The Therapeutic Conversation

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Editorial

Welcome/ Kia Ora

I am delighted to welcome you to the second issue of The Therapeutic Conversation (TTC).

It is heartening to see the interest shown in the budding journal. This interest is expressed by the number of papers submitted for publication in this issue and by the warm response that was made to papers in the first issue.

This issue includes two invitations to further develop the Conversational Model. One way is by of action taken to encourage further research. The second takes the form of a Call for Papers for Issue 3 and the encouragement for you to add your voice by engaging with our ongoing conversation in TTC.

Like Issue 1, Issue 2 includes contributions from members of the Psychodynamic Interpersonal Therapy Significant Interest Group (PIT SIG) of the UK and from members of the Australia New Zealand Association of Psychotherapy (ANZAP). Papers, reviews and poetry contained within gloriously meet the stated desire to produce a journal which is written from our clinical experience and informed by "themes and ideas emerging out of relational, developmental, neuroscientific, linguistic, philosophical, phenomenological and intersubjective approaches to psychotherapy".

Contributions explore the history and place of verbal non-interpretive interventions. They explore empathy as well as the proto-conversation, and malevolent transformation. They look at the inanimate as a Selfobject, and at the intimate experience of a session. Ozymandias, Freud, the frightening Mr Babadook and the poet's voice make appearances. The papers are alive with personal and client content. They are thoughtful and also provide much food for thought.

I hope you enjoy reading each contribution as much as I have.

Margie Darcy
Editor

Papers

Is there more to the Conversational Model than interpretation?

Simon Heyland & Frank Margison

Summary

This paper explores the history and place of verbal non-interpretive interventions [VNIIs] in psychoanalysis and psychodynamic psychotherapy, including a summary of relevant research findings, and then focuses on the central role VNIIs have in the Conversational Model [CM] / Psychodynamic Interpersonal Therapy [PIT].

The history of VNIIs in psychoanalysis and psychodynamic psychotherapy involves a century-long journey from relative neglect to significant value. Within psychoanalysis, primacy has always been given to transference interpretation as the mutative agent; the act which leads to therapeutic change. Its principal derivatives, the psychodynamic psychotherapies, generally have a somewhat more pluralistic stance, in which a range of types of intervention are viewed as effective. Empirical studies support this stance. CM/PIT stands out amongst contemporary psychodynamic psychotherapies as the model which places most emphasis on VNIIs and which has the most correspondingly sophisticated technical framework for their use.

VNIIs can be defined as any verbal utterance made by the therapist which does not have the immediate function of provoking insight.

The history of Non-interpretive interventions: Psychoanalysis

Freud wrote comparatively little about technique, and his few technical papers make scarce reference to non-interpretive interventions. Despite this, Freud clearly advocated – and practised – in an active and emotionally engaged way. If we take Freud's papers on technique collectively it is clear that he acknowledged, to varying degrees, the roles of three aspects of technique: transference interpretation; relationship with the doctor; and certain VNIIs including sympathetic understanding, responsiveness, making suggestions, and teaching/mentoring. However transference interpretation was seen as the best candidate for a distinctive mutative agent, and secured the central place in psychoanalytic technique, brought to life by Strachey's (1934) famous metaphor of transference interpretations being the currants in the analytic cake.

VNIIs gained some ground within psychoanalysis in the 1950s, tolerated for their utility as stepping stones to interpretation. Tolerance grew to acceptance, probably by association with the emergence of the focus on the therapeutic relationship championed by key theorists including Donald Winnicott, Michael Balint, and Heinz Kohut. Verbal non-interpretive interventions began to be regarded as manifestations of that relationship.

Greenson (1967), also famous for developing the concept of the working alliance, described a threefold framework for psychoanalytic interventions (confrontation; clarification; interpretation) which has become widely adopted in psychoanalytic practice. Greenson held that the therapeutic agent is transference interpretation, but the analyst must also demonstrate warmth, responsiveness, humanness and compassion, have therapeutic intent, and sympathetically explain the procedures and processes of analysis, all of which imply VNIIs.

Greenberg and Mitchell (1983) described the several ways that psychoanalysis has struggled to reconcile disparate models, but in none of the models they describe is a key role explicitly given to VNIIs, although they refer to the work of Kohut and Guntrip in this direction as "utopian" (op cit, p. 370).

Gabbard & Westen (2003) classified psychoanalytic interventions into three groups:

- Fostering insight - interpretation and free association
- Mutative aspects of relationship - mainly to do with internalisation of the therapeutic relationship

- Secondary strategies - suggestions for change, confrontation of dysfunctional beliefs, explicit mutual problem-solving, exposure, self-disclosure, affirmation, and facilitative strategies (such as social niceties, humour, educational comments, soothing comments)

Although the above shows that during the 20th century psychoanalysis moved towards acknowledging the role of VNIIs, they are still seen as adjuncts, subordinate to the 'true gold' of transference interpretation. Indeed, some writers such as Laplanche and Pontalis, (1973, p.227) make the concept self-referential by defining psychoanalysis in terms of interpretation, "psychoanalysis itself may be defined in terms of [interpretation], as the bringing out of the latent meaning of any given material."

Psychodynamic psychotherapy

In the principal derivative of psychoanalysis, psychodynamic psychotherapy, there is now a well-established culture giving weight to both interpretive and non-interpretive interventions. This difference from psychoanalysis may be due in part to the significant and growing empirical research base for psychodynamic psychotherapy, which has permitted close examination of its verbal interventions, both interpretive and non-interpretive. The overall impact of research findings has been a rise in status of VNIIs in psychodynamic psychotherapy technique, with less emphasis on transference interpretation, and increased emphasis on emotional experiencing. Distinctive and essential features of psychodynamic psychotherapy have been empirically derived, which include a specific role for focus on affect (Diener et al, 2007).

Psychodynamic psychotherapy research

Naturalistic outcome studies of psychoanalysis and long-term psychodynamic psychotherapy report that non-interpretive interventions are more common and more effective than expected, and the expected impact of transference interpretation was not found (Wallerstein 1988, 1994, 2006 and Sandell et al 2000). Psychotherapy process-outcome studies show that interpretations are a minority of total interventions (and transference interpretations even less common). High levels of transference interpretation may sometimes be associated with poor patient outcomes (Piper et al, 1993). Data from some of these studies also reveal the extent of use of VNIIs, showing that 80-96% of therapist utterances per session were VNIIs (Ogrodniczuk et al 1999, Connolly et al 1999, Gibbons et al 2007). A review by Hoglend (2004) concluded that (i) high levels of transference interpretation do not resolve problems associated with difficult, defensive, or uninvolved patients, and (ii) even highly suitable patients or patients with mature interpersonal relationships may react negatively to high levels of transference interpretations in brief therapy (Hoglend 2004, Hoglend & Gabbard 2012).

Conversational Model/Psychodynamic-Interpersonal Therapy

Despite 'development of insight' now being regarded as just one of several mechanisms of change within psychodynamic psychotherapy, the role of VNIIs is still generally seen as secondary to interpretation. This is not, however, the case in CM/PIT. Given the centrality of forming a mutual conversation in CM/PIT, this model inherently advocates for VNIIs; CM/PIT sees interpretation as one facet of an approach that layers interventions as part of a deepening conversation. VNIIs are often employed in this model to develop a shared understanding between patient and therapist, and can be the key to unlocking essential aspects of the patient's experience as the dyad work together to feel a way towards an emerging whole.

Paradoxically, the CM/PIT approach developed from insight into how not to engage in psychotherapy. The conversational model began when Robert Hobson and Russell Meares, working in London, described therapist behaviours which were anti-therapeutic and could result in persecution (Meares & Hobson, 1977). Key features are listed in Table 1. This approach drew attention to the way in which interpretations might be used to gain dominance within an antitherapeutic, asymmetric relationship.

Table 1. Features of the persecutory therapist

Feature	Therapist behaviours
Intrusion	Repeated questions (especially "Why…..?") Excessive empathy
Derogation	Using confrontation or interpretation to patronise, punish or dominate the patient
Invalidation	Suggesting that the real meaning of what the patient is saying lies somewhere else
Opaqueness	Failure to reply to direct questions Inadequate information about therapy Giving mixed messages

A modern way of seeing this process is as a series of micro-aggressions from the therapist who is often unaware of the psychotherapy interventions causing damage. Hobson and Meares describe, at worst, a highly asymmetric power relationship where the therapist feels entitled to impose a privileged view on the recipient through the means of non-negotiable "interpretations".

The following clinical example evocatively describes derogation where the therapist reflects after the event on the misuse of the power asymmetry. Bott-Spillius (1992) realises that under the guise of doing something "appropriate" she has nonetheless responded with a lack of empathy:

> ...I think he had experienced this interpretation as somewhat attacking and humiliating in spite of the care with which I had phrased it. And in fact I think I was feeling more attacked by his devaluation of me and of his analysis than I had realized, and more attacking in return than I knew. I was coping with his contempt and depreciation by going 'correct' on him, freezing into analytic propriety. This meant that everything I said was more or less appropriate but lacked empathy...

Bott-Spillius, 1992 p66

Hobson continued defining the conversational model and theory with co-workers in Manchester, UK, initially as part of a programme to develop a researchable therapy, and by the late 1970s Hobson and colleagues had delineated some characteristics of his style – grounding the theory into close observation of Hobson's practice (Goldberg et al, 1984, Maguire et al, 1984). At this point it was called a Conversational Model of Therapy, but in collaboration with Shapiro and other UK colleagues it was further manualised and the model was then entitled psychodynamic-interpersonal therapy (PIT). However the original name of "a conversational model" was never abandoned in the UK, and remains the name used in Australia where Meares and colleagues have also continued developing the model, for use with borderline personality disorder and disorders of the self.

The UK work was an early example of therapy manualisation and adherence measurement (Margison 1998). Using video-recordings of clinical work, a set of operationalized definitions of model behaviours was derived. This set included VNIIs. One finding from this preliminary CM research was that prototypical model behaviour was characterised by a high frequency of two VNIIs: "understanding hypotheses" and "restatements" of the patient's verbal material. Understanding hypotheses extend simple restatement or paraphrasing by adding new material from the therapist, intended to generate shared understanding. Together these two interventions accounted for over 60% of verbal interventions of therapists familiar with the CM (Goldberg et al, 1984).

A key theoretical concept in CM/PIT is that 'feeling' is a complex phenomenon, including but not limited to affect. Feeling is a form of 'emotional knowing', which lends value and coherence to experience (Hobson, 1985). The therapist is constantly aiming to develop a shared feeling language. For fuller descriptions of the underlying theory see also Barkham et al (2018), Meares (2000, 2005), and Moorey & Guthrie (2003). Many process outcome studies in PIT show that therapists familiar with the CM use high levels of VNIIs intended to develop the therapeutic conversation using a variety of methodologies (see Barkham et al, 2018, pps. 32-37).

Implications of theory for clinical practice

There is no specific element of CM/PIT which is exclusive to its practice, but its overall approach is characterised by emphasis on the therapeutic relationship, working in the here-and-now, and symbolical transformation (Moorey & Guthrie 2003). It is notable how this framework does not use the usual psychodynamic classification of interpretative versus non-interpretative interventions.

The practical implications of the CM/PIT approach include giving primacy to staying with the in-the-room experience, and a symbolical attitude in the therapist (Hobson, 1985). This means an attitude of treating words, gestures and other communications from the patient as presentations of raw pre-conceptual experiencing. These sometimes primitive or chaotic communications can be thought of as proto-symbols, or potential metaphors. Shared exploration of feelings can convert this raw 'experiencing' into organized 'experience' in the form of a shared feeling language. By this process of symbolical transformation, taking place within a therapeutic relationship, disavowed or dissociated aspects of the self can assimilated into a larger sense of self. CM/PI therapists immerse themselves in the 'minute particulars' of the evolving conversation to develop this 'shared feeling-language' with the patient (Hobson, 1985), clarifying, elaborating and developing what the patient is experiencing and feeling. Overall, priority is given to value before meaning (Meares, 2000). The development of the conversation itself is therapeutic, not a consequence of the therapy. It can be seen from this very brief description of a complex process that transference interpretation does not have a privileged position within CM/PIT.

Components and interventions

The model has been conceptualised as consisting of seven different but interlinking components (see Table 2). None are exclusive to PIT, but collectively they form a specific definable model of therapy (Guthrie 1999b).

Table 2. Main components of psychodynamic-interpersonal therapy

Component	Key verbal interventions
Exploratory rationale	Linking interpersonal difficulties with symptoms
Shared understanding	Clarifying patient's experience by: Use of statements Language of mutuality Negotiation Use of metaphor Understanding hypotheses
Focus on here-and-now	Stay with immediate experience by: Basing interventions on cues (verbal, vocal, non-verbal and internal) Confrontation Focus on feelings
Focus on difficult feelings	Confronting / presenting the client with disowned aspects of experience (done using the same interventions as shared understanding)
Gaining insight	Linking hypotheses Explanatory hypotheses
Sequencing interventions	Progression from feeling to explanation
Making changes	Acknowledging and encouraging changes

Adapted from Guthrie (1999b) and Margison (2002)

In the following section we discuss verbal interventions in PIT. The intention is to show that this model consists of both generic and characteristic uses of psychodynamic interventions, illustrated with reference to other psychodynamic models where appropriate. We then describe key features of the style of intervention, as this is particularly well-described in this model of therapy.

Use of interpretive interventions

PIT, like all psychodynamic psychotherapies, lies somewhere on the expressive-supportive spectrum outlined by Gabbard (2010). As can be seen from Table 2, PIT interventions aimed at promoting insight and understanding about the nature of problems are called linking and explanatory hypotheses.

Linking hypotheses are statements which link feelings that have emerged in the therapy sessions to other feelings both inside and outside the therapy. They usually draw links between the patient-therapist relationship and other important relationships in the patient's life, past or present (i.e. they involve what in other models is described as the transference).

Explanatory hypotheses are complex series of statements which build up to suggest possible underlying reasons for problems and difficulties in relationships. They usually refer to repeated patterns inside and outside of therapy. They approximate in some ways to transference interpretations, but they can be seen to build over extended sections of a session or even across sessions.

In PIT, linking and explanatory hypotheses are often used as sequential interventions, by developing many links before tentatively pulling them together through an explanatory hypothesis. The term hypothesis is used by Hobson to stress that the intervention is open to refutation and is always delivered tentatively encouraging a shared conversation. The importance of progressive well-graded steps in interpretation was already long-established in broader psychodynamic practice, even as far back as the early days of psychoanalysis (eg Strachey 1934), but in PIT this gradual unfolding within a conversation is seen as a therapeutic agent in itself.

Generic uses of verbal non-interpretive interventions

Many of the uses of verbal non-interpretive interventions in PIT can be considered as common factors across psychodynamic and relational therapies and beyond. For example, the concept of linking interpersonal difficulties with emotional (or somatic) symptoms is central to all psychodynamic psychotherapies (and to psychoanalysis).

Some interventions can be better described by examining the underlying purpose rather than the precise form of the intervention.

For example, confrontation is one of the purposes of verbal non-interpretive interventions aimed at drawing the patient's attention to avoided issues. PIT makes use of confrontation, for example commenting on expressed but unacknowledged feelings, or an absence of feeling (Guthrie 1999b). However, the way confrontation is achieved is often different. Based on the work on the persecutory therapist it would be rare to confront denial or contradiction directly. Instead the therapist would be more likely to draw links with other situations where the pain was too great to acknowledge something, rather than confront avoided material directly.

Other 'generic' uses of verbal non-interpretive interventions in CM/PIT may include the following

- Explanations of procedure (eg frequency and duration of sessions)
- Responding to cues (gestural, vocal, verbal, countertransferential)
- Sequencing interventions so that explanation comes after exploration of feeling
- Acknowledging and encouraging change

However, reading case examples from Meares and Hobson draws attention to the particular way these general approaches serve the focus of developing a therapeutic conversation. They are important in building a therapeutic alliance with a shared purpose, a shared way of approaching the problem, and a positive relationship of mutual respect, and to that extent are shared across relational therapies and beyond. As described below, these non-interpretive interventions are crucial where the person potentially faces the experience of shame when exploring sensitive memories and feelings.

Characteristic uses of verbal non-interpretive interventions

As we saw earlier, the characteristic emphasis in PIT is on the therapeutic relationship, working in the here-and-now, and symbolical transformation. The corresponding and characteristic set of verbal non-interpretive interventions includes (i)understanding hypotheses, (ii)staying with feelings in the here-and-now, and (iii)use of metaphor. Each will be considered in turn.

Understanding hypotheses

PIT advocates a stance of paying very close attention to the 'minute particulars' of the patient's present experience, including words, tone of voice, facial expression, and gesture. Based on these cues (and the countertransference) the therapist then offers an understanding hypothesis. These interventions can be defined as attempts by the therapist to understand the nature of the patient's experience now, using words which try to extend or slightly go beyond what the patient has just said:

PATIENT "I feel dead inside"

THERAPIST ".....I wonder if it's hard to feel anything at all..... kind of..... empty, ...maybe."

The patient may then amplify or correct what has been said by the therapist. Hobson writes:

> "By tentatively suggesting hypotheses, I am hoping to promote a dialogue. My inner action of empathy is phrased in statements about his experience 'now', which I hope will convey an openness to be corrected – a wish for negotiation, for mutual understanding. Furthermore they intimate the importance of getting in touch with and 'staying with' his experiencing".

Hobson, 1985 p169

This deceptively simple process is the essence of the therapeutic conversation which lies at the heart of the model. It is regarded by some investigators as the most characteristic component of PIT. In a preliminary research study it accounted for over 40% of all verbal interventions in a prototypical session (Goldberg et al 1984).

Understanding hypotheses attempt to extend (not just reflect) the patient's feeling. This aspect is crucial as it signifies the therapist's engagement not just in the patient's painful experience, but in the process of symbolical transformation. Understanding hypotheses go beyond empathy. They could be described as exploratory non-interpretive interventions.

Here-and-now focus on staying with feelings

An understanding hypothesis may be followed by an intervention designed to actively focus on the immediate experience. The aim is to enhance the immediacy and 'wholeness' of experienced feelings (Margison & Moss 1986), instead of talking about feelings in the abstract or as if they belong only to the past:

Example 1: Not using here-and-now

PATIENT "when my grandmother died, I didn't say goodnight to her before she went to bed.....I know it seems a small thing.... I know she knew that I loved her... but it really used to upset me.. that I hadn't said goodnight....and ...that was the last time I saw her"

THERAPIST "you must have been very upset"

PATIENT "yes I was, it seems such a long time ago though"

Example 2: Using here-and-now

PATIENT "when my grandmother died, I didn't say goodnight to her before she went to bed…...I know it seems a small thing.... I know she knew that I loved her... but it really used to upset me.. that I hadn't said goodnight....and ...that was the last time I saw her"

THERAPIST "and there's something of that upset and sadness now....you feel it now...here....with me"

PATIENT "uh…yes…"

THERAPIST " can we stay with that feeling "

PATIENT (begins to cry and explore the warded-off feelings)

Both examples show sensitivity on the part of the therapist, picking up the painful feeling of loss. However, when the intervention is framed by use of the past tense, the feelings remain in the past (and therefore inaccessible). In contrast, the use of a here-and-now focus enables the patient to access warded-off, unresolved feelings.

(i) Here-and-now focus: This has latterly been recognised as important in other psychodynamic models (Summers & Barber, 2010, Bateman & Fonagy, 2004), and in contemporary psychoanalysis (Gabbard & Westen, 2003, Jimenez, 2006). This convergence between models is very welcome, however from a CM/PIT perspective precisely how this type of intervention is used makes all the difference. To illustrate this point, we have taken a published example from short-term dynamic therapy (STDP):

Therapist "....What might I be thinking of you if you came here and just cried your eyes out?"

Patient "I don't know."

Therapist "Can we sit with it for just a moment and see"

McCullogh & Magill (2009. p267)

The STDP therapist request to "sit with it" could seem - on the face of it - similar to the PIT approach. In fact they are profoundly different. The difference is that the PIT therapist is focusing on a feeling present in the room, whereas the STDP therapist is using a type of imaginal exposure in an attempt to bypass a block to expressing feeling. The latter is a more abstract and intellectual exercise, further from the patient's immediate affective experience.

(ii)Staying with feelings. A focus on affect has always been an essential aspect of psychoanalysis and psychodynamic psychotherapy, and the phrase "follow the affect" is standard psychoanalytic advice (Jimenez 2006). Precisely how this is to be done, however, is rarely stated. Within psychodynamic psychotherapy, consistent empathic and affective attunement is a key technique. The corresponding intervention has been described as 'paying attention to and inquiring about what the patient is feeling in the here-and-now' (Summers & Barber 2010). A step closer is the STDP definition of clarification as listening carefully and reflecting back what has been said, (McCullogh & Magill 2009). Both styles of interventions fall short however of the explicit and exploratory PIT approach, in which staying with feelings is key to an alive and profound mutual exploration of the patient's inner world, finding words for the forms of feeling which Hobson described as the heart of psychotherapy.

Use of metaphor

In PIT, the term 'metaphor' can refer to (i)phrases which represent feelings (ii)words which have some unconscious proto-symbolic meaning (Meares 2005), and (iii) gestures or vocal tones embodying the feeling (Margison 2010). The therapist picks up important metaphors used by the patient to aid the exploration and amplification of feeling as well as encouraging the develop of a symbolical attitude:

Example: extending the patient's metaphor

PATIENT "I feel on edge all the time… I just can't settle…"

THERAPIST "Sounds as if you feel sort of… wound up....."

PATIENT "Yeah… I feel myself getting tighter and tighter inside… everything's rigid.."

THERAPIST "… feels a bit like you feel like a spring.. that's all coiled up… being turned tighter and tighter"

PATIENT "yeah, I think sometimes people do things deliberately to wind me up… I'm sure I'm going to just snap…"

This patient's internal affective experience 'on edge/can't settle' is treated metaphorically. Once amplified, the feeling reveals an important interpersonal issue.

A patient seen by one of us [SH] with psychogenic symptoms of Huntingdon's disease frequently crossed his arms in a characteristic manner during sessions. This gesture was a proto-symbolic metaphor on several levels: an identification with his dead wife, a reminder of adolescent physical prowess, and a mark of religious suffering. During therapy, we extended his gestural metaphor to include his overwhelming need to be protected from a dissociated enraged aspect of himself.

Style of verbal intervention in PIT

From the earliest studies on PIT (Goldberg et al, 1984) a "style" has been recognised that is intrinsic to PIT which fosters exploration and the development of a shared feeling language. This style change is relatively easy to learn and may be dismissed as "introductory skills", but in our view are key elements of CM/PIT. Three components, which are not specific to PIT, were highlighted as crucial to develop when learning this approach to therapy

- Use of statements
- Language of mutuality
- Negotiating style

Use of statements rather than questions

This seemingly innocuous distinction is in fact important in keeping the focus on experience rather than knowledge. A question demands, or at least implies, an answer:

PATIENT "Sometimes my sister just takes over, she's so bossy"

THERAPIST "In what way is she bossy?"

PATIENT "Well she tells me how to decorate my house, and she tells me which men I should go out with, and she ....."

Use of a question results in the patient giving the therapist more information about the sister (not about the patient). A statement, on the other hand, is owned by the speaker and can therefore be more readily ignored (or elaborated) by the hearer:

PATIENT "Sometimes my sister just takes over, she's so bossy"

THERAPIST "That sounds difficult"

PATIENT "Yes it is.....it makes me feel so frustrated..... and....angry"

Use of a statement results in three important benefits: the patient feels understood, it creates an atmosphere of reflection, and from this the patient's feelings regarding her sister emerge. It also avoids one antitherapeutic possibility - asking a question can sometimes be a defensive manoeuvre by a therapist, moving the conversation away from a moment in which the therapist feels uncomfortable. When trying to use a PIT approach we are sometimes aware of the urge to ask a question: the urge may turn out to be defensive rather than therapeutic.

Use of a language of mutuality

The model advocates deliberate use of the terms such as 'I' and 'we' in preference to ad hoc variation between more personal and more abstract forms of speech. A brief example of abstract speech would be an intervention such as "Perhaps it's an effort to come here". The PIT intervention would be "Perhaps you feel it's an effort to come here to see me." The latter indicates active and mutual involvement in exploration and directly refers to the therapy relationship.

Negotiating style

Negotiating style in PIT is characterised by tentativeness and by explicitly acknowledging errors made by the therapist. This feature of PIT is an example of the systematic application of a communication style which seems to be implicit in many other forms of psychodynamic psychotherapy nowadays (eg Gabbard 2010, Ponsi 2000, McCullough & Magill 2009). It arises from a constant awareness of the possibility that something intended as therapeutic may be experienced as persecutory, so the therapist frequently checks to make sure that there is still a mutual understanding.

Combined verbal and non-verbal interventions

PIT advocates that therapists show attention to patient's non-verbal cues by mirroring gestures and body postures whilst verbally intervening. The most obvious clinical scenarios for this would be when (i)experiencing somatic countertransference, or (ii)working with psychosomatic disorders.

This multi-channel style of intervention is related to Winnicott's concept of the need for the mother to meet her baby's spontaneous gesture in order to affirm the baby's True Self (Winnicott 1960, 1964). There are obvious links also to recent developmental research into the microprocesses inherent in mother-infant interaction, where attention to non-verbal behaviour is important (Stern 1985, Fonagy & Target, 2004, Jimenez, 2006). Letting the patient know that you have noticed and are attending to, and wish to recognise their somatic feeling-state is a potent way to try to 'meet' somatised distress.

Conclusion

Verbal non-interpretive interventions have historically been an undervalued and neglected aspect of technique in psychoanalysis and in psychodynamic psychotherapies. These models share theoretical foundations which prioritise transference interpretation as the main agent of change, which has inevitably relegated non-interpretive interventions to secondary status. During the 20th century there has been a gradual shift towards acknowledging

the value of VNIIs and classifying them, whilst still regarding them as preliminary to interpretation. This position appears to have been at least partially challenged in recent decades by the development of, and research support for, psychodynamic psychotherapies.

Verbal non-interpretive interventions form a broad category which covers most of the spectrum from supportive to exploratory interventions. This breadth of categorisation seems appropriate given that VNIIs constitute the vast majority of what psychodynamic therapists say to their patients. In fact, the predominance of VNIIs over interpretive interventions in empirical studies of psychodynamic psychotherapy is very striking.

Although it could be argued that VNIIs are merely padding and add little to the process of change, in our view it makes more sense to see certain VNIIs as intrinsic and central to the therapeutic process. CM/PIT is a psychodynamic model partly derived from study of actual practice. It is strongly empirically supported, has a detailed framework for verbal non-interpretive interventions and a characteristic style of communication, and has a particularly well-defined and sophisticated approach to the technical skill of handling the affective content of the therapeutic relationship. This is done in an exploratory rather than supportive way, and is augmented by a stepped approach to interpretation. Collectively, the end-product of this clinical approach is an exploratory (rather than supportive) relational form of psychodynamic psychotherapy, often involving early and deep contact with transference issues but not primarily via interpretation (Moorey 2011, personal communication).

Furthermore, some psychoanalysts and psychotherapy researchers are now suggesting – on the basis of emerging process research findings – that narrative itself is a vehicle of change; the shared conversation allows the person to develop a story about their lives with a different quality of inner coherence (Person et al 2005, Summers & Barber 2010). We might see this as a welcome move towards a position which CM/PIT has always held.

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Empathy in Psychodynamic Interpersonal Therapy: A theoretical review.

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Abstract

Empathy is a multidimensional construct encompassing the ability to feel and understand the emotion of another person. It is seen as the precursor and facilitator for many therapies. Psychodynamic Interpersonal Therapy (PIT) is an evidence-based therapy for people with a range of mental health difficulties. A central component of PIT is using empathic communication to support people's understanding of their emotional experiences, yet this is rarely referred to explicitly in PIT literature. Through this narrative review we investigate the role of empathy within PIT. Illuminating the role of empathy in PIT could reciprocally enhance treatment delivery and training. We begin by articulating core concepts and processes in PIT, then summarise contemporary empathy research. We conclude by bringing these together to describe the nature and role of empathic communication in PIT, and the potential role of PIT in enhancing empathy both within and outside therapy. Findings concur that empathy is a nuanced concept combining both cognitive and affective components, which when combined, map onto PIT processes and skills. Innovations in empathy theory could support developing PIT therapy and training. Furthermore, PIT concepts and skills could be deployed to build empathy skills within other therapy modalities and outside the therapeutic sphere.

Keywords: Empathy, Psychodynamic Interpersonal Therapy, Interpersonal, Psychotherapy, Empathic understanding.

Highlights:

Empathy and Psychodynamic Interpersonal Therapy research has developed separately.

A narrative review synthesises the current stance of both concepts.

There appears to be a reciprocal role between empathy and PIT.

PIT skills could be used to build empathy in and outside therapy.

Empathy findings could support the development of PIT theory, practice and training.

Introduction

Psychodynamic Interpersonal Therapy (PIT, otherwise known as the Conversational Model; CM) is a simple, brief, modern psychodynamic therapy with an evidence base for a range of different mental health problems including self-harm (e.g. Guthrie et al., 2001), depression (e.g. Shapiro & Firth, 1987), borderline personality disorder (BPD; e.g. Korner, Gerull, Meares, & Stevenson, 2006) and medically unexplained symptoms (e.g. Guthrie, Creed, Dawson, & Tomenson, 1991; for reviews see Barkham, Guthrie, Hardy, & Margison, 2017; Guthrie & Moghavemi, 2013; Paley et al, 2008). PIT is designed to be easily accessible and teachable (Guthrie & Moghavemi, 2013).

There are two variants of PIT, developed in parallel by one-time collaborators Bob Hobson and Russell Meares. The models are largely the same albeit with some variation in practice (Barkham et al, 2017). Hobson's PIT, which is practiced in the UK, focused on training and developing a research base with populations where traditional treatments had not been effective (e.g., 'treatment-resistant' depression [Guthrie et al, 1999] and medically unexplained symptoms [Sattel et al, 2012]). Meares's variant (still known as the conversational model) was developed when he returned to Australia after his initial collaboration with Hobson, and places

more emphasis on the impact of trauma on memory and the self (Meares, 1995, 1998, 2000), the relationship of play and creativity in the development of the self (Meares, 2005, 2016, 2018), and developing therapy manuals to support individuals with a diagnosis of BPD (Meares, 2012a, 2012b). In this article we will treat both these models as interchangeable.

The Collins English dictionary describes empathy as "the ability to share another person's feelings and emotions as if they were your own." (Collins, 2020). Empathy has been identified as a key factor in the development of a therapeutic alliance and positive therapy outcomes, and is generally seen as desirable by clients (Swift & Callahan, 2010; Lambert & Barley, 2001). The ability to pick up emotions in others is assumed to be a foundation for most psychological therapies, including non-relational therapies such as Cognitive Behavioural Therapy (CBT; Thwaites & Bennett-Levy, 2007).

There is a large academic literature on empathy, including how it should be defined, its underlying components and how it can be measured (Hall & Schwartz, 2019). Yet, despite the obvious and important overlap between both PIT and empathy, the literature has evolved separately, resulting in two archives that have not been integrated. Nevertheless, the literature around empathy is split between researchers and practitioners, leading to incompatibilities between findings and their clinical and research implications (Barnett & Mann, 2013). Retrieving the literature yielded numerous results from the medical literature and psychological understanding of empathy more generally.

A recent textbook on PIT theory and practice states that "empathic understanding is particularly important in the PI model" (Barkham et al, 2017, p.91). However, this concept is not explained within the book, which makes no reference to contemporary research and theory on empathy. Indeed, the concept is rarely referred to explicitly in PIT texts, which instead refer to seemingly related but more obscure notions such as "empathic resonance" (Meares, 2000, p. 71), "mutuality, a feeling with" (Hobson, 1985, p.10) and "feeling of at-oneness" [Meares, 2012b, p. 14]). These unexplained nuances can easily be interpreted differently depending on one's understanding of empathy. Unpacking how 'resonance' or 'mutuality' is understood in terms of the wider (non-therapeutic) empathy literature could allow an unambiguous grasp of the underlying process (e.g., whether it is related to emotional or cognitive aspects of empathy) and whether it is a skill that can be learned, a state that is aspired to or a trait that should be sought in therapists. The current theoretical review aims to address these issues by using contemporary research and theory on empathy to illuminate the nature of empathic states and behaviours in PIT. In so doing, we hope to develop a deeper understanding of the processes by which PIT alleviate interpersonal distress for service users, the skills needed to elicit them and how these might be enhanced via training or supervision. In addition, we aim to contribute to the academic literature on empathy itself, particularly on how to foster empathic communication skills in medical and psychological professions training, repair interpersonal problems within therapeutic relationships, and build empathy within populations where there are identified complexities or challenges in this domain (i.e., people with ASC, schizophrenia). We also hope to clarify how PIT can be distinguished from other person-centred models that place particular emphasis on the role of empathy.

To address these points, the review aims to examine and clarify the relationship between empathy and PIT. We begin by summarising the current understanding of empathy within the academic literature on the subject. We then consider the PIT theory base and explore the key concepts of the model. The paucity in connection will then be addressed by weaving together the two literatures across several key themes.

Method

The search followed the recommendations of Baumeister and Leary (1997) to reflect the available literature. The literature search was completed in May 2020. The PIT and empathy literatures were searched separately as the purpose of the review was to identify areas of theoretical overlap between the two areas that might but not currently be explicit. Psychology, sociology and medical databases were searched for relevant literature (PsycInfo, EMBASE, Medline, CINAHL, Web of Science and Google Scholar). The PIT search used the terms "Psychodynamic Interpersonal Therapy" OR "Conversational Model" to include both strands of the model. The reference lists of the model's special interest groups (Psychodynamic Interpersonal Therapy Special Interest Group; PITSIG; Australia and New Zealand Association

of Psychotherapy; ANZAP) were searched to ensure key texts were found. Empathy reviews were searched using the terms "Literature Review" OR "Systematic Review" OR "systematic literature review" AND "empathy" OR "empath*" OR "affective empathy" OR "cognitive empathy". Backwards citation searching was also used.

PIT papers were included if they focused on PIT theory or its evidence base. The search of the empathy literature focused on identifying recent reviews of the area (both quantitative and qualitative, published since 2000) to ensure that our analysis was based on well-established contemporary thinking about the topic. Papers were reviewed until the point of theoretical saturation, the point where no new information was presented which addressed the aims of the review.

A narrative review was chosen as it is the recommended approach for the integration and critical appraisal of theoretical concepts (Baumeister, 2013; Baumeister & Leary, 1997; Greenhalgh, Thorne, & Malterud, 2018). Furthermore, a narrative approach is better able to answer the aim of the review, investigating the relationship between PIT and empathy. The recommendations by Baumeister and Leary (1997) were followed, for example depicting sufficient coverage of the cited literature, adjusting conclusions based on the evidence, integrating appropriately and proposing further avenues for research.

Empathy

This section introduces some of the main perspectives on empathy within contemporary academic literature on the topic, drawing on narrative and systematic literature reviews and meta-analyses pertaining to different aspects of empathy published since 2000; where possible, reviews published since 2015 were the main focus. We draw on reviews on how to define and understand the concept (e.g., Cuff, Brown, Taylor, & Howat, 2016; Gibbons, 2011; Hollan & Throop, 2008), how to measure it (e.g., Gerdes, Segal, & Lietz, 2010; Murphy & Lilienfeld, 2019; Yu & Kirk, 2009) and changes in empathy across development (e.g., Boele et al, 2019; Silke, Brady, Boylan, & Dolan, 2018; Stern & Cassidy, 2018). It also encompasses reviews from the medical sphere on understanding the change in empathy in medical/nursing training (e.g., Ferreira-Valente et al, 2017; Jeffrey, 2016; Spatoula, Panagopoulou, & Montgomery, 2019), effects of empathy on patient outcome (e.g., Derksen, Bensing, & Lagro-Janssen, 2013; Jani, Blane, & Mercer, 2012; Lelorain, Brédart, Dolbeault, & Sultan, 2012) and how empathy can be trained (e.g., Brunero, Lamont, & Coates, 2010; Engbers, 2020; Levett-Jones, Cant, & Lapkin, 2019). Individual differences in empathy, particularly for people with autism spectrum conditions (ASC; e.g., Harmsen, 2019; van der Zee & Derksen, 2020), schizophrenia (e.g., Bonfils, Lysaker, Minor, & Salyers, 2016; Bragado-Jimenez & Taylor, 2012) and offending behaviours (such as violence, bullying and aggression; e.g., Harris & Picchioni, 2013; Mitsopoulou & Giovazolias, 2015; Van Langen, Wissink, Van Vugt, Van der Stouwe, & Stams, 2014) were also considered. These reviews exist but we do not focus on these issues within the review for the sake of clarity and brevity. Perhaps surprisingly, only a small number of reviews were found on empathy in psychotherapy (e.g., Aragno, 2018; Elliott, Bohart, Watson, & Greenberg, 2011; Feller & Cottone, 2003; Nienhuis et al, 2018), reflecting the separate development of the psychotherapy and empathy literatures.

What is empathy?

The concept of empathy has proved divisive over the years (Aragno, 2008), with inconsistent definitions of the term having a significant impact on research and practice in this area (Cuff et al, 2016). Hall and Schwartz's (2019) recent review of how empathy is conceptualised suggests that use of the term varies immensely, with different definitions emphasising overlapping but often distinct features, with real practical consequences. For instance, the empirical relationship between empathy and therapeutic outcomes differs significantly according to the definition of empathy used (Cuff et al, 2016).

Cuff and colleagues (2016) describe eight key issues that have been the focus of significant debate within the field: how to distinguish empathy from other concepts; the role of cognitive versus affective aspects of empathy; whether the emotion in the observer is congruent or incongruent to the others emotion; the role of external triggers; distinguishing who has ownership of the emotion, that the self is feeling an emotion owned by another (self-other distinction and merging); whether empathy is a trait or a state; and the role of automatic versus controlled processes in empathy. Defining empathy involves distinguishing it from other concepts, such as sympathy, compassion and tenderness. Unlike sympathy, which is described as feeling for another (e.g., feeling pity or concern

for them), empathy involves feeling with another, that is, sharing their feeling to some extent (ibid). Nevertheless, it has been argued that empathic concern, a common construct in empathy measures, is aligned with feelings of sympathy, compassion and tenderness towards another (Hall & Schwartz, 2019). These perhaps reflect a person's predisposed attitudes or stance in relating to others, often regarded as empathic attitude (Thwaites & Bennett-Levy, 2007). Distinguishing sympathy and empathy empirically can therefore be challenging. A key difference is that empathy requires some kind of 'match' or congruency between the emotions experienced by the observer and another (so-called empathic accuracy), which may not be the case for feelings such as sympathy, compassion, tenderness.

The relative role of cognitive versus affective aspects of empathy has been a key debate within the literature regarding underlying psychological processes (Hall & Schwartz, 2019). Broadly defined, cognitive empathy is the mental understanding of another's emotional state, akin to theory of mind, which may involve controlled, perspective taking elements; affective empathy, in contrast, is the automatic and felt-sense of another's emotions (Cuff et al, 2016). Neuroanatomical findings suggest that the two processes have distinct neural correlates, with both being relevant to interpreting the feelings of other people (Elliott et al, 2011; Preston & de Waal, 2002; Wondra & Ellsworth, 2015). Affective models emphasise perception-action links and the role of so-called mirror neurons that simulate the experience of another in the observer's brain. In contrast, the cognitive aspects of empathy are emphasised by appraisal models, which argue that the observer feels the emotion relating to their appraisal of the other person's situation rather than the emotion directly (Wondra and Ellsworth, 2015). There is also evidence for emotion regulation aspects of empathy, claimed to alleviate personal distress to allow compassionate, helpful responses (Elliott et al, 2011).

Whether empathy requires a triggering stimulus in others has also been considered. Findings indicate that both real and imagined or fictional stimuli can trigger empathic responses, and that empathy processes can be activated intentionally when no emotion expression is available in the other (Cuff et al, 2016). Imagination, reflection and intentional empathy are thought to draw from cognitive empathy processes are controllable by the individual (ibid). On the other hand, automatic affective responses tend to be triggered by external stimuli (Cuff et al, 2016).

The question of whether someone is able to share another's emotion whilst distinguishing between one's own emotional experience and the other's (as opposed to another's emotions merging with, and being confused for, one's own), is another key conceptual issue in this area. Complete immersion in the other's emotion is seen as emotional contagion rather than empathy because the latter involves correctly locating the origin of the emotion in the other (Cuff et al, 2016). Emotion contagion is principally seen as a result of affective empathy processes. Various complexities around emotion contagion remain, including whether it is the same emotion as the other person, an emotion experience stimulated in the observer (which may not be the same) or general physiological arousal (such as anxiety or distress) in response to an other's emotions (Hall & Schwartz, 2019). One possibility is that emotional contagion is on a continuum with affective empathy, with increasing arousal undermining the individual's capacity for reflection and thereby diminishing emotional meta-awareness.

There has also been extensive discussion of whether empathy is a trait, a state or an interaction between the two, with the role of person-specific versus situation-specific factors being widely debated (Cuff et al, 2016). Several reviews (e.g., Cheon, Mathur & Chiao, 2010; Cuff et al, 2016; Silke et al, 2018; Stern & Cassidy, 2018) conclude that both trait and state factors contribute to the experience of empathy and how this relates to behaviour. Of note, most self-report measures are based on the assumption that empathy is related to personality and individual traits (Hall & Schwartz, 2019), which may skew our understanding of the concept and the conclusions that can be drawn from the literature. Indeed, although empathy is referred to as a trait it is also widely described as a process, a capacity, a motivation, a behaviour, or a combination of these (Hall & Schwartz, 2019). Moreover, it has been suggested that empathy does not necessarily involve a behavioural outcome, therefore the subjective experience, the state, is the defining feature (Cuff et a, 2016). Empathy can lead to behaviours, such as prosocial or sympathetic responses, but these motivations are potentially moderated or activated by other processes (ibid).

On the basis of this review, Cuff et al (2016) conclude that "Empathy is an emotional response (af-

fective), dependent upon the interaction between trait capacities and state influences. Empathic processes are automatically elicited but are also shaped by top-down control processes. The resulting emotion is similar to one's perception (directly experienced or imagined) and understanding (cognitive empathy) of the stimulus emotion, with recognition that the source of the emotion is not one's own" (p. 150).

This definition is necessarily multi-faceted, with the different aspects of empathy being measured in different ways (see below) and relating differently to other variables. Put this way, empathy is an umbrella term for all of these underlying features (Hall & Schwartz, 2019). However, there are still questions from definitions as to how many of these features above are required to be empathic, or whether the umbrella term offers more confusion rather than integration (ibid). For that reason, authors should qualify what they mean when they use the term of empathy for the sake of clarity, and accordingly, we follow this in the remainder of the paper.

According to Elliot and colleagues (2011), three main features distinguish therapeutic empathy (i.e., that seen in psychological therapies) from general empathy: empathic rapport, being the demonstrable wish to understand the person through a compassionate stance; communicative attunement, being the effortful attention on the moment to moment experiences of the client; person empathy, being the understanding of the person's world based on their past and current circumstances, related to the evolving psychological formulation. Thwaites and Bennett-Levy theorised a therapeutic empathy system (2007), comprising four components: empathic attunement (a perceptual skill that indicates mindful attention to the client, such as their non-verbal and verbal communication, which places particular emphasis on the affective aspect of empathy), empathic attitude/stance (including qualities and values of the therapist, such as a benevolent and helping disposition), empathy knowledge (learning through professional development which distinguishes natural and therapeutic empathy, and which arguably draws more on cognitive empathy processes), and empathy communication skills (how empathic understanding is articulated to the client in line with modality specific techniques and formulations).

Measuring empathy

Vagueness and inconsistency in defining empathy has understandably had an impact on the measurement of empathy (Gerdes et al, 2010; Hall & Schwartz, 2019). There are four ways in which empathy has been measured: self-report, observer ratings/other-report (also known as client measures in therapy; e.g., empathy scale of the Barrett-Lennard Relationship Inventory, which includes items such as the therapist's name "usually senses or realises what I am feeling"; Barrett-Lennard, 2015), behavioural/performance measures (task based measure to decipher emotions in others; e.g., Reading the Mind in the Eyes Test; Baron-Cohen, Wheelwright, Hill, Raste, & Plumb, 2001) and physiological/neurological measurement (e.g., fMRI scans [Hall & Schwartz, 2019]).

Self-report measures dominate the literature, with 80% of studies using at least one self-report measure within a recent review (Hall & Schwartz, 2019). Gerdes et al (2010) surmise that most self-report empathy measures are inconsistent with definitions of empathy, with most measuring sympathy. Many tools have been developed over the years and each have different interpretations of the empathy concept. The dimensional split between cognitive and affective components of empathy is often reflected in measure development, as some primarily depict affective (e.g., Mehrabian and Epstein's questionnaire; Mehrabian & Epstein, 1972), others cognitive empathy (e.g., Hogan's empathy scale; Hogan, 1969) and some both affective and cognitive components (e.g., Empathy quotient; Baron-Cohen & Wheelwright, 2004; Interpersonal Reactivity Index; IRI; Davies, 1980). Other reviews also describe concepts which include moral and behavioural aspects of empathy (Hong & Han, 2020; Yu & Kirk, 2009). According to Hall and Schwartz (2019), the IRI (Davis, 1980, 1983), a self-report questionnaire that measures both cognitive and affective empathy is the most widely used measure. The IRI has four subscales: empathic concern (statements that reflect feelings of concern or sympathy for others), perspective taking (statements that reflect thinking from another's point of view), personal distress (statements that reflect feelings of anxiety when in an emotionally loaded interpersonal situation) and fantasy (statements which indicate an ability to imagine or feel emotions with fictional characters). The IRI is seen as a measure of trait (Hall & Schwartz, 2019), however, in some respects, it asks how often they experience the state too (e.g., "I am often quite touched by things that I see happen"; Davis, 1980). Evidence suggests that self-re-

port results from a range of empathy measures account for only 1% of the variance in behavioural cognitive empathy, suggesting that individuals cannot validly self-report their empathic ability (Murphy & Lilienfield, 2019).

Observer methods have been thought to have greater objectivity than self-report questionnaires (Yu & Kirk, 2009). However, these raise questions about whether observers show the same inter-rater reliability as in the tool's development (ibid). Client based measures predict the outcome of therapy better than observer and therapist measures, although the latter are still significant predictors (Greenberg, Elliott, Watson & Bohart, 2001). This is true even though patient-report empathy measures are limited by the fact that patient perspectives have rarely been considered in their development (Gerdes et al, 2010; Yu & Kirk, 2009). Physiological or neurological measurement of empathy are the least common, likely due to the resources and logistics they necessitate (Gerdes et al, 2010).

One largely unresolved issue is whether empathy is better measured as an attitude, an experience or a skill. Certainly, well-validated, objective measures of affective empathy performance or ability are largely lacking (Gerdes et al, 2010), meaning that researchers and practitioners have to rely on self-report measures of empathy or tools, such as the IRI (Davis, 1980), which arguably captures cognitive perspective taking, rather than affective empathy.

Development and correlates of empathy

Early experiences of empathy in the primary care-giver relationship have demonstrable impacts on infants (Aragno, 2008), suggesting that our brains are "hardwired for social connection" (de Waal, 2008, p. 292). Findings from a recent review indicate that higher personal distress (and high anxiety) in new mothers is associated with lower cognitive empathy. They suggest that higher personal distress can impact on caregiving and can increase the risk of maltreatment (Boorman, Creedy, Fenwick, & Muurlink, 2019). A parent's ability to recognise and respond congruently to the experience of empathy is related to a more secure attachment with the child, better coping and less fear and anger in infants (Beebe, 2005, 2009, cited in Gibbons, 2011; Boorman et al, 2019). High relationship quality in both the parent-child relationship and the peer-child relationship are associated with better adolescent empathy (as measured by a meta-analysis of both cognitive and affective empathy tools), with peer-child relationships being the most strongly correlated (Boele et al 2019). According to Boele and colleagues (2019), there are two main theories about the development of empathy, one based on social learning theory (Bandura, 1971) which suggests that children model parent empathic behaviour, and the other suggesting that secure attachment with the parent results in the child's psychological needs being satisfied, thereby enabling capacity to reflect on another's emotions (Bowlby, 1982).

Other individual differences have been found, such as impairments in distinct aspects of empathy, rather than a global difficulty. People with autism spectrum conditions (ASC) have been found to have lower cognitive empathy but unimpaired affective empathy, with the converse being found for individuals with psychopathy (Cuff et al, 2016; Murphy & Lilienfield, 2019). Various social communication, social reward and mirroring functions are indicated to underly empathy difficulties for individuals with ASC (Harmsen, 2019; van der Zee & Derksen, 2020).

Empathy is thought to have numerous effects on a person's interpersonal relationships and outcomes. Evidence suggests that empathy and pro-social behaviour are imperative for developing heathy, satisfying relationships and social competence (Sened et al, 2017; Silke et al, 2018). It is also associated with various other benefits, such as less aggression, bullying and anti-social behaviour and higher academic achievement (Mitsopoulou & Giovazolias, 2015; Sened et al, 2017; Silke et al, 2018). Yet, investigations have determined the relationship between empathy and other outcomes is moderated by other variables: a multitude of individual and contextual factors (such as personality, social skills, personal values, parents, school, media), which further reflects its complexity (Silke et al, 2018).

Clinical and therapist empathy

In models such as psychoanalysis, empathy is the vehicle for building trust and rapport, allowing access to the client's emotional experience (Aragno, 2008) and a precursor to specific therapeutic interventions (Thwaites & Bennett-Levy, 2007). A recent meta-analysis including therapist, client and observer rating measures suggests that therapist empathy is significantly associated with therapeutic alliance (Nienhuis et al, 2018). Nienhuis et al (2018) found that a client's race significantly

moderated the alliance, indicating that therapists who are sensitive to culture are more empathic and better at building therapeutic relationships. Being culturally sensitive is especially important when discussing empathy, as there is evidence of different ways of interpreting emotional experiences and receiving empathic communications that depend on an individual's culture (Cheon et al, 2010; Hollan & Throop, 2008).

Evidence suggests that empathy contributes to around 9-10% of therapy outcome (Elliott et al, 2011; Greenberg et al, 2001). Elliott et al (2001) suggest that empathy leads to good outcomes in psychological therapy as it provides a corrective emotional experience where the client feels understood, in turn increasing therapy satisfaction. Further, it provides feelings of safety and compliance with therapeutic goals. This is also supported by evidence from medical settings, with findings suggesting that physician empathy is associated with increased patient satisfaction and enablement and lower distress (Neumann et al, 2007; Derksen et al, 2013).

A complex relationship has been found between empathy and burnout. Lower cognitive empathy and higher affective empathy, in particular on the personal distress scale of the IRI, is associated with burnout. When separated from other concepts, emotion contagion, the vicarious affective experience of empathy, was positively correlated with burnout (Hunt, Denieffe & Gooney, 2017). Emotion regulation abilities and their use in empathic encounters can reduce the likelihood of burnout (ibid). Indeed, emotion regulation skills are considered instrumental in the development and continued capacity for empathy (Gerdes et al, 2010; Gibbons, 2011).

Empathy has been described as "dynamic, learnable, and developable" (Cheon et al, 2010, p. 39). How to train empathy has been a particular focus in the medical and nursing literatures, consistent with policies such as the "6 Cs" (Department of Health, 2012) and the NHS constitution values (Department of Health and Social Care, 2015). Empathy training has shown to be effective, especially where the training uses an experiential component (Brunero et al, 2010). Furthermore, experiences of taking the role of the service user or other person followed by a period of guided reflection drew trainees to feel particularly affected empathically (Engbers, 2020; Levett-Jones et al, 2019). However, results are contradictory and inconsistent, which may be a product of the multidimensional nature of empathy discussed above (Karayiannis, Roupa, Noulla, Farmakas, & Papastavrou, 2017). Wild (2020) also proposes that there is no "algorithm" for empathy and highlights the risk of teaching empathic/compassionate platitudes of concern rather than true empathy.

Psychodynamic Interpersonal Therapy (PIT) and the Conversational Model (CM)

In this section we present the past and present literature and theory base for PIT. In the development of the model, Hobson and Meares cite a fusion of key influences between psychodynamic (particularly Jungian concepts; Hobson, 1971), attachment theories, (such as symbolic play from Winnicott; Meares & Hobson, 1977) with inspiration from the creative arts (Meares, 2007). In PIT, psychopathology is seen as arising from disruptions in the self resulting from traumatic interpersonal experiences (Hobson, 1985). The model focuses on supporting individuals through understanding key aspects: myself and relating to others, experiences of feeling, language and symbols, through recognising the minute particulars using key PIT techniques. We will unpack these in turn to explicate the central principles of PIT theory.

Myself and Relating to others

In PIT the emphasis is on "being with", rather than "doing to", a person (Hobson, 1985). PIT is fundamentally an interpersonal model, rooted in key concepts from attachment theory (Meares & Hobson, 1977). By this view, our innate need to connect leads us to develop patterns of relating based on our earliest relationship with our caregivers (Meares, 2018). Guthrie and Moorey (2018) describes the sense of self (as seen in PIT) as a product of good-enough care-giving relationships. It is akin to the stream of consciousness, both a moving and stable sense of who one is (past and present). PIT draws on the concept of the duplex, Jamesian self (Appendix B; Meares, 2012b), which was extended by Meares to encompass the tripartite self, I, Me and Myself. 'I' is the "core" of one oneself, that is, one's felt experience of inner life; Hobson (1985) notes that 'I' can be different in different contexts or be associated with different feelings, reflecting multiple aspects of the self that be thought of as members of a "community of selves" or identities that collectively make up the individual. 'Me' is one's autobiographical identi-

ty, and relates to our ability to reflect on aspects of our self (i.e., our fluctuating inner and outer experience) and construct narratives around them. 'Myself' develops in the context of significant relationships and is the variable part of self which adapts and changes between 'me' and other people, the state of 'me' that others are aware of, that has been shown to others (Meares, 2000, 2004, 2020).

In PIT, one's sense of well-being, value and personal worth is determined by the relationship between 'I' and 'Me', which is intrinsically linked with our experiences in early care-giver relationships. By this view, developing and having positive relationships with aspects of the self, the 'I', is rooted with a sense of positive affect (such as feelings of vitality and wellbeing, towards feelings of warmth and intimacy; Meares, 2004). Repeated empathic failures within early "proto-conversations" (i.e., mismatches between the child's needs and primary care-giver responses) and lack of good-enough care can lead to anxiety that disrupts the development of the self (Meares, 1995). This can result in intolerable, or conflicting, thoughts and feelings going unnoticed, being avoided or suppressed, resulting in a split in the self. In extreme cases (e.g., borderline personality disorder), this can cause "traumatic adualism"; that is, an inability to reflect on and understand the self (Meares, 2020). Disconnections in the self are related to the feelings of vitality, warmth and intimacy being thwarted (Meares, 2004). To maintain some sense of stability, the person can also unwittingly present a "false self" that does not connect with inner experience but exists to conform socially, allow continuation of relationships or to avoid pain (Korner, Bendit, Ptok, Tuckwell, & Butt, 2010). Inside, however, the 'true' self continues to experience the pain of empathic failure as their feelings continue to go unrecognised by others. Conflicting different selves risk(s) disorganisation

The primary aim of PIT is to help the person recognise, organise and recombine the experience of the self (the 'me') through self-exploration and an optimum relationship with others characterised by "aloneness-togetherness". This is a reciprocal relationship giving value to both parties, since "the self arises and remains between people" (Hobson, 1971, p. 97). The therapeutic relationship in PIT is constructed to simulate the "safe base" that positive early attachments represent, enabling service-users to develop their capacity for creative self-reflection, come to know and value aspects of themselves, and test how these relate to the wider social world. The relationship goes beyond mere attachment, however, and the model's principles of a healthy proto-conversation (coupling, amplification and representation, with attention to immediate experience, and a mirroring response from the therapist) evoke self-recognition and shared positive affect.

Unlike other therapy models, the aim of PIT is to create a certain social interaction, not simply to develop skills (Haliburn, 2009; Halovic et al, 2018; Korner & McLean, 2017; Meares, 2006, 2020). Establishing a connection based on aloneness-togetherness intends to help ease the suffering caused by maladaptive interpersonal relating (Meares 2004). Finding a fit between a person and therapist is crucial to the therapy if this fit was lacking in their childhoods (Meares & Hobson, 1977). As Hobson (1985, p. 135) states, "I can only find myself in and between me and my fellows in a human conversation", identifying the creation of the triadic relationship (therapist, service-user and the 'third space' between them) as the centrally important goal. In PIT, therefore, a relationship characterised by mutual understanding is the central mechanism of change, as it allows for awareness and acceptance of the self and, thereby, to repair the damage caused by earlier empathic failures. The person develops a different relationship with themselves, there is a positive change in the "Me" and the "I" becomes more connected and coherent, resulting in feelings of well-being and more adaptive behaviour (Blagys & Hilsenroth, 2000; Haliburn, 2009, p. 32).

Next, to consider how contemporary thinking about empathy might illuminate what is happening here, empathy is conceivably the precursor and/or the process of reaching a state of mutual understanding and aloneness-togetherness, the mediator to develop the space between the individual and their therapist (i.e., the third space; Hobson, 1985). The creation of aloneness-togetherness requires an element of empathic skill, but importantly is not a test of empathic accuracy. This reflects on earlier descriptions of separateness-merging, referring to the importance of recognising an emotion reaction, but that this is owned by the other (Cuff et al, 2016). Empathy within the therapist needs to be congruent with the person's present feeling, as well as congruent with their prevailing relational stance (ibid). A careful balance is required within these concepts and the parallel PIT process of aloneness-togetherness to foster the self

(ibid). If the therapist is too polarised on the continuum of congruence the interaction can become persecutory. If the therapist is too congruent (too empathically accurate), it can feel like an intrusion into the individuals mind, the therapist can appear magical, as if they can read minds, which can increase feelings of threat. Incongruence can lead to feeling misunderstood or derogated (made to feel different/problematic; Hobson, 1985; Meares & Hobson, 1977). On the continuum of merged-separateness, too extreme on either end can also be problematic. Too merged, such as the therapist providing interpretations for service-user, can encourage a dependence on an all-knowing therapist, insight has been given, not developed. Too separate, with the therapist not giving any emotional resonance or verbal feedback within the therapy, could lead to a feeling of opaqueness (too neutral, not in the therapy as two people; ibid). Hobson (1985) describes the mutual destruction that can be found through eye contact, as if it can pass on ill-intent or infect the other. This may be related to the concept of emotional contagion. When the service-user has experienced ill-intent or abuse from others, eye contact can perhaps heighten the connection of feeling between too people, which could feel threatening due to the unfamiliarity of sharing feelings safely.

In PIT, empathy is seen as having a crucial impact on the development of the self, particularly through the role of the primary caregiver in the protoconversation. The protoconversation is about developing "empathic resonance", a feeling of matching in the infant (Meares, 1999, p. 451). The PIT therapist is essentially engaged in a process that mirrors that seen in early relationships. The three parts of the protoconversation in symbolic play: coupling, amplification and representation, each relating to the concept of empathy in slightly different ways. Coupling requires an empathic attitude and stance (to pick up the information and then attend to the immediate experience). This maps on to the empathic attitude/stance reflected in the therapeutic empathy system (Thwaites & Bennett-Levy, 2007). When reflecting on Cuff and colleagues (2016) definition of empathy being an "emotional response", the attitude or stance seems a prerequisite to this. It is, perhaps, a priming of conditions that enable the therapist to attend to the service-users experience (i.e., reflexivity). Additionally, this infers a relationship with the trait capacity for empathy (the pre-existing qualities and abilities that enable this stance within a therapist; Cuff et al, 2016). The ability for the therapist to couple will also likely be affected by state influences (situational factors), such as limited expression in the service-user or incongruent cues (verbally expressing one feeling but non-verbally expressing another e.g., saying they are fine but with a quiet tone or sad expression). As to how the emotional response of empathy happens in coupling to existent and non-existent cues, the literature informs us about the distinction between the intentional act of making this happen (top-down, intentional empathy) versus the automatic elicitation of the shared feeling (Cuff et al, 2016). The use of intentional empathy within therapy appears useful in regard to incongruent or limited expression in the other, and reflects taking on more cognitive empathic features (such as using imagination with understanding based on the person's past and current experiences), as well as the utilisation of empathic knowledge (skills to enable empathy acquired through professional training; Thwaites & Bennett-Levy, 2007). The empathic stance and attitude as well as positive regard and genuineness are important aspects of the relationship in PIT as well as in the empathy literature (Feller & Cottone, 2003; Hobson, 1971). Amplification requires the observer to be able to recognise the emotional expression in the other. The recognition of the emotional expression in the other uses an interaction of affective and cognitive outcomes of empathy, mentally simulating what a person might be feeling versus sharing the feeling of the service-user (Cuff et al, 2016). This advocates for the empathic attunement (attending to current cues) aspect of the model of therapeutic empathy (Thwaites & Bennett-Levy, 2007). Amplification needs to maintain congruence to the attuned emotion while extending the emotional experience. Finally, this is then representing the emotion congruently through empathic communication abilities such as those described by Thwaites and Bennett-Levy (2007; Hobson, 1985; Meares, 1999). This empathic representation is not the emotional response which defines empathy but is the outcome and extension of that response within the therapist (Cuff et al, 2016). Empathic representation in PIT is not solely about comprehending the person's emotional state, it also aims to put into words what is not explicitly spoken about by the person overtly, because it is either suppressed or not recognised. It can only be seen in the vocal and non-verbal expressions of the feeling (i.e., a higher vocal tone indicating doubt) through perspective

taking and imagination (Meares, 2005, 2006). All in all, empathy described here and reflected in the literature reflects both cognitive and affective features of empathy, bringing together original ideas that empathy within PIT was cognitive in style (Meares, 2006) and "visceral", emotional, a felt sense, not an intellectual exercise (Hobson, 1985, p. 170).

There is a tripartite process of empathy in PIT: it first attends closely to the person's verbal and non-verbal expressions; secondly, it reflects the therapists' own inner experience; and thirdly, hold both sets of information to develop an evolving shared understanding of the interactions (Meares, 2006, 2012, p. 174). The second stage involves the therapist being reflective of their own inner experience relating to the interaction. Reflection is imperative to distinguish between the urge to make a sympathetic ("I'm sorry") rather than an empathetic response ("I understand"), as well as to monitor one's own feelings and anxieties regarding the therapy that could impact on the response (Meares, 2012b). This reflects the duality of the empathic process: the therapist and service-user are not just observing, but involved in creating a scaffolding of a person's self through their emerging narrative (Meares, 2005). "The therapist's capacity of empathy is the principle agent of beneficial change" (Meares, 2005, p. 181). In using the term 'empathy' here, Meares is referring to all of the different features of empathy: the affective capacity to hold and contain feelings without being overwhelmed by emotional contagion (by not recognising the feeling as owned by the other), the cognitive capacity to hold the service-users perspective as well as imagine their feeling based on their history and experiences (Hall & Schwartz, 2019). Plus, it is likely referring to the features of empathy that relate to building the therapeutic relationship, such as trait features of empathic stance and attitude that reflect benevolence and empathic concern, resulting in feeling cared for (Thwaites & Bennett-Levy, 2007).

Experience of feeling

The main task of the therapist in PIT is to be continually searching to understand the client's present experience of feeling (Paley et al, 2008). Hobson's experience of feeling involves inseparable interaction between the mind and body. Guthrie and Moorey (2018) summarise Hobson's (1985) concept of experience in four parts:

"First, it is a kind of knowing, a kind of sense of something. Second, it is felt in the body, from inside. Third, experiencing is always in relation to things, persons and situations. Finally, experiencing is not static and there is a sense of flow" (p. 284).

The experience of feeling is not merely emotion (i.e., the basic, universally recognisable emotions such as happiness, sadness and anger), nor just affect. It involves creating shared, personal meaning between service-user and therapist (Hobson, 1985). A 'form of feeling', which is a verbal, associative picture (such as a symbol or metaphor), represents this immediate shared meaning (Meares, 2020). As we cannot fully experience what someone else is feeling, especially when the someone's ability to reflect on their experience is limited, the closest way is expressing our feelings using symbols (Hobson, 1985).

According to Meares (1995), experiences of trauma at key stages of the person's development results in them being unable to recognise what they are feeling and its significance. Intolerable feelings resulting from invalidating or abusive events are recorded along with associated contextual cues in memory but without an episodic sense of time. When this memory is triggered (e.g., by the environment, therapist or the service-user's inner experience), it can intrude as a feeling but without awareness of the original trauma and is thereby experienced as pertaining to the present rather than the past (Meares, 1999; Guthrie & Moghavemi, 2013). Meares calls this "stimulus entrapment" (2000, p. 59). These feelings are often pushed away or disavowed to survive experiences that are intolerable in the absence of the tools and language needed to approach them (Hobson, 1985).

Within the safety of the relationship in PIT, the 'form of feeling' is shaped through conversations between the therapist and service-user, with the therapist recognising, extending and exploring the service-user's experience. Over time, 'forms of feeling' develop a shared, personally meaningful language that enables the expression of avoided or unrecognised feelings (Guthrie & Moorey, 2018; Hobson, 1985; Meares, 2012b).

Hobson (1985) acknowledges that a therapist is unable to fully experience another's experience; it is an "exercise of empathy and striving for understanding" (p. 191; Paley et al, 2008). This appears to relate to the limits of the features of empathy, an exercise of intentional empathy employing cognitive and affective capacities to attune to the ser-

vice-user's feelings (Cuff et al, 2016). It also links to the different definitions of emotional contagion. These are argued between the emotion being the same as the other, emotion triggered in the observer that may not be the same, or the triggered physiological arousal (Hall & Schwartz, 2019). As experience of the 'form of feeling' is abstract and analogical, it must be met in the therapist as a sense of feeling, affective, rather than a cognitive, imaginal process (Hobson, 1985). The process of "experiencing together" through empathy, creating the 'form of feeling' is the start of facing latent feelings. Each time a symbol is presented and shaped, it allows safe, contained exploration of guarded experiences. Through this, the hidden, unknown pain becomes less uncertain; in turn, knowing the pain enables starting to manage the pain (Guthrie & Moorey, 2018). Sympathy (alleviating pain) rather than empathy (staying with the pain), would not promote connectedness nor make sense of the experience. It can also be interpreted as invalidating the person's experience (Meares, 2006).

Language and symbols

PIT uses "feeling language", sharing and shaping of immediate experiences through verbal and non-verbal symbols (Hobson, 1985, p. 7). The sharing of experiences through language, utilising the empathic attitude and shaping cognitive and affective empathic information, is crucial in this relational model (Cuff et al, 2016; Hobson, 1985). Feeling language is distinct from the factual language we use to talk about objects, what Hobson (1985) calls "jam jar" language. Feeling language is a non-linear, associational language associated with inner speech, rather than the linear, grammatical language that we use within social speech. Analogical language is used by children as they play, which is thought to be how the self is constructed (Meares, 1995; 2012b). Creative play is considered vital in therapy (Hobson, 1971). Adults can use non-linear associational language through metaphor, which is "…a means of visualising the inner world" (Meares, 2000, p. 125). It shares a feeling of play and relatedness (intimate, with positive affect), yet when used in PIT the language becomes the map for fluctuations in therapy and the therapeutic relationship (Meares, 2004). To maintain the shared language, Hobson (1985) describes the language must be jargon-free, and use a tentative, negotiating style including "I and we" pronouns. The use of statements rather than questions sets PIT's language style apart from other modalities. The resulting therapist language evokes mutuality, two humans (i.e., not expert-patient) engaging and sharing in conversation, focusing on what is happening in the therapy (Barkham et al, 2017).

For individuals who have experienced repeated attacks on their sense of self, their "me" narrative is not reflective of the true self, the "I" (Meares, 1995). As the development of the self was interrupted, their language about the self becomes linear, lacking affect, reflecting the disconnection from their inner experience (Meares, 1999). However, they are then trapped in unhelpful patterns and unable to express their feelings in a way that provides resonance (Meares, 2004).

The therapeutic frame increases feelings of safety by having the expectations of the therapy, service-user, and therapist discussed explicitly at the start (Barkham et al, 2017; Hobson, 1985; Margison & Shapiro, 1986). Storytelling is the way humans understand themselves and their experience (Korner & McLean, 2010). To help service users express their ideas, feelings and tell their story, therapists use a language of mutuality, playfully alive with symbols (which prevents continuation of the linear narrative). The sense of alienation can be alleviated through metaphor as this creates an ability to resonate with guarded-off experiences (Meares, 1998). PIT uses language to link together emotions, memories and relationships (Guthrie & Moghavemi, 2013). Metaphors can persevere and evolve to hold important themes over therapy (Barkham et al, 2017). Service-users test out new ways of talking elsewhere once they have been learned through the conversation in PIT (Hobson, 1971). Symbolic language, charged with affect, evokes the imagination, which allows new ways to solve problems and create new meaning. It "dissolves, diffuses, and dissipates in an effort to unify" experiences and therefore, the self (Hobson, 1985, p. 107). Symbols and metaphor contain overwhelming feelings so that they can be examined and understood until they no longer present the same amount of uncertainty (Guthrie & Moorey, 2018).

In PIT, a tentative, negotiating style is used to allow for collaboration within the process of coupling, amplifying and representation (Guthrie & Moorey, 2018; Korner et al, 2017). This is necessary as not to invalidate a person's experience (Meares & Hobson, 1977). Empathy in PIT has two responsibilities, one to understand another's experience (particularly in understanding an un-

derlying avoided fear), but also to make sure this is communicated appropriately with the specific needs of the person in mind. Empathic understanding prioritises congruency with the present non-verbal behaviours over being empathically accurate for non-present cues (Hobson, 1971). This is related in the literature to the zone of proximal development by Vygotsky (1978, cited in Zonzi et al, 2014), which reflects the zone where service-users feel comfortable to approach and embed new (perhaps previously avoided) information. The therapist needs to judge what might be tolerable for the service-user to hear, providing too empathically accurate hypotheses (particularly about a person's most intimate, warded off feelings) can be damaging (Meares, 2005). Revealing too empathically precise statements too early in therapy can be seen by service users as omniscient, invalidating or derogating, which can destabilise the balance of aloneness-togetherness (Meares & Hobson, 1977).

The 'minute particulars' and specific PIT interventions

The minute particulars describe the "moments of aliveness", the moment-to-moment noticing of the myriad of behaviours (non-verbal, verbal, vocal) that happen within an interaction (Meares, 2004). Minute particulars often go unnoticed in conversation, but are imperative in PIT as they contain the "germs of the self" (Meares, 2004, p. 51). The minute particulars are the first step in how the conversation needs to take place, rather than what needs to be said, focusing on micro-expressions that reflect the nuances of feeling (Guthrie & Moorey, 2018).

The minute particulars are noticed and regarded as "cues". Picking up cues is a key technique that brings together the theory of PIT: identifying present feeling and immediately resonating through coupling, amplification and representation via symbolic language. It is imperative that the words of the therapist are congruent with the cue (attending to non-verbal behaviour, whilst staying close to the words of the service-user). Congruence is associated with a 'fit' and positive affect, but incongruence can lead to feelings of persecution (Korner & McLean, 2017; Meares, 1999, 2004; Meares & Hobson, 1977). The therapist then amplifies, building on what is most alive, consequently increasing the feeling of awareness and personal being (Meares, 2004). Evidence suggests that focusing on small changes within therapy can impact session outcome, as service-users are encouraged to stay with and explore challenging feelings (Hardy et al, 1999; Mackay, Barkham, & Stiles, 1998; Rudkin, Llewelyn, Hardy, Stiles, & Barkham, 2007).

The symbolic resonance created between the service-user and therapist is represented verbally in the form of hypotheses. There are three types of hypotheses. Firstly, understanding hypotheses, which present a tentative description of the cue the therapist has picked up, such as noticing a shift in emotional expression, or picking up on a symbol presented (e.g., "It seems like you felt on edge…"). Secondly, linking hypotheses aim to further explore tentatively to patterns in events and/or relationships, such as within therapy, in related interpersonal situations in past or present (e.g., "I'm wondering if you worry that I will not understand either…"). Lastly, after insight from the service user, explanatory hypotheses aim to suppose the reasons underlying the pattern. They are the "because…", the fear that underlies the conflict/avoidance, such as abandonment (e.g., "I wonder if you are worried that if you open pandora's box, the feelings will overwhelm you" [Barkham et al, 2017; Hobson, 1985]). Importantly, they should use service-users own words to enhance their narrative and base these on present cues. This would relate to the therapist attending to the 'state' aspects of empathy, noting the changes in context (Cuff et al, 2016). This illustrates that attending to just the affective or cognitive aspects, ending in the emotional response of empathy is insufficient for PIT. It requires a thinking about what is present and congruent, then a consideration over what is appropriate to share through hypotheses (Hobson, 1985). Hypotheses aim to organise and encourage the development of a reciprocal "feeling conversation" so that learning can be generalised to the person's life (Barkham et al, 2017; Hobson, 1985; Margison & Shapiro, 1986).

Understanding hypotheses are described as an "expression of empathy" (Hobson, 1985, p. 198). A tentative delivery of hypotheses is crucial to encourage dialogue. Allowing to be corrected permits for the hypothesis to be tested and evolve, reaching mutual understanding though the "resolution of misunderstandings" (Hobson, 1985, p.198; Meares, 2005). Hypotheses are a form of empathic communication (Korner et al, 2010). that can be arrived at through affective empathy, or cognitive empathy (i.e., through facial expressions, memories or projecting own experience onto the

service user; Cuff et al, 2016). However, Hobson argues that abstract representation of emotion is more connected to affective empathy (Hobson, 1971).

PIT and Empathy: Broader Issues

The following section discusses some broader issues raised by the review that must be considered if we are to understand the relationship between empathy and PIT.

It is not surprising that PIT has empathy as a core component, as Carl Rogers' person-centred counselling was a key influence and had compatible principles of empathy (Barkham et al, 2017). Rogers' (1980, cited in Greenberg et al, 2001) description of empathy conveys a crucial therapist stance, to build meaning, which involves sensitivity, willingness to understand a person's inner experiences and perspective. To communicate this empathy, it is not just repeated back but captures the implicit and explicit nuances of feeling. Rogers' notions of empathy within the therapeutic sphere can still be felt in contemporary therapies (Feller & Cottone, 2003). Empathy was clearly distinguished from sympathy, which Rogers scorned. Rogers viewed the meaning of feeling as the priority, developing the sense of safety necessary to permit productive exploration (Elliot et al, 2011). Despite its Rogerian influence, PIT has distinguishable features to person-centred approaches, particularly its psychodynamic roots. PIT uses the ability to make dynamic interpretations, ability to work with avoided feelings, balancing interpretation in a supportive manner, and working with the relationship (and the feelings between therapist and service-user e.g., transference and counter-transference) as the vehicle for change (Lemma, Roth & Pilling, 2008). The use of symbols and semiotic language is also provided in contemporary reviews of empathy (Aragno, 2008).

The impact of culture on empathy is important to consider within PIT. Cultures may vary on how feelings and experiences are interpreted (Cheon et al, 2010). Symbols, through idiom, are a crucial part of the communication. However, there is evidence that metaphors and sayings (such as expressions of pain) are culturally specific (ibid). Some non-verbal behaviours are universal and others not (e.g., some cultures may nod when not understanding). There is evidence that similarities in therapist and service-user culture may result in them being more attuned, which supports better understanding and affects emotional reactivity in the therapist (Cheon, et al 2010). As non-verbal expressions of empathy are seen as crucial in therapeutic safety, it is perhaps not surprising that difficulty interpreting cues has been found to impact on quality of care and service-user dissatisfaction (Lorié, Reinero, Phillips, Zhang, & Riess, 2017). Consequently, as a modality that uses potentially culturally specific idioms, Lorié and colleagues (2017) suggest that therapists should investigate local cultural nuances and attend training on relevant cross-cultural communication. Training would lower the risk of implicit biases and perceived prejudice in service users. Enhancing cultural empathy is very much in the spirit of PIT which fosters "genuine, respectful curiosity as well as… tolerance of uncertainty or ambiguity" (Gibbons, 2011, p. 245); it is not typically referred to in papers on the model, however, and may therefore be overlooked by therapists.

Therapist perceptions of therapy are often inconsistent with service-users' (Nienhuis et al, 2018). This is perhaps reflective of the limits of empathy, that often the affect (such as emotion contagion) is a triggered response rather than always the same response (Hall & Schwartz, 2019). For PIT, a model where the relationship is seen as the main vehicle of change, a recommendation would be to review the process with service user feedback to maintain shared curiosity and resolution of misunderstandings (Hobson, 1971, 1985).

Wild (2020) states there is "no algorithm for empathy" (p. 339). Wild (2020) reflects on the effects of behavioural training techniques for empathy (i.e., being taught things to say or do that show empathy "without engaging in lengthy conversations about patients' emotional experience" such as showing a "caring glance" such as the E.M.P.A.T.H.Y skills; Riess & Kraft-Todd, 2014). When put in practice, such techniques can be viewed as hollow if they are not accompanied by attending congruently to present cues, resulting in the service user feeling alienated. Empathy is "an inner experience, rather than an outer act" (Wild, 2020, p. 340). Can behavioural techniques be truly empathic in the absence of true feeling, or are they simply sympathetic platitudes? Wild (2020, p.342) suggests forgoing scripts and encourages "being with the patient", which gives contemporary endorsement to key empathic principles of PIT (i.e., "empathic resonance" [Meares, 2000, p. 71], "mutuality, a feeling with," [Hobson, 1985, p.10]). This supports the careful balance between separateness and merging because some merging

is necessary to avoid the feelings of alienation (Cuff et al, 2016). Additionally, this supports the difference between aspects of the therapist empathy model. Knowing about empathy is not enough alone, it is simply 'jam jar' knowledge. True empathy requires feeling with, empathic attitude or empathic attunement (Thwaites and Bennett-Levy, 2007).

Furthermore, Thwaites and Bennett-Levy's (2007) model refers to the "self as therapist" (empathy techniques, cognitive ability) and "person of the therapist" (empathic ability/attitude developed through childhood, predominantly affective; p. 602). These processes are developed through self-reflection, practice and feedback. The model illustrates that both processes are needed to create meaning for complex feelings or when a person is in dire distress, a core need in people who have difficulties with interpersonal relating. Incorporating these ideas can inform therapy training and supervision practices within PIT. Training should combine a focus on empathic skills and the underlying stance, representing the heart of the model, through relationships (Paley et al, 2008; Teófilo et al, 2019). The evidence indicates that training should be experiential, taking the role of the service user, and then followed by guided reflection (Brunero et al, 2010; Engbers, 2020; Gibbons, 2011; Levett-Jones et al, 2019). Training and supervision should also manage the risk of burnout by encouraging the use of emotion regulation strategies in difficult empathic encounters (Hunt et al, 2017).

A key finding is that empathic failures can be as therapeutic as empathic accuracy (Cuff et al, 2016; Meares, 2005). Indeed, there is a growing evidence that attending to and repairing therapeutic ruptures result in positive outcomes of therapy (Safran, Muran, & Eubanks-Carter, 2011). Therapist mentalisation, an analogous term for a cognitive feature of empathy, is thought to mediate the resolution of ruptures (Safran, Muran, & Shaker, 2014). Attending to ruptures, however, requires the same tentative nature of linking whilst monitoring what is shared regarding the communication of the emotional response/outcome of empathy (Safran et al, 2011). Too empathically accurate can be punitive (Meares & Hobson, 1977), however empathic failures can also reactivate traumatic experiences from development (Gibbons, 2011; Meares, 1995). Accurate therapeutic empathy is often recognising misunderstandings and spending time to understand the service-users experience more (Gibbons, 2011). Therefore, there is a meta-empathic approach to be held within PIT, which is to gauge the appropriate level of empathic intensity. This can be cultivated using key principles of PIT such as a negotiation, collaboration and creating a shared language that is rich in personal meaning and reviewed through reflection (particularly listening to audio-clips; Barkham et al, 2017).

This review followed the recommendations of Baumeister and Leary (1997) for narrative reviews of theoretical concepts, which were considered most appropriate to our aim of examining and clarifying the relationship between empathy and PIT. The search process outlined in the method is replicable. An alternative might have been to adopt a scoping review methodology, a lesser-known approach designed to provide an overview of all the available literature in an area (Arksey and O'Malley, 2005). Arksey and O'Malley (2005) depict an explicit framework to conduct these reviews to provide an overview of all the available literature, rather than to synthesise them. This could have lowered the risk of bias by allowing for more replicability of data selection and summary. On the other hand, we sought to identify the literature on PIT and interpret through the lens of theory and models of empathy. Indeed, as it is a theoretical review that required a synthesis of predominantly conceptual literature, it does not lend itself to a scoping review. Instead, a narrative review process follows the integration of multiple theories to allow conclusions to be drawn (Baumeister & Leary, 1997). Yet, this raises the question of bias as interpreting data is subjective, even if the data selection process is replicable. Narrative reviews offer a construct to allow synthesis of theoretical data, but, due to its weight on interpretation, illuminates the risk of bias in this approach. Consequently, conclusions need to be viewed with this in mind.

Conclusion

The purpose of this theoretical review was to examine and clarify the relationship between empathy and PIT. Furthermore, the review hoped to elucidate the nature and role of empathy in PIT, with a view to understanding how the therapy relieves distress and how PIT training and delivery can be enhanced. By drawing links between PIT theory and the wider academic literature on empathy, we also sought to develop a deeper understanding of how basic PIT techniques might be used to enhance empathic communication and

resolve interpersonal difficulties outside the purely clinical sphere.

Empathy is a multi-faceted concept that has been poorly understood over the years, resulting in a plethora of incompatible definitions and potentially unhelpful measurement tools (Hall & Schwartz, 2019). The definition derived by Cuff and colleagues (2016) is that empathy is an emotional response to another's emotional state that arises as a result of multiple cognitive and affective processes, both intentional and automatic. There are many traits and processes that can facilitate (such as priming using reflexivity or a compassionate, empathic stance; Thwaites & Bennett-Levy, 2007) or block the creation of this state (such as anxiety and personal distress; Boorman et al, 2019) but these are not empathy per se. Researchers and theorists need to be careful to clarify what they mean when they use the term empathy, or say that therapists should "empathise", because of the multi-faceted nature of the concept (Hall & Schwartz, 2019).

Our analysis suggests that empathy is of central importance in PIT. Although most PIT theorists tend not to make detailed, explicit reference to empathy, and the general academic literature on empathy is very rarely cited in their works, it is evident that empathy relates to PIT in numerous ways. PIT therapists are encouraged to draw on both cognitive and affective processes to recognise their clients' emotional state as it is reflected in their own thoughts and feelings, using both spontaneous emotional responses and deliberate mental simulation to feel/think their way into another's shoes. An optimum (accurate but not intrusively so) level of empathic congruency or "fit" is sought and then communicated through core PIT techniques (e.g., tentative understanding hypotheses; the development of a mutual feeling language). By mirroring the client's emotional state, the therapist enables the client to (re)construct and (re) connect with their sense of self, generating feelings of vitality, warmth and intimacy (Meares, 1999, 2005). The PIT concept of aloneness-togetherness captures the kind of empathic relationship that is sought in therapy, where self and other are connected (i.e., have a shared emotional experience) but also separate (i.e., differentiated; Cuff et al, 2016; Hobson, 1985). By this view, all of Thwaites and Bennett-Levy's (2007) therapeutic empathy skills and behaviour (empathic attitude, attunement, knowledge and communication) are central principles and interventions in PIT.

A common topic in the wider academic literature is how to enhance empathy, yet psychotherapeutic techniques are rarely considered in this field. Guthrie and colleagues (2018) evaluated the impact of training practitioners from other modalities in basic PIT skills to enhance empathy; this might be applicable beyond the therapeutic sphere. The review highlighted that PIT could fill current gaps in the literature regarding explicit skills in how to foster empathy (such as attending to minute particulars and coupling by picking up cues), how to reflect on the relationship between therapist and service-user (using aloneness-togetherness), and finally, how to summarise these using words in a way that provides a feeling of fit (Meares, 1999, 2005). Furthermore, attention is prioritised if there are ruptures, reflecting the importance of the relational even in cognitive models (Thwaites & Bennett-Levy, 2007). The research surrounding this depicts the importance of empathy (such as Thwaites & Bennett-Levy, 2007), however there is little explicit information available about how empathy is fostered (i.e., suggestions to show empathy through "empathy dots" without a description of what this entails; Richards & Whyte, 2011). Recent work suggests that PIT can be used as an adjunct to enhance empathic behaviour in other therapies, using transtheoretical principles (Guthrie et al, 2018). Furthermore, due to the importance of all aspects of empathy in promoting social cohesion (through building secure relationships through all life stages; Gibbons, 2011; Boele et al, 2019; Sened et al, 2017; Silke et al, 2018), and prosocial behaviour (de Waal, 2008; as well as lowering risk of aggression and violence; Harris & Picchioni, 2013; Mitsopoulou & Giovazolias, 2015), PIT provides both a conceptual framework and simple steps to foster this within life more generally.

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The inanimate and the selfobject: how connections to non-humans support a cohesive sense of self

Leo LaDell

ABSTRACT

In Kohut's original introduction to the concept of a selfobject (2009), it is conceived as a person who provides certain self-supportive functions to a subject. Subsequent writers extended the idea of a selfobject to focus on a function in which a subject has subjective intrapsychic experiences in relationship with another. Such experiences may serve both enhancing and limiting roles. This dissertation will investigate how selfobject relationships can exist between subjects and inanimate objects or conceptual entities. Clinical material will support the conclusion that relationships with non-human living things, art forms, and other venues for personal expression provide enlivening, valuing, self-building experiences of a similar quality to interpersonal ones. Possibilities for working with these relationships in a clinical setting will be explored.

INTRODUCTION

Psychotherapeutic work in the Conversational Model involves supporting the growth and maintenance of the patient's sense of self (2012). The theory and practice of the Model guides the practitioner in establishing a welcoming environment where an empathetic focus on the minute particulars (Meares, 2005) of the therapeutic conversation nourishes the self. In addition to a catalogue of difficulties, patients often bring assets to the work that reflect their self-supportive experiences in previous relationships. Therapists have the opportunity to aid in the exploration of these experiences. When considering the type of connections that are supportive of the self's cohesiveness and robustness, Kohut found that "the self, in order to emerge from a less differentiated matrix, needs certain kinds of inputs from objects to achieve and maintain the self's cohesion, boundaries, vitality and balance" (Wolf, 1994, p. 3).

In agreement with Meares' (2005) understanding of the importance of empathy in the therapeutic setting, Kohut suggested that empathy serves as a vital self-supportive input for the patient. He noted that patient self-cohesion declined as a result of empathic failures. Objects which provide inputs that potentially function to the self are called selfobjects. For Kohut (2009) these selfobject functions constitute needs which are present for all to a varying degrees throughout the lifespan (Wolf, 1994). He noted that having beneficial selfobject experiences doesn't remove the need for them; such experiences help one choose and use selfobjects better (Lichtenberg, 1991). When these needs are unmet or denied, or when problematic selfobject experiences occur, self-cohesion diminishes. Kohut's selfobject theory represented a signification change in direction from previous perspectives on patient needs. Kohut considered the felt or expressed needs to be legitimate attempts to repair self deficits, so a patient's attempt to elicit a response from the therapist is not defensive (Bacal, 2013).

Since selfobject relationships exist throughout the lifespan, practitioners can expect patients to have experienced them prior to therapy. This provides a potential model of beneficial connection that can be usefully explored in the therapeutic relationship In order to understand the nature and benefits of selfobjects, I will consider what sort of objects or experiences qualify and how they affect subjects. The investigation begins with a consideration of selfobject characteristics. My personal journey towards a sense of their importance follows. With selfobjects described, I will explore the possibility of relationships with non-human selfobjects. Two case examples will illustrate such connections, including a personal account and a clinical patient experience. The final section suggests possibilities for therapeutic work with selfobject relationships.

What Can a Selfobject Be? Or: What Can Trigger Selfobject Experiences?

To be considered a selfobject, something must provide certain functions that affect the self. The effect may be beneficial or detrimental to the self depending on the nature of the experience (Lichtenberg, 1991). What sort of functions must be

there, and how will we know whether the self has experienced these functions? I will explore these functions and then consider the nature of a self, with emphasis on its cohesiveness.

Kohut (2009) seemed to sometimes suggest that only self-supportive, vitalising relationships can be selfobject relationships, and at other times he refers to detrimental selfobject relationships (Lichtenberg, 1991). For brevity I will use the terms 'selfobject', 'selfobject relationship', and 'selfobject experience' to mean self-beneficial phenomena unless noted otherwise.

Since the introduction of the term selfobject, numerous writers have expanded on the concept and have shifted focus from selfobjects to selfobject experiences. Lichtenberg (1991) notes that many selfobject relationship trigger an intrapsychic experience, so there is less emphasis on the nature of the selfobject and what it provides, and more on the felt experience of a subject who is in relationship with a selfobject. The subject has a sense that the feeling is connected to the relationship; i.e., there is a feeling that the selfobject is at least part of the 'source' of the feeling (Bacal, 2013 p. 22). For the subject, the sense that the relationship is providing something is metaphorical; e.g., is a subject feels as if the selfobject relationship makes them more capable, this is not an assertion that the selfobject literally 'transfers capability' (Lichtenberg, 1991). Wolf (1994) contends that not all interpersonal experiences are selfobject experiences. For example, learning a skill from a person with whom there is little sense of connection, support, or intimacy is an interpersonal but not selfobject experience.

With the premise that selfobject relationships support self-cohesion, and emphasis shifted from the nature of a selfobject to selfobject experiences, two factors must be considered for this investigation: what do selfobject experiences offer, and what are the effects for the self Kohut (2009) explained that selfobject relationships had a transference-like quality, and he suggested three types of transference: mirroring, idealising, and twinship. Subsequent contributions (Wolf, 1994) have expanded the list to seven types as described below:

Mirroring: the feelings experienced by the subject include acceptance, receiving a response from the other, affirmation, and worthiness.

Idealising: the subject experiences a connection with a powerful, capable other who offers protection and seems to have "qualities the subject experiences as lacking in the self" (Wolf, 1994, p. 6). This may feel supportive even for those whose previous encounters with powerful other were painful — when we might expect the subject to eschew the concept of a 'superior' other and an 'inferior' self. Fairbairn seems to support the felt need for type of experience when he notes that for some subjects, it is "better to be a sinner in a world ruled by God, than to live in a world ruled by the Devil" (Fairbairn, 1943, as cited in Davies, 2004, p. 722)

Twinship: the subject feels fundamental similar to the selfobject, including tastes, habits, appearance, or opinions.

Merger: this transference experience is thought to be primitive, as it may indicate the subject's difficulty in acknowledging another's subjectivity. The self needs to feel part of one whole with the selfobject.

Adversarial: the selfobject is experienced as limiting (with a nonetheless supportive tone) and provides boundedness and a sense of autonomy for the self, confirming that the two are not, in fact, one. This provides space for the subject to exist as an independent self. This might be considered to be opposite to an intrusive other which allows no independence. Subjects sometimes feel the need for the holding, limiting experience of another to support boundedness. Lichtenberg (1991) suggests that adversarial relationships can also inspire vitalising feelings of resistance and anger.

Efficacy: the subject has the experience of eliciting a response from the selfobject and may benefit from the feeling of agency in triggering this response.

Vitalising: the feeling of attunement from the other is experienced as being flexible based on the subject's inner state. This feeling of being understood is a critical feature of the selfobject experience; As Meares suggests, it "is not admiration but connection" (Meares, 2005, p. 35) that is crucial in providing the sense of value that support the growth and maintenance of self.

What is the nature of the self that these transference-like experiences are thought to support? Kohut did not offer a thorough definition of self but suggest it was the "initiating center of the personality" (Banai, Mikulincer, and Shaver, 2005, p.225). Within the Conversational Model, Meares

(2012) has focused on a Jamesian notion of self which depicts the robust self as having duality, movement, positive feeling, nonlinearity, coherence, continuity, temporality, spatiality, content beyond the immediate present, ownership, boundedness, and agency. The qualities of aliveness and vitality are emphasised, and Meares settles on four central features of self: doubleness, positive feeling, nonlinear movement, and cohesion (Meares, 2012).

For this dissertation I will develop my argument using Meares' four-featured notion of self. If something is a selfobject we can expect it to trigger the transference-like experiences with the result of an increase, perhaps both immediate and over time, of the presence of these four features of self. Some authors have tested this supportive connection between selfobject relationships and self. Banai et al. (2005) investigated whether unmet or denied selfobject needs lead to lack of self-cohesion. By operationalising Kohut's understanding of selfobject with inventory of questions for study participants, the authors determined that fulfilment of selfobject needs is indeed important to self-cohesion. They contended that unmet selfobject needs, or absence of selfobject experiences, can lead to self disorders, pathological narcissism, low functioning, and poor affect regulation. I begin considering non-human sources of selfobject experiences by describing a personal journey towards understanding the need for self-supporting experiences.

APPROACHING UNDERSTANDING OF THE NEED FOR SELFOBJECT EXPERIENCE

Some years before I began my studies of psychology and psychotherapy I noticed a curious phenomenon that appeared in my self and some others. There appeared to be exceptions to general difficulties with confidence, self-esteem, and assertiveness. An artist friend who had been diagnosed with a self disorder usually seemed highly anxious, even to the point of visibly trembling, in the presence of strangers. He often expressed harsh self-judgements that seem to exemplify Meares' (2012) 'scripts': saying that he was incapable, worthless and the like. However, when this man discussed the songwriting of favourite musicians or the drawing of artists he respected, his demeanour changed visibly. His voice became steadier and stronger, the trembling ceased, and he spoke knowledgeably and confidently about these apparently beloved topics.

As I began to gain competence and interest in performing and learning about music, I seemed to see similar phenomena in others. In the recording 'Trouble Don't Last' by Eddie Jones (performing as Guitar Slim), some studio chatter is included. We can hear the singer talking to his band and responses as follows:

> Studio Staff: "Take 5"
>
> Eddie, in an apologetic tone: "I should have all this stuff wrote down, that's what I should have. It's hard to think of 'em, it's hard to think of 'em, man, I'm telling ya" — apparently struggling to remember a song or lyrics.
>
> Studio staff and other musicians, in an impatient tone: "We're waiting on you", perhaps informing him that he is 'wasting' time.
>
> Eddie, in a quite deferential tone: "Ok, All right, all right".

(Vincent, 1991)

The tone of this last utterance of Eddie's seems troublingly familiar from my childhood in the American South: a victim of racism seeking safety through apparent deference. However, Eddie then begins to sing, and the power, vitality and confidence in his voice is striking. We seem to hear the unapologetic voice of a robust self. I noticed this contrast in other performers who almost seemed to be two different selves: the non-performer and the performer.

I too experienced differing internal states when performing and non-performing. When I pick up an instrument, with an audience or not, I feel fully myself with an effortless shedding of tendencies to comply with others' apparent wishes (as discussed in detail in the case example section below). As I considered what might explain these different self states, I found a metaphor useful: a garden of selves. As I learned about the nature of a robust self in studying the Conversational Model, I wondered whether it would be useful to think of people as having many selves rather than one, with a range of robustness among them.

As in a garden, each self begins as a seed in early childhood, and while some flourish with nourishing conditions others struggle to grow or

lay dormant in when an enriching environment is lacking. In myself I felt that while disagreeing openly with an authority figure was forbidden in childhood, pursuing academic achievement was encouraged and respected. So the 'seed' of speaking my mind struggled, while I felt relaxed and confident — as if a strong tree — in academic settings.

Reflecting on the idea of many selves altered an idea of the self that I had formed in a personal therapy relationship. Through this work I realised that from my earliest memory I had behaved and felt as if in any relationship between two people (and particularly within my earliest relationship, mother-son) there is only one self, and its ownership is contested. In a doer and done-to struggle, the self is the prize claimed by the more powerful participant (Benjamin, 2014). This idea of one contested self sat alongside the multiple, or 'garden of selves' notion, but the two concepts did not fit together well. I had difficulty reconciling many-selves with one self.

As I learned some of Meares' (2005) theory about development of self, including how parents' (or later, therapists') attunement, empathy, and establishment of a play space support the self's growth, I began to understand the genesis of my feeling that my self was under threat or sometimes lost to another. I concluded that each of us has a self (or feels a sense of self), but in adverse conditions, the self goes offline in a manner suggested by Hughlings Jackson's notion of dissolution of self (Meares, 2005). This left me with the question of how to explain experiences that have no human other but nonetheless appear to support the self's cohesion (i.e., the self being 'online') in a way that resembles a beneficial intersubjective human relationship.

Kohut's (2009) description of selfobject relationships as providing self-supportive functions seemed to offer an explanation for the phenomena I noticed in myself and others. Perhaps instead of many selves with varying robustness, we have one self and many selfobject relationships. Studying the work of additional authors (Lichtenberg, 1991) who explored selfobject relationships suggested the possibility that selfobject experiences have a similar intersubjective feeling to the self-supportive relatedness described by Meares (2014). This left one consideration to explore: if multiple felt self-states can be described as selfobject experiences of one self in relationship with a nurturing other, could that other be a concept, art form, or inanimate object as I suspected?

Relationships with a concept or thing

In a discussion of art and selfobject experiences, Author Carl Rotenberg (2013) contends that paintings can trigger selfobject experiences. He notes that the intrapsychic feelings involved in viewing a painting have a self-supportive function that resembles human relationships. Rotenberg contends that the relationship involved is between the viewer and the painter; i.e., the painting has selfobject qualities because of the human behind the creation. If, for example, a viewer feels a sense that the painting connects with their inner self, this is a feeling of the painter connecting to the self. There is therefore support here for the notion of an inanimate object triggering selfobject experiences, but only if the object was created by a human. Perhaps for theists we might expect such selfobject relationships to exist due to the connection between a self and the God that created the object. One may feel sustained or heartened by a rainbow not for its colour or rarity, but due to the notion that its creator's beneficial intention was evident. However, this does not explain self-sustaining relationships with objects or concepts which — to a given self — do not feel connected to source or designer

In another investigation of non-human selfobjects, Sue-Ellen Brown conducted a series of interviews to determine whether companion animals were a "provider of self-cohesion, self esteem, calmness, soothing and acceptance" (Brown, 2007, p. 329). She found that relationships with animals can trigger selfobject experiences. While we may hold (cognitively) that a pet's subjectivity is different from a person's (e.g., a guinea pig may value a person in some sense, but not in the same sense that a human can value someone), our tendency to interpret the experience as valuing may be what is important. Indeed, this interpretation may be unconscious and may be evidenced by experiencing the feeling that results from 'being' valued. Brown considers the relationship to exist between the self and the animal — not between the self and a human or other designer that created the animal.

These discussions suggest that a selfobject may not need to actually have subjectivity (e.g., an inanimate object like a painting); nor does the self have to believe it was created via human subjec-

tivity (the artist behind the work). It merely has to trigger a feeling of the other's subjectivity. A dog who lays her chin on our knee when we are sad may not understand our sadness in the way a human would, but if we feel cared-for and perhaps valued, this provides a selfobject experience.

What comes before us and what we create: Forms and Ideals

In some cases relationships with concepts may trigger an intrapsychic experience that occurs in early selfobject relationships. The newborn arrives with the mother, father or other caregiver already there. We might suppose that the infant has no concept of the caregiver ever having not existed: this comes later. Perhaps one facet of the potentially self-sustaining nature of this early relationship is its timeless, eternal and therefore reliable quality. If the caregiver always was, then perhaps they will always be, and the infant may feel held by this reliability.

A concept can also feel as if it has always been. In the Phaedo, Plato writes in the character of Socrates:

> And if it is true that we acquired our knowledge before our birth, and lost it at the moment of birth, but afterward, by the exercise of our senses upon sensible objects, recover the knowledge that we once had before, I suppose that what we call learning will be the recovery of our own knowledge, and surely we should be right in calling this recollection.

(Hamilton and Cairns, 1985, p. 59)

Plato's argument is based on the notion that from our earliest awareness life, we understand some concepts without being taught. For him is follows that we recollect knowledge of the essence or form of equality, good and similar concepts. He contends that both they and our souls existed before birth, and since they have always been, they must have an existence separate from humans. Thus equality is an ideal, and pursuing it may feel like connecting with an idealised other: a transference-like, self-sustaining experience. We might wonder whether Plato, in positing the existence of eternal ideals, was exhibiting the inherent need for selfobject relationships described by Kohut (2009).

Those who attempt to relate with concepts through acts of behaving or creativity may enjoy a self-sustaining sense that they have connected with an ideal other. One who thinks they have acted wisely or (like my artist friend) created a drawing that successfully depicts the essence of a scene can feel that they have generated something eternal; while they know the action or creation is ephemeral, its relationship to an eternal quality (Wisdom or Art) offers a feeling of permanence: whatever happens in the future, the self will have made a mark that connects with an ideal. This may provide a powerful sense of agency: a connection with an impermanent selfobject such as a person might feel precarious: if the other is lost, then perhaps the self will lose the self-supportive benefits of that person. By contrast, a selfobject relationship with an eternal concept or ideal might offer a feeling of reliability that resembles a young infant's sense of a mother's permanence.

Hagman (2013) considers the ability to cope with another's subjectivity (and perhaps their vulnerability or death) to be a feature of mature selfobject experience. Thus relationships with concepts may be more easily established for selves in an archaic or immature state. I will explore the clinical implications of this notion at the end of this dissertation. In the next section I will use two cases to further explore whether concepts and inanimate objects can trigger selfobject experiences that support the self.

Case Example One: Personal Development and Selfobject Experiences

I was born in the late 1960s in the American South to a mother who longed for a male child after the arrival of three daughters. The expectation combined with a fixed blueprint concerning the behaviour of children to offer little or no understanding of my inner state. I was not received as a unique individual but rather as 'the son'. While this dynamic came with numerous gender-based limits, an overarching demand was felt as far more important: loyalty, expressed as obedience. In our family a child's greatest sin was disobedience and the highest goal compliance.

Obedience was expected not only in behaviour but in beliefs and opinions; for example, if our mother preferred a certain race, religion or even model of car, deviation from this preference was not tolerated. What would happen if we did not comply with commands and views? It is perhaps

a reflection of the intensity of these expectations and the earliness of my exposure to them that I can find no adequate words to describe the consequences. It amounted to loss of love and relationship with a dreadful tone, but without a rational sense of specifics.

My earliest experience of my mother was of a monolithic, powerful authority whose orders must be obeyed in exchange for safety and caretaking. I had little opportunity to exist in a play space with an unintrusively-attending other: I most often received intrusive direction or lack of interest (Meares, 2005). However, by early childhood I sensed her persistent anxiety and horror when faced with her own or her children's vulnerability. She seemed to experience what I would later learn to call reversals: "oscillations in selfstate" (Meares, 2014, p.87) that would lead to shifts from narcissistic inflexibility to helplessness. The result was that some affects of the children (e.g., anger) were rejected with fury and implied threat, while others (e.g., fear, sadness) aroused her terror. Most of my emotional experiences received no attunement or understanding, and this had numerous effects, including a deficit in my sense of autonomy and agency, and my inability to experience her as a selfobject.

The latter challenge was worsened by my growing awareness of her vulnerability. I was unable to maintain idealism of her strength, capability and wisdom as the falseness of her confidence emerged. Her battle with alcoholism during my late childhood and teenage years underscored her fragility but did not lessen my feelings of dependence. Indeed, I continued to feel the sense that my subjectivity was unseen even as I could see how little she truly valued her own. I was left ambivalently attached: a self feeling a deep sense of vulnerability and need for support, while recoiling from and avoiding the falseness of what was offered. These offerings were adequate for a pet: food, shelter, treats (freely and generously given) and the promise of caretaking. However, this combined with absence of attunement to my inner experience to resulted in a slave-like feeling of obedient, abject dependence alternating with simmering rage and fear.

While this difficult experience left me with a self ill-prepared for mutually fulfilling human relationships, it allowed for growth in some areas. Academic achievement was respected, so when engaging in school and related activities I enjoyed greater confidence and a sense of groundedness. The same benefits applied traditionally male pursuits such as certain sports. I enjoyed these while receiving approval for engaging in them.

I felt that some other activities were 'my own' due to the absence of input from my mother or others. I loved listen to music, playing games and watching television, and I was free to choose how (and in some cases when) I did all of these things. I had no fear of doing them 'wrong' nor anger or shame at complying in doing them 'right'. All of these areas of self development were precious to me, but the tendency for my self to go offline in the context of relationships continued to be painful as I entered adulthood. I lacked sufficient selfobject experiences to support robust self-cohesion.

In close friend and romantic relationships, the doer and done-to dynamic undermined the establishment of selfobject experiences (Benjamin, 2014). Like my mother, I experienced reversals, though with perhaps less frequency and force. In relationships I alternated between two poles: feeling that I must comply with others' apparent needs in a pathological accommodation that engendered shame (Brandchaft, 2007); or angrily feeling that the other must comply with (and anticipate) my needs, leading to feelings of guilt for the contempt of the other that I experienced as I shifted from compliance to defiance (Fosshage, 1998). These uncomfortable feelings inspired behaviours that mimicked my early 'rewards' for compliance; e.g., using food as a treat. These behaviours, with hollow, brief feelings of relief, provided no deep nourishment. I found little room in between these two ends of a continuum, as my self followed its familiar path.

A profound change in my self began with a new relationship with music. By the time I entered university, I had enjoyed listening to music for many years. I had developed a taste in music which felt personal and even played some music casually. I hoped to one day play music publicly but could not apply myself to the task, starting and stopping numerous times. This was a solo pursuit, and while I had experienced no intrusion in my musical development, I had also felt little support or interest. My father taught me some basics, but a divorce and the redirection of his attention away from family ended that musical relationship.

While at university I saw a live Blues performance where multiple musicians inspired

me: the sounds and their ability were intriguing, but there was something else: a sense of being in the presence of robust selves — neither offensive nor defensive, as if they were fully comfortable in their right to be on the stage. Their expertise was evident, but I didn't link it with their apparent comfort. I sensed that they loved something in an unguarded way, without apparently worrying how that love could make them vulnerable to being enslaved. I lived the belief that if you loved something, you would never be safe having boundaries with it. This showed that there was another possibility.

This experience initiated a deeper relationship with music: Blues music in particular. The felt sense was that my relationship was with a pure essence of the music, and I developed an aspiration to express this essence as completely as possible. Though I had a love of this essence, it felt possible and desirable to relate to it as my unique self. One of the things I admired about some musicians was that they appeared to maintain their confidence in expressing music in their own way while still remaining faithful to its essence. I did not feel in relationship to other adherents but respected them based on how well they seemed to demonstrate their connection to the music. I did not feel jealous of their relationship with music and therefore didn't tend to feel competitive, but I could feel envy of their ability to channel it.

I seemed to begin a new selfobject relationship; not with other people (the musicians); but with the idea or pure essence of Blues music. I visualised this music as a river, capable of movement and change, but always identified as the same river, with a feeling of it having always been, despite the rational objection that it could hardly have existed before humans did. I sensed that it was waiting for me to arrive and welcomed me. Along with other practitioners, I was invited to enter the river to connect with its essence.

Around the time that my relationship with music deepened, I entered an insight-based therapy which increased my understanding of the challenges I faced in human relationships. A later (and continuing) Conversational Model-based therapy has had profound benefits for my ability to remain a robust self in the context of human relationships. While this therapeutic relationship has been invaluable, my connection to music has been an indispensable factor in my self development. How did this relationship with music provide the transference-like experiences that suggest a selfobject relationship? Following is an analysis of my connection with music based on the transference-like phenomena described previously.

Mirroring: listening to and performing this music offers a feeling of worthiness and acceptance: if I take the opportunity to connect with music, I am rewarded with this feeling, and it feels as if the music is giving me a precious gift.

Idealising: - I hold deep respect for the music and have a sense of its power and strength; I have also discovered that it provides solace — a sense that it is larger than me and that my devotion to it does me credit. I feel that I understand something important and that the music has a timelessness that contrasts with my impermanence.

Twinship: the awareness that this type of music feels special to me among all types of music offers a sense that there is a fundamental fit, match or similarity between the music and me.

Merger - at times, when wondering 'am I doing it right', I feel a need to be perfectly matched with the essence, and can temporarily forget the importance of doing it my way. This sometimes results from a very difficult experience with other musicians or a major musical career challenge.

Adversarial - when distraction, other outside factors, etc, hampers my ability to connect to the river — the essence - I am shown that I am off track by the absence of the sound I seek and the good feelings it can offer. Rather than wanting to quit, I generally feel inspired to try harder as a result.

Efficacy - when the relationship seems robust, it feels as if playing music gives me feedback in the form of a feeling of well-being or even joy. The music also seems to offer access to my own feelings and provides a holding environment (Meares, 2005) for some feelings to emerge. I have some control in eliciting this response, as it only happens when I am devoted and let my defences go.

Vitalising - how can the essence of Blues music 'understand' me or fit with my inner state? There is a feeling of meaningful coincidence when I hear music that happens to fit my mood, and I nearly always find something in music that touches my inner state. It feels as if the particular music is just what I needed, and when I pick up a guitar, it is always possible to make music that fits my inner experience.

The presence of these transference-like

phenomena suggest that my relationship with music has triggered selfobject experiences. Using Kohut's (2009) notion that selfobject relationships support the self, we can consider whether my relationship with music had beneficial effects on my sense of self, with four features as described by Meares (2012).

Doubleness: when I speak about, perform, listen to or in other ways pursue my connection with music, I find myself able to reflect on the inner feeling in these experiences and become aware of how its apparent effect on others arouses thoughts and feelings with myself. I attribute this — at least in part — to the holding environment the connection provides as a protection from decent down the hierarchy of consciousness (Meares, 2014) to a more defensive position. For example, a person can trigger conflict when I am performing by perhaps making a demanding request. If such a request was made in another setting, I might struggle to think clearly, mired in a trauma system (Meares, 2012), torn between a fight-stance of wanting to attack the request or a flight-stance of complying (with underlying shame), likely resulting in a freeze response: no action, and the suspension of my ability to access a genuinely self-guided response. However, if the request comes while I am on stage, my service to the essence of music and its holding of me support a calm reflectiveness. With little or no urge to defend myself, I would be able to consider how I would like to respond to the request.

Positive feeling: a change comes over me when I pick up a guitar or other instrument: I feel strength, safety, and groundedness. The feeling tone is both internal and external: I am safe within and without. On multiple occasions friends or acquaintances have commented that relating to me when I am at a performance feels quite different than at other times. This apparent change in the expectational field may reflect my different inner state (Meares, 2014).

Nonlinear movement: this aspect of music's effect on my self is apparent in improvisation, which is ubiquitous in Blues music. When I perform, listen to or write music, thoughts and feelings arise from countless sources, often layered with meaning and connections to other experiences. All of my performing has an improvisational quality, and even within the structure of the music, I feel free to interpret and express whatever arises with a sense of trust in that freedom. When connected to music I experience flow and momentum. With this persistent inertia of self, inner calm prevails; a welcome change from a frozen self, which scrambles anxiously to find safety.

Cohesion: music offers me a sense of who I am and who I am not, as in the expression to 'know my own mind'. Within a trauma system I lose who I am, but when connected with music, I know that I am both a devotee and beneficiary, with part of me immersed in a self-sustaining river. I am aware of with a sense of the limits of myself. I have the experience of two selves in relationship with others when my connection to music is active. Gone is the feeling of there being only one self, with a winner and loser, or predator and prey. Recalling musical experience seems to activate a right-brain-based access to "emotionally-toned memories" (Schore, 2011, p. 93) that supports affect regulation and protects against the potentially self-threatening nature of uncomfortable affects.

This personal case presentation appears to depict a selfobject relationship with a concept of music, as both transference-like phenomena and benefits to the self are present. A second case example presents a relationship between a self and inanimate object.

Case Example Two: Tamsin

Tamsin is a New Zealand woman in her early thirties who shares custody of two young sons with an ex-partner (their father) and has lived with a new male partner for the past year. Our therapeutic relationship began two years ago when she sought therapy with me for anxiety and persistent feelings of emptiness. Born with parents of two cultures - New Zealand European and Pasifika - she maintains a difficult relationship with her mother and a more comfortable but distant relationship with her father and her younger sister and brother.

Tamsin's parents presented differing parenting styles: her Pasifika mother was intrusive and demanding, and she enforced adherence to her culture. The mother considered Tamsin to be simply Pasifika, with no acknowledgement of her paternal heritage. Tamsin's father was abandoning and apparently surrendered any cultural influence on her to his wife's preference. Tamsin was therefore born into a framework of what her mother believed a Pasifika daughter must be: ceaselessly productive, accommodating to elders and extend-

ed family, high achieving, responsible for the care of younger siblings and obedient to parents commands.

Tamsin's inner experience was alternately ignored or expected to align with maternal views. Despite her mother's agenda, Tamsin found some aspects of Pasifika attitudes aversive; e.g., she valued a regular, plentiful sleep schedule but explained that her Mother's culturally-driven habit of allowing guests to visit and chat at all hours left the children exhausted. However, Tamsin did not consider expressing this view, as she predicted a harsh response. When her parents divorced in her middle childhood, both relied on Tamsin for emotional support and actively sought to secure her loyalty in rivalry with each other. She described a lifelong experience of feeling deeply responsible for the well-being of the other in all relationships.

Tamsin described some painful events which help illustrate a childhood lacking in selfobject experiences. Her father would often spend time in a private room in the home with children prohibited from disturbing him. Tamsin recalls desperately trying to think of justifications for knocking at his door so that she could secure his attention and approval. Her attempts to say just the 'right' thing to inspire his interest were met with criticism and contempt for her evident need. In our sessions Tamsin sometimes becomes quiet and seems uncomfortable. When we discuss the experience she explains that she doesn't know what to say and is afraid of saying the wrong thing and wasting my time.

Bacal (2013) points out that previous selfobject experiences influence a subject's expectations in subsequent selfobject relationships. Many times I felt that Tamsin expected me to show disinterest or even — like her father — criticise her attempt to fill the silence. This expectational field seemed to reflect an ambivalent attachment: despite her apparent expectation that her attempt to connect would fail, she continued to make the attempt (Main, 1996). The lack of connection with her father suggests his unavailability as a selfobject.

After her parents divorced, Tamsin lived with her mother, who spent two years confined to a couch most of the day, withdrawn into emotional distress. Tamsin's job of helping with care of her younger siblings grew into a parent-like responsibility, and meaningful connection with her mother — even with the condition of compliance — was unavailable. It appears that Tamsin's mother may have initially provided some selfobject functions (e.g., idealisation) but later failed to trigger selfobject experiences.

In adult relationships Tamsin demonstrated pathological accommodation (Brandchaft, 2007) with great underlying resentment. She expressed either complete loyalty and obedience or complete avoidance, with little experience between these extremes. Once emancipated from her family home, she minimised contact with her mother, who had returned to her intrusive pattern. Tamsin says that she now desires no relationship with her mother, whose attempts to connect feel false and repulsive. At times Tamsin's resolve wavers, and she re-establishes relations with her mother, but this invariably proves to be painful and short-lived. Tamsin no longer intensely craves her father's attention. She seems to have given up on a deep relationship with him and interacts with him in a casual, surface-level manner.

After Tamsin left home as an adult, she began collecting houseplants. She loves her plants and says that she feels she has a relationship with them. Tamsin calls them her 'babies', and this reflects her sense of their preciousness and her responsibility for their care. As with her children, she feels guilty when they have problems, but with plants she is more able to forgive herself for perceived errors. Houseplants seem to aid Tamsin's reflection and understanding of her human relationships. She once reported that she overwatered a plant in winter, and it wilted. This led her to realise that she was trying too hard to accommodate and win over a potential love interest. In our discussions she theorised that this man was a 'winter tree', who could not tolerate excessive attention. This marked a major shift in her relationships; for the first time, she deeply understood that some of the responsibility for a failed relationship lay with the other.She resolved to seek another form of 'tree' — a man who could receive and reciprocate her care. Her relationship with plants scaffolded her understanding.

With her collection of plants Tamsin experiences far gentler shifts in feeling that with humans. With the latter these changes are sometimes extreme. Tamsin reported the example of loyally reading each of an author's books and recommending them to others with enthusiasm. At some point she would read a sentence or phrase in the book that arouse displeasure, and henceforth she would

never read the author again and would lose all appreciation of her previous reading. With plants she can tolerate disappointment; when one dies she may guilt at first or some disappointment with the plant, but she is able to move on with more humour and a sense that she did her best. Plants appear to offer transference-like experiences as follows.

Mirroring: finding exotic, challenging plants and caring for them until they thrive is affirming for Tamsin and offers a sense that she has done well.

Idealising: she speaks with respect about some plants — 'you can't kill' a spider plant. Tamsin appears to feel that others find her hard to care for and feels guilty about her needs, but she seems to respect the resilience of a spider plant. She also speaks with enthusiasm about the rarity and beauty of exotic plants and seems to feel that they deserve special care. Successes in care for them seem to confer a sense of specialness to Tamsin.

Twinship: her selection of plants and understanding of them is personal. She 'gets' them and feels satisfaction in knowing how to choose once that fit her.

Merger: this only seems to partially apply when Tamsin's mood is quite low as a result of relationship struggles. At these times she may feel that a plant's failure to thrive means that she is a failure.

Adversarial: plants 'tell' her when she has gotten it right to wrong by flourishing or struggling. This gives her a sense that she is in a relationship with another who is separate and won't simply comply nor dominate. The plants respond as if they have desires and feelings separate from hers — and they can refuse to be understood and respond in surprising ways.

Efficacy: when she either intuitively or in a more conscious, organised way relates to her plants in an effective way, they respond by flourishing, giving her a sense of competence and joy.

Vitalising: she sometimes has a sense that the plants behave in ways that match her inner state — when she is anxious and overtending as with an overwatered plant in winter, they droop and decline in complementarity; when she is more settled and relaxed, they thrive.

The presence of these transference-like phenomena suggests the possibility that Tamsin's plants offer a selfobject relationship. We can therefore expect that the relationship will have a self-supportive function:

Doubleness: when another human shows that she is not doing it right, she either complies with resentment or withdraws and shuns them, with little or no access to a non-defence understanding of what she deeply wants. With plants, she is able to withstand their responses to her mistakes; admitting, for example, that she overwatered the winter tree (literally and metaphorically) and reflecting on why she did so.

Positive feeling: her eyes shine and her face changes with a smile, with sounds of relaxation when she discusses plants. She says that when she repots them or prunes them, she gets a deep sense of well-being, and worries leave her for a time.

Nonlinear movement: Tamsin reports that when she is caring for plants or thinking about them, she feels a sense of flow, and her thoughts range — seemingly at random — to memories and associations connected with them.

Cohesion: her love of plants feels authentically her own; she feels competent and even opinionated about which plants she wants and how to best care for them. Tamsin doesn't feel that she must comply with or defend against others' views about plants, and this feels personal. For example: in one of our earliest sessions she reported she always took cuttings from previous therapists' plants . It seemed that she felt it was safe to ask for connection to a part of the therapist's life when it's a plant, but she would not ask for any other 'special' consideration from a therapist. With me, she said that for the first time she brought a plant rather than taking one. Tamsin would not usually assume a therapist wants was she has to offer ('I want to say the right thing'), but when it is a plant, she can confidently offer it. Her valuing of plants seems to help her value herself.

Since both transference-like experiences and self-supportive qualities appear to derive from Tamsin's relationship with plants, I conclude that they are selfobjects for her. The triggering of selfobject experiences by both inanimate objects and concepts suggests that selfobjects need not have subjectivity; they must merely be felt to have subjectivity by a self. In the final section of this dissertation I will consider how this finding may be used in a clinical setting.

Borrowing the robustness of SELF In safe rela-

tionships

According to Graham and van Biene's (2007) hierarchy of engagement, the initial phase of therapy with a patient whose self is fragile benefits from a focus on safety, with little or no inclusion of imaginative play or mutual reflection. The therapist's subjectivity may be difficult for such patients to tolerate. Hagman (2013) indicates that mature selfobject experiences, which are available to more cohesive selves, can integrate the subjectivity of the selfobject. However, when the selfobject has no subjectivity and is only felt to have it, perhaps the self can more easily benefit from the relationship.

When a self is in relationship with a human, the other's inner state is never received with perfect accuracy; the self interprets and makes meaning of the other. However, a fragile self cannot easily find safety through this interpretation when the other intends harm or behaves in a way that strongly suggests a threat. For example, is Tamsin hears another use a loud, strident voice when trying to encourage her, she will struggle to interpret the other as helpful; instead, she will feel their behaviour as a threat. Since she was often felt hurt by others who yelled angrily (and could encounter humans with ill intentions at any point), selfobject experiences will be unlikely for her with those who are loud and strident.

In her relationship with plants, the felt subjectivity of the other is entirely personal and generated by Tamsin's self. She is far more free to interpret the selfobject's nature as beneficial. A human could respond to Tamsin's vulnerability with intentional cruelty, but while a plant may seem to do so (by its failure to thrive for example), it cannot actually be cruel and so will not explicitly or implicitly communicate harmful intentions. A fragile self may therefore more safely establish and reflect upon selfobject relationships with non-humans that with humans. Such a safe selfobject relationship can provide a valuable step towards tolerating human subjectivity. While they may offer what Meares calls "pre-intimate relatedness" (Meares, 2014, p. 149), selfobject experiences may have a self-supportive role that resembles that found in human intimacy.

In the therapeutic relationship Meares (2012) stresses the importance of supporting reflection and responding to moments of aliveness. With a distressed or fragile patient, reflective ability and aliveness my emerge only rarely. A patient may initially present with a story of many failed human relationships, with no exceptions to the chronicle of disappointment (Meares, 2005). By looking out for and attempting to connect with the patient's non-human selfobject experiences, the therapist may find instances of reflection and vitality. In this way some features of a cohesive self may enter the conversation even when they are unavailable in human relationships.

Once in my personal therapy I discussed a difficult early event and experienced painful feelings of deadness and shame. Within this state I said that I wished that in those early years I had felt the way I feel when playing music. My therapist offered a reflection that encouraged me to expand this idea. I related a story of playing a show on a tour far from home, when my mother and some of her friends arrived too late to see the performance due to the driver's error. As I sat on the edge of the stage, still energised by the recent performance, my mother sputtered and fumed, apparently embarrassed but looking for someone to blame.

In other circumstances I would feel immense external internal pressure to accommodate her by downplaying her error or even trying to take some responsibility for it. However, with the connection to music active, I felt completely relaxed, confident, and even compassionate for her embarrassment. I had no urge to be false or accommodating at the expense of my self. As I related this story to my therapist, I felt myself sit up in my chair with a stronger voice and relaxation and pleasure in my face. We spoke both about my anecdote and how it seemed to affect me in the present. I prized this experience for the feeling of understanding and nourishment it offered. When I later learned of James' notion of pure experience as moments where the contiguity of experience is suffused through by intersections with deep layers of meaning and similarity (Meares, 2019), I recalled both my long-ago time on the stage in North Carolina and the discussion of it in therapy with a sense of deep connection and the meeting of inner and outer experience.

Conclusion

The exploration of selfobject relationships involves an understanding of the importance of intrapsychic selfobject experiences. In this dissertations the investigation of the nature of connections

between the self and concepts or inanimate objects focused on whether the latter triggered selfobject experiences in subjects — not on whether their inherent qualities resemble those of human selfobjects. Plants and Music are unlike humans in many ways, but because relationships with these non-human entities involve transference-like phenomena and self-supportive effects, they may be considered selfobjects.

For me, Tamsin, and others, touching into non-human selfobject experiences provides not only a momentary support for self-cohesion; it also seems to combine with our beneficial human selfobject relationships in therapy to increase the robustness of self in a lasting way. Over the course of the two-year therapeutic relationship with Tamsin, both of us have grown in our ability to experience and demonstrate doubleness, positive feeling, nonlinear movement, and cohesion in our selves. This has resulted both in our selfobject experiences in relationship with each other and in our connections to music and plants.

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The session

Loyola Woods-Cameron

Once again, together
Remembering, re-membering
Those words that quicken, moments that thicken,
Warm, connected, language that loves
A mother's mouth offering me
The gift of meaning, the inner seaming
Of self

But she often was not there,
Or being there,
she cut the threads or unravelled the soul.
Or her face was fear,
Hard to come near that…

So now it is you, asked and needed,
That stitches this quilt with me.
Small tiny movements that pierce but join.
We speak, we muse, we shape,
We selve.

Manifestations of the malevolent transformation- using the Conversational Model to work with the darkly disrupted.

Carol Marando

Introduction

This article contains extracts from my 2020 Master's thesis, which is a case study based on a two-year training psychotherapy with Ray, a client diagnosed with Narcissistic Personality Disorder (NDP) and Borderline Personality Disorder (BDP). In this therapy I endeavoured to use the principles of The Conversational Model (CM), and my thesis aimed to prove that the CM was an efficacious model to use with this client. The client did improve in tangible ways.

I've selected some significant parts of my thesis, including theoretical discussions about disorganised attachment, vulnerable narcissism and countertransference. These understandings underpinned my ability to make sense of the confusing and sometimes frightening events that unfolded in the therapy room.

The main section of this paper attempts to explain Ray's intense affective states and what it was like to be in a therapeutic relationship with him. I identify major principles of the CM and show how understanding and applying them helped me survive Ray's rage, contempt and despair. Looking back, I realise that I was totally unprepared for the world of pain about to be unleashed on me, but I also recognise that Ray taught me about the impacts of childhood trauma in a way that is forever seared in my memory.

The Psychodynamic Formulation

Ray was a 41-year old male who presented with a long history of psychiatric disturbance and therapeutic engagement. He described his problems as complex PTSD, "developmental arrest', severe depression and anxiety ("a backlog of fear deep inside me"), loneliness, lack of direction and meaning, inability to trust self or others, and detachment (dissociation). He stated, "I don't know what I like…I don't know who I am", "I can't accept my own reality". These statements described a severe disruption of self. Ray was frightened that the rage within him would manifest in hurting himself or others. He exhibited paranoia, obsessive compulsive and narcissistic traits, as well as poor emotional regulation and mood instability. He had a history of suicidal ideation beginning at eleven years of age.

A history of repeated childhood trauma resulted in and perpetuated insecure and avoidant attachment. He reported sexual abuse at the age of seven. Dysfunctional relationships in the family meant that Ray's mental health and developmental needs were poorly managed, and he encountered ongoing difficulties at school and with his peers, possibly worsened by severe social anxiety.

In addition to these ongoing difficulties Ray had recently been forced to leave a trauma support group after being a member for 14 years. This was experienced as re-traumatising, and he was having difficulty managing his rage, resentment and hurt, which manifested in long, violent monologues laced with malice and threatening language. Soon after therapy began Ray sustained a debilitating injury and was evicted from his home of 10-plus years. These incidents triggered murderous rage, despair and hopelessness.

His problems were perpetuated and maintained by his disorganised avoidant attachment style, which underscored chronic relationship difficulties and instability, and an inability to accept the help that he desperately craved. Relationships were a source of perpetual drama, triggering mood volatility. His erratic, shifting self-states and angry, threatening demeanour made interactions with others fraught and dangerous. He lacked a sense of personal safety and was aggressively defensive and avoidant at times. Mental rigidity marked by fixed ideas and paranoia signified a closed intrapersonal system resistant to influence and self-sabotaging.

These pathologies made Ray deeply suspicious of any "helper" and triggered passive-aggressive behaviour, causing difficulty in therapeutic engagement from the onset. His defensive closed mindedness (which served a protective function) made maintaining a sense of safe connection challenging for both me and Ray. However, he also demonstrated the capacity to show thoughtfulness and kindness and had a dark wit and metaphorical turn of phrase. His continued willingness to pur-

sue treatment was a positive trait.

From the onset of therapy, I realised managing my countertransference would be vital. The focus of therapy was to attempt to build a sense of safety and trust in the relationship, and the creation a template for working through difficulties and disjunctions together. Maintaining an attuned presence and withstanding Ray's rage, contempt and hopelessness were to be major challenges.

The evolution of disorganised attachment - "fright without solution"

The capacity of the infant to manage and cope with stress relies on attuned, regulating maternal behaviour (Hesse & Main, 2006). A frightened or threatened child turns to an attachment figure for reassurance and security; if the figure is itself the source of the threat, the child is confronted with a behaviourally and emotionally irresolvable situation, or "fright without solution" (ibid). These children become disorganized and disorientated under stress and no single behavioural strategy will suffice to relieve the threat; it becomes an enduring approach-avoidance bind (Holmes, 2004).

Frightened or dissociative (traumatised) parents may attack or threaten the child, or go into flight mode, which can be seen as frightened withdrawal from the infant. This behaviour correlates with dissociative behaviour in the child, the frequent outcome of which is infant disorganized attachment (Hesse & Main, 2006).

Ray, like all children, needed an external regulator, but his parents were dysregulated themselves. "Disorganised attachment offers no reliable comfort" (De Young, 2015, p. 49). Ray was alone with his distress, and he dissociated "in order not to feel the pain of self-disintegration with no hope of repair" (ibid). Disorganised attachment is a predictor of varying forms of psychopathology such as BPD (Hesse and Main, 2006). Affect and impulse dysregulation are sometimes seen as the core of BPD and are also major features of NPD; in BPD the individual switches from state to state depending on their relationship with the environment; or subconscious cues from others (Meares, 2012).

The Malevolent Transformation

CM theory defines repeated failures of attunement in interactions between mother and child (or therapist and client) as traumatic interpersonal disjunctions; Ray repeatedly experienced these relational blows from infancy. His mother, anxious and frightened by her child's distressed affect, which triggered her own trauma, could not attune to him and regulate hi (or her own) affective states.

When such disjunctions "are great and repeated, a prevailing attitude of hatred will develop (in the child), and with it low self-esteem"; this is called "the malevolent transformation" of traumatic experience (Sullivan, 1995). Fear of intimacy also arises from this process; the "tender emotions" cannot be shown by the child who, "lives among enemies". Powerful avoidance systems are built around the core of self and traumatic memories to protect against additional damage from the re-experiencing of trauma (Meares, 2012, p. 270). These avoidance systems become default ways of being (in relationship) and thus pathological.

The "malevolent transformation" protects against "the pain and anxiety of being rejected or punished for seeking what was not to be had"; if this was met by retribution, and reprimand, "that at least was under one's control" (Sullivan, 1995).

Ray stated that at around 9 years of age, after moving overseas and learning enough of the new language to communicate the basics, he stopped speaking English, the only language with which he could communicate with his mother. I hypothesize that this was one of the methods employed by Ray to limit the painful psychic blows that characterised their traumatic relatedness. It also feels like a violent act of self-sabotage designed to inflict pain (strike before being struck). I believe this adds weight to the idea that a malevolent transformation occurred; he developed a closed psychic system edging towards pathological narcissism as a survival strategy.

BPD and NPD; Underneath and Alongside

Borderline Personality Disorder is a narcissistic disorder in itself; forms of narcissism are fundamental driving factors in the defence of the self (Williamson, 2015). Stone (1993, p. 300) states that patients with psychopathy or antisocial personalities are "by definition self-seeking and contemptuous of others… therefore also narcissistic". He believes that the overlap between borderline and narcissism exists on a continuum from "BPD patients with Narcissistic traits" (less difficult to treat) to "BPD patients with Narcissis-

tic Personality and Psychopathology" (extremely difficult to treat) (Stone, 2003). By these measures Ray would be at the extreme end of treatability.

Kernberg (2009) saw BPD as the underlying formation and drive of NPD, believing that pathological narcissism develops later than BPD. Both disorders are driven by fear of re-experiencing the traumatic pain of abandonment and the terror of dissolution and display frantic efforts to preserve the damaged, fragile self. There is also the common pattern of unstable interpersonal relationships, "when the sudden switch is triggered, narcissistic specialness reverts to the Borderline self and narcissistic rage and contempt for the split-off (dissociated) self in the other" (Williamson, 2015).

I argue that in order to understand Ray, it was necessary to acknowledge and understand the overlap or fusion between BPD and NPD. Narcissistic traits were at the forefront of his personality and presentation, whilst borderline traits underscored it. He possessed the affective instability and dissociative self-states common to both disorders, as well as the chronic feelings of emptiness, inappropriate, uncontrollable anger, paranoia and chronic suicidality. Ray's narcissism seemed to be the first line of defence, protecting an extreme vulnerability to profound feelings of inferiority, worthlessness, emptiness and shame. Sadly, borderline traits exacerbated his instability and the intensity and intractability of negative affect.

Vulnerable Narcissism

Gabbard (1989, p. 293) describes the hypervigilant (vulnerable) narcissist as plagued by "painful internal experiences of vulnerability, inferiority, emptiness, boredom, fear and lack of self-confidence". This hypervigilance scrutinizes others for the potential to trigger one or more of these painful states; others are seen as dangerous, able to cause painful emotions. They are not to be trusted. A coping strategy is to hurt first by devaluation and attack (ibid). This was a characteristic of Ray's interpersonal style and affected all of his relationships, it seemed likely that others would have felt as I did, vulnerable to attack and frustrated by a feeling of relational "stuckness" or "groundhog day"; I felt that I had to endlessly prove myself to be trustworthy; I was always under suspicion.

A Closed System

Howell (2003) focuses on the relational and dissociative aspects of narcissism, describing it as "an inevitable result of trauma-generated dissociation", causing the breakdown of the interpersonal and intrapsychic mutuality of relationships. The sufferer can neither reflect on his or her internal world nor get their need for connection met in relationships. They are at the mercy of a closed psychic system that blocks personal growth and transformation, unable to interact in mutually beneficial ways with others.

This reflects the trauma of the infant, unable to develop an integrated self, trapped in traumatic consciousness and unable to get help and support from the outside (Howell, 2003, Meares, 2005). A closed system prohibits interpersonal intersubjectivity, the mutual recognition of separate, self-reflective and agentic selves. "Lack of awareness of one's impact on others characterises the closed system" (Howell, 2003, p. 55).

The idea of a closed system perfectly describes the terrible bind Ray was in, desperate for intimacy and connection, but unable to let others in and unaware of the painful and disconnecting effects of his words and actions. Interactions with Ray brought the notion of safe boundaries into the foreground early on in the therapy, and I had to negotiate to protect the safety of the therapeutic space by asking Ray to be very mindful of allowing his rage to spill out over me; personal attacks were not ok and made the therapy room unsafe. He understood and agreed with this and did manage himself better after this intervention.

Affect and the Principles of the Conversational Model

The CM is a relational process model, which aims to potentiate the emergence of self and to integrate into the self those unconscious traumatic memory systems that repeatedly intrude or overthrow healthy mental functioning (Meares et al., 2012, p. 7). Its objective is maturational. These core aims, and the principles of the model, guided my reflective thinking and interventions whilst working with Ray. I looked for the emergence of positive parts of Ray's fractured and fragile sense of self and tried to couple with and amplify those parts, hoping to provide space for reflection and growth.

Noticing fragments of positivity, however, was often impossible, particularly when Ray was triggered into traumatic memory scripts. In what follows I describe how Ray's trauma erupted into our conversations and interactions and the ways

this triggered strong countertransfence experiences in me. I briefly describe the way that CM principles helped me make sense of, and work with, my experiences in the therapy room.

Vignette: Contempt 1 (Listening)

One of the most confusing dilemmas for me as a therapist was Ray's insistence that he could not possibly be expected to look after himself on the one hand, and his contempt for anyone attempting to provide the care he craved. The grandiose part of Ray would argue that his trauma was so special it required the invention of a new therapy, anything less was contemptible. The vulnerable part felt the stinging shame of his neediness and raged against helpers, attacking them savagely. Ray regularly expressed his anger about the fact that a student (me) had been assigned to his case. He felt this was a sign that "the system" was destroying him by its neglect of his needs.

A core principle of the CM is therapist listening in a particular way to what is offered. Listening to the "music" of the words, seeking out the underlying affective tone helped me to stay connected to Ray, even when I felt that I was being attacked (Meares et al., 2012). Beneath his contempt I heard his painful desperation and sense of worthlessness- his deep fear that nothing could help- that he would be stuck forever in his rage and despair. His sense of time slipping away.

Vignette: Contempt 2: The Mincer (Choose What Is Most Alive, Affirm the Positive, Use of Metaphor)

Ray used the metaphor of the mincer to describe his treatment by therapists, health care professionals and society in general. A powerful and disturbing image, it captured his sense of being trapped in his trauma, it was killing him, no matter where he turned or what he did. It captured the powerlessness he felt, and the unshakeable belief that others were doing things to him, using him for their own purposes, betraying him, looking at him hatefully. Watching him die. It was a stark representation of the confusing polarities I was often confronted with in the therapy room, either profound helplessness and hopelessness or blistering contempt and anger.

Each encounter with a "caregiver figure" triggered Ray's early trauma (and expectational fields) around his original caregivers who, themselves dysregulated, consistently failed to attune to his emotional and psychological needs, sending him into the shame of his "badness"; the threat of being unseen, unvalidated, unlovable and totally alone was ever present. De Young's (2015, p. xiii) definition of shame is relevant here; "shame is an experience of one's felt sense of self disintegrating in relation to a dysregulating other".

Ironically, the metaphor of the mincer captures how I felt at times in the therapy room; like the one being minced. The image of the mincer was offered as a throw away remark, but it was a powerful example of Ray's vivid imagery and dark humour, which reflected positive and creative aspects of him. I used my curious delight in his mischievous creativity rather than responding negatively to the horror of the imagery. This demonstrates the CM principles of "choosing what is most alive", finding vitality amidst the deadness in the psychic life of the client and affirming the positive. Ray's humour and creativity were positive points of connection between us that I found a welcome relief. I hoped Ray could absorb my valuing him in this way.

The use of metaphor is another CM principle that allows each person to "show the shape of their inner experience", representing an "inner worldness" (Meares et al., 2012). Ray excelled at use of metaphor in the form of images and stories, and I always looked for the meaning of these windows into his inner world and used his imagery when an opportunity arose.

Figure 1. The Mincer by Jon Ellis

Paranoid Ideation 1: Vignette: The Wise King (Using Empathy)

Meares (2012, p. 268) considers paranoid ideas an aspect of the "malignant internalization" of traumatic experience; intrinsic to Sullivan's (1995) concept of "malevolent transformation" (discussed above). In Sullivan's system, "personality development is skewed around trauma, distorted by systems of avoidance" (ibid). Paranoid ideas are the manifestation of a triggered traumatic memory system; others are experienced as the original traumatizer. Paranoid ideas come with a paranoid stance that expects to be hurt again; this stance is strategic, protecting against intrusion and possible damage to "areas of psychic life that are highly valued and sensed as intensely personal" (Meares, 2012, p. 286).

Ray often repeated the story by Gibran (2016) about the wise and mighty king who was beloved by his people. One night a witch entered the city and poisoned it's only well. The next day all the inhabitants of the city (except for the King) drank from the well and became mad, and soon the people began to dissent saying, "The king is mad, surely we cannot be ruled by a mad king. We must dethrone him". That evening the king drank deeply from the well and then there was great rejoicing in the city because the king had regained his reason.

The story represents a profound paranoia around opening up to any new information or ideas that challenged Ray's thinking and behaviours; I imagine it felt terrifyingly intrusive. The idea of absorbing any information that therapists were trying to give him was consistently met with contempt or rage, which protected him from the shamefulness of needing others. Ray's rigid system of meaning, developed over many years, had an important function, it protected him from this toxic shame, which threatened to psychically annihilate him.

A core principle of the CM is the use of empathy (Meares et al., 2012). Attuning empathically allowed me to feel alongside Ray as a companion in the therapeutic endeavour, and to imagine the corrosive impact of a lifetime without the benefits of deep human connection, rather than focusing on the behaviours that made connection almost impossible.

Paranoid Ideation 2: Vignette: "Optimism Bias" (Notice Repetitions)

"Optimism bias" was a term I was to hear repeatedly during sessions with Ray, it represented "fixed ideas" in Ray's closed psychic system, other people cannot help, they will make things worse (Howell, 2003). Labelling therapist's positive reflections (hope) "optimism bias" allowed Ray to quickly deflect input that risked the triggering of fear or shame. He was paranoid that therapists were trying to inject him with "optimism bias", he felt assaulted and violated. Ray described therapists as "corrupt policemen", charged with caring and protection, but (in his experience) blaming, uncaring and dangerous.

When I suggested he'd felt "imposed upon" by therapists, he responded, "I've been outright betrayed". On another occasion he said of optimism bias, "you won't read in the Nazi literature that there's something wrong with thinking they are the superior race".

Denying the therapist pleasure from helping seems punitive and is a manifestation of a devaluing disorganised attachment style that rejects the efforts of helpers. Very early on in therapy I commented that although he felt consistently let down by therapists he kept coming to therapy. To this he replied, "when you say it like that, I feel foolish" and went on to rage about his father's physical abuse.

It was difficult not to feel the rage was directed at me. My validation of his perseverance was violently rejected; in shutting down my attempts to reflect back a positive attribute it seemed that he maintained an inner homeostasis.

The CM principle of noticing repetitions often alerted me to core aspects of Ray's psychopathology, prompting me to reflect on both the function of the behaviours (in maintaining homeostasis of Ray's closed psychic system) and the effects of the pathology on Ray's other relationships (Meares et al., 2012). Knowing this allowed me to choose to offer a different response, imbued with empathy rather than judgement and hurt.

Isolation and Loneliness: A Vignette: The Fisherman

(identifying the appearance of the traumatic system and the notion of transference)

Hobson describes isolation as "an abyss

of nothingness" lying "beneath a chaos of disconnected fragments" (Hobson, 1985, p. 270). He continues, "in loneliness we are inarticulate. There are no words. That is the agony" (ibid). Hobson connects loneliness and intense shame "…it is not at all acceptable to say, "I am lonely"" (Hobson, 1985, p. 268). If one can "speak out of" loneliness perhaps "our speaking will find an echo in the loneliness of another" (Hobson, 1985, p. 267).

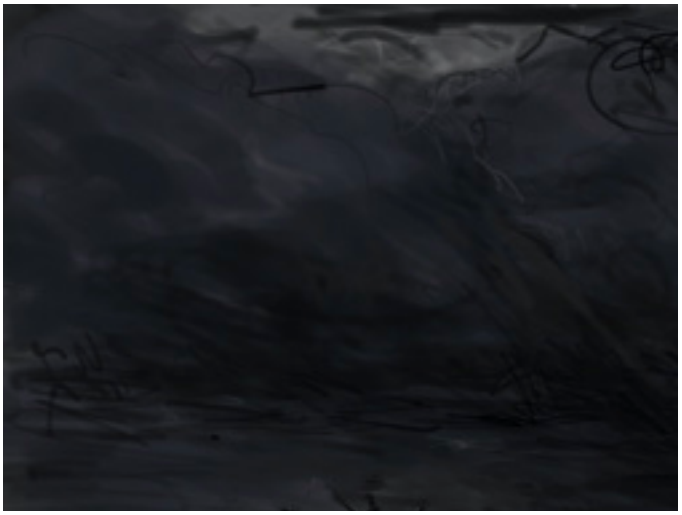

Figure 2. The Fisherman by Jon Ellis

Ray was a fisherman. There was no doubt in my mind he got some pleasure and satisfaction from fishing. He would tell me how he prepared and cooked the fish for his dinner; a new recipe he would try. Quite normal really; providing something alive that the attentive CM therapist could represent, opening up to the positive.

On one particular occasion I learnt that this was not to be. I reeled in shock as I was savagely punished after making a positive reflection about his fishing. Did I understand nothing about him at all? I was just like the other therapists that would tell him how lucky he was to have his fishing; we were all infected with optimism bias, a term Ray repeated again and again. In reflection I believe my positive reflection was felt as minimizing the severity of his condition; a gross lack of attunement, because for Ray, there was a deeper, darker meaning; fishing was a torment, a distraction, an irrational compulsive obsession, a pathetic substitute for life.

Alone in his kayak, late at night, he felt desolate isolation, hopelessness, and fear so deep that the spectre of death opened to him in all its horror.

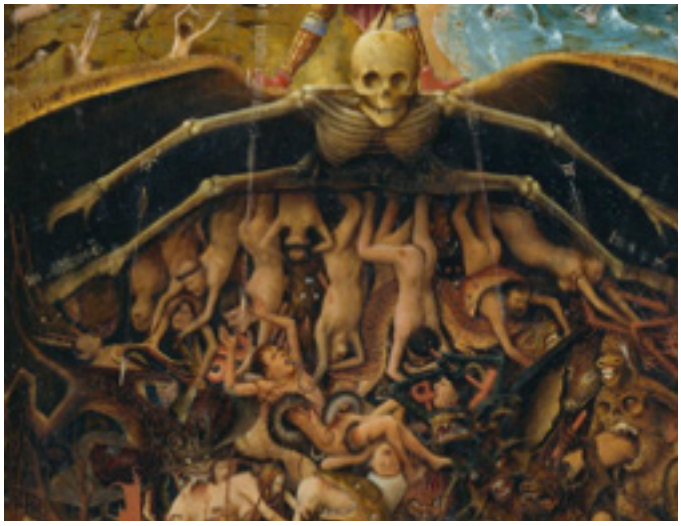

Figure 3. The Last Judgement by Jan Van Eyck

I felt burning shame when this happened, I was wrong; just another not good enough therapist.

In reflecting on this vignette, I applied the CM principle of identifying the appearance of the traumatic system and the notion of transference (Meares et al., 2012). Ray often spoke about fishing in a passionate way, and I was naturally curious and resonated with his enthusiasm. This particular occasion was underscored by a sudden shift of self-state to a traumatic memory system. Ray's posture and facial expressions changed, his mood suddenly shifted to anger and indignation, and his tone of voice lost its vitality, becoming deadened…callous. The life was sucked out of the room. I "became" the traumatising other and he the child suffering yet another demeaning relational "blow".

Understanding these self-state changes as the emergence of traumatic memory systems allowed me to understand my feelings of "not good enough" as countertransference and the whole vignette as an enactment.

Chronic Suicidal Ideation (Potentiating Reflection, Use What Is given)

Chronic suicidal ideation is one of Ray's most debilitating symptoms; the idea of not being began at about the age of 11. Bendit (2011) puts forward a theory that allowed me to understand suicidal ideation in a profound way; chronic suicidal ideation originates in the first 8 months of life, when babies have little control over anything

and no mental capacity to reflect on the past or the future. Babies are "in the moment", and therefore suffering is endless (Kendall et al., 2009, in Bendit, 2011).

In the situation of chronic parental non-responsiveness, the baby is stuck in an endless suffering that is recorded in implicit memory; becoming a core affective experience, impacting the ability to form and trust future relationships. Any future experience of intense emotional pain will trigger encoded feelings, actions and experiences (the internal working model) that says, this pain is unbearable, endless and there is no one there to help (Bendit, 2011).

Later, non-responsiveness by an emotionally important person can trigger these encoded feelings; hence adult relationships are fraught with painful reenactments. This vulnerability to minor events reflects the "exquisite sensitivity to abandonment" criteria for BPD, and can lead to the rise of suicidal thoughts, hence the chronic suicidality of the BPD client.

The brief piece of therapeutic dialogue I have chosen reflects Ray's chronic suicidal thinking. It is therapeutically beneficial for the therapist to convey (implicitly and explicitly) that it is acceptable and important to discuss suicidal thoughts and feelings; the therapist should adopt the stance of wanting to know and understand the experience of the client (Meares et al., 2012). By simply repeating Ray's words "It would be a relief" (using what is given) I signal my understanding and create a space where he can explore his thoughts more deeply. I implicitly convey that I will not abandon him in deep despair (aloneness-togetherness). I am demonstrating the CM principle of potentiating reflection, opening up a space for reflective capacity to arise (Meares et al., 2012).

Ray's response is full of sadness and linguistically somewhat disorganized, reflecting inner fragmentation, however he appears to feel relief, signified by the deep sigh.

Ray had a cancerous mole removed and I asked how he felt about this experience.

R: Well…you know…like…I mean it was a bit of a shock

CM: Yeah

R: (very softly, with sadness) …but I talked to myself that… in actual fact it would be a relief…

CM: It would be a relief…

R: Yeah...(silence for a while)…That way I wouldn't…yeah…I wouldn't have to go through the…trauma…and drama of…um…having to contemplate it either… the rest of my life myself… or have to actually go that violent way…do it myself…I thought maybe that's better.

CM: Mm…it would make that decision for you in a way…yeah…

R: Yeah… (deep sigh) …yeah…'cause I've been on the precipice for such a long time now on and off…

CM: On the edge… We sat in thoughtful silence for a while.

Shame

Nathanson (1992, p. 183) states that both narcissistic and borderline clients are "shame-bound people loaded with self-dismissal and self-disgust… their entire character …deeply entwined with…complex forms of shame…". De Young (2015, p. 49) links disorganised attachment with a core of shame "strongly laced with fear, panic and disorientation". Clients who have suffered severe relational trauma in their early development carry the risk of falling into "frightening, disorienting, self-shattering shame" (ibid). They may live severely constricted emotional lives in the unconscious hope that annihilating shame will not happen to them again (De Young, 2015).

Ray's shame was ever present in the therapy room. I learnt to equate his behaviours with how close our discussion brought him to his core of toxic shame; subjects that implicitly or explicitly triggered a sense of inferiority (e.g., school or tafe) created acute shame.

Rage- no one can be trusted

"At the extremes of these presentations are narcissistic patients who readily react to perceived slights with "self-righteous rage" and patients for whom shame is experienced or defended against in paranoid states in which others are seen as actively tormenting or accusing the self." (Zaslav, 1998, p. 155).

If something in the present moment, a look, a facial expression or a tone of voice triggers a

traumatic memory script, then particular (pre-determined) behaviours can erupt suddenly, heralding a shifting emotional self-state (this is characteristic of the BPD patient) (Zaslav, 1998). The Narcissistic patient, perceiving lack of adequate attention or support from the therapist, may experience deep feelings of emptiness and hopelessness, or, more typically for Ray, trigger volatile expressions of anger. Ray was acutely shame prone and held bitter, resentful feelings about his treatment at the hands of others over his life, parents, relatives, teachers, friends, society at large and particularly therapists. He was hypervigilant and paranoid about being mistreated or humiliated. He trusted no-one.

Countertransference

"The countertransference challenges posed by patients with narcissistic disturbances are extraordinary, and at times, perceived as unbearable to the clinician. The capacity to identify, understand, and contextualize these countertransference experiences is central to the effective treatment of narcissistic personality disorder." (Gabbard, 2009, p.13)

My countertransference undermined my confidence. Ray's chronic suicidal ideation created strong countertransference feelings in me, including terrifying feelings of responsibility for his survival, which literally kept me awake at night. My fear and anxiety could also turn to bitter anger. I felt manipulated, Ray seemed to toy with me, like a worm on the end of a hook, and this left me angry and resentful. My shame was triggered by feelings of failure; I could not "fix" Ray. Overcome with anger and hurt (why was he not grateful?), at times I fantasised about terminating therapy with Ray.

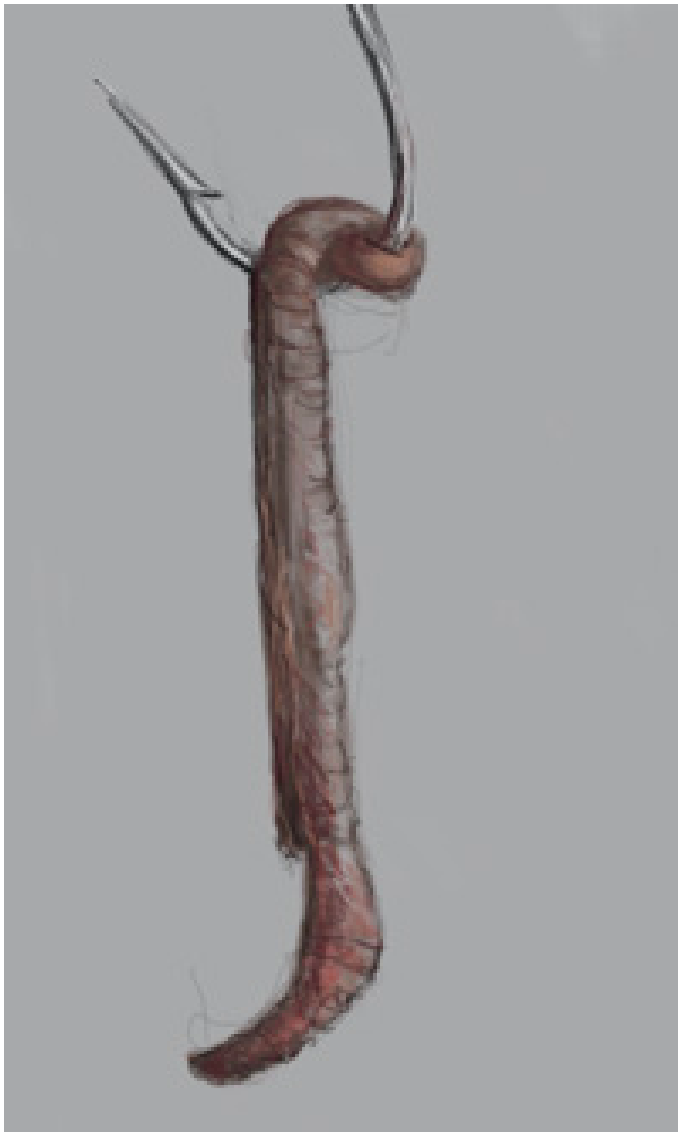

Figure 4 Worm on a hook, by Jon Ellis

The flip side was that I learnt that countertransference also gave me vital information and insight into Ray's traumatic past and helped me empathise with the pain and despair he felt. When I became an actor in his traumatic memory scripts and he played out the role of the aggressor, I felt the terror and despair of the abused child. I realised how terrifying these feelings must have been for the child who had no secure base, no one to turn to…no safety.

Gabbard lists countertransference responses as boredom, stating, "the therapist may feel ineffectual, colourless, invisible and deskilled" and "a sense of dread before sessions" (ibid, p.134). At times during the therapy, I feared our sessions, my sense of powerlessness was overwhelming.

Another marker of countertransference is subjugation (constriction) and a feeling of being under intense scrutiny from the hypervigilant nar-

cissist. This triggered a painful self-consciousness in me at times, and I sometimes dissociated due to overwhelming stress triggered by Ray's critical gaze.

Finally, and unsurprisingly Gabbard identifies feelings of being the object of contempt- 'of being devalued and criticized by the patient, accompanied by anger, resentment and dread in working with such patients" (ibid, p. 135).

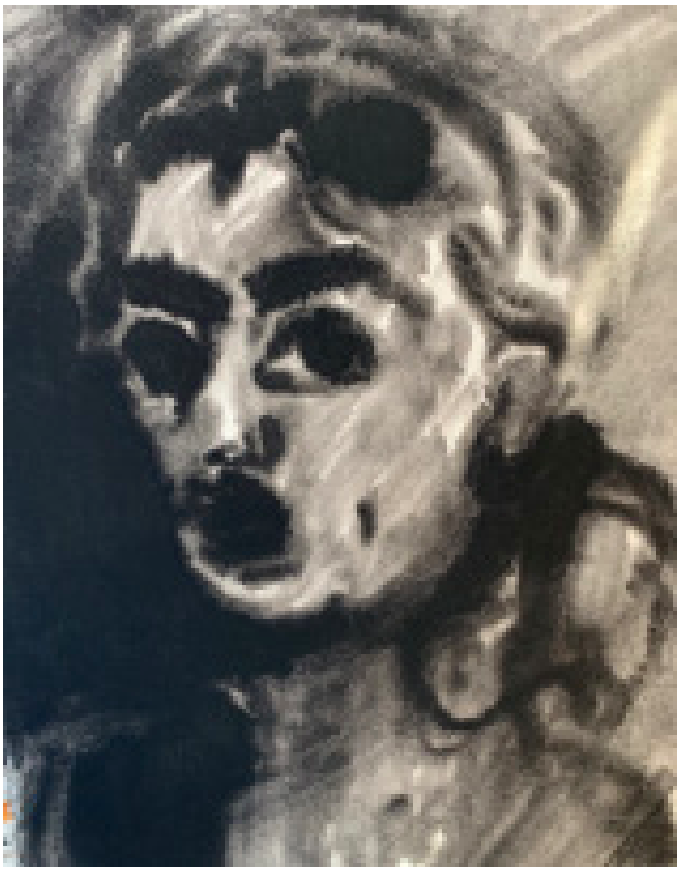

Figure 5. Self Portrait by Carol Marando

Supervision

Supervision with these types of clients is vital because of the overwhelming effects of the countertransference. The training therapist in particular is in danger of being taken hostage by these feelings, losing clarity and the perspective to make sense of what is happening in the therapy room. Supervisor support and encouragement is necessary as the novice CM therapist struggles to interpret the minute particulars, signifying the client's shift into traumatic memory script. Of particular importance to me was understanding how my lack of attunement created therapeutic disjunctions, and then talking through ways to repair the relationship. Supervision reminds us to continually go back to the principles of the model.

Therapy with Ray at times triggered my own traumatic memory scripts and I often used my personal therapy to work on my feelings of powerlessness; I learnt to name them and sit with them and realised that I was resonating with Ray's own sense of powerlessness. I had to learn to hold and contain myself so that I could be a stable, secure figure for my client. My anxiety was as destabilising for Ray as his could be for me; managing it was my constant work. Managing my expectations (of myself) was also important, learning to be satisfied with "good enough".

Summary

Vulnerable Narcissism and Borderline Personality Disorder can be seen as the result of repeated relational childhood trauma and frantic efforts to preserve the damaged, fragile self. The Conversational Model provides a deep understanding of the wide ranging and complex manifestations of trauma. In this article I have used attachment theory and Sullivan's theory of "malevolent transformation" to explain my understanding of how Ray's development was disrupted, and his current issues evolved. I speak to the profound challenges to the therapeutic relationship and describe how I experienced and made meaning of the extremes of affect that I was presented with when Ray's traumatic memory system (and my own) was triggered in the therapy room. I've explained how the principles of the CM inform and guide the therapist. The CM stresses the fundamental need for awareness of countertransference and supervision in order to comprehend the underlying relational dynamics at play.

The Protoconversation and the Conversational Model

Alyona Cerfontyne

"If you talk to a man in a language he understands, that goes to his head.

If you talk to him in his language, that goes to his heart."
— Nelson Mandela

Introduction

Around the age of 2-3 months infants and their caregivers, particularly mothers, increasingly start engaging in a turn-taking communicative pattern, resembling an adult-like conversation. Such interactions are known as protoconversation (Yoo et al., 2018). Assumed to be a part of the intuitive parenting program (Demuth, 2013), protoconversation is one form of play between the mother and the child, which evokes a sense of closeness and pleasure. This playful interaction, in which the mother responds to the baby's cues as if she understands them, facilitates a natural emergence of the positive sense of personal value, necessary for the development and evolution of self (Haliburn et al., 2018).

Self is a highly unique form of fluid consciousness that can only arise in harmonious relatedness with others (Meares et al., 2012). Self is not an inborn quality (Guthrie & Moorey, 2018) and cannot be developed in isolation. When a mother "echoes" infant's expressions either in vocalizations, words or movements, the child experiences a pleasurable state of being where the child's inner world is congruent with the world outside. Meares et al. (2012) call this experience a "fit" and highlight that "fit" is a whole-person experience with an enhanced sense of substance, personal boundaries, cohesion and rhythm. An emergence of self, therefore, requires resonance with an other. Just like an embryo's heart needs a structural and nurturing environment to develop a heartbeat, so self grows in a harmonious interplay with others.

The concept of self is one of the fundamental foci of the Conversational Model of psychotherapy. The Conversational Model, founded in memory research, linguistics, neurophysiological data and observations of clinical practice, emphasizes the human development process and the importance of the client's attachment and traumatic experiences (Haliburn et al., 2018). Typical activities of a mother in the protoconversation – coupling, amplification and representation – are performed by the therapist in this therapeutic approach, aiming to facilitate a reflective awareness of inner feelings and promote a heightened sense of self (Meares et al., 2012). However, therapeutic activity analogous to protoconversation does not just involve words, it also includes the tone of voice, the facial expressions, the movements of the body and the mother's/therapist's own feelings (Guthrie & Moorey, 2018). In this essay, I will reflect on these core elements of protoconversation, using vignettes from my clinical practice.

Movements of the Body

Yvonne came to the session in a visibly anxious state, tense, fidgeting and shaking. Without much smalltalk, she started to unload about the "mess her husband's affairs got her in". I tried to follow her story closely, using short verbal utterances and repeating affective expressions along the way, but it seemed as if Yvonne barely noticed them. Feeling like there was no space for me to say anything, I pushed myself through my own dissociation, relaxed and focussed on listening to Yvonne. When this shift happened, for some reason, my body started to swing back and forth, while I was nodding silently.

Yvonne spoke for two hours, with little pausing. At the end she felt drained, but lighter. I felt like she needed a hug, and, with consent, we hugged. Later, Yvonne told me that the night after our session, she was finally able to sleep.

Paraphrasing the Bible, I think "in the beginning was the Touch", as we all start experiencing the world around us through physical contact. Being held by our caregivers, especially our mother, is our first interaction with the world outside us and our first shared experience with another human. Protoconversation can also be a conversation without words, with mother-infant communication consisting of solely kinesthetic and tactile interactions (Demuth, 2015). For example, when a baby grasps her mother's finger and the mother gently moves it in response or when the mother follows the child's head movements with her own, a delicate, playful dance takes place between the

two. Such shared emotional experiences in which two people are together but recognize each other's individuality are called intersubjectivity (Markodimitraki & Kalpidou, 2019) and foster a healthy development of self.

The question of touch in therapy is a delicate subject, where the perceptions of both client and therapist need to be considered to avoid boundary violations and disturbance to the therapeutic relationship. In my clinical experience, I recall more often incidents when female clients, moved by a feeling of relief or gratitude, spontaneously hug me at the end of the session. However, sometimes I sense the client's need for a hug – as in the described situation with Yvonne.

While touch can be both therapeutic and disruptive, the coordination of client's and therapist's bodily movement, called nonverbal synchrony (Ramseyer & Tschacher, 2014), has been found to create an atmosphere of emotional connection during sessions, improving the therapeutic alliance and leading to better therapy outcomes. Often, while listening to my clients sharing highly emotional stories or being in distress, I notice how I start to sway my body. Sometimes I swing side-to-side, as if I am rocking myself. Other times, it is a back-and-forth motion. This expression of emotion through motion, known as embodiment (Ramseyer & Tschacher, 2014), can "speak" understanding and attunement "louder" than words. Further, facilitated by mirror neurons, the therapist's body movements can be used for emotional regulation during highly activated phases in therapy (Ramseyer & Tschacher, 2014). Reflecting on Yvonne's session, I wonder if my body rocking resonated with her more than any words could? She has been lied to by her husband and words meant very little in her current inner world.

Facial Expression

Teena sees me for her marital issues that started after the passing away of her mother. In our session, Teena is sharing with me how she always wanted her mother to have soft pink hair, but her mother wanted her hair "just like the other ladies at the bowling club". Teena talks in a matter-of-fact manner, with little emotion. I listen to her and try to add some affect-laden words, such as "difficult", "sad", "hard" to our conversation. Teena seems to ignore them and switches to talking about her husband.

Somewhere half-way through the session, instead of verbally responding to Teena, I just sit there and think how the death of her mother might have felt for her, looking at her. "What's that face?" exclaims Teena, trying to make a joke and get me to change my facial expression. I can see how my thoughtful and somewhat solemn face has shifted something in her.

At the beginning of the second month of life, infants develop an ability of face perception, which leads to recognition of the mother's face and longer and more intentional mother-infant interactions. Such interactions typically consist of mutual gazing, cooing and, when the mother shows adequate affection, smiling (Wörmann et al., 2013). The nature of these imitative interactions is primarily emotional (Markodimitraki & Kalpidou, 2019). It is important to note that, in a protoconversation, the mother's face is more than a mirror of the baby's face. Her face, an analogue for the infant, the infant's representation, amplifies what the child presents and expresses a deeper understanding of the baby's experience (Meares et al., 2012). In the example above, my face probably expresses more than Teena is sharing. It is possible that I was able to amplify her unspoken feelings of sadness and grief related to her mother's death, creating an emotional shift and a stronger feeling of relatedness.

Further, Teena's attempt to shift the mood into a more positive state aligns with a common pattern in emotional attunement in mother-infant exchanges. Studies found that babies tend to regulate the mother's descending affect by ascending in their own (Kokkinaki et al., 2017). A possible explanation lies in the attempt to avoid the breakdown of communication and a sense of interpersonal disconnectedness (Kokkinaki et al., 2017). Connecting this mutual emotional regulation to the concept of self, I also wonder if the mother's downward

affect is disruptive to the pleasurable sense of self that a child experiences in happy attunement with the mother. If Teena, for example, was feeling good finally being able to share her story with me and was enjoying our session, my thoughtful solemn face could have disrupted that positive feeling.

Tone of Voice

Exhausted as after a long, labour-intensive day, Jacinta finally finished telling me her story. It has been close to 90 minutes of horrific details surrounding the death of her sadistic father and abused to the state of muteness and extreme fragility mother. The story came out as a flood, with me, the therapist, simply providing the riverbed for the flood. I barely said or asked anything the entire session, and just kept swinging back and forth and humming as Jacinta was talking. Our time was up, and Jacinta looked at me, fully composed, fists clenched and back straight, like a soldier who just won an important battle. She did not cry at all.

J: I think this is it. I thought I would cry but I did not. Quite difficult to hear, right?

T: That's ok, that's what I am here for…[after a pause, in a gentle, soft voice, leaning closer to Jacinta] How are you feeling now?

J: You see… when you talk to me like this, this is when it really gets to me… and I want to cry… [tearing up]

Human babies learn to recognize the mother's voice before they are born (Sai, 2005). From birth, they continue to develop an ability to modulate the middle-ear muscles to recognize human voices (Porges, 2011). Cross-cultural studies have demonstrated that the mother's voice shows the same characteristics in different languages. Slow tempo, repetitiveness, exaggerated intonation, higher pitch and vowel elongation are features of the mother's talk during protoconversation (Demuth, 2015). In the vignette with Jacinta, however, it appears that not these qualities of my voice, but a caring emotion expressed in it touched her. Maybe she suddenly allowed herself to feel a tiny bit of grief in that moment? Or experienced empathy and connection she has been deprived for most of her life? Or maybe my sad but caring voice resonated with how she felt for her late mother, who perished under the abuse of her husband? Whatever the right answer might be, the tone of voice mattered.

Interestingly, there is emerging research distinguishing two types of interactions during a protoconversation. Early on, infants produce both speech-like vocalizations (protophones) and cries as signs of distress (Yoo et al., 2018). Caregivers intuitively recognize protophones as speech even when the sounds are far removed from speech and respond to them in a turn-taking manner. Cries, however, are recognized as signs of distress and are responded to in an overlapping manner with an attempt to sooth, not to engage (Yoo et al., 2018). This overlapping pattern is sometimes called protosong and is typical of many non-Western cultures as the main protoconversational pattern (Demuth, 2013). Translated to therapy, it is possible that a therapist may need to recognize these two states in clients – a storytelling, more present state and an emotional cry masked as a story – to respond adequately. Jacinta's story, like the one of Yvonne, could be a "cry" - and she needed soothing rather than coupling and amplifying typical of a speech-promoting protoconversation. As Yoo et al. (2018) note, cry sounds are not the potential material for speech and, therefore, should not elicit alternating caregiver vocal responses typical of a protoconversation. Whether alternating or overlapping, the tone of voice used by the therapist to stay close with the client's emotions is an important element of the Conversational Model (Meares et al., 2012).

Words

Imogen, an aspiring psychology student, is telling me in her first session how her boyfriend Mitch can be quite nasty to her.

I: His behaviour is just not on sometimes…

T: Not on?

I: Yes, he can be quite… sinister.

T: Sinister? [amplified and somewhat concerned]

I: Now that I hear you say that I guess that's too harsh. No, not sinister… just hurtful. I know he does not mean it. He just never learnt how to be affectionate.…

T: Never learnt how to be affectionate?

I: Yes, his dad left when he was one.

That's how I learn that Mitch has a difficult child-

hood history with his father leaving when he was just one year old and his mother, probably feeling guilty, rarely contradicting and disciplining him.

The above transcript is an example of a therapeutic protoconversation, in which the therapist focuses on the client's affect-laden verbal cues. By taking turns and staying closely with what the client is sharing, the therapist attempts to create an intimate experience shared and felt by both people in their own individuality. The term aloneness-togetherness (Barkham et al., 2017) is used to describe such therapeutic interactions. The primary goal of such interactions is to connect and build a therapeutic alliance with the client, by creating a feeling of being understood. Just like a caregiver in a protoconversation shows investment in the relationship with the infant by engaging in the infant's vocal explorations (Yoo et al., 2018), so does the therapist by responding to the client's verbal cues.

Responding in the client's language may also create a natural rhythm in the conversation familiar from mother-infant interactions. Cross-cultural studies have shown that caregivers typically respond to their infants' vocalization within one second from the vocalization offset (Yoo et al., 2018). As it typically takes around 600ms to produce a single word (Yoo et al., 2018), using the language already "produced" by the client" helps the therapist to respond within the "natural" one-second interval.

Picking up cues and using the client's language not only promotes "bonding" between the therapist and the client (Meares et al., 2012), but also facilitates a cocreation of shared reality that can be jointly explored. Like in this vignette, drawing the client's attention to the spoken word "sinister" results in a correction to the client's perception of her boyfriend and promotes a richer exploration. As in the Biblical story, the therapist helps the client to "separate the wheat from the chaff". As a result, the person's sense of self may be experienced as clearer, more homogenous and harmonious.

In this essay, I have attempted to reflect on protoconversation within the context of the Conversational Model using vignettes from my clinical practice as illustrations. Therapeutic protoconversation, like the one taking place between a caregiver and a child, is not limited to words or vocalizations. It also includes embodiments, facial expressions, tone of voice and the therapist's own feelings. Oftentimes, these elements of protoconversation appear to be more powerful and resonant than the use of verbal language. Just as turn-taking interactions between a caregiver and a child promote social engagement and development of self, so these protoconversational techniques can be applied in therapy to stimulate a heightened, more congruent sense of self, synonymous with well-being.

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FILM REVIEW

NOMADLAND/ON TRANSIENCE

The Eternal Nature of the Ephemeral

Brendan McPhillips

Cultures are strange animals. When everything is humming along nicely it is as if their values and habits and ideas and behaviours are immortally shaped. It's always been this way, and always will be this way. Only when this supposedly solid tectonic plate gets ruptured by something so vast that the centre can no longer hold do these values, habits, ideas and behaviours get shown to be ephemeral constructions vulnerable to change.

The 2020 film Nomadland is based on Jessica Bruder's 2017 book Nomadland: Surviving America in the Twenty-First Century. Bruder spent time with those displaced by the upheaval following the 2008 financial catastrophe. They could only afford to live in their vans, and, travelling from place to place, formed a community of sorts. Although the film is fiction, most of the characters are the actual nomads from the book. Unable to be predicted by the makers of the film, it was released last year when the world was again facing a civilization-disrupting catastrophe.

The interweaving of fiction and reality to help us deal with times of catastrophe is not new. Freud had a stab at it in 1916 with his short paper On Transience. The War was two years into its generation-murdering progress, and his three sons, Martin, Oliver and Ernst had all been drafted. Importantly, although Mourning and Melancholia was not published until the following year, it was finished two months before On Transience, and Freud clearly refers to the concepts he developed. He begins with a purported event that had occurred just before the War broke out:

Not long ago I went on a summer walk through a smiling countryside in the company of a taciturn friend and of a young but already famous poet.

The poet laments that he can never value beautiful things such as are before them in nature because they are all to pass away. Freud rails against him:

On the contrary, an increase! Transience value is scarcity value in time. Limitation in the possibility of an enjoyment raises the value of the enjoyment. It was incomprehensible, I declared, that the thought of the transience of beauty should interfere with our joy in it. As regards the beauty of Nature, each time it is destroyed by winter it comes again next year, so that in relation to the length of our lives it can in fact be regarded as eternal. The beauty of the human form and face vanish for ever in the course of our own lives, but their evanescence only lends them a fresh charm. A flower that blossoms only for a single night does not seem to us on that account less lovely. Nor can I understand any better why the beauty and perfection of a work of art or of an intellectual achievement should lose its worth because of its temporal limitation.

This seems hardly like the Sigmund 'normal-human-misery-is-the-best-we-can-hope-for Freud we have come to know and love. But Freud himself has more to say about transience, and there is more to this than perhaps even Freud, himself, is aware.

I'm not sure if she read On Transience, but the actress, Frances McDormand, certainly read Bruder's book, and, inspired, approached relative newbie film maker, Chinese-American Chloé Zhao, to write, direct, edit and produce the film. Her previous films, Songs My Brothers Taught Me and The Rider, which also cast non-actors, had certainly been noticed: of The Rider, a semi-documentary about a cowboy who suffers a head injury after being thrown from his horse, Peter Keough of The Boston Globe wrote: "[The film] achieves what cinema is capable of at its best: It reproduces a world with such acuteness, fidelity, and empathy that it transcends the mundane and touches on the universal." Such might be the judgment of Nomadland. Certainly the judgment of the Academy garnered it Best Film, Best Director and Best Actress (McDormand). Newbie no more.

For a film about poverty, loss and the vast nothingness of America's west, Nomadland is so rich, so mythic, and so full of poetic allusion that it is hard not to think there's something about poverty, loss and emptiness that we've all been missing.

It opens with a statement of actual, real-life fact: because of reduced demand the Gypsum factory

in Empire, Nevada closed on the 31st of January 2011. As there was no other reason for the existence of the town, the zip code has been discontinued. Perhaps not quite salt ploughed into the earth of Carthage, but an end with no hope of resuscitation. It might be fact but already 'Empire' suggests a mythic landscape. Suggests destruction. Suggests transience. Suggests Ozymandias. Nothing lasts no matter the rhetoric.

It is mid-winter. Fern (McDormand), a 60-something year old women is going through boxes in a storage facility. It is bleak, desolate, with patches of snow on the ground. She picks up a jacket and is near to tears. It is now night. In her van she approaches a camping ground; we notice a wedding ring. She is quietly, almost distractedly, singing What Child is this? the 19th century Christmas carol set to the tune of Greensleeves. At the reception desk it seems that there may have been a mistake in her booking, and, indeed, there is no room at the Inn. But Fern clarifies that she is with the Amazon CamperForce. Yes, there is room.

As with much of this film, what is portrayed is real. Amazon has set up vast distribution centres that are staffed by itinerant workers. This is the real promotion:

The Amazon CamperForce program brings together a community of enthusiastic RV'ers for seasonal workamping job opportunities. Come help make our Amazon customers smile by working in one of our state-of-the-art fulfillment centers. You could be picking, packing, and shipping customer orders in a highly technological and safe work environment. All it takes is applying, reserving your own campground spot, showing up and making history!

The next morning Fern and others are inducted by a bright, smiling team leader, and she starts packing boxes in a Valhalla-sized building. Maybe not bright and smiling herself, she is, nonetheless, efficient and seemingly content. Over lunch, in the Valhalla-sized cafeteria, she begins to meet other workers who also live in their vans at the camping ground. Amazon is not wrong – a community begins to form. She meets Linda May, one of the main characters in Bruder's book. Fern shows Linda May how she has made the most of the small space inside her van. How she has found a secure place for the crockery set her father gave her on her 18th birthday, a set he had collected by scouring garage sales and stores until he had every piece. How she has called her van 'Vanguard'. There is no sentimentality here; just how to make a life with very little, and staying constantly on your toes. She goes to sleep with a Santa Claus light beside her.

As some reviewers of the film have pointed out, Amazon might be 'state-of-the-art, but is far from being squeaky clean regarding its treatment of these itinerant workers. The internet reveals a less-than-optimal attitude toward those hurt while doing their job: Bezos' billions don't come from a personal care for those earning it for him. However, the plight of these workers in the face of capitalism and its discontents is not Zhao's focus; there is no us versus them morality infusing the film. Indeed, if there is a criticism of the film, and it would be a small one, I feel that sometimes there is a slightly-too-conscious anti-Hollywood sentiment operating. One scene has Fern taking an abandoned dog to the campground office. The woman at reception asks Fern if she could take it. Not without compassion she says no, walks away, and doesn't return. We watch the dog whimpering. Hard to see Spielberg leaving it there.

To my mind there are two key scenes that, for all their ordinariness, or perhaps because of their ordinariness, define Nomadland. The first occurs in a supermarket. Fern is shopping. A woman and her two daughters greet her. Clearly they are good friends. The woman, concerned about her friend's plight, tells Fern that they have a spare room in their house, and she is very welcome to stay. Without angst Fern declines, saying she is doing well. One of the daughters has been tutored by Fern. She asks the girl if she remembers the speech she taught her. She does, and recites:

> To-morrow, and to-morrow, and to-morrow,
>
> Creeps in this petty pace from day to day,
>
> To the last syllable of recorded time;
>
> And all our yesterdays have lighted fools
>
> The way to dusty death. Out, out, brief candle!
>
> Life's but a walking shadow, a poor player
>
> That struts and frets his hour upon the stage
>
> And then is heard no more: it is a tale
>
> Told by an idiot, full of sound and fury
>
> Signifying nothing.

Macbeth has just found out that his wife is dead. Bad as they both have behaved, here is a human being stripped bare; a human grief without the frills. Utter emptiness and a great, yawning abyss of deluded nothing. We don't yet know it, but Fern's husband Bo has recently died of cancer. Perhaps in this vale of tears we do just make up jejune stories of an afterlife and a resurrection to get us through the bleak truth that all is dust.

The Amazon 'season' ends, and Fern is out of work. For her, being older, there is nothing. She takes up Linda May's offer to travel south where it is warmer to a community led by Bob Wills. In real life Bob does provide a focus for people wandering across American, living on the edge. His own edge, he tells Fern later in the film, is the death of his son from suicide five years ago:

How can I be on this earth when he's not. Those were hard, hard days. I felt I could honour him by serving and helping people. There's a lot of people who don't get over grief and loss, and that's ok … you will meet Bo again.

Around the campfire they tell their stories of wounding and loss, and of how getting in their van and travelling the road has been their salvation. There are lectures on how to manage the toilet cans inside the vans; a place to barter goods where Fern meets Dave (David Strathairn); a hall for dancing where Dave asks Fern to dance. The song is Let's fall in love again, so things can be the way they use to be.

The community 'season' ends for another year, and everyone leaves except Fern and a woman called Swankie. Daring to disturb Swankie who puts a pirate's flag on her van when she doesn't want to be disturbed, Fern knocks and tells the irate woman that she has a flat tyre and needs a lift to town. Swankie doesn't pull any punches: 'You're van's ratty, and you need to get it fixed. You can die out here'. As it turns out, Swankie herself is dying. Small cell lung cancer has metastasized to her brain, 'and I'm not going back into hospital'. Instead, armed with Jack Kevorkian, she is going back to Alaska to see again the place where swallows' nests are built into the side of a cliff next to a pool of water:

It looks like I'm flying with them … I had thought that if I could die at that moment my life would be complete right then.

Zhao's direction and Joshua James Richards' cinematography are what fashion the deep poetic and mythic 'feel' of this film. There are long sequences of America's open plains with a single road winding across. The other element that takes us into an otherworldly realm is the music of Italian composer, Ludovico Einaudi weaving in and out. To be honest I'm not a particular fan. Wikipedia describes his style as 'ambient, meditative and introspective'. To my ears, on a good day it does do that, but on a bad it is saccharine. In Nomadland (and also in The Father, that other great film this season of loss) he is having a good day. The three elements work together to take us into states of reverie where timelessness rules, where there is no to-morrow nor yester-day. And not just in scenes of Fern on the road. In her van she pulls out pictures of Bo when he was young, and they were both young. Zhao lures us into meditation, and then, without warning, she snaps us back. In a bar, while the pianist is playing a song to Friends who had to go away, she tells friends still with her:

It got so bad at the end that I just wanted to put my thumb on the drip to let him go … he could've gone sooner without pain.

There is a counterpoint here: image and story form patterns of the finite and the infinite. Fern goes to an ancient rainforest with great fallen trees. In a pool in the forest she floats naked in the shape of a crucifix. With Linda May she gets a job in Badlands National Park (which can only be a homage to Terence Malick, with whose films, including Badlands, this has so much in common). They help with a birthday party for a 12 year old girl; they pretend to be in a beauty salon with facial packs and cucumbers on their eyes. Time ain't going nowhere except forward.

All this time there is a story being built of Fern and Dave. He has a job as tour guide in the park. She goes with him and a group to old and strange rock formations, originally volcanic, but weathered over time into a vast maze. Helping her clean her van, he accidentally drops the box containing her crockery; we watch her gluing the pieces back together. Now working together in a restaurant at a town called Wall Drug they go to look at the stars. The guide tells them to open their hands:

Atoms from these stars are in your hands

Dave photographs Fern beside a vast, replica dinosaur. They laugh with each other at the reptile park as a crocodile lunges at a fish being held by a Wall Drug's version of Steve Irwin. Fern pushes Dave:

He wants you next

Dave's son turns up. There has been an estrangement, but now his girlfriend is pregnant and he wants to be reconciled.

Will you come with me, Fern?

I might drop by some day, Dave.

Another day, another job. A potato processing plant. Fern gets an email from Swankie. Attached is a video of the swallows. Another day, another road. It's freezing again. Parking for the night she's told to move on. The van won't start. At the mechanic's:

You should sell it. It will cost more to repair it than it's worth.

I can't. You don't understand … it's my home.

Fern contacts her sister for the money. She travels to where she lives. It's suburbia-central and her sister is settled-down-with-my-real-estate-husband-central. The sisters talk. It becomes clear that Fern left home as soon as she could, married Bo, and lived in Empire all their married life. Now Bo is dead and Empire no longer exists, her sister wants her to stay:

No! I can't live here!

You left a big hole by leaving Fern!

Suddenly we are on the street standing back from Fern and her sister. It is early morning. They embrace. Fern walks away to the right of the screen. We have returned to her walking away from the dog. She won't be back.

And so to the second key scene. Earlier in the film Fern is approached by a young man, Derek, who asks for a cigarette. She gives it to him along with a lighter. A small encounter of many, many small encounters. But this one is different, though not obviously so at the time. Travelling again she again comes across him. He is sitting on the ground playing a guitar. He gives her a lighter – he'd remember her generosity and she is moved. Fern asks if he's got a girl. He hasn't, but there is someone he likes, though he doesn't know how to talk with her. Fern asks if he's tried poetry. He hasn't. She suggests one she spoke as her wedding vow:

Shall I compare thee to a summer's day?

Thou art more lovely and more temperate:

Rough winds to shake the darling buds of May,

And summer's lease hath all too short a date:

Sometime too hot the eye of heaven shines,

And often is his gold complexion dimm'd;

And every fair from fair sometime declines,

By chance or nature's changing course untrimm'd;

But thy eternal summer shall not fade, nor lose possession of that fair thou owest;

Nor shall Death brag thou wander'st in his shade,

When in eternal lines to time thou grow'st:

So long as men can breathe, or eyes can see,

So long lives this, and this gives life to thee.

Whatever else Will Shakespeare's Sonnets are about, they demonstrate an obsession with time and its ravages that borders on the maniacal. It is hard to think of another body of literature that has itself as its own purpose; and that purpose being the preservation in time, until infinity might hit, of his love. And this, the eighteenth in the series of one hundred and fifty-four, being the most loved and the most beautiful, is perhaps the closest we might come as humanity to cheating loss.

Again entering in a scene that is mundane, the sublime inserts itself. And in so doing it gives the answer to the question posed by Macbeth's nihilism: if we are such fools as to believe that our lives have meaning and value, why bother with anything? The greatness of Shakespeare's answer here is, for me, that there is no appeal to a deus ex machina to save us from grief, no hope offered of an afterlife in which all loss shall be transcended. We, ourselves, can fashion the infinite. And fashion it we do, with Zhao's film being a perfect exemplar.

Nor was Freud keen on the idea of a deus ex machina, or any deus for that matter. Our happiness and our misery are a function of our psychic balance. Loss disturbs that balance, and it is this pain that explains to Freud the reluctance of his companions to embrace beauty even though it passes. He is aware that his words of encouragement quoted above have no effect on them. Freud concludes that they were both resistant because they could not bear the pain of mourning. But, while this is an everyday phenomenon, he notes that it is a puzzle to psychologists. The ego develops libidinal attachments to objects. When those objects are no longer present there is consequently room for another attachment. But this is not what happens. When we lose something or someone we

love we cling desperately to the memories, rather than being able to replace the lost object without effort.

However, it is not only people that generate attachment within us. There are also ideas and ideologies and ways of being that become adamantine. Wars, financial crises and pandemics have a way of disrupting these ideas and ideologies and ways of being such that they begin to seem less than rock-solid:

A year later the war broke out and robbed the world of its beauties. It destroyed not only the beauty of the countrysides through which it passed and the works of art which it met with on its path but it also shattered our pride in the achievements of our civilization, our admiration for many philosophers and artists and our hopes of a final triumph over the differences between nations and races. It tarnished the lofty impartiality of our science, it revealed our instincts in all their nakedness and let loose the evil spirits within us which we thought had been tamed for ever by centuries of continuous education by the noblest minds. It made our country small again and made the rest of the world far remote. It robbed us of very much that we had loved, and showed us how ephemeral were many things that we had regarded as changeless.

But Freud will have none of the melancholy of the two young people. Time heals all, and all will once again be well:

Mourning, as we know, however painful it may be, comes to a spontaneous end. When it has renounced everything that has been lost, then it has consumed itself, and our libido is once more free (in so far as we are still young and active) to replace the lost objects by fresh ones equally or still more precious. It is to be hoped that the same will be true of the losses caused by this war. When once the mourning is over, it will be found that our high opinion of the riches of civilization has lost nothing from our discovery of their fragility. We shall build up again all that war has destroyed, and perhaps on firmer ground and more lastingly than before.

A strange appearance again of Polly-Anna Freud, a side of himself by which perhaps even he was bemused.

Certainly not a bemusement that would have afflicted boots-in-the-mud Fern – could there be anyone less-Polly-Anna in this film – who appears at Dave's place. It is picture-perfect. His son and partner and their baby welcoming her, and Dave saying in so many words that he loves her and wants her to stay. She is tempted. She tells his son's partner about her home in Empire. How she would look out the back door and there was just

desert, desert, desert all the way to the mountains.

There is a wistful longing in this: could things be the way they use to be? At night there is a dinner. It is family and she is welcome to belong. She hums What Child is this? After dinner she watches Dave and his son play the piano together while a fire burns in the gently in the background. She is tempted. But in the middle of the night she goes out to sleep in the van, and early next morning leaves without saying goodbye. There is room at the Inn, but she doesn't want it. Instead she walks on a beach with wild wind and waves. This is her home.

As if to complete the cycle, it is Christmas again and Fern is back at Amazon. And then back with Bob Wills' community around the fire. Swankie is dead. Everyone throws stones in the fire with a memory. Fern says to Bob

My Dad use to say 'What's remembered lives'.

The cycle isn't quite finished. Fern is again at the storage facility in Empire. Going through her possessions she says

I don't need anything.

She revisits the now-dilapidated work-place. A tear, the second, forms as she looks at Bo's old work-station. Now at the house they shared, she walks through the empty rooms and opens the back door. There is the desert leading to the mountains. Now in her van, we follow Fern as she drives toward them. Swallows and mountains both partake of the infinite; that which is indestructible.

I said at the start of this essay that, like Nomadland, Freud's paper was an interweaving of fiction and reality. This is because, in a paper published this year in the International Journal of Psychoanalysis, the philosopher and psychoanalyst Jonathan Lear argues that, in relation to the walk in the country, the purported walk is entirely fictitious. Entitled Transience and hope: A return to Freud in a time of pandemic, Lear revisits On Transience to glean whatever wisdom Freud may have found as he himself was also struggling with a civilization-threatening catastrophe. There has been much speculation over time as to the identities of his two companions, with many concluding they

were Lou Andreas-Salome and Rainer Maria Rilke. Lear thinks the walk never happened, and that Freud made it up to work through deep psychic fracturing as a result of the War. He notes that the paper was written after the war had started. It had already caused immense destruction, and was not about to end any time soon. Freud admits that this caused a wound to 'our pride' as a civilization. Lear reasons that the wound was to Freud's own soul:

There is something personal here: not just that Freud is personally affected, but that

this somehow has to do with who he is. Freud is ashamed. He says that war "showed us

how ephemeral were many things that we had regarded as changeless". But that alone

cannot explain shattered pride. It must have been that he himself – and his intended

readers – were somehow invested, not just in these cultural achievements, but in their

being eternal or "changeless". The narcissism of this group seems to have been entangled

in an illusion that civilization is itself an endless journey – a long trip in a civilizing direction,

one that moves towards peace and mutual understanding, in which increased knowledge

is a civilizing force, and reason and creative art promote social and psychic harmony. On

this image, civilization opens indefinitely into the future and in the direction of the good.

It is in this context that we can understand what Freud means by war tarnishing the "lofty

impartiality" of our science. War does not show scientific results false, but it does destroy

the illusion that science facilitates peaceful progress for all; and it shows how science is

used to destroy civilization. Freud thus admits to a twofold illusion: first, that civilization

is an endless progressive journey; second, that by participating in that journey one can

take pride in oneself because one thereby partakes, as best one can, in something

eternal and good. Disillusion thus comes as a blow to Freud's sense of self. Shattered

pride means that he was implicated in the illusion – not simply because he participated in it, but because he identified with it.

What doesn't get articulated in Freud's paper, but does in Lear's, is that the struggle is not occurring between the disconsolate companions unable to bear loss and Freud clarion-call for the inevitability of transience and the certainty of civilization reviving itself, but, indeed, within the psyche of Freud himself. It is he who is ambivalent in the face of the destruction of values which he both held and championed. It is he who is wounded by the passing away of all the ideas that had seemed so certain. But, Lear says, Freud has also stumbled across the solution, or a solution of sorts, in his realization in both On Transience and Mourning and Melancholia that the process of grieving is finite. One does eventually, in the course of grief's normal progression, return to life. Freud does imply that this is a repetitive process, but not of the same ilk as the repetition-compulsion that characterises the Death Instinct. Lear concludes:

the world may overwhelm us, it may destroy us, it may eliminate any chance of happiness or psychic well-being, it may make us miserable for life. But if it does not, then it is characteristic of us that we respond to loss with pain and suffering but then tend in the direction of returning to life. The return is itself an expression of hope. We may not be able to say what we are hoping for – but in the broadest and most indeterminate sense, hope hopes for the good. So what we have here is a return of hope which is itself a hope for a return of the good. From Freud's point of view, this is who we are when we are doing well.

There is perhaps a strange mirroring in these two works, Nomadland and On Transience, that causes unintended reflections on the authors themselves. With Freud, in the face of the destruction of his ideals and the possibility that his sons could be killed, he constructed a fiction to work his way toward hope for himself. Chloé Zhao was born in China, schooled in England, and has subsequently lived in America, where she studied film-making. In 2013, during the filming of Songs My Brothers Taught Me, Zhao gave and interview to Filmmaker magazine:

It goes back to when I was a teenager in China, being in a place where there are lies everywhere.

You felt like you were never going to be able to get out. A lot of info I received when I was younger was not true, and I became very rebellious toward my family and my background. I went to England suddenly and relearned my history. Studying political science in a liberal arts college was a way for me to figure out what is real. Arm yourself with information, and then challenge that too.

Nomadland was doing well in China, and China was trying to claim Zhao for its own, when her 2013 comments were discovered. Since then, unsurprisingly, she has been dropped like a hot potato by official sites. Perhaps, as with Freud, the outer crises have led to her constructing a vehicle for maintaining hope and life.

FILM REVIEW.

THE BABADOOK

Psychological Horror

Australia

Director: Jennifer Kent

Netflix

Kim Hopkirk

I would never choose to watch horror. I'm not interested in being frightened, having the terrifying sensations of fear and adrenaline coursing through my body from deliberate actions of my own. But this is a genre that many people love. Some can't get enough of it, some say it makes their internal world make sense.

The Babadook came to my attention first through an adolescent with dissociative tendencies. She loved horror. Then my adult sons spoke of it in glowing terms. They wanted a family movie night, watching The Babadook together. I made sure I had their hands to grip onto, on either side of me, on the comfy lounge where I could thrust my face against a shoulder if it would prove to be too much.

The Babadook turned out to be an extraordinary movie to watch and I believe it visually represents the disintegrating of a mind, as well as the process of healing from the disintegration.

We meet Amelia (Essie Davies), who is single mother to Samuel (Noah Wiseman). Samuel is six, turning seven, and is intensely attached to Amelia. He is unable to make his own friends, and the viewer perceives him as odd and disturbed, as does his cousin and aunt. He screams, and insists on carrying around homemade weaponry and is fixated on magic tricks. Samuel was born under traumatic circumstances; his father died in a car accident whilst taking Amelia to hospital to give birth. Amelia was completely shattered by the loss of the love of her life, yet she attempts to get on with her life as a mother, and as a person.

We begin to see signs that Amelia is not managing. She is sleep-deprived, and she frequently has to deal with Samuel's night-terrors. He needs her embrace, but he grips her tight in a stranglehold of terror. Her frustration and her kindness compete with each other. She puts him to bed and she reads books to him to soothe him in the hope they can get a good night sleep. He finds a book on the bookshelf called "Mr Babadook" which is a pop-up book with frightening images. The book is about a supernatural and frightening entity called the Babadook who wants to be let in. This creature intrudes into this normal book-reading routine of their family life, and disturbs the loving bond between mother and child. Frightened by the book, and its power to disturb, Amelia destroys it. However, she discovers that you cannot ever get rid of the Babadook.

We then watch in horror as the disintegration of Amelia prompts Samuel to attempt to protect his mother whilst simultaneously terrified of the Babadook.

The film is moody and claustrophobic. The house is dark and depressing, with a sense of empty spaces and dark corners. It has a basement in which nobody goes into, and Amelia keeps her dead husband's things locked down there.

The Director, Jennifer Kent, cleverly doesn't allow the Babadook creature to take up much of the screen time, rather she focuses on the implication of the Babadook being present, for example, in the flip of a dark coat leaving the room. We hear sounds, yet they can all be explained. The director engages with the metaphor of darkness, just at the verge of our peripheral vision, so we doubt what we perceive.

As we watch Amelia's mind disintegrate, and the trauma turns up in full force, with all of its grief, fear, and rage, we witness the manifestation of the Babadook within her. As she unravels, we see Samuel getting a little more normal. He doesn't look strange, he is not behaving so oddly. He uses his magic skills and homemade weaponry to help protect his mother from the Babadook. Yet he too is terrified.

We catch the parts of Amelia's mind that was traumatised by the accident and the terrifying loss that she experienced that she has been so valiantly putting behind her. She attempted to dissociate the trauma of this loss by locking the dead husband in the basement so to speak. But we begin to see that she has all this rage, this resentment, indeed, this hatred, that Samuel is alive and her beloved is dead. Samuel had been enacting this hatred, he became the strange unlikeable child that no one liked. It seemed that there was unconscious pact that he would protect her from her feelings by being this disturbed and painful child. With her lack of sleep, and Samuel showing further disturbance, what had been dissociated was turning up. Turning up in the form of the Babadook. The Babadook had to be created to manage her frightening rage towards Samuel, and his terror of his mother whom he also has to protect. He takes his fantasy of being a magician seriously, he is a magician with magical powers of protection, and he adds weapons for good measure. But he does have an ally in the elderly woman next door, who loves them both, and he knows she will look out for him, but also his mother.

At one point, we see Samuel is thrown about by an unseen energy force. We know it is the Babadook, but we can also consider that it is the mother, in a dissociated state, who is throwing him about. After all, Amelia's voice does change into a deep and threatening male voice, and she does hold a knife to his throat. This is the cleverness of the film; we are left in doubt as to whether it is the Babadook, or is it her.

The performances of both Essie and Noah are extraordinary. Noah really embodies this disturbed, odd child who becomes more and more normal as the Babadook distorts his mother further and further out of shape. One feels so much for this child, trying to use magical abilities when actually he is little, and terrified of his mother. This exemplifies the frightening confusion of traumatic attachment systems. Essie Davies shows us a pained, fragile young woman just trying to get on with life, attempting to ignore her son's oddness while she shuts down her own traumatic loss.

The ending is an important and rich possibility of healing. However, on discussion blogs a lot of people were really disappointed by the end. I'm not going to reveal it, but for me, it held connection, inclusion, and not dissociation. I will leave it up to you to decide.

The film is a visual study of dissociation, trauma zones, traumatising attachment systems, enactments and reversals. I also think that the Babadook can turn up in any exhausted and distressed parent to a small, or large degree. The large degrees are when we see infanticide, infant's bodies in suitcases in a lake, and other such horrifying stories.

In small degrees, the Babadook has turned up in me, and watching this with my 2 adult sons gave the 3 of us a chance to be able to swap stories about when the Babadook turned up in me, as an exhausted mother, desperate for the child to stop screaming, to go to sleep, let me have some peace. I was able to find the language of the horror and the shame I felt that I had that capacity, and they had their own remembrances, for instance, me speaking in a voice that was not me. The Babadook gave us the visual language, and we were able to talk about it together without guilt, or shame, and it was deeply freeing and moving for all of us.

I am deeply grateful that my children asked me to watch it, and although that was never their agenda to reveal how I have been the Babadook from time to time in their lives, we can now speak with humour and deep understanding about these crazy parts that live inside of me, their mother. The movie entreats us to understand that these parts don't go away, and one cannot simply banish or disconnect from those most painful of feelings. Actually, they need a conscious place to reside within a person, and then they don't destroy that person, or those dear to them.

BOOK REVIEW

The Poet's Voice in the Making of Mind

Russell Meares

New York, NY: Routledge, 2016.

Acknowledgments, introduction,

references, and author index. 222 pp.

$33.56 paper. ISBN: 9780415572347

Terry Marks-Tarlow

The Poet's Voice in the Making of Mind tackles one of the most fascinating mysteries of all: how the human mind comes into being and what distinguishes it from our nearest simian relatives. The book sweeps across evolution and development at a dizzying pace, touching upon biology, philosophy, linguistics, psychotherapy, literature, human development, and neuroscience. Meares's through line is how the germ of mind gets planted in each child initially through play. The process begins with the earliest conversations between mother and child, when instinctively the mother sets up a kind of pretend game that is half real, half imaginary. Mother speaks to baby "as if " the infant understands; and through her words and coos, she pours hopes, dreams, intentions, and perceptions into the space between herself and the baby. Amazingly, from the start, baby does understand mother's love, her underlying intentions, and the nuances of her tone. Through this dialogue, a child slowly internalizes a mother's pictures of inner and outer worlds, eventually understanding even the content of her words.

Meares's primary thesis is that these early, playful exchanges between mother and child constitute the origins not only of a baby's mind, but also of what is uniquely human about our capacity to symbolize, including the full range of cultures across place and time. Within the alchemy of love and care for children, Meares asserts that the instinct to play brings the highest expressions of self—creativity and culture.

When we read a book, we not only read what the book has to say about the topic at hand, but we also read the personhood of the author. As if by osmosis, readers implicitly understand writers in much the same way that babies internalize the perspectives of their mothers. Such underground communication becomes especially pronounced in books with a well-developed perspective. The Poet's Voice in the Making of Mind is just this sort of book. Within a couple of paragraphs of the introduction, I began marveling at the mind of the man behind the words. Meares brings the passion, curiosity, creativity, and compassion of a psychiatrist who has scaled the pinnacles of the healthy, creative mind, yet who has also spent decades working with the broken minds of some of the most troubled, character-disordered patients of all.

This book embodies the spirit of its own argument in multiple ways. It seems also as if the reader enters into conversation with Meares by becoming privy to a succession of his intellectual and cultural mentors and heroes. These include William James, Robert Hobson, Ferdinand de Saussure, Hughlings Jackson, William Shakespeare, Lev Vygotsky, and Wolf Singer. Meares designs each page to evoke a feeling and picture rather than to analyze a topic or defend an idea. Each chapter represents the "doubleness" of real-imaginary by demonstrating how uniquely human aspects of symbol, metaphor, and creativity emerge within the fertile, ambiguous spaces existing between this word and that one, self and other, inner and outer, private and public.

The book is written in nontechnical language. Every chapter is unique and serves as its own stand-alone verse circling a central image. A story about a waving game with Meares's infant granddaughter becomes a teaching tale about perspective taking. Two ambiguous lines from a Shakespeare play launch the holistic potential of the human imagination. The book radiates out from the making of the individual's mind to ever wider spheres of culture.

In multiple ways, the arc from early to later conversations between mother and child resembles the arc created here between author and reader. The author writes as if the reader understands, by offering lovely metaphors and evocative images packed with meaning and associations. The writing is clear and minimalist; the imagery is compelling. Meanwhile, this stripped-down-to-its-barest-essence, minimalist quality is both the book's strength as well as its weakness. During my first reading, the sparsely fleshed out allusions

left my head spinning. I confess, this is exactly the feeling I get the first time I read a poem. The book, intended for a generalist audience, begs for a second reading, and even a third. Just as with poetry, there is more to appreciate with every pass. For, no matter what the occupation or background of the reader, with enough patience, eventually the reader does understand. Meares's brilliance is well worth fleshing out every word and connecting every dot. Through the poet's voice, the universe opens to its fullest capacity.

Encouraging Research in the Conversational Model

An initiative

Anthony Korner

The Conversational Model (CM) has always had an important grounding in research. It is an open model, recognizing the need to take in new information and make adjustments to theory in the light of new evidence. Moreover, the CM has endeavoured to minimise reliance on meta-psychological theories, rather emphasizing the need to look at the problems of psychotherapy in ways that could potentially be accessible to scientific investigation.

The model emerged in the context of Meares and Hobson working with patients that were considered 'untreatable' with psychotherapy. The outcome of this collaboration was a form of therapy that could be applied to patients that had been difficult to treat with conventional methods, who would now be identified as having Borderline Personality Disorder (BPD) or other severe Personality Disorders. Some would now be considered to have Complex Post-Traumatic Stress Disorder. The CM has since been evaluated for BPD and other patient contexts with a significant body of research supporting its use (Stevenson & Meares, 1992; Stevenson et al, 2005; Korner et al, 2006; Walton et al, 2020). The development of shorter forms of treatment based on the CM in Australia and the UK have provided more recent foci for research (Guthrie et al, 2001; Stevenson et al, 2019). It can be argued that the willingness of CM practitioners to engage in research, has been an important foundation for the success of the model.

With its emphasis on Self and forms of feeling, the CM also emphasizes whole-person responses in interaction with others. Self is a concept that has objective correlates with regard to autonomic activity and the central nervous system (the default network). This provides a potential avenue for research into psychotherapy process at an intersubjective level (Korner, 2015; 2021).

The second focus of the CM is that of Trauma. There is a burgeoning amount of research in this field, and there is increasing pressure to provide Trauma-Informed Care. The CM has been in the forefront of psychodynamic approaches that recognize the significance of trauma during development as well as throughout life. The emergence of Complex Post-Traumatic Stress Disorder as a diagnosis and the increasing number of diagnoses where trauma is recognized as a major factor reflect the need for continuing research in this area. In Australia, CM practitioners have made a significant contribution to the trauma literature through publications such as Humanising Mental Health Care in Australia (Benjamin, Haliburn, King (eds), 2019).

Trainees are encouraged to focus on, and write about, clinical experience in training. Research at the level of the single case and research referencing the experience of the therapist are frequent subjects for the treatises produced through both the ANZAP and Westmead Training programs. The model of the participant-observer (also the 'scientist-practitioner') is important to effective clinical practice. Practice-based evidence is considered to be of equal importance to evidence-based practice.

Psychotherapists tend to have a diverse range of interests. For some, research may extend to the arts and literature. Indeed, The Poet's Voice in the Making of Mind (Meares, 2016), reminds us of the connection between poetry and therapy. It isn't unusual in the human world, for artistic developments to precede scientific discovery.

It is in this light that we announce, in this issue of The Therapeutic Conversation (TTC), that ANZAP has made a decision to introduce a new avenue towards full membership of the organization. That is, the category of Research Member of ANZAP. This would be applicable to people who have trained clinically in the model, continue to have some clinical practice but whose work is particularly oriented to research.

It is clear in the current political climate, that there will be continuing pressure for therapies to be able to demonstrate efficacy and a developing understanding of psychotherapy process, in order to be able to meet demands for evidence-based practice. Continuing research in the field needs to be seen as integral to psychotherapeutic work. However, as clinicians working with the private, personal world of self, this research needs to include the voice of experience, extending to the lived experience and spiritual perspectives of both therapists and patients. We hope that TTC will encourage a diversity of research covering the range of experi-

ence that can be shared and from which we can all learn.

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The Therapeutic Conversation

Call for papers for Issue 3

The Therapeutic Conversation (TTC)provides an ideal opportunity for trainees and members of ANZAP and PITSIG to publish work relevant to the process of psychotherapy. Papers may be relevant to work with individuals or to promoting broad social cohesion and prevention of trauma. Work may have an objective, scientific style although there is also room for personal contributions, reflecting the individual voice, the perspective of lived experience and work that may draw upon literature and the arts or involve poetic expression.

Papers may be up to 5000 words in length and will be peer-reviewed. The peer review is designed to help authors develop their work further – we have a policy of constructive criticism.

The 3rd Issue of TTC will be published on Friday, 19 November 2021.

The due date for submissions is **Monday, 1 November 2021**.

Please contact Margie Darcy on Margie@Margie-Darcy.com if you wish to submit a paper.