sensations such as sinking, falling, exploding," when caught within a primitive state of mind.

Winnicott's (1974) paper describes patients in therapy as experiencing a powerful 'fear of breakdown', which he sees as the sequelae of infantile 'primitive agonies'. He considers that the adult client's fear of the breakdown which they believe is about to happen is actually the fear of a breakdown that has already been experienced in infancy. "It is the fear of the original agony which caused the defence organisation." Although

viewing this 'fear of breakdown' as being related to the individual's past experiences, he also considers "there must be expected a common denominator of the same fear, indicating the existence of universal phenomena."(Winnicott 1974, p88). He asserts that his theory of the fear of breakdown can be generalised to the fear of death, seeing that it is the death that happened but was not experienced that is being feared. "Death looked at in this way as something that happened to the patient, but which the patient was not mature enough to experience, is the meaning of annihilation. It is like this, that a pattern developed in which the continuity of being was interrupted by the patient's infantile reactions to impingement, these being environmental factors that were allowed to impinge by failures of the facilitating environment" (Winnicott 1974, p93). Likewise he considers that this theory can be generalised to encompass emptiness, belonging to the past, when a lack of psychological maturity meant that it could not be experienced "to understand that it is necessary to think not of trauma but of nothing happening when something might profitably have happened. It is easier for a patient to remember trauma than to remember nothing happening when it might have happened. At the time the patient did not know what might have happened, and so could not experience anything except to note that something might have been." (ibid., p94).

Participant E describes touching a sense of emptiness, and associating it with being a baby:

> ...on one occasion watching a mother who seems to be deliberately ignoring a child who was in this clearly very distressed, agitated state…and I just couldn't bear it, so I just know from the number of times I've had that kind of experience…this is something to do with me as a baby…and I'm…made acutely kind of aware, emotionally aware, not by observing it so much, but by just feeling

Winnicott sees this fear as carried around in the unconscious of the client until it emerges within the therapy, for the client there remains this hidden aspect where ego integration is "too immature to gather all this phenomena into the area of personal omnipotence." Winnicott asks the question – why is the patient worried by something that belongs to the past? He answers that it "must be that the original experience of primitive agony cannot get into the past tense unless the ego can first gather it into its own present time experience and into omnipotent control now (assuming the auxiliary ego-supporting function of the mother [analyst])". This means that the client is unable

to continue development in this area but must continue to search for "the past detail which is *not yet experienced*. This search takes the form of a looking for this detail in the future." To summarise, along with Winnicott (1974), the fear of breakdown is a fear of a past event that has not yet been experienced because it was psychologically unsafe to do so. The patient's need, and an aim of this therapy then, is to enable the patient to experience it with a new significant other (the therapist) who is able to be dependable, soothing and affect regulating (Van Sweden 1995, p91).

Participant D describes her experience and understanding of her early trauma. She describes revisiting a place which she thought of as total death:

> …in hindsight it took me right back to the death anxiety that I always maintain I was born with. … she (mum) told me a story about holding me in her arms a few hours after I was born, looking down the road and seeing a hearse, and she told me, as a child, and, well, as a baby, that 'poor Mr so-and-so, he had to die to make room for you to be born', and this myth hung around for me in a very frightening form, that if, if, somebody has to die in order for a new baby to be born, so you can imagine, new life, for me, or knowledge of new life, was quite terrifying because I didn't know if it would be me that was chosen to be the one that was, sacrificed, if you like….. having been a child with a very conscious fear of death, it had led me into all kinds of bizarre behaviour as a kid, like I'd be put to bed at seven o'clock and I would make about half a dozen trips downstairs to make sure that my mother was breathing, and to make sure that her… I knew how to take my mother's pulse as a little child – strange that I end up in the medical profession, but, or certainly in the nursing profession, but I was very aware that it was my job to keep her alive, so I thought, and I, it filled me with night terrors and lots of neurotic behaviour….

Grotstein (1984, p211) recognises that primitive defences which developed to ensure survival in early infancy remain present in the individual, often causing great distress and relational failure. He sums it up as follows: "when innocence has been deprived of its entitlement it becomes a diabolical spirit." I know that many participants and clients will recognise the truth in this statement. The feeling of being at the mercy of unconscious forces and the desperate need to try to control them in order to function in everyday life will be a familiar struggle. I will now look in more detail at the primitive

defences that can develop originally as a survival mechanism but which now are part of the sequelae of that early infantile trauma.

Primitive defences

Early infancy is a dangerous time for both humans and animals, when they are totally dependent on their caretakers for their survival. It is imperative that the infant stays with the caretaker and primitive defences develop to 'wall off unbearable anxiety' (Adams 2006, p132) thus enabling the infant to defend against feared annihilation and enable psychic survival.

Kalsched (1996) refers to the anxiety that results from cumulative traumas resulting from unmet dependency needs, using Winnicott's (1963, p90) phrase 'primitive agonies' and Kohut's (1977, p104) term 'disintegration anxiety' which he describes as "an unnameable dread associated with the threatened dissolution of the coherent self." He considers that this threat of annihilation must be avoided at all costs and that "because such trauma often occurs in early infancy before a coherent ego (and its defences) is formed, *a second line of defences* comes into play to prevent the 'unthinkable' from being *experienced"* (Kohut 1977, p1). In psychoanalytic terms these defences are known as primitive defences, and "both *characterise* severe psychopathology and also (once in place) *cause* it" (ibid., p2), that is, those defences which once enabled survival now are the source of the client's problems.

Wilkinson (2010, p157) recognises dissociation as an effective defensive system designed to manage the traumatised aspect of life allowing the "apparently normal personality" to go on with the business of life. Hurvich (1989) considers that pathological annihilation anxieties are a consequence and correlate of psychic trauma, ego weakness, object loss, and pathology of the self. He sees that annihilation experiences and anxieties are universal in early childhood, where psychic dangers are regularly experienced as traumatic. He makes the link between annihilation anxiety and the threat to psychic survival, experienced as a present menace or as an anticipation of an imminent catastrophe. Hurvich describes the experience of overwhelmed helplessness as having much in common with Jones' 'aphanisis', Klein's 'psychotic anxiety', Schur's 'primary anxiety', Winnicott's 'unthinkable anxiety', Bion's 'nameless dread', Stern's 'biotrauma', Frosch's 'basic anxiety', Little's 'annihilation anxiety' and

Kohut's 'disintegration anxiety'. Derivatives of underlying annihilation anxieties are fears of being overwhelmed, destroyed, abandoned, mortified, mutilated, suffocated or drowned, of intolerable feeling states, losing mental, physical or bodily control, of going insane, dissolving, being absorbed, invaded, or shattered, of exploding, melting, leaking out, evaporating or fading away.

The fear in such clients is seen as of catastrophe and fragmentation resulting in an extreme fear of annihilation. Little (1958, p84) writes "there is only a state of being or of experiencing, and no sense of there being a person….There is only an anger, fear, love…..but no person feeling anger, fear or love…..It is a state of undifferentiation, both as regards psyche and soma, experienced as chaos." Gottlieb (1992, p254) continues "it is terrifying to reach this state since it implies losing the already fragile sense of identity. The patient teetering on the brink of fragmentation "becomes for the moment only a pain, rage, mess, scream and is wholly dependent on the therapist for containment." It is this area of infant development that is considered by some theorists to be the source of seemingly unpredictable terror states in adulthood.

Participants G and H identify how they believe that they revisited primitive experiences in their adult lives:

> …it was like a life or death decision, and I turned round and went head first, tracking this pain in my shoulder, butting out of this confined space, and you know, eventually kind of, collapsed onto the floor, you know, not being really able to really make much sense of it, ... which was like a battle for my own life really, it was a life and death thing…quite a profound experience

> I recognise that if I was in situations where there was a lot of anger around me I completely dissociated…in terror…

> …and I wouldn't be present, but I would look like I was, and that happened to me at work…I spent a lot of time dissociated in a way that I don't any more,

Winnicott (1963) considers that the commonly used word 'anxiety' insufficiently describes the 'primitive agonies' experienced by the infant. The experience of these 'primitive agonies' leads to the development of primitive defences against a repetition (1974, pp89-90). Because the levels of anxiety experienced by the child are beyond its

tolerance defence mechanisms are born, but these, moving into adulthood, outlive their value and the defences which served to save the child now cause problems in the adult's life and often bring them into therapy. He describes his understanding of primitive defences using his own particular phrases. Other theorists have different ways of describing these defences; however, I will use Winnicott's descriptions to introduce each section, introducing other theorists' contributions as appropriate.

Disintegration (a defence against the return to an unintegrated state)

According to Winnicott (1965), prior to the development of self the infant psyche can be considered to be unintegrated. This is not a problem if the environment supplies that which the infant needs without too much interference or overwhelming of the infant. Where the environment is unaccommodating of the infant's needs the infant may split off parts of experiences which cannot be integrated. Bick (1968, p56) considers that the infant searches "for a container" which can "momentarily… [hold] the parts of the personality together". Ferenczi (1930) considered that the continuity of being is maintained by psychic fragmentation, which although resulting in unbearable pain allows survival. He recognises that repeated and early onset failures of the environment are more severe, resulting in splitting or separating off aspects of experiences which cannot be understood or integrated, but which can remain within the psyche, resulting in fragmentation. Adams (2009, p132) proposes that "repeated shock states within attachment relationships and unrepaired distress during the formative years contribute to an inherent vulnerability to psychic shattering and abrupt fragmentation." Bollas (1987) would also recognise that experiencing the state of unintegration brings with it the passivity of disorientating confusion.

Participant G describes her disintegrating experience:

> ..once things became unlocked they tumbled out, I couldn't stop them, I couldn't put the lid back on, and part of me didn't want to, I didn't know where it was going, I didn't know sometimes if I'd ever get better, if I'd ever feel normal, or the sense of normality I thought I'd had before, which I realise wasn't really normality at all…

The above participant's words seem to give a description of the lack of integration which may be occurring in aspects of the personality. It is evident from the participant's words - "part of me didn't want to" that she holds this concept as a way of understanding herself. When she is experiencing the feelings described above she highlights the feelings of disintegration.

Self-holding (a defence against falling for ever)

In early infancy the infant is completely dependent on its caregiver. When that dependency fails because the caregiver is unable or unwilling to respond the infant must look to itself to 'hold together'. Symington (1985, p486) (in Adams 2006) identifies this self holding which results in a subsequent fear of dependency, (what has failed once cannot be trusted again), leaving only the self to be relied upon. He recognises that "the primitive fear of the state of disintegration underlies the fear of being dependant; that to experience infantile feelings of helplessness brings back echoes of that very early unheld precariousness, and this in turn motivates the patient to hold himself together."

Participant I describes how she learned to hold herself together:

> …the terror is based in reality, that, and in the relationship with my Mom, and then obviously consequently in lots of other relationships since….I felt that 'you need to pull yourself together, why would you need this, why would you want this? You need to grow up and get on with it.' So that it was that sort of terror of being shamed in that, in that way is there in the reality for me.

In the above quotation the participant clearly identifies the defence that she prescribes for herself "you need to pull yourself together…you need to grow up and get on with it". This seems to correlate with Symington's (1985) thinking that where dependency cannot be relied upon, the self must supply the holding.

Depersonalisation (a defence against failure to indwell)

This can be seen as the inability to feel alive and real, when aspects of the self are split off from experience, this can result in a 'self' which feels alien to the main personality structure.

Grotstein (1994, p xviii) recognises "The infant who feels critically unable to *attach* to a mother who may have difficulty in *bonding* may experience him/herself to be at risk for

annihilation and may therefore seek to preserve him/herself by *withdrawal into alienation* – from the mother and from the self" seen by Winnicott as "failure to go on being".

Eigen (2001) describes the way that terror, whether from an external or internal source leaves an imprint on the personality of the individual. "The individual was born into a frightened and frightening world, a world in which being frightened plays a significant role" cited in Wilkinson (2010, pp24-25).

When a person has split off aspects of themselves it is difficult for them to know what is missing. Some clients might describe feelings of emptiness and inadequacy. This mirrors the infant's parents' failure to recognise how they were failing to help their child to develop a sense of his/her self through misattunement to the child and its needs. Borgogno and Vigna-Taglianti (2008, p321) recognise that as adults these individuals feel an 'intense uneasiness', but are unaware that they have been deprived. They consider that they can only discover this in analysis when they obtain, through 'experiencing it' a psychic environment different from the one they grew up in, recovering at the same time within themselves those resources they had never imagined they could have.

Exploitation of primary narcissism (a defence against loss of the sense of realness)

When aspects of self are split off to defend against experiences of repeated neglect or trauma this could result in a feeling of not being real, so to avoid this feeling, a further defence is required. Some theorists including Winnicott (1963) and Adams (2009) consider that such a defence system uses primary narcissism.

Kalsched (1996) writes that Winnicott considers that the failure of the environment/mother to provide 'good enough' care can result in an effective relationship between inner and outer reality. If this care is impoverished or neglectful "a split opens up between the infant's psychosomatic 'true' self, and a (primarily mental) 'false' self", which has emerged as a protection against further trauma. Winnicott sees this as a division to protect from 'unthinkable agonies' from early trauma. He emphasises the caretaking nature of this splitting, whereas Kalsched highlights its persecutory dimension.

The development of autistic states relating to phenomena (a defence against loss of the capacity to relate to objects)

Autistic in this context is reflected by the roots of the word – 'aut - self' and 'ism – orientational state'; a tendency to be preoccupied by oneself, implying that the individual sees things in terms of fantasies and dreams instead of reality. It was a phrase originally coined by Bleuler (1911) for an aspect of schizophrenia and is not the same as autism as a developmental disorder.

A number of authors have attempted to explain why our experiences of infancy are not usually available to everyday consciousness. Hopper (2003), in reviewing the aetiology within cumulative trauma and failed dependency in disavowal, dissociation and splitting, considers that "in order for life to continue and psychic paralysis [to be] avoided the entire experience [of annihilation anxiety] is encysted or encapsulated, producing autistic islands of experience" (2003, p59). Tustin (1990, p123) also recognises this 'autistic encapsulation' seeing it as an inchoate defence against trauma which can be remembered either by events in the here and now, or result from therapeutic re-experiencing. These states enable the individual to compartmentalise painful, distressing experiences which were unable to be processed at the time to be shut away so that the individual can continue with the other tasks of development.

The participants in this study would recognise the idea of encapsulation of infancy experiences which are largely kept away from everyday experience by powerful defences like inner walls behind which dwells these unintegrated experiences. These defences serve to cover over developmental wounds, submerging emotion and leaving the client "frozen, starving and unable to ask for help" (Adams 2006, p130). She recognises that these clients are susceptible to emotional flooding and disruptive functioning under stress.

Participant H describes her experience of this:

> I was utterly exhausted, I wouldn't sleep all night because I'd be so triggered around stuff happening for me and my whole body was on hyper-alert, I just couldn't relax enough to sleep, and I would quite often have strong memories of things in those sleepless nights of first memories of things I had completely forgotten, shut away, sometimes had no idea where they came from, it's like they came from another life, I

kind of knew things that I'd never known, but the problem with that was I was always on my own…

This participant could be seen to be describing experiences which she considers to be re-emergence of encapsulated or primitive states, these autistic islands of experience (Hopper 2003, p59) which defend the person against the experience and allow them to continue with life.

At interview, the following participant, E, describes experiences with a client which illustrate an autistic world (my words in parentheses):

[it] was hugely traumatising and I think she actually withdrew from speech with adults..

(So she went into a sort of elective mutism)

Yes and created… I don't know to what extent she'd done this previously with her mother who she also kind of denied she'd ever had any contact…you know she knew her mother was there but there was no..as she recalled it as an adult, there was no, there was never any love between her and her mother and she'd always refused to accept any dependency on her mother and as far as she knew even as a baby. And she'd created some form of thinking in language for herself which was to do with hand gestures so that she had a complete almost dictionary of hand gestures which had certain meanings and she could either form them on her hands and then there was this autistic world between her eyes and her hands

Adams (2009) concurs with Berenstein (1995) regarding the enduring nature of these primitive defences "it is impossible to live with such anxiety. The mind springs into action to save the child; the defence mechanisms are born. Inevitably, however, the defence mechanisms outlive their value. The child grows older and more competent, is no longer realistically on the brink of destruction, yet the defences refuse to die. Not in touch really with the real world, the defences insist that if they are abandoned then death will follow. The terror of this possibility gives them continued life at a terrible price; little by little they get in the way of a child's development, isolating him from reality and the warmth of other human beings" (Adams 2009, p xvii). She quotes Hopper's (2003) comparison of these encapsulated selves to sets of Russian dolls. These selves develop in parallel to each other, and the encapsulation, or autistic state, defends the

individual from the experience of the loss of relationship with others, and emphasise safety at any cost.

Having looked at the primitive defences which are responses to frequent misattunements which can be seen as traumatic and cumulative I will now look further at cumulative trauma.

Cumulative trauma

Cumulative trauma is seen as repeated instances of trauma frequently occurring, eventually resulting in damaging effects to the whole personality.

Eigen (2004, p590) gives this powerful description of the effects of cumulative trauma, "Injury unites injury, spreading through psychic time dimensions, wounds linking together from early to late, late to early, symphonies of injury, creating vast seas of suffering drawn together in one insistent pain point. Trickles of pain unite with other trickles, forming networks of suffering through the psychic body and often in the body itself. Trauma hits soul and body in one blow, in many blows."

Participant E describes how in a current time of emotional trauma he regresses to helplessness which he sees as reconfiguring earlier trauma:

> A recent example in my life would be when there was a complaint about some of my work by a client which had to be investigated …and that occurred at a time [of] relationship breakdown with psychotherapy supervisors…and I think that triggered some quite intense regression so that…I could not rationally assess what had gone on in interactions between me and other people where I couldn't be sure that I wasn't reacting through some intense paranoid shame type feelings.

Participant G explains:

> I actually catharted a lot alone, erm, which probably wasn't the best thing to do, because there was nobody there I remember… just going up there and crouching underneath the table in a corner, like foetal, just shaking from head to foot with no sense of how to ground myself, no kind of understanding of what was happening, ….completely freaking out like a frightened animal, er, so I know that I, you know, I had lost… I'd completely gone…

The above participant is describing her experience of the emergence of her distress and the loss of her 'self' in this process.

When Khan (1963) describes 'cumulative trauma' he considers the impact of seemingly minor events which coalesce into significant accumulations of traumatic sequelae. It is now accepted by many practitioners and theorists that such cumulative traumas can have devastating effect upon the individual. When we are looking at repetitive misattunements, non-availabilities, deprivations, in early and later childhood the impact upon the individual can have all the character of post traumatic stress. Borgogno and Vigna-Taglianti (2008, p317) recognise that "….ommisive and depriving parents that not infrequently have been at the very source of these patients' psychic grief".

Kalsched (1996, p1) considers these experiences as overwhelming the usual defensive measures which Freud (1920, p27) described as a 'protective shield against stimuli.' He describes these experiences as traumatic to the infant. Trauma has its origins in Greek and means wound, so Kalsched is describing an infantile wounding. Such trauma varies from acute experiences of child abuse, to the deprivations experienced when normal infancy needs are unmet, identified as 'cumulative traumas' (Khan 1963). When individuals describe trauma they are often describing a discrete event or events which are in isolation from an individual's everyday life. Kalsched (1996) however, thinking particularly about childhood trauma, considers trauma to mean any experience that causes the child unbearable psychic pain or anxiety, meaning that it overwhelms normal defences and ranges from experiences of child abuse to 'cumulative traumas' of unmet dependency needs (Khan 1963) including the deprivations described by Winnicott as 'primitive agonies' which are 'unthinkable' (1963, p90). Blum (2004, p20) comments on the definition of trauma and the wide spectrum of traumatic effects from a "transient loss of ego regulation to the regression, helplessness, disorganisation, and paralysing panic of massive trauma," considering that "trauma may be so narrowly defined that the ego is considered totally overwhelmed with no possibility of adequate registration of the trauma or response to the trauma. At another extreme, trauma may be loosely identified with any noxious experience or developmental interference." Hurvich (2004) also acknowledges the overwhelming nature of the experience of trauma. He quotes from Greenacre (1967, p128) "any conditions which seem definitely unfavourable, noxious,

dramatically injurious to the developing young individual". These theorists and others are identifying the loss of ego function which is associated with trauma and traumatic sequelae, however, theorists who place cumulative trauma as a result of infantile deprivation site the trauma prior to the development of ego, so along with the traumatologists they can agree that in trauma there is no ego present to mediate or integrate these traumatic events.

Kalsched (1996) relates Jungian theory to the world of trauma. He shows how, as a result of cumulative or acute trauma in early childhood, defences which originally developed to protect the individual, can become malevolent and destructive resulting in a repeated inner traumatisation. He quotes from Jung (1928, paragraphs 266-267) "Traumatic complex brings about the dissociation of the psyche. The complex is not under the control of the will and for this reason it possesses the quality of psychic autonomy. Its autonomy consists in its power to manifest itself independently of the will, and even in direct opposition to conscious tendencies: it forces itself tyrannically upon the conscious mind. The explosion of affect is a complete invasion of the individual, it pounces upon him like an enemy or a wild animal."

Having explored the experience of a non-facilitating environment in early infancy and its subsequent effects in anxiety, terror and trauma, I will now look at how the therapist's role can begin to contain and heal such experiences.

The therapist as transformational object

In a previous chapter, I have considered the role of the therapist in developing and maintaining a reparative relationship. Responses to trauma and terror can be recognised as the earliest defences which are laid down in infancy, therefore a return to elements of the infancy state could enable new ways of responding to traumatic events to develop. Borgogno and Vigna-Taglianti (2008, p317) consider that "the intrapsychic can relive within the inter-psychic, becoming a masterly key for recognition and transformation of traumatic and traumatising past events." They are identifying that the intrapsychic world of the client can be reprised within the inter-psychic therapeutic relationship and so offer transformation.

Gottlieb (1992), in striving to understand Bollas's (1987) concept of 'transformational object', formulates that patients seek within the transference such a transformational object which she calls 'transformational transference' which is associated with early environmental deficit. She connects such patients with high levels of demand and dependence, and the need for maternal containment. This maternal presence is viewed by Hedges (1994) as a 'protective shield', protecting the infant against stress, strain and trauma. Where this protective shield has not developed the individual can in adult life break down in times of stress and trauma. The therapist's aim can be to help the client to develop, within a long term relationship, such a protective shield. In this section I will specifically consider how the therapist, because of the nature and depth of the relationship, can help to regulate and contain the client's experiences of trauma and terror in a way that should have been available to the child in infancy.

Little (1990) describes the type and depth of relationship in regression to dependence and views it as "a means by which areas where psychotic anxieties predominate can be explored, early experiences uncovered, and underlying delusional ideas recognised and resolved, via the transference/countertransference partnership of analyst and analysand" (Little 1990, p83). From my perspective, in describing psychotic anxiety she is referring to those areas which Winnicott would view as the state of being prior to the development of the self. Kalsched (1996) acknowledges Winnicott's and Kohut's assertions that 'unthinkable anxiety' originates in the symbiotic stage of development when the infant is dependent on the mother for the mediation of experience including anxiety. He identifies that in a distressing situation for the baby then ideally the mother's presence will transform the baby's state. Cohen (1985, p180), cited in Steele et al., stated that "the traumatic state cannot be represented...therefore cannot be interpreted...[it] can only be modified by interactions with need-mediating objects". Kalsched (1996) acknowledges that both Winnicott and Kohut have placed a level of 'unthinkable' anxiety within the symbiotic stage of development where the child is totally dependent on the mother. The mother's role is to regulate this anxiety. If for whatever reason the mother fails to regulate the baby becomes distressed and eventually traumatised.

The following participant, D, describes an evocative experience in her personal therapy in which she re-experiences some aspects of her infancy. She has experienced a trauma in her early childhood which is re-experienced as a result of the therapeutic relationship:

…when this regression began in my analysis I think it would probably be about six or seven years through treatment, and I was seeing him four times a week at that time, and I sensed a…I sensed a real 'going-down' sensation, the nearest I can get to it is if I talk about what I experienced when I had to be resuscitated after my breast, my first breast cancer op, was a sense that all of life was draining away from me, I'm….sort of reliably told by the medics around that's exactly how I looked, as if life was draining away from me, and it didn't turn out to be a scary thing at all in reality, but in my analysis feeling that all of life was draining away from me was a very terrifying place because I thought I would lose contact with my analyst,…I was lying on the couch one day and I felt very little, and I kept saying to him, 'you're like the weather men', now I don't know if you remember all those years ago, you used to get clocks and there used to be the lady came out on a fair day, and the man came out on a, on a miserable day, and I kept saying to him, 'you keep coming in and out, you keep…one minute I think you're there, and the next minute I, you're gone again and I can't find you,' and I couldn't find him visually, even though my eyes were open and he was sitting behind me, if I turned my head I could have seen him, but I wouldn't have seen him; I was eighteen months old when I had a second operation on one of my eyes, and in those days when they operated an eye, and had to cover it, they covered – crazy, crazy thinking – they covered both eyes because they thought you'd strain the good eye, so what came out of this, regression with (therapist's name) was I had suddenly become the blind child, the child with both eyes covered, and I couldn't find the people that I needed even though I'm told I was in a cot and there were cot-sides up in the hospital, the sense of people coming in and out, and that still for me today, I can sense when people are moving, well, I feel they're moving in and out of consciousness, unconsciousness, visibility, whatever, my eyes are really important, response mechanism to me is when a person is really here with me, or whether they've gone somewhere, so that was another illustration of what came out of the regression, but I can think of times,…I just remember a descent into, it was a real going-down place where I no longer had any vision and I did still have sound though, I could hear if he, if he moved in his chair and then it was something very physical, and I remember saying, I think I said this at the time or maybe it was some sessions afterwards, but I had the physical experience of my heart breaking and the grief of a

broken heart which was one hundred per cent, no 'a little bit dead and a little bit alive', it was just a total, total place and the thing, I mean I've lost a lot of the information around that time, but what I remember him doing was, it was winter and he picked up my jacket that was on the chair and he just placed it very gently over my face, now I do remember my face as being…I was just awash with grief, and I think I'd got tears and snot and everything else, and I hadn't, couldn't, I couldn't clean myself up, I couldn't do anything…..and so he put this coat over my face, and I thought he'd just dropped soil on my coffin, I thought, I, that's all I could think of what's happening to me, 'oh, now I am really dead, now I'm really dead'

She clearly identifies the link between her infant experience and the later experience with her therapist, making the connection with the life or death nature of these experiences and identifies the feelings of terror which are associated. Indeed, so profound are these experiences that some authors, such as Siegel (2003, p9) claim that they affect the individual at a neurological level "overwhelmingly stressful experiences may have their greatest impact on the growth of the mind at the time when specific areas of the brain are in rapid periods of development and reorganisation….trauma during the early years may have lasting effects on deep brain structures….specific 'states of mind' can also be deeply ingrained as a form of memory of trauma, a lasting effect of early traumatic experience. States of fear, anger, or shame can re-emerge as a characteristic trait of the individual's responses."

Fromm, (2007, p2) in his commentary on Winnicott's 1977 paper, recognises that during these times of infantile trauma, what is missing is an 'other' who is able to help the infant through the difficult experiences. He writes, "if only there had been someone at the point of crisis to encompass the child, to recognise that the child has feelings about what is going on, and to help him through the shattering effect of losing all that is familiar, then perhaps some of the shock and trauma could have been absorbed." He goes on to describe how Winnicott links this early trauma with a reaction to trauma in the here and now, seeing that responses to trauma are laid down in early infancy and are then repeated in response to later trauma. He describes how an early trauma which has occurred in a relationship of dependence has resulted in a defence of self-sufficiency to contract the child against his/her own need, and he describes how, through the process of therapeutic regression and the re-experiencing in the here and now of such trauma in

relationship could result in the patient referring to this part of her therapy as "the time when I began to want to live". He describes Winnicott's therapeutic stance as "about the developmental fact that moments of pain must be experienced – and can only be experienced if another person is present – in order for them to be transformed into moments of truth". Many clients present for therapy with self-sufficiency as a defensive position. When they have been let down in their first beginnings by those who should have cared for them, unconsciously they are guarded against being in that position with any other person again. They value their abilities to sort things for themselves and are extremely shocked and frustrated when these defences cease to enable them to overcome their current difficulties. They can be resistant to anything that looks like dependency, even though this is the very relationship which can bring healing through the reprise of a significant relationship of the same quality as their earliest relationship. My personal therapy was marked initially by high levels of shame and fear from which I could not allow myself, or any other, to know the depth of my need. I also experience this with my clients, who try to self-sufficiently use their habitual cognitive defences, to *intra*personally solve *inter*personal problems. They have learned this stance because historically there was no one willing or able to support them in times of difficulty or trauma.

Steele et al. (2001) have identified that strong social support is essential to prevent trauma related disorders because most chronically traumatised individuals have insecure attachment through basic security never having been achieved. This must first, then, be provided by the therapist before addressing the trauma. They also identify that *dependency need* emerges in the work with this client group.

Trying to address the trauma with the client prior to the establishment of a supportive alliance with the therapist could lead to re-traumatisation (Steele et al. 2001). Participant A identifies how a traumatic experience had impacted upon his client but had become complex because of a lack of emotional support at the time of the trauma. The participant is describing his understanding that early relational damage must be addressed through the therapeutic relationship prior to the addressing and resolution of this trauma and distress:

Her trauma was the sudden death of her father, and her mother going crazy, which we could not repair because there was already a lack of emotional security with that mother before that, although she kept going back to that scene. I needed to go back and be that good mother before we could come back and deal with that (traumatic memory)… Khan coined the term 'cumulative trauma' when you're dealing with that accumulation and that lack of reliability on someone, then you've got to go in and establish that first, before you deal with … those painful traumatic incidences….With depressed mothers, you can't really do a great deal of work with the traumatic incidences that come along in life, until you repair the lack of vitality from the depressed mother…..beyond the basic fault, actually, but to it for the sake of repairing and finding the security…..

If we accept the theory that clients, having had early stage developmental deficit where ego boundaries have not yet developed, are still searching for a transformational object in order to develop a coherent inner world and so repair the 'basic fault' then it is clear to see the possibilities for the therapeutic relationship to be a source of emotional repair. When the 'injury' is seen to have occurred prior to the development of the self, then clients will re-experience these archaic feelings. The therapeutic relationship taking on some of the aspects of the early infant caretaker relationship then becomes a vehicle to contain the client's dependency. Steele et al (2001), making the link between the experience of dependency and its relationship to survival needs, concur with Mitchell (1991) and his understanding that dependency desires expressed in therapy can represent ego needs, not symbolic wishes or fantasies and that these needs must be met before anything else can occur in therapy. They recognise that in failed dependency situations, where the environmental provision has been insufficient for the infant, there is a risk to the client of "severe deterioration in functioning, self-destructive acts and disintegration." Adams (2006, p257) also recognises consequences of failed dependency in an impoverished psychic organisation forming a 'black hole' and so connecting it to Balint's 'basic fault' and Grotstein's 'implosive centripetal pull into the void'.

Participant C identifies her experiences of developing dependency during therapy:

...it wasn't until I got deeper into therapy that I was realising that I was dependent…and like if my therapist had to move to a different room it was like I'd get in there and say, 'I just can't work in here' it was just like every little thing was almost impossible…

Participant G describes what she sees as the re-emergence of infancy experiences during therapy:

> I was utterly exhausted I wouldn't sleep all night because I'd be so triggered around stuff happening for me and my whole body was on hyper-alert, I just couldn't relax enough to sleep and I would quite often have strong memories in those sleepless nights of first memories of things I had completely forgotten, shut away, sometimes had no idea where they came from, it's like they came from another life…

Some clients, as the therapeutic relationship develops and starts to become more intimate and meaningful, experience what is known as negative therapeutic reaction. This is a phrase used to describe the aversive and resistant reaction as traumatic material first begins to emerge from the unconscious. When this happens, clients are frequently thrown back on primitive defence structures and it is at this point that clients can sabotage their lives, their relationships or their therapy. Participant I describes how her attempt to give her client an object for security is met with rejection:

> This is the client group that I have often felt the desire to give, provide some kind of transitional object, and the difficulty in introducing that into the work, sometimes, the feeling of them wanting to have, and yet, not allowing themselves to take, has been difficult, and therefore sometimes meant that that's not happened, or that it's somehow destructed the intention of the transitional object… for example, Christmas I bought a client a scarf and put some perfume on it that he particularly likes, that he's smelt on me when he's been close to me, and met with his absolute rage when I gave it to him, that he couldn't have that, that that couldn't be tolerated…I feel like I hit that ecstasy and pain place a lot with this client group.

Clients can be faced with the threat of the re-emergence of these previously destructive experiences and defensively feel they must be avoided at all costs as there is a threat to the very organisation of the self and fragmentation.

Participant G describes the emergence and her response to terrifying feelings which emerged as a result of her therapy:

> "crouching underneath the table in a corner, like foetal, just shaking from head to foot with no sense of how to ground myself, no kind of understanding of what was happening, and him coming up to the room, and apparently putting his hand out to kind

of touch me, and me completely freaking out like a frightened animal, so I know that I, … I had lost… I'd completely gone"

Kalsched (1996) accounts for negative therapeutic reaction by identifying that the process of integration is not experienced as desirable for these patients. "These patients do not experience an increase of power or enhanced functioning when the repressed affect or traumatogenic experience first emerges into consciousness. They go numb, or split, or act out, somatise or abuse substances. Their very survival as cohesive 'selves' depended upon primitive dissociative operations which *resist* integration of the trauma and its associated affects – even to the point of dividing up the ego's 'selves' into part-personalities." Hedges accounts for these experiences thus, "Reviving memories of failed attempts at connection entails reliving primitive organising experiences which are bound to emerge as the early developmental period comes into focus" (Hedges 1994, p6).

Kalsched (1996) recognises that the child originally "must feel that it is too frightening to be weak in an unfriendly and menacing world……and if you cannot change your world, you can try to change yourself. Thus he comes to fear and hate his own weakness and neediness; and now he faces the task of growing up with an intolerance of his immaturity" (Guntrip 1969). Van Sweden (1995, p174) recognises the difficulty in negotiating this stage of the therapy "Initially, the analyst's efforts to establish an emotional connection may be looked upon by the analysand with suspicion and distrust. What basis does the analysand have for believing that this connection with the analyst will be reliable if the original connection with the mother was not?" Etherington (2003, p16) asks the question, - "How do we learn to relate to others intimately when our early and most important relationships have caused fear, shame and distress?" Clients who have been shamed for their vulnerability and need in infancy and childhood are ashamed of their dependency needs emerging in the therapeutic relationship. This shame persists even when the client has insight into their story, because to re-enter a dependency relationship re-awakens the fear and 'unbearable anxiety' associated with re-entering the trauma, such anxieties can make a client resistant to change and the therapist must work persistently and consistently to develop and maintain the client's trust.

Participant H describes the dependency which results from the regression (Steele et al. 2001):

> …and she'd say things like, "why would I tell you?" because she'd gone back to that place where there was no point in, you know…'you don't tell adults anything, you don't communicate' she had her own…so there'd be moments in therapy sessions when she'd be doing all this sort of thing, so there was definitely a real regression there and it included a lot of dependency…the demand on me as therapist was very intense….We had sessions twice a week and the sessions were an hour and a half because it seemed that for her to do any work, to really get into it and then just…in whatever way possible to come out of it again…[took] an hour and a half or longer.

Van Sweden (1995) recognises that in the regression to dependence process the client can re-experience the early mother/infant relationship. Within this re-experiencing is then the emergence of terror, pain, and rage that resulted from the original maternal failure which is frightening to experience, but the client can be helped and supported to understand causality and reparation.

Little (1990) concurs with Winnicott's assertion that the mother's inability or unavailability to transform the baby's distressed state results in trauma, implying that the baby has experienced a break in the continuity of life and that primitive defences would be rallied to defend against 'unthinkable anxiety 'or "a return to the acute confusional state that belongs to disintegration of nascent ego structure." The unconscious threat of a potential return to a dependent relationship refigures the previous failed dependency and so can involve "a frightening return to the earliest unintegrated state." She describes her first therapy session with Winnicott as bringing a repeat of an experience of terror and how Winnicott held her and managed her during her regressive experiences. She identifies how the healthy part of her and this traumatised part of her existed together within and how during her therapy there was a challenge: "which would prove the stronger, the sickness or the health, which were both there" (Little 1990, p70).

Wilkinson (2010) comments on early Psychoanalytic understanding that regression involves an altered state of mind which is primitive and also that abstinence on the part of the therapist could replay original traumatic experiences. She advocates for attention

to affect with the therapist regulating the amount of arousal experienced by the client. She considers that the therapeutic relationship has at its heart the creation of a sustaining, containing relationship in which unintegrated affect can be integrated and fear and terror attenuated. She cites Krowski (1997, p171) "it is only when a containing maternal object has been internalised [in therapy] that rage and hatred….can be faced". She concludes that "it is the internalising of the containing maternal object that is at the heart of a regression process in treatment that emerges as truly therapeutic" (Wilkinson 2010, p160). The therapeutic relationship will then be a dependent one, where the needed regulation, containment and support will be provided by the therapist in a way that recognises the needs of the client but still acknowledges the adult aspects of the client in the here and now.

The following participants, I and B, identify how their therapists were available to them and able to offer reparative relationships, transforming their distressed states:

> That I might be able to ask for reassurance from her, that I might be able to ask for some affirming of me, that I might be able to ask for her to hold me, I might be able to ask for her to tell me how I appear, or to tell me how I come across, or just to tell me how I'm perceived,

> It was how she leant forward about two thirds of the way into the work, and how she just very, very gently just touched me just there on the hand, it was just that kind of a touch and with it pulled me and her into a closer space

The above participants identify the importance of the therapist's presence and touch as a form of non-verbal contact. Wallin (2007) makes a clear link between the development of a secure therapeutic relationship and the client's ability to confront trauma helpfully. He considers that the goal of therapy is to resolve the patient's trauma, whether that be an acute traumatic event or of the chronic nature of cumulative trauma. He understands cumulative trauma as the child's repeated experiences of fear, helplessness, shame and abandonment requiring the development of primitive defences which may remain into adulthood. He advocates for the development of a new secure attachment relationship with the psychotherapist. This empathic, attuned relationship attenuates the impact of original trauma and provides a wedge between the old, traumatic attachment patterns that enrage and terrify and the here and now of relationships that are supportive and

empathic. He views working with the body as a key aspect of therapy with such patients because of the propensity of traumatised infants to use dissociation - the "escape where there is no escape" (Putnam 1997) which he describes as having two aspects; a failure of integration of the trauma together with a hypnoid state, or separate state of mind, where the relation of self to reality is altered. The presence of dissociation, he says, makes it very difficult or impossible to confront and address the traumatic experiences. The loss of contact with the body which dissociation brings means that the somatic markers of clients' stories can be inaccessible.

Wosket (1999) identifies ethical and appropriate use of touch as a therapeutic intervention for some clients. Hedges (1994) recognises that specifically where there is early development damage some form of physical touch is required to transform states and establish connection.

Participant B describes the importance of touch in establishing connection with her therapist:

> Largely not in words, largely in action her knowingness of me, but letting me know in, in a often very non-verbal way, a touch or a gesture, or a look, more than a word……..something about being loved, I think, and having a sense of being loved.

Both personally and professionally, I consider touch and sometimes physical holding to be necessary and advisable to provide that sense of physicality and regulation which has been missing for these clients. In identifying that clients are in touch with more inchoate states then those means of contact which are appropriate to early infancy are useful to establish contact. Communication with infants is largely non-verbal so interventions of touch and holding are key. Van Sweden (1995, p165) identifies the value of remaining 'with' the client, and conversely, 'withdrawal' through misattunement or emotional unavailability can "precipitate psychotic disorganisation". He notes that the therapist should initiate and maintain contact in ways that support the dependent relationship. This statement goes with the usual proviso that this must be fully considered in supervision and the appropriateness or otherwise be ascertained prior to a move into this area, however, I think that avoiding touch and holding where there is cumulative trauma means that the client is unable to benefit from that sense of physical containment and affect regulation which make for a sense of security both within the therapeutic

relationship and outside of it. I agree with Lazarus (1994, p256) who says, "One of the worst professional and ethical violations is that of permitting current risk management principles to take precedence over humane intentions."

Countertransference as means of repair

The therapist's response to the client's transference, their countertransference, is a vehicle for understanding the client and their story. We have seen in an earlier chapter how these responses can be used to inform and guide the therapeutic process. Gottlieb (1992) identifies that the medium of transference/countertransference recreates within the therapy the previous early deficit relationship. She describes this situation as the area of the 'basic fault' (Balint 1968) where during the developmental stage of dependency damage has occurred to the infant's nascent being. She recognises that "so much damage has occurred that a well- defined ego cannot be said to exist and the predominantly psychotic anxieties about fragmentation, disintegration and loss of identity are paramount" (Gottlieb 1992, p1). Because of this damage ego boundaries are not well established, there is no 'me' and 'not me' and no internalised good object. This results in the search for the good object in the external object. Van Sweden (1995, p156) acknowledges the opportunity for the therapist to become a "maternal constant within the transference" so providing the opportunity for integration and developmental progression. Erskine (2007, p137) understands this process thus, "Through the psychotherapist's awareness of his or her own emotional reactions and associations to the client, together with an understanding of child development and self-protective reactions, that the therapist can sense the client's unconscious communication of relational conflicts or traumatic experiences of early childhood and that through affective and rhythmic attunement and an awareness of the importance of relational needs, they can create a sensitive phenomenological and historical inquiry that allows such pre-symbolic emotional memory to be symbolically communicated through a shared language with an attuned and involved listener".

Kalsched (1996) describes how, in the intimacy of the transferential relationship, it is possible to observe moment-by-moment changes, to re-experience aspects of the original trauma within the therapeutic relationship and undo the primitive defences. Ferenczi (1932) also considered that revisiting traumatic early events was necessary in

order to integrate the experience, and that the therapeutic setting was the place to do this. Bollas (1987, p33) recognises that in the early developmental phase the mother is not "identified as an *object* so much as a *process* transforming the infant's experiences". Through the "resolution of discomfort" by the mother providing milk "the pain of hunger, a moment of emptiness, is transformed by mother's milk into an experience of fullness. This is a primary transformation: emptiness, agony, and rage *become* fullness and content". Gottlieb (1992) then identifies that the mother is not known as an object, but rather as a process with the capacity to transform the infant's world. Thus cumulative transformations, because of their constancy, result in the differentiation of ego and object which, together with the emergence of the infant's ego development "may further transform the object world" (Gottlieb 1992, p256). What is recreated in the therapeutic relationship, if all goes well, is a process which has the capacity to transform the world of the infant within the adult, having the possibility to result in the development of a sense of self and of security. Killingmo (1989) sees the therapeutic relationship as agent for change, recognising that recent literature and research sees that insight and relationship work hand in hand, and that the therapist's role as a 'new object' is the catalyst for change.

Participant C describes the relationship as it has developed with her therapist, and Participant I expresses her experience of this:

> It's like my therapist was my whole world, I just lived for the sessions,

> I have much more of a sense of liking me…. I've had much more of an 'ok'-ness of who I am…. And more of the physical sense of myself, I feel a lot less fragmented physically.

Fromm (2007) in describing the work of C. Winnicott (1980) comments that her client "having achieved the ability to truly depend on Ms. Winnicott, …could then re-connect with her very early depending on a teddy bear and on her mother as well". He notes that Volkan (2006) calls this "the re-libidinisation of the patient's inner world – meaning the coming to life of early experiences with people who really mattered to the person, experiences that reassure the person about the foundations of their place in the world" (Volkan 2006, p3).

Participant H recalls:

> ….it was a life and death thing, and it was quite a profound experience,……. this was a real developmental stuff about separation, identity, about coming into the world, about that survival, so that is, that is the memory that most comes to mind in that, and although there weren't transitional objects that were given to me, from that experience, actually making sense of it was really important..…. it was actually within the therapy room…

The following participant, B, describes her therapist's recognition of the pre-verbal nature of her work:

> …one of the very first things that she said to me, 'your life hung on a balance, you know what that's like'…….. it meant that in terms of regression, the primitive, the pre-verbal it was instant with her, as soon as I started in therapy………I knew I was being kept alive, because she knew she'd opened the door to the bit where I'd hung in the balance….

In describing such patients and the difficulty in working with them Borgogno and Vigna-Taglianti (2008, p316) recognise the inability of the patient to speak or think about their pervasive difficulties until such time as there is a therapeutic container for them and how this "occurs when we are facing histories marked by pre-verbal traumatic events that have created such damage to the structuring of the ego that the patient's dramatic nature can no longer be 'dramatized' and, instead of anxieties, catastrophic terror has settled in".

Participant I reflects on her experience:

> Feeling like my body doesn't, isn't together, that my arms and my body don't function together, that my legs don't function together [my brain is] separate, that separate, thinking and feeling are separate.

Participant B recalls:

> I would say it felt pre-verbal.... I couldn't find language though I was in terror at times though I couldn't move it in any way forward……

Borgogno and Vigna-Taglianti (2008, p317) go on to describe the analyst's role: "these are precisely the situations in which the analyst, along with his hard work of decoding and 'interpreting' the dissociated feelings and roles, will have to provide and to give existence to those parental functions and those aspects of the infantile self that have been omitted and are lacking in the patient's history. In other words, the analyst will have to be both, and at the same time, the suffering and inadequate parent the patient has had and a parent different from the one fate provided him with. Moreover, the analyst will have to be both the child that the patient was, and the child who is able to feel, to react, and also able to make himself heard; the very child the patient has never been and known in his childhood."

Participant H, speaking of herself as a therapist, describes her experience of being in the presence of her client's terror:

> But I stood, and I could hear voices in the room…and all of them agitated and worried, it was quite crazy-making, you know, if I, you know, hadn't got a handle on it and not understanding what was going on, so you'd think, 'I'm going barking here', but I kind of had a sense of what that meant, you know, it was the levels of terror that were in her really,

Borgogno andVigna-Taglianti (2008, p314) highlight that where trauma originates in the pre-verbal this can be experienced in the therapeutic relationship transferentially and this area is the "domain of non-occurred or non-completed symbolisation, that with the passing of time can be slowly reintroduced into the analysis by the functions that the analyst performs, so that the patient will eventually be able to find the symbolisation within himself" thus enabling "the transmission of the emotional alphabet that is needed to master the lived experiences" and that "trauma for them would consist of the very fact that something that should have happened has, actually, not occurred"(Ferenczi 1932; Winnicott 1963; Bokanowski 2004; Borgogno 2005; 2006).

Siegel (2003, p48) identifies how individuals with unresolved trauma use the attachment relationship to enable them to re-enter terrifying states within the therapeutic relationship to permanently alter the primitive defences. This safety is not through

words but through the nature of the relationship "traumatic states can be re-experienced, communicated if possible, and altered into more adaptive patterns in the future." "One view of development is that it involves the organisation, disorganisation, and re-organisation of patterns in the flow of states of mind. In this manner, development requires periods of disequilibrium in order to move forward in its ever-changing trajectory. In unresolved trauma, such forward movement has stopped. Restrictive or chaotic states preclude adaptive development from occurring." The effects of unresolved trauma are considered by Schore (2003, p108), seeing that "the loss of the ability to regulate the intensity of affects is the most far-reaching effect of early traumatic abuse and neglect". He highlights the fact that contemporary studies focus on the connection between early traumatic attachment experiences and the inability of some personality developments to regulate fear and terror states. He considers that there is evidence to connect neurobiology with attachment theory, hypothesising that the infant's "capacity to cope with stress" is correlated with certain maternal behaviours. He views the attachment relationship between mother and infant as crucial in developing the capacity to regulate emotion. He argues that a secure attachment relationship can facilitate the ability to self-regulate in later life. Schore's conclusion in this process is that "the dyadic regulation of emotion", psychobiologically, modulates positive states, such as excitement and joy, and also negative states, such as fear and aggression.

Goleman (1996) believes that it is the element of perceived helplessness which makes the experience of trauma overwhelming for the individual. The impact of trauma upon an individual is subjectively experienced and that the closer the relationship, the more significant the impact upon the individual. This also means though that as the relationship with the therapist becomes close then that relationship is significant in helping the client to change and develop.

Participant E describes traumatic feelings of helplessness and powerlessness:

> …that sort of intense feeling of pain and sort of wrongness and powerlessness about something terrible going on, to me that something…to a small child that's… terrible, that's the word for it…

Kalsched (1996) recognises that the fear of breakdown and psychological collapse is heightened in some individuals, but it may not be evident at the outset of therapy. He

considers that 'fear of breakdown' can come to the fore as a 'dominating factor' when therapy is progressing well. He considers that in high functioning clients who are well compensated against their need for dependency it may not emerge early in the relationship. When the relationship moves to this level the therapist's failures and misattunements result in fear and anxiety culminating in 'fear of breakdown'. He describes the meaning as "a failure of a defence organization" (Kalsched 1996, p88). This breakdown is of the self and it is the organisation of the ego that is threatened. Indeed, this could be seen as a reprise of the breakdown that occurred when the false self was created in order to protect the true self. The therapeutic task is to help the client to begin to develop a narrative to express the experience, and words to express the primitive emotions. This dual conception of the self, involving a highly developed, socially adroit false self and a more primitive, emotional, true self can help us understand the therapeutic value of regressive experiences. One way of seeing the client's regression in therapy is as a way for them to tell the story of their developmental experience and so identify their developmental needs. This pre-verbal communication is not available to consciousness through language. Pre-verbal memories can be made manifest in behaviour patterns, emotional responses and relationships. In regression to dependency, experience is not available in the form of a narrative memory, but recollections of abandonment, neglect and cumulative trauma can be stored on a physiological level (Erskine, 2007).

Conclusion

"Living with terror changes you. It burrows into your soul. It pulls you apart thought by thought. It inhabits your sleep. It visits when you least expect it, even when you are miles or years from its home. It recreates you, unbidden and unwelcomed…it is impossible to speak directly of terror. The experience of terror falls beyond the capacities of our normal language" (Hudnall Stamm et al. 2004, p370).

In this chapter I have highlighted the participants' experiences of terror, offering some theoretical input to make sense of the experience, and particularly looking at how the therapeutic relationship can be used to address these issues. I have described how trauma resulting from maternal deprivation which has occurred prior to the development of language, can be revisited in a therapeutic relationship which facilitates regression to

dependence. When trauma relating to nascent relationships emerges, it can provoke a re-experiencing of the terror of disintegration and breakdown. I have described how terror relates to infantile experience, using data from participants to illustrate these processes. I have explored the development of primitive defences in relation to cumulative trauma, highlighting the therapist's response and capacity to transform.

The experience of terror and trauma can disrupt functionality, and some orientations and medical professionals seek to avoid such disruption by using cognitive interventions and strategies which assist the client to manage their symptoms rather than resolve them. I do not believe that the treatment of symptoms is appropriate for the clients who are featured in this study. Such experiences haunt and oppress the lives of such clients, and should therefore be addressed rather than avoided. The therapeutic relationship offers the means for such resolution. The participants have described how the terror, panic and anxiety symptoms which some of them have experienced prior to and during therapy have been alleviated or transformed as a result of the therapeutic relationship.

The development of a secure therapeutic relationship is necessary to enable the client to feel sufficient safety to begin to regress, yet this development itself can result in the emergence of disowned feelings of rage and fear. When the relationship is strong enough to survive the expression of rage and fear, and the client is able to relate to the therapist from the true self, and this is accepted by the therapist, then defences are not rebuilt and eventually the client can integrate the needs and emotions of the true self and become whole. Successful negotiation of the regression to dependence can resolve such primitive anxiety by providing reassurance and continuity of being, allowing maturity to later development. Therapists who have participated in my research have identified feeling moments of risk from clients whose rage was expressed. My own rage and terror scared me and it did get acted out. My therapist contained me physically and emotionally, and accepted my rage and its manifestation as one would an infant's, with tolerance and through management (Winnicott 1963).

This chapter has been particularly influenced by the material shared with me by the participant who has withdrawn, therefore I have been unable to write down her words, but they are in me and are therefore implicitly within this work.

It seems appropriate at this point to apprise the reader of my experience of writing this chapter. I have written it during a particularly difficult time in my own life when I have been experiencing terror as a result of current serious health concerns, and life or death has been ever on my mind. To be immersed in the data on terror has been very difficult and I could not have done it without the support and love of those who are important to me. I found it easy to find and understand the theories which surround terror, but difficult to find my own voice, particularly my academic voice, because at times I have not felt grown up enough to have one. It has been very difficult to put into words that which I know, both personally and professionally. While trying to write I have been frequently regressed and unable to think or articulate. This is the situation that my clients and participants have also found themselves in, and why they have struggled so much to live in an adult world whilst at times feeling very small and vulnerable and unable to rely upon themselves.

It is important to consider the impact on my therapeutic work during this period. From a regressed place it has often been hard to manage my client's material when I have been scared for my own life, and feeling very vulnerable myself. As many of my clients have absent or unavailable mothers I have been concerned that I could re-enact their previous experience by being psychologically unavailable. Practically, I have also had to consider if my illness would result in my giving up practice and the impact of this upon them and their continuing need of me. In a positive sense, having had these experiences myself, means I have a greater understanding and empathy with the life and death struggle that some of my clients have found themselves in. I have revisited, from a new perspective, what I believe to be the life and death struggle of my early infancy, and in doing this I have had what I believe to be a here-and-now experience of the there-and-then, I have re-experienced the feelings of annihilation, abandonment and threatened death. Suttie (1935, p31) has identified the seriousness of a situation where the relationship with the mother is threatened. He highlights the importance for the infant of the need to retain the mother – "a need which, if thwarted, must produce the utmost extent of terror and rage, since the loss of the mother, under natural conditions, is but the precursor of death itself".

Chapter Seven

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Shame in Regression to Dependence

"Shame, blame, disrespect, betrayal, and the withholding of affection damage the roots from which love grows. Love can only survive these injuries if they are acknowledged, healed and rare" (Brenne Brown 2010, p26).

Introduction

Because of my personal and professional experiences of shame within the regressive process, I was led to ask the participants of their experiences. The data in this chapter relates to their experiences of shame and some destructive aspects of it. Although shame is a normal human emotion, some theorists recognise other toxic aspects to shame. I will first explain shame as a normal human emotion before exploring the thinking around the more destructive nature of shame as described by my participants. I will identify the connection between shame and regression, and consider how this impacts on the therapeutic relationship when working with regression. As I will show shame to be a relational wounding I will also show how the therapeutic relationship is a means of repairing this wounding, offering also some suggestions on the use of metaphor and creativity to diffuse shame.

Shame as normal human emotion, or as a destructive force

Kauffman (1994) uses Schneider's (1977) identification of the word 'shame' as having its origin in two words with opposite meanings – 'cover' and 'exposure', leading him to consider shame as a regulative principle. He then identifies normative (healthy) shame leading to self-experience and self-exposure, and dysregulative (toxic) shame involving inhibition or exposure.

There are two main theoretical areas of the study of shame: shame concerning the development of the self within Self-Psychology; and shame as a defensive power from the humanistic-existential theories. Both of these theoretical areas link shame and early

developmental experience. Lansky (1994) locates the potential for shame in early infant development and Shaw (1998) suggests in the pre-verbal stage.

Participant G recognises the pre-verbal origins of the shame she experienced:

> Yeah, I think I was often in shame, but to me it's all part of the same process …..if it's that very early pre-verbal stuff, it's just there, it's embedded in that whole process…

Bradshaw (1988) describes the development and interpersonal nature of shame in early infancy. He recognises that the feeling of shame belongs within humanity, identifying limits and boundaries of the self and others, helping individuals to know their need of others. He identifies 'the interpersonal bridge' which is an emotional bond formed between child and caretaker, and represents the significance of the other to the child. Gestalt therapists Perls, Hefferline and Goodman (1951) view the self as created at the contact-boundary between the self and the environment, and that the self is a system of awareness at the boundary between self and other. Erikson (1950) cites shame in the second stage of psychosocial development concerning the development of this bond of the interpersonal bridge between self and other. In this view with the establishment of this significant relationship in early infancy comes the recognition of the importance of the relationship and with it the potential for shame. In the infant's early environment their significant others show them what is acceptable, either explicitly or implicitly. This can be demonstrated to the infant verbally or non-verbally, so when the infant spontaneously takes action, needs, feels, thinks, looks like, the way in which they move can be met with approval or disapproval within their environment. In healthy development the child needs to learn that his developing autonomy will not destroy the interpersonal bridge. From this position the other's approval or disapproval has profound importance for the infant and can be part of a normal socialisation process or can result in psychopathology, thereby constricting the self-development and leaving the infant with a negative reaction to themselves. Bradshaw (1988) considers that when the child's parents are shame-based they are only able to focus on their own need and, therefore, are unable to address the child's need when it clashes with the parent's need. The child grows up and develops, but underneath still remains the neglected child with 'a hole in the soul' (Tomkins 1962; 1963) which is unable to be filled with adult to adult relationships, because it is the child's needs that are yearned for.

Bradshaw (1988, p vii) describes how shame can be healthy, when the infant experiences his own limits, or can be experienced as toxic, "Shame as a healthy human emotion can be transformed into shame as a state of being. As a state of being, shame takes over one's whole identity. To have shame as an identity is to believe that one's being is flawed, that one is defective as a human being. Once shame is transformed into an identity, it becomes toxic and dehumanising." Shame carries with it feelings of being defective, unlovable, dirty, and can be based on any aspect of a person. This sense of being shameful develops over the years and the infant is unable to internalise a sense of himself/herself as loved and respected. This situation can arise as a result of a lack of empathy, misattunement and cumulative trauma, and, of course, in all other types of abuse (Bradshaw 1988; Erskine 1995).

Speaking in his role as a therapist Participant A relates his understanding of this type of shame:

> …so I think of shame, I always think of it as a relational rupture caused by humiliation, criticism, putting somebody down, ignoring someone, diminishing them in some way, so you've got a relational rupture…

He identifies below his understanding of the steps and the defences leading to the experience of toxic shame:

> …I look at shame in five parts, it's [1] the hurt of not being accepted for who I am, there's something really fundamentally wrong with me. [2] The fear of future rejection as I am, so my behaviour is unacceptable, so if I cry I am going to be rejected, hurt for crying and fear that I'm going to get further rejected. Then there's [3] a kind of compliance with the other persons humiliation. You're just a baby grow up…[4]So the person pulls themselves together and then [5] the disavowal of their anger. They don't dare get angry at that person because they're afraid of the rejection. …….And then they wind up with the fundamental belief about themselves, something's wrong with me.

Participant E views his own experiences through his understanding of Winnicott's conceptualisation, identifying a reprise of shame feelings in his everyday life:

> I have certainly had times when I felt very…lost in very intense shame feelings…that I could associate with times of being a very small baby or small child…I would get the feelings in relations to certain sorts of images…I could see a child in a

pushchair…going along a road with someone pushing and feel a disconnection…as it looked to me…like between the adult mother or parent and the child…and then feeling intense pain…an overwhelming…sense of kind of lostness and…disconnection...

The destructive force

Because of the central role played by shame in social and self development, when it becomes a state of being, taking over the whole identity, it can result in the development of feelings of inadequacy and worthlessness resulting in poor functioning and emotional distress, feelings of isolation because of difficulty in relating to others, and ultimately lead to psychopathology (Lewis 1971), affecting the ability to trust oneself and one's own judgement, feelings or desires, (Bradshaw 1998). Originally Piaget (1896-1980) thought that thoughts and feelings about the inner self were not possible until middle childhood, however current thinking accepts the infant and child's ability to emotionally respond and react to both others and self. Current evidence shows that shame emerges early in the period of infancy (Draghi-Lorenz, Reddy and Costall, 2001). From the human development perspective of Erikson (1950) shame is seen as a potential developmental outcome occurring in early infancy when the infant does not see their acceptance in their mother's eyes, seeing instead disapproval, disgust or disdain. When an infant has experienced non-acceptance of itself frequently and over a relatively long period of time, the experience of shame is internalised and the self and all the expressions of that self feel shameful.

Solomon and Siegel (2003) cite early exposure to shame and humiliation as frequent accompaniments to early child abuse. Fosha (2002) identifies fear and shame arising when the response of the attachment figure to the child's affective experience is traumatic. According to Fosha when there is no repair of this trauma the child experiences emotional overwhelm, loss of self and lack of safety in the emotional environment. Fosha then identifies that these affects are pathogenic and can be experienced by the individual who is alone.

Participant E describes the feelings which accompany shame and how the lack of an empathic other triggers feelings of despair:

…I was going through a much more intense period of primitive shame feelings...was that much harder to bear...I think that triggered some quite intense regression so that for

example there will be times when I could not rationally assess what had gone on in interactions between me and other people, where I couldn't be sure that I wasn't reacting through some intense paranoid shame type feelings... that intensity or the… that sort of intense feeling of pain and sort of wrongness and powerless about something terrible going on, to me that's something...to a small child that's...terrible is the word for it…and then a sense of ' well, where did this go, because if I didn't have anyone then, who did that for me, or didn't usually do it for me then, what's the point of reliving that feeling again…because it was a despairing, pointless…

Agazarian (1994) recognises the anguish of shame and the defences of paranoia and despair which can lead to the loss of an aspect of the self which is needed for intimacy, and without it feelings of emptiness ensue and can be presented at assessment by the client even though the external features of their life appear to be fulfilling. Bradshaw (1988) constructs self-alienation as resulting from shame. From this construction, if an aspect of self is deemed unacceptable within the family system, then it may be disowned, and then when it is subsequently felt it brings shame with it and as feelings, needs and drives become shame bound more of the person is alienated. This is seen to result in objectification of aspects of self, when eyes are "inward, watching and scrutinising every minute detail of behaviour," (1988, p13). He (1988, p14) uses Winnicott's concept of the 'false self' to describe a cover by which the vulnerable 'true self' is hidden. This is a misnomer as Winnicott's concept is better described as 'an incomplete self' as it is missing the completing aspect of the 'true self'. He sees the creation of the 'false self' as an escape from exposure, developed to cover up a "deep sense of self-rupture, the hole in their soul." He recognises the hiding nature of toxic shame, seeing its development when the unexpected exposure of vulnerability occurs before the child has their ego boundaries for protection.

Evans (1994) described these experiences of shame as "a descent into hell", Kaufman (1992) cites Tomkins (1962/1963) as seeing shame as "a sickness of the soul" and Lewis (1987, p95) describes shame as "a momentary 'destruction' of the self in acute denigration". Bradshaw (1988, p55) terms shame as the master emotion, because as it is internalised all other emotions are bound by shame. He cites Kaufman's term of internal shame spirals where shame feelings "flow in a circle, endlessly triggering each other" (ibid, p60).

In Winnicott's (1967) construction of the development of self in infancy he identifies the mother's face as the child's first mirror, thus, if the child sees the mother's expression of disapproval, disgust, disdain then the child will ascribe these characteristics to the developing self, which includes the infant's needs, likes, dislikes, looks, shape, feelings; the entirety of its being. He considers that to look creatively at the world, the infant must first of all have been seen and internalised that experience. The infant depends on the mother's facial expressions when looking at her to establish its own sense of self. Jacobs (1998) identifies that Erikson (1950) associates shame with the inability to perform tasks and a self image of being immature. Jacobs differentiates this from shame associated with damage to the self. Bradshaw (1988) considers that "our families are where we first learn about ourselves" where our "significant relationships are our source relationships" and the learning about ourselves and our relationships from these sources is taken into adult relationships (1988, p29). Josselson (1992, p117) identifies shame as resulting from "putting forward some valued part of ourselves and seeing revulsion in another's eyes". When this revulsion or non-acceptance is seen in the mother's eyes in infancy the effects upon the developing personality can be devastating.

A number of theorists recognise the reduction in functionality as being part of the shame process, for example, Nathanson (1987) cites Darwin on shame, "persons in this condition lose their presence of mind and utter singularly inappropriate remarks" (1872 - 1979, p332). Kalsched (1996) cites Joyce McDougall's term 'alexithymia' – having no words for feelings. Shaw (1998) also recognises the wordless component of shame placing the experience of shame in the pre-verbal, quoting from Kaufman (1993) that "shame begins as a largely wordless experience". Shaw makes a comparison between Kohut's (1967) 'nameless shame' and Tomkins (1962/1963) naming of the affects of shame. Erskine (1995) identifies how there can be no language of emotion, "When there has been a lack of attunement, acknowledgement, or validation of needs or feelings within the family or school system, the client may have no language of relationship with which to communicate about his or her affects and needs" (Basch 1985; Tustin 1986).

Kaufman (1993) sees shame as intrapsychically internalised. Shaw considered that there appear to be two types of shame response; an innate biologically driven affect, and an

internalised response within relationship. The biological affect is triggered in the here-and – now environment, 'relational shame' can occur within relationship or when one is alone in relationship with one's self. Relational shame is of interest to psychotherapy as a whole and also to this research because as clients regress within the therapeutic relationship they re-experience their vulnerability and dependence on the other, and therefore experience the shame that is within, finding their needs and vulnerabilities shameful and expecting in the transference relationship that the therapist will also find them shameful.

Participant B describes how becoming psychologically vulnerable would be perceived as shameful because of her historic learning:

> Psychosis was a break or a breach in reality, or rather that's how I grew up, grew up …was taught…but growing up as an adult as well…so therefore it was pathological…thus it would carry a shame with it if ever I were to experience it for myself, and certainly carry a shame if anybody else were to know.

Solomon and Siegel (2003, p242) construct the experiencing of fear and shame (which are normal emotional responses to external situations) as problematic when they are generated by the attachment figure itself "when shame and fear are elicited by disruptive experiences with attachment figures *and* cannot be dyadicly repaired, individuals find themselves alone, emotionally overwhelmed, unable to be real and unable to count on the safety of the emotional environment. Highly aversive, the hallmark of *the pathogenic affects* is that they are experienced by an individual who is alone, as the affect-regulating attachment relationship has collapsed".

Fosha (2002), cited in Soloman and Siegel (2003), called fear and shame pathogenic affects arising when the attachment figure's response is disturbing and disruptive.

There is general agreement that shame follows some kind of exposure which reveals a vulnerable side of self. Wurmser (1987) summarises what we are most ashamed about, the main points being; I am weak and a failure; I am dirty, messy and disgusting; I am defective, physically or mentally. All of these views contribute to the sense of being wrong and feeling wrong. This non-acceptance which begins as an external experience is seen to become internalised as part of the self.

Participants H and C describe their internalisation of childhood messages:

> How did it manifest? In all kinds of ways, it's like I couldn't own my own skin, you know, shame just for existing, shame, shame for feeling, shame for whatever feeling, you know the messages in my childhood were, 'don't feel, just don't', so... don't need...'don't exist.'

> I think it was just feeling bad about myself all the time, and I couldn't get anything right.

Wright (1991) associates being 'seen' with shame, but also acknowledges that shame can occur in isolation when both aspects of self and other are intrapsychically experienced. He quotes from Lynd (1958) that "shame forces into awareness some aspect of one's self that one had not realised". Clients often experience buried needs and thus feel shame as they come into awareness during therapy, but ultimately the experience of shame can increase self-awareness and understanding of one's own needs and identity. He argues that shame begins in the experience of being seen by the other and the realisation that the other can see things about us that we may not be aware of. The experience of shame, then, occurs when one's awareness of one's self shifts from the embodied experience to a perceived objective view of one's self. He also quotes from Sartre (1957) writing about the threat of the other, and the other's objectively defining of the self. Wright sees that the threat of attack by the other is a threat to annihilate the subjective self, by becoming an object of the other in their subjective world.

The term 'toxic shame' is widely used by theorists, but is primarily a term used in Transactional Analysis (Stewart and Joines 1987). Bradshaw (1988) defines toxic shame as encompassing the whole personality and resulting in feelings of being defective, while guarding against the exposure of the inner self to others. Because of the pain of exposure the self can disown the shamed parts of self. In recent years shame has been of interest to theorists from a variety of orientations, but it was seen with Adam and Eve, when their eyes were open and they felt shame (Genesis). Nathanson (1992) notes that Darwin was also interested in shame, seeing it as an innate universal feeling.

Kaufman (1992) sees the striving for perfection as a defensive strategy against shame and the pursuit of power as an attempt to cover the sense of defectiveness that accompanies shame. As someone increases their power, their vulnerability increases because shame travels down the dominance hierarchy. Lewis (1987) identifies narcissism as a defence against self-hatred caused by shame. Bradshaw (1988) sees the striving for power and control as avoiding shame and vulnerability. In disowning the shamed self we are driven outside the self; we then objectify the self and see ourselves as defective. As with Kaufman, pursuit of power and control is seen as a compensation for this sense of defectiveness.

Shame and the therapeutic relationship

Therapists working from a Relational/Developmental perspective identify extreme shame reactions as emerging from early infancy and childhood, so would also expect that shame would be experienced in clients who are revisiting these early developmental phases. The source of these present experiences of shame is sited in the client's past history, the history of their early relational experiences. Wilkinson (2010) describes early relational trauma and its effects as 'the old present'.

Jacobs (1995, p87) recognises the potentially shame-invoking elements of the therapeutic setting when the client is shame based, seeing that "such a patient will likely be exquisitely sensitive to the signs of the differential, easily wounded by its emergence, and assimilate it readily into a fixed belief that this difference is a confirmation of his unworthiness and of the therapist's understandable distaste for him and his needs."

The following participants, H and C, identify their experiences of shame in therapy, recognising that the shame seems to be part of their existence:

> Loads of shame...oh God, well just shame for being, just for existing,

> I think it was just feeling bad about myself all the time, and...I couldn't get anything right,

> Well, I think there are some levels of trauma, particularly with shame, 'cos I think shame is a trauma, that causes a separation in self,

Participant C gives us a glimpse of the internalised inner voice through which she shames herself:

> …it was just unbearable, and then it was like, 'come on, you're older than the rest of this group, and you need to be hugged at the end, this is ridiculous', but I did…

She describes the effects of shame and its impact within her therapy:

> Never once in the sixteen years I was with my therapist, did I get a whiff of being shamed… I felt shame anyway….

> If I opened my mouth, which was very rare, I would just absolutely blush to the roots of my hair, I desperately, to be able to say anything was terrible, so it was like anything like that, was such an ordeal…. I think at the beginning it was definitely enormous, the shame, just embarrassment and thinking, 'I shouldn't be here, I shouldn't need to be held, I shouldn't need all of this'…and being quite angry that she had created all of this for me…..

It is important to note that in society, and in the client population, such experiences may be described differently as shyness, social anxiety, and social phobia. The participants in this study have all been immersed in a Relational/Developmental model which places such experience and their development within the construct of infant development stages. Shame and guilt are two major forms of negative reaction to one's self. Shame is the feeling that 'I am not ok', guilt is the feeling of having done something bad. Shame as an experience in therapy is common and yet often not identified or acknowledged as the therapist may also be caught up in the shame process. The experience of shame is frequently accompanied by the need cover up or hide. In the therapeutic relationship the client may not identify this, but if recognised by the therapist the experience and effects of shame can be brought into the client's awareness, so that over time the shame reaction can become moderated. The experience of shame in a shame prone person can seem very natural and therefore is not identified as an issue in its own right. A person experiencing shame may find speech and articulation difficult when viewing shame through a developmental lens because of its developmental positioning in early infancy. Because of the development of shame in early infancy shame feelings are often not in verbal awareness.

Participant G describes how she as therapist tries to help the client with shame:

> ….if it's that very early pre-verbal stuff, it's just there, it's embedded in that whole process, and I feel very….. very respectful of shame, and I don't want to do anything to compound it, and I recognise it's there not of the person's choosing, and that therefore it's my job as a therapist to do whatever is needed to reduce the effect of the shame, 'cos I can't take it away,**.......** which often means trying really hard to make sure they hear me, because in their shame they don't hear the support that I'm offering, so I have to often get right down there and try and make the eye contact, which could be seen as intrusive, but there's a thing about trying to find the person…and accept them in their shame…

The power of the therapist in shame bound clients can be experienced as if it were the shaming parent that the client grew up in contact with. Sometimes therapy can replay these past experiences and the client resorts to learned defences against feeling wrong and bad.

Participant I explains how her therapist caused her shame and how this reconfigured experiences of her infancy and childhood:

> It was explicit, that she clearly said that we couldn't work if I didn't take more responsibility, and that she was angry with me for not coming, not being there, and I think I then became the compliant child then and did, and was the good girl and did everything she wanted me to do, I came out the right door, did all the things she wanted me to do, so it felt like it repeated the pattern of… cos that's how it would have been with my mum, that I couldn't tolerate her reaction to my being lost, so I was compliant then….

Josselson (1992) considers that the extreme of shame is the experience of annihilation, if 'I' am not seen, 'I' cease to exist, and fragmentation occurs. Seeing acceptance in the eyes of others is essential to the development of a healthy self. When shame is understood and acknowledged by the therapist it can allow the client to work through their experience and develop a reparative relationship which allows the client to start to develop an identity which is not shame bound and 'wrong'.

Participant B describes her archaic shame and how it emerged during therapy. She recognises her therapist's non-shaming stance:

I never felt shamed by her, I felt ashamed, profoundly ashamed - dreadfully, excruciatingly, psychotically, I felt psychotic with shame…I can remember sitting in places and so on afterwards, just thinking, 'I'm crazy. I am crazy, I can't even work out what I'm seeing any more' you know, that kind of…seriously I need to ground myself before I move, kind of crazy, but I ,…so though I felt that, although I felt crazy and was experiencing it, she never, she never shamed me, and I was able to know that and although I felt it in response, actually, I could see that there was nothing in her that was doing it or there was no intent….

Even when the therapist is accepting and non-shaming, archaic shame does not just disappear, and can impact the work at any point. From my own experience, both personally and professionally, even when the shame process is identified sufficiently well to enable the client to allow regressive needs to surface, shame is still present within the work and can surface with renewed vigour when there has been a break in the relationship for holidays or illness, and also when the client is about to make a new leap forward in the development of the relationship, that is, when the client is about to risk exposure of self, or of needs of the self, by identifying them to the therapist, shame can be present, preventing such exposure and resulting in the client remaining silent.

Participant C identifies how shame was present well into the regressive phase of the work:

…[regressive needs] didn't disappear, and just seemed to be there long after I felt I ought to need it

Erskine (1995) recognises that when a client has internalised a sense of shame in childhood they can adopt a belief that "there's something wrong with me" which Erskine sees as a confluence with those who have shamed them. He describes this as consisting of "a child's defensive transposition of sadness and fear, a disavowal and retroflection of anger at not being treated respectfully, and a fixated diminished self-concept in confluence with the introjected criticism" (Erskine 1995, p5).

Participant G demonstrates how this concept remains active within the therapeutic relationship when she identifies how the 'blame' for occurrences in the relationship rests with her and not with the other, in this case the therapist:,

> You know, I wasn't always confident that I would be able to, and I used to blame myself, but the thought never occurred to me to blame my therapists for not making the right intervention

And she describes how acceptance from her therapist defused shame:

> I was accepted in my shame, you know, and actually I don't remember us working that directly ever with my shame, but we worked a lot with the abused, abused by, not directly abused, but abused by the environment…and neglected child…

Erskine (1995) considers that to work with shame requires the therapist to discover the uniqueness of each client's psychodynamics. This enquiry into the phenomenological experience will increase understanding for both therapist and client "the therapeutic processes of attunement and involvement acknowledge the difficulty in revealing the inner confusion and struggles, value the desperate attempt at self-support and coping, and simultaneously provide a sense of the therapist's presence" (Erskine 1995, p114; Evans 1994). Kalsched (1996) identifies that therapist's self-disclosure in the face of the client's shame can result in a shared humanity experience, so enabling the client to experience her vulnerability with reduced shame.

Working with empathy and attunement is essential for developmental repair. This enables the therapist to identify the client's experiencing of shame. When clients do successfully bring to light their shameful feelings the quality of the therapist's presence and empathy can be a healing experience. If the therapist is able to share a personal but processed shame issue it can give the client a shared experience of the humanity of both parties, seeing shame as present in all humanity rather than solely an experience about themselves.

Participant B shows how her therapist takes the responsibility for an action within the relationship which was determined by her attunement to the client's process, therefore avoiding the client's potential shaming by needing to initiate the action:

> So she was radical and proactive in saying things to me, so I would get there and we would sit down and she might say something like, 'you know, I've just so been thinking about you and this is what I would like you to do', and she'd name the thing that I was

most scared of, so she clearly would play with ideas so that meant I could do it, even if I felt ashamed, it was her who'd done it…yes..

Erskine (1995, p8) advocates for respectful enquiry, aiming for affective attunement for effective therapy. He considers that "attunement occurs in the therapist's honouring the client's developmental level of coping with shame and the absence of any defining or categorising of the client's fantasies, motivations, or behaviour. Attunement also involves sensitively communicating to the client that the therapist is aware of the inner struggles; that he or she is not all alone in the sadness at not having been accepted as one is, and in the fear of loss of relationship because of whom one is". He recognises that confrontation, emphasis on emotional expression, excessive focus on aggression, or emphasis only on the here-and-now may cause shame to be experienced by the client. The genuine enquiry into the other's experience, motivation, self-definition, and the way they make meaning avoids the potential for shame and so enhances interpersonal contact. Erskine (1995, p109) considers that "when the sense of shame has become fixated it represents an intrapsychic conflict".

Clark (1993, p52) also recognises the necessity of empathic transactions to diffuse shame identifying the potential interpersonal transmission of shame. She recommends that when therapists fall into the client's shame process "the only way to get out successfully is to use their theory as a ladder to let them out so that they can once again be of some use to the client".

Participant B identifies how the therapist's apparent confidence in her attunement and acceptance of herself led to her initiation of physical contact which alleviated the client's feelings of shame:

> So, so there was a terrific amount of risk taking and proactivity on her behalf. She was unashamed about using herself physically as a mother would. Unashamed, beautifully, physically so comfortable, and so comfortable in her own body, so I never had to go through that excruciating thing of thinking, I need someone to hold me, it was just so seamlessly done, or she'd even say, 'we won't start, just come here, just come here' or she would just say 'sit down, we're just going to sit here for a while', she wouldn't even say 'you need this'.. and sometimes she wouldn't move at all, but it was that kind of proactivity so I didn't feel ashamed.

Erskine (1995) identifies the unconscious hope in the client that the caregiver will heal the relational breach. The therapist's task is validation, normalisation, acknowledgement and presence through which the shame can be diffused.

In the following quotation Participant B demonstrates her ultimate understanding of the therapeutic relationship she was in:

> The other thing was she could tolerate quiet, hours and hours of quiet. So although I said the bits she might say come or do, actually for the most part it was a therapy of being… not a therapy of doing. …and the last thing I think, she loved me.

As in the infancy relationship when the therapist becomes a significant other there is a potential for shame to occur. The power of a negative therapeutic intervention can be seen in some of the participants' comments about their therapists and how early relational shame appears to became triggered.

The following participant, I, gives details:

> I think what was happening as well in that first therapy was that, I was I was angry with the therapist that I had then and that also got into the process of me not going, that the more she told me off for getting it wrong, at one point, the more I didn't go, and the more she said I wasn't taking responsibility the more fragmented I became….
>
> I did tell her on one occasion that I was really angry with her, that I felt missed by her and I felt told off by her, and my experience was that she was very defensive, in response to that, and I gave up, and just went for being compliant…..

Lewis (1971) has recognised that "when the therapist failed to recognise the patient's feeling of shame, the patient's problems were prolonged or worsened. When the therapist recognised the shame and helped the patient to deal with it, the treatment was shorter." (cited in Bradshaw 1988, p239).

Feelings of shame for needs are a common experience. Bradshaw (1988) identifies that in toxic shame, the binding of feelings, needs and drives, with shame occurs. This means that any feeling, need or drive is accompanied by shame. "When these are bound by shame, you are shamed to the core" (1988, p12). Kalsched (1996, p24) describes vulnerable longings which, when experienced, serve as warnings to the client's psyche

of potential re-traumatisation, so a splitting occurs to separate feeling from affect, as described by Participant I:

> …the terror was also about feeling shamed around needing, feeling shamed about wanting and needing of her, and that I couldn't do it all for myself, and that I couldn't be full without needing of her,

She describes below how originally in the maternal relationship she was shamed and how she has internalised this in other relationships:

> … in the relationship with my Mom, and then obviously consequently in lots of other relationships since I felt that 'you need to pull yourself together, why would you need this, why would you want this? You need to grow up and get on with it.' …so that it was that sort of terror of being shamed in that way… is there in the reality for me.

Participant B describes how her therapist's intuition and understanding of her pre-empted the potential for shame around needs:

> So… where she'd got to in her own journey was profound anyway, so there was that, she had an incredible ability to normalise something before I'd even got round to saying what it was, so she kind of laid the path of it before I even opened my mouth… which I used to think was, again that was one of the things that stopped shame, or even if I felt it, somehow I could manage…

Bradshaw (1988) describes the negative shaming, self-deprecating voices which dwell in a shame based person, that is, a person for whom shame has become an aspect of personality, telling them that they are unlovable, worthless and bad and may be experienced either consciously or unconsciously. He considers that these voices originally keep the child 'bad' and the parent 'good', thus maintaining the bond between infant and parent. In adult life these critical internal voices can remain essentially shaming the individual in the same ways in which they were implicitly or explicitly shamed in infancy, but in reality the consequences of these voices are that the individual avoids external shaming because the internal shaming prevents exposure, and that because of this shame flourishes in secret and the spontaneous expression of the individual is blocked. Wurmser (1981) points to the shame-based person's core feeling

of unlovability. He describes shame using Freud's words as being "the fear of the super-ego".

Participant I identifies a critical inner voice that she uses upon herself and how she recognises the transferential component of her relationship with her therapist, which is re-enacting her earlier experiences within the mother/infant relationship:

> I think a constant sort of me going with 'I'm sure you'll think I'm ridiculous about this, I'm sure… you'll think I should be over all this, I'm sure you'll think that I'm ridiculous that I still have these issues at this age, sort of constantly going with that over and over again, and her acceptance of that, but also me seeing in the transference that she was irritated with me, angry with me…me seeing all of that and working to break that, that transference, 'cos that was always there, I would always see her irritation, I would always see her annoyance at me….

> …a repeat then of what I would have experienced with my mum, because I remember with my mum, around that sort of age three/four I would get told off for coming home out of the wrong door, from nursery school when she told me where she was going to be I'd come out of the wrong door, and I'd get told off for it, and that's what I experienced with my first therapist, that, that wasn't allowed, me being little and not knowing how to be in life just wasn't allowed, so…

Participant I effectively describes the effects of shame on the therapeutic relationship and on her own behaviour:

> …I would become confluent, and immediately as I saw that I was getting to a vulnerable edge of really me being me separate to her and that there was the possibility that she could judge me and condemn me I'd become very confluent again, so I'd know that shame was around it at that point…I wouldn't go, I wouldn't go to sessions, I'd miss sessions, I'd forget sessions, I'd turn up late…when shame was very high that was, that was definitely around, physically I would feel shame, that I would feel less connected with her…. more removed, more inside myself…kind of a being there, but not being there… feeling very separate… very in me…less able to take her in in any way. Sometimes feeling enormous in that, feeling… unwieldy and…like my body's not connected together properly, that….and clumsiness…

Infants are dependent upon their caretakers for their needs to be met. When needs for dependency, physical contact, mirroring, empathy and any other need have been neglected by the caretaker these needs can become a source of shame. The need can then become a source of shame, for example where physical contact has been experienced as shameful in childhood the individual in adult life shamed both by physical contact itself and the need for it. Bradshaw (1988) formulates that a sense of personal value is lost when children are given the message by their parents/caregiver that their needs are not important. In this view when need deprivation is experienced, awareness of needs can be lost. The following participant, I, identifies the conflict around needing touch in her therapy:

> I get incredibly shamed with physical contact but it was one of things that I said that I wanted to work on when I went, went into this therapy, and I'm not sure about that, about…..why it's not there, why…..it's not to say that there's no physical contact with the therapist that I work with now, there is, but not, not a prolonged being held…

Participant E recognises that shame issues around touch link back to issues around touch with his mother:

> I think it stirred up intense shame issues for me, which go right back to my early childhood, and I think…rejection to do with touch with my own mother…and issues that…clearly got caught up with it all…

Participant K describes how it appears that her need for physical contact emerged in the form of a dream, but how her internalised rules of behaviour would have prevented her from asking her therapist for physical contact were it not for the therapist's intervention:

> …I probably did feel shamed that I even said it, [the dream of being held] and then to have it offered and not [be shamed for it]…

The following participant, A, identifies how one therapist shamed him for his dependency, demanding that he remain in an adult state:

> my early therapy was pretty heady, pretty cognitive…certainly the deep regressive work I did was not regression to dependency because I had already learned not to depend in a regressive way on that therapist, that was a therapist who wanted me in my adult and saw any of my feelings as somewhat manipulative and rackety

> The non-healing events were often the times people wanted me to shape up, to act more adult, and yet some really good therapy was also very confrontational about changing my behaviour, but often people… particularly in some of the therapy that went along with my training in hind sight was off

Kalsched (1996, p23) recognises that when clients' childhood dependency needs have been met with derision, or denied, they can experience a self-attack upon their neediness, considering that this archaic defensive system comes into play as a result of unbearable childhood trauma. In therapy then the client experiences extreme feelings of shame for need which initially may be held out of awareness as a defensive protection. Bradshaw (1988) also considers that the emotional neglect of developmental dependency needs constitutes abandonment.

For the therapist the demand for perfectionism from oneself as a defence against shame (Bradshaw 1988) can mean that the therapist attempts to 'get it right' in order to avoid shame. This results in a movement away from the relationship with the client and an attempt to be 'something that I am not' at the moment, thus presenting a false self rather than real self engagement (Winnicott. 1984).

Participants B and A describe the presence of shame within regressive work:

> …it would depend on how that person and I were best working together, so if they were best cognitive I'd work through it through a teaching model if it was best behaviour I'd work through it and start, I'd start with where they're at, I'm highly likely to name it as a possibility, so I'm usually proactive, say, 'it sounds like….' or 'it fits what I've read about', and then to start and talk about shame, so I'm doing it very much as a concept, I'm not talking about it about the client and theirs, I'm placing it almost like a, how you would a, a, a meal on a table for them to choose to taste or not, so I do it then, then I want to look and see, if, if that's beginning to fit, if I'm wide of the mark, if I'm there, if there's a tolerance, and I would work to increase knowledge about it as a concept first, and then gradually, at the least, at the areas where I'm least likely to either induce shame from their own, or to create shame by me, or the feeling of shame by me, I'd start at those and do it very carefully and continually link it back up in to cognition, so I'd be constant.

So many people have been in therapy and in the third session they start to spontaneously regress and cry in therapy and in the next five sessions they're stoic as can be because they're so ashamed of that spontaneous regression and then we've got to work through…There is I think a bit of a social function for the shame, as the test of the therapist in preparation for further regression…I mean we are in danger of ascribing too much intent, but that's the meaning I bring to it. I have to pass this enacted slow test of working through this shame, before I have earned the right to be their partner in regressive work…certainly arousing and alivening I've had people regress and wind up sucking on my finger as though it's a nipple…I don't get an erection out of it but I feel very alive and tingling and contactful….and for me, sexually, there's nothing sexual about holding someone who is regressed.

Participant A, speaking as a therapist, describes the process of shame caused by an internal critical 'voice':

… the internalised object, internal critical parent who is resentful and hateful, who sees the child finally getting what the child needs and then that parent ego state or that introjection comes on with a vengeance and eats up the person internally… it shows up as they're criticising themselves, "I'm a baby, I didn't need it, I should grow up" …"my therapist is just doing this to keep me dependant" .. all that kind of either criticism of the therapist or self- criticism, that is generally a very envious…. stage and so what has to happen is, along with the potential of setting up the supportive regression, you may have to stop it and go back and deal with all their internal criticism and deal with the source of that criticism and the envy or the hatred that's there, before you can go back and do more other regressive work.

Bradshaw (1988, p115) considers that to recover from toxic shame the individual must come out of hiding. He offers some suggestions for the client to combat toxic shame: sharing feelings with significant others, re-establishing an interpersonal bridge with another who is non-shaming, recognising the reality of his story and associated affect, recognition and re-integration of split-off parts. By holding attitudes of love, compassion and acceptance the therapist is able to provide a buffer against shame.

Participant C identifies the long term process involved in coming out of shame:

I think it gradually diminished, but it took a long, long time… again it was by being accepted, no matter what state I was in…

Metaphor and shame

Using metaphor, either one that the client introduces or one introduced by the therapist, can help to titrate shame. When working with metaphor we move the interaction into the third person and out of the here-and-now relationship with the therapist. In this way the client can engage some objectivity and talk 'about' rather than 'be in' the experience. This movement away from subjective experiencing can help to alleviate some shame and allow the client to talk about subjects which they consider shameful from a 'once removed' place. Loue (2008) sees the use of metaphor as a way of enabling the client to externalise what is seen as 'the problem'. She considers that in working with metaphor we give the client permission to explore their thoughts, feelings, behaviours, ideas and fantasies. Such permission in itself can be shame-reducing, but from my experience, personally and professionally, the use of metaphor and stories enables the client to initially broach and consider issues which may be too shameful to own, but through the use of story they are able to assess the therapist's response, and to explore thoughts and feelings which may eventually become owned and accepted. Zeig (1980) identifies how the use of metaphor can desensitise clients against fears; I would include shame in this. This 'stepped' process can titrate shame.

Participant B illustrates this use of metaphor in relation to her work with clients:

> There's a huge safety in it because if we find a metaphor that the other's willing to engage with we play in the metaphor without the word 'I'.. So it's a third person, …a deeply emotional engagement, but it's in the third person, and interestingly, it does cause change… so it might deal with a tiny bit of shame, but it won't deal with the in-depth bit until you do it for yourself, but it starts your toe in the water…

Tompkins et al. (2005, p2) recognise that "clients will often switch to metaphor whenever they need to…talk about something obliquely". They recognise that some experiences are too difficult to talk about in other ways. Clark (1993) describes how initially the client has the belief that the therapist sees some aspect of them as shameful, so using metaphor enables the client to test out the therapist's responses to the issue before owning it, so lessening the risk of shame.

Use of creativity

The following participant, B, describes how she and her clients use metaphor within the work:

> The thing about metaphor, as a developmental process, it's clearly observable that children go through different, different developmental processes and that they will work a tremendous amount initially with symbolisation, so much so that therapists have developed with that whole field of play therapy, for instance, and that following that language develops enormously very, very rapidly, symbolisation continues alongside it, but language becomes, an adjunct and it then will begin to take over, and that's part of the developmental process, and that, like Kenneth Wright says, that can be experienced near, or experience far, and that even in children who are being very well met in their appropriate, language development, will many times when they're on the cusp of trying with things, they'll use metaphor as well, they'll say something like, 'it was just like a giant', you know, 'it was as big as a so-and-so', and then they start to expand on it, because working in metaphor has the capacity for play in there, has the capacity to take us into our different senses, and our fantasy rather than the way in which words can often close it down…

Participant E describes his use of visual aids to achieve to also achieve distance, and therefore make the work less challenging for the client:

> …she would experience herself as being alone in space, like this tiny dot on a huge white table, with nothing around her, and on a sheet of paper, 'cos we were in the art room, she drew this tiny dot,…almost as if this…she was barely existing, it was the tiniest speck of vitality that had almost been extinguished, and then I very carefully and gently just drew a small arc, some distance away, a small arc, not too close, but with that slight sense of holding or…I just drew it, and she was sort of fascinated by it…we used the same drawing many times in sessions, and she would draw like a, like a small tiny, like a worm or snake, snake type tendril that would go out towards… go out towards the arc…

Generally the participants seem to imply that working through shame had allowed the regressive work to take place. Participant C was specific about this and she connects the diminishment of shame with the experience of acceptance within the therapeutic relationship:

I think it gradually diminished, but it took a long, long time and …again it was by being accepted, no matter what state I was in…

Conclusion

In this chapter I have explored the development of shame in infancy both normative and destructive aspects. Through the participants' data I have demonstrated how they view the impact of shame as being carried into adult life, and how they see this emerging in the therapeutic relationship. I have shown how the therapeutic relationship can offer resolution and a repair to what can be considered as the toxic aspects of shame.

In the interviews with participants I was aware of the potential for shame to be present in both them and me. My stance was to minimise shame in the same way that I would with a client, that is, through empathic attunement to them and to their process, and through sharing experiences and understanding of shame with the participant at the time, thus attempting to minimise the distance between us and give a shared sense of humanity.

Throughout this chapter I have highlighted the participants' experiences of feelings of shame. If it is accepted that shame for being, destructive or toxic shame, develops in the pre-verbal experience, then when working with clients in the regressive phases of their therapy its emergence would be expected. If therapists and clients recognise the origin of shame bound needs, feelings and behaviours the therapist can seek to normalise and validate these feelings both in the there-and-then and in the here-and-now, and clients can view these previously shaming aspects with compassion and understanding, thereby reducing shame. By formulating and naming these experiences as related to shame, both therapist and client, having a shared understanding, now have a way to move forward; the issue has become actionable.

Feelings of shame result in vulnerable aspects of self being hidden, therefore it may not be evident to the therapist, especially when their own shame issues remain unaddressed. It takes bravery as a therapist to feel shame, even if countertransferentially (that is, the client's disowned or disavowed shame) yet still bring it into the therapeutic arena. Maroda (1991, p65) advocates for therapists' self awareness - "a level of expertise can only be as great as our level of self awareness and our capacity to bear being seen

realistically by others". Evans (1994, p107) considers this to be particularly true when working with shame processes. He supports the view that it is necessary for therapists to face their own 'enemy within' in order to facilitate the client's self-awareness. He considers that in facing the enemy within he has diminished the enemy's power, "I am no longer ashamed of being ashamed". Jacobs (1995, p90) considers that therapy can offer resolution for internalised shame, "thus, the most basic shaming self-statement 'I am unfit for human company', has the most potential for resolution by paying close attention to the vicissitudes of shame between the therapist and the patient. In my opinion, the resolution of internalised shame is one of the greatest gifts we can offer to patients as they work to transform their contacting and their lives."

Participant B describes how her self-acceptance and her knowledge of herself as a therapist developed when she had worked through shame in her own therapy:

> I lost it, it just evaporated, just went, it still comes back under stress, but I lost any kind of effort, you know, and I could just feel…. I had a courage in my alrightness to do things and it wasn't repeating what she had done, it was finding the right way for me and the people I was working with.

When asked how her therapy addressed her shame process Participant H responded:

> Well, first of all there was fun, there was never much fun in my childhood, there was fun in the therapy as well as the other stuff, and there was also laughter which was really important to me, and there was just a real sense of affectionate engagement which was really important, and a welcoming, welcoming me into the room which was very important, and for me you know, 'cos I'd got, I had so many kind of quite powerful, strong, dependant/independent kind of….to offer that was huge for me, really… it really takes me a lot to trust, it did in those days, to trust anybody, so working with those trust issues, welcoming me in...to if I'd done paintings or poems I was first greeted with real interest, you know, in what I'd got to say, and no big deal about tears, you know that, that was really important as well,

I consider that addressing such toxic shame is an important task of therapy, which once addressed leaves the client with more freedom to reveal their story in a meaningful way, allowing the therapist to appropriately respond in a reparative way.

Thinking and writing about shame has had an impact on me as a researcher and I have presented this in greater depth in the Methodology chapter. Through the whole project I have experienced shame about not being good enough, and shame about the expression of myself in my work and in my writing not being good enough. I have been very concerned that the exposure of my personal journey and my professional work may be negatively viewed by my peers, this reaction is shame in action where my critical inner voice advises keeping silent and hiding myself. I recognise that this is a process that my colleagues and I battle with in therapy, supervision, training and writing.

Participant D describes her work with a particular client, and her fear that her spontaneous response would be judged negatively by her professional colleagues:

> The thing that I will always be ashamed of, and carry to my grave I suppose, that the day she smashed up in here, and smashed up a… something glass, and took this piece of glass to me, and I *whoosh*, walloped her across the face…I felt absolutely dreadful, and it didn't matter who I read on it…or…hate in the countertransference, or whatever I picked up, nobody got close to the fact that I, and I mean I really shocked her, and I shocked myself, and I thought…I'll probably be banned for life now.

This participant has formulated her experience here as being under attack and she has seen her response as self-defensive, yet her fear is that because of her response to this she will be struck off. Data from participants has shown presence of shame and a recognition that it is emergent in the regression to dependence process for both client and therapist. The participants have shown that in the therapist's expectation that shame may be present, steps can be taken to pre-empt the toxic nature of shame within the therapeutic relationship. The participants have identified creative ways of working with shame which has enabled clients to work through it in an appropriate way. This chapter and the preceding one on terror both address areas of experience which can be of concern to both therapists and clients. It is in addressing areas such as these that boundary issues come to the fore. My next chapter will explore the purpose and importance of boundary in relation to regression to dependence.

Chapter Eight

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A Question of Boundary

"The question of boundaries is the first to be encountered; from it all others flow. To draw a boundary around anything is to define, analyse and reconstruct it" (Fernand Braudel).

> ….I usually made her a drink when she came, and if I wasn't very careful at the beginning she would sit holding her cup, she would start drinking and then she would just start staring, and she would just stare, and I'd suddenly realise she was going, if I was able to contact her at that point I would do, get the cup out the way and things, but she would gradually just go deeper and deeper and deeper, and she might start crying, she might start coughing and heaving 'cos she'd been orally abused, sometimes she would shut herself away into the corner, and occasionally I would have to just go out of the room, get a duvet, give her the duvet and leave her, and she used to go to sleep after the session, and that was often the only way she would come round, so she….I used to assign four hours, so that she'd got time to have the session, time to get her back from her…wherever she'd gone, and then I'd let her go to sleep, and then wake her up with a cup of tea, and then she'd go home,

Introduction

In the above extract Participant C is describing her work with a regressed client. It is evident that she has acted in ways that some psychotherapists might consider to be inappropriate. I have written in earlier chapters about the concepts which relate to the possible necessity of boundary adaptations. From the birth of Psychoanalysis attention has been given to how the therapist should behave in relation to their client, and in current day, the professional bodies that govern counselling and psychotherapy describe the ethical and professional responsibilities of the therapist and seek to describe a setting which is accountable and safe.

The two main professional organisations governing counselling and psychotherapy are the British Association for Counselling and Psychotherapy, and the United Kingdom Council for Psychotherapy. Both organisations have codes of conduct for their members

to adhere to. These are The Ethical Framework for Good Practice in Counselling and Psychotherapy – BACP (2010), and UKCP Ethical Principles and Code of Professional Conduct (2009). The BACP information sheet for prospective clients identifies both implicit and explicit rules which are embedded in all therapy. It also recognises that specific boundaries may be negotiated at the start of therapy. This document identifies the difference between therapist orientations and the effect of such orientations upon the boundaries that the therapist holds, more humanistic therapists may use touch and self-disclosure, while more psychodynamic therapists may not.

Both of the above documents have at their heart the interests of the client. They do not offer a comprehensive list of do's and don'ts; rather they form a guide in which the therapist is able to identify the spirit of good practice which is contained within. There is nothing regarding the boundary changes that I have written of that is contradicted specifically in either document, however, within the profession itself there are accepted ways of behaving. Beginner training courses in both counselling and psychotherapy tend to have clear indicators that students stay within clearly defined parameters for the conduct of their therapeutic role. This will also be defined by the orientation of the training that they are undertaking. The NHS and other employer and placement agencies also have strict guidelines regarding the ways of conducting therapy which would include the timing of sessions, payment, use of touch, length of sessions and the importance of adherence to the therapeutic frame.

Wosket (1999) considers that rules can limit the effectiveness of therapy. She is not describing boundary violations, rather boundary crossings which are in the interest of clients. The adaptations to the therapist's usual way of being in order to address the regressive needs of their client could be considered to fall into this category. The complex nature of boundary is recognised by Gutheil and Gabbard (1993, pp1-4) who acknowledge that "like many concepts in psychotherapy, such as 'therapy', 'transference,' and 'alliance', defining boundaries "proves slippery on closer observation", noting that "clinicians tend to feel that they understand the concept of boundaries instinctively, but using it in practice or explaining it to others is often challenging". They identify that "the historical tradition that current therapists have inherited has resulted in some of the difficulty in defining appropriate boundaries, for

instance the way that Freud described therapeutic technique is different from the way he practiced therapy". They recognise that "technique changes with treatments" and that therefore "there may be a built-in confusion between the notion of therapeutic boundaries and adjusting the technique to the ego organisation of the patient".

In the following chapter I will explore such boundary adaptations, using data from participants and comments from other theorists and practitioners. I will also describe my own experiences regarding this issue.

The therapeutic frame

In order to identify the nature of these boundary adaptations it is important to understand the meaning of 'the therapeutic frame'. Milner (1952) coined the phrase 'analytic frame' in writing an analogy between boundaries in therapy and a picture frame. The frame identifies the difference in reality both within itself and outside itself. Winnicott (1956) identifies the 'setting' as the summation of all aspects of management. He has described it as the facilitating environment. Young (2005) identifies the frame as consisting of the physical setting, the contract and a state of mind. He considers maintenance of the boundary to provide containment whereby "the patient is being helped to hold himself together". Overall these theorists are trying to describe the analytic space in which the work of therapy is contained.

Participant B, speaking as a therapist, relates the importance of boundary and consistency:

> I'd be thinking about boundary setting very clearly from the outset with this type of clients, not with rigidity, but with clarity

> …these are the type of clients that I would be wanting to see on the same session every week, and not making changes, so that we'd have, we'd develop some consistency in my contact with them over time. I'd also be wanting to focus a lot on containment and safety…I think with…this type of client that I tend to focus more on safety than I do possibly with other clients that have more of a capacity to contain themselves.

Crossing boundaries

"Psychotherapists do seem to be able to help people; perhaps because they often manage to outgrow the handicaps imposed by their training. Wherever two or three psychotherapists are gathered together, confessions gradually emerge about their deviations from orthodoxy" (Mair 1992, p152). Smith and Fitzpatrick (1995, p500) seem to concur, acknowledging that "boundaries are regularly transgressed by even the most competent of therapists, and such transgressions are not always to the detriment of the client." They highlight the difference between boundary crossing and boundary violation, seeing that the former is a departure from accepted practice that may or may not benefit the client, and that the latter is a departure from accepted practice that places the client or process at risk - the task for the therapist is to distinguish between the two. From their research Johnston and Farber (1996, pp391, 397) cited in Wosket (1999) concluded that clients infrequently challenged their therapist's boundaries, but when they did so "psychotherapists accommodated their requests in most cases." recognising that this "stands in opposition to the generally accepted image of the psychotherapist standing firm in the face of persistent attempts by the patient to challenge existing boundaries, and suggests a spirit of cooperation and good faith underemphasised in theoretical writings."

Pope and Keith-Spiegel (2008, p638) consider that decisions about boundary must be grounded in an ethical approach. They explain that non-sexual boundary crossing can "enrich psychotherapy, serve the treatment plan, and strengthen the therapist/client working relationship". They also accept that boundary crossings can "undermine the therapy, disrupt the therapist-patient alliance, and cause harm to clients." They highlight the importance of the therapist and the client sharing the understanding of the adaptation of a boundary. The client's understanding must be ascertained by the therapist. They also recognise that boundary adaptation must be considered in a new way for each client given their particular history and make up. Totton (2012) concurs with this position, yet observes the widely held belief that all clients at all times should be treated within the same set of boundaries. He notes that Sandler (1983) considers that therapists rely upon "educated instincts" to form their response rather than consulting with the rule book. Totton considers that therapy culture "militate[s] against these adaptations and adjustments." Whilst recognising that some well-known therapeutic celebrities have

revealed their boundary crossings, others, like Winnicott, never revealed to his peers that he worked with touch. He voices the concern that the codification of the concept of appropriate boundaries for psychotherapy "increasingly forces all therapists and counsellors into defensive practice", considering that such defensive practice results in the avoidance of the possibility of litigation at the expense of therapeutic treatment.

As I have reflected on these issues I have remembered many supervision sessions where I was reluctant to tell my clinical supervisor that I had stepped outside an accepted boundary for a therapeutic advantage, such as allowing a client to go a little over time or allowing contact outside of a session. In each circumstance I had a clear rationale and a treatment plan for such boundary changes, yet I was afraid of the judgement of my supervisor, who I believed held tightly to all boundaries. If the rules about boundary are not made specifically, they are there implicitly to the point that many therapists are afraid to talk about touching their clients or other boundary adaptations or describe the use of self with their peers and supervisors. Wosket (1999, p13) recognises that the professionalisation of counselling and psychotherapy, and the professional assessment of competence can lead to the repression of those therapists who take an individualistic or unorthodox stance. She identifies the dichotomy between that which is shared by therapists privately, and that which is shared in the public domain, maintaining that "healthy unorthodoxy has been driven underground" and that therapists "are becoming squeamish about admitting publicly to aspects of their work that may be misconstrued, for example touching clients or engaging in regressive work." She fears that we are in danger of succumbing to "therapeutic correctness". On page 133 she states her belief "that rules can limit therapeutic effectiveness even as they also importantly define the boundaries of safe practice." Sandler (1983, pp36-37) recognised the "conviction of many analysts [is] that they do not do 'proper' analysis…that what is actually done in the analytic consulting room is not 'kosher', that colleagues would criticise it if they knew about it". But he explains that "any analyst worth his salt will adapt to specific patients on the basis of his interaction with those patients. He will modify his approach so that he can get as good as possible a working analytic situation developing."

In his 2013 contribution, Bollas is describing his work with clients in breakdown phases of their analysis, and how it may be necessary to change the therapeutic frame in order

to manage the phase of therapy that they are in. He identifies the difficulty he has faced in sharing his ways of treating these patients with some practitioners and professional bodies. He clearly demonstrates the caution that many practitioners feel when discussing their client.

Through the process of this research I have also become aware of some of my own implicit rules which would have been influencing me to stay within the therapeutically accepted "safe" boundaries and how my failure to comply would result in my feelings of shame, yet to fail to meet the client's therapeutic needs would transgress my value of beneficence. This is because my therapeutic home is largely within the theory (but not the practice) of Psychoanalysis. Gutheil and Gabbard (1993) highlight that boundaries are different for different therapeutic ideologies, the bottom line is – is there a body of professional literature, a clinical rationale in existence. Other orientations may not have the same difficulties with letting go of these accepted boundaries (Wosket 1999), however, orientations which accept some alteration of the frame, such as CBT and other short term cognitive interventions, may not work within the unconscious relationship, and may not have an understanding of the impact and meaning of boundary upon the client.

The UKCP acknowledges that considerable personal variation exists within the field, that relationships between patient and therapist vary from therapist to therapist and, of course, there are variations between patients with any one therapist.

Regression and boundaries

As far back as the 1930s Ferenczi (1931, 1932, 1933) was successful in working with patients that were found to be unsuitable for analytic treatment by other analysts because he believed that in order to heal, some patients needed to regress to a former developmental state, and to do this required changes to the analytic stance, a movement of the therapeutic frame and a potential relaxing of boundary. Balint (1959, 1968) also worked with clients who had insufficient ego strength to work within the traditional methodology. His understanding of the importance of the dyadic relationship in psychotherapy meant that the role of the therapist was as an involved and responsive participant. Little (1981), although valuing psychoanalytic technique for most patients, also recognised that for clients having problems of existence, survival and identity,

adaptations in technique were necessary. From an integrative and relational perspective the intent is to provide a corrective emotional experience, and where the therapeutic need is to work in areas of the mind prior to the development of language the reliance upon verbal connectedness is insufficient.

As we have already seen, working with regression in psychotherapy has a significant impact on the therapeutic boundaries. This is considered to be particularly important when the client is regressed and, for the moment, is relating to the therapist from what might be seen as an infantile ego state. Winnicott (1984, p288) sees it thus, "In so far as the patient is regressed (for a moment or for an hour, or over a long period of time) the couch is the analyst, the pillows are breasts, the analyst is the mother at a certain past era." Winnicott is identifying the loss of the 'as if' component of the transference and views the client's way of relating to the therapist at that time as originating in an earlier phase of development. Because the client is mainly relating from this regressed phase then for that period the therapist must be aware that the client's normal functioning capacity may be absent for minutes, hours or days.

Participant D describes her state of mind after such an experience in therapy:

> …I was in such an altered state of consciousness, I think if I'd been the therapist I'd have been very worried about me leaving and driving …..in fact, I did nearly kill myself on that occasion.

Some theorists identify that clients who present for therapy therefore may initially appear to be high-functioning whilst concealing a heavily defended, vulnerable self-state. Adams (2009) quotes Siegel (1999) regarding the co-existence of these two aspects of the self, seeing that the client can be triggered into 'low-road' functioning. Many clients can present with distress and confusion regarding the dichotomy between these very different self-states. These experiences can be very frightening, and it is important that therapists allow for the neediness that may develop, rather than expecting the adult part of self to manage. It is this neediness and vulnerability which is seen to necessitate the changes to the usual boundaries.

Balint (1968), Winnicott (1958/1984) and Van Sweden (1995) have all written about the need to step outside of the boundaries in order to work with patients with early

relational trauma. The following participants, E and C, relate some of the changes in boundary they have accommodated when working with their clients. These participants are describing variations in timings and duration of sessions which would not be advocated by the professional bodies in their official literature:

> …some days she'd stay all day (at the facility) and then late afternoon ask to see me again and often, quite appropriately, she'd finally worked something out or come out of something and could see me again and tell me that she had worked something out or come through something but it had taken four or five hours, and needed to see me again to finish off.

> …I set aside four hours, didn't always need it, I would like to be free to be able to do that, so to do what I feel the client needs is essential for me to work in the way I want to work, within ethical boundaries…when somebody's coughing and heaving and completely out of contact with you and you're out of contact with them, then you've got to stay with it and just be able to tolerate it yourself,

Participant I also relates her intent to let the client know that they have made an impact upon her. This can be seen to be very different from the theme of the detached 'opaque mirror' of classical Psychoanalysis or from the stance in Cognitive Behavioural Therapy where the therapist treats the patient according to a set protocol, the patient leaves taking homework with them:

> …by letting them know their impact on me, and sometimes asking them what they think they might want their impact to be on me,…I find there's unconscious acting out going on…that sometimes they can let themselves know…what impact they want to have on me, that they want me to feel angry, or jealous, or whatever that might be, that actually then that's there to be worked on.

The participant identifies how in making an impact upon her the client is able to get a sense of the interpersonal relationship.

Movement of ego boundaries

In Winnicott's (1958/1984) explanation of the requirement for a change in the therapeutic stance with regressed patients he again makes the link between mother/infant and therapist/client. He considers that, in the client's interest, the client's

need may mean that the therapist is required to give the client more of themselves than they normally would, and that this may be uncomfortable.

As already shown in an earlier chapter Participant I describes the movement of her internal boundary:

> … yes, the ecstasy and pain, it felt like, that…and I feel like I hit that ecstasy and pain place a lot with this client group.

Bromberg (2012) considers that the analyst's professional role "is subsumed within a shared personal field" and identifies the joint creation "of a relational unconscious that is mediated by state-sharing – a process in which analyst and patient gradually are able to invite increased permeability between their respective self-state boundaries". This has a flavour of Winnicott's understanding of the ego-support provided by maternal care and therefore also ideally provided by the therapist. Bollas (1987, p41) comments that "Winnicott knew that he was immersed in the patient's unconscious reconstruction of a child's environment, and I understand that it was a feature of his technique to adapt himself to the patient's ego defects and characterological biases in order to allow for the transference to evolve without the impingement of a premature use of analytic interpretation. From this experiencing of the early infant environment, the analyst could then interpret the past as it was re-created through the transference". He considers that the mother, in serving as a supplementary ego, (Heimann 1956), transmits to the infant the language of their relationship through idiom of gesture, gaze and intersubjective utterance. Therefore he considers this first subjective experience of the object as transformational. He goes on to develop the theme that means that the adult patient seeks for this transformation of self which is a memory of this first relationship, "to remember not cognitively but existentially – through intense affective experience – a relationship which was identified with cumulative transformational experiences of the self" (Bollas 1987, p17).

Little (1981, p57) describes the analyst's total response to the client's needs. She specifies that "the analyst goes with the patient as far into the patient's illness as it is possible for him to go. There may have to be times – moments, or split seconds even – when, psychically, for the analyst nothing exists but the patient, and nothing exists of himself apart from the patient. He allows the patient to enter his own inner world and

become part of it." Modell (1969) considers that it is only when the analyst is willing to fully experience the patient's pain that hope begins to be instilled. Lipton (1977), in recognising the intersubjective nature of the therapeutic relationship, noted that it is ultimately impossible to be precise about the nature of the personal relationship between therapist and patient.

Weiss (2002, p12) identifies the difficulty for the therapist when the client's dependency needs push into the therapist's personal boundaries. He identifies how the therapist's countertransference, which initially may be nurturing and responsive to the needs, can become withholding because of the therapist's feelings of invasion, and he sees such difficulties as resulting from the therapist's unresolved issue around dependency.

Adaptation of techniques

In his 1994 contribution Hedges formulates the re-experiencing within the therapeutic relationship of the very earliest infantile organising experience which results in a dread of contact and relational withdrawal. He identifies the therapist's task to find ways of maintaining contact in ways that are relevant and age appropriate to communicate with these early aspects of infant personality. Balint (1968) considers that there can be a gulf between the therapist and the regressed client that the client cannot bridge alone. Balint clearly states his conviction that "in certain cases, in particular with a regressed patient, [the therapist] may go further towards satisfying some demands in order to secure the existence of a therapeutic relationship." Van Sweden (1995) agrees that the emergence of infantile relational needs requires adjustment in the therapeutic stance to allow for some gratification of these needs.

Participant C at the beginning of this chapter has identified ways in which she has adjusted the boundaries in the work with her client in order to manage the process of psychotherapy. She has provided her client with a drink, has relaxed the time boundary, and has provided nurturing in the form of a duvet. In varying the boundary in these ways she would consider that such boundary adjustments were necessary to enable the client to stay in therapy and still function in her 'outside' life. Her aim would also be to give the client an experience of receiving care and nurturing in a relational way. When this participant was describing her work with regressed clients I was aware of a trust

being placed in me, because as I have explained, there is a degree of "we don't talk about this", which would have come from her training and from her experience within the profession.

Participants B and I identify the interventions they might use in regressive therapy:

> I might get hold of their face and turn it, and say, "look at me, look at me, what are you seeing…"

> I put my hand on the top of his head, on the crown of his head, and something really changed in his body,

Little (1981, p143) formulates the development of ego defects as resulting from deficient mothering in infancy. When these phases re-emerge in their therapy (in regression) she considers that they are unable to use dialogue and interpretation and therefore need "a new set of experiences of good-enough mothering" before being able to develop sufficient ego use language. She recognises that this may be more difficult for the analyst, but is necessary for some people who otherwise would not tolerate the therapeutic process to remain in therapy. In her description of her therapy with Ella Sharpe, Little (1981, p290) describes Sharpe as lending her books and making her comfortable in her seat. She makes a comparison between Sharpe's 'mothering', and Winnicott's, saying that "I learnt from Winnicott about the patient showing the analyst how to do his analysis, as a baby shows the mother how to handle it", and this was such a contrast with Sharpe's authoritarian way of 'mother (or analyst) knows best'. Giovacchini (1990) quotes from Winnicott regarding the conflict between the client's needs and the therapist's needs. He considers that a regressed client, from their point of view, is being reasonable in protesting about a gap in therapy because of the therapist's holiday. Management of this would involve recognising the need, but still addressing one's own need to go on holiday.

Erskine (1998) considers that the expression of love is a relational need which is to be seen, honoured and accepted by the therapist. When the therapist accepts the client's expression of love it is validating and respectful.

The following participant, I, reflects on her hope that, at the end of therapy, her clients are able to give and receive love in a healthy and appropriate way:

> ….that they're able to express love and feel love (for the therapist) without pushing it away, or hungering to the point of starvation.

Little (1981, p151) also reflects upon the inter-relationship between the therapist and the client; she sees that although the therapist makes adaptations according to the needs of the client these are dependent upon his experience of himself, and how he experiences the client at that time "I do this, here, now, with this patient. I do not do that with him, now or ever. I do not do this with him at another time, I do not do this at all with another patient," making the point that the individual therapist must determine his own limits, but that someone who is unwilling to make adaptations may then be limited in either the range of clients, or in his results.

Fromm (2007, pp5-6) in his writing about C. Winnicott's work identifies that she was able "to hold the analytic role within herself so fully that it was not threatened by stepping out of that framework to some degree." I would consider this as the process of developing expertise, that when experience, theories, personal knowledge come together in an integration within the therapist, then the ethical position of acting therapeutically will be maintained even when stepping outside of normally held boundaries.

Other participants have identified other ways in which they have relaxed the normal therapeutic boundaries such as contact outside of sessions, the giving of transitional objects, provision of physical touch and holding and other ways of attempting to meet the client's needs relationally.

Participant K describes how, in recognition of her need, her therapist maintained a form of contact with her:

> …..when she went away she'd give me her itinerary so I knew exactly where she was going to be staying……

She also identifies how she has relaxed the boundary with her own clients:

> I can remember him coming….or phoning me up, or texting me in the middle of the night, and … me phoning him back the next morning which was a Saturday morning, and I saw him on Saturday morning,

Participant I describes her thoughts on giving transitional objects:

> I have often felt the desire to give, provide some kind of transitional object, and the difficulty in introducing that into the work, sometimes… the feeling of them wanting to have, and yet, not allowing themselves to take, has been difficult.

In these examples not only is the actual therapeutic boundary altered, but also the therapist's own personal boundary is affected. The relationship when viewed from a Relational/Developmental perspective is not as clear cut as the professional relationship originally advocated (if not practised) by Freud and traditional Psychoanalysts. Van Sweden (1995) specifies that working within the two person relationship involves the use of the therapist's self and therefore their entire person. Winnicott (1958/1984) establishes that this use of the therapist's self in the therapeutic dyad is comparable with the mother's response to the infant. Totton (2012) identifies the mutuality in the therapeutic relationship as "a place where two subjectives meet". He uses the word 'boundlessness' to denote non-defensive practice where the therapist offers from their abundance.

The participants in this study have identified the adaptations to boundary made by their therapists have been highly significant in terms of their development and repair, and that these moments have had great significance in terms of their growth and repair. I would echo this from my own experience. The times when my therapist has adjusted the boundary for me have felt caring and have given me a sense of his involvement in the relationship. These moments have indicated a depth of relationship which goes way beyond what might be seen in a basic counselling relationship.

The real relationship

Clarkson (2003) has identified five aspects of the therapeutic relationship which I have detailed in the Literature Review under the heading - Contemporary concepts on the therapeutic relationship. The real relationship is one such aspect and Greenson's (1978) understanding is cited by Duquette (2011, p55) as "the realistic and genuine relationship" between therapist and client. Duquette (2011, p59) considers that the therapist's humanness is essential to the development of a real relationship, and that if the therapist allows their real self to enter the relationship then this relationship "can be used as a consistent referent" for the client. This view of the relationship concurs with

Buber's (1957) stance that as therapist we should drop superiority and drop into the abyss, where the self of the therapist is exposed to the self of the client.

Participant B, speaking as a therapist, is describing working with in-depth relationships where there is a real relationship of love; where even after the therapeutic relationship has ended the love remains:

> …there've been clients that have lived on in my life for ever, they've never, ever gone out of it, I have no problem whatsoever at immediately recalling them, and seeing them in all different states and stages, they're there now in my mind …they will be a part of my, my inner life and on the times when I have seen them, coincidently or as part of other things, I know I am in theirs, so there is something about working at this level that isn't just about the therapeutic time, it's for ever.

Participant D speaking of her therapeutic work describes the pain and the importance of the relationship with her client:

> …every minute of those two years was hell, her rage was absolutely colossal with, and I understand it technically, but it was a lifeline for her and that lifeline was being cut, but I always promised her that she would never lose contact with me as long as I stayed alive, and so I do her cocktail of medicines every month, visit her at her home and do that. Now, I don't know if that's me acting out, or just being human, because I don't want to do it, and sometimes it feels like a humbug on my day off, but I know it's so vital to her, that I keep doing it, and I think some things, you know, they go on beyond treatment, really…

Boundaries and touch

Participants H and K describe their experiences of touch from their therapists:

> "The therapeutic touch was like…warm electricity going through me"

Participant K also describes other aspects of nurturing received from her therapist:

> …she held me, she stroked me, she sang to me, she covered me up with a duvet…

In any writing on the subject of boundaries the issue of touch will inevitably arise. There is a large body of literature concerning touch, largely focussed on boundaries around sexual contact. Freud considered that touch in the therapeutic relationship could

lead to sexual entanglement. In the move towards two-person psychology starting with Ferenczi (1953) the idea that touch within the therapeutic relationship could offer some sort of repair was mooted. The relational turn in psychotherapy has resulted in the inter-subjective nature of the relationship being explored and some therapists consider therapeutic touch useful within the relationship (Toronto 2001). The use of therapeutic touch in psychotherapy is still a contentious issue, raising fears in the therapeutic community of abuse and exploitation (Holub and Lee 1990). A full exploration of the impact of touch upon the therapeutic relationship is beyond the scope of this work, therefore I am considering it from the perspective of its relationship to boundary rather than as a subject for discussion in its own right.

Chu (1998) warns of the dangers associated with touch with abused clients which can result in dissociation causing a sense of disconnection from themselves and from the therapist. For any intervention, and touch is just one of them, the impact, meaning and effect upon the client should be thoroughly considered, explored in supervision and discussed with the client on an on-going basis.

Gabbard (1989) considers that any changes in boundary must be openly discussed in order to ensure the safety of the therapeutic relationship.

Participant A, speaking as a therapist, describes his ethical thoughts around touch:

> How can you do a serious early childhood or traumatic therapy without touch? Now how much touch, when is that touch initiated, what is the quality of the contract for the touch, what is safe touch versus none safe touch, those are all the issues that have to be decided on, on an individual basis.

Participants K and C describe how they would manage therapeutic touch with ethical considerations:

> I might talk about touch rather than do the touch…….to actually say you know, 'I wish you were about this big because then I could just pick you up and give you a hug'……And there's a lot of ethical stuff about whether you do or not, and boundaries……I wouldn't avoid touch because of that, you know, I'd just make sure it was ethical and it was checked out etc.

...the one thing I would do was to say, 'my hand's here if you want to hold it', and she would sometimes hold it, but that was all within her control so that the minute she wanted to let go again, she could, but rather than me doing the touching because at that point she couldn't handle it…it was like an invasion.

Gutheil and Gabbard (1993, p191) make an important distinction between the developmental needs of the client and libidinal demands, "In attempting to delineate the appropriate role for the therapist vis-à-vis the patient's wishes and longings to be loved and held, it is useful to differentiate between 'libidinal demands', which cannot be gratified without entering into ethical transgressions and damaging enactments, and 'growth needs,' which prevent growth if not gratified to some extent."

Participant C demonstrates how important she considers touch to be in her therapeutic work:

I want to be free to touch a client if I feel that's right, there are some clients I would never touch from the start to finish of therapy, but if somebody said to me, "if you work here you can't touch", I think I would say, "well, I'm sorry, I can't work here…"

Participant A identifies how he as a therapist contracts for touch:

…it's also got to be negotiated. Somehow it's got to be contracted for. That contract doesn't always have to be in so many words, it can be simply be like… can I touch you and they just nod yes… the moment they stiffen up, when you reach out to touch them and they stiffen up, that's a no…how do I know? Agreement, contract the process of being together they're mostly non-verbally asking for it. But it's also thinking developmentally certain ages and certain activities of a child you would never hold them, because to hold them would stop their rambunctiousness ….so it's thinking developmentally, really thinking about 'what does a normal kid need in this kind of a crisis?'

The UKCP also support the inclusion in a therapeutic contract of a clause for touch. In conclusion they make the point that the difference between a boundary crossing which is benign or harmful depends upon whether clinical judgement has been used to make the decision, whether adequate discussion and exploration have taken place, and whether documentation has adequately recorded details.

Fear of litigation

Wosket (1999) expresses concern that touch as an important therapeutic intervention will be jettisoned for fear of accusations of abuse or litigation. She cites Hunter & Struve (1998, p67) "within the prevailing climate, most clinicians have resolved the cultural and professional tensions surrounding the use of touch by adopting a one word guideline: *Don't!*".

Current society is highly litigious and professionals from all disciplines are increasingly concerned about legal action. The use of touch and holding is a sensitive area and one open to abuse. However, I do not consider this as reason to withhold it from the therapeutic relationship.

Two of my participants after their interview told me that although they strongly believed that touch was essential when working with regression, and they believed that it had been essential within their own therapy, they felt unable to offer it to their own clients because of the fear of complaint, which in their working life was grounded in experience. Touch is a developmental need and many clients have been starved of it. I agree with Lazarus (1994, p256) who says, "One of the worst professional and ethical violations is that of permitting current risk management principles to take precedence over humane intentions."

The importance of supervision

Steele et al. (2001) advocate for collaboration between therapist and patient and consultation with another professional. They quote Dalenberg (2000, p229) referring to 'boundary crossings' for therapeutic advantage as opposed to 'boundary violations' which are harmful to the patient. Pope and Keith-Spiegel (2008) discuss the use of self disclosure as a therapeutic tool. They establish the importance of discussion in supervision regarding self disclosures.

Gutheil and Gabbard (1993) make the point that if there is physical contact and the patient expects it and grants consent; no actual violation occurs. They identify that risk management requires careful consideration of departure from usual practice together with recording of such together with consultation with another professional.

The type of therapy that I'm describing in this thesis is complex and involves the consciousness and the unconsciousness of both the client and the therapist. If issues are truly unconscious then of course we cannot know them, but they can emerge and remain powerful within the therapeutic relationship. What is needed is another who is able to look into the relationship from an experienced, supportive place. This is the place of supervision. It is essential that the therapist obtains supervision from a practitioner who understands their way of working and the client group that they work with in order to be able to offer support and appropriate challenge. The supervisor should know enough about the therapist's own processes to be able to ascertain their part of the therapeutic relationship. Finding the right supervisor is of key importance to practitioners involved in it.

Conclusion

In this chapter I have considered why therapists would choose to relax boundaries within psychotherapy. I have explored the client's need for this and the intrapsychic and inter-psychic processes which develop in a Relational/Developmental therapy. I have identified how boundaries may be appropriately relaxed, according to the needs of the client, as part of the regressive process. In the psychotherapy world currently there is a marked division between those who recognise powerful unconscious processes at play within the therapeutic relationship, but who see insight alone as the therapeutic goal, those who recognise the therapeutic relationship but consider that the work should be done in the here-and-now, and those therapists who understand and work with the unconscious processes and developmental needs but who see the here and now as an arena to offer the client a repair of archaic wounding. Wosket (1999, p164) asks, "What therapeutic opportunities might be afforded when a counsellor extends or moves beyond the boundaries normally governing their practice?" The participant's stories have given to me clear indications of the importance of a therapist's willingness to move outside of their own accepted boundaries within the relationship with them. In fact it has been as important as the actual intervention itself. It has provided evidence of the relational and mutual nature of their relationship.

Those who work with regression are not advocating for an abandonment of the therapeutic frame, far from it. A therapeutic need is being identified in some

psychotherapy clients which must be recognised and addressed if these clients are to be successfully worked with. As we have seen in earlier chapters, the movement away from the traditional tenets of Psychoanalysis towards the dyadic relationship and the idea that the therapeutic relationship, through the process of transference and countertransference, could refigure and help to repair the deprivations of early childhood, meant that the therapeutic stance would change from one of professional distance (Gutheil and Gabbard 1993) to a relationship whereby the needs of the client would be attended to within the relationship.

I will now move towards my conclusions of this work, reflecting upon the contents and process of the research itself and the themes which emerged from the participant data, making recommendations for clients, therapists, supervisors and trainers involved in the practice of psychotherapy when working with this client group.

<center>Chapter Nine</center>

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<center>Reflections and Conclusions</center>

Introduction

In writing this research thesis I have told my personal story as much as I am able, seeing my story as an intrinsic part of my research and of my clinical practice. Reflexivity is a priority for me, and as such the use of myself is an important aspect of my way of being and is evident in everything that I do, so it has therefore been an integral part of my process throughout this work.

My aim then has been to further understand the experience of regression to dependence, and to assess how my participants, as clients and therapists, view the process. I have established that the narrative of regression to dependence can describe and account for the experiences of participants and clients, and how the use of this narrative enables an effective clinical formulation to then be used within the therapeutic context. I have identified how practitioners, by having knowledge of relevant theoretical concepts and an understanding of the necessity to address the pre-verbal stages in an appropriate manner, can offer a therapeutic 'second chance' for their clients to have 'a new beginning' which both mourns the loss of what should have been, and celebrates the emergence of their true self as the ultimate outcome (Balint 1968). I consider that understanding these concepts is essential for practitioners working with clients who are experiencing regression to dependence. The education and training of psychotherapists is incomplete without such understanding; they must be able to recognise such a process or the potential for it, in clients so that they are able to make decisions about the most effective way to work with them.

One of my original aims in undertaking this research was to illuminate the experience of clients in this therapeutic process. As I have stated earlier, much of the literature has a strong Psychoanalytic perspective, but there is very little regarding the client's experience of this process. One exception would be Margaret Little's writing, but even this lacks detail. My personal experience was very powerful, when I was in the middle of episodes of regression it felt extremely traumatic and frightening, but I was able to

<center></center>

identify the theoretical constructs very clearly when I stepped out of the experiencing. My therapist, whilst being supportive, containing and loving was often as lost as I was, and it was frequently our shared understanding of the process itself that enabled successful progression, and also developed the therapeutic relationship itself. At these times I held onto Margaret Little's book like a transitional object, taking it everywhere with me, because I considered we had had similar experiences, for which she had found words and meaning - here was someone who had made the journey and had come through the other side.

Although my original objective was to elicit data regarding the experience, I also believed that there was a lack of in-depth knowledge regarding theories which conceptualise the development of the self, and the practical application of ideas and methods, which would enable Integrative Psychotherapists to work with the kind of distressed clients that I have been concerned with in this thesis. My choice of participants, however, did not demonstrate this hypothesis because, given their level of expertise and experience, there was no lack, and in fact they demonstrated that having such knowledge enabled them to effectively work with this client base. My experience as a supervisor and trainer however, has shown that many highly qualified practitioners do not have such knowledge. Integration of theories can mean that an in-depth knowledge is not possible in training unless an individual takes up the task personally. It seems essential when working with these clients that this knowledge is available for the therapist to draw upon. For me, Winnicott offered a bridge for this gap, and offered to me a framework within which I was able to understand my own process. Bornstein (2013) also acknowledges Winnicott's contribution to his personal development, highlighting that Winnicott offers a bridge between theory and technique. He acknowledges that Psychoanalytic theories of the mind are "rich and exciting" but that the technique that is associated with it has left him feeling anxious and frustrated. Bornstein (2013) identifies the gap between the description of what is occurring in the psychotherapeutic relationship, and what is actually taking place experientially. For me, this is one of the attractions of Winnicott's work. It moves away from dry, bald descriptions into a more numinous, experiential arena.

The following table identifies the key findings which emerged from this research study. The implications for the practice of psychotherapy are identified, and my recommendations, which have emerged from this study, are shown. The chapter then follows with a discussion based upon these findings.

Key findings and the resulting implications for those involved in psychotherapy:

Key Findings	Recommendations
The Significance of the Process of Regression to Dependence	The potential for personal integration of aspects of self The potential for growth as a result of regression to dependence The presence of anxiety as an indicator of spontaneous regression The importance of the therapeutic relationship The therapist's use of self as facilitative partner
Implications for the Client	Length of needed therapy Cost Personal challenge
Implications and Recommendations for the Therapist	Necessity for theoretical understanding of regression to dependence A recognition and understanding of issues of boundary with this client group The need for support for the therapist Personal therapy Supervision The need for a high level of skill and experience in the therapist

Implications and Recommendations for Psychotherapy Training	The theoretical base should include such theory that will provide a structure for the experience of regression to dependence
	Provision of specific training to support the process
	Facilitators should be experienced as both trainers and practitioners to enable the application of theory to practice to be taught effectively and facilitate development of trainees
Implications and Recommendations for Supervisors	The need to understand and support the process as appropriate
	The importance of knowing the limitations of the supervisee
	A sufficiently shared understanding of the process

Implications for Integrative Psychotherapy of the emergent themes

Working with regression to dependence – its essence/qualities

Winterson (2011, p144) quotes Hartley's (1953, p5) beliefs about the past;

"The past is a foreign country: they do things differently there." But she considers that revisiting the past has benefits too, "Yes, the past is another country, but one that we can visit, and once there we can bring back the things we need." I consider bringing back the things we need as part of a developing emotional maturity, such maturity being the capacity to get our needs met. Achieving this level of maturity in my own case began with regression to dependence.

Regression to dependence, the concept that given the right environment, a person can return to their early developmental history and, through the unconscious process of the transference, re-experience their early inchoate relationship within the therapeutic relationship, has been the subject of this study. Working with this concept requires the therapist to have an understanding of infant development, because aspects of the client's presenting behaviour are viewed as pertaining to stages of infant development. As I have identified throughout this work, I have experienced this process personally and professionally, and I think that viewing the process from both sides has given me a

unique insight into the process itself, and a belief in its usefulness and effectiveness. This then leads me to stress the importance of a thorough knowledge of infant psychological development in order to work with clients experiencing this process.

This study has demonstrated the value of therapists being able to recognise a regressive process occurring in the relationship with their client, and knowing how to facilitate this appropriately. To do this therapists need an understanding of what the need to regress represents developmentally, that is, a return to a needed relationship which holds the potential to repair aspects of self in a facilitating environment. To do this the therapist needs to have sufficient understanding to identify the unmet need.

The therapist must be willing to be a participant in the needed relationship, taking on some aspects of the original needed relationship. To achieve this the therapist must be a safe, containing, holding, attentive and loving other.

The facilitation of such a process relies upon the development of a relationship which has enough similarity to the early infant relationship, yet which has significant differences. The aim of the relationship is both to identify the place of damage and trauma and to offer repair addressing any emerging infantile needs appropriately. These needs can be thought of as remaining in the psyche of the individual on an unconscious level, whilst being acted out or felt at an unconscious level, as the search for the lost or insufficient relationship of infancy. The development of this new relationship requires the therapist to be aware of this process and able to adapt to their client's needs on this developmental level as well as at other relational levels.

It seems essential that the therapist has experienced a successful dependency relationship, either in infancy or in therapy, so as to be able to have an understanding of the developmental needs of the client from an experiential perspective. If the therapist has experienced a therapeutic repair then they will also hold a sense of what this feels like as an adult, and how a repair can be offered. The therapist must be prepared to 'be with' the very experience of the unfolding transference process, recognising and meeting the emerging, previously unmet needs, whilst keeping hold of an awareness of 'what's me and what's not me' - their own boundary. The therapist must be able to engage with the regressive process in whatever way the client is available, be it

emotionally, physically or psychologically, and either symbolically or literally. The therapist should be an object of transformation for the client, and offer a reparative experience.

The data from this study has demonstrated how the formulation of a client's distress as a return to the early developmental arena gives a narrative which identifies a plan of action for both therapist and client. If both parties accept the narrative for the experience then there is the possibility that it can be worked with, the client can experience what is seen as their early infantile unmet needs and the therapist, who takes on some aspects of the caretaking relationship, can acknowledge and validate them, sometimes meet them and in this way offer a repair. Therapists should be able to find a voice and give narrative to the experience of being in the moment in the therapy, and begin to describe the process in which the client is immersed. Working with the likely narrative of both mother and child can help to identify that which was missing so that it can be understood, and disowned aspects of self can be integrated. The therapeutic importance of the development of a narrative between mother and child builds upon the concepts formulated by Winnicott, Little, Balint and others.

Through the participants' narratives presented here, it is apparent that for many of them integration is a process which follows experiences of chaos and disintegration. Van Sweden (1995) considers that the journey of regression to dependence may be difficult, and integration is achieved through chaos and disintegration. Once the dependent relationship is established the additional ego support supplied by the therapist is often sufficient to keep any psychological or emotional disruption within the therapeutic setting (Winnicott 1958/1984). I consider that a relational therapy minimises such disruption because of the potential for flexibility of boundaries, and the therapist's availability can sufficiently support the client. As I have described previously, when I was experiencing a high level of emotional disruption as my infantile needs began to emerge and I felt shame for them, the provision of increased and extended sessions, and contact in between sessions allowed my functioning to continue.

It is the therapist's role to hold an awareness of boundaries, safety, touch and malignance. It has been said to me a number of times during my practice as a therapist, supervisor and trainer that I should not advocate for the use of touch in today's litigious

climate, particularly when training new psychotherapists. I can understand why this is an area of concern. The use of any boundary adjustment and particularly touch, must have a rationale which is in the interest of the client. However, if touch is accepted as a necessary component of therapy in some cases, then it no longer becomes a boundary violation, any more than an osteopath is violating a boundary in touching a patient. As a practitioner I am always cautious and I ensure that touch is contracted for, in a formal way in my initial contract with clients, and moment by moment verbally within clinical work. I have grave concern when, as Lazarus considers (1994, p256) "one of the worst professional and ethical violations is that of permitting current risk management principles to take precedence over humane intentions."

It is my intention, in the publication of this work, to both inform and encourage practitioners to recognise this process, to develop an understanding of relevant theory in order to work with it and to address it appropriately for therapists themselves and for their clients, or to refer on if that is more appropriate, but most of all to recognise the potential for this process.

Aims of Integrative Psychotherapy in regression to dependence

One of the aims of Integrative Psychotherapy using an overarching Relational/Developmental framework is that aspects of the client's self, which may be constructed as 'split off', disowned, disavowed or projected from the sense of self, are integrated into a cohesive whole, much as in the philosophy of Integrative Psychotherapy itself, disparate parts can be held together in a contained and cohesive way (SPTI 2003). In regression to dependence, the aim for the client at the end of therapy is to have integrated split off infancy experiences, to have a narrative for the whole of the self, to be accepted by the self, and to let non-existence become existence.

Participant I is describing the results of her regressive therapy:

> Physically I feel more joined up…. my body feels like it belongs together….it felt much more fragmented than it does now…..acting from a place of anxiety rather than acting from a place of the real me….I'm actually saying things that come right from the core of me and that aren't channelled through the anxious part of me…..I have a sense of her

[the therapist] feeling tenderly towards me, and that feels precious…. I can be all that I am and still be held in a tender way.

This is an example of the Integrative aspect of therapy whereby the client's previously disowned parts are integrated into a whole, and where all aspects of self can be acknowledged and owned. Understanding this concept can then enable the client to be willing to allow the relationship and the transference to develop whereby the 'primitive agony' may be re-experienced in a titrated form and gradually be able to gather the "original failure of the facilitating environment into the area of his or her omnipotence and the experience of omnipotence which belongs to the state of dependence" (Kalsched 1996, p91).

Participant I illustrates her growth in this area:

> it felt much more fragmented than it does now, a lot of stuff about worrying about what other people think, sort of acting from a place of my anxiety rather than acting from a place of the real me, it feels like that's a big place that I'm finding now that, I'm actually saying things that come right from the core of me and that aren't channelled through the anxious part of me that worries what people think,

This participant demonstrates the potential for growth and change as a result of regression and progression.

Anxiety viewed as spontaneous regression to dependence

I have identified earlier that clients who present with chronic anxiety may find that their anxiety has its roots in the failure of their early relational environments to meet their needs. Data from participants, and my own experiences, have led me to formulate this issue as existential. From this construction it can be seen as a precursor of regression to dependence, and may indicate to the therapist the possibility that the anxiety and panic attacks as experienced by the client may actually be spontaneous regressions. These existential feelings of life and death may be considered as remaining powerfully active at an unconscious level in those people who have not had their anxieties contained by a powerful and protective other in their early infancy.

This also resonates with Winnicott's (1965) understanding of the development of the capacity to be alone, where the experience of the infant of being alone in the presence of

mother implies a special type of relationship, one which Winnicott called 'ego-relatedness'(p30). He has identified that at a very early stage ego-support from the mother is necessary in order to balance the immature ego. Winnicott considered that the development of this capacity to be alone is vital for the infant, and consequently the adult, to be able to truly relax. This is because the infant ego had been protected from impingement by ego-relatedness in the form of ego-support from the mother, which then in adulthood becomes internalised and introjected. Some clients avoid experiencing aloneness by distracting themselves by 'doing'. They thus remain in perpetual motion, of which anxiety is a form, in order to avoid the re-experiencing the immature aloneness which has not been supported in infancy, as these examples from Participants C and H have demonstrated earlier:

> …in nursing and things like that I would be terrified a lot of the time, I would just be petrified…

> …that nameless dread of… that I can still feel sometimes…there'll be a surge of something… an anxiety which has no reason nor rhyme nor even a shape, it's just terror or anxiety…

These excerpts give a sense of the participants' experiences which I consider to be spontaneous regressions to existential fears, and this is a development on from Winnicott's understanding.

Change in perspective as a result of this study

Winnicott (1958/1984) and Van Sweden (1995) describe the regression to dependence process and the experiences they describe are familiar to me, personally and professionally. However, there are differences which seem to relate to differing client populations, changes in society and changes in health care provisions. Also important is the perspective from which theorists write. From an Integrative, Relational/Developmental perspective the changes in the therapeutic stance, as described by those from the analytic tradition, are less significant and do not mean the abandonment of any technique, but rather relate to understanding and addressing the relational needs of the client as they emerge. What I see in clients' presentation is initially less extreme than may be described by some theorists, yet just as serious and life-affecting.

In initial sessions, with a client who seems to present with early relational trauma, there may be two avenues to consider; first, the client may be experiencing spontaneous regressions in the here-and-now which are life disrupting. This may need strategies to be developed to enable the client to manage these experiences, through understanding and taking control, although sometimes, this can present a difficulty because as the client develops control they may become unwilling to return to the potential disruption of the regressive experience. Over time the client may then become more stable and their functioning in everyday life be improved. Secondly, and concurrently, the undoing of defences relating to the early trauma should be explored and worked with.

Participant G describes the importance of her regressive experience in therapy:

> Yes, it was amazing, the difference in me… the hallmarks of that were definitely…the key times, the critical moments were definitely those points of regression, it wasn't the regression itself, it was the moving through the regression,

A way of viewing the process described in this research, which ties in with Balint's (1968) work 'The Basic Fault', is that foundations of a person are laid down in early infancy and are intended to support the structure. Where foundations are flawed and weakened it takes time, effort and energy to maintain them and keep the structure standing; this is the role of the defences. Viewed as a metaphor where a house stands on poor or inadequate foundations the structure itself is effected and may require frequent shoring up, which can be costly in both time and energy. Attending to problems in the foundations can involve undoing and taking apart, and making a mess, but will result in a stable structure which requires less time and energy, leaving time and energy to be devoted to living life. The psychotherapeutic aim then is to identify a fault or deficiency, to offer repair, thus removing the need for shoring up and enabling the person to move on with life.

Once the therapist has identified the level of the client's regression to early infancy then the facilitation of such a relationship requires the therapist's adaptation to the needs of the client. Of course, the whole object of working with regression to dependence is to work through to a place of progression, that is, where these aspects of the client which have been split off, restricted, retarded or disowned, are integrated into the client's sense of self. This process offers the hope of a new beginning, from an attachment

perspective, the hope of developing a new attachment style, maybe a first taste of security within relationship.

Whilst it is a contention of my study that the work of Winnicott and the other Object Relations theorists has much to offer Integrative Psychotherapists of today and that the use of such theory can help therapists to work more effectively with this client group, it is important to point out that there are some significant differences. Winnicott was working five times per week in order to sufficiently support his regressed patients, yet the participants in this study, work once or twice weekly and manage to engage and support regressed patients. Whilst some patients do struggle and need more support, the slow movement towards regression which occurs in a developed and supportive therapeutic relationship can mean that most clients maintain functionality, even through high levels of distress. The data from this study indicates that clients can experience regression to dependence and maintain their everyday lives. Van Sweden (1995, p202) recognises that "in individuals whose emotional support system is limited" there is more risk of breakdown, but Bollas (2013) describes how some clients (presumably those with a more effective emotional support system) can achieve regression and progression in a slow and cumulative way.

The relational tilt (Mitchell 1988) in psychotherapy has as its aim to further understand the needs of a client in psychotherapy. Therapists can meet clients with empathy, compassion and presence, and ideally establish relationships which are meaningful and significant for both parties (Erskine and Trautmann 2004). Attunement is a key aspect of relational psychotherapy and is of primary importance in regression to dependence, because if following the formulation that this is a revisiting of early infantile relationship, then the therapist's attunement is key in addressing the client's needs in such a way that impingement does not occur. In my personal therapy, my therapist's failures in attunement caused significant pain. When a therapist understands in detail the stages of development and the early development needs of a client in therapy, it is my contention that attunement can be more precise and therefore more effective. I recognise that my therapist always wanted to be attuned but often failed because of his inability to spot my regressed ego state. Often this was because I was a master of disguise, that is, my "false-self presentation disguised the severity" of my trauma (Van Sweden 1995,

p208). However, I believe that sometimes the failure to successfully attune was due to a lack of understanding of the process I was engaged in. At times when I was regressed to a pre-verbal stage I was unable to express my needs to my therapist without moving away from them and thus feeling impinged upon. At the time I felt rage that my infantile communications, such as tears or discomfort, were not successfully attuned to, and this, in part, mirrored my early infancy experience. In working with the pre-verbal, because of the lack of language, an understanding of the minutiae becomes more important, so that the therapist is able to attune more effectively to the client's infantile communications.

Winnicott (1965), Balint (1959) and Van Sweden (1995) all discuss the importance of silence in regression. My participants did not mention the importance of silence in particular, they did however, describe the importance of their therapists' attunement. It is my contention that it is not the silence itself that is important; it is the therapist's attention to whatever is the client's need in the moment. If that is silence, then not to be silent would be an impingement, but if the need is for contact then to offer silence would be an impingement. All of the theorists above come from a Psychoanalytic perspective where interpretation is the main means of interaction, so it is clear to see that the client's response of protest to a miss-placed interpretation could result in a conclusion by the therapist that silence is what is needed, when in fact it is interpretation that is *not* needed. With appropriate attunement silence can, of course, be beneficial and this is in stark contrast to some contemporary psychotherapy approaches where the 'fifty minute hour' must be filled with manualised intervention.

Reflections on terror: a sickness of the spirit

I have named the experiencing of childhood terror 'a sickness of spirit', and living with terror does change you, partly because of the feelings of madness it engenders when strange phenomena are experienced. One only has to look at those suffering from Post-Traumatic Stress Disorder to see how their lives are decimated by repeatedly reliving the experience. This experience though, is at least known and a cause is identified. To live with strange experiences and surfacing terror is very frightening and limits the lives of those who are affected. To help an individual to address these issues and to emerge from them with a sense of story, and the understanding and compassion for themselves

that this brings is a great privilege. During regression to dependence experiences of terror may be viewed as the re-emergence of infantile feelings related to the environment present at the time, that is, the infant/caretaker relationship. Data from participants shows this experience of terror emerging at times of spontaneous regression and during therapy which is addressing early infancy.

Participant H demonstrates her countertransferential experiences of the client's fears and terror:

> a fear that it would…that I would be unable to hold it with her, that it was so overwhelming, that 'was this a good idea' you know, 'should I be doing this' but I also knew it could happen to her even outside a therapy session, it wasn't necessarily the therapy that was triggering it, it meant that the session would always go on longer than an hour, and it meant…and it was exhausting, physically and emotionally, mentally exhausting to stay with,

Bollas (2013, p1) describes working with patients in the process of breakdown and the difficulties for the analyst when patients tip into psychosis. He makes an interesting statement though, about regression to dependence, "If the analysand regresses to dependence in a rather ordinary way – lessening defences, opening up the self to interpretive transformation, abandoning disturbed character patterns – the self will usually break down in a slow and cumulative way".

The therapist must also have resilience and the capacity and ability to tolerate profound distress and emotional pain in self and other as it arises within the regressive process.

Summary of findings relating to the process of regression to dependence

This research contributes to the theory and practice of psychotherapy and will be of interest to a range of audiences. These include, of course, those who are involved in the practice of psychotherapy: psychotherapists, supervisors, trainers and clients engaging in psychotherapy. There are other disciplines that may also have an interest in these findings, such as Social Scientists that are involved in understanding the development of personal identity, identity process and the development of self, while those who work

with trauma survivors may consider the impact of earlier developmental trauma upon recovery. Mental Health professionals may consider these findings when service users do not respond to other treatments or protocols. My recommendations for the practice of Integrative Psychotherapy when working with regression to dependence are based on data from participants, but are supported by my own experiences and theorists writing about this subject:

- The therapist must be able to recognise a regressive process in a client, and understand the need to facilitate this process.
- The therapist must have an understanding of what this need to regress represents developmentally, and be able to identify the unmet needs.
- The therapist must be able to recognise the developmental need to be met by the therapist, and be able to take on some aspects of the role of primary caregiver.
- The therapist must have experienced care first hand so that they have a knowledge of the client's developmental need experientially.
- The therapist must be able to enter into the very experience of the transference relationship, being sufficiently in the enacted transference relationship to recognise and meet the unmet need, but at the same time hold an awareness of their own boundary.
- The therapist must be able to help the client to have a narrative for the experience of being in the moment in the therapy, and begin to describe that process.
- The therapist must also be able to give voice to the likely narrative of both mother and child, so that what is missing can be known and understood.
- The therapist should be able to engage with the regressive process at any point that the client is available, that is, emotionally, physically and psychologically and either symbolically or literally.
- The therapist must attend to the relationship and be a safe, containing, holding, attentive and loving other, having an awareness of boundaries, safety, touch and malignance.
- The therapist must have the capacity for, and be able to tolerate, profound distress and emotional pain in self and other.

- The therapist must be an object of transformation, helping the client to turn emotional pain into understanding, and able to offer the client a reparative experience

The therapist's use of self

The therapist's use of self is an important aspect of Integrative Psychotherapy. This is much more than countertransferentially. It involves the therapist being willing to be seen and known as themselves by their clients. The data from this study has demonstrated how, when therapists are willing to be spontaneous and real with their client, and are willing to allow love to develop, then this can bring healing. Participant B acknowledges the importance of her therapist's love for her:

> It was a therapy of being…not a therapy of doing…and the last thing I think, she loved me. I thought she did and actually, later on, I knew she did, but it was utterly unconditional and she didn't want anything back, it wasn't a possessive love.

Suttie (1935, p215) also recognises that such love is the "effective agent in therapy". When practitioners reach the depth of relationship in psychotherapy, and experience the countertransferences which enable us to identify and address maternal need, an attitude of love has developed. These relationships are not easy options and require high levels of commitment from both client and therapist. When therapists talk about love, relaxing boundaries, and touch other psychotherapists can make this uncomfortable for them. It is my experience that some therapists feel safer when in-depth personal relationships are not seen as aspects of therapeutic relationships, and may well attempt to shame practitioners who speak about this. I have seen this in workshops and conferences where rather than an attitude of shared learning and curiosity about difference there is instead a self-righteous posturing. There may be concern about litigation and shame. Where practitioners focus on theory this may feel safer than focusing on what goes on between two people. I have tried to close the theory-practice gap, but in reality it is very difficult to write about the process.

Working with regression to dependence - support for the therapist

Importance of personal therapy

One of the key means of support for the therapist is personal therapy. Many psychotherapy graduates finish therapy at the end of their training, but in working with clients in the regression to dependence process, where the therapist's countertransference can be an evocation of their own infancy experience, the therapeutic aim is to establish primary maternal preoccupation, and to achieve this there must be a memory of maternal nurture in the therapist's experience of infancy, whether actual or therapeutic which also accords with Polanyi's (1967/1983) valuing of personal and tacit knowledge.

Participant B identifies how her experience in the countertransference may connect with her own infancy experience, and how she would be able to manage this therapeutically by, in effect, parenting her own child ego:

> It might mean, countertransferentially, that what I'm experiencing of them might trigger a reaction in child ego in me, but I would be expecting myself to manage that [expecting] the parent in me to be available to myself…

This is the main reason why I consider that therapists should have resolved their own issues around the maternal relationship in order to effectively work with clients. In my own experience, the nurture I received from my therapist is now modelled by me with my own clients, in the same way that we can learn how to care for others by being cared for ourselves.

Most reputable training organisations, whose psychotherapy approach involves long-term work with complex and distressed clients, make personal therapy compulsory for those wishing to train as therapists. The professional body (UKCP) which oversees such psychotherapy training also requires long-term engagement in personal psychotherapy for students. There are two aspects to this, one is that the student is psychologically supported whilst in training, the other is to enable the student to gain insight into themselves, their motivations and their unconscious processes, so that they are able to successfully separate their processes from those brought into the room by their clients.

Many therapists who work developmentally at depth with clients continue to engage in personal therapy over extended periods and re-engage as appropriate as an ethical stance. As my participants are all practicing psychotherapists I am going to allow them to speak for themselves regarding this point, therefore Participants I, E and K describe their understanding of the necessity to be psychologically available to their clients:

> It does feel important to me that I have an understanding of this work, like a personal understanding of it; I'm not sure that mine will be the same as theirs [clients'] always…it feels like I can only have so much of an understanding. If I'm not prepared to go there, if I'm not available to open up and work at depth in relationship and be vulnerable myself, it doesn't feel like I can support the vulnerability of a client working in that way.

> I don't think you can go into the client's inner world, object world, whatever you want to call it, without to some extent going into your own,

> I think a big part of what I've learned from my own therapy and working with clients is that very often it isn't anything that I say, which I'd always thought it would be, I thought that it was gonna be that golden phrase that actually gets somewhere, but actually I'm far more free now at going with observing and just imagining what they might need at that moment, and going with that,

Therapists can use their own experience to understand, empathise and have compassion for their client as Participant C comments:

> ….just that depth of pain they were going to, I went right to the edge myself and still felt….. [I] came back from it.

Some practitioners and theorists recognise that the therapist's own history and personal experiences can negatively impact upon the therapy offered. This is known as pro-active countertransference. Weiss (2002) identifies that the therapist's unresolved dependency issues can result in initial welcome of the client's dependence with the aim of meeting their own dependency needs, but subsequently withdrawing when the client's needs become too great. Participant A reflects upon his experience of this issue:

> It's the people who push for regressive therapy out of their own unfinished business. The bigger problem is the therapists who are against regressive therapy because of their

own unfinished business, and that's the bigger group. Now some of it is simply by theory and not knowing the psychotherapy field well enough, some of it was by group prejudice, "In our theory, in our association we don't do regressive work"… "Or we never touch because it's always going to become sexualised" or "you'll always be infantilising someone".

I consider my personal therapy to have been invaluable in enhancing my ability to work with regressed clients. Understanding, empathy and intuition have helped me to recognise regression and respond to early relational need in an appropriate way. While not all therapists would have the need for personal regression to dependence, I consider that they must have addressed at depth their core experiencing in order to work at such depth with others.

Supervision

Supervision is an important aspect of support for all therapists. In regression to dependence the supervisor should have an understanding of regression to dependence and be able to help their supervisee to recognise the potential for regression to dependence, and to be able to assess suitability of the supervisee to work with this process. Knowledge of regression to dependence would enable the supervisor to support their supervisee through issues of safety, boundary and holding. As I write this, I am reminded of a supervisor of mine who had a vast amount of theoretical knowledge and therapeutic experience. In one supervision session she told me not to touch the client, (I had laid my hand on his arm) as I might confuse him, presumably she considered that he may interpret this movement of boundary as having a sexual motive. Caution with the use of touch is always appropriate, but my personal experience and theoretical understanding had led me to believe that with this client in particular, and in other similar cases, touch was an essential part of the therapy. At the time I experienced shame and professional doubt as a result, fearing that my supervisor knew more than me and that my tacit knowing of this client was misguided, yet believing that this client needed contact with me in a way that words alone could not achieve. It was after this incident that I began to search for a new supervisor. Working with regression to dependence can be very hard on the therapist, and the role of the supervisor and their understanding of this process are crucial for successful outcomes. If a therapist and client are embroiled in a transferential enactment then the supervisor may be able to

keep an overview of the process as a whole. In my own practice a sympathetic and knowledgeable supervisor, with an understanding of the nature of this work and able to hold the whole picture has enabled me to tolerate not knowing and still maintain my equilibrium. Participant E describes talking about therapeutic touch with his client to a supervisor:

> I later was talking to a supervisor who was extremely experienced in trauma work, and who I think initially listened to what I was doing and was willing to trust it, and then later decided that I must be in the…I must be wrong…[she said] "don't, you must never use touch with, with such traumatised clients" that it could trigger off an episode of dissociation or whatever, just the touch itself, and I was trying to say, "well, this isn't the case for this particular client" but she didn't believe me, she thought I was wrong.

Therapists can experience such shame with supervisors and peers, but also in the therapeutic relationship.

Reflections on shame in regression to dependence

Several of my participants have identified the toxic nature of shame, for example Participant B has described multiple layers of shame, viewing shame as trauma, and Participants H and C describe shame for being, shame for existing. Bradshaw (1988) concurs, seeing that living with shame is life limiting, a person with toxic shame lives in fear; fear of discovery, fear of exposure, fear that their flawed self will be seen by others and rejected. When working with failed dependency in the pre-verbal arena Participants G and E identify shame as existentially present, and the therapist must expect to find it in both client and therapist. Participant I relates her experience of shame within a therapeutic relationship:

> [I feel] constantly shoved away, constantly rejected, often feel that I'm going to be rubbished or attacked, I get very hurt by these clients…it feels very costly to engage in real relationships with these clients.

This demonstrates how a therapist can be effected by shame and so must have an understanding, not only of shame itself, but of their own vulnerability to shame and should have sufficiently worked through their own shame issues in order to be able to get beyond being blocked by shame in the therapeutic relationship. Once again we return to the importance of personal therapy for practitioners. The nature of the shame

process is such that it is largely ignored as identified by Nathanson (1992, p16) who describes humanity living "in an atmosphere of shame" seeing that "shame – our reaction to it and our avoidance of it – becomes the emotion of politics and conformity. It guides and creates fashion; its influence in civilisation is paramount." The avoidance of shame has also been significant in psychotherapy education and training. Data from this study indicates that psychotherapy training should include a focus on shame both for the client and for the therapist, helping the trainee therapists to explore their own vulnerability to shame, and the potential for it within regressive work. Therapists and supervisors of trainees should also have this awareness and capacity.

Reflections on a question of boundary

Boundaries are important in psychotherapy. They define the relationship, making it known and safe. A client has expectations of boundary and so does the therapist. Research has shown that when boundaries are breached, the client usually suffers. However in regression to dependence, we are looking at changes in boundary to reflect the therapist's responsiveness to the needs of the client. These are boundary crossings which are formulated as being in the interest of the client's development. Participants in this study have indicated the significance and meaning when their therapists have crossed boundaries, experiencing such adaptations to the therapeutic frame as offering healing and repair. Therapists have choice about which boundaries are movable and which are not, and it is important to note that clients' needs do not always have to be gratified, just acknowledged as valid. However, working with regression to dependence does require more of the therapist, and therapists must be free to make a decision to work with this process or to refer on. I know for myself as a therapist that often I have felt discomfort when my personal boundaries have been challenged and it is at that point that I must acknowledge and consider my own needs as well as those of my client. The participants in this study have identified difficulty experienced when personal boundaries are challenged within client work, such as, needing 'to assign four hours' for a particular client (Participant C), feeling 'ecstasy and pain'(Participant I) and Participant D experiencing that 'every minute of those two years was hell, her rage was absolutely colossal'.

Implications for training

Psychotherapists in training should have sufficient understanding of regression to dependence to be able to recognise clients who are likely to enter a regressive process (Van Sweden 1995). This process could be identified because of an indication of significant neglect in their early relational history, a history of repeated disruption in their later relationships with self or others, or from the therapist's countertransferential experiencing in initial interviews. They should be taught to recognise and acknowledge their limitations, or the limitations of their work setting, which may not allow for the sort of long term relational therapy needed to work with regression to dependence. This sort of psychotherapy is a relational, interpersonal process and it does not fit with some models of psychotherapy (Elkins 2007). Observations of potential regression should be discussed in supervision in order to discuss the appropriateness or otherwise of working with any particular client. Integrative trainee therapists should be taught human development and possibly experience some form of infant observation as it relates to the regressive process, and study case material relating to clients who have experienced regression to dependence, in order to be able to appropriately facilitate regression to dependence when they have had sufficient experience. Upon qualification graduates should have awareness that it is often not appropriate or advisable to finish personal therapy at the end of training. Again, I will allow one of my participants, A, to elucidate further:

> I think the biggest problem is that most therapists haven't done their work themselves that they really need to do and they are afraid of their own regression and they project that right into the theory, they project that right into the methods and they criticise those therapists who would do those methods.

The relevance of shame to the practice of psychotherapy should be fully explored and discussed, particularly with regressive processes to enable the trainee to have sufficient theory, understanding and experiencing to work with regression to dependence. The regressive experiences and therapeutic interventions described by participants indicate a wide, varied and sometimes messy and apparently disorganised process. This way of working requires the ability to tolerate ambiguities, to live without knowing, and to be comfortable with something that may look to outsiders as chaotic.

When I taught the basic understanding of regression to dependence to my final year Masters students other professionals commented on my 'wrongness', seeing that such knowledge should only be available to the experienced practitioner. I am reminded of the quotation from Pasteur's (1854) lecture regarding the sharing of knowledge, "In the fields of observation chance favors only the prepared mind"

I would want my students to be aware of the possibility of regressive experiences when they came across them after training. Experience is an important factor when working with such clients, however, trainees and newly qualified therapists must be aware of the processes that some clients experience, and what to do about them, even if that means referral to a more experienced practitioner. Van Sweden (1995, p203) comments "regression to dependence as a concept should also be a part of the curriculum of training institutes". The comments of my well-respected peers shamed me, and I was also fearful of exposing my own processes to others and being seen as unsuitable as a therapist, trainer and researcher. John's (2009) comments have foundations in history where practitioners have been ostracised for failing to adhere to the traditional path. I was conscious that Margaret Little, in revealing her therapy with Winnicott, had been viewed by her peers as unfit for practice. Yalom (1980, p402) recognises such shame for practitioners and the training of practitioners, "during the course of effective psychotherapy the therapist frequently reaches out to the patient in a human and deeply personal manner. Though this reaching out is often a critical event in therapy, it resides outside official ideological doctrine; it is generally not reported in psychiatric literature (usually because of shame or fear of censure) nor is it taught to students (both because it lies outside of normal theory and because it might encourage 'excesses')".

Historically in the profession of psychotherapy the popular ideological doctrine demands adherence. Those who step outside of this are ostracised in one way or another, for example, at the moment Cognitive Behavioural Therapy is the popular mode of therapy and those outside of this exalted position may be seen as inferior (Elkins 2007). It is my firm recommendation that therapists, supervisors and trainers of trainee Integrative Psychotherapists should have an intimate knowledge of a full spectrum of in-depth therapy including regression to dependence.

The challenge of the cultural context

As I have mentioned earlier in this work, at least two participants told me, off the record, of their experiences of clients making complaints about the use of touch. In all cases this was not upheld, but the cultural and social context of blame and claim in which we live appears to be becoming more litigious, and therefore therapists may be more reluctant to step outside of recognised guidelines. Psychotherapy as a profession, and particularly Integrative Psychotherapy, straddles the medical model and the Humanistic view of human behaviour which holds a hopeful, constructive view of human beings and of their capacity to be self-determining, considering diagnoses and treatment plans whilst at the same time recognising that relationship is the key factor. If a potential client with chronic anxiety symptoms attends for therapy I may see early relational failure as the root which may need several years to address in therapy. If the same client presented at their GP seeing their issues as a medical problem, they may be given a short course of CBT and perhaps medication to address the symptoms. Cost is an important factor in State provision for psychological help and may offer a short term treatment to alleviate symptomology whilst failing to address the living burden of extreme damage within the client's internal world. Winterson (2011, p140) acknowledges that "when money becomes the core value, then education drives towards utility, or that the life of the mind will not be counted as a good unless it produces measurable results." This research then attempts to lay out some of the foundations of what might constitute evidence in this area, evidence that can be used by therapists themselves to articulate a rationale, but which also could begin the process of change in health care provision.

Elkins (2007, p66) identifies the confusion resulting from the influence of the medical model, considering that "the medical model in psychotherapy is a descriptive schema borrowed from the practice of medicine and superimposed on the practices of psychotherapy". He considers that this model "obscures the fact that psychotherapy is an interpersonal process" and that it does not account "for the fact that the vast majority of clients use psychotherapy for support, guidance, and personal growth instead of treatment for mental illness". Elkins identified the difficulty in differentiating "problems in living" from "mental illness". Health care provision seeks to resolve mental illness, restoring the client to functionality rather than having an interest in seeking contentment

and fulfilment, and so the development of potential long-term relational problems may not be addressed.

Cognitive interventions and short term therapies cannot address relational deprivation in infancy, they just cover it over leaving the client feeling that they have tried to get help, but it has not helped and adds to their feelings of failure. Thinking and theories around regression seem to have got lost in new waves of therapy. Mitchell (1988) has explored the development of new theories and comments on the spawning of one theoretical system after another which do not hold on to the validity of earlier theories, but present themselves as the latest development.

Some clients presenting for therapy may have already received short-term, symptom-relieving therapy, but Winterson (2011, p222) identifies the chronic inevitability of the re-emergence of early relational wounding "You cannot disown what is yours. Flung out, there is always the return, the reckoning, the revenge, perhaps the reconciliation. There is always the return. And the wound will take you there. It is a blood-trail." This study offers a means for therapists and theorists to be able to move beyond mere symptom management via the construct of relational wounding towards more effective and thorough ways of addressing these kinds of experiences, which have long lasting effects and enable clients to progress.

As knowledge of psychology has developed, so has the ability to work with patients previously seen as unsuitable for psychotherapy. This however is not the main issue as I see it. Those whose lives could be changed by regression to dependence do not have the opportunity. To provide a free long term psychotherapy service might be too costly for society, but not to resolve these long term issues is too costly for the individual.

In summary

My recommendations then are as follows:

- That the therapist engages in intensive personal therapy to address personal developmental lack, and to have an experience of the interaction between themselves and the therapist as primary caregiver, and have been able to internalise this, if that has been absent in their own childhood. There should also

be a willingness to continue in personal therapy, or re-engage in it as issues emerge. Participants A, B, E, I, and K, for example, support this view.

- To receive supervision with a supportive supervisor who has an understanding of the regression to dependence process, including an understanding of boundary issues, safety and the potential for shame.

- That trainers, therapists and supervisors of Integrative Psychotherapy trainees should also be practitioners who are highly trained, experienced and skilled and have intimate knowledge of depth psychotherapy, including regression to dependence.

Reflections on the research process

My choice of participants

I recognise that in being an integral part of the research process I have also influenced the study and how the results have been constructed. I have reflected upon my reasons for my choice of participants and I believe that this came from a desire to understand the experience through the eyes of those who had experienced it, but also witnessed and understood it. I had a premise that many Integrative Psychotherapists, and indeed many therapists from other orientations, did not have sufficient understanding of theory to navigate through some of the more troublesome aspects of the process of regression to dependence, a position which Weiss (2002) highlights as a factor affecting the therapist's response to regression. Therefore I chose participants who were able to share their understanding with me, and show their ability to work with regression to dependence.

The participants I chose all had the capacity to articulate their theoretical understanding of this process, to a greater or lesser degree, and had personal and clinical experience of regression to dependence. My experience is that many practitioners working from a relational perspective may be comfortable with adapting to the perceived needs of the client, but lack a detailed understanding of early infant development and its importance when working with regression to dependence. My experience as a supervisor and trainer has shown me that some practitioners clearly intend to offer best practice for the client, and are able to offer quality relational experiences, but, because of a lack of knowledge

of the potential for regression to dependence, may not in fact offer the type of reparative relationship considered necessary for this group of clients to achieve healing and progression. What would this look like in practice? A therapist who cannot recognise the signs exhibited by a client with a failed early dependency, may, through fear or lack of knowledge, challenge the dependency inappropriately rather than allowing it, seeing it as a pathological defence rather than a developmental need which should be attended to. Participant G illustrates (in my view) how premature withdrawal from the dependency aspect of the relationship, may occur:

> [I] got it wrong when I thought a client was stuck and really didn't need me anymore but they weren't owning their own growth, then I kind of tried to work with them to wean them off…and they haven't been ready

My stance as a therapist is to bear with periods when both the client and I feel stuck, to trust in the process, knowing that in infancy and childhood, if given the correct support, children naturally grow up and away from dependence upon their parents. This is my experience of dependence in therapy – it does not have to be chased away, it dissipates and is replaced by intimacy, mutuality and respect.

Traditional analysts may see the regression either as resistance to the working through of neuroses, or from an Object Relations perspective, may recognise that this is a regression to dependence, but may not be prepared to step outside their traditional boundaries in order to effect a repair, and may instead help the client to mourn their loss. Whilst this is an important process in itself I do not consider that it offers the relational repair that is possible if there is knowledge of this process, the skill to work with it, together with a willingness to truly meet the client in love. Van Sweden (1995) identifies that in order to work successfully with clients presenting with failed early dependency knowledge of the process is necessary together with skill and willingness.

The inability to remember experiences in infancy has been seen as a problem irresolvable by analysis. My belief is that the transference relationship which is played out in the therapy room can illuminate the client's early relationship, and their infancy experience can be appropriately extrapolated from this. Both Van Sweden (1995) and Winnicott (1960) contend that it is not through infant observation, but through the transference that we get a clear picture, and my experience accords with this. Pre-verbal

memories are embedded within the individual and as they are retrieved through the transference they can be acknowledged, given language and the opportunity for healing, and thus these aspects of self can ultimately be integrated. Access to these fragments of memory may only be available through the regression to dependence relationship, but if these stories remain unaddressed, they can live in the unconscious of the client, being acted out over and over again, resulting in the repeated patterns of failed relationships, difficult work situations, loneliness and despair.

Whilst not a part of my research, the medical model as applied to psychotherapy has effects upon psychotherapy practice and upon me as a practitioner. Clients presenting for therapy may also have expectations of psychotherapy based upon the template of the medical model, for example, they may expect the therapist to control the session, ask diagnostic questions, offer a treatment and subsequent cure via the expertise of the therapist. Many new clients have no understanding or expectation of the relational nature of Integrative Psychotherapy.

Within this study I have attempted to make another integration: the integration of literature, myself as researcher, and data from my participants in order to present a reflexive and organic growth in understanding through the work which I intended to reflect the dawning of understanding and growth that is my aim for practitioners and for their clients.

The limitations of this study

Having now completed this project I have reflected upon its limitations. If I had included a wider range of theoretical orientations I think that I may have obtained richer results, although, had I done this, more participants would have been needed in order to obtain sufficient data to address the research question. I hypothesise that with a wider range of participants from different orientations the data would have shown the lack of useful theoretical understanding much more clearly.

The people who responded to me as part of my recruitment strategy were required to have experience of working with regression. However, this also means that theoretically and clinically they are largely coming from the perspective of successfully working with regression and their training culture has resulted in the adoption of these common

concepts. Prospective participants who had negative experiences with regressed clients, or personally in therapy, and who therefore may not have worked with this concept, would probably not have replied. I have also wondered what the possible outcomes might have been if I had chosen participants without ascertaining their level of theoretical understanding or their ability to articulate this. A different interviewer, who didn't have my history or my theoretical immersion into this field, may have asked different questions and drawn differing conclusions from the data.

I also recognise that my personal experience has resulted in a depth of tacit knowing and that it is hard for me to move away from this in order to be objective. This knowledge was a key factor in my choice of the methodology, as I knew I would not be able to separate myself from my tacit knowing.

Things I would have done differently

I would have liked to have interviewed the participants as therapists where they only spoke about their client work and I think that a research project with this as its focus could deliver important results. I regret not having my recorder turned on from arrival at the interviews until departure. I consider that I was unable to use valuable data because it had not been recorded, but my inexperience as a researcher, and wanting to get it right, led to more formality than was helpful

Practitioner as researcher

There is a close link between my personal and professional interests and this research, as I have identified throughout this work. I believe that there is an untapped resource in the work of experienced practitioners which is only recently receiving attention. My interest guided my need to research so that I could help my clients more effectively. At a training course led by Stephen Johnson, (October 2009) a theorist and practitioner, who describes character styles and treatment plans in an Integrative and effective way, he described to me the reasons that he first started to research, starting from the question, "How can I most effectively help my patients?" This question led to in depth research into the development of personality and the treatment needed in individual character styles. I share this ambition that my research will aid myself and others to more effectively help the clients that we work with. My aim is to disseminate the results

of my research to enable practitioners to think about some of their more complex clients from the position of their early developmental history and, if appropriate, to explore the possibility that regression to dependence might afford.

My position as researcher in this process

"There is another level to the demands that heuristic research makes on the researcher. Deeply engaging in these tacit processes changes the researcher" (West 1998, p63).

Semi-structured interviewing gave the participants the freedom to find their own direction and to share what was important to them. My task was to seek clarification when necessary and maintain focus on the research question.

I recognise that, as the researcher, I have also been a participant in this study. This would seem to be the appropriate place to reflect upon the effect that conducting this research has had upon my practice. My understanding of the topic of this study has developed greatly, whilst my previous understanding contained some theoretical concepts and a large amount of intuition, I am now much more able to articulate why I do what I do. This helped me to be more confident in my actions and in relation to boundary. In the process of reflecting upon my personal psychology I have learned more about myself, my own fear of intimacy, and difficulty with not knowing. Overall I am left with two conclusions about the process of regression to dependence, first, how essential it is for some people to revisit a time before their interpersonal damage occurred, and secondly, what a difficult process this can be.

Palmer (2008, p477) presents the notion that reflection on therapeutic work can reveal "the analyst's work to himself, and as such, is a valuable technique for self-analysis". It will be evident to the reader how my reflection has revealed my work to me. When I began this study I had no concept how much self-reflection and exploration of my personal experience would feature and that it would develop an autoethnographical nature.

During the process of this study I have constantly analysed my own therapy. This has had both negative and positive connotations. Analysis has resulted in some difficulty in my being able to be just a client, and I have often viewed my therapist's responses to me negatively, however, this study has also aided my personal growth in and out of

therapy. I have lived with quite long periods of regression as a result of the immersion into the material of this study, both theory and data. I have also benefited in terms of my client work as I have gained more understanding and experience over this period. Dickson-Swift et al. (2007) and Cromby (2012) have identified the challenges for qualitative research when dealing with emotive issues. Dickson-Swift et al. (p342) acknowledge the emotional costs involved in sensitive research "Feelings of vulnerability for these researchers often came from the fact that in doing the research they were sometimes learning things about themselves". Cromby (2012, p9) recognises that "there are issues for qualitative clinical research that flow from the ineffability of embodied experience, the way its totality cannot be expressed or described in words".

I have been very grateful to my participants for sharing their experiences with me, but when one of my participants withdrew at a late stage of my research I was hurt and shocked and felt sabotaged. I believe that this withdrawal was due to an issue unrelated to the research, but within the profession, where her protests had not been heard. I concluded that this was an episode of 'horizontal violence' (Roberts 1983) that is, when authority oppresses, then anger gets acted out with peers.

I do not consider myself to be an academic even though I teach; my teaching style and my writing style are based on my experiences and reflexivity. As a person with dyspraxia I have found the organised chaos of researching very difficult, and I have become overwhelmed at times by trying to hold large amounts of information, and at the same time trying to organise them. This, together with the regressive nature of the work, has often left me unable to continue, and has undoubtedly effected the writing up of this project. When I am teaching I hope that my passion and the depth of my experiencing bring the work alive to my students, in the same way that the intuitive and attuned mother gives of her inner experiencing rather than that which is only consciously learned. I hope that this same depth and quality is available to the reader.

BenEzer (2012) identifies his connection with the work of Winnicott. He uses Winnicott's concept of potential space as a principle for intercultural psychotherapy, seeing that the co-creation of potential space can become a mutual creative space, Integrative Psychotherapists view the relational as a co-created space. Formulating the origins of relational trauma and distress in adulthood as having their roots in infantile

experiences enables both therapist and client to have a shared story, enabling them to make sense of their experiencing, developing a narrative within which the therapist can support clients more effectively and providing a space for the client to creatively explore their identity and relationships. It therefore makes sense to revisit these notions in the training and practice of psychotherapy.

In this thesis I have been exploring and describing the concept of regression to dependence, whereby the therapeutic setting is seen to facilitate a return to the earliest phases of early development, to infancy. This return is necessary for some clients because it results from damage caused to the developing self by failures in early relationships. As this putative trauma occurred pre-verbally, when it is experienced in therapy it may be difficult for both client and therapist to find words to describe the experience. The development of a narrative helps to develop meaning and also provides a language through which the experience can be understood, enabling shared language as ultimately "both the baby and the regressed patient in the end have no choice but to learn to speak the language - i.e. vocabulary and grammar - of the adult on whom they are dependent, the baby for his life, the regressed patient for his restoration!"(Balint 1959, p72).

Future research

As this research has focused on Integrative Psychotherapists a wider research project based upon other theoretical orientations might yield interesting data. I have identified earlier in this conclusion that one of my hypotheses at the beginning of this study was that the majority of therapists do not have sufficient theoretical knowledge of the regression to dependence process to be able to successfully work with it. Further research could involve interviewing a wider range of theorists from different orientations about some of the indicative factors for regression to dependence to ascertain their understanding of what is occurring. I hypothesise that looking at the experience of clients who are not psychotherapists might give enlightening data from their perspective. I would also be interested to undertake research on the training of psychotherapists and their preparation for the work which has been the subject of this study. A case study with input from both therapist and client in an on-going regression to dependence may give an experiential inside view of the process itself, where the use

of supervision, notes and personal journals could add to the richness of the data; although the ethics of this research would need to be seriously considered.

A final word in conclusion

The reader will observe that I have frequently used the words of others to say what I have been unable to say. I think that spending a large proportion of my life with inadequate words to describe my experiences has taught me that even if I do not have the words, words can be found that speak for me. Margaret Little has been an important model for my development and I shall use her words to express my personal position: "It comes down to our fundamental honesty or hypocrisy, integrity or the lack of it. We have to admit the limitations of our knowledge, skill, and insight. We may have to act on the principle of the 'balance of good over bad'; we may be using what we have faute de mieux. Or we may use what we have because it is worth using. What we have is what is in ourselves and in our patients: bodies, sensations, and emotions; movement and actions; words, ideas, thoughts, intelligence, and imagination. And that is quite a lot" (Little 1981, p153).

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Appendix 1: Information sheet for participants

Date 6/2/08

Dear

Re: **A study of Regression to Dependency- the experience of regression to dependency in the adult client in psychotherapy**.

I would like to interview you as part of a study I am undertaking for my PhD. I am based at De Montfort University, Leicester.

I am aiming to explore with practicing therapists the role that regression to dependency plays in psychotherapy with adult clients. I am interested in exploring your thoughts about this process, both from your own experience and in your therapeutic work.

As you will be aware the relationship between client and psychotherapist has been a matter of interest in the profession since its Freudian beginnings. Regression within the therapeutic relationship can offer a new experience of early ego states. I am interested to explore the role this is believed to play in repairing the ego, which some schools of therapy believe is especially vulnerable in its relationship with the first caregiver in infancy. My study aims to discover how clients and therapists experience this process, and their views on this aspect of their therapeutic relationship.

I enclose an information sheet which gives you more information regarding what participation in the study would involve. If, following reading this information, you would be interested in participating in the study, I would be most grateful if you would complete the enclosed form and return it to me in the stamped addressed envelope and I will make contact with you so that we can make arrangements to meet.

Thank you for taking the time to read this information.

Yours sincerely,

Lorraine Price

Reply Slip:

I would be interested in participating in the research study:

Regression to Dependency- the experience of regression to dependency in the adult client in psychotherapy

Please contact me to make arrangements for us to meet:

Signature: Date:

Name:

Address:

Telephone: email address:

Appendix 2: Consent form

CONSENT FORM

Title of Project: A study of Regression to Dependency- the experience of regression to dependency in the adult client in psychotherapy.

Name of Researcher: Lorraine Price.

Please complete and initial boxes below to indicate your consent:

1. I confirm that I have read and understand the information sheet dated June 2008 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

   ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, without my legal rights being affected.

   ☐

3. I agree to my interview being tape recorded by the researcher for later analysis.

   ☐

4. I understand that I have the opportunity to review the written transcript of my interview and make any amendments I feel are appropriate.

   ☐

5. I agree to take part in the above study.

   ☐

_____
Name of participant

_____   _____
Signature   Date

_____
Name of Researcher

_____   _____
Signature   Date